ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028561
Case Name	TRAYLOR, RUFUS CHARLES v. YELLOW CHECKER CAB
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0335
Number of Pages of Decision	22
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Stephen Martay
Respondent Attorney	Jessica Bell

DATE FILED: 7/1/2021

/s/Maria Portela, Commissioner

Signature

21IWCC0335

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUFUS CHARLES TRAYLOR,

Petitioner,

vs. NO: 18 WC 28561

YELLOW CHECKER CAB,

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, employment relationship, notice, wage/benefit rate, causation, medical expenses and nature and extent, and being advised of the facts and law, affirms and adopts, with the following change, the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the Order section, on page 2, we strike the second sentence that begins with "The arbitrator further finds" and ends with "condition." We note that all other issues were moot due to Petitioner's failure to prove an employment relationship with Respondent.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 23, 2019, is hereby affirmed and adopted with the change noted above.

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.

July 1, 2021

/s/ *Maria E. Portela*

SE/
O: 5/18/21
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0335
NOTICE OF ARBITRATOR DECISION

TRAYLOR, RUFUS CHARLES Case# **18WC028561**
Employee/Petitioner

YELLOW CHECKER CAB
Employer/Respondent

On 9/23/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.87% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0264 HEYL ROYSTER VOELKER & ALLEN
JESSICA BELL
PO BOX 6199
PEORIA, IL 61601-6199

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

☐ 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

Rufus Charles Traylor
Employee/Petitioner

v.

Yellow Checker Cab
Employer/Respondent

Case # **18** WC **28561**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Peoria**, on **July 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/31/2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On this date, Petitioner ***did 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 $**0.0**; the average weekly wage was $**0.0.**

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 $**0.0** for TTD, $**0.0** for TPD, $**0.0** for maintenance, and $**0.0** for other benefits, for a total credit of $**0.0**.

Respondent is entitled to a credit of $**0.0** under Section 8(j) of the Act.

ORDER

The arbitrator finds Petitioner failed to prove an employee-employer relationship existed between Petitioner and Respondent on the alleged date of accident. The arbitrator further finds Petitioner failed to prove an accident and causation for his current condition. As such, 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

August 31, 2019
Date

ICArbDec p. 2

SEP 23 2019

Statement of Facts

Rufus Traylor ("Petitioner") filed an application for adjustment of claim alleging a work-related injury of August 31, 2018. The case appeared before Arbitrator Seal for arbitration on July 11, 2019 in Peoria, Illinois. At the time of hearing, a Request for Hearing was submitted as Arbitrator's Exhibit 1. Arbitrator's Exhibit 1 indicates the issues in dispute are employee/employer relationship, accident, notice, causation, average weekly wage, medical bills, nature and extent of the injury, penalties pursuant to Sections 19(k), 19(l), and fees per section 16.

At the time of arbitration, Petitioner testified that he worked at Yellow Checker Cab on August 31, 2018, and that he had been working there for about two and a half years at that time. Petitioner testified his job title was "driving a cab," and that his job duties were "driving." Petitioner testified he leased a vehicle from a location on Cass Street in Peoria, that Yellow Checker Cab owned the vehicle that he drove every day – but, he admitted that he did not drive the same vehicle every day. Petitioner testified that, while he drove a different vehicle every day, the vehicles all said "Yellow Checker Cab" on them. Petitioner testified "Yellow Checker Cab" set his schedule, and that he worked noon to midnight, six or seven days a week. (TT, pgs. 11-14).

Petitioner further testified that cab trips were dispatched through a tablet in the vehicle. Petitioner testified the tablet was owned by Yellow Checker Cab. Petitioner testified that he earned fares both through trips dispatched to the tablet and also through "flag trips" – the instance of someone simply flagging down a passing cab. Petitioner testified that he accepted cash and credit as payment for fares, and that the credit/debit machine for payment was provided by Yellow Checker Cab. (TT, pgs. 14-17).

Petitioner testified that, at the end of his "shift," he would "cash out" with the dispatcher, and that the money was split 50/50. Petitioner further testified he was "on a lease" and that he had to pay his lease payment

out of the money at the end of the night. Petitioner testified he was provided with a debit card by "Yellow Checker Cab," and that they would a percentage out of the card. (TT, pgs. 17-20).

Petitioner testified he was not permitted to smoke, eat, or talk on the phone in the cab, as prohibited by "Yellow Checker Cab owner." Petitioner testified the cabs he leased were insured by Yellow Checker Cab. He further testified that he did *not* receive a 1099 tax form from Yellow Checker Cab. (TT, pgs. 21-24).

On August 31, 2018, the alleged date of accident, Petitioner testified he leased a vehicle at 12:00 noon from Yellow Checker Cab. He transported a client to Bloomington. Upon returning from Bloomington, he was in an accident when he claimed a semi-truck stopped in front of him, causing him to spin around on the highway and hit a guardrail. Petitioner testified Yellow Checker Cab secured a tow truck to take the Petitioner and the cab he had leased back to Peoria. (TT, pgs. 24-28).

Petitioner testified he injured his back, right shoulder, and neck. He testified he experienced "dizziness in the head" as well. Petitioner testified he presented to OSF Medical Center on September 1, 2018, where he was examined, and diagnostic tests were done. He further testified he started treating at Tuttle Chiropractic Care on September 5, 2018. (Tt, pgs. 28-31).

Petitioner denied problems with his back, neck, head, or shoulder prior to August 31, 2018. (TT, pg. 31).

Petitioner testified that, as of the date of arbitration, he continues to experience problems with his back, shoulder, head, or neck. Specifically, he testified that he can't walk "as far," can't stay out for long periods of time when the weather is bad. His sexual life is "kind of messed up," and he is still in pain "every now and then." (TT, pgs. 32-33).

On cross-examination, Petitioner admitted he has a long history of driving taxi cabs, including leasing vehicles from companies other than Yellow Checker Cab. Petitioner admitted he has been involved in other motor vehicle accidents prior to August 31, 2018. On cross-examination, Petitioner again denied problems with his back, neck, or shoulder prior to August 31, 2018. Respondent introduced Respondent's Exhibit 9, records

from OSF Medical Center, wherein Petitioner presented for treatment December 7, 2017, following a motor vehicle accident, with complaints of neck and back pain. (TT, pgs. 35-38).

Respondent further introduced Respondent's Exhibit 10, medical records from Methodist Medical Center indicating that Petitioner sought treatment on March 9, 2009 with complaints of neck and right shoulder pain after hitting a pothole at the airport. Respondent's Exhibit 11 was introduced, revealing Petitioner's treatment at Methodist Medical Center on January 28, 2003 following a motor vehicle accident when he complained of neck pain. Respondent introduced Respondent's Exhibit 12, a medical record from Heartland Health Center from August 4, 2009, wherein the Petitioner presented to the emergency room complain of "significant pain" in both shoulders, neck, and middle back. (TT, pgs. 38-41).

Petitioner testified he could lease a vehicle for 12 hours or 7 days, but he never elected the 7-day lease. Petitioner admitted that he could take the leased cab wherever he wanted to wait for a dispatched fare – but, he denied being able to lease a vehicle and not pick up a single fare during a given lease term. On cross-examination, Petitioner admitted that he could choose to reject a job/fare that was offered through the bidding system and, in fact, that he did reject jobs. Petitioner later testified that he didn't reject "no trips." (TT, pgs. 41-47, 111).

Respondent introduced Respondent's Exhibit 2, a service agreement from Creative Mobile Technologies. Petitioner testified he was familiar with the agreement, agreeing that he signed the agreement in December 2016. Petitioner agreed that Creative Mobile Technologies is the company that provides the debit/credit card that the Petitioner used to accept fares that were not paid in cash. Petitioner admitted he was not required to accept credit card payments and could choose to only accept cash payments. Petitioner agreed that he submitted a W-9 to Creative Mobile Technologies in conjunction with the service agreement, and he admitted that the W-9 he prepared indicated that he was submitting it for a "sole proprietorship." (TT, pgs. 47-49).

Petitioner's tax documents were introduced as Respondent's Exhibit 3. Petitioner admitted that he provided a release for Respondent to secure his tax records prior to arbitration. Respondent's Exhibit 3 includes tax documents filed by Petitioner for the 2018 tax year. Exhibit 3 shows no wages, salaries, or tips were claimed by the Petitioner in 2018. Schedule 1, which was filed with Petitioner's 2018 tax documents indicates Petitioner reported $33,600 in "business income," in 2018, which Petitioner testified was from the taxi cab business. Petitioner agreed that Line 57 of Schedule 4 of his 2018 tax documents was a "self-employment tax," which Petitioner paid in the amount of approximately $4,700. Petitioner also admitted he submitted a Schedule C with his 2018 tax documents. Respondent's Exhibit 3 indicates Schedule C is used to calculate "profit or loss from business as a sole proprietorship." Petitioner admitted Respondent's Exhibit 3 were his tax documents, that he signed and filed them with the IRS, and that he reported his business was "taxi driver." (Tt, pgs. 49-52).

Petitioner admitted that the taxi cabs were *leased* and that he had to pay for his lease. Petitioner testified that the lease was paid for upon return of the vehicle, not when it was initially leased. Petitioner testified that sometimes fares were paid through a "voucher system." Petitioner testified that the cash that he received when he returned the taxi at the end of his lease would be the cash for the vouchers/coupons he presented. Petitioner testified that, if he accepted zero vouchers/coupons for fares, he would receive zero cash at the end of the lease and he would simply pay for his lease. (Tt, pgs. 53-54).

John Franks testified on behalf of Respondent. Mr. Franks testified that he owns several businesses, including Morton Washington Taxi, Movement Technologies, and Peoria Yellow Checker Cab. Mr. Franks testified he is owner and President of Peoria Yellow Checker Cab, and he had that same title in August 2018. Mr. Franks testified he was familiar with Petitioner based on his history of leasing taxi cabs. Mr. Franks testified he first met Mr. Traylor around 2008, when Mr. Traylor first began leasing taxi cabs. (TT, pgs. 60-62).

Mr. Franks testified that, on the alleged date of accident of August 31, 2018, Mr. Traylor had leased a 2007 Chrysler with a VIN number ending in 2116. Respondent's Exhibit 8 was introduced and identified by Mr.

Franks as an automobile insurance policy for Morton Washington Taxi, Inc. Mr. Franks referred to Page 17, which included a schedule of automobiles covered under the policy. Mr. Franks identified the vehicle leased by Petitioner on the alleged date of injury, confirming it was covered by a policy owned by Morton Washington Taxi. Mr. Franks further testified that the 2007 Chrysler leased by Petitioner on the alleged date of accident was *not* owned by Peoria Yellow Checker Cab, but rather Morton Washington Taxi. (Tt, pgs. 62-63).

Mr. Franks testified regarding the business of taxi cab leasing. Mr. Franks testified that any licensed or credentialed taxi drivers can show up at the Cass Street location to lease a vehicle. Mr. Franks testified that the licensing/credentialing requirement is a requirement of the City of Peoria. Mr. Franks testified that any credentialed driver could request a lease "any time, 24 hours." In August 2018, Mr. Franks testified there was someone physically at the Cass Street location 24 hours a day so that a lease could be requested at any time. Mr. Franks confirmed a lease could be requested at 3 a.m., at 1 p.m. "any time of the day." (TT, pgs. 63-65).

Mr. Franks testified the cost of lease varies based on the time, day, month, or week of the lease. Mr. Franks testified the driver chooses how long the lease of the vehicle is for. Mr. Franks testified that the taxi owner (Morton Washington Taxi in this case) does not limit the options regarding the duration of the lease. Mr. Franks testified that the driver can return a vehicle before the expiration of the lease, or keep it after the expiration, at which time a new lease is charge, with that decision being the decision solely of the leasing driver. Mr. Franks testified that the driver chooses the vehicle they want to lease, with no restrictions from Morton Washington Taxi. (Tt, pgs. 65-66, 84).

Mr. Franks identified Respondent's Exhibit 1 as a Lease Agreement. Petitioner identified the lease agreement on direct examination and agreed that he signed it in December 2016. Mr. Franks testified that he signed the agreement entered into with Petitioner on December 2016. Mr. Franks testified that the Lease Agreement sets forth the parameters of the lease of a taxi vehicle. Mr. Franks denied any other rules or

regulations governing the lease of the vehicle. Mr. Franks denied any other rules or regulations governing how the vehicle can be used while leased. (TT, pgs. 66-67).

Mr. Franks testified that once a credentialed driver shows up to lease a vehicle, they choose a vehicle, are provided the keys, and leave. Mr. Franks testified there are no geographic limitations at all as to where the driver can go with the leased vehicle. Mr. Franks testified that there are no rules or minimums for fares that must be accepted while leasing a vehicle, indicating that a driver can lease a vehicle and pick up zero fares during the term of the lease. Mr. Franks testified he was personally aware of the Petitioner leasing a vehicle and picking up zero fares during the term of the lease. (TT, pgs. 67-68, 101).

Mr. Franks testified regarding how drivers are informed of potential jobs. Mr. Franks testified of two potential ways for drivers to receive potential jobs from dispatch: (1) a tablet computer/TomTom GPS device in the vehicle, or (2) a driver's own personal device capable of receiving job opportunities. Mr. Franks testified that the TomTom GPS in the taxi vehicles are provided by Creative Mobile Technologies (CMT). Mr. Franks testified that a driver is not required to utilize the TomTom devices to secure fares, as they can get flag fares or accept calls directly from potential clients. Mr. Franks further indicated a driver could lease a vehicle pursuant to the lease agreement and accept jobs through another taxi company's dispatch service. (TT, pgs. 68-70). Mr. Franks testified that a rider will call the dispatch service and request a trip. An algorithm identifies the most appropriate vehicle based on a number of factors, which the primary factor being where the vehicle is located at the time of the request, and sends the potential job to the TomTom system in that taxi cab for the driver to accept, reject, or ignore. Mr. Franks testified that there are geographic areas that tend to get more job offers based on their location and drivers are free to position themselves in those areas to have more opportunities for jobs. (TT, pgs. 86-87).

Mr. Franks testified that he keeps a record of vehicle leases. Respondent's Exhibit 7 was identified as the business record of leases from January – August 2018 by Petitioner. Specific to August 31, 2018, Mr. Franks

testified that the Petitioner leased a taxi for 12 hours, specifically taxi number 14, which had a lease price of $100. Mr. Franks testified there is information pertaining to a "lease surcharge discount percentage," which is applicable if a driver has a history of accidents that causes the cost of insurance for that driver to increase. Mr. Franks testified this does *not* represent a percentage of the Petitioner's fares taken by the leasing company. (TT, pgs. 70-73).

Mr. Franks provided detail regarding how the voucher system works. Mr. Franks testified that a voucher presented by a driver at the end of their lease term results in a credit to the driver for the cost of the lease. Mr. Franks testified that the drivers select the fare they charge for any trip. Mr. Franks testified that there are no restrictions or limitations regarding what fares can be charged, other than what is set by the City of Peoria regarding a flag fare. Otherwise, a driver can set a fare at whatever he/she wants. (TT, pgs. 73-74).

Mr. Franks identified Respondent's Exhibit 6 a trip data for the time period of January 2018 - August 2018. Mr. Franks testified that the exhibit consists of a summary page for a given month, followed by the actual trip data for that month for Petitioner. Regarding August 31, 2018, the alleged accident date, Mr. Franks testified that the Petitioner did not report any fares for that day. Mr. Franks further explained the lack of trip data on Respondent's Exhibit 6 for August 31, 2018 indicates Petitioner **did not accept any jobs** through the bid board/CMT TomTom/dispatch service. (TT, pgs. 74-78).

Mr. Franks also testified regarding Respondent's Exhibit 5, identifying it as a chart listing every job the Petitioner accepted/rejected through the TomTom GPS system. Mr. Franks testified that Exhibit 5 indicates that, on August 31, 2018, Petitioner was offered three jobs through the TomTom GPS service, all of which he rejected. One job was actually rejected by the Petitioner by selecting "reject" when it was offered on the TomTom GPS. One job was "no accept NBA 4" which Mr. Franks testified means that the Petitioner bid on a trip in a particular geographic area, but that he didn't accept it. The last job was "no accept," which means a job was offered via the TomTom GPS service, but the Petitioner ignored it and the job "timed out." (TT, pgs. 78-80).

Mr. Franks denied ever paying Petitioner wages or an hourly rate. Mr. Franks denied issuing Petitioner a W-2 or 1099. Mr. Franks denied paying Petitioner a commission, or anything corresponding to his lease of a taxi cab. Mr. Franks denied taking a commission or fee for any fares collected by Petitioner, whether it be one from the TomTom GPS, a flag fare, or through a voucher. Mr. Franks testified that he neither buys nor leases the credit card readers from CMT, as CMT has an agreement with the driver for the provision of that technology/service. Mr. Franks testified that CMT charges the driver a fee of $.25 per trip, with that fee going directly to CMT and no percentage going to the leasing cab company. Mr. Franks denied an expectation or requirement that drivers report cash fares at the expiration of their lease, indicating the leasing company would have no knowledge at all of what fares were charged/collected if they were only cash fares. (TT, pgs. 80-81, 87, 90-91, 99-100. See also Rx. 2).

Mr. Franks testified that the driver is responsible for damage to a vehicle that is leased during the term of the lease. Mr. Franks testified that the vehicles available for lease at the Cass Street location vary in appearance – both in color (yellow, green, black, and other colors), decal/painting, and identifying phone numbers (approximately 25 different phone numbers). Mr. Franks testified that there are no requirements regarding the purchase of gasoline, whether from the Cass Street location or any other fuel provider, or no requirements regarding where vehicle repairs/service must be made. Mr. Franks testified that subleasing of the taxis is permitted, though Petitioner never subleased his vehicles. (TT, pgs. 81-85).

Respondent submitted several exhibits at arbitration, including "Taxicab Lease Agreement with Independent Contractor," labeled Respondent's Exhibit 1. Paragraphs 18-31 of Rx. 1 consist of the terms pertaining to the Independent Contractor relationship created by the agreement. Paragraph 18 specifically indicates "Lessee (Petitioner in this case) enters into the agreement for the purpose of operating, as an Independent Contractor, Lessee's own business."

Arbitrator's Findings

A/B. Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act? Was there an employee-employer relationship?

As a preliminary matter, the Arbitrator notes Petitioner filed this workers' compensation claim against Yellow Checker Cab. Unrebutted evidence at arbitration is clear that the vehicle driven by Petitioner on the date of accident was both owned and insured by Morton Washington Taxi, LLC. Further, the Arbitrator notes that Morton Washington Taxi, LLC is one of the parties with whom Petitioner entered into a leasing agreement with. The Arbitrator notes that all of the evidence is clear that the business that was done on the alleged date of accident was between Petitioner and Morton Washington Taxi, LLC. The lease submitted as Rx. 1 was in effect on August 31, 2018, and bound Petitioner and Morton Washington Taxi; the vehicle Petitioner was leasing was owned by Morton Washington Taxi; and there was no evidence presented by Petitioner to suggest otherwise. Therefore, the Arbitrator finds that Petitioner failed to present sufficient credible evidence to establish an employee-employer relationship existed between Petitioner and Respondent on the alleged date of accident.

In addition to the facts above regarding vehicle ownership, the Arbitrator notes that Rx. 1 specifically indicates the lease agreement Petitioner signed in December 2016 provided that the petitioner would be an independent contractor. The lease agreement further notes income or compensation is not provided by Lessor and is the sole property of Lessee (¶21), that Lessee is not obligated to charge any particular rates (¶22), that lessee is not required by Lessor to operate the Taxicab in any prescribed manner or accept any calls (¶23), that Lessee is not required to report the location of Taxicab at any time (¶24), that Lessee is not required to account to Lessor any amounts collected or furnish a record of Lessee's activities (¶25), and that Lessee is not restricted in any manner as to where the Taxicab is operated (¶26). Finally, the lease agreement specifically notes the Lessor shall not provide workers' compensation insurance or benefits to Lessee and "***Lessee expressly waives any right to worker's compensation benefits from Lessor.***" (Rx. 1-3, 4). The arbitrator notes Petitioner acknowledged receipt and signing of this agreement on December 2016. Basic contract law would apply to

conclude Petitioner has clearly waived his right to recover worker's compensation benefits from Respondent by signing this Lease Agreement. Further, the lease agreement clearly provides Petitioner is an independent contractor and that no employee-employer relationship existed.

An evaluation of the evidence presented makes it clear that, even if the lease agreement did not provide that Petitioner was an independent contractor and not an employee, the facts of this case confirm that. In *Yellow Cab Company v. Industrial Commission* and *West Cab Company v. Industrial Commission*, the Court outlined nine factors that must be considered regarding cab drivers in an independent contractor analysis. Those factors are:

(1) Whether the driver accepted radio calls from the company;

(2) Whether the driver had his radio and cab repaired by the company;

(3) Whether the vehicles were painted alike with the name of the company and its phone number on the vehicle;

(4) Whether the cab company could refuse the driver a cab;

(5) Whether the company had control of the work shifts and assignments;

(6) Whether the company required that gasoline be purchased from the company;

(7) Whether the repair and tow services was supplied by the company;

(8) Whether the company had the right to discharge the driver or cancel the lease without cause; and

(9) Whether the lease contained a prohibition of subleasing the taxi cab.

While the terms of the contracts in this instant case are not determinative of whether an employer-employee

relationship existed under the Act, both Petitioner and Respondent's witness, Mr. Franks, testified that potential jobs were dispatched to Petitioner through a TomTom GPS system in the vehicles. While the driver *could* accept "radio calls" from Respondent, he was not required to do so, nor was he limited to calls from

Respondent while leasing a vehicle with Respondent. Petitioner could accept "radio calls" from other taxi cab companies while leasing a vehicle from Respondent.

Petitioner presented no testimony that the taxi and "radio" were repaired by Respondent. The lease agreement indicates Petitioner is responsible for repair of damage to the taxicab while leased by Petitioner. (Rx. 1-3, ¶15(f), although Mr. Franks admitted Respondent often gets stuck with damages incurred during the course of a lease.

Petitioner provided no testimony that the taxicabs available for lease were painted alike with the name of the company and its phone number on the vehicle. In fact, Mr. Franks testified that the vehicles were all different, consisting of several different colors, different decals/markings, and at least twenty-five different phone numbers for the different taxi cab options.

Petitioner provided no testimony that Respondent could, or did, refuse Petitioner a cab at any given time. Mr. Franks testified the only time a cab would be refused is if a driver was obviously impaired at the time of requesting a lease.

Most significantly, Petitioner did not present persuasive, credible evidence that Respondent had control over the work shifts and assignments. Most of the testimony presented at arbitration pertained to this issue of control. Petitioner attempted to paint a picture wherein Respondent controlled most, if not all, aspects of the relationship outlined in the Lease Agreement. However, Petitioner's testimony was self-serving, inconsistent with the terms of the lease both parties agreed to, and inconsistent with the credible testimony presented through Mr. Franks. The arbitrator notes that Petitioner's testimony was inconsistent with not only his own on direct vs. cross or redirect, but also that of the lease agreement and of Mr. Franks.

The Arbitrator finds Petitioner not credible. Petitioner repeatedly denied experiencing problems with his back, neck, or right shoulder prior to August 2018 on multiple occasions. These claims were disproved by Respondent's exhibits showing multiple office visits wherein Petitioner presented for treatment complaining

specifically of issues with the neck, back, or shoulder, sometimes following an alleged motor vehicle accident. Petitioner testified that he didn't reject many trips, but Respondent's Exhibit 5 indicates otherwise. On January 1, 2018, alone, Petitioner rejected 23 trips that were offered. From January 1, 2018, through August 31, 2018, Petitioner rejected (or ignored) 1,491 jobs that were offered to him. Petitioner provided no testimony to rebut or explain this.

Almost all of Petitioner's testimony was contradicted by Mr. Franks. Petitioner testified he had a schedule, Mr. Franks rebutted that. Petitioner testified he had an assigned shift, Mr. Franks indicated vehicles could be leased 24/7. Petitioner testified he was assigned a vehicle; Mr. Franks testified Petitioner chose the vehicle he wanted to lease. Petitioner testified his fares were split 50/50, presumably implying Respondent took 50% of the fare Petitioner charged. Not only did Mr. Franks clearly deny taking any portion, percentage, commission, etc., of Petitioner's fares, the lease agreement makes it clear that Petitioner's fares were the sole property of Petitioner. Further, Petitioner presented no actual evidence to support this claim, other than his own testimony, which was plainly not credible.

Petitioner testified Respondent took a portion of his credit card fares, but the evidence did not show this. It is clear from the evidence presented that Petitioner ***elected*** to have CMT credit card machine available for his lease, as he entered into an agreement with CMT for the provision of their hardware/software in December 2016. CMT charged a fee for every credit card transaction. It is clear Respondent had nothing to do with the provision, usage, or service of the credit card machine.

Likewise, it is clear that Respondent had nothing to do with the provision, usage, or service of the TomTom GPS hardware in the taxicabs, as this was also provided through CMT. Mr. Franks testified Petitioner could choose to use this tool or use his own device to access the dispatch service. Respondent did not collect any fees for the use of the TomTom GPS.

Petitioner presented no testimony that Respondent controlled his work shifts or assignments. It is clear from the credible evidence presented that Petitioner could request a taxi cab to lease any day of the week at any time. Petitioner could choose his own vehicle and do as he chose throughout the term of the lease. Petitioner could even keep the vehicle beyond the term of the lease and create a new lease for the same time period at his discretion. There were no geographical limits on where Petitioner could travel with the leased vehicle. There were no requirements that he pick up any number of riders/fares. Petitioner decided the fare he charged himself. Petitioner decided whether to accept or reject any job offered to him. Petitioner elected whether to accept credit card payments. Petitioner did not have to report any fares or trips to Respondent.

Petitioner presented no evidence that Respondent required that gasoline be purchased through Respondent. In fact, Mr. Franks testified to the contrary. While the lease agreement required taxicabs to returned with a full tank of gas, there was no requirement regarding where, when, or what type of fuel could be purchased.

Petitioner testified that, on the date of accident, the taxi he was driving was towed by a company secured by Yellow Checker Cab. While the tow company may have been arranged by Morton Washington Taxi (since it's clear the Petitioner had leased a vehicle from Morton Washington Taxi on the date of accident), the lease agreement makes it clear that the Lessee (Petitioner) is responsible for the cost of repair and/or towing services incurred during the term of the lease. (Rx. 1-2, 3. ¶15(d), (f)).

Petitioner failed to present evidence to suggest Respondent could terminate the lease agreement without cause. The lease agreement specifically provides the circumstances in which Respondent could terminate the lease, each of which suggests a "for cause" justification for termination of the lease. There is no provision that Respondent can terminate the lease at any time without cause or notice to Petitioner.

Petitioner did not present evidence of a prohibition against subleasing, nor is one prohibited in the Lease Agreement. In fact, Mr. Franks testified that subleasing was permitted, though Petitioner did not choose to do so.

Mr. Franks testified that Morton Washington Taxi's business was the leasing of taxi cabs. He received no profit/income from Petitioner's lease of a vehicle. He received the cost of the vehicle lease and nothing else. Petitioner could lease a vehicle on any day, at any time. Petitioner could lease a vehicle and accept one job during the term of his lease, or no jobs. Petitioner could accept cash payments or use a credit card machine. Petitioner could accept jobs through Respondent's dispatch service, another taxi company's dispatch service, flag jobs, or through direct calls to Petitioner. Petitioner could charge whatever fare he wanted and accept payment however and whenever he wanted. Petitioner could lease a vehicle and travel wherever he wanted during the course of the lease, for whatever purpose he chose.

Considering all of the factors outlined in the relevant case law and the entirety of the record, it is clear that the respondent did not exercise the requisite control and that no employee-employer relationship existed between Petitioner and Respondent.

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

E. Was timely notice of the accident provided to Respondent?

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

G. What were Petitioner's earnings?

J. Were the medical services that were provided to petitioner reasonable and necessary?

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

M. Should penalties or fees be imposed upon Respondent?

Because the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence the existence of an employee-employer relationship, the remaining issues are moot. In any event, the Arbitrator specifically notes that neither penalties nor fees would be appropriate in this instance as Respondent's denial of benefits was neither unreasonable nor vexatious and was based upon a good faith basis of which they presented overwhelming evidence in favor at arbitration.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC014298
Case Name	SPEAR, ANDREW v. DRIVER SOLUTIONS, INC AND RIVERPORT INSURANCE SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0336
Number of Pages of Decision	30
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Matthew Kelly
Respondent Attorney	Stephen Klyczek

DATE FILED: 7/2/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0336

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrew Spear,

Petitioner,

vs. NO: 13 WC 14298

Driver Solutions, Inc, and Riverport Insurance Services,

Respondent.

DECISION AND OPINION ON REMAND

This matter appears before the Commission following the Decision and Order of the Honorable Daniel P. Duffy, Circuit Court of Cook County, Law Division – Tax and Miscellaneous Section, dated 11/5/19 wherein he reversed the Commission's decision entered on 3/7/19 in case 19 IWCC 0148 and remanded the matter "… to the Commission for entry of findings consistent with this opinion and order." (C.C. Order, p.16). Pursuant to this Order, and after considering the issues of medical expenses, temporary total disability, maintenance, and nature and extent, the Commission reverses the Decision of the Arbitrator as stated herein, and remands this case to the Arbitrator consistent with this order and for a determination of a further amount of TTD/maintenance 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).

Procedural History

I. Arbitration Decision

The Arbitrator found "Petitioner failed to prove that his condition of ill-being in his low back after June 11, 2013 was causally connected to the work accident." (Arb.Dec., p.21). In light of the Arbitrator's finding as to causation, the Arbitrator found Petitioner "… is not entitled to an award of medical bills for the treatment rendered after June 11, 2013." (Arb.Dec., p.23). In addition, the Arbitrator found that "… Petitioner is not entitled to maintenance benefits for the period of time claimed, that being, January 27, 2017 – October 5, 2017." (Arb.Dec., p.23). The

Arbitrator also found that "… Petitioner is not entitled to penalties or attorney fees." (Arb.Dec., p.23). Finally, the Arbitrator found that as a result of the accident Petitioner "… sustained a thoracic sprain/strain, back strain, a chest contusion" and that "[b]ased on the above factors, and the record taken as a whole, … Petitioner sustained permanent partial disability to the extent of 3% loss of a person-as-a-whole pursuant to Section 8(d)(2) of the Act." (Arb.Dec., p.23).

II. Commission Decision and Opinion on Review

The Commission affirmed and adopted the Arbitrator's decision, with one Commissioner dissenting.

III. Circuit Court Decision and Order

The Circuit Court, Judge Daniel P. Duffy presiding, found "… the record establishes that the Claimant suffered a work-related injury – including an injury to his pre-operated lumbar spine – on April 16, 2013. The record is totally devoid of competent evidence establishing that the aggravation of Spear's lumbar spine injury was the result of any incident subsequent to April 16 that served to sever the chain of causation. The court further finds the decision of the Commission to the contrary is manifestly incorrect and the opposite conclusion is clearly apparent. See *Navistar International Transportation Corp. v. Industrial Commission*, 331 Ill.App3d 405, 771 N.E.2d 35 (1st Dist. 2002); *Pietrzak v. Industrial Commission*, 329 Ill.App.3d 828, 769 N.E.2d 66 (1st. Dist. 2002)." (Circuit Court Opinion and Order, p.15). As a result, the court reversed the Commission and remanded the matter to the Commission for entry of findings consistent with his Order. (Id., p.16). In addition, the court found the "… reversal [of Dr. Wiley's previously held causation opinions] was obtained during the course of the adversarial process and that the employer's actions were not unreasonable or vexatious, or merely to cause a delay in treatment and therefore denies Spears request to impose Section 19(k) or Section 19(l) sanctions or attorney's fees on the employer." (Id., p.16). (See attached Circuit Court Opinion and Order).

Statement of Facts

I. Testimony of Petitioner

Petitioner, a 31-year old delivery truck driver, testified that on 4/16/13 he was employed by Driver Solutions. (T.14). He noted that he "… was leased to a company by the name of Wert's Beverage and I was a liquor delivery driver." (T.14). He indicated that on 4/16/13 he "[s]tarted [his] day in Mt. Vernon, Illinois, started [his] delivery route, and ended with [his] injury in Charleston." (T.14). On the date in question, Petitioner stated that he "… unloaded a couple of loads into the building, came back outside, it was raining pretty good, loaded [his] dolly up inside [his] truck, was getting ready to come down the dolly ramp and the dolly just started to get away from [him], started sliding on the dolly ramp, and [he] tried to hold on to it which [he] held on to it and it kind of jerked [him] and [he] kind of twisted and at that point [he] felt a lot of pain throughout [his] back and throughout [his] legs and [his] chest and [he] just immediately felt a lot of pain going throughout [his] body." (T.15). He noted that he manually loaded the dolly with cases of liquor weighing 200 to 250 pounds. (T.16).

Petitioner testified that he was not able to finish his shift after the accident, noting that "… after I got hurt I went inside, I was – pushed a dolly inside. I just kind of was hurled over the dolly and the owner of the store came up to me and asked me if I was okay and I told him – I just told him what happened. I didn't feel okay, told him my back was hurting really bad and my leg was tingling me and we both walked outside and I was kind of just walking kind of funny and we walked outside and I told him I didn't think I could do any more. I didn't feel able perform any more work. The gentleman actually unloaded the rest of his load while I got into my truck and called my employer, Wert's, and informed them of what happened. The gentleman got the rest of his load out, he threw the dolly into the back of the truck for me, raised the ramp, closed the door, and I – while I was on the phone with my employer the employer told me to bring the truck down to Mt. Vernon, that they were unable to come up to get me." (T.17). He noted that he was able to drive his truck to Mt. Vernon, but that it was very difficult. (T.17).

Petitioner testified that when he got to Mt. Vernon "[t]he employer came out, just kind of talked to me for a little bit, I kind of told him what happened. And during the time from me leaving Charleston to Mt. Vernon I also spoke to Driver Solutions." (T.17). He stated he spoke to a woman in the office who instructed him to "… get up to St. Louis to go to Concentra so that's when I got in my personal vehicle and drove the three hours or whatever it was to St. Louis to go to Concentra." (T.18). Petitioner indicated "I wouldn't really say they did much that day. Kind of examined me, asked me what my complaints were and that was it." (T.19). He noted that when he initiated care at Concentra his complaints included "[l]ow back pain, my left leg was a little tingly. I had some abdominal pain. Like I explained on that, felt like a cork screw, my muscles felt all twisted up, my left side chest felt a little pain, upper back, like, muscular felt really tight to me." (T.19-20). He agreed that he was seen at Concentra multiple times between the date of the accident and 5/22/13, and that he believed they ordered physical therapy at Professional Rehabilitation in Troy. (T.19). He was also pretty sure the doctors at Concentra placed restrictions on him and took him off work, although he could not readily recall. (T.20).

Petitioner agreed that his last evaluation at Concentra took place on 5/22/13 with Dr. Peter Mirkin. (T.20). He also agreed that he then pursued a course of treatment with Dr. Mirkin. (T.20-21). He agreed that there was also a nurse case manager involved in his treatment at that time, assisting him with scheduling appointments and securing authorization for treatment. (T.21). Petitioner indicated that he did not choose to treat with Dr. Mirkin, and that Dr. Mirkin was an in-house doctor at Concentra that his employer chose for him. (T.21-22). He noted that he shared his complaints with Dr. Mirkin "[e]very time" and that Dr. Mirkin "… ordered a lot of stuff…", including a myelogram of his lumbar and thoracic spine that took place in July of 2013 at De Peres Hospital. (T.22). In addition, he agreed that Dr. Mirkin referred him for some injections which were administered by Dr. Boutwell in August of 2013. (T.22-23).

Petitioner agreed that at some point Dr. Mirkin discussed surgery with him. (T.23). He agreed that prior to surgery his employer had him seen by Dr. Wilke on 10/7/13 for purposes of a §12 evaluation. (T.23). He noted that the surgery was eventually authorized, and that he subsequently underwent lumbar surgery at the hands of Dr. Mirkin on 10/22/13. (T.24). He agreed that following surgery Dr. Mirkin recommended physical therapy and a bone stimulator. (T.24). He noted that his symptoms did not resolve following this surgery. (T.24-25).

Petitioner agreed that he had previously undergone lumbar surgery in 2003 under Dr. David Lange. (T.24). He later indicated that the surgery was at L5. (T.32). He noted that after this surgery he "[d]id wonderful. I returned right back to work and no problems at all." (T.32). He denied having any problems performing his job duties at any point between 2003 and the accident in April of 2013 as a result of mid and low back or left leg difficulties. (T.32).

Petitioner agreed with the records if they show he last saw Dr. Mirkin on 4/7/14. (T.25).

Petitioner indicated that he then sought treatment with Dr. Thomas Lee per the suggestion of Mike Sudekum, co-counsel on his case. (T.26). Petitioner noted that "[a]fter the evaluation with Dr. Lee we did a scan. Or we did a scan before Dr. Lee and he recommended surgery." (T.27). He agreed that prior to surgery his employer scheduled another evaluation by Dr. Wilke, which took place on 5/6/14. (T.27). He indicated that after this second evaluation by Dr. Wilke the workers' compensation carrier authorized the surgeries with Dr. Lee. (T.27). He noted that he then had two surgeries with Dr. Lee, one month apart. (T.27-28). He agreed that the first surgery took place on 10/9/14 and the second occurred on 10/21/14, both surgeries being performed at St. Anthony Medical Center in south St. Louis. (T.28).

Petitioner agreed that following surgery he underwent more than one course of physical therapy under Dr. Lee's care, "[i]ncluding aquatic and land…", as well as two functional capacity evaluations, the second one occurring in December of 2016. (T.28). Petitioner agreed with the records if they show Dr. Lee released him from care on 1/5/17. (T.29). He also noted that Dr. Lee released him to return to work with "[a] long list of [permanent] restrictions." (T.29).

Petitioner testified that thereafter he "… continued to see Dr. Boutwell [per the referral of Dr. Lee] which I've seen for probably two years, two plus years for pain management." (T.29). Petitioner agreed with the records if they show that he first saw Dr. Boutwell in March of 2015. (T.29-30). He also agreed that Dr. Boutwell has performed multiple injections, and that he continued to receive TTD benefits from his employer throughout the course of his treatment up until "… the last Friday of January, the 27th or something", presumably of 2017. (T.30). He indicated that most recently received a course of injections from Dr. Boutwell a "[c]ouple weeks ago… [T]hey did a series of three injections all two weeks apart and they were all approved by the insurance company." (T.30). In addition, he noted that the nurse case manager still "… shows up to every doctor's appointment… [and] schedules everything… makes sure everything is approved before it's scheduled." (T.30).

When asked whether he has been compliant with his doctor's treatment recommendations, Petitioner responded: "I've done everything they've asked." (T.31). As far as his plans for future medical care and treatment is concerned, Petitioner testified that he "… want[s] to continue to follow Dr. Boutwell's plans and orders, what she's ordered and prescribed, to continue the maintenance of the injections like she's ordered, to continue the medication prescriptions to help try to maintain this pain and discomfort that I have and just try to continue to get as good as I can. I really don't know what other course of action besides following Dr. Boutwell's orders." (T.31).

Petitioner indicated that he has not been able to perform his job duties since the accident in April of 2013. (T.33). He noted that he had been a truck driver since "[o]h, gosh. 2007." (T.33). He stated that he was a steel hauler flatbed driver and that his truck driving jobs involved manual labor. (T.33). He noted that he was able to perform all the duties associated with these truck driving jobs without difficulties as it concerns his back. (T.33).

Petitioner stated that he undertook a job search after Dr. Lee concluded he had reached MMI and released him from care in January of 2017. (T.33). He indicated that he provided job search logs to his attorney and he had "… even gone on a few interviews." (T.33-34). He noted that neither Driver Services nor the workers' compensation carrier tendered any job search assistance, and that his employer "… actually released [him] three days after [his] injury… The employer told [him] they no longer needed [his] services and they were releasing [him]… They fired [him]." (T.34). He agreed that the job search logs show that he made approximately 200 contacts since he was found to be at MMI by Dr. Lee in January of 2017, noting that "[he] didn't count them. [He] just did as many as [he] could when [he] was able to." (T.35). He noted that several of those job search logs referred to "Indeed", which he explained is an online job search [website?] that he used and which he did not hear back from. (T.35).

Petitioner agreed that at the request of his attorney he visited vocational counselor Steve Dolan in July of 2017. (T.36). He indicated that he provided Mr. Dolan with fairly detailed information as to his job history and educational background. (T.36). He noted that he received a GED and "… continued on to get a vocational degree with heating and air conditioning and that's it." (T.36). As far as jobs he's had since high school, Petitioner noted that "I worked in a kitchen putting myself through heating and air conditioning school. After I completed heating and air conditioning school I was an installer for about a year and a half before I got laid off. Once I got laid off I continued to go back in the kitchen to put myself through trucking school because the only job I could find with – I have a little bit of a troubled past. I put myself through trucking school, found a job and was a truck driver ever since", specifically from 2007 until the injury in April of 2013. (T.36-37). Petitioner indicated that he is still looking for work "[a]s much as I can. My phone's on and off here and there and I just don't have as much access as I did" due to his financial difficulties. (T.37). When asked whether those financial difficulties have caused issues in his job search, Petitioner responded: "I'd say every issue with it, yes." (T.37). In addition, Petitioner noted that he has applied for and been approved for Social Security Disability and Medicaid. (T.37). He also noted that he receives food stamps through the state of Missouri. (T.38).

Currently, Petitioner noted complaints of "[l]ow back pain. Majority is left hip going – tingling down [his] left leg. I get pain into [his] groin, get tightness in [his] mid-back and [his] upper back. That's basically [his] chief complaints. The groin pain is in and out, it's not a constant, it's more of when [his] pain level's increased with the nerve." (T.38). When asked whether he has trouble sitting for a long period of time, given his standing up and sitting down since he's been at the hearing site, Petitioner responded: "[l]ike getting comfortable. The pressure of sitting down on the hip, like I don't know how to explain it." (T.38). The Arbitrator stated for the record that "… what I've noticed is after he sits down, after a minute or two he shifts and he's keeping weight off his left hip and leans more – these chairs that we're sitting in have arms on them. He'll use the arm on the right and take weight off the left hip." (T.39).

Petitioner testified that on a good day his pain level is a five and that on a bad day it's a nine on a ten-point scale. (T.39). He indicated that he presently takes gabapentin, 3600 milligrams day, for the nerve pain and tizanidine to try to help relax his muscles. (T.39). In addition, he takes an anti-depressant, topiramate for migraines, Nexium for heartburn and a blood pressure reducer. (T.40). Petitioner noted that he drove himself to the docket site in Quincy the day before the hearing and that "[i]t was about a three-hour drive. Very uncomfortable." (T.40-41). He also indicated that he "… stopped probably three times" in route and that he got a hotel room in Quincy, which he paid for "[w]ith a loan that I've gotten from my father-in-law." (T.41).

When asked how the accident has impacted his life, Petitioner testified: "[j]ust greatly. Just with my child, my wife, just everything. I mean, I got a nine-year-old daughter, she just turned nine. I've missed basically four years of her life being able to grow with her and play with her and function with her. Me and my wife's relationship. I sleep in the back bedroom. I haven't slept with my wife in probably three years. We fight all the time. She's told me she wants a divorce and it's because of me. I mean, it's – my head. I'm just not there where I was before. There's a lot of anger and hostility going on right now." (T.41-42).

When asked to describe his normal route on a given day, Petitioner stated: "[i]t just depends. Normally I try to take my daughter to school. I get up and throw something in the microwave for her for breakfast, or in the toaster, and take her to school and I try to come home and try to vacuum and try to do something around the house before, like, the onset of the pain kicks in because throughout the day it just gets worse. The mornings are a lot easier. After I do a couple things I'll normally try to lay down to try to relieve the pain through the hip. After maybe an hour or so I'll get up and walk around. I try to keep myself busy and not make my mind go crazy." (T.42). He noted he did not have any of these difficulties before the accident. (T.42-43).

On cross, Petitioner indicated that Gwynn, the nurse case manager, was the one who told him to go see Dr. Mirkin. (T.44). He agreed that he had already been fired by Respondent when Dr. Mirkin reported, on 6/11/13, that he could return to work. (T.44). He indicated that he looked for work after 6/11/13, noting that "I don't know how long it took, maybe a week or so. I found a gentleman that was hauling some intermodal truck and I did some drop and hook for him and that's all I did, no manual labor, just backed up to a trailer, hooked up to an air line and dropped it back off at a dock, and I probably pulled two or three loads for him and that was it." (T.45). He stated that the gentleman's name was "Dennis" and that he was paid in cash. (T.45). He noted that he "… continued to complain to Gwynn about my complaints the entire time, making calls to him telling him I needed to get back into the doctor. There was a day I was told – I just – I was working. I was driving, my entire leg went numb on me. I couldn't shift the truck, nothing. I had to pull the truck over to the side of the road, put the truck into park and I left the truck there and that was the last time I ever got into a truck again." (T.46). He indicated that this occurred not long before he went back to Dr. Mirkin. (T.46). Petitioner denied working for anyone before or after Dennis, nor has he been self-employed. (T.47-48).

Petitioner acknowledged that in January of 2012 he was involved in a motor vehicle accident when he was rear-ended by another rig. (T.49). He indicated that he was an

independent contractor at the time and was driving a flatbed 18-wheeler. (T.49). He noted that he injured "[j]ust [his] neck" and ended up undergoing neck surgery at the hands of Dr. Lucas Curylo sometime between January and July of 2012. (T.49-50). He agreed that Dr. Curylo returned him to full duty work on 7/19/12 and that he thereupon returned to work for a previous employer, PI & I Motor Express. (T.50-51). He indicated that he worked for this company "[u]ntil I got a local job" which he noted "… had to be until the end of the year … because then I got into some local work with ProDriver, ProDrivers, and then I think I only worked there maybe a week or two because they weren't working me… [and then] I ended up working for Driver Solutions." (T.51-53). He noted that he drove flatbed 18-wheel trucks for these companies. (T.53). He stated that "[t]he only other truck I've ever switched is when I went and hauled liquor." (T.53).

On re-direct, Petitioner agreed with the records if they show the first time he saw Dr. Mirkin was at Concentra. (T.54). He also reiterated that the drop and hook driving that he did briefly after his release by Dr. Mirkin did not involve any manual labor, noting that the "… most I did, like I said, was hooking an air line." (T.54).

II. Selected Medical/Personnel Records

In a Concentra office note dated 4/16/13, Dr. Gustavo M. Galeano recorded that the patient was "… a 30 year old male employee of Drivers Solution who complains about his Back which was injured on 4/16/2013." (PX2). It was noted that the "[p]atient states: 'Coming down ramp. Hurt middle back.'" (PX2). It was also recorded that "[p]atient was delivering cases of liquor and the dolly slipped on the wet ramp and he held onto the dolly and felt a jerk in his left back. He has severe pain left chest and thoracic spine. He has had previous neck and low back surgery. He has pain on dep [*sic*] breathing and some tingling in his left leg. The pain began immediately a few hours ago. The pain is located on left chest. The symptoms are exacerbated by flexion, extension, standing, coughing, sneezing or deep breath." (PX2). Upon physical examination, Dr. Galeano noted that "Pt. is in severe distress" and that there was "[g]uarding in right sidebending, guarding in left sidebending, guarding in extension and guarding in flexion. ROM of the trunk decreased to flexion extension right sidebending left sidebending with pain. T6 T7 T8 on the left Palpation of the spine is positive for pain…" (PX2). It was noted that Petitioner was taken off work by the provider, prescribed medication, including Vicodin, and instructed to return the following day. (PX2). X-rays of the thoracic spine performed on that date revealed no acute fractures. (PX2).

In a separate Concentra "Physician Work Activity Status Report" dated 4/16/13, the following diagnosis was noted: "Other Chest Pain", thoracic spine pain and thoracic strain. (PX2). The patient's status was shown as "No Activity – Returning for follow-up visit." (PX2).

In a Concentra office note dated 4/17/13, Dr. Rudolph Catanzaro recorded the patient "… returns for followup concerning the back pain, thoracic strain, and left rib pain which he sustained at work on 04/16/2013… He states that the medication has not helped his pain at all and he still has considerable pain; however, in general, he states he has a little bit less acute pain compared with his previously noted pain on 04/16/2013. He denies any pain radiating down his leg. He states that he has difficulty bending or twisting because of the pain as well as the muscle

spasms in the back." (PX2). Upon examination, Dr. Galeano noted that the patient "… moves very slowly with obvious back pain. His gait is very slow and guarded." (PX2). He also noted a "… well-healed lumbar incisional scar from previously spinal fusion for a herniated disk. Palpation reveals moderate tenderness and 1+ muscle spasm of the area of T5 through L2. There is also 1+ muscle spasm of the paravertebral musculature at that site." (PX2). Dr. Catanzaro's diagnosis was "[t]horacic strain, severe; left rib pain, moderate; and back pain, severe." (PX2). Petitioner was allowed to perform "[l]ight duty work. No lifting over any amount. No pushing over any amount. No bending at all. Unable to drive company vehicle. Return for follow up on 04/19/2013." (PX2).

In a Concentra office note dated 4/19/13, Dr. Galeano recorded that "[t]he pain is located on left mid back and thoracic region. The pain is described as moderate and aching… The paid did not radiate. The symptoms are exacerbated by flexion or twisting… Denies paresthesias of the leg." (PX2). Dr. Galeano's diagnosis was thoracic strain and back strain. (PX2). Petitioner was restricted to modified activity with no bending more than 5 times per hour, no pushing/pulling/lifting over 1 lb. of force, and no driving of company vehicle. (PX2).

In a Concentra office note dated 4/23/13, Dr. Dennis Keesal recorded that "[p]atient has not been working because no light duty available. Patient continues to have pain left posterior chest on movement, deep breathing and coughing… The pain is located on left posterior chest. The pain radiates to the anterior aspect of the left chest and the hip. The symptoms are exacerbated by twisting, coughing, sneezing or deep breath." (PX2). Dr. Keesal's assessment was chest wall contusion and possible rib fracture, unspecified. (PX2). Petitioner was restricted to modified activity of no bending, no lifting/pushing/pulling over 1 lb., and no driving of company vehicle. (PX2). Dr. Keesal also recommended physical therapy 3 times a week for 1-2 weeks. (PX2).

In a Concentra office note dated 4/26/13, Dr. Galeano recorded that the patient "… feels the pattern of symptoms is improving but still having some pain in the area. L middle back[.] Patient taking prescribed medications[.] [S]ome improvement with medication. Ha[s] not ha[d] any therapy yet[.] The pain is located on left posterior medial infrascapular region. The pain is described as moderate, dull and sharp at times… The pain radiated to the lower portion of the left side back and the buttock area. The symptoms are exacerbated by flexion, extension or pushing. The symptoms are alleviated by resting." (PX2). Dr. Galeano's assessment was chest wall contusion and back pain. (PX2). Petitioner was restricted to modified activity of no bending more than 1 time per hour, no lifting/pushing/pulling over 1 lb., and no driving of company vehicle. (PX2).

In an "Employer's First Report of Injury" prepared by Ruth Ortega on 4/30/13, it was noted that Petitioner was injured on 4/16/13 at 10:30 a.m. when "[h]e was coming down the ramp of the truck with a loaded two wheel dolly." (PX17). Ms. Ortega recorded that "[i]t was raining, his dolly slipped, this caused him to hand on and something pulled in his back." (PX17). She described the injury as affecting the "[m]idle and left side of back. Employee has pre-existing back injury and surgery from previous job" and that it occurred while "[t]rying to hang on to the Dolly." (PX17).

In a Concentra note dated 5/7/13, Dr. Galeano recorded "Pt is here for f/up on on [*sic*] chest wall contusion/CT report. He feels the pattern of symptoms is stable, no [*sic*] much improvement. Patient has been working within the duty restrictions. Patient taking prescribed medications[.] [S]ome improvement with medication. Patient has not had physical therapy. The pain is located on left posterior mid chest. The pain is described as dull, stabbing and moderate… The pain radiated to the lower portion of the left side of his lumbar. The symptoms are exacerbated by walking, flexion or extension. The symptoms are alleviated by resting." (PX2). Dr. Galeano's assessment was chest wall contusion and back pain. (PX2). Petitioner was restricted to modified activity of no bending more than 1 time per hour, no lifting/pushing/pulling over 1 lb., and no driving of company vehicle. (PX2).

In a Concentra office note dated 5/10/13, Dr. Galeano recorded that the patient "… feels the pattern of symptoms is stable/improved 25% as pt stated. Patient has been working within the duty restrictions… [S]ome improvement with medication. Patient has had physical therapy… The pain is located on left mid back and thoracic. The pain is described as aching and dull… The pain did not radiate… Denies paresthesias, sensory loss, weakness, numbness and abdominal pain." (PX2). Dr. Galeano's assessment was back strain/pain and contusion of the thorax. (PX2). Once again, Petitioner was restricted to modified activity of no bending more than 1 time per hour, no lifting/pushing/pulling over 1 lb., and no driving of company vehicle. (PX2).

In a Concentra office note dated 5/15/13, Dr. Galeano recorded that the patient "… feels the pattern of symptoms is no better. Patient has been working within the duty restrictions. Patient has been taking their medications and has not noted any improvement. Patient has had physical therapy and does not feel better. The pain is located on left mid back and thoracic region midline. The pain is described as aching, shooting, stabbing, moderate and severe. The pain radiated to the upper portion of the thoracic. The symptoms are exacerbated by activity or movement. He cannot identify any alleviating factors. Denies paresthesias, numbness, weakness, shortness of breath and difficulty breathing." (PX2). Dr. Galeano's assessment was lumbar radiculopathy, lumbar strain, back pain, back strain, contusion of the thorax. (PX2). Once again, Petitioner was restricted to modified activity of no bending more than 1 time per hour, no lifting/pushing/pulling over 1 lb., and no driving of company vehicle. (PX2).

In a Concentra office note dated 5/22/13, Dr. R. Peter Mirkin recorded the patient had been "… referred to me for a strain injury. He twisted his back and felt pain at the thoracolumbar junction. He has been off work since the time of the injury. He has been treated with 5 sessions of therapy and medications. He tells me he is much better, but does not think he can return to full work." (PX3). Dr. Mirkin's impression was "… that this is a patient with a strain injury. He has no signs of radicular symptoms. At this point in time, he feels he cannot return to full work… I recommend work with a 40-pound restriction, 6 hours a day. I think, in the meantime, he would benefit from 2 weeks of half-day work hardening. I will see him back when that is complete and I expect he will return to full work at that time." (PX3).

In a letter dated 6/10/13, Dr. Mirkin recorded that Petitioner "… was referred to me for a strain injury. He tells me that he has had pain in the left thoracolumbar junction. He tells me he has been doing therapy but he cannot complete any of his therapy. When I first walk in the room he is sitting on the table moving his legs back and forth with no sign of abnormality. He walks

with a normal nonantalgic gait. His range of motion of his lumbar spine is 90 percent normal." (PX3). He noted that x-rays of the lumbar spine and thoracolumbar junction showed a solid fusion at L5/S1. (PX3). He stated that "[a]t this point in time, I see no evidence of any significant abnormality. He has been off work for months, and I think it is time for him to return to full work. I really have nothing to offer him from a surgical point of view. He is very unhappy with my assessment, but he is exhibiting severe signs of symptom magnification behavior. He tells me he cannot lift even 30 to 35 pounds. I would note that he is a 6 feet, 1 inch, well-muscled 309 pound male who appears to be in no discomfort whatsoever." (PX3).

In a separate "Physician's Statement" dated 6/10/13, Dr. Mirkin noted that Petitioner was discharged at MMI and was able to return to work without restrictions on that date. (PX3).

In a letter addressed to Berkley Risk Administrators dated 7/12/13, Dr. Mirkin recorded that he "… previously released Mr. Spear based on my June 11, 2013 note. Mr. Spear indicates he has pain in the lower lumbar spine, the mid thoracic spine, and occasionally in the neck. He tells me he has decided he wants to have further treatment for this." (PX3). Dr. Mirkin ordered a myelogram at that time. (PX3).

A thoracic and lumbar myelogram performed on 7/19/13 was interpreted as revealing no several central stenosis throughout the lumbar spine. (PX4). A CT of the lumbar spine performed on the same date was interpreted as revealing 1) postsurgical complete osseous fusion across the L5/S1 interbody space, left L5 and S1 pedicle screw and rod fixation at L5 and S1, and complete osseous fusion across the bilateral L5/S1 facet joints with no evidence of hardware failure; and 2) broad-based central disc protrusion at L4/5 level which contributes to moderate central canal stenosis, disc protrusion and ligamentum flavum hypertrophy contributing to moderate bilateral lateral recess stenosis, and disc protrusion and bilateral facet arthropathy contributing to mild bilateral neural foraminal exit stenosis. (PX4). A CT of the thoracic spine also performed on 7/19/13 revealed 10 mild broad-based central disc protrusion at T6/7 without significant central canal stenosis or neural foraminal exit stenosis, and 2) no other significant disc profile abnormality, central canal stenosis, or neural foraminal exit stenosis throughout the remainder of the thoracic spine. (PX4).

In a letter addressed to Berkley Risk Administrators dated 7/26/13, Dr. Mirkin recorded that the patient "… has had his myelogram and it reveals slight bulging in the thoracic spine. The most significant finding is a large disc herniation and stenosis at L4/5 cephalad to the prior surgery. Mr. Spear tells me he has back pain and pain down his left leg. He tells me he cannot drive safely and he is afraid he will get in an accident. His examination is unchanged." (PX3). Dr. Mirkin recommended some epidural steroids and "[i]f he fails to improve with that then I would offer him a decompression and fusion at L4/5. He very likely needs to start thinking about a lighter occupation as he tells me he has to do heavy lifting and he has already had one spine surgery." (PX3).

In a separate "Physician's Statement" dated 7/26/13, Dr. Mirkin noted that Petitioner could return to work with a 15 lbs. lifting restriction and no commercial driving. (PX3).

In a progress note dated 8/1/13, Dr. Michael Boedefeld of Professional Pain Physicians

recorded that the patient had been "… referred to the pain management clinic with complaints of lower back pain and left hip and leg pain. His pain started 3 months ago after an injury at work. The pain started suddenly. He describes the pain as shooting, sharp, burning and aching. The pain is severe, constant and getting worse with time. He notes numbness and tingling in the left leg." (PX5). Dr. Boedefeld's assessment was 1) thoracic or lumbosacral neuritis or radiculitis, unspecified, and 2) displacement of lumbar intervertebral disc without myelopathy. (PX5). Dr. Boedefeld indicated that he "… reviewed the patient's CT myelogram. He has a disc protrusion above his fusion level at L4-5 and at L2-3. His pain is consistent with L4 and L2 radiculopathy. I will treat him with a left L2 and L4 transforaminal epidural steroid injection under fluoroscopic guidance." (PX5). This injection was administered that day. (PX5). Dr. Boedefeld administered another epidural steroid injection on 8/15/13, this time at left L4 and L5. (PX5). Petitioner noted minimal improvement following both injections. (PX5).

In a letter addressed to Berkley Risk Administrators dated 9/6/13, Dr. Mirkin recorded that the patient informed him that "… he had injections that did not help. He complains of severe pain in his back and down his legs. He tells me that when he has pain he has convulsions and his eyes roll back in his head." (PX3). Dr. Mirkin reviewed the myelogram and noted "… a herniated disc and degenerative disease at L4/5. At L5/S1 he has signs of a prior fusion attempt. I cannot tell whether it is completely healed." (PX3). Dr. Mirkin noted that "[t]he only thing else I have to offer him would be removal of the previous hardware and decompression and fusion at L4/5 and possibly L5/S1. He is at increased risk because this is a revision procedure and his morbid obesity. I certainly do not think it is going to get him back to full work, but I really have nothing else to offer him. He can work with the previous restrictions. We will schedule this if and when we receive clearance." (PX3).

In a letter addressed to Berkley Risk Administrators dated 9/25/13, Dr. Mirkin recorded that "[w]e have been informed that he is having a second opinion at the end of October. He complains of severe pain in his back and down his legs. He has been calling, asking for pain medication. I have informed him that it is unlikely I will continue to give him narcotics as we wait for a second opinion for a long period of time. Mr. Spear tells me he can no longer live with the problem." (PX3). Dr. Mirkin noted that "[t]he only thing I have to offer him would be the surgery we previously discussed. I think it is unrealistic to make a patient wait six weeks for a second opinion and then an unknown amount of time before the report is ready. I recommend he discuss this with his legal counsel. I have given him some non narcotic pain reliever." (PX3).

In a separate "Physician's Statement" dated 9/25/13, Dr. Mirkin noted that Petitioner was unable to work until further notice. (PX3).

On 10/22/13 Petitioner underwent surgery at the hands of Dr. Mirkin consisting of 1) explore fusion; 2) remove previous segmental instrumentation, lumbar spine; 3) bilateral revision decompressions, L4, L5, S1 with decompression of spinal nerve roots; 4) interbody fusion, L4-L5; 5) placement of interbody cage x 2, L4-L5; 6) segmental instrumentation, L4, L5, S1; 7) posterolateral fusion, L4, L5, S1. (PX4). The pre and post-operative diagnoses included degenerative disk disease, herniated disk, L4-L5 cephalad to prior fusion, L5-S1. (PX4).

In a letter dated 10/25/13, Dr. Mirkin recorded that the patient "… tells me yesterday his

wife was changing his dressing and he passed out and awoke in an ambulance. He was taken to the hospital and told he had an injured shoulder. He is seeing another physician for that. We brought him here to check out his back. He tells me he has some pain in his right buttock." (PX3). Dr. Mirkin recommended that Petitioner "… resume his exercise. I do not think he needs any dressing changes. I have instructed him to keep the wound open as I did in the hospital. He is going to see another doctor for his shoulder problem. It appears he either passed out or tripped and fell at home, but I do not think he has done any major damage to his back." (PX3).

In a letter addressed to Berkley Risk Administrators dated 11/4/13, Dr. Mirkin recorded that the patient "… tells me his back is doing well. He is walking independently. Neurologically he is intact. Motor and sensory exam are intact… I will start him on therapy. We tried to fit him with a brace but he is too large for any brace available. We did fit him with a bone stimulator and instructed him in its use. I will see him back in six weeks and get a repeat x-ray at that time and perhaps return him to light work if that is available." (PX3).

In a letter addressed to Berkley Risk Administrators dated 12/16/13, Dr. Mirkin recorded that the patient "… tells me his back is doing well but he 'doubles up on his narcotics'. He tells me he still has pain in his right shoulder. His shoulder is still in a sling, and according to him he cannot do anything with his right shoulder." (PX3). Upon examination, Dr. Mirkin noted that Petitioner "… is walking with a cane. Neurologically he is intact. Straight leg raise is negative… He has exaggerated pain response to palpation of his lumbar spine. He complains of pain when I lightly touch his back and distract his leg." (PX3). He indicated that x-rays taken in the office that day revealed excellent position of the hardware and a maturing fusion. (PX3). He also noted that Petitioner "… is now 321 pounds. I recommend he pursue aggressive weight loss. I think he can work with a 15 pound lifting restriction. He appears to be displaying significant symptom magnification behavior. I do not think there is any anatomical reason he needs the cane anymore. I recommend he try to wean himself off that. I will see him back in six weeks. His prognosis is quite guarded." (PX3).

In a letter addressed to Berkley Risk Administrators dated 1/8/14, Dr. Mirkin recorded that the patient was "… in the office crying. I would note that I watched him walk in and he was walking barely putting his cane down, however, when he was in my office he has a severe limp. He tells me his pain is in his back and down his legs. He thinks he may have a L2/3 disc problem. He has had a prior fusion at L5-S1 and I performed a decompression and fusion at L4/5." (PX3). Dr. Mirkin recommended a myelogram and noted that Petitioner "… is not doing anything in therapy so there is no reason to continue it." (PX3). Dr. Mirkin also maintained the same 15-pound lifting restriction with no bending or stooping at that time. (PX3).

A lumbar myelography performed on 1/15/14 was interpreted as revealing an anterior and posterior decompression and instrumentation L4-5 and L5-S1 and L2-3 disc level extradural defect and grade 1 retrolisthesis. (PX4).

In a letter addressed to Berkley Risk Administrators dated 1/27/14, Dr. Mirkin recorded that Petitioner was "… doing slightly better today. He is walking upright… His myelogram reveals no compression of the nerve roots. The radiologist opines that there is a failed fusion at L4/5. I had a discussion with the radiologist. Certainly, you would not expect to have bony

consolidation at this point in time, so I do not think it is a failed fusion, it is a fusion in progress." (PX3). Dr. Mirkin noted that Petitioner "… wants to start back on some therapy, and I think it is safe to do so. He can work light duty if that is available… He has gained a considerable amount of weight and I recommend he try to manage that." (PX3). A separate "Physician's Statement" on that date noted the previous 15-pound lifting restrictions with no bending or stooping. (PX3).

In a report dated 2/27/14, orthopedic surgeon Dr. Thomas K. Lee recorded that the patient presented with "… a chief complaint of right more so that left groin pain and low back pain." (PX6). Dr. Lee noted by way of history that on 4/16/13 Petitioner was delivering liquor with a two-wheel dolly when he "… twisted to get control of it, dropped it and fell to the ground. He reports pain in the center of the low back across from left to right and down both hips to the groin and the tops of both thighs. Then it goes down the inside of both legs to the feet." (PX6). Following his examination, Dr. Lee's impression was that Petitioner was "[s]tatus post L4-5 discectomy and fusion, rule out delayed union. Medial position of right S1 screw." (PX6). Dr. Lee stated that "[t]he patient is not at maximum medical improvement for the work injury. He has a component of dysesthetic pain with symptoms and findings consistent with dysesthetic pain from the S1 screw. I recommend revising the hardware. He is approaching five months postoperative. I therefore also recommend at the same time exploring the fusion at L4-5. I am not seeing convincing evidence of solid bridging at L4-5 yet. It might be that additional bone graft would be indicated if not solidly fused to get him more quickly to MMI. He is medically unable to resume his previous occupation. I would place his current restrictions at no lifting more than 30 lbs." (PX6).

In a letter to Berkley Risk Administrators dated 3/10/14, Dr. Mirkin recorded the patient "… tells me he has persistent pain. He wants to be able to return to work as a truck driver." (PX3). Dr. Mirkin noted that Petitioner "… now weighs 337 pounds. He is morbidly obese." (PX3). Dr. Mirkin stated Petitioner was "… not making much progress in therapy. I have told him he may need to consider a career change. Unfortunately, he continues to gain weight and is relatively sedentary. His prognosis is quite poor. X-rays today show progression and no signs of fusion failure. I will keep him in therapy… He can work with a 20 pound lifting restriction." (PX3).

In a letter dated 4/7/14, Dr. Mirkin recorded that the patient "… tells me nothing has helped him, he still has pain in his left leg and his back. He tells me he cannot move without having pain." (PX3). Dr. Mirkin concluded that "[a]t this point in time I think he is essentially medically stationary. I think he can work with a 35 pound lifting restriction. In addition to having a prior fusion, he underwent a single level L4-5 fusion and is displaying symptom magnification behavior. He also has gained considerable weight. He had a CT scan on 01/15/2014 with revealed hardware in satisfactory position. The radiologist opined that he may have a failed fusion at that time, but certainly on the x-rays today he appears to have consolidation without any failure of fusion. I would be happy to see him back after a second opinion, but I really do not know what else I would have to offer him. I think he needs to seek a job where he is not required to lift more than 35 pounds and pursue an aggressive weight loss program." (PX3).

In a report dated 6/30/14, Dr. Lee recorded that he had previously seen Petitioner on

2/27/14 for an IME, and that "[h]e reports low back pain down into his hips and groin. The pain has increased in both legs, right worse than the left. He describes a burning component to his symptoms. They are constant. There is numbness and tingling in both feet and legs." (PX6). Dr. Lee noted that "[w]e discussed removing the hardware, exploring, and planning to revise the S1 screw position under CT image guidance… I placed him on a restriction of lifting no more than 30 pounds, and we will see him back as soon as possible with the preoperative testing… [H]e wishes to proceed with proposed L4-5, L5-S1 exploration with possible reinstrumentation and fusion, removal of right S1 screw, possible revision screw placement with cellular allograft." (PX6). Dr. Lee discussed other potential operative scenarios in a letter dated 7/28/14 and kept Petitioner on the same restrictions. (PX6).

On approximately 10/8/14, Petitioner underwent surgery at the hands of Dr. Lee. (PX7). While the operative report does not state the procedures performed, it appears the surgery consisted of hardware removal L4-L5, L5-S1, L2-3 posterior lumbar interbody fusion with cage placement, L3-4 osteotomy and posterior spinal fusion L2 through S1, based on a history and physical recorded on 11/21/14. The postoperative diagnosis was 1) L4-5 incomplete fusion; 2) medial position of right S1 screw; 3) left L3-4 neural fibrosis; 4) L3-4 hypermobility, and 5) L2-3 spondylolisthesis. (PX7).

In an operative report dated 11/22/15, Dr. Lee noted that the following operation was performed: 1) L3-4 lateral interbody fusion; 2) placement of LDR Avenue-L cage; 3) cellular allograft (NuVasive Medical); and 4) left lateral pre-psoas approach. (PX7). No post-operative diagnosis was listed (and for that matter, neither was the surgeon or anesthetist), but the pre-operative diagnosis was shown as 1) incomplete fusion at L4-5; 2) medial position of right S1 screw; and 3) L2-3 and L3-4 spondylolisthesis. (PX7).

In a report dated 1/6/15, Dr. Joseph Yazdi, an associate of Dr. Lee at Tesson Heights Orthopedics, recorded that Petitioner was about six weeks post surgery and that the symptoms he had previously in his right leg "… have really resolved and he now has issues with his left leg… He has some intermittent tingling down the left lateral leg and foot. He also has some burning in the same distribution. This has really not changed in the last six weeks. He also complains of constant aching pain in his left flank and left thigh that is about 8/10 in severity. There are times when he goes from a standing to a sitting position and all of a sudden he gets severe tingling and tension that involves the entire left side of his body including his face, tongue, arm, trunk and leg. He also breaks out into a cold sweat. He has to be helped up to a standing position for the symptoms to subside. These do not happen every time but happen once in a while. Recently he switched from a walker to a quad cane." (PX6). Following his examination, Dr. Yazdi's impression was that "Mr. Spear has done well with his third and fourth back surgeries. Obviously, the recovery is going to be somewhat slow. I have asked him to start taking off the TLSO for short periods of time. He should definitely wear it when he has back pain. I also gave him a prescription for physical therapy, and we will give him a prescription for Percocet as well as refill his Parafon Forte. He has been on OxyContin ER as well." (PX6).

In an operative report dated 1/12/15, Dr. Kenneth G. Smith noted a pre and postoperative diagnosis of L4-5 lumbar disk disease. (PX7). The operation performed was "[l]ateral exposure of the L4-5 lumbar disk space to facilitate in lateral interbody fusion at the L4-5 disk space."

(PX7). Dr. Smith also noted that "Dr. Thomas Lee performed the interbody fusion and will dictate his portion separately." (PX7).

In a report dated 2/17/15, Dr. Lee recorded that Petitioner "… feels totally different. Pleased with his progress. Numbness in the leg resolved. He is left at this point with the tingling which is not as problematic as the numbness was … He will get pain in the left sacroiliac joint that is limiting at that point. He walks with a cane or else he could not make it that far [i.e. walk 100 yards]." (PX6). Dr. Lee's impression was left sacroiliac dysfunction status post L2-S1 revision fusion with revision of the left S1 screw for hardware impingement. (PX6). Dr. Lee noted that Petitioner "… continues to improve dropping down to the 5/325 strength for the breakthrough pain and I wrote for a maximum of eight per day until he gets to see Dr. Boutwell. He has been out of the brace up to four hours per day. He has not been able to wean beyond that. We have encouraged him to do so. We will continue the therapy… We are going to refer him to Dr. Boutwell for injections and pain management and to assist with weaning the meds… His job has been terminated, thus we wrote off work status but we can provide light-duty restriction notes as needed. His physical capabilities are improving but he is not yet ready to return to truck driving work. He is neurologically improved and has a solid-appearing fusion. We will see him back in six weeks for followup and anticipate maximum medical improvement from my standpoint in 12 weeks." (PX6).

In a letter to Berkley Assigned Risk Services dated 3/31/15, Dr. Lee noted that Petitioner was doing better and getting stronger, although he had some tingling as well as "… intermittent left lower extremity symptoms anterior thigh to the medial foot and great toe. Walking increases the symptoms if he pushes too hard he states. He had some popping in the right greater trochanter region with some of the therapy exercises, hyperflexion with a TheraBand or something of that nature, and they are working with that. He is down to three hours a day with the brace." (PX6). He noted that his movement patterns, though improved, were consistent with core weakness and that he was no longer using the quad cane but was down to a single-point cane. (PX6). Dr. Lee indicated that "[w]e are going to continue the therapy. We are going to project maximum medical improvement as early as May or June." (PX6).

In a letter to Berkley Assigned Risk Services dated 5/12/15, Dr. Lee noted that Petitioner reported "… back pain and thoracic knots but leg feels much better than pre-op. He stopped using his cane for a while but he got some left hip pain so he has gone back to using it. Also he tried a climber, some type of stair stepper, and it increased the hip pain and he also has the right hip pain. He discontinued the OxyContin. He is now taking 5-mg Percocet averaging three to four per day. He takes the gabapentin and tizanidine." (PX6). Dr. Lee concluded that Petitioner was "… showing continued improvement. It is okay to add an NSAID. I sent request to Dr. Boutwell for sacroiliac injections and we gave the therapist some input for that and strengthening the thoracic muscles as he is going through the rehab process. I will plan to see him back in two months. I am going to have him continue his followup for completion through Dr. Boutwell or I can see him back at periodic intervals until he reaches resolution as per his preference." (PX6).

In a letter to Berkley Assigned Risk Services dated 7/7/15, Dr. Lee recorded that Petitioner was doing well except for the left hip, sacroiliac region, and that therapy and the TENS unit have helped. (PX6). He noted that the first sacroiliac injection had been scheduled

and that Mr. Spear had been able to successfully wean the medications, "… tak[ing] like two or three on non-physical therapy days in general and maybe five to six on physical therapy days." (PX6). Dr. Lee indicated that he "… wrote to advance [Petitioner] through work conditioning and work hardening. He will continue treating with Dr. Boutwell and first sacroiliac joint are coming. I will see him in two months. We will get an FCE at the conclusion and I suspect we can probably provide permanent restrictions at that time and possible MMI." (PX6).

On 7/16/15, Petitioner underwent a left SI joint procedure by Dr. Boutwell. (PX8). He had additional injections on 7/30/15, 8/13/15, 9/22/16, 10/6/16, 7/27/17, 8/10/17, and 8/24/17. (PX8).

On 9/16/15 Petitioner underwent an FCE at PRORehab which noted Petitioner demonstrated the physical capabilities and tolerances to function at least in the Medium physical demand level, lifting up to 23 pounds, pushing 54 pounds, pulling 60 pounds and frequent standing. (PX10). It was also noted that the physical demand level of his job was a Very Heavy physical demand level. (PX10).

In a progress note dated 9/29/15, Dr. Lee recorded that the patient "… presents today for lumbar pain and left hip. The onset of the issue began 2 years ago. FCE has made it necessary to come for an appointment today. The pain is generally located left hip and left side of low back and includes dysasthetic pain to the left anterior thigh. He does feel that it is much improved from preop in that regard…. Numbness is associated with the pain and Tingling is associated with the pain down the top of the left leg…" (PX6). Dr. Lee's assessment was low back pain and lumbar radiculopathy. (PX6). Dr. Lee ordered a CT lumbar spine and issued a light duty note. (PX6). In a "Physician's Statement for Work Restriction/Status" on that date, Dr. Lee imposed the following light duty restrictions: "No lifting more than 25 lbs. No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking, Frequent standing. Driving will be determined by DOT guidelines and CT results which is pending." (PX6).

A CT scan of the lumbosacral spine performed on 10/20/15 revealed extensive post surgical fixation and disc replacement from L2-L3 through L5-S1, and no evidence for nonfusion/nonunion. (PX11).

In a letter to Berkley Assigned Risk Services dated 11/12/15, Dr. Lee noted he had reviewed the CT scan and it shows "… the vast majority of the fusion beds to be well-fused. The only level that shows any question is the L3-4 level. This does correlate with his symptoms of left anterior thigh pain and the location of his back pain. I recommend an external bone growth stimulator." (PX6). Dr. Lee also stated "… based on the amount of fusion we are seeing [Petitioner] will ultimately work with restrictions in the medium demand category somewhat above the 25-pound lifting restriction and 60-pound pushing/pulling restriction. I think I would leave him at that for now, but estimate improvement at least to the 30 to 35-pound lifting range and 70-pound pushing/pulling range upon completion of treatment, thus I think he will end up in the medium demand category. I do think frequent change of positions, however, will be needed, so I do not see him returning to a commercial truck driving occupation, but I do think he stands to gain some functional improvement and some symptomatic improvement from the use of the bone growth stimulator and it could prevent the need for further surgeries in the future." (PX6).

In a progress note dated 1/27/16, Dr. Lee noted that Petitioner's "… current symptoms include low back is numb feeling demonstrates apprximately [*sic*] L3 toward L5." (PX6). Dr. Lee's assessment was pseudoarthrosis of lumbar spine, L3-4. (PX6). He also indicated that the patient was to see "… manufacturer's representative for bopne [*sic*] stimulator, re adherence of pads issue, resume wearing at night (average < 3 hours per[]day of wear." (PX6). In a "Physician's Statement for Work Restriction/Status" on that date, Dr. Lee noted that Petitioner "… may return to work until re-evaluated by a provider in this office at their next appointment. 02/24/2016." (PX6). Petitioner was given the following restrictions: "No lifting more than 25 lbs. No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking and frequent standing. Driving will be determined by DOT guidelines." (PX6). The same restrictions were imposed following his next visit on 3/2/16. (PX6).

In a progress note dated 4/20/16, Dr. Lee noted that Petitioner's pain had not changed since his previous visit, and that it included back and bilateral hip pain into the groin. (PX6). Dr. Lee's assessment, once again, was pseudoarthrosis of lumbar spine, L3-4. (PX6). Dr. Lee indicated that Petitioner "… will begin aquatic therapy while he continues the bone growth stimulator[.] His usual work involves lifting 75 lb[.] liquor cases and sitting driving 15 hours per day. Based on his description I am not anticipating he will be able to return to his previous level of work. I anticipate MMI at 2 months from now with permanent restrictions." (PX6).

In a "Physician's Statement for Work Restriction/Status" dated 4/20/16, Dr. Lee noted that Petitioner could return to work on 5/25/16 with the same restrictions as previously outlined – namely "No lifting more than 25 lbs. No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking and frequent standing. Driving will be determined by DOT guidelines." (PX6).

In a progress note dated 6/1/16, Dr. Lee recorded that Petitioner's pain was unchanged since his previous visit, and that "[h]e has now been wearing the stimulator without significant interuption [*sic*] since January. The quatic [*sic*] phase of therapy went well. We are advancing him to work conditioning." (PX6).

In a "Physician's Statement for Work Restriction/Status" dated 6/1/16, Dr. Lee noted Petitioner could return to work with the same restrictions as previously outlined – namely "No lifting more than 25 lbs. No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking and frequent standing. Driving will be determined by DOT guidelines." (PX6).

In a progress note dated 7/20/16, Dr. Lee noted that Petitioner's "… fusion per x-ray appears healed, though the arc of motion is markedly reduced on the flexion and extension. I wrote for work hardening. We discussed likely release with permanent restrictions in the medium demand range at the next visit If SI symptoms are problematic we could consider SI injections. If LBP interferes w[i]th satisfactory release then would repeat CT scan." (PX6).

In a "Physician's Statement for Work Restriction/Status" dated 7/20/16, Dr. Lee noted that Petitioner could return to work on 7/21/16 with restrictions of "No lifting more than 30-35 lbs, No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking and frequent standing. Driving will be determined by DOT guidelines." (PX6).

In a progress note dated 11/9/16, Dr. Lee noted that "[w]e are checking Vit D which will guide increased supplementation. He will continue and attem[p]t to increase the bone stimulator wear, for the life of the new stimulator battery then discontinue. The goal is to promote increase the fusion consolidation at L3-4 over the long term. Plan DS from surgical f/u at next follow up visit." (PX6).

In a "Physician's Statement for Work Restriction/Status" dated 11/9/16, Dr. Lee noted that Petitioner could return to work on 11/10/16 with restrictions of "No lifting more than 30-35 lbs, No pushing or pulling more than 60 lbs. Occasional bending, sitting, walking and frequent standing. Driving will be determined by DOT guidelines." (PX6).

On 12/20/16, Petitioner underwent an FCE at The Work Center, Inc. which showed that he performed at a Medium physical work demand level below waist heights and Medium-Heavy work demand level above waist heights. (PX12). It was also noted that he provided an "acceptable" effort, but that he also demonstrated some inconsistencies. (PX12).

In a progress note dated 1/5/17, Dr. Lee stated that Petitioner "… is overall improved and at MMI from a surgical standpoint. He will continue to use the bone growth stimulator until the battery expires to aid further bone consolidation. He is discharged with permanent restrictions (please see work release). No further follow-up is scheduled with my office." (PX6).

In a "Physician's Statement for Work Restriction/Status" dated 1/5/17, Dr. Lee noted that Petitioner could return to work on that date with the following restrictions: "No lifting more than 30-35 lbs, no pushing or pulling of more than 60 lbs. Occasional bending, sitting, walking, frequent standing with frequent change of position as needed. Driving of a light category truck is okay. Light duty truck is defined as a truck under 3 tons of capacity as defined by DOT." (PX6). Dr. Lee also indicated that "[p]atient has been released from our medical care." (PX6).

In a letter to Petitioner's counsel dated 4/12/17, Dr. Lee recorded that "[o]n 4/16 2013 the patient reported an injury resulting from slipping on a wet ramp while using a dolly. He injured the left side of his back. He also reported tingling in his left leg. This began on the date of the accident. His range of motion on that date was guarded in left side bending and the showed range of motion of the trunk to be decreased to flexion, extension and pain with left side bending. He had tenderness in the left medial back on deep palpation. On 5/7/2013 Dr. Galeano at Concentra also reported that the pain radiated to the lower portion of the left side of his lumbar region. Motion was decreased to left side bending with pain…" (PX6). Dr. Lee's impression was L4-5 herniated disc and L2-3 protrusion. (PX6). Dr. Lee stated "[t]he patient sustained the above injuries to his lumbar spine on April 16, 2013. He had the objective findings at the surgeries of a large herniation at L4-5 on 10/2/13, and on 10/9/14 a retained L4-5 fragment and the protrusion at L2-3. The records show that the patient had corresponding symptoms the same day of the accident. The pre-existing L5-S1 surgery was 10 years prior and I have seen no evidence that the patient had symptoms from the above diagnosis leading up to the accident. His injury mechanism is sufficient in my experience to explain the above diagnosis. He was functioning at his job prior. On the above basis it can be said that the permanent disability was caused or contributed to by the work injury of 4/16/2013, and that the treatment I provided was related [to] this injury." (PX6).

III. Testimony of Dr. Thomas K. Lee (5/25/17 & 6/1/17)

Board certified orthopedic surgeon Dr. Lee testified that he evaluated Petitioner at the request of Mr. Spear's attorney on 2/27/14. (PX1, pp.4-5). Dr. Lee recorded a history of accident wherein Petitioner "… was delivering liquor with a two-wheeled dolly. He was running out of the back of the truck, twisted, got control of it, dropped and fell to the ground." (PX1, p.5). Following his examination, Dr. Lee's diagnosis was "[s]tatus post L4-5 discectomy and fusion, rule out delayed union, medial position of right S1 screw." (PX1, p.6). Dr. Lee believed that Petitioner was in need of more treatment and recommended "… revising the hardware and exploring the fusion at L4-5." (PX1, pp.6-7).

Dr. Lee testified that he was of the opinion that Petitioner "… was unable to resume his previous occupation and placed certain restrictions of no lifting more than 30 pounds." (PX1, p.7). Dr. Lee also noted that "… it does appear from the start that this was related to the work accident." (PX1, p.7). He indicted as well that he believed the restrictions on Petitioner's ability to work were causally related to the incident on 4/16/13 as described. (PX1, p.8).

Dr. Lee noted that he next saw Petitioner on 6/30/14 at which time they "… discussed removing the hardware, exploring, and planning to revise the S1 screw position. I ordered some preoperative x-rays. We checked some lab tests and we talked about the various intraoperative scenarios that might really decide what the final construct of hardware replacement would be, adjusted his medications, and talked about minimizing the narcotic usage." (PX1, pp.8-9).

Dr. Lee indicated that he next saw Petitioner on 7/28/14 at which time his diagnosis was "[p]ossible L4-5 nonunion, right S1 screw penetration." (PX1, p.9). He noted that his plan for surgery remained unchanged and that he continued to keep Petitioner on the same work restrictions. (PX1, p.9).

Dr. Lee testified that he eventually performed surgery on 10/9/14 consisting of "… L2-3 laminectomy and discectomy. It also included an L2 to L5 fusion. It included revision of hardware, Medtronic. It included an L2-3 posterior lumbar interbody fusion. And also an L2-3 care that was Medtronic. And a L3-4 posterior osteotomy." (PX1, p.10). Dr. Lee indicated that his post-operative diagnosis was "L4-5 incomplete fusion, medial position right screw. Left L3-4 neurofibrosis, L3-4 hypermobility. L2-3 spondylolisthesis." (PX1, p.10). Dr. Lee also opined that Petitioner was unable to work altogether as of the date of surgery. (PX1, pp.10-11). In addition, Dr. Lee noted that the surgery evidenced some neurofibrosis at L3-4, or scar tissue around the nerve roots, and that as a result he needed one more surgery. (PX1, p.11).

Dr. Lee testified that he subsequently performed this additional surgery on 11/22/14 at St. Anthony's Medical Center. (PX1, p.11). He noted that this procedure consisted of "L3-4 lateral interbody fusion with cage placement, cellular allograft placement. And this was done through a left side approach." (PX1, pp.11-12). Dr. Lee indicated that Petitioner's diagnosis following this second procedure was "[i]ncomplete fusion at L4-5, medial position of right S1 screw. And L2-3 and L3-4 spondylolisthesis." (PX1, p.12).

Dr. Lee indicated that he continued to see Petitioner thereafter, starting him on a course

of physical therapy on 2/17/15 and referring him to Dr. Boutwell for pain management. (PX1, p.13). Dr. Lee noted that Petitioner remained unable to work through 9/29/15 when he allowed Petitioner to work in a light duty capacity for the first time. (PX1, p.16). He also ordered a CAT scan at that time, the results of which revealed that "[t]he vast majority of the fusion was well fused. There was question at L3-4. Correlated with his left anterior thigh pain and the location of his back pain." (PX1, pp.16-17). Dr. Lee recommended an external bone growth stimulator to help solidify the fusion. (PX1, p.17). Dr. Lee indicated that following his review of the CT scan on 11/12/15, and "… based on the amount of fusion we were seeing, that [Petitioner] would ultimately work in the medium demand category above the 25-pound lifting restriction… I didn't see him returning to commercial truck driving." (PX1, pp.17-18).

Dr. Lee testified that he continued to see Petitioner, and maintain his restrictions, and that at the time of his 4/20/16 visit he "… anticipated two more months of active treatment and permanent restrictions and that [Petitioner] would not be able to return to his previous level of work." 9PX1, p.20). Dr. Lee believed that he ordered an FCE at the time of his 11/9/16 visit, and that the FCE was completed on 12/20/16. (PX1, p.22).

Dr. Lee stated that at the time of his 1/5/17 visit, Petitioner "… had low back pain, paresthesias in the left leg, left leg pain, left hip pain. Felt the pain hadn't changed from the previous visit. Was moderate and had pressure, like dull, burning quality radiating to the left hip." (PX1, p.21). Dr. Lee agreed he subsequently received additional records from Petitioner's attorney, including records from Concentra, Dr. Mirkin and Dr. Wilke. (PX1, pp.22-23). Dr. Lee testified that at the conclusion of his treatment of Petitioner, and following his review of the additional records, his diagnosis Mr. Spear had "… a pseudoarthrosis of his lumbar spine. He had disc herniation at L4-5. He had screw penetration at S1. So the incomplete fusion was the L4-5 level. The medial position screw was on the right at S1. He had L3-4 hypermobility as well. He had left side L3-4 neurofibrosis. And he had L2-3 spondylolisthesis." (PX1, p.24). Dr. Lee was also of the opinion that the accident on 4/16/13 was "… a causative factor in all of those diagnoses." (PX1, pp.24-25). He likewise agreed that the accident in question more likely than not caused those diagnoses. (PX1, p.25). In addition, Dr. Lee felt that all of the treatment he rendered -- including surgery, therapy and pain management services – were reasonable and necessary in order to cure or relieve Petitioner of the effects of his injury of 4/16/13. (PX1, p.25).

Dr. Lee agreed that as of his last visit on 1/5/17 he placed permanent work restrictions on Petitioner, as outlined in his records. (PX1, pp.25-26). He indicated that he felt those restrictions were causally related to the accident. (PX1, pp.26,28).

When asked about Petitioner's prognosis, Dr. Lee responded: "[w]ell, I think he's very motivated. I think he'll maintain his level of conditioning that he's achieved. And I think he does have some risk of further problems down the line." (PX1, p.26). He also noted that there could easily be changes in Petitioner's restrictions and that "… he likely will have a deterioration of function of some degree over time." (PX1, p.26). More to the point, Dr. Lee indicated that he did not anticipate Petitioner getting any better with respect to his ability to return to work. (PX1, p.27). In addition, Dr. Lee believed that Petitioner was in need of ongoing pain management as of the last time he saw him in January of 2017, and that "… there is a good likelihood that it will be indefinitely." (PX1, p.27).

On cross, when asked whether the evaluator's reference to inconsistent performance and inconsistent effort in Petitioner's 9/16/15 FCE resulted in an invalid FCE, Dr. Lee responded: "I would have to do the FCE myself to answer your question because I don't know what Mr. Burello (the FCE evaluator) means by inconsistent performance or unacceptable effort." (PX1, p.30). When asked his definition of inconsistent performance and unacceptable effort, Dr. Lee testified: "I evaluate a patient's functional capacity evaluation to use that as a tool to help me decide what their actual physical capabilities are… [Inconsistent performance] is a term used by some physical therapists, and it has meaning to them." (PX1, p.31).

With respect to the December 2016 FCE's reference to acceptable effort but with demonstrated inconsistencies, Dr. Lee indicated that he did not know what the evaluator meant by inconsistencies and that he would have to look at the findings. (PX1, pp.33-35).

Dr. Lee agreed that the Concentra note of Dr. Galeno from 4/16/13 shows a specific complaint of severe pain in Petitioner's left chest and thoracic spine. (PX1, pp.37-39). When asked if there is any indication in this history of any pain below the thoracic spine or chest, Dr. Lee stated: "[w]ell, he complains about his back, which was injured on 4/16. I can't tell from this note… I don't know what he means." (PX1, p.39). He agreed that there was no specific reference to low back pain in this note, although there was a reference to tingling in the left leg, which he acknowledged you can see in individuals who have had previous fusion surgery at L5-S1 with instrumentation. (PX1, p.39). When asked whether it was true, then, that the only symptom that corresponds to the lumbar herniation on 4/16/13 would be tingling in the left leg, Dr. Lee testified: "So, no. The answer is that he hurt his middle back, which is what I saw him for, what he describes as his middle back is the patient's statement." (PX1, p.41). He went on to state that "L2-3 in most patient's way of thinking is their middle back. Sorry to tell you that. But that's a fact in my experience." (PX1, pp.41-42). He agreed, however, that the chest and the thoracic spine are not the low back. (PX1, p.42).

With respect to the 4/17/13 Concentra record, and its reference to back pain, thoracic strain and left rib pain sustained at work on 4/16/13, Dr. Lee noted that "[t]hey can be symptoms of lumbar spine pathology. Thoracic strain can be a compensation trying to protect your lower back." (PX1, p.42). He agreed that the reference to back pain, and difficulty bending or twisting due to pain, does not specify if it was low, mid or upper back. (PX1, pp.43-43). He likewise agreed that x-rays of the thoracic spine and left rib were taken at that time, and that there was no indication that there were any x-rays of the lumbar spine. (PX1, p.43). When asked whether it would make sense for the doctors at this clinic to x-ray the lumbar spine if they felt it was injured, Dr. Lee indicated "… you'll have to ask them." (PX1, p.43). Dr. Lee opined that the diagnosis of thoracic strain at the time was "… compensatory due to the lumbar spine injury." (PX1, p.44). He also believed that Dr. Galeona's assessment of thoracic strain and back strain following Petitioner's visit on 4/19/13 included a problem with his low back because the note "… says the pain is located on the left mid back and the thoracic region. So he's differentiating it, too. So I think we're talking about the upper lumbar spine perhaps or – yeah, probably down to L2 from Dr. Galeano's mind." (PX1, p.45). He also stated his belief, as noted with respect to earlier notes, that the reference to pain in the left posterior chest on 4/23/13 was "… compensatory for a lumbar spine injury in this patient's case." (PX1, p.46).

With respect to the 4/23/13 note of Dr. Kiesel, indicating an assessment of chest wall contusion and possible fracture of the rib, unspecified, and whether that includes a low back injury or pathology, Dr. Lee stated "[y]ou'll have to ask Dr. Kiesel because I don't know what he means by possible." (PX1, p.47).

With respect to the evaluation date of 5/9/13, and the note prepared as a result of that visit, Dr. Lee acknowledged that the patient reported moderate to severe left inferior and medial scapular edge myofascial restriction and pain, which he agreed would be in the upper back area by the shoulder blade. (PX1, p.51). Dr. Lee testified that "… I think in that assessment, as I look at it with this fresh in mind as well, the patient is reporting severe left inferior pain. So that's inferior to something but we don't know what, and medial scapular edge myofascial restriction. So I think that I would assume that that is something L2 or below, or at least it's consistent with L2 or below." (PX1, p.51). When asked whether the reference to mid back in the therapy notes also includes a portion of the low back, Dr. Lee testified that "… for that question you ought to ask the physical therapist." (PX1, p.54).

Dr. Lee agreed that there is no reference to groin or leg pain in the 4/16/13 Concentra note, while there is a reference to some tingling in the leg. (PX1, p.56). When asked whether he read the 4/16/13 note as indicating that there were complaints of low back pain, Dr. Lee testified: "[w]ell, we know that he hurt his middle back and that would include L2 from Dr. Galeano's perspective from the best I can tell." (PX1, pp.56-57).

On re-direct, Dr. Lee indicated that none of the information raised on cross concerning the office notes from Concentra changed his opinions as to diagnosis, treatment, work restrictions and medical causation. (PX1, p.60). He agreed as well that virtually every one of those notes referenced Petitioner's low back, mid back and left lower extremity in some manner. (PX1, pp.60-61). He likewise agreed that the 5/15/13 note referenced specific assessment of lumbar radiculopathy and lumbar strain associated with that treatment. (PX1, p.61). Dr. Lee also indicated that he did not find any of those office notes inconsistent with the patient's presentation to his office on the date of his first evaluation. (PX1, p.61).

Dr. Lee reiterated that he believed that '[t]he accident caused the condition that I treated him for", and that the accident on 4/16/13 did cause the need for treatment, including surgery, therapy the bone stimulator, diagnostic studies and referrals to Dr. Boutwell for additional pain management. (PX1, pp.61-62). He also was of the opinion that the accident caused the need for the permanent restrictions he placed on Petitioner. (PX1, p.62).

On re-cross, when asked to look at the 5/15/13 office note and point out what objective findings or subjective complaints support a diagnosis of lumbar radiculopathy or lumbar strain, Dr. Lee responded: "… I think that's a question better for Dr. Galeano because the only thing I'm really seeing is gross exam of the spine. And then he really doesn't talk about – so I really don't know what he did as an exam. So no, I don't see anything that – I would recommend talking to Dr. Galeano." (PX1, p.62).

IV. Testimony of J. Stephen Dolan, M.A., C.R.C. (8/29/17)

Mr. Dolan testified that he is a vocational rehabilitation counselor and that he issued a report following his meeting with Petitioner on 7/25/17. (PX14, pp.4-7). Following evaluation, Mr. Dolan was of the opinion that Mr. Spears did not have access to a reasonably stable labor market. (PX14, p.13). Mr. Dolan noted that this was based on "… Dr. Lee's restrictions, which eliminate all of the jobs that Mr. Spear has ever done. And the fact that he's being treated by a pain management physician. And Dr. Lee in his deposition indicated that he's going to need to continue to be treated by a pain management doctor. I don't think he's going to be a viable candidate for employment." (PX14, p.14). He agreed that this opinion was based at least in part on Mr. Spear's age, academic skills, employment history and work restrictions, adding that Petitioner "… simply doesn't have the skills to work in a job that would meet those restrictions." (PX14, p.14).

On cross, Mr. Dolan indicated that he was aware Petitioner was released to full duty work by Dr. Mirkin, a treating surgeon, on 6/10/13. (PX14, p.15). He stated that he did not include this in his report "[b]ecause [Petitioner] almost immediately had to have a surgery … because of mistakes Mirkin had made… There was a screw that was up against a nerve root." (PX14, p.15). When asked whether Petitioner could return to work as a commercial driver if he were able to pass a DOT physical, Mr. Dolan responded: "I don't see how he could if he can't sit more than occasionally." (PX14, pp.16-17). He indicated that if the DOT was aware of Dr. Lee's restrictions they wouldn't pass him "… because you have to be able to sit for long periods of time. They don't test that because it would take hours to test that." (PX14, p.17). He noted that he is basing his conclusions on "… Dr. Lee's restrictions plus the fact that he's being treated for a chronic pain problem." (PX14, pp.17-18). He noted that "[i]f a person is in chronic pain, they're going to have trouble tolerating a normal work day." (PX14, pp.19-20).

Mr. Dolan stated that in his opinion "… even if [Petitioner] did find such a job, and there certainly are jobs that meet these restrictions, that he's not going to be able to do it for very long because he has a chronic pain problem. Maybe for a short time…" (PX14, p.22). He acknowledged that Petitioner was not taking any narcotic pain medication, but noted that "… you're assuming that the pain is under control. I don't think that's true." (PX14, p.22). When asked whether Dr. Boutwell's statement, in her 2/7/17 report, to the effect that Petitioner's symptoms were stable would lead him to believe that Mr. Spears' pain was being managed and controlled, Mr. Dolan responded: "No. The word stable doesn't mean resolved. It means that they're not changing." (PX14, p.24). He did concede, however, that one doesn't need to be pain free to go back to work, and that it was possible that could return to work if their pain was controlled and being managed, but noted that it "… also depends on whether or not activities such as working would cause it to cease to be stable." (PX14, p.24). He also agreed that we wouldn't know that unless they went back to work "[o]r if they went through some sort of work simulation." (PX14, pp.24-25).

Mr. Dolan agreed that he did not perform a labor market survey and that he did not provide Mr. Spears with any assistance to find a job. (PX14, p.25). He noted that Petitioner provided him with documentation of a job search that included 134 employer contacts. (PX14, p.25). Mr. Dolan stated that he "… wouldn't have any problem with that number of inquiries. I do have a problem with the fact that he was inquiring about jobs that don't meet his restrictions." (PX14, p.25). He also conceded that it was "probably true" that the best way to determine if an

individual can be gainfully employed would be to find a job and to attempt to work that job. (PX14, pp.25-26).

V. Testimony of Dr. Keith D. Wilkey (4/7/17)

Board certified orthopedic spine surgeon Dr. Wilkey testified that he saw Petitioner on two occasions – on 10/7/13 and 5/6/14 -- and that he was "… originally asked to provide a second opinion for clearance for surgery for an adjacent segment deterioration and possible injury." (RX1, pp.4-6). Dr. Wilkey noted that "[w]hat I really remember is when he came back to me the second time, when he had a malpositioned screw, that's what I really remember about Mr. Spear. But I do recall on the first visit I was asked to provide a second opinion for surgery, which I thought he needed." (RX1, p.12).

Dr. Wilkey indicated that following his examination on 10/7/13 he arrived at a diagnosis of "… a herniated disk resulting in central stenosis, left leg radiculopathy, status post fusion L5-S1, and no evidence of thoracic disease ongoing." (RX1, pp.10-11). Dr. Wilkey testified that based upon "… the information that I had and what I had obtained from Mr. Spear, I determined that the work-related injury of April 16th [2013] was the causative or prevailing factor for his complaints at that time." (RX1, p.11). He noted that at the time of his examination he "… thought Dr. Mirkin had his diagnosis and condition well diagnosed and had an acceptable treatment plan." (RX1, p.11). He also indicated that he "… didn't think [Petitioner] should work. I thought he should remain off work so the restriction was no current work." (RX1, p.11).

Dr. Wilkey testified that at the time of his second IME on 5/6/14 he "… was asked a very specific question. Does this person have a malpositioned screw? And the answer to that was clearly yes." (RX1, p.16). He noted that at that time he recommended that "[t]he screw be removed and he potentially needs another bone graft, but I don't recall specifically." (RX1, p.16). He also indicated that he still thought Petitioner needed to remain off work. (RX1, p.16).

In reviewing the records, Dr. Wilkey indicated that the records of treatment from 4/16/13 through 9/25/13 did not support what Petitioner told him in October of 2013, noting that "[h]e told me he developed immediate onset of low back, left groin, and leg pain. This was immediate onset, and he is describing a left leg radiculopathy. So that is essentially the summary of what he told me his symptoms were on the onset. And 95 percent of my opinion initially was based upon that statement – or those statements." (RX1, p.19). Dr. Wilkey testified that he then "… spent a considerable amount of time diffing through the records and actually getting what the doctors summarized his complaints at each of those visits… [a]nd indeed, he did have complaints of some left leg tingling but no leg pain or back pain until – my note says that there was no mention of any back pain or leg pain until July 12th of 2013 and July 26th of 2013, respectively, for each of those body parts. So essentially he went from the injury date in mid April through May, June, July three months later. That's when he really started focusing, and his complaint became back and leg pain, which is quite a bit different than what he described to me initially, and that's the reason I changed my opinion." (RX1, pp.20-21).

Dr. Wilkey testified that after his second IME in May of 2014, he was of the opinion that "… the need for the cause of the surgery that I recommended in May of 2014 was causally

related to the surgery that was undertaken sometime after that October … evaluation." (RX1, p.22). He indicated that he initially thought that the surgery in 2013 was causally related to the alleged work accident "… given what I was led to believe. And then after doing the detective work, the answer is no, I don't. I think I was initially incorrect. With the additional information that I was given and spent time looking through, my opinion changed, and I don't think it's related to the work accident. I think it's just adjacent segment degeneration as to be expected of anybody following a fusion." (RX1, p.22). He noted that Petitioner had a pre-existing condition – a degenerative disc at L4-5 – and that "[m]y opinion in October of 2013 was based upon the fact that he developed immediate onset of left leg pain, and that wasn't the case as it turns out to be." (RX1, p.22). Along these lines, he stated that he was aware that Petitioner had previously undergone surgery by Dr. Lang consisting of a unilateral fusion at L5-S1. (RX1, pp.22-23).

On cross, Dr. Wilkey agreed that he changed the opinion expressed in his initial report, and that this was predicated upon his review of records forwarded to him by defense counsel. (RX1, pp.23-24). He noted that Petitioner "… told me that he had the immediate onset of low back and left leg pain. That's completely different than what the actual facts are" based on records dated 7/12/13 and 7/26/13. (RX1, p.24).

Dr. Wilkey testified that he did not have an opinion as to whether the 4/16/13 accident might or could have contributed to cause the diagnosis and need for treatment provided by Drs. Mirkin and Lee, noting that "... I think they were treating adjacent segment disease. That's all I can say." (RX1, pp.25-26). He agreed that it was his opinion that the biggest part of Petitioner's problem was the preexisting adjacent segmental deterioration. (RX1, p.26). He also conceded that he could not rule out that the accident might have at least been a causative factor in aggravating that underlying deterioration. (RX1, p.26). Likewise, he was willing to concede that it might have been at least something of a causative factor in his need for the subsequent treatment undertaken by Drs. Mirkin and Lee. (RX1, p.26).

Dr. Wilkey agreed that the initial Concentra note dated 4/16/13 references tingling in the left leg, which he noted "… would be an abnormal complaint. [But] [t]here was no finding of any neurological numbness that I recall from that report." (RX1, p.27). However, he conceded that if Petitioner was having some tingling in his left leg it could possibly be indicative of some nerve root involvement meaning from his low back. (RX1, p.28). He also agreed that when he was seen the next day he had complaints of low back pain, thoracic pain, and left rib pain. (RX1, p.28). However, he noted that "… my interpretation of that back pain was it was thoracic back pain, not lumbar pain… So yes, it is a diagnosis of back pain. And yes, I could be wrong, but I don't think I am." (RX1, pp.28-29). With respect to the next office note two days later, on 4/19/13, and its reference to both thoracic and back strains, Dr. Wilkey noted that "… it's not lumbar strain. It's back strain." (RX1, p.30). With respect to a reference in the 4/23/13 note to pain radiating to the left hip, Dr. Wilkey testified that "[t]hey're not describing leg radiculopathy. Buttock pain radiating down the back of the thigh to the foot, that's radicular pain." (RX1, pp.30-31).

When confronted with the 4/26/13 Concentra note referencing pain radiating to the lower portion of the left side back in the buttock area, Dr. Wilkey agreed that we may have "[p]ossibly" reached the lumbar spine. (RX1, pp.32-33). However, he noted that there was "[n]o

mention of leg pain here." (RX1, p.33). As a result of this note, while noting that there was no mention of lumbar pain, Dr. Wilkey was willing to agree that Petitioner had lumbar complaints ten days out from the accident. (RX1, p.33). However, Dr. Wilkey stated that "[t]he reason I changed my opinion is because it had to do with leg pain which he said he had immediately, and we haven't hit anything about leg pain yet." (RX1, p.35). He agreed that there were left lumbar complaints at the time of the 5/7/13 visit, stating that "… it does say that it radiates from the chest wall to his lumbar spine." (RX1, p.35). After some prodding, Dr. Wilkey was also willing to concede -- "[i]f you take that sentence out of context" -- that complaints in the lower left lumbar area could be consistent with his diagnosis of L4-5 disk herniation, but he claimed "… that's not what the examiner is describing." (RX1, p.36).

When shown a physical therapy note dated 5/9/13 referencing low back and paresthesia/tingling in the lower back, Dr. Wilkey was only willing to concede that this "[p]ossibly" showed a radicular component in the left lower extremity related to his lumbar problems. (RX1, p.38). He also conceded that treatment undertaken at that time was directed to Petitioner's low back. (RX1, p.38). He also acknowledged that this same physical therapy facility recorded intermittent radiating symptoms in the left lower extremity and constant back pain on 5/13/13. (RX1, p.39).

When asked whether this evidence showed that Petitioner had some radicular symptoms and some lumbar complaints before July of 2013, as he claimed, Dr. Wilkey responded: "[n]o. I'm not going to concede that. His main complaint was thoracic chest pain all throughout the whole time he was being seen, up until July." (RX1, p.40). Dr. Wilkey was also asked about the Concentra report dated 5/15/13 that showed leg radiculopathy and lumbar strain as assessments one and two, respectively. (RX1, p.42). He finally agreed that by this point Petitioner had been diagnosed with these two findings. (RX1, pp.42-43). However, Dr. Wilkey then goes on to maintain that "[t]here weren't any [lumbar radicular complaints] until July, and I'm still going to state that." (RX1, p.44). He claimed that "… the focus was on the thoracic spine up until July. You may be able to find little bits and pieces that fit the picture that you [Petitioner's attorney] want to paint, but that's not what these doctors were dealing with." (RX1, p.45).

When asked whether he had any file contents other than defense counsel's 12/22/16 letter when he authored his 1/15/17 report, Dr. Wilkey replied: "I don't think so." (RX1, p.43). He later claimed that he misunderstood the question and that defense counsel sent him his IME reports. (RX1, pp.46-47). When confronted with his reference in his 1/15/17 report referencing no lower back or leg pain until 7/12/13 and 7/26/13, Dr. Wilkey claimed that his report was "… very accurate." (RX1, p.47). He agreed that his report said he was changing his causation opinion because there was no indication of low back or left leg symptoms prior to July of 2013, not that his main complaint wasn't his low back. (RX1, p.48). He then agreed that "[y]es, he had lumbar complaints. I will agree with you there" only to once again maintain that his statement to the contrary in his report was accurate. (RX1, p.49).

Dr. Wilkey agreed that the mechanism of injury he noted in his 10/7/13 report could "[p]ossibly" aggravate a preexisting lumbar condition. (RX1, p.50). He also agreed that he confirmed a diffuse disk herniation at L4-5 via his review of the diagnostic studies, and that it was the type of finding that could "[p]ossibly" have been caused or at least aggravated by the mechanism as described to him by Petitioner. (RX1, p.53). He agreed that his assessment at the

time of his October 2013 evaluation was that of herniated disk, left leg radiculopathy, status post fusion L5-S1. (RX1, p.55). However, when asked about his 1/15/17 reports reference to only a disk bulge and mild stenosis, Dr. Wilkey stated: "I'm not making a distinction there medically. I'm saying that he had a disk bulge. It could be a herniation. It's a disk abnormality. There's no doubt he had that." (RX1, p.54).

On re-direct, Dr. Wilkey agreed Petitioner initially treated with various doctors at Concentra who were not surgeons and ultimately was referred to Dr. Mirkin. (RX1, p.62). He agreed that in Dr. Mirkin's 5/22/13 report there was no mention of a low back condition with radiculopathy, and that "[t]here's no indication from Dr. Mirkin that this was even a lumbar or a radicular complaint unless almost his very last record. Basically he was treating him for a thoracic, thoracolumbar strain." (RX1, pp.62-63). He also noted that given his pre-existing condition he would expect Petitioner to have occasional lumbar pain and tingling down a leg, noting "[t]he rate of adjacent segment deterioration is about 30 percent in the population that has a fusion. Generally these people will become symptomatic within ten years and require surgical – some type of surgical intervention." (RX1, p.63). Dr. Wilkey testified "… I base my decision upon, for the most part, what Dr. Mirkin was alluding to. And up until his very last note … he wasn't treating radiculopathy. He was threating thoracolumbar thoracic pain." (RX1, p.64).

Conclusions of Law

Based on the above, and pursuant to the Circuit Court Decision and Order of Judge Duffy, the Commission reverses the Arbitrator's decision and finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on 4/16/13, and that Petitioner's current condition of ill-being relative to his lumbar spine condition is causally related to said accident. In conjunction with the Circuit Court Order, the Commission relies on the opinion of treating orthopedic surgeon Dr. Lee over that of Respondent's §12 examining physician Dr. Wilkey, who had previously opined that Petitioner's lumbar condition and need for surgery was causally related to the accident in question on no less than two occasions, before being asked by defense counsel to re-consider his opinion two-and-a-half years later. Furthermore, even after changing his opinion, Dr. Wilkey conceded that he could not rule out that the accident might have at least been a causative factor in aggravating Petitioner's preexisting adjacent segmental deterioration. (RX1, p.26).

The Commission also finds, based on the above finding as to causation, that Petitioner is entitled to the reasonable and necessary medical expenses related to said injury as set forth in PX13, pursuant to §8(a) and §8.2 of the Act.

In addition, with respect to Petitioner's claim for maintenance benefits, the record shows that in a progress note dated 1/5/17, Dr. Lee stated that Petitioner "… is overall improved and at MMI from a surgical standpoint. He will continue to use the bone growth stimulator until the battery expires to aid further bone consolidation. He is discharged with permanent restrictions (please see work release). No further follow-up is scheduled with my office." (PX6). In a separate "Physician's Statement for Work Restriction/Status" on that date, Dr. Lee noted that Petitioner could return to work at that time with the following restrictions: "No lifting more than 30-35 lbs, no pushing or pulling of more than 60 lbs. Occasional bending, sitting, walking, frequent standing with frequent change of position as needed. Driving of a light category truck

is okay. Light duty truck is defined as a truck under 3 tons of capacity as defined by DOT." (PX6). Dr. Lee also indicated that "[p]atient has been released from our medical care." (PX6).

Petitioner testified that he undertook a job search after Dr. Lee concluded he had reached MMI and released him from care in January of 2017. (T.33). He indicated that he provided job search logs to his attorney and he had "… even gone on a few interviews." (T.33-34). He noted that neither Driver Services nor the workers' compensation carrier tendered any job search assistance, and that his employer "… actually released [him] three days after [his] injury… The employer told [him] they no longer needed [his] services and they were releasing [him]… They fired [him]." (T.34). He agreed that the job search logs show that he made approximately 200 contacts since he was found to be at MMI by Dr. Lee in January of 2017, noting that "[he] didn't count them. [He] just did as many as [he] could when [he] was able to." (T.35).

Based on the above, and in light of Judge Duffy's remand order regarding causation, the Commission finds that Petitioner is entitled to maintenance benefits from 1/5/17, the date of Dr. Lee's release to light duty work, through 10/5/17, the date of the hearing at arbitration, for a period of 39-1/7 weeks.

Finally, based on the above, and the record taken as a whole, the Commission finds that a determination as to the nature and extent of Petitioner's injuries is premature at this time. The Commission notes that treating orthopedic surgeon Dr. Lee had released Petitioner from his care with light duty restrictions on 1/5/17. However, Respondent provided Mr. Spear with absolutely no job search assistance much less vocational rehabilitation services. Instead, Petitioner was forced to conduct a job search on his own, with not unexpected results. Furthermore, while vocational rehabilitation counselor J. Stephen Dolan testified that he believed Petitioner did not have access to a reasonably stable labor market and was not a viable candidate for employment (PX14, pp.13-14), he conceded that there "certainly are jobs that meet [his] restrictions…" which he may be able to do for a short time. (PX14, p.22). He also acknowledged that it was possible that a person could return to work if their pain was controlled and being managed (PX14, p.24), and that you would not know that unless that person went back to work "[o]r if they went through some sort of work simulation." (PX14, pp.24-25). Mr. Dolan also agreed it was "probably true" that the best way to determine if an individual can be gainfully employed would be to find a job and to attempt to work that job. (PX14, pp.25-26).

Therefore, based on the above, the Commission finds that Petitioner is entitled to vocational rehabilitation services pursuant to §8(a) of the Act.

Finally, the Commission notes that in order to facilitate and allow Petitioner to receive these vocational rehabilitation services, this matter will need to be remanded to arbitration. As such, the Commission, sua sponte, hereby converts the matter presently before us to a proceeding pursuant to §19(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 39-1/7 weeks, from 1/5/17 through 10/5/17, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX13, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall authorize and pay for vocational rehabilitation services, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter is hereby converted to a proceeding pursuant to §19(b) 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 of the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

July 2 2021

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

TJT: pmo
o 5/18/21
51

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC002370
Case Name	WILLIAMS, REGINALD v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0337
Number of Pages of Decision	10
Decision Issued By	Maria Portela, Commissioner

Pro Se Petitioner	Reginal Williams
Respondent Attorney	Donald Chittick

DATE FILED: 7/2/2021

/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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REGINALD WILLIAMS,

Petitioner,

vs. NO: 13 WC 2370

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of causation and nature and extent, and being advised of the facts and law, reverses the Order of the Arbitrator as stated below, but attaches the Order for the statement of facts and procedural history, 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 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 disagrees with the Arbitrator's analysis that the "law of the case" doctrine precludes Petitioner from being entitled to a permanent partial disability (PPD) award. It is not completely clear what the Arbitrator considered to be the "binding language employed by Judge McGing," but it seems she was referring to the line in the Circuit Court Order that Petitioner's "lack of credible testimony matched with inconsistent complaints and numerous ER visits make it impossible to determine what, if anything, is causally related to the incident of January 7, 2013." *Cir.Ct.Order at 30; See also Arb.Order at 3.* The Arbitrator also wrote, without citing to any authority, "Causation to a current condition of ill-being is a required element that Petitioner has the burden of proving to be entitled to a permanency award in this case." *Id. at 3*.

We initially note that there is no "binding language" in the Circuit Court Order that precludes Petitioner from receiving an evidentiary hearing regarding permanent partial disability. To the contrary, the Circuit Court confirmed the Commission Decision in its entirety, which included a remand to the Arbitrator pursuant to *Thomas*. This is not a situation where the Commission previously

found no causal connection *at all* between the accident and the alleged injury and, therefore, denied *all* benefits. Of course, in such situations, the matter would not be remanded to the Arbitrator because there would be no remaining issues to be determined.

However, in the case at bar, the Commission found that Petitioner's "current condition" was not causally related to his work accident and found that he reached maximum medical improvement (MMI) as of December 16, 2014. All temporary total disability (TTD) and medical benefits *after* that date were denied. However, that Decision was remanded to the Arbitrator "for **further proceedings** for a determination of a further amount of [TTD] or of **compensation for permanent disability, if any, pursuant to Thomas**…." *Comm.Dec. at 1* (Emphasis added.).

There would have been no reason for the Commission to remand this matter, pursuant to *Thomas*, if it had intended its finding of no causation after December 16, 2014 to preclude a permanency award. To the contrary, the plain language of the decision indicates that there should be an evidentiary hearing on the issue of permanency, "if any."

On remand, instead of holding an evidentiary hearing with testimony from Petitioner regarding his condition-of-ill-being prior to the date causation was found to no longer exist, the Arbitrator decided the "if any" question based on the "law of the case" doctrine. In its brief on review, Respondent did not cite any precedent to support its assertion that Petitioner is not entitled to a permanency award on the basis that "current causation" had already been terminated in a §19(b) decision. Furthermore, the examples Respondent gave of circumstances when no PPD might be awarded (e.g., a minor injury with no residual effects or when a claimant fails to meet his burden of proof) are possible outcomes that would be determined *after a hearing* on the matter; not based on "law of the case." Although Respondent's statement seems axiomatic that "causation to a current condition of ill-being is a required element that Petitioner must prove in order to be entitled to a PPD award" (*R-brief at 4*), we do not believe Respondent is accurately applying the principle in this case. In *Nat'l Freight Ind. v. IWCC*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473, the Appellate Court addressed the situation where a claimant sustained two work-related accidents, involving injury to the same body part (low back), while working for two different employers. The Court wrote:

> In appeal No. 5-12-0047WC, claimant challenges the Commission's decision as it relates to permanency in case No. 08 WC 56874 against Fischer Lumber. As noted earlier, the arbitrator determined that the injuries claimant sustained on November 6, 2006, while working for Fischer Lumber, had not reached maximum medical improvement by December 3, 2008, the day prior to claimant's second accident. Therefore, the arbitrator stated, "no permanency is awarded." The Commission affirmed this finding. On appeal, claimant does not dispute the finding that he was not at maximum medical improvement prior to the December 4, 2008, motor-vehicle accident. He asserts, however, that he is entitled to a permanency award from Fischer Lumber "for his non-operated herniated disc at L3-4."
>
> Initially, we note that it is not clear what the arbitrator meant when he stated that "no permanency is awarded." Was he denying claimant a permanency award from Fischer Lumber outright? Or did he conclude that it was premature to assess permanency given that claimant had yet to reach maximum medical improvement? Our difficulty in interpreting the arbitrator's finding is compounded by the fact that, although the Commission affirmed and adopted the decision of the arbitrator, it also remanded the 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*." (Emphasis added.) See *Thomas*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794. **To the extent that it was the intent of the arbitrator and the Commission to rule on the propriety of a permanency award, we conclude that it was improper to do so at this stage of the proceedings.**

Nat'l Freight at ¶¶37-38; 485 (Emphasis added). The Court concluded:

> the parties clearly intended to proceed pursuant to section 19(b) of the Act. Moreover, the foregoing establishes that **claimant did not intend the section 19(b) proceeding to resolve the issue of permanency**. Indeed, we note that while some of the doctors were posed questions regarding permanency, none of them expressed an opinion related to the issue of permanent disability, presumably because claimant had yet to reach maximum medical improvement. As such, **to the extent that the arbitrator and the Commission addressed the propriety of permanency with respect to the injury claimant sustained while claimant was employed by Fischer Lumber, we find that it was improper to do so at this stage of the proceedings**.
>
> Moreover, we find **it would be inconsistent to determine that the injury claimant sustained while working for National Freight constituted an independent, intervening cause and award no permanency for the injury claimant sustained while working for Fischer Lumber**. In this regard, we note that our analysis affirming the Commission's finding that the motor-vehicle accident in which claimant was involved while working for National Freight constituted an independent, intervening cause was based on the finding that **the second accident resulted in a change to claimant's symptoms, the pathology of claimant's condition, the type of surgical intervention, and his ability to work**. In other words, **we concluded that the second accident** did not simply represent a continuation of the injury resulting from the first accident. Rather, it **caused a separate and distinct injury that broke the causal chain**. **Since claimant suffered separate and distinct injuries arising from two different accidents, he should be allowed to seek a permanency award for each accident**. If the two injuries are divisible, as the Commission found, it should be able to assign separate permanency awards for each of the two accidents. Accordingly, we vacate the Commission's finding that claimant is not entitled to a permanency award from Fischer Lumber and **remand the matter to the Commission with instructions that it determine the permanency attributable to each separate injury**.
>
> III. CONCLUSION
> For the reasons set forth above, we conclude that the Commission properly determined that **the injury** claimant sustained on December 4, 2008, while **working for National Freight constituted an independent, intervening cause breaking the causal connection** between claimant's current condition of ill-being and the injury he sustained on November 6, 2006, while working for Fischer Lumber. **However, we vacate the Commission's finding that claimant is not entitled to a permanency award from Fischer Lumber** and remand this cause for further proceedings pursuant to *Thomas*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794.

Nat'l Freight Ind. v. IWCC at ¶¶ 42-45; 488 (Emphases added). Therefore, the Court held that, even

though there was an intervening accident that broke the causal connection of the first accident, the claimant was still entitled to a permanency award for the first accident. Furthermore, the issue of permanency was premature since the hearing had been held pursuant to §19(b).

We are mindful of the differences between *Nat'l Freight* and the case at bar. For example, *Nat'l Freight* involved a claimant who sustained two *work-related* accidents with two different employers, and it was found that the second accident broke the chain of causation from the first. In contrast, causation in Petitioner's case was terminated based on his lack of credibility and the opinion of Respondent's §12 examiner (as opposed to an intervening accident). Another difference is that the claimant in *Nat'l Freight* was found *not* to have yet been at MMI from the first accident while Petitioner was explicitly found to be at MMI from his work accident. Third, in *Nat'l Freight* no doctors expressed an opinion related to permanent disability "presumably because claimant had yet to reach" MMI. *Nat'l Freight* at 487. In contrast, Respondent's examiner, Dr. Levin, did determine an impairment rating since he had opined that Petitioner had reached MMI. However, none of these differences change the fact that the initial arbitration hearing was held under §19(b) of the Act.

To briefly summarize the case at bar, although Petitioner was still seeking treatment, Dr. Levin opined that Petitioner was at MMI as of December 16, 2014. The Commission agreed with this MMI date and terminated causation, TTD and medical expenses on the basis that Petitioner's testimony was not credible. He "appeared to exaggerate the severity of his symptoms as they did not correlate to clinical findings, and Petitioner appeared to be seeking pain medication and trying to bolster his workers' compensation claim." *Comm.Dec. at 1-2*. Of course, Petitioner's lack of credibility would be a factor in determining whether he is ultimately entitled to a permanency award (or how much), but we do not find the Commission's previous finding regarding causation to be "law of the case" regarding his entitlement to a permanency hearing.

As it relates to the case at bar, and despite the differences between the cases, the key points from *Nat'l Freight* are the Court's holdings that:

1) a determination of permanency is premature when the hearing is held under §19(b); and

2) a permanency award may be appropriate for a work accident even if there is a subsequent accident that breaks the causal connection of the first accident.

We find there should not be a distinction whether causation is terminated by an intervening accident or, instead, because the Commission terminated causation based on a §12 opinion and Petitioner's lack of credibility. In both scenarios, causation has been terminated. Despite that "severing" of causation, the Court in *Nat'l Freight* found that the claimant was still entitled to a permanency award for the first accident.

Applying *Nat'l Freight* to the case at bar, this was a §19(b) hearing. Although the Commission could terminate causation as to TTD and medical, it would have been improper for the Commission to have made a determination as to permanency because that was not an issue before it. The Commission acknowledged this by using the *Thomas* remand language in its decision. Therefore, the Commission's finding that causation had ended for TTD and medical, as of the date of Dr. Levin's examination, is not "law of the case" regarding permanency.

Finally, although Petitioner's Petition for Review did not list TTD as an issue, his *pro se* brief on review, filed November 18, 2020, is titled "Petitioner's Request for Total Temporary Disability Award" and focused primarily on his allegation of unpaid TTD. The original Arbitration decision found Respondent was entitled to a credit of $97,120.57 for TTD paid. The Commission modified the decision regarding causation and medical expenses and reduced the TTD award. It otherwise affirmed and adopted the decision, which includes the Arbitrator's finding regarding Respondent's credit. The Circuit Court confirmed the Commission Decision in its entirety. Therefore, the issues of TTD period and Respondent's credit are "law of the case." Respondent argues that it is entitled to a credit for overpayment of TTD in the amount of $5,931.18. We find that the application of this credit should be addressed by the Arbitrator, on remand, after a hearing on permanency pursuant to *Thomas*.

Based on the above, we hereby:

1) Deny Petitioner's request for past TTD since that issue is settled.

2) Vacate the Arbitrator's Order that the "law of the case" doctrine precludes Petitioner from being entitled to a permanency award. We find that, pursuant to *Nat'l Freight,* the prior hearing was held under §19(b) and permanency was not at issue.

3) Remand the matter to the Arbitrator, pursuant to *Thomas*, to hold an evidentiary hearing on the issue of permanency. To be clear, we are not instructing the Arbitrator to award permanent partial disability in this case. Rather, the determination of a permanency award, **if any**, must be made after an evidentiary hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

This decision is interlocutory and is not subject to review.

July 2, 2021 /s/ *Maria E. Portela*

SE/ /s/ *Thomas J. Tyrrell*
O: 5/18/21
49 /s/ *Kathryn A. Doerries*

21IWCC0337

STATE OF ILLINOIS)
)
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
ORDER

REGINALD WILLIAMS,
Employee/Petitioner

v.

CITY OF CHICAGO,
Employer/Respondent.

Case # **13WC2370**

consolidated case: N/A

APPEARANCES

On July 23, 2020, Mr. Al Koritsaris, (hereinafter "Mr. Koritsaris") appeared on behalf of the Petitioner and Respondent's counsel, Mr. Donald Chittick (hereinafter "Mr. Chittick") appeared on behalf of the City of Chicago (hereinafter "Respondent").

BACKGROUND

By way of background, former Arbitrator George Andros (hereinafter "Arbitrator Andros") conducted a 19(b)/8(a) hearing in this case on April 28, 2016 and May 17, 2016 and issued a decision finding Mr. Reginald Williams's (hereinafter "Petitioner") condition casually related to the injury, awarded surgery, awarded unpaid medical, prospective surgery, and temporary total disability was awarded up until the end of trial. Respondent filed a timely review thereafter. In a Decision and Opinion on Review issues on April 18, 2018, a unanimous Commission reversed the Arbitrator's finding of causation. The Commission found that Petitioner was not credible, failed to prove causation as to his current condition, and maximum medical improvement on December 16, 2014, the date of Dr. Levin's Section 12 examination. The Commission awarded temporary total disability and certain medical expenses. Petitioner filed a Circuit Court review thereafter. In a 32-page Order and Opinion issued on December 4, 2018, Judge McGing confirmed the Commission's decision.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On December 19, 2020, Petitioner's counsel and Respondent's counsel presented their distinct positions regarding this matter.

Petitioner's counsel presented the following position on proceeding to hearing on the nature and extent of Petitioner's alleged injury on January 7, 2013 following the 19(b) hearing, Commission review and Circuit Court appeal:

Petitioner was injured on January 7, 2013 while working for the City of Chicago. He was injured as a passenger in a City truck that was going to a job, when the truck slammed into a viaduct a very high speed. Petitioner injured his back as a result of the collision. The claim was initially accepted by the Respondent and deemed compensable. Petitioner underwent significant treatment to his lower back including medication therapy,

physical therapy and lumbar epidural steroid injections. He remained off work during this time and was paid TTD benefits for several months. Petitioner remained symptomatic following the aforementioned treatment and surgical intervention was recommended.

On December 16, 2014, he was seen for a Section 12 examination by Dr. Levin who opined that the Petitioner did suffer an injury do his lower back related to the occurrence, however disagreed that the Petitioner required surgery. He opined that the petitioner reached MMI and could return back to work with no restrictions. He also provided an impairment rating of % loss of a person. TTD benefits were severed following the Section 12 exam.

The case was tried before Arbitrator Andros who held that the Petitioner's current condition of ill-being as of the time of trial was related to the January 7, 2013 occurrence, awarded the surgery, awarded all of the unpaid medical bills submitted and awarded TTD benefits from the date of injury to the time of trial. (172 2/7 weeks).

The case was reviewed by the Respondent and the Commission held that the Petitioner's current condition was not causally related to the work injury, held that the surgery was not reasonable and/or necessary and held that the Petitioner reached MMI on December 16, 2014, the day that he appeared for the Section 12 exam. Further, the Commission reduced the TTD period owed to the Petitioner to 101 1/7 weeks and upheld the Arbitrator's decision that the unpaid bills submitted were the responsibility of the Respondent.

The case was appealed to the Circuit Court and they affirmed the Commission's decision. The Petitioner attempted to appeal to the 1st district pro se but the Appellate Court denied to hear the appeal due to it being filed untimely and remanded to the Commission.

Petitioner's position is that he is entitled to a PPD award for the injury and treatment that occurred from January 7, 2013 to December 16, 2014, since the Commission held the Petitioner was at MMI as of that date. This would include an unoperated herniated disc with injections. Further, the Petitioner's position is that the Arbitrator would have to determine what the PPD is by considering the impairment rating provided by Dr. Levin along with the other four factors delineated by the Act.

In contrast, Respondent's counsel presented the following response:

The Commission found (and the Circuit Court affirmed) that "Petitioner failed to prove that his current condition of ill-being is causally connected to the work accident of January 7, 2013." The Commission *could have* made a more narrow ruling only (i.e. "the need for surgery is not causally related to the accident," or "Petitioner's lost time from work after X date is not causally related to the injury"); however, the panel of three Commissioners chose to use broader language and deny causation entirely. This was, in part, based on the Commission finding "Petitioner's testimony not to be credible."

My opponent seems to be arguing that Petitioner is entitled to an award of PPD merely by virtue of the fact that there was an accident that arose out of and in the course of employment. However, it is easy enough to imagine any number of scenarios in which a Petitioner might have a work-related accident that doesn't give rise to an award of PPD (as in the case of a minor injury that fully heals with no residual effects *or* where Petitioner's evidence/testimony is so lacking that he fails to meet his burden of proof). This is why causation to a current condition of ill-being is a required element that Petitioner must prove in order to be entitled to a PPD award, and, here, the "law of the case" is that Petitioner has failed to establish this element.

Petitioner's counsel refuted Respondent's position that the Petitioner is not entitled to PPD award since the Commission held that the Petitioner's current condition of ill-being was not causally related to the occurrence.

Petitioner maintains that the Commission's order when read plainly infers that the Petitioner's condition at the time of trial, which was a surgical back injury was not related to the occurrence. The commission did not mean that the Petitioner's back injury was not causally related to the occurrence because the Commission clearly states that the Petitioner reached MMI as of the Section 12 exam and awarded TTD and medical bills. Further the Commission did not comment on permanency since nature and extent was not an issue at the initial 19(b) trial. Further, if the Commission meant to state that the Petitioner failed to prove causation of any existing back injury it would be a legal impossibility based on that premise to award medical bills and TTD. As such PPD needs to be determined either after testimony or by simply looking at the Section 12 report, Petitioner's testimony about his job duties, job physical demand letter, etc.

After hearing the parties' arguments and due deliberation, I hereby **make findings and reach conclusions as follows:**

ANALYSIS

The issue presented is whether Petitioner is entitled to a PPD award for the injury and treatment that occurred from January 7, 2013 to December 16, 2014, since the Commission held the Petitioner was at MMI as of that date. This would include an unoperated herniated disc with injections. Further, the Petitioner's position is that the Arbitrator would have to determine what the PPD is by considering the impairment rating provided by Dr. Levin along with the other four factors delineated by the Act.

The Commission found that Petitioner was not credible, failed to prove causation as to his current condition, and maximum medical improvement on December 16, 2014, the date of Dr. Levin's Section 12 examination. The Commission awarded temporary total disability and certain medical expenses. Petitioner filed a Circuit Court review thereafter. In a 32-page Order and Opinion issued on December 4, 2018, Judge McGing confirmed the Commission's decision. Specifically, the Court found that Petitioner failed to meet his burden of proof on the issue of causation and that his "lack of credible testimony matched with inconsistent complaints and numerous emergency room visits make it impossible to determine what, if anything, is casually related to the incident of January 7, 2013." Causation to a current condition of ill-being is a required element that Petitioner has the burden of proving to be entitled to a permanency award in this case.

Under the law-of-the-case doctrine, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Miller v. Lockport Realty Group, Inc.*, 377 Ill. App. 3d 369, 374, 878 N.E.2d 171, 315 Ill. Dec. 945 (2007). The Appellate court has held that principles underlying the law-of-the-case doctrine should be applied to matters resolved in proceedings before the Commission. *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 786 N.E.2d 218, 271 Ill. Dec. 960 (2003). This doctrine has been specifically applied to determinations of causal connection. Once the first causation finding became a final judgment, it also became the law of the case and was not subject to further review. *Ming Auto Body / Ming of Decatur, Inc. v. Indus. Comm'n*, 387 Ill. App. 3d 244; 899 N.E.2d 365; 2008 Ill. App. LEXIS 1132; 326 Ill. Dec. 148 (2008).

Based on the foregoing, the Arbitrator, having considered the principle of the "law of the case doctrine" and the binding language employed by Judge McGing, finds that, since Petitioner failed to establish causation to any condition, he is not entitled to a permanency award.

Unless a Petition for Review is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

Signature of Arbitrator

8/19/2020
Date

AUG 26 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC035770
Case Name	STEWART, JAMES v. THE AMERICAN COAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0338
Number of Pages of Decision	13
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Julie Webb

DATE FILED: 7/2/2021

/s/Deborah Simpson, Commissioner

Signature

21IWCC0338

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: Occupational disease	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES STEWART,

Petitioner,

vs. NO: 15 WC 35770

THE AMERICAN COAL 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, reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that he suffered from an occupational lung disease that arose out of and in the course of his coalmine employment.

I. FINDINGS OF FACT

a. Petitioner's Testimony

Petitioner was regularly exposed to coal and rock dust while working underground in coalmines for 20.5 years. On August 15, 2015, Petitioner was again exposed to coal dust as he worked his final shift as Respondent's pump foreman. Petitioner testified that he then quit and left Respondent's mine due to his ongoing leg problems. He testified that the stressfulness of his job did not substantially affect his decision to quit, although he acknowledged that in his exit interview, he indicated that he could not handle the job's stress. Petitioner testified that irregular blood pressure and being out of breath were also among his reasons for leaving the mine.

Prior to quitting on August 15, 2015, Petitioner had worked for Respondent since December 5, 1994 with the last 11 years of employment in the pump foreman position. Petitioner testified that he first noticed breathing problems in 2010 when he had to walk up a slope to evacuate the mine. Petitioner further testified that while working in the mines, he needed to take breaks and sometimes required his coworkers' help to finish a job due to his breathing problems.

At the hearing, Petitioner testified that his breathing problems had worsened since 2010. He becomes short of breath after walking one-and-a-half blocks and needs to stop after climbing one flight of stairs. Petitioner explained that when he tries to walk any distance, he gets short of breath, his leg pain increases, and he sometimes cannot feel his feet. Petitioner further testified that he can no longer go fishing and hunting as he once enjoyed. He testified that he was also no longer able to perform his coalmining job, because he would not be able to breath. For his breathing problems, Petitioner now takes Albuterol three times a day.

Additionally, Petitioner has smoked since 1989 and currently smokes half a pack of cigarettes per day. Aside from his breathing problems, Petitioner also has vein problems in his legs, high blood pressure, irritable bowel syndrome, and a history of heart aneurysms. After leaving the mine, Petitioner applied for Social Security Disability in October 2015. Petitioner testified that he has needed assistance with ambulation for some time, occasionally uses a scooter or walker, and cannot walk on uneven ground.

b. Deposition Testimony of Dr. Suhail Istanbouly

Dr. Istanbouly specializes in pulmonary and critical care medicine with 30% of his practice concerning the treatment of coalminers. Nevertheless, he is not a certified B-reader. Upon referral from Petitioner's attorney, Dr. Istanbouly examined Petitioner on February 16, 2016. Dr. Istanbouly testified that Petitioner reported having a chronic daily cough for several years that was sometimes severe. He testified that the cough was triggered by strenuous activity and productive of mild, dark brownish sputum. Dr. Istanbouly also testified that Petitioner had exertional dyspnea and experienced shortness of breath from walking two blocks.

Dr. Istanbouly opined that Petitioner's daily cough indicated underlying chronic bronchitis with the two contributing factors of long-term coal dust inhalation and smoking. He testified that Petitioner's sputum production in the morning was also consistent with chronic bronchitis. Dr. Istanbouly further opined that Petitioner's exertional dyspnea indicated abnormal lung function that could be coal workers' pneumoconiosis ("CWP") and chronic bronchitis.

Dr. Istanbouly testified that although Petitioner's chest examination was normal, it was not unusual for someone with CWP to have no abnormalities on examination. He testified that Petitioner's spirometry test was also within a normal range and showed no obstructive defect, but nevertheless, it was not unusual for someone with CWP to have normal pulmonary function tests.

Dr. Istanbouly further opined that Petitioner's chest X-ray from October 6, 2015 showed mild interstitial fibrosis bilaterally with small tiny opacities consistent with simple CWP. His diagnosis for Petitioner was simple CWP caused by long-term coal dust inhalation. However, Dr. Istanbouly explained that he himself did not assign profusion ratings to films and could not tell whether the profusion on Petitioner's film was 0/1 or 1/0. Nevertheless, Dr. Istanbouly opined that Petitioner had damage to his lungs as a result of his occupational exposure to coalmine dust.

c. Deposition Testimony of Dr. Henry K. Smith

Dr. Smith, a board certified radiologist, has been a certified B-reader since 1987. However,

without any lapse to his certification, Dr. Smith failed the recertification examination twice for over-reading, which meant that he found more disease than was present on the standard film.

At the request of Petitioner's attorney, Dr. Smith reviewed Petitioner's chest X-ray dated October 6, 2015. Dr. Smith testified that Petitioner's films were of diagnostic quality and revealed interstitial fibrosis at a classification of p/p with all zones involved and profusion at 1/1. Dr. Smith opined that the X-ray was consistent with a CWP diagnosis. He testified that the scarring reflected by opacities on chest imaging was permanent. However, Dr. Smith indicated that to see if functional impairment was present and to what degree, pulmonary function testing was needed.

d. Deposition Testimony of Dr. Cristopher Meyer

Dr. Meyer is a board certified radiologist and B-reader who performed approximately 30 to 40 B-readings per week. After first becoming a B-reader in 1999, Dr. Meyer had also been asked to take an academic role with the American College of Radiology's course for the B-reading examination. He is on the ACR Pneumoconiosis Task Force that is redesigning the course and submitting cases for the training module and examination. Dr. Meyer has also served as a board examiner for the American Board of Radiology and was asked to be part of the examination writing committee for the thoracic imaging examination.

At Respondent's request, Dr. Meyer reviewed Petitioner's chest X-ray dated October 6, 2015. Dr. Meyer testified that Petitioner's film showed clear lungs with no small rounded, small irregular, or large opacities. He opined that the film revealed no radiographic findings of CWP. As such, Dr. Meyer gave Petitioner's film a 0/0 profusion rating.

Nevertheless, Dr. Meyer conceded that despite the negative chest X-rays, Petitioner could still have CWP on a pathological level. Additionally, Dr. Meyer noted that mild simple CWP was generally asymptomatic.

e. Deposition Testimony of James R. Castle

Dr. Castle is board certified in internal medicine with a subspecialty in pulmonary disease. For 30 years, Dr. Castle had his own practice that focused on pulmonary and chest diseases. However, in January 2007, he quit seeing patients and decided to semi-retire. Dr. Castle now performs medicolegal examinations or records reviews concerning occupational lung disease part-time. Dr. Castle had been a certified B-reader since 1985 with his most recent certification being good through June 30, 2017.

At Respondent's request, Dr. Castle reviewed Petitioner's medical records and performed a B-reading of his October 6, 2015 chest X-ray. Dr. Castle testified that there was no restriction on Petitioner's pulmonary function testing and no fibrosis affecting gas transfer based upon his performed diffusion capacity. Dr. Castle found that Petitioner fell in a Class 0 impairment and was capable of heavy manual labor based on his respiratory system. Dr. Castle further opined that Petitioner's chest X-ray showed no findings of CWP. He testified that Petitioner had no evidence of any obstruction, restriction, or pulmonary impairment from any cause, including CWP or smoking. As such, Dr. Castle opined that Petitioner did not suffer from any pulmonary disease or

impairment occurring as a result of his occupational exposure to coalmine dust.

Nevertheless, Dr. Castle testified that most individuals with CWP were asymptomatic. He further testified that it was possible for someone with CWP to have normal pulmonary function tests and no abnormalities on examination.

f. Treatment and Employment Records

Although many of Petitioner's treatment records concern conditions unrelated to his alleged respiratory disability, his lungs were often examined. The earliest relevant examination occurred on February 6, 2003 at Petitioner's vascular surgery consultation with Dr. Mark Gazall. Although this visit concerned varicose veins, Dr. Gazall noted that Petitioner's lungs had clear breath sounds and normal diaphragmatic excursion. Petitioner denied shortness of breath with activity at that time.

Several years later, on January 11, 2007, a chest X-ray was obtained with negative results. Petitioner then presented to Primary Care Group after a hyperventilation episode at work. Petitioner reported that he was in a meeting when he could not get a deep breath and passed out. He complained of job stress, anxiety, dyspnea, and shortness of breath. A lung examination revealed normal resonance, no flatness or dullness, normal tactile fremitus, and normal breath sounds. Dr. Larry Jones diagnosed Petitioner with resolved hyperventilation, anxiety and depression, and tobacco use disorder.

Petitioner returned to Primary Care Group on February 20, 2008 with a cough, headache, sinus pain, and congestion. It was noted that difficulty breathing, sputum production, and wheezing were not present. Petitioner also exhibited normal breath sounds on examination. He was diagnosed with acute bronchitis.

Several months later, on November 28, 2008, Petitioner presented to Harrisburg Medical Center with chest discomfort and palpitations. An EKG revealed supraventricular tachycardia. Nevertheless, Petitioner's lungs were clear to auscultation bilaterally. Petitioner with discharged with a Toprol prescription. The following day, a chest X-ray further revealed no acute cardiopulmonary process and lungs that were clear of active infiltrate. Shortly thereafter, in December 2008, Petitioner sought treatment for his left leg cellulitis and venous insufficiency. At his December 5, 2008 visit, Dr. Jones noted that Petitioner's lungs had normal breath sounds.

Petitioner returned to Primary Care Group half a year later on May 19, 2009 for acute maxillary sinusitis and paroxysmal supraventricular tachycardia. At that time, Petitioner's lung examination revealed normal excursion with symmetric chest walls, quiet and easy respiratory effort with no use of accessory muscles, normal breath sounds, no adventitious sounds, and normal vocal resonance. He then returned on September 21, 2009 with a cough, runny nose, stuffiness, and right ear pain. At that time, he was diagnosed with otitis media purulent.

In February and March of 2010, Petitioner treated for heart palpitations and supraventricular tachycardia. At his February 18, 2010 visit, Dr. Jones noted that Petitioner smoked one pack of cigarettes per day, yet had normal breath sounds on examination. On March

3, 2010, an ECG revealed normal results and fair-to-good exercise tolerance. The following day, a Cardiolite stress test further revealed good exercise tolerance with an adequate heart rate and blood pressure response, no ischemia during exercise or recovery, and no evidence of focal reversible defects. Also on March 4, 2010, an echocardiogram showed an enlarged aortic root, preserved systolic function, concentric hypertrophy of the left ventricle, trivial mitral and tricuspid regurgitation with no pulmonary hypertension, and trivial pulmonic and aortic insufficiencies. Petitioner was then admitted to Harrisburg Medical Center from March 8 to March 9, 2010 for acute chest pain with a history of recurrent palpitations and chronic tobacco use. During this visit, a chest X-ray showed new mild cardiomegaly with no acute cardiopulmonary process.

Several months later, on August 14, 2010, Petitioner treated at Primary Care Group for hypertension. Upon review of Petitioner's respiratory symptoms, he had no chronic cough, no decreased exercise tolerance, and no wheezing. An examination of Petitioner's lungs revealed normal breath sounds with no adventitious sounds.

Petitioner returned to Primary Care Group on October 29, 2010 with a fever, chills, and a cough with no difficulty breathing. A chest X-ray was obtained and found a questionable left basilar airspace opacity that could represent atelectasis. The radiologist stated that infectious process could not be excluded. Petitioner's assessment at that time was a viral infection, leg cellulitis/abscess, and chronic venous stasis. Petitioner was then admitted to Harrisburg Medical Center on October 30 and November 1, 2010 for his cellulitis. At the time of his discharge, Petitioner's lung examination revealed no wheezing, rales, or rhonchi. A chest X-ray also noted no active cardiopulmonary disease.

Petitioner was again admitted to Harrisburg Medical Clinic from May 2, 2011 to May 7, 2011 for septic shock. Petitioner reported that he had been working underground in the coalmine when he developed a fever, chills, nausea, a headache, and increasing redness in his left leg. A pulmonary examination revealed bilaterally diminished lungs with some rales. A chest X-ray was also obtained and showed no active cardiopulmonary disease or significant interval change. Petitioner's diagnoses included septic shock, left leg cellulitis and chronic lymphedema, depression, anxiety, and GERD.

On August 9, 2011, Petitioner returned to Harrisburg Medical Center after suffering a syncope episode at work. On examination, Petitioner's lungs were clear. A chest X-ray also revealed mild cardiomegaly with no acute cardiopulmonary process. That same day, Petitioner followed up at Alexander Family Practice. Dr. James Alexander reported that Petitioner had been working in a hot area with little air and did not keep up on his hydration at the time of the incident. On examination, Petitioner's lungs had normal breath and voice sounds with no rales or crackles. Dr. Alexander diagnosed Petitioner with dehydration, heat exhaustion, and sinusitis.

Thereafter, on November 3, 2011, Petitioner treated at Heartland Regional Medical Center for unrelated cervical issues. At this visit, Petitioner's lung examination revealed scattered wheezes. Petitioner also reported a chronic cough due to smoking and working in a lot of dust.

From May 29, 2012 to July 2, 2012, Petitioner then treated at Primary Care Group for depression. During these visits, Petitioner noted no difficulty breathing, cough, or bloody sputum.

Petitioner's chest and lung examinations also revealed normal excursion with symmetric chest walls, quiet and easy respiratory effort with no use of accessory muscles, and normal resonance.

On February 2, 2013, Petitioner returned to Primary Care Group with laryngitis. Petitioner's symptoms did not include difficulty breathing or a cough. Petitioner's examination also revealed normal breath sounds, no adventitious sounds, and normal vocal resonance. When he returned on April 2, 2013 for depression, Petitioner again did not have difficulty breathing, a cough, or bloody sputum. At that time, Petitioner's lungs had normal excursion with symmetric chest walls, quiet and easy respiratory effort with no use of accessory muscles, normal breath sounds, no adventitious sounds, and normal vocal resonance.

Petitioner was then admitted to Harrisburg Medical Center from July 22, 2013 to July 30, 2013 for sepsis, lower extremity cellulitis, and hypertension. A chest X-ray taken on July 22, 2013 showed cardiomegaly without evidence of failure, no acute pathology, and clear lungs. Also, upon being admitted, a pulmonary examination revealed diminished lungs bilaterally and some scattered rhonchi with expiratory wheezes. A subsequent chest X-ray obtained on July 24, 2013 found no acute pathology and clear lungs.

Petitioner thereafter treated at Primary Care Group on August 6, 2013, May 5, 2014, September 30, 2014, and February 4, 2015 for several unrelated conditions, including his leg problems. At all these visits, Petitioner's chest and lung examinations yielded normal results.

On June 1, 2015, Respondent's Senior Vice President hand delivered a letter to Petitioner stating that there would be mass layoffs on August 24, 2015. Respondent informed Petitioner that his position could be eliminated. Then, on August 14, 2015, Petitioner handed in his voluntary resignation to Respondent and filled out an exit interview form. In the exit interview, Petitioner stated that he was leaving for personal reasons, because he could not handle the stress.

Petitioner was again admitted to Harrisburg Medical Clinic from November 12, 2015 to November 14, 2015 for left leg cellulitis. Upon being admitted, Petitioner denied shortness of breath, a dry or productive cough, night coughing, and hemoptysis. A chest X-ray obtained on November 12, 2015 also showed no cardiopulmonary disease. When Petitioner was discharged on November 14, 2015, his respiratory examination found clear lungs to auscultation bilaterally.

On January 8, 2016, a mental disorders disability benefits questionnaire was filled out with Veterans Affairs. Petitioner reported that he had been put on medication for depression after he had problems at his job. He explained that he was never given enough people to do his foreman job and started to stress. Petitioner further indicated that he had begun working longer hours and had to go into the water by himself, despite telling Respondent he could not do so. Petitioner noted that he had left leg problems that involved horrible infections and 11 hospital visits in ten years. Petitioner stated that he could not do it anymore and left his job last August. He indicated that he was now working toward getting disability due to his left leg. In terms of sleeping, Petitioner noted breathing problems, specifically coughing, that woke him up. Dr. Theresa Kelly opined that Petitioner's depressive symptoms involved his current situation of work issues, legal issues, physical ailments, a lack of finances, and a lack of interaction with his children.

Petitioner then filled out a Social Security Administration form over the phone on March 21, 2016. This form discussed his leg pain and did not mention any respiratory illness. Petitioner stated this his infections and swelling limited his ability to work, because he could not walk or stand for more than an hour and could not sit for more than 25 minutes without switching positions. Petitioner further noted that he could no longer walk for long periods of time, ride a bike, be active, and work. He indicated that he could not get around due to his leg infections and pain.

Petitioner next treated at Primary Care Group on June 16, 2016 for anxiety with an associated symptom of dizziness in the mornings. It was noted that Petitioner had no difficulty breathing and had normal breath sounds on examination. Dr. Jones diagnosed Petitioner with anxiety, depression, and limb pain. Shortly thereafter, on June 21, 2016, Petitioner underwent pulmonary function testing that displayed normal diffusion capacity.

Petitioner next presented for occupational therapy on June 23, 2016 for his lymphedema and leg pain. He then reported that he had stopped working in August 2015 due to his leg swelling and inability to complete his job duties. Petitioner indicated that it was difficult for him to walk due to the swelling and pain.

On June 24, 2016, another disability benefits questionnaire was filled out with Veterans Affairs. Petitioner then claimed that his anxiety was due to a hearing problem; however, Dr. Jonathan Denman found insufficient evidence to suggest that tinnitus had caused Petitioner's depression. Petitioner also noted that he had not worked since he retired on August 16, 2015 due to his difficulty sitting and standing. He further reported having two incidents of panic-like symptoms while working in the mines where he became overwhelmed with things that needed done. Dr. Denman noted that Petitioner was also in the process of obtaining a black lung diagnosis.

On July 6, 2016, Petitioner filled out a smoking cessation assessment, in which he expressed an interest in quitting after smoking for 20 years. The reasons he listed for wanting to quit included his ongoing shortness of breath, difficulty breathing, and morning coughing spells.

Petitioner then returned to Veterans Affairs on July 29, 2016 for a physical therapy consultation regarding his lymphedema. The physical therapist determined that Petitioner would benefit from a seated walker to improve his safety and mobility.

On October 25, 2016, Petitioner presented to the Veterans Affairs emergency room with chills, nausea, and potential sepsis. He denied a cough and shortness of breath. On examination, Petitioner's lungs were clear bilaterally with symmetric expansion, even respirations without use of accessory muscles, and no hyperinflation or intercostal indrawing. A thorax CT revealed an enlarged 4R lymph node, enlarged main pulmonary artery, and thoracic aortic aneurysms.

Petitioner next presented for a vascular consultation on October 27, 2016. Dr. Robert Miller indicated that his recent chest X-ray had been abnormal with suggested widening of the mediastinum and questionable mass retrocardiac. Dr. Miller noted that Petitioner had no history of shortness of breath or exercise intolerance. He diagnosed Petitioner with pulmonary artery and thoracic aortic aneurysms. The next day, Petitioner filled out another smoking cessation screening and stated that he was interested in quitting due to his ongoing shortness of breath, routine morning

coughing spells, and new onset of elevated blood pressure.

On November 1, 2016, Petitioner returned to Veterans Affairs for his anxiety. On examination, he had no crackles, wheezing, or rhonchi. He then underwent an echocardiogram on November 10, 2016, which showed a dilated aortic root and ascending aorta, aneurysmal pulmonary artery, left ventricular hypertrophy, indeterminate diastolic function, no tricuspid regurgitation, pulmonic valve doppler, and an aortic valve that appeared to open adequately.

Petitioner next saw Dr. Christian Posner, a cardiologist, on November 14, 2016. Dr. Posner noted that while working on a home construction project six months prior, Petitioner had an episode of chest discomfort with shortness of breath and diaphoresis. Dr. Posner also stated that Petitioner had exertional shortness of breath during the past year and syncope after vigorous coughing for the past two years. He further indicated that Petitioner had a diagnosis of black lung disease after working in the coalmines for 21 years. On examination, Petitioner's lungs were clear to auscultation with no rales, wheezes, or rhonchi. Dr. Posner's impression was chest pain, a thoracic aortic aneurysm, a dilated pulmonary artery, systemic hypertension, hyperlipidemia, paroxysmal supraventricular tachycardia, chronic tobacco use, chronic lung disease, and morbid obesity. In the accompanying nursing note, Petitioner also stated that he had some shortness of breath in the mornings until he cleared his lungs. He further reported that his activity was limited and that he used a walker.

On November 17, 2016, a thoracic CT showed aneurysmal dilation of the ascending thoracic aorta, a suggestion of left ventricular hypertrophy, and significant dilation of the main pulmonary artery. Petitioner then underwent a stress test on November 23, 2016 that found reversible perfusion defects of the apex and anterolateral wall that could be related to motion artifact at the apex and to normalization artifact at the anterolateral wall due to Petitioner's size.

Then, on January 30, 2017, Petitioner requested a scooter due to his venous insufficiency and lower extremity edema. Petitioner's active problems at this visit with Veterans Affairs included occupational lung disease. However, on examination, Petitioner's lungs had no crackles, wheezing, or rhonchi.

Thereafter, on February 6, 2017, Administrative Law Judge Michael S. Worral issued a Social Security Administration Decision finding that Petitioner had been disabled since August 16, 2015. Judge Worral found that Petitioner's impairments included peripheral vascular disease, chronic lymphedema of the left lower extremity, dilation of the main pulmonary artery, left ventricular hypertrophy, aneurysmal dilation of the ascending aorta, and obesity. Judge Worral determined that Petitioner was unable to work on a regular or continuous basis and indicated that Petitioner had reported an inability to sustain gainful employment due to his left lower extremity cellulitis and edema. Based on Petitioner's age, education, work experience, and residual functional capacity, Judge Worral determined that there was not a significant number jobs in the national economy that Petitioner could perform.

On February 10, 2017, a disability benefits questionnaire was filled out regarding Petitioner's venous insufficiency. The evaluator noted that Petitioner had quit working at the coalmines secondary to his difficulty performing his job, walking, and sitting for long periods.

The evaluator indicated that Petitioner's vascular condition had impacted his ability to work and that Petitioner was best suited for a sedentary job.

Shortly thereafter, at a physical therapy visit on February 27, 2017, Petitioner requested a scooter after noting difficulty going through stores due to his leg pain and swelling. The physical therapist indicated that Petitioner had difficulty ambulating community distances secondary to his severe left extremity pain and edema from venous insufficiency.

Petitioner followed up with his cardiologist, Dr. Posner, on March 3, 2017 and September 7, 2017. At both visits, Petitioner reported no exertional shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, exertional chest pressure, lightheadedness, dizziness, or syncope. Additionally, on examination, Petitioner's lungs were clear to auscultation with no rales, wheezes, or rhonchi.

Petitioner thereafter treated at Veterans Affairs on October 10, 2017 and January 2, 2018 for unrelated issues. At both visits, occupational lung disease was listed as one of Petitioner's conditions. Nevertheless, his lung examinations revealed no crackles, wheezing, or rhonchi. When he returned to Veterans Affairs on July 10, 2018, Petitioner was diagnosed with COPD and given an Albuterol inhaler. Nevertheless, on examination, Petitioner's lungs still had no crackles, wheezing, or rhonchi.

On January 4, 2019, Petitioner returned to Veterans Affairs for his aneurysm. His conditions listed at that time included occupational lung disease. Nevertheless, there was again no crackles, wheezing, or rhonchi on Petitioner's lung examination. He was diagnosed with COPD, diabetes mellitus, and irritable bowel syndrome.

Lastly, on January 11, 2019, a disability benefits questionnaire from Veterans Affairs indicated that Petitioner regularly used a walker for ambulation due to his left leg lymphedema. A second disability benefits questionnaire was also filled out for Petitioner's rhinitis, in which Petitioner reported seeing an ENT doctor for chronic sinus problems a few years after leaving military service. The evaluator stated that although Petitioner claimed his sinus problems had developed while on active military duty, he had also stated at an April 6, 1993 doctor's visit that he had broken his nose as a child and had sinus problems through high school. The evaluator therefore opined that Petitioner's sinus problems were a preexisting condition and found no evidence that Petitioner's prior military duty had aggravated his sinus problems.

II. CONCLUSIONS OF LAW

Following a careful review of the entire record, the Commission reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that he suffered from CWP or any other occupational lung disease that was causally related to his work in the coalmines.

Although both Istanbouly and Dr. Smith determined that Petitioner's chest X-rays were consistent with a CWP diagnosis, the Commission finds that Dr. Istanbouly's opinion lacks persuasiveness since he is not a certified B-reader. As such, Dr. Istanbouly did not assign profusion ratings to films and could not tell if the profusion on Petitioner's film was 0/1 or 1/0.

Dr. Istanbouly also testified that Petitioner had exertional dyspnea, shortness of breath, and a chronic daily cough for years that was productive of mild, dark brownish sputum. He opined that Petitioner's chronic daily cough and sputum production indicated underlying chronic bronchitis with the contributing factors of long-term coal dust inhalation and smoking. He further testified that Petitioner's exertional dyspnea indicated abnormal lung function that could be CWP and chronic bronchitis. However, the treatment records do not corroborate Dr. Istanbouly's belief that Petitioner had suffered from a chronic daily cough for years, sputum production, or exertional dyspnea. Instead, the numerous lung examinations throughout Petitioner's treatment records almost all yielded normal results, and Petitioner did not consistently or frequently complain of coughing, shortness of breath, and sputum production to his doctors. Additionally, the few records in which Petitioner complained of respiratory symptoms appear to correlate with conditions unrelated to CWP, such as sinusitis, a viral infection, acute bronchitis, smoking, and a hyperventilation episode. Contrary to Dr. Istanbouly's opinion, the treatment records do not indicate a pattern of ongoing respiratory findings related to Petitioner's coalmine work.

Although Dr. Smith offered a more persuasive opinion as a certified B-reader, it is nonetheless notable that Dr. Smith failed two B-reading recertification examinations for over-reading films, which meant he found more disease than was present. Dr. Smith also indicated that valid pulmonary function testing was needed to determine the presence of functional impairment. However, Dr. Istanbouly determined that Petitioner's spirometry test did not show an obstructive defect and was within a normal range. Dr. Castle also testified that there was no restriction on Petitioner's pulmonary function testing and no evidence of fibrosis affecting gas transfer based upon his performed diffusion capacity. The treatment records also show that the pulmonary function testing performed on June 21, 2016 found normal diffusion capacity.

In contrast to the opinions of Dr. Istanbouly and Dr. Smith, Dr. Meyer and Dr. Castle opined that Petitioner's X-rays were inconsistent with a CWP diagnosis. Both Dr. Meyer and Dr. Castle were certified B-readers. Dr. Castle further opined that Petitioner did not suffer from any pulmonary disease or impairment as a result of his occupational exposure to coalmine dust. He testified that Petitioner had no evidence of any obstruction, restriction, or pulmonary impairment from any cause, including CWP and smoking.

Although the doctors acknowledged that someone with CWP could be asymptomatic and still have normal physical examinations, the treatment records nevertheless lend more support to the opinions of Dr. Meyer and Dr. Castle over those of Dr. Istanbouly and Dr. Smith. In the few treatment notes in which Petitioner did express respiratory symptoms, he related those symptoms to his long history of smoking as opposed to an occupational lung disease. Specifically, in his smoking cessation assessment dated July 6, 2016, Petitioner reported that he had smoked for over 20 years and was interested in quitting due to his ongoing shortness of breath and morning coughing spells. In another smoking cessation assessment on October 28, 2016, Petitioner attributed his reasons for wanting to quit smoking to his ongoing shortness of breath, routine morning coughing spells, and new onset of elevated blood pressure. Even though Dr. Istanbouly related Petitioner's symptoms to CWP, he nevertheless conceded that Petitioner's smoking history was significant and that coughing, sputum production, and shortness of breath could be associated with a significant smoking history.

Additionally, Petitioner was diagnosed with COPD on July 10, 2018. Petitioner testified that he used an Albuterol inhaler three times a day for his breathing problems. However, the treatment records show that Petitioner was prescribed the Albuterol inhaler for his COPD rather than for any CWP diagnosis.

Moreover, the record establishes that Petitioner left his employment at the coalmine due to his severe leg problems and stress as opposed to any respiratory issues. In his exit interview, Petitioner indicated that he was quitting for personal reasons since he could not handle the stress. Petitioner did not cite to any respiratory problems on the exit interview form. The disability benefits questionnaires in the treatment records also indicate that Petitioner had experienced notable anxiety episodes due to his job-related stress.

Furthermore, in the Social Security Administration form dated March 21, 2016, Petitioner related his inability to work to his ongoing leg problems. Petitioner did not claim any respiratory condition or impairment when seeking Social Security Disability. Thereafter, Judge Worral issued a Social Security Administration Decision finding that Petitioner had been disabled since August 16, 2015 due to impairments that included peripheral vascular disease, chronic lymphedema of the left lower extremity, dilation of the main pulmonary artery, left ventricular hypertrophy, aneurysmal dilation of the ascending aorta, and obesity. There was no mention of any disability related to CWP or any other occupational lung disease in the Social Security Administration documents. These records, along with Petitioner's treatment records, instead indicate that his disability and inability to work resulted from his severe leg infections and other unrelated conditions. Petitioner even obtained a motorized scooter due to his ongoing leg problems.

In consideration of the above, the Commission finds that Petitioner's current condition is not causally related to any CWP diagnosis and is instead due to his numerous other ailments, including his left leg problems, heart condition, and history of smoking. Petitioner's treatment records do not establish a pattern of any chronic respiratory complaints. Moreover, for the reasons previously discussed, the Commission finds the opinions of Dr. Meyer and Dr. Castle to be more persuasive than those of Dr. Smith and Dr. Istanbouly. The Commission thus finds that Petitioner failed to prove that he suffered from causally related CWP, and by extension, failed to establish disablement from CWP or any other occupational disease pursuant to §1(e) and §1(f) of the Illinois Workers' Occupational Diseases Act. The Commission reverses the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated September 20, 2019 is hereby reversed as stated herein.

IT IS FURTHER ORDERED that all benefits under the Act are hereby denied.

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

July 2, 2021

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

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

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

DLS/met
O- 5/5/21
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC008459
Case Name	SMITH, EDWARD L v. PARSEC INDUSTRIES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0339
Number of Pages of Decision	13
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	John Popelka
Respondent Attorney	Robert Maciorowski

DATE FILED: 7/2/2021

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD L. SMITH,

Petitioner,

vs. NO: 13 WC 08459

PARSEC INDUSTRIES,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Respondent's timely filed Petition for Review of the Decision of the Arbitrator. The issues on Review are the Arbitrator's denial of Respondent's request to bifurcate the hearing, accident with respect to claimed repetitive trauma injuries, notice, causal connection, liability for reasonable and necessary medical expenses, entitlement to temporary total disability benefits, entitlement to permanent disability benefits, "award does not comply with 8(e)(9)," and Respondent's Motion to Strike The Petitioner's Statement of Exceptions and Brief. Notice having been given to all parties, the Commission, being advised of the facts and law, finds the Arbitrator's denial of bifurcation was not an abuse of discretion and denies Respondent's motion to strike for the reasons stated below. The Commission further corrects the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. Denial of Respondent's Request to Bifurcate the Hearing

Commission Rule 9030.20(g) provides, "Bifurcated hearings will be allowed only for good cause. Examples of good cause include, but are not limited to, situations in which the number or location of witnesses makes it impossible to conclude the hearing in one day or the testimony of a witness must be taken prior to a deposition." *50 Ill. Adm. Code 9030.20(g)*. The granting or denial of a motion for a continuance lies within the sound discretion of the arbitrator or Commission, whose decision will not be reversed absent an abuse of that discretion. *South Chicago Community*

Hospital v. Industrial Commission, 44 Ill. 2d 119, 123, 254 N.E.2d 448, 450 (1969). Here, the Arbitrator concluded bifurcation was not warranted given Respondent was on notice that Petitioner had hearsay objections to the job description, yet elected not to have a witness available at trial. The Commission agrees that Respondent failed to make a showing of good cause and we find the Arbitrator's denial of bifurcation was not an abuse of discretion.

II. Respondent's Motion to Strike Petitioner's Brief

Respondent's "Motion to Strike The Petitioner's Statement of Exceptions and Brief" contends Petitioner filed a Statement of Exceptions in violation of the Commission Rules. The Commission disagrees. The Commission notes Petitioner never claimed to be entitled to file a Statement of Exceptions; rather, the Notice of Motion attached to Petitioner's brief states it is a "Response" brief, and this is how the Commission viewed the brief. The Commission denies Respondent's motion to strike.

III. Permanent Partial Disability

The Commission affirms the percentage loss of use awarded for Petitioner's bilateral hands and left arm; however, we observe the permanent partial disability award was miscalculated. Section 8(e)9 provides that repetitive trauma carpal tunnel syndrome injuries occurring on or after June 28, 2011 are based on percentage loss of 190 weeks. *820 ILCS 305/8(e)9*. Therefore, Petitioner's permanent partial disability award is calculated as follows:

15% loss of use of the Right Hand:	15% x 190 weeks =	28.5 weeks
15% loss of use of the Left Hand:	15% x 190 weeks =	28.5 weeks
15% loss of use of the Left Arm:	15% x 253 weeks =	37.95 weeks
	Total:	94.95 weeks

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $493.33 per week for a period of 21 2/7 weeks, representing January 7, 2013 through June 5, 2013, 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 the sum of $95.50 for medical expenses, as provided in §8(a), subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $444.00 per week for a period of 28.5 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused 15% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $444.00 per week for a period of 28.5 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused 15% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $444.00 per week for a period of 37.95 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused 15% loss of use of the left arm.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,300.00. 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.

July 2, 2021

/s/ Deborah J. Baker

DJB/mck

O: 5/18/21

/s/ Stephen Mathis

43

/s/ Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0339

SMITH, EDWARD L
Employee/Petitioner

Case# **13WC008459**

PARSEC INDUSTRIES
Employer/Respondent

On 4/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Edward L. Smith
Employee/Petitioner

Case # **13** WC **8459**

v.

Parsec Industries
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **March 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 8, 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 $**38,480.00**; the average weekly wage was $**740.00**.

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

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

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

Respondent shall be given a credit of $**8,527.55** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,527.55**.

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 $**95.50**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**493.33**/week for **21-2/7** weeks, commencing **January 7, 2013** through **June 5, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**444.00**/week for **99.45** weeks, because the injuries sustained caused permanent partial disability to the extent of **15%** loss of use of the left hand and **15%** loss of use of the right hand pursuant to Section 8(e)(9) of the Act and **15%** loss of use of the left arm pursuant to Section 8(e)(10) of the Act.

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

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

Arbitrator Anthony C. Erbacci

APR 12 2019

April 9, 2019
Date

FACTS:

Petitioner worked as a union crane operator for Respondent since September 20, 2005. On June 8, 2012, he was operating a MiJack crane working trackside in Elwood, Illinois. He used the crane to load and unload containers from train cars and trucks. He averaged working with 75 to 150 containers per day. The job required him to sit in the seat of the cab of the crane. He testified he worked with both hands on controls 8 to 12 hours per day. On each side his hands would rest on two knobs of hand controls that moved independent of each other. As he worked these controls, his elbows were bent at 90° to 120° throughout the day. The two individual knobs controlled by each hand moved independent of each other, and the operation of the crane required the knobs on each side (left and right) to move independent of each other. Petitioner demonstrated to the Arbitrator that as he moved the levers forward with his hands he would move his wrists from a position of flexion when the dual controls were moved toward his body to extension when the levers were pushed away from his body, each motion to 70 to 90 degrees. He performed these activities requiring extension to flexion of his wrists continuously throughout the course of an 8 to 12 hour day for seven years prior to his date of accident.

Petitioner testified that as he performed these activities, he developed pain in both of his wrists and his left elbow. He reported these complaints on June 8, 2012 to the safety man, Chuck Lecko. Mr. Lecko filled out a report and told Petitioner he would get in touch with corporate to set up a doctor appointment. Petitioner testified that he continued working for five months before he was scheduled by Respondent to see a doctor. He further testified that he had no prior injuries to his right hand or wrist, his left hand or wrist, or his left elbow.

Petitioner was sent by his employer to Physicians Immediate Care on November 3, 2012. Petitioner testified he told the doctor what his job duties were and demonstrated how he used his hands. The nurse's notes reflect that Petitioner was complaining of numbness and tingling in both hands, notes the onset of the symptoms was work-related, and states that he repeatedly used his hands to operate a crane over the past seven years.(PX#1,p.72) The history further notes that over the last few months Petitioner experienced increased pain to the point that he could not hold a pen, and that he denied previous injury or non-work related trauma to the hands.(Id.) The physician's dictated notes from November 3, 2012 include a history of pain, numbness and tingling to Petitioner's bilateral wrists extending and radiating down into his fingertips.(Id.at83) It notes he worked as a crane operator and had been doing repetitive motions with his hands for more than seven years where he is required to do different twisting and turning at the wrist base and pressing of buttons. It notes that for the last several months he has complained of numbness, tingling and pain to his bilateral wrists and radiating to his fingers, and denied any non-work related incident or event correlating with the development of the condition. Petitioner was provided with bilateral splints and released to light duty work. The clinic records include a note that authorization was provided by the Respondent for the visit as a work-related injury.(Id.at79)

After undergoing for bilateral EMG\NCVs, Petitioner was seen by Dr. Michael Cohen on November 15, 2012. Dr. Cohen performed right carpal tunnel release surgery on January 7, 2013 and left carpal tunnel release and left cubital tunnel release on February 4, 2013, both at AmSurg Surgical Center. Petitioner underwent physical therapy at ATI from February 25, 2013 through March 5, 2013. At that point he developed an infection in his left elbow that was surgically treated by Dr. Cohen on March 6, 2013. Petitioner resumed physical therapy from April 11, 2013 through June 3, 2013. He was eventually released to return to full duty work by Dr. Cohen on June 5, 2013.

Petitioner testified he returned to work as a crane operator for Respondent. As he performed his work activities, he began to develop pain in his left elbow. Petitioner was last seen by Dr. Cohen on July 11, 2013, at which time he continued to complain of increasing pain in his left elbow.

On December 7, 2013, Petitioner was seen by Dr. Jeffrey Coe. Dr. Coe examined Petitioner and found postoperative scarring of both hands and his left elbow, decreased range of motion of the left forearm and supination, mild atrophy of the left upper arm, residual deficit and sensation in the right index finger and weakness in petitioner's left hand to grip. Dr. Coe concluded that Petitioner's upper extremity symptoms and state of impairment was causally related to his work as a crane operator for Respondent.

On March 13, 2014, Petitioner was examined by Dr. Atluri at the request of Respondent. Dr. Atluri noted that Petitioner continued to experience tingling in the tips of his bilateral index, middle and ring fingers, occasional discomfort in the left elbow when he rests his arm on an armrest, but improvement overall in the numbness and tingling than it was preoperatively. Dr. Atluri noted that Petitioner described work activities involving frequent use of his hands, but concluded, based on written materials that were provided to him, that Petitioner's bilateral upper extremity conditions were not work-related.

Petitioner testified that at the time of arbitration, he continued to have numbness and tingling on a constant basis into the tips of his fingers and difficulty with fine manipulation of his fingers. He also testified to the same symptoms in his left hand. With respect to his left elbow, he testified that he experiences pain off and on 4 to 5 times per week toward the end of the day of work. Petitioner testified that before the accident his hobbies included lawnmower, chainsaw and motorcycle repair, which he has been unable to perform since the accident.

On cross-examination, Petitioner testified that he still works for Respondent as a crane operator and frequently works 12 hour days. He has been a cigarette smoker for 25 years, and smokes one and a half packs per day. He last saw Dr. Cohen on July 11, 2013.

Respondent presented Respondent's terminal manager, Matt Sipich, to testify. He has known Petitioner for 20 years, but has not operated the cranes Petitioner uses for 14 to 15 years. He testified he never operated a crane for Parsec. He reviewed an operator's manual for one of the cranes Petitioner operates, and testified that the force needed to operate the levers was minimal. On cross-examination, he was shown the cab layout from the operator's manual he testified about on direct examination. He was unable to identify whether the cab layout was for the 1000R or the 1200R model.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator reviewed the medical records offered into evidence, and read the evidence depositions of Dr. Jeffrey Coe and Dr. Atluri. The Arbitrator carefully listened to the testimony of the

witnesses and evaluated their demeanor. Based on the foregoing, the Arbitrator concludes that Petitioner sustained an accidental injury on June 8, 2012 that arose out of and in the course of his employment by Respondent. In so finding, the Arbitrator finds that Petitioner's testimony was credible in all respects.

In support of this decision, the Arbitrator finds Petitioner's testimony was unrebutted that he reported his symptoms as work related to his safety man, Chuck Lecko, on June 8, 2012. Petitioner testified Mr. Lecko prepared an accident report and told him he would arrange for a medical evaluation. This testimony was unrebutted. The Arbitrator notes that Dr. Cohen acknowledged the June 8, 2012 date of injury on a work comp verification form from Gallagher Bassett (PX#4,p.32) and that Respondent, through Gallagher Bassett, acknowledged that date of accident in an April 11, 2013 letter scheduling a Section 12 exam.(PX#7)

The Arbitrator further notes that the histories provided to Physicians Immediate Care, Dr. Cohen, Dr. Coe and Dr. Atluri are all consistent with Petitioner's testimony concerning his work activities with Respondent. The medical report from Petitioner's initial visit on November 3, 2012 at Physicians Immediate Care states that he denied any non-work related incident or event correlating with the development of his condition (PX#1, p.72) and the Arbitrator finds no credible evidence in the record to the contrary.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

Petitioner testified that on June 8, 2012 he gave notice of his injuries resulting from his work activities to the safety man, Chuck Lecko. Petitioner testified that Mr. Lecko filled out an accident report and told him he would arrange for Petitioner to be seen by a physician. The Arbitrator finds Petitioner's testimony was credible and unrebutted by Respondent. Based on the foregoing, the Arbitrator finds that Petitioner gave timely notice of the accident to Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator affirms his findings of fact and conclusions of law contained in the paragraphs above and incorporates them herein by this reference. Based on the medical records and the evidence depositions presented by the parties, as well as Petitioner's testimony, which the Arbitrator deems credible in all respects, the Arbitrator finds that Petitioner's current conditions of ill being are causally related to the accident.

After a five month delay following Petitioner reporting his symptoms, Respondent had Petitioner evaluated at Physicians Immediate Care. The initial history provided by Petitioner to Physicians Immediate Care is fully consistent with Petitioner's testimony at arbitration concerning the onset of his symptoms and their cause. Petitioner demonstrated his work activities to the physician, and his records state that Petitioner's condition was work-related. It was also acknowledged to be work-related by Respondent when the facility obtained verbal authorization from Respondent to treat Petitioner. The Arbitrator also notes that the insurance adjuster authorized and approved the three

surgeries Petitioner underwent by Dr. Cohen. The Arbitrator further notes that Respondent paid for the medical care and paid temporary total disability benefits to Petitioner for a portion of the time he was off work.

The Arbitrator also relies on the report and evidence deposition of Dr. Jeffrey Coe. Dr. Coe stated in his report that Petitioner's condition of ill-being was causally related to his work activities for Respondent, and further stated that Petitioner's treatment was reasonable and necessary as a result of those injuries. In his evidence deposition, Dr. Coe testified that one third of his practice involves working as medical director for several companies, and one of the industries he worked most with was railroads. He testified that he worked as the medical director of the Chicago and Northwestern Railroad, was regional medical director for the Union Pacific Railroad and most recently is the medical director of the Canadian National Railroad USA America Operations. Dr. Coe was familiar with Respondent as an outside contractor at the intermodal yards in northern Illinois. Dr. Coe testified he is familiar with the operation of the cranes and has observed the crane operators performing their work. Dr. Coe testified on cross examination that as Petitioner sits in the cab, his arms are bent at the elbow and he moves his arms and hands back and forth with flexion and extension repeatedly in a bent position. He noted that Petitioner's arms are at mostly a 90° angle for much of the day with some flexion and extension from that position, which puts a bend or a kink in the nerve. Since he is unable to go to full extension, he is unable to relieve pressure on the ulnar nerve at the elbow resulting in static pressure on the ulnar nerve in the left upper extremity. Based on Dr. Coe's experience with the types of cranes Petitioner operated in the intermodal railroad yards of northern Illinois, the Arbitrator finds Dr. Coe's testimony to be persuasive and credible.

The Arbitrator also reviewed the report and evidence deposition of Dr. Atluri. Dr. Atluri concluded that Petitioner's work activities were not a causative factor in his bilateral carpal tunnel or left cubital tunnel conditions. Dr. Atluri testified that he relied, in part, on the written job assessment provided to him by Respondent of Petitioner's job. Petitioner objected to Dr. Atluri's testimony in reliance of the job description based on hearsay, and objected to the job description when Respondent attempted to introduce it into evidence as RX#2. The Arbitrator rejected the job description from evidence as hearsay. Dr. Atluri also testified that based on the crane operator manual, the job activities could not have caused carpal tunnel syndrome, and further testified that Petitioner told him he did not engage in intensive use of his hands in awkward positioning. Petitioner contradicted this testimony at arbitration. The Arbitrator also notes that Dr. Atluri testified he was not provided any records from Physicians Immediate Care, was not told that the work comp carrier authorized Petitioner's treatment and surgeries and was only provided Dr. Cohen's surgical reports, not his other records. He testified on cross examination that he understood Petitioner did not use his hands to operate the crane continuously and believed that Petitioner would have developed the bilateral carpal tunnel syndrome and left cubital tunnel syndrome in 2002 even if he was not working for Parsec. Dr. Atluri's report indicates that the patient described his work activities to him, but acknowledged on cross examination that he did not record any of the actual statements in his report and did not document Petitioner's description of his work activities in his handwritten notes. Dr. Atluri acknowledged that Petitioner's pain got worse while operating his crane, but further testified that he had information suggesting that Petitioner developed his conditions doing something other than operating his crane. The Arbitrator finds no evidence of those activities in the record. Based on the foregoing, the Arbitrator finds Dr. Atluri's opinions to be less persuasive and credible than the opinions of Dr. Coe.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained in the paragraphs above, and incorporates them herein by this reference. Petitioner presented an outstanding medical bill from ATI Physical Therapy in the amount of $95.50. According to the bill, the unpaid charges for services provided on May 14, 2013 related to range of motion measurements. Respondent presented evidence that it paid for all other services on May 14, 2013, but denied this charge based on a lack of documentation of the service performed. The Arbitrator finds that the May 14, 2013 progress note from ATI contains extensive documentation of Petitioner's active range of motion. Based on this documentation, the Arbitrator awards Petitioner's outstanding medical charge of $95.50.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

Petitioner claims he was temporarily totally disabled from January 7, 2013 through June 5, 2013, representing 21-2/7 weeks. Respondent alleges that Petitioner missed a Section 12 examination on May 6, 2013, and should not be awarded benefits after that date if TTD is awarded.

Petitioner offered into evidence a number of documents as Petitioner's Group Exhibit No. 7. They include an April 11, 2013 letter from Donna Rosinski scheduling the Section 12 examination; confirmation of a fax sent by Petitioner's counsel to Donna Rosinski the next day, April 12, 2013, acknowledging the examination but requiring that a travel check be issued to Petitioner within 24 hours of the appointment, or Petitioner would not attend without further notice; and a fax confirmation by Petitioner's counsel to Respondent's counsel, stating that Petitioner's counsel left a voice message for the adjuster the weekend before the scheduled exam stating that Petitioner had not received the travel check, as his reason for not attending the examination. Respondent did not object to the introduction of this evidence. Respondent attempted to introduce evidence supporting its contention that a travel check was issued and received by Petitioner, but the evidence was objected to on the basis of hearsay and sustained by the Arbitrator. Based on the evidence contained in the record, and based further on the Arbitrator's findings of accident, notice and causation, and noting that Petitioner was released to return back to full duty work by Dr. Cohen on June 5, 2013, the Arbitrator awards Petitioner temporary total disability benefits from January 7, 2013 through June 5, 2013, representing 21-2/7 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 2% of the left upper extremity due to the left cubital tunnel syndrome and 2% impairment of the right upper extremity for the right carpal tunnel condition. No ratable impairment was found for the left carpal tunnel syndrome. These impairments were determined by Dr. Atluri,

pursuant to the most current edition of the American Medical Association's Guide to the Evaluation of Permanent Impairment. (RX#1) The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted that Petitioner's condition of ill-being was not causally related to his work activities but due to some other undocumented activities not found in the record. The Arbitrator accorded little weight to Dr. Atluri's opinion. Because of this, the Arbitrator therefore gives minimal 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 crane operator at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. The Arbitrator notes the Petitioner has ongoing symptoms of numbness and tingling in his hands to the tips of his fingers bilaterally, and that these symptoms are constant. Petitioner also testified to pain off and on 4 to 5 times a week in his left elbow toward the end of the workday. This testimony is consistent with the ongoing complaints documented in Dr. Cohen's July 11, 2013 report with respect to the left elbow, and the complaints to both Dr. Coe and Dr. Atluri made by Petitioner. Because of Petitioner's ongoing symptoms, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because of Petitioner's advanced age and ongoing symptoms, 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 that Petitioner testified he continues to work for Respondent and is working 12 hour shifts. The Arbitrator further notes that Petitioner has constant complaints of numbness and tingling in his bilateral hands and pain off-and-on in his left elbow toward the end of the workday. Because of the severity of Petitioner's ongoing symptoms, his advanced age and his extensive work week, the Arbitrator finds that Petitioner's ongoing symptoms could impact his future earnings capacity to continue his employment as a crane operator. The Arbitrator therefore gives greater weight to this factor.

With respect to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner complained of constant numbness and tingling in his bilateral hands and fingers, the inability to continue working on his hobby repairing lawnmowers, chainsaws and motorcycles, and his ongoing complaints of pain in his left elbow, all of which are supported by the medical records of Dr. Cohen, Dr. Coe and Dr. Atluri. 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 15% loss of use of the left hand and 15% loss of use of the right hand pursuant to Section 8(e)(9) of the Act and 15% loss of use of the left arm pursuant to Section 8(e)(10) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC011909
Case Name	WALLACE, NICHOLAS v. MACOMB PARK DISTRICT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0340
Number of Pages of Decision	41
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Stephen Martay
Respondent Attorney	Cesar Fernandez

DATE FILED: 7/2/2021

DISSENT

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0340

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nicholas Wallace,

Petitioner,

vs. NO: 19 WC 11909[1]

Macomb Park District,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical treatment and temporary total disability, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner testified that on 8/2/18 he worked at Macomb Park District, where he was employed for two seasons. (T.14). He noted that a season lasted anywhere from March through October, "… depending on the big boss, what call she makes when the season is starting." (T.15). When asked if he worked full time during this period, he replied: "Yes. It varied. Some weeks I put in over 40 hours, and some it was less." (T.15). He stated that he did not have an official job title, but that he did "… everything from landscaping to mechanical work. Anything that needed to be done basically I did." (T.15-16). He noted that "[l]andscaping includes mowing, weeding, trimming of hedges, any type of mechanical work that needs to be done on machines that we have out there." (T.16). He indicated that he used to work on or fix ball pitching machines as well as mowers and lawn care equipment, "… small engine work." (T.17).

[1] The Arbitrator issued separate decisions for claim 19 WC 11909 and companion claim 18 WC 26931, awarding compensation in the former and denying same in the latter. However, a Petition for Review was only filed on 19 WC 11909. Thus, this review concerns only the Arbitrator's decision in claim 19 WC 11909.

Petitioner testified that on 8/2/18 he reported to work at around 8:00 am. (T.17-18). He noted "[t]hat day [we] were supposed to be installing a fence. It was a vinyl fencing in and around the course." (T.18). He stated that he was to perform this job with one other guy, David Bainbridge. (T.18). He indicated that they were to tear out the old fence and put in a new vinyl fence using an auger. (T.18-19). He noted that two guys would hold the auger to dig the holes "[a]nd then you pull it up to get the dirt out of the hole, and we had to do that and then fill the holes with concrete and set the posts in the concrete." (T.19). When asked to describe the auger, Petitioner stated: "[i]t's got a big drill bit, and then it's got a motor on top with 2 handles on either side where each person can hold the auger." (T.19). He agreed that it is a two-person job, at least the type he used. (T.19).

Petitioner noted that the fencing was going around a putt-putt course and that it was probably four to five feet high and came in eight to ten-foot sections. (T.20). He estimated that they probably had to dig 11 or 12 holes, maybe more, and that "[y]ou have to dig down pretty far so the posts don't fall over, so probably around 3 feet, 4 feet [deep]." (T.20-21). He indicated that concrete and then the posts go into the holes. (T.21). He could not recall if they dug all the holes first or if they dug the holes as they went. (T.21). He believed each hole took around 5 to 10 minutes each to dig, depending on if they had any trouble getting through, noting that once you hit a certain depth you would have to go through clay "[a]nd the clay is really hard to get through, and it really starts to jostle the auger bit and everything. So sometimes it can take 10 minutes per hole." (T.21). He noted that you would also have to sometimes use a spade to get some of the dirt remnants from the bottom of the hole. (T.22).

Petitioner testified that on 8/2/18 "[m]e and David were using the auger to drill one of the holes. And as you are digging, you have to go down and then bring the auger back up several times to get the dirt out of the hole as you are using the auger. And as I was lifting it up, I felt something in my left shoulder pop." (T.22). He indicated that the pop was "[m]ore on the top and the back of the [left] shoulder." (T.23). He noted that following the injury he stopped working for "[s]ay probably like half an hour, 45 minutes. I think it was about lunch or so, so we took lunch." (T.23). He stated that "… I told David that I hurt it when it happened" and that "I had mentioned something to Terry [Stoneking], but it was nothing like was written down or anything. I just said, I mentioned that I had done something to my shoulder. I didn't know what I did, but, you know, it hurt." (T.23-24). He noted that Mr. Stoneking was his boss at Ball Fore, where he was working. (T.24). When asked when he notified Mr. Stoneking of the injury, he replied: "I believe it was like right before lunch maybe, like after it happened. We meet at the table several times a day and just talk about whatever." (T.24). He agreed that following the incident he went to lunch; however, he noted that Mr. Stoneking was not at this lunch. (T.24). He noted that "[w]e all break for lunch, and then we come back and maybe discuss again what we were going to do. But I had mentioned [to Mr. Stoneking] before we had left for lunch that I had done something to my shoulder." (T.24-25). He indicated that this discussion was in person and occurred around 11:00 am "… at like the picnic table where we meet at." (T.25).

Petitioner agreed that following the incident he continued working full time for the park district. (T.25-26). When asked why he did not seek treatment right away, he responded: "[h]onestly, I was really trying to see if it was going to get any better. I wasn't sure what I did,

but I knew I was in pain. So I just kind of continued to see if it was going to heal up or if it was something like more permanent." (T.26).

He agreed that he presented to Dr. Blair Rhode on 9/18/18 and that he complained of left shoulder and low back pain from a work injury involving the use of an auger. (T.26). He agreed that Dr. Rhode recommended that he undergo an MRI of the left shoulder, physical therapy for his back and that he could return to work with no lifting over 20 pounds. (T.26-27). He believed he notified his employer about those work restrictions, and that it would have been in person, although he could not remember if he brought in a note. (T.27).

He agreed he underwent an MRI of the left shoulder on 9/26/18, and that his final day of work for the Macomb Park District was on 10/2/18. (T.27). He indicated that that was probably the day they ended the season. (T.27-28). He agreed that he saw a physician's assistant at Dr. Rhode's office on that same day (10/2/18), and that his restriction of no lifting over 20 pounds was continued with the added restriction of no vibratory tools. (T.28). He agreed that it was also recommended that he go for more therapy. (T.28).

Petitioner agreed that on 10/17/18 Dr. Rhode recommended he return to work with no lifting over 20 pounds. (T.28). He also underwent a shoulder injection on that date. (T.28). He agreed that he had one session of therapy at ATI on 10/29/18 but was discharged due to financial issues. (T.28). He agreed that he returned to Dr. Rhode's office on 11/13/18, 12/18/18 and 12/26/18 at which time he was told to continue with the same restrictions. (T.28-29). He received a second left shoulder injection on 12/26/18. (T.29).

Petitioner agreed that on 1/7/19 he presented to Dr. Lawrence Li at the request of Respondent for purposes of a §12 examination. (T.29). He noted that the examination with Dr. Li took "… just probably around 10 or 15 minutes. It wasn't that long." (T.38). He agreed that Dr. Li physically manipulated his left shoulder, and he recalled a test "… where he grabbed my arm and just kind of moved it up really fast", which he noted caused pain and almost made him jump up off the table. (T.39).

Petitioner agreed that on 1/23/19 he returned to Dr. Rhode at which time they discussed the possibility of surgery. (T.29-30). He agreed that Dr. Rhode also returned him to work again with no lifting over 20 pounds. (T.30). He agreed that he returned to Dr. Rhode on 2/20/19 at which time he finally recommended that he undergo surgery on his left arm and continued the same work restrictions. (T.30). He agreed that he also brought a copy of Dr. Li's §12 report with him to this visit, and that Dr. Rhode reviewed said report. (T.30).

He agreed he saw Dr. Rhode again on 3/20/19 at which time he made the same recommendations as to surgery and no lifting over 20 pounds. (T.30-31).

Petitioner agreed that on 3/25/19 he took a job with the City of Macomb, which is different than the Park District. (T.31). He noted that "I applied actually to the park district again first. I did not get hired there, and I really needed money. So I applied to the City of Macomb as well, and they hired me. And it was basically doing the same type of job. It's for the city, but it's for the cemetery." (T.31). He indicated that the city was aware of his work restrictions, and during

the time he worked for the city he adhered to those work restrictions. (T.31).

He agreed that he returned to Dr. Rhode's office on 4/16/19, 5/15/19, and 6/12/19 at which time he was given the same restrictions and surgical recommendation. (T.32).

Petitioner agreed that on 6/25/19 his employment for the City of Macomb ended. (T.32). When asked why it was discontinued, he replied: "… I had struggled with the issue between me and my boss about the work that I can do and can't do with my shoulder, and I was on 2 different types of pain medication. So on one specific day I had – I believe it was the 24th, I had left. I had gotten sick because I had been in the sun all day with that medication, and I chose to leave work. And because I didn't call my boss and tell him that I was leaving, I was terminated." (T.32-33).

He agreed that since his termination he has seen Dr. Rhode four more times – on 8/7/19, 8/15/19, 9/4/19, and 11/8/19. (T.33). He agreed that throughout that time he's either taken him off work or kept him on restricted work and recommended left shoulder surgery. (T.33). He did not believe that he's seen Dr. Rhode or any other physician since that date. (T.33).

Petitioner denied having any issues with his left shoulder prior to 8/2/18. (T.33-34). He agreed he was previously in the Marines. (T.34). He indicated he never had any issues with his left shoulder in the Marines. (T.34). However, he noted that he suffered a traumatic brain injury and suffers from PTSD. (T.34). He noted that he had previously worked for Verizon in sales. (T.34-35). He denied suffering any injuries during that time. (T.35). He also denied filing any workers' compensation claims in the State of Illinois other than the one currently in dispute. (T.35).

Petitioner testified that he is no longer employed by the Macomb Park District and that he is not employed by anybody at this time. (T.35-36). He noted he has been applying for jobs, specifically "… stuff that's not physical, anything from just office jobs and just anything where I'm doing anything physical." (T.35-36). He indicated he has not been hired by anybody to do any sort of job since 6/25/19. (T.36). He noted that Respondent did pay not him any benefits for being off work between 10/3/18 and 3/25/19 or between 6/26/19 and the day of trial, 1/15/20. (T.36).

Petitioner testified that he still experiences pain in his left shoulder, noting that "[t]he issues I have, extreme pain to even lift my arm up. Most mornings I have trouble even putting a shirt on. It requires me taking my pain medication, and it's hard for me to even just do simple everyday tasks let alone anything like really physical." (T.37). He indicated he can drive a car "… but I do have pain even just using the steering wheel and making a turn." (T.37). In addition, he noted that "… they've got me on 150-milligram [T]ramadols and also 10-milligram Norco." (T.37). He stated that this medication is prescribed by Dr. Rhode, and that he was also given Lidocaine patches which he was directed to place on the affected area where he is having pain. (T.38).

Petitioner indicated that he would like the judge to award the prospective medical treatment recommended by Dr. Rhode, specifically the surgical procedure he recommended. (T.39). He agreed that he presently has outstanding medical bills, including bills owed to Dr. Rhode at Orland Park Orthopaedics in the amount of $10,238.41, ATI Physical Therapy in the amount of $$433.04, Orthopedic and Sports Enhancement in the amount of $2,720.00 for the MRI, prescriptions

through RX Development in the amount of $14,890.35, and lab testing at Persistent Labs in the amount of $17,566.84. (T.39-40). That accurately states the outstanding medical bills to the best of his knowledge. (T.40).

Petitioner agreed that at some point he filled out a formal accident report. (T.41). Petitioner was shown the Illinois Form 45 submitted at RX12. (T.41-42). He agreed it was his handwriting on this document, and that on this form, with respect to what he was doing at the time of the accident, "I put use of auger and then also using gas-powered trimmer because that also added onto the injury after – this is after the auger. So I put both of those on there." (T.42). He also indicated that he wrote 8/2/18 and 9/12/18 for the date. (T.42-43). When asked why he placed the 9/12/18 date on there, he replied: "I don't remember exactly why that date was on there." (T.43). He agreed the report was dated 9/19/18. (T.43).

Petitioner was shown another Illinois Form 45 dated 9/19/18 that he indicated he did not sign and which was typed by someone else. (T.43-44). When asked if this report was the same as the one he turned in on 9/19/18, he responded: "[t]here's some differences in this report." (T.44). He agreed that this report does not say anything about 8/2/18. (T.44).

On cross examination, he agreed the Application for Adjustment of Claim offered at RX1 alleged a date of accident of 9/10/18. (T.45). When asked if he signed that form, Petitioner replied: "I guess so." (T.45). When asked if that was his signature, he stated: "[i]t looks like it." (T.46). He noted that the date next to his signature is 9/10/18. (T.46). He acknowledged that he did not see August 2nd on that form, noting that "[t]his [Application] might have been for the back injury. I know I had lifted some concrete right off the ground. They were replacing the playground equipment, and that might have been the date from that." (T.46-47). When asked if the lifting concrete was after the auger, he replied: "I can't – Honestly, I can't remember. I do not remember… I don't want to say yes or no if I don't remember." (T.47). He agreed that when he told Neil, Terry's supervisor, that he hurt himself at work, he gave Mr. Wallace the workers' comp form to fill out right away. (T.47). He noted that was "… the first time I think Terry probably said something to Neil or had me call down to the park district. Neil is usually not out there too much, and we really don't report to him." (T.47-48). He agreed Terry was there when he was using the auger, noting that he worked with Terry "[a]lmost every day" and that Terry "… leaves in and out, but he was there probably for some of the day and gone for some of it." (T.47-48).

Petitioner indicated that "[a]ll these dates get mixed up in my head, and I'm trying to keep everything straight." (T.48). He could not remember if he looked at a text or something to tell Dr. Li what date he was injured. (T.48-49). He also wasn't sure what he told Dr. Rhode's office what happened on 9/12/18, noting "I have PTSD and TBI, so it's hard for me to keep stuff like that straight." (T.49). He indicated that the traumatic brain injury was from a large explosion in Iraq that the doctors say caused damage to his brain. (T.49). He noted that as a result he experiences memory loss and headaches. (T.50).

He agreed Dr. Rhode's office sent him for physical therapy at ATI, first for the back, not the shoulder. (T.50). He agreed he only went to therapy one time and that he missed several sessions because his car broke down. (T.50-51). He agreed he was discharged after he did not go for a while, noting "[i]t was pretty far away. It was like over an hour drive just to go there." (T.51).

When asked if he ever had a conversation with anyone from the park district about an injury from heavy lifting, he replied: "Well, I believe when I filled out that form, I remember Neil being in the office with me at Ball Fore when he had me fill out that form, and I had said something about maybe the concrete lifting as well." (T.51). However, he could not remember whether they took the playground equipment out before or after using the auger. (T.51-52).

Petitioner agreed that he performed his regular duties the entire season in 2018 and that he was not limited in performing his duties before the accident. (T.52). He indicated that after using the auger "I was having extreme pain in my shoulder, so I had to tone down everything that I was doing. And that's why on the form as well to like using anything where I had to lift up, it was hard for me to do, using any of the trimmers. Anything where I wasn't really using my shoulder I could still do, and then the other stuff that I had to do, you know, I would struggle with, anything that required me to lift my arm up." (T.52).

He agreed that after using the auger he did a lot of painting, namely the obstacles on the mini-golf course including "… different figures and stuff that they wanted painted." (T.53). He noted that he also painted parts of a diesel tank with Ben Bainbridge, which required climbing on a ladder and painting the top. (T.53). He indicated he was able to do that part of it. (T.53). He agreed that he also painted some parking lot blocks and handicap spots, but he could not recall painting shelter houses. (T.53-54). He indicated that after using the auger he also did "[j]ust the everyday stuff, the trimming and mowing." (T.54). He stated that it would have been more than six holes that he dug, and that some holes had to get filled in because they were out of line. (T.54).

Petitioner indicated that he knows he complained about his shoulder being injured on a regular basis to "[j]ust anybody. Like when we were there working, you know, sitting at the table. Sitting at the table I might say something." (T.55). He stated that he probably said something to Terry, and that Neil might be there sometimes, although he wasn't there very often. (T.55). He agreed that Terry would be the guy you would report an injury to first. (T.55). He also agreed he raised some issues with Neil about wages, after getting a raise recently, but he did not know if he told him anything about being injured at work. (T.55-56). However, he testified that he did finally talk to him about being injured and he brought the form down to be filled out and signed. (T.56). He could not remember if he worked any more after filling out the form. (T.56).

He believed that on 3/11/19 he applied for work with the city at Oakwood Cemetery, and that he would have started work a couple of weeks later. (T.56). He stated that he told his boss Gary Rhode "[r]ight off the bat" about his physical limitations and gave him a light duty slip. (T.57). He did not know if they asked about that on the application or not, but he knows he sent it to Gary. (T.57). He agreed that he told them he had experience in construction, knew about sewers and had some mechanical knowledge. (T.57).

Petitioner indicated that his shoulder is about the same as when he filled out the accident report, noting "… there's been periods where it's gotten worse and a little better, but it's generally about the same as when I injured it." (T.57-58). He denied having any new accidents or injuries since using the auger. (T.58).

He agreed that he applied to go back to work for the Park District around March of 2019,

or about the same time he applied at the cemetery. (T.58). When asked if he would have been doing the same work for the Park District, he stated: "I'm really not for sure what Ball Fore would have had me do. I would have been on some type of light duty. I can't say for sure." (T.58-59). He indicated that he did not put anything on his application for Ball Fore that he had limitations, noting that's something he probably would have told them if they hired him back. (T.59).

He agreed that he went through a lot of lab studies, including blood and urine tests to determine the amount of narcotics in his system. (T.59). He indicated that he still takes narcotics as needed, but that he doesn't take them all the time because it's hard on the system and he wants to be able to function and drive a car. (T.60).

On re-direct examination, Petitioner stated that it does not require heavy lifting to paint at the mini-golf, the diesel tank, parking lots and possibly shelter houses. (T.60-61). He was shown RX7, the Application he filled out for the City of Macomb. (T.61). He agreed it looks like his handwriting. (T.61). He noted it does not ask him to list any work restrictions on that application. (T.620. He agreed that as a result he would have had no reason to list any work restriction. (T.62). He agreed it was his testimony that he told Gary, and that Gary still hired him. (T.62). When asked how often he is taking medication, he stated: "[i]t depends on the pain level, how much I can tolerate and what I'm doing. Most of the time I'm taking several times a week." (T.62).

On re-cross examination, Petitioner noted that some of the painting he did after the auger required reaching, but he did most of the painting with his right arm. (T.63). He indicated that at the cemetery they had Kubota zero-turn mowers. (T.63). He also stated that he would use gas-powered weed whackers but that "I always tried to use this arm (indicating) to pull start as much as I can. And that was one of the things that me and Gary would kind of get into it about because some days I would really be in pain. The only reason I was even able to work really was because I was on the pain meds, and it allowed me to move my arm around." (T.63-64).

When questioned by the Arbitrator, Petitioner indicated he would use his right arm for most of his duties when he worked for the city. (T.64). He also testified that he is left-handed. (T.64).

When asked by defense counsel why he would paint with his right arm if he is left-handed, he noted that "I can use both arms to paint." (T.65).

Petitioner was later recalled to testify by his attorney. (T.111). He agreed that he was in the room when Mr. Stoneking testified. (T.112). He noted that he disagreed with Mr. Stoneking's claim that he [Mr. Wallace] never told him about his left shoulder injury. (T.112). He testified that "… we have a very casual kind of relationship at work. I know I had mentioned it several times maybe sitting at the table or anything, but I was never given the opportunity to fill out – It was never taken like seriously. He never said, okay, let's fill out this paperwork. But I know that I mentioned that I hurt my shoulder at work more than once, you know, a bunch of times probably sitting at that picnic table. But I just was never taken seriously, and I was never given a form to fill out." (T.112-113).

On cross examination, when asked if he ever asked for a form, Petitioner replied: "I engaged in a conversation that my shoulder was hurting in hopes that my boss would do something

about it, and nothing was ever done." (T.113). He noted that "Neil was very more to the point about it…" (T.114).

On re-direct examination, Petitioner agreed that Neil was the one who provided him with the Form 45 after receiving the application. (T.114).

Testimony of Terry Stoneking

Mr. Stoneking testified that he has worked for the Macomb Park District for 8 to 10 years as the manager of the facility. (T.67-68). He noted that the facility is "… a park consisting of mini-golf, driving range, batting cages, we have a little basketball, and we have a little volleyball." (T.68). He agreed that Petitioner worked in his department as a seasonal worker, and that he was considered Mr. Wallace's supervisor. (T.68). He noted that Petitioner's duties were "… pretty much like everybody else that we have there. We mow and fix things. We get ball machines that need to be toned up and things that just normally you have to do to keep the place going." (T.68). He indicated that he would see Petitioner almost every day unless Mr. Wallace had something else going on. (T.69). He noted that the shift was usually from about 8:00 am to between noon and 1:00 pm, which is when the facility opened. (T.69).

Mr. Stoneking testified that during the summer of 2018 Petitioner never complained to him about any type of injury he sustained at work. (T.69). He also indicated that he did not observe him appearing to be in pain or limited in what he could do. (T.69-70).

He recalled having to get an auger in 2018. (T.70). When asked if it was on 8/2/18, based on the rental agreement, he stated: "I'm guessing. I really don't know the dates back then, but I'm guessing that's correct if that's what it says." (T.70). He agreed that the Park District does not own an auger, and that they would have to rent one if they needed to use it. (T.70). He agreed he would have no reason to dispute the date on the rental agreement. (T.70). He stated that the purpose of the auger was to make three holes to set up two vinyl fences. (T.71). He noted that "… we needed 6 [holes] altogether. Maybe it was 3 posts. I'm thinking it was, but we only used the auger for one set [of fencing]. We didn't use the auger for the other set. We dug it by hand." (T.71). He stated that "I was there, but I wasn't physically involved except the second fence I helped one of the other guys dig the holes." (T.71). He believed they used the auger to dig three holes for three posts. (T.72). He noted that in the beginning Dave and Nick were using the auger. (T.72). He indicated that it's a 2-man auger with a spiral blade and 4 bars sticking out so that 2 people could hold it, one person on each side. (T.72-73). He agreed that as the auger was spinning, they would push it down into the ground to dig the hole. (T.73).

Mr. Stoneking testified that "[w]ith the auger, we were only going about 2 foot deep, maybe 3 foot because of the post itself and the concrete. So I wouldn't say it took anymore than 10 to 15 minutes to do it [per hole], not even that, I don't believe." (T73-74). When asked how much of that 10-15 minutes was spent actually using the auger, he stated: "[i]t couldn't have took [sic] much more than 5 minutes to dig that hole with the auger." (T.74). He noted that he did not hear Petitioner complain about hurting himself. (T.74). He testified that after using the auger he observed Petitioner performing other job duties, noting that "… I believe it was afterwards that we painted shelter houses, he painted the diesel tank out back, and pretty much generally did what he

normally did do." (T.74-75). He indicated that Petitioner did not say anything to him about needing assistance or having limitations. (T.75). He also denied that Petitioner ever mentioned that he was sore or having physical difficulty while they sat at the picnic table and talked. (T.75).

He noted that the painting activities are not part of Petitioner's regular duties and "[w]e won't paint them again for a few more years." (T.75). He indicated that the diesel tank is big, maybe four or five feet long and is on a brace that is maybe six feet off the ground. (T.76). He stated that if you used a six-foot ladder "… you could probably stand on the top to paint the top" of the tank. (T.76). He noted that the top of the tank might be 7 or 8 feet high. (T.77). He stated that if Petitioner used a normal ladder "… you would still have to reach because the thing is round. So you still have to reach to paint the top of it." (T.77).

Mr. Stoneking agreed that in September of 2018 Petitioner raised the issue of wages once as they were sitting around the table. (T.77-78). He noted that "… the way I understood it from him was that [Petitioner's mother] felt he should get more money for what he does do. Like he and myself were the only ones that worked on the batting cages. The other guys didn't do it. And I think she felt that since he did that, he should make more money than what they do." (T.78-79). He noted that Petitioner did not ask for more money but "I think he said something about he wasn't going to work on the batting cages anymore because of what the people that maintain them make compared to what he makes." (T.79).

Mr. Stoneking indicated that he later became aware that Petitioner made a claim that he was injured at work. (T.79). He testified that he didn't know that he was aware of this in mid-September of 2018 "… because Nick never told me. I had to get it – Honestly, the way I found out about it to a point was that he left a medical report or something from a doctor on the microwave, which was in the office. And then eventually I talked to Neil, and he told me what was going on." (T.79-80). He noted that this could have been towards the end of September of 2018 "… because we closed in October." (T.80). He indicated that Petitioner did not finish out the season, noting that "… from what I remember, he just quit coming. As a matter of fact, one of the guys that worked for me told me he wasn't coming back." (T.80).

On cross examination, Mr. Stoneking agreed that he testified the auger from 8/2 was a 2-man auger. (T.81). He noted that there is a such thing as a one-man auger, although he couldn't tell you the size of the bits that drill the hole, although he would guess they would be the same size. (T.81-82). He indicated that when he went in to rent it, he was told that a one-man auger was harder to handle. (T.82). He agreed that the auger is a vibratory tool, noting that "I didn't handle it, but I would think that it would vibrate a little bit going into the ground." (T.82). He stated that he didn't handle it "[b]ecause I had 2 other guys do it." (T.82). When asked if there was any pushback from digging into the ground, he noted that "… when you start drilling the hole, you go down a way, and then you have to pull the auger back out to clear the dirt out of the bit and then go down again." (T.82-83). He agreed that it would be safe to say that there would be some resistance as you were digging down. (T.83). He also agreed that he believed they were digging about 2 to 3 feet deep and that it took about 10 to 15 minutes per hole. (T.83).

He reiterated that at no time after 8/2/18 did Petitioner tell him about any injury to his shoulder or any part of his body. (T.83). He agreed that after 8/2 Petitioner did mostly painting,

which he would not consider heavy work. (T.84). He indicated once again that he did not believe Petitioner finished the season, although he wasn't sure. (T.84). He noted that Petitioner "… had a friend that worked for me, and that's where I got most of my information. And I asked him one morning where Nick is at, and he said Nick's not coming back. And they used to talk a lot together." (T.85). He noted that "I believe [Petitioner] had visited a doctor or something, and the paper was laying on the microwave in the thing. So I asked Neil about it and asked him if he had heard anything, and he said no. But later on Neil picked it up from somewhere. Then he started filling me in on what was going on. But I never actually talked to Nick about it, period." (T.85).

When asked how Petitioner would have gotten hold of an Illinois Form 45, Mr. Stoneking testified that "… we have an accident report sheet that when anything happens, we fill it out. Well, I couldn't fill it out because I didn't know what happened." (T.86). He indicated that he would be the one to fill out those sheets and Petitioner would sign it. (T.86). He was not aware of any such forms in this case because he didn't fill it out. (T.86-87).

On re-direct examination, Mr. Stoneking stated that he thought Neil may have given Petitioner an accident report, but he wasn't involved with what went on between them. (T.87).

Testimony of Neil Armstrong

Mr. Armstrong testified that he works for the Macomb Park District as superintendent of support services. (T.88). He noted that he has worked there in a full-time capacity for 2 years, 3 months and worked in a part-time capacity from 2012 to 2017. (T.88). He indicated that he "… handle[s] the security and safety of the park district, so I handle the summer safety patrols, on the OSHA guide, work with maintenance, make sure that they're in compliance with what we do." (T.89).

When asked about his involvement with work injuries, he noted: "[t]hey come to me. Either they are reported to the supervisor, whomever, and then come up the chain to me until I give them to the business manager to then send them off." (T.89). He indicated that he works with Terry Stoneking and his crew, and that "[a]nywhere from 2 to 4 days a week I see him, either Terry at the office or going out on site." (T.89). When asked how often he would see Petitioner performing his job duties in the summer of 2018, Mr. Armstrong replied: "[p]retty much the days I went out there, so if I was out, depending on how many days a week I would go out to Ball Fore, typically Mr. Wallace was there." (T.89-90). He testified that he did not remember Petitioner expressing any signs of discomfort or being in pain, and never observed him appearing to have some sort of limitation physically. (T.90).

Mr. Armstrong stated that if someone is injured on the job they "[s]hould report it to their supervisor or can come up to the office and get the Form 45, Illinois worker comp form from either Sharon, our secretary, or business manager or myself to report that so we can start the process." (T.90). He noted that he first learned that Petitioner was complaining of a work injury "[w]hen I got the notice from the attorney that there was a claim filed. That would have been early, mid-September." (T.90-91). He could not recall having any conversations with Petitioner just prior to that time about issues he was having. (T.91). However, he did note that there was "… a conversation that we had through Messenger that he made some remarks about not earning what

he thought were proper wages." (T.91). He could not think of any other issues Petitioner may have brought up at that time, including needing accommodations for anything. (T.91). With respect to Petitioner's complaint about wages, Mr. Armstrong stated that "I had referred that they had received a bump in wages from the previous year to $10 dollars, and then any wage increase would be addressed … at the beginning of the 2019 season", or the Spring of 2019. (T.91-92). He could not recall Petitioner telling him about having a disability from being a veteran. (T.92). He was also not aware of any injuries or conditions throughout the summer which would have impacted Petitioner's ability to perform his job duties. (T.92).

Mr. Armstrong testified that he was not told about the injury until he got the notice from the attorney. (T.92-93). He noted that after that "I had asked him to fill out the Illinois Form 45 because we needed it so we could get our process going to take care of this matter." (T.93). He indicated that it was a week, a week and a half before Petitioner sent the form back to him. (T.93). When asked if he investigated Petitioner's claim that he was injured at work, Mr. Armstrong stated: "I asked. I said did anybody get any information from Mr. Wallace being hurt, and nobody, Terry had not said that he had been notified of any kind of injury." (T.93).

On cross examination, Mr. Armstrong agreed he visits the worksite 2 to 4 times a week at which time he sees everybody, including Terry and Nick and whoever else is working. (T.94). He noted he spends anywhere from 10 minutes to an hour there, and that they've "… had some discussion sitting around, you know, whatever." (T.94-95).

He agreed that after receiving the Application for Adjustment of Claim he had Petitioner filled out a Form 45. (T.95). Mr. Armstrong was shown RX12. (T.95). He agreed that to the best of his knowledge this was the form Mr. Wallace filled out. (T.95). He noted that the form says that the accidents occurred on 9/12/18 and 8/2. (T.95). He agreed this form was filled out on 9/19. (T.96). He indicated that he did not know who filled this form out or who typed it, although he stated that "I would believe it would be our business manager." (T.96). He did not know why the typed accident report would have 9/10/18 listed as the date of accident when Petitioner put 9/12 and 8/2/19. (T.97). He agreed that the report Petitioner filled out did not mention use of an auger. (T.97). He also agreed that he did not know why there would be those discrepancies. (T.97).

On re-direct examination, Mr. Armstrong indicated that he did not know whether the insurance company fills out the First Reports of Injury. (T.98). He was shown RX1, the Application filed by Petitioner, and RX3, the First Report of Injury. (T.98). When asked to compare the allegations made in those documents, he agreed that RX1 and RX3 both describe the accident as repetitive heavy lifting, the date of accident as 9/10/18 and the body part affected as shoulder and back. (T.98-99).

On re-cross examination, Mr. Armstrong agreed that RX1 shows an AWW of $400 and RX4 shows an AWW of zero dollars. (T.100). He did not see Petitioner's email address listed on RX1 while the typed Form 45 shows Mr. Wallace's email address. (T.100). Thus, he agreed that these forms aren't exactly identical. (T.100-101).

Testimony of Jim Kasper

Private investigator Jim Kasper testified that he was hired to surveil Petitioner in March [2019]. (T.102-103). He agreed that surveillance was performed between 4/19/19 and 4/23/19. (T.1-2-103). He indicated that he obtained approximately 60 minutes of videotape as a result. (T.103). When asked to summarize what is on the video, Mr. Kasper testified that Mr. Wallace is seen "… walking, driving, riding a zero-turn tractor, utilizing a weed whacker, and going to the liquor [store] in Macomb. And that's about the 60 minutes of it." (T.103-104). He agreed that the discs have been in his possession since the videos were taken and that they have not been edited in any manner. (T.104). He also agreed that they have been kept in the ordinary course of his business. (T.104). The disc was marked as RX13. (T.104).

Mr. Kasper testified that he did not observe Petitioner at times other than those depicted on the video. (T.105). When asked if he saw Petitioner doing pull-ups, he replied: "Oh, no, sir." (T.105). He also noted that he did not see Mr. Wallace doing any strenuous activities with his arms. (T.105-106). When asked if everything significant involving Petitioner's activities is on the video, he responded: "Yes, that was obtainable other than a few seconds it takes to turn on the camera before the camera turns on and begins moving." (T.106).

On cross examination, Mr. Kasper testified that he conducted surveillance on 3/21, 3/22, 3/23, 4/19, 4/24, 4/25 and 4/26 [of 2019]. (T.107). He agreed that this represented 7 days of actual in-person surveillance which was condensed down to 60 minutes of video. (T.107-108). When asked if his testimony was that Petitioner did not do any strenuous activity in that 60 minutes, he replied: "[t]he activities I observed I documented whenever possible." (T.108). He agreed Petitioner wasn't doing any strenuous activity during that time. (T.108). He indicated that this is the first time these videos have been turned over and out of his possession. (T.108). He agreed they were never provided to defense counsel or Dr. Li for review. (T.108-109).

Medical/Personnel/Business Records

A rental receipt dated 8/2/18 from Commercial Rental noted that a "2-man auger 8" was rented that day to the Macomb Park District to be used at "Ball Four [sic]." (RX10).

An Application for Adjustment of Claim (18 WC 26931) filed by Martay Law Office on 9/10/18 alleges a date of accident of 9/10/18 involving the left shoulder and back due to "[r]epetitive heavy lifting." (RX1). Petitioner's signature is also dated 9/10/18. (RX1).

An email from Respondent's Superintendent of Support Services, Neil Armstrong, to Petitioner on 9/12/18 requested that the latter "[p]lease fill out the attached form and send it back to Macomb Park District." (RX2).

In an Orland Park Orthopedics office note dated 9/18/18, Savannah Murphy, P.A. recorded that "Mr. Wallace presents to our clinic for evaluation of left shoulder, low back pain, and radiculopathy which began developing 08-02-18 after using machinery at work and which became significantly worse around 09-12-18. He denies every [sic] having shoulder injury. He has had history of low back pain, but his current condition is worse than any pain he had prior. He has had

radiculopathy prior, but always down the right leg. His left shoulder has severe anterior pain and weakness. He is left hand dominant. His low back pain is constant and he has nukbness [sic], tingling and pain that radiates down bilateral legs. He currently works with Macomb park district and has been there for 2 years." (PX1). Upon examination of the left shoulder it was noted that "[p]atient has a positive impingement sign, specifically with external rotation – representing the anterior (supraspinatus) rotator cuff." (PX1). The diagnosis was shoulder pain. (PX1). An MRI of the left shoulder was ordered as well as physical therapy for the low back. (PX1).

An unsigned, typewritten Illinois Form 45: Employer's First Report of Injury dated 9/19/18 shows that Petitioner was alleging an accident on 9/10/18 as a result of "repetitive heavy lifting, left shoulder, back." (RX3). With respect to how the injury occurred, it was noted: "strain or injury by repetitive motion." (RX3). The body parts affected were noted as "multiple body parts – multiple body parts – specific injury – sprain/strain." (RX3).

A hand-written Illinois Form 45: Employer's First Report of Injury dated 9/19/18, signed by Petitioner, alleged a date of accident of "Sept 12, 2018 Aug 2" while "using gas powered trimmer/use of auger." (RX12). With respect to how the accident occurred, it was noted: "holding trimmer for extended time." (RX12). The body part affected was noted to be "left shoulder strain/tear in socket." (RX12). As to what object directly harmed the employee, it was noted: "trimmer/auger." (RX12).

An MRI of the left shoulder performed on 9/26/18 was interpreted as revealing "[m]ild acromioclavicular arthrosis [and] [n]o focal rotator cuff tear or discrete labral tear." (PX1).

Petitioner returned to PA Murphy at Orland Park Orthopedics on 10/2/18 at which time she noted that "[p]atient's MRI read does not indicate rotator cuff tear, but his physical exam is indicative of RTC pathology with impingement. Patient is very symptomatic. Will review MRI with Dr. Rhode." (PX1). The patient was to start PT that day and was to remain on modified work only. (PX1).

Petitioner returned to Orland Park Orthopedics on 10/17/18 at which time he saw Dr. Blair Rhode for the first time. (PX1). Dr. Rhode recorded that the patient presented for follow-up of left shoulder and low back pain, noting that "[s]ymptoms are secondary to an injury while at work." (PX1). Dr. Rhode noted a positive impingement sign on exam as well as a negative Speed's test of the biceps. (PX1). His assessment was left shoulder pain, bilateral low back pain and rotator cuff strain. (PX1). A subacromial steroid injection was performed on that date. (PX1).

In an ATI Physical Therapy Discharge Summary dated 10/29/18, it was noted: "[p]atient has been unable to attend therapy since initial evaluation [on 10/2/18] due to financial strain and unable to get a ride to therapy. Patient has been discharged from Physical Therapy." (PX3).

In an office note dated 11/13/18, PA Murphy recorded that the patient related that the injection performed at the last visit "… has significantly improved his symptoms. He continues to have some pain with overhead motions and lifting and use of the shoulder, but it is improved. He continues to do home therapy exercises." (PX1). Petitioner was to continue modified work status and follow up with Dr. Rhode in 4 weeks. (PX1).

In an office note dated 12/18/18, PA Murphy recorded that the patient "… was having improvement of his symptoms after the injection 2 months ago, but his [sic] the last couple weeks, he is experiencing worsening of his shoulder pain. He continues to do daily home exercises." (PX1). Petitioner was to continue modified duty status given his continued symptoms and was to follow up with Dr. Rhode in one week to "… discuss need for repeat injection and continued therapy, versus surgical intervention." (PX1).

On 12/26/18, Petitioner returned to Dr. Rhode at which time he was administered another injection in the left sub-acromial space. (PX1). Petitioner was to remain on modified light duty and follow up in 4 weeks. (PX1).

In an office note dated 1/23/19, Dr. Rhode recorded that the injections provided temporary relief and that his symptoms continue. (PX1). Upon examination, in addition to a positive impingement sign, Dr. Rhode also noted a positive Speed's test and positive O'Brien's for SLAP lesion. (PX1). He indicated that he discussed with the patient "… the potential need for an arthroscopic subacromial decompression, biceps tenodesed [sic] with possible rotator cuff repair. At this point, the patient will consider surgery. We'll continue the patient light duty." (PX1).

Dr. Rhode next saw Petitioner on 2/20/19 at which time he reviewed the IME report of Dr. Li. (PX1). Dr. Rhode noted Petitioner was modified-light duty pending authorization for biceps tenodesis versus SLAP repair. (PX1).

In an office note dated 3/20/19, Dr. Rhode recorded that "[t]he patient returns for reevaluation of his left shoulder and low back injury. He reiterated his injuries. He states that he sustained his lumbar injury while working with concrete on July 15, 2018. He injured his shoulder working with an auger on August 2, 2018. He states that he reported his injury to tear he [sic] on August 4, 2018. On September 11, 2018, he told kneel [sic] and an email about his injury. He filed an injury report on September 10, 2018." (PX1). Dr. Rhode recorded that the patient "… continues to have symptomatology related to his biceps labral complex. We continue to recommend surgical intervention in the form of arthroscopic SLAP reconstruction versus biceps tenodesis. I believe the patient will likely require a biceps tenodesis based upon the subacute nature of the labral pathology and the patient's age." (PX1). Petitioner was to remain on modified light duty. (PX1).

Petitioner returned to PA Murphy on 4/16/19 at which time it was noted that he was to remain on modified light duty while awaiting authorization for shoulder surgery. (PX1).

An Amended Application for Adjustment of Claim (18 WC 26931) filed by Martay Law Office on 4/22/19 alleged an injury to the "[b]ack" on 6/27/18 due to "[r]epetitive heavy lifting of concrete." (RX4). Petitioner's signature is dated 4/22/19. (RX4).

An Application for Adjustment of Claim (19 WC 11909) filed by Martay Law Office on 4/22/19 alleged a date of accident of 9/10/18 involving the left shoulder as a result of "[w]orking with auger." (RX5). Petitioner's signature is dated 4/22/19. (RX5).

An Amended Application for Adjustment of Claim (19 WC 11909) filed by Martay Law

Office on 4/23/19 alleged a date of accident of 8/2/18 involving the left shoulder as a result of "[w]orking with auger." (RX6). Petitioner's signature is dated 4/23/19. (RX6).

In an office note dated 5/15/19, Dr. Rhode recorded that the patient continues to be symptomatic while awaiting surgical authorization. (PX1). The same could be said of the office visit to Dr. Rhode on 6/12/19, 8/7/19 and 9/4/19. (PX1).

A Macomb Service and Salary Record contains the following entry next to the date of 6/25/19: "Terminated due to poor attitude not reporting to supervisor and leaving work without notifying supervisor." (RX7).

In a City of Macomb Oakwood Cemetery memo directed to the payroll department and dated 6/27/19, Gary Rhoads stated that "[t]his is to inform you that Nicholas Wallace was terminated from his position. This is due to poor attitude, not reporting to supervisor when leaving work and not calling supervisor when he was going to be absent from work and other issues. His last day of work was June 25, 2019." (RX7).

In a letter dated 9/10/19, Macomb City Business Office Manager Kerry Rhoads stated that "[t]he City does not have a written job description for seasonal part-time temporary positions. The duties for work at the Cemetery are; mowing, weed eating, landscaping, and all other duties as assigned." (RX7).

In his last office note, dated 11/8/19, Dr. Rhode once again recorded that "[t]he patient continues to be symptomatic from his work-related left shoulder injury. He continues to await authorization. He will follow-up in 4 weeks while we await authorization." (PX1).

Testimony of Dr. Blair Rhode (6/3/19)

Dr. Rhode testified that he is board certified in orthopedics and has a board certification in sports medicine. (PX2, p.5). He noted that as a sports medicine doctor he concentrates primarily on knees, shoulders and elbows. (PX2, p.5). He indicated that about 50% of his practice involves shoulder injuries, and he would consider his to be a high-volume practice. (PX2, p.5). He stated that probably 5% of his practice involves back injuries, and that he performs approximately 200 shoulder surgeries a year. (PX2, pp.5-6). However, he noted that he does not do back surgery but instead refers those cases out. (PX2, p.6).

Dr. Rhode noted Savannah Murphy is the physician's assistant in his office in Peoria and that she examines some of his patients. (PX2, p.8). He agreed that Ms. Murphy is under his supervision. (PX2, p.8). He likewise agreed that Ms. Murphy initially saw Petitioner on 9/18/18. (PX2, pp.8-9). He indicated that at that time the patient presented for evaluation of a work-related left shoulder and low back injury that occurred on 8/2/18, noting that "[h]e was using machinery while at work, and his symptoms worsened. The patient denied having a prior left shoulder injury. He did have a prior history of low back pain, but this symptomatology was made worse after his injury." (PX2, p.9). He stated that following physical examination, the provisional diagnosis was rotator cuff strain and that a recommendation was made for physical therapy and an MRI of the left shoulder. (PX2, pp.9-10). He believed the MRI was ordered "[b]ased upon his symptoms,

specifically the positive impingement sign with the strength loss to supraspinatus isolation, [Ms. Murphy] was concerned for a rotator cuff tear." (PX2, p.10). He also noted that Petitioner was placed on modified light duty on 9/18 based on Department of Labor guidelines, which would be 10 pounds frequent, 20 pounds maximum, limited pushing/pulling and occasional repetitive grasp. (PX2, pp.10-11).

Dr. Rhode agreed that Petitioner next saw Petitioner on 10/2/18 at which time he presented with the MRI which was performed on 9/26/18. (PX2, p.11). He noted that the patient was to stay on modified duty and follow up with him at his next visit. (PX2, p.11). He also indicated that Petitioner was just starting physical therapy at that time. (PX2, p.12).

Dr. Rhode agreed that he first saw Petitioner on 10/17/18. (PX2, p.12). He noted that at that visit Petitioner "… reiterated that he had sustained his injuries secondary to a single event operating an auger." (PX2, p.12). He indicated that Petitioner's motion was somewhat improved at that time, but that he continued to have a loss of strength and a positive impingement sign. (PX2, p.12). Dr. Rhode stated that they elected to continue conservative care and performed a left subacromial steroid injection at that time. (PX2, p.12). He indicated that the injection would serve both a diagnostic and a therapeutic purpose. (PX2, p.12).

He agreed Petitioner followed up with Ms. Murphy on 11/13/18 at which time he reported that the injection had significantly improved his symptoms, although he continued to have symptoms with overhead activity and lifting. (PX2, p.13). Petitioner was to remain on modified duty and follow up with Dr. Rhode in a month. (PX2, p.13). He noted that the significant improvement following the injection was "… supportive of the diagnosis of a rotator cuff injury." (PX2, p.13).

He agreed that Ms. Murphy saw Petitioner again on 12/18/18 at which time he noted worsening of his symptomatology over the last couple of weeks. (PX2, p.13). He noted that this "… would be typical if the injection isn't going to be the end-all/be-all as far as treatment." (PX2, p.14). Petitioner was to remain on modified duty and follow up with Dr. Rhode. (PX2, p.14).

He agreed that he next saw Petitioner on 12/26/18 at which time Mr. Wallace "… continued to be symptomatic, continued to have strength loss." (PX2, p.14). Dr. Rhode repeated the subacromial injection and continued the patient on modified duty. (PX2, p.14).

He agreed he next saw Petitioner on 1/23/19, or after the IME of Dr. Lawrence Lee [sic]. (PX2, p.15). He noted that on the date of this exam, Petitioner continued to be significantly symptomatic and "… was having more symptomatology over his rotator cuff as well as his biceps. This was the first time we started to discuss with the patient the potential need for surgery." (PX2, p.15). He agreed that there may be a typo in these reports if they say the patient had three injections, since he believed it was actually two injections in his office. (PX2, pp.15-16). He also noted that "[a]t this point, we were discussing an arthroscopic subacromial decompression, possible rotator cuff and a possible biceps tenodesis." (PX2, p.16). They continued Petitioner on modified light duty at that time. (PX2, p.16).

He agreed he next saw Petitioner on 2/20/19 at which time he continued to be symptomatic.

(PX2, p.16). He noted that in reviewing the IME report of Dr. Lee [sic], "… we found that Dr. Lee [sic] diagnosed the patient with a positive impingement sign suggestive of rotator cuff pathology and a lumbar strain. He did not feel that the patient demonstrated evidence of radiculopathy. He also found the patient's history was inconsistent relative to the medical records that were provided to Dr. Lee [sic]." (PX2, pp.16-17). He also noted that "[a]t that point, we were making a formal recommendation for surgery." (PX2, p.17). They also continued him on modified light duty at that time, noting that Petitioner "… continued to be symptomatic. He continued to have lateral shoulder pain symptomatology with forward reach and overhead lift, so I felt it was appropriate to put him on restrictions." (PX2, p.17).

Dr. Rhode agreed he next saw Petitioner on 3/20/19 at which point nothing had changed and his recommendations remained the same. (PX2, p.18). He also saw the patient on 4/16/19 and 5/15/19. (PX2, p.18). He agreed that the last time he saw Petitioner was about two weeks ago at which point he was still recommending surgery and keeping him on light duty. (PX2, p.18).

Dr. Rhode testified that he reviewed Dr. Lee's [sic] entire 1/7/19 IME report, noting that he did not agree with Dr. Lee's [sic] opinion that Petitioner's injuries were not related to any sort of work injury. (PX2, p.19). In fact, Dr. Rhode stated that he did not "… feel that Dr. Lee [sic] ever declared that these injuries were not related… [Dr. Li] does talk about having an inconsistent history, but he never … declares no causal connection… He just basically has an issue with the patient being a poor historian." (PX2, pp.19-20). Dr. Rhode testified that "[r]elative to our intake, I believe the patient has always been consistent with an August 2nd injury date secondary to using an auger, so I don't know where the issue is as far as the history and the lack of an event." (PX2, p.20). He agreed that if a patient was being untruthful with him he would mark that in his reports, same with someone showing signs of symptom magnification. (PX2, p.20). He indicated that at no time during the course of his treatment of Petitioner has this been in any of his reports. (PX2, p.20). He stated that he "… did not note it as [he] did not feel the patient was inconsistent." (PX2, pp.20-21). Dr. Rhode also took issue with Dr. Lee's [sic] representation that PA Murphy recorded on 9/18/18 that Petitioner denied ever having a shoulder injury, that she found a negative impingement sign at that time, and that he had normal strength. (PX2, p.21). He noted that he would agree with Dr. Lee's [sic] diagnosis, although he believed "… the patient has a component of biceps pathology as well." (PX2, p.22). He likewise agreed with Dr. Lee's [sic] opinions as to work restrictions, although he felt Petitioner was capable of doing some activity, including overhead work, noting "I guess maybe we were just trying to make it so they could accommodate him a little more." (PX2, pp.22-23).

Dr. Rhode testified that "[i]t's my opinion that the patient sustained a left shoulder rotator cuff injury on August 2nd, 2018, while operating an auger and developed sudden onset shoulder pain," based on the multiple intakes performed at his office, including his own on 10/17/[18]. (PX2, pp.23). Dr. Rhode also believed that Petitioner's need for left shoulder surgery is related to the work injury on 8/2/18. (PX2, p.24). He noted that this is based "… upon the history, the subjective complaints, the sequential physical exam findings, the positive response to the two injections but yet symptoms return. At this point, I believe the patient is a surgical candidate." (PX2, p.24). Likewise, he believed that Petitioner's work restrictions were related to the 8/2/18 injury. (PX2, p.24).

On cross examination, when asked if it was his opinion that Petitioner had one specific accident as opposed to a repetitive-trauma type condition, Dr. Rhode responded: "[t]he patient related that his symptomatology developed on August 2nd, 2018, while operating an auger. It does not appear that he continued to work, and his symptomatology continued to worsen as documented by the – the comment in the index noted that on September 12th, 2018, his symptomatology was significantly worsened." (PX2, p.25). He also testified that they recorded his symptoms became significantly worse around 9/12/[18], although he had no indication as to what happened on that date. (PX2, pp.25-26).

When asked what his understanding was as to what happened on 8/2/18, Dr. Rhode stated: "[h]e was working an auger when he experienced sudden onset left shoulder pain." (PX2, p.26). However, he did not know if Petitioner was pulling, pushing, lifting, pounding or what he was doing. (PX2, p.26). As a result, he acknowledged he had no idea as to the mechanism of injury. (PX2, p.26). Dr. Rhode testified that he believed Petitioner sustained a lumbar strain and a rotator cuff strain as a result of what he was doing on 8/2/18. (PX2, p.26). He noted that he reviewed the MRI films and he agreed with the radiologist that there was no indication of a rotator cuff tear. (PX2, pp.26-27). He also noted that "… the biceps was without pathology on MRI." (PX2, p.27).

In addition, he indicated that he had nothing documented about any accidents or injuries before 8/2/18. (PX2, pp.27-28). He stated that he did not evaluate Petitioner's lower back; however, he testified that "[b]ased upon the initial intake and the review of the PA's notes, I think the patient sustained a lumbar strain which resolved", resulting in no permanent disability and no need for additional treatment. (PX2, p.28). He agreed that typically you would expect symptoms from a lumbar strain fairly quickly, noting that "… if you strain your back, the symptom onset should be immediate." (PX2, pp.28-29). When asked if that was generally due to inflammation in the area that's injured, he replied: "[i]nflammation and – I mean, obviously, this is a musculoligamentous strain. You're tearing tissue." (PX2, p.29).

Dr. Rhode agreed you would also expect inflammation and symptoms in the shoulder within hours or a couple of days after the injury occurred. (PX2, p.29). He also agreed the MRI [of the shoulder] only showed some degenerative changes in the AC joint. (PX2, p.29). When asked if those degenerative changes were aggravated by his job activities, Dr. Rhode testified that "I don't feel that the AC changes were symptomatic or related." (PX2, pp.29-30). When asked if there would be inflammation around the rotator cuff, he responded: "[t]here would be inflammation around the tendon. My interpretation of the MRI on October 17th, 2018, was mild cuff tendinitis without evidence of tear, but there was not a full thickness tear." (PX2, p.30). He noted with a strain that "… typically won't be painful with palpation. It would be a provocative maneuver, which, for the rotator cuff, would be the impingement maneuver." (PX2, p.30).

Similarly, Dr. Rhode agreed that typically you would expect symptoms fairly quickly if there was a biceps tendon injury, and that "[t]here may be tenderness and/or a positive Speed's maneuver." (PX2, pp.30-31). When asked where the tenderness would be, he replied: "[t]he biceps is more anterior, so it's going to be more in the front of the shoulder", at the shoulder side of the biceps as opposed to the elbow side. (PX2, p.31). He agreed that the first positive Speed's test for Petitioner was on 1/23/19. (PX2, p.31). However, he noted that "… this inflammatory process has been going on since the injury. If you look at where the biceps runs relative to the rotator cuff

there, they touch. They're intimately associated with each other. So if you've got this disease process that keeps progressing, it can affect the biceps as well. My opinion is he didn't have an intervening injury. We've had him on modified duty, so there would – this is a progression of the pathology that happened on August 2nd." (PX2, pp.31-32). He noted that "[t]he biceps tendon runs right on the front side of the rotator cuff. So the same stuff that is beating up the rotator cuff is beating up the biceps tendon." (PX2, p.32).

Dr. Rhode testified that his current surgical recommendation "… would be a subacromial decompression, assess the rotator cuff and a possible biceps tenodesis." (PX2, p.34). He also indicated that since the patient has an audible pop on exam relative to his biceps that "… ultimately the biceps would have to be assessed intraoperatively." (PX2, p.34). In addition, he stated that while in February of 2019 he thought the problem was more biceps, "… I continue to believe that the rotator cuff is a component." (PX2, p.35).

Dr. Rhode agreed that if Petitioner told Dr. Lee [sic] that he injured his back lifting concrete while dealing with playground equipment, that would be different from what he told him [Dr. Rhode], as would the claim that he injured himself on 9/10 rather than in August. (PX2, p.36). In this respect, he agreed that the history documented is different. (PX2, p.36).

When asked what would happen if Petitioner does not have surgery, Dr. Rhode testified: "I think he'll continue to be symptomatic. This is not a patient that has a full thickness tear. So it's not a situation that he's going to, you know, propagate the tear and be irreparable. I think it's more so a symptom-based thing." (PX2, pp.36-37). He acknowledged that his symptoms could resolve over time, noting "[i]t's possible. But the further we get out from the injury and then he doesn't get better, the less likely that is… [Y]ou can't say that we haven't tried a conservative course." (PX2, p.37).

On re-direct examination, Dr. Rhode agreed that while Ms. Murphy performed an examination of the back when she first saw Petitioner, he [Dr. Rhode] did not examine the back. (PX2, pp.37-38). He agreed that he treats a lot of work injuries. (PX2, p.38). He also noted that it was not uncommon for someone not to get to him for an exam in the first week after the injury. (PX2, p.38). When asked if a month would be uncommon, Dr. Rhode replied: "[y]ou know, I published a significant amount in access issues. In fact, part of the reason I am in the Peoria area is due to the lack of access to treatment. So, no, I don't think that would be uncommon." (PX2, p.38).

Finally, Dr. Rhode agreed that over the roughly eight months he and his office have treated Petitioner, he has not seen any significant improvement to the point where he's released Mr. Wallace from his care. (PX2, p.39).

Testimony of Dr. Lawrence Li (8/19/19)

Board-certified orthopedic surgeon Dr. Li testified that "I practice orthopedics with a focus on shoulders, hands and knees. I treat upper and lower extremity conditions both operatively and non-operatively. I treat spinal conditions only non-operatively." (RX8, pp.4-5). He noted that he does about five IMEs a week, and about 85% of those are on behalf of Respondents. (RX8, p.6).

Dr. Li agreed that he performed an IME in this case and issued a report dated 1/7/19. (RX8, p.6). By way of history, he noted that Petitioner had worked for the Park District for two years as a seasonal worker and "[h]e told me that around September 10th [2018] he was using an auger. And he would have to bring the auger up to empty dirt, and that's how he hurt his shoulder. He operates the auger and the dirt together may weigh up to 100 pounds. He states that he was digging eight to ten holes on a day. He estimates it takes him ten minutes to dig each hole. He specifically recalls one time when he pulled it up and jerked his shoulder. And then when I asked him when he first saw a doctor, he said he went to Orland Park Orthopedics at the request of his attorney." (RX8, p.8). Dr. Li also noted Petitioner told him that "… in early September he was removing some old playground equipment and was lifting concrete that was very heavy, and that's where he hurt his lumbar spine. He states he kept on working, and then was referred to therapy." (RX8, p.9). Dr. Li stated that Petitioner was "… somewhat unsure of the day. At first he told me it was at the end of September, but then he checked his cell phone, and then he kind of nailed it around September 10th [2018]." (RX8, p.9).

When asked if Petitioner's PTSD would have anything to do with his shoulder or back injuries, Dr. Li replied, simply, "no." (RX8, p.9).

Upon exam, Dr. Li noted full range of motion, normal strength, no tenderness over the AC joint, a positive Neer and Hawkins impingement test and negative load and O'Brien's test for the biceps. (RX8, pp.9-10). With respect to the spine he noted that Petitioner could touch his hands to his toes, straight leg raise was about 70 degrees, causing pain in the lumbar spine, with no radiculopathy with straight leg raise, normal range of motion of the hips, negative figure 4 test, five out of five strength from L3-S1, intact sensation L3-S1 and no atrophy, which meant he was using both legs equally. (RX8, p.10).

Dr. Li's diagnosis was left shoulder rotator cuff strain and impingement syndrome as well as a lumbar strain. (RX8, p.11). He noted that someone with impingement syndrome "… would have issues with let's say painting or reaching something overhead. They wouldn't have any issues with lifting boxes from the floor." (RX8, p.11). He indicated that a lot of times impingement syndrome is caused by repetitive work, but that "[i]t's also possible to injure your rotator cuff on a one time event. That gets inflamed, and then it's impinged upon when they raise their arm up." (RX8, p.12). However, he noted that "… for the traumatic types, those usually resolve because they are not doing repetitive trauma. And once the inflammation is down, everything is fine." (RX8, p.12).

When asked his opinion as to whether there was a causal relationship between the history of lifting concrete at the playground and his lower back complaints, Dr. Li stated: "… if it was strictly, you know, only what he told me, that makes sense. He lifted concrete, he hurt his back. But … I found there was a discrepancy in what he told me and what was documented in the medical records… [H]e doesn't really give the mechanism of injury … in the medical records in the lumbar spine at all. I mean, he's basically from – I got back pain from working. Where what he gave me was very distinct and he was lifting heavy concrete and that's what caused his pain." (RX8, pp.12-13). When asked the significance of there not being a specific history in the medical records, Dr. Li replied: "I think that it goes to whether he was confused or whether the history is accurate. Because I would expect that a very specific day where he's lifting concrete out of the playground,

if he remembers to tell me, he would remember to tell the other doctors too." (RX8, p.13).

When asked his opinion as to whether there was a causal relationship between the history of lifting an auger and the left shoulder impingement syndrome, Dr. Li responded: "[a]gain, if I was the only one that ever saw him, he told me that, that certainly is a mechanism for causing a shoulder problem. But I found that in the records I reviewed, I think the first two visits, the first one was September 18 and the second one was perhaps ten days later, he said there was no injury to the shoulder. He got pain in the shoulder from working, but never an jury [sic] to the shoulder. It wasn't until October 17 that he reported the auger injury. I think that's again very inconsistent, because I feel that the auger injury is very specific to be mentioned." (RX8, pp.13-14). He noted that Petitioner "… gave me a specific incident. He said he was lifting an auger up and he felt pain in that shoulder." (RX8, p.14). He stated that it is very important to know the mechanism of injury and "… whether it makes biomechanical sense or not… [a]nd then there is also whether the mechanism is acutely traumatic or kind of repetitive low grade trauma but on a chronic basis." (RX8, p.15).

Dr. Li agreed that prior to his deposition he was provided with Dr. Rhode's deposition transcript. (RX8, p.15). He noted that "[i]t didn't change my opinions on causation, but it did clarify a few points." (RX8, p.15). He indicated that when he saw Dr. Rhode's reference to five minus out of five "I assumed that was normal. I have never seen five minus. I have on occasion four plus, but I have never seen five minus. So, that confused me." (RX8, p.16). He also noted that he was "confused about" the impingement test, which he had said was negative and which was documented as positive. (RX8, p.16). He stated that he therefore agreed with the impingement syndrome diagnosis involving the rotator cuff. (RX8, p.16).

Dr. Li agreed that it was accurate to say Dr. Rhode noted a biceps issue a couple months later, noting that "… up until January the Speed's test was always negative. There was never an issue with the biceps. And I think around January then the Speed's test became positive, and then it's been positive ever since." (RX8, pp.16-17). He noted that "Speed's test is a shoulder provocative test to look for biceps pathology" at the biceps tendon that attaches to the shoulder. (RX8, p.17). When asked his opinion as to whether there was any relationship between the work activities described by Petitioner and his biceps tendon in the left arm, Dr. Li stated: "It's my opinion that whatever issues he has with the biceps now is not related to the alleged injury when he was lifting the auger, because he didn't have any biceps pathology on the MRI, he didn't have any biceps positive testing for the biceps in physical examination from me. He didn't have any positive physical examination findings for Dr. Rhode up until January. So, that would be approximately three to four months after the injury. So, that came on after the injury." (RX8, pp.17-18). He also noted that if the biceps tendon had been irritated or injured in some manner as a result of a particular incident, he would expect symptoms to develop in a matter of weeks. (RX8, p.18).

Dr. Li testified that "… one would not expect someone with impingement syndrome to get biceps tendonitis. They are not associated." (RX8, p.19). However, he noted that "[i]f someone had tore their rotator cuff, their biceps tendon would be exposed. There would be a relationship. In this case the rotator cuff is completely intact. There would be a barrier between the subacromial bursitis and the impingement and the biceps tendon." (RX8, p.19).

Dr. Li agreed he prepared a two-page report dated 8/15/19 after reviewing Dr. Rhode's deposition transcript and more recent medical records. (RX8, pp.19-20). He noted that he thought conservative treatment for the shoulder was initially appropriate and that he "… recommended corticosteroid injection followed by physical therapy for six to eight weeks, and if that fails, then I think surgery is an option." (RX8, p.20). He indicated that his review of the deposition transcript and recent medical records has not changed his opinion as to the need for treatment. (RX8, p.20). He also stated that "… in someone who has impingement syndrome or rotator cuff issues I generally make a simple distinction just no overhead work. They should be able to lift from floor to waist. In this case he had a lumbar spine issue. But for the rotator cuff, below the chest should not be a problem." (RX8, p.20). With respect to the lower back, Dr. Li noted that he recommended no lifting from floor to waist at the time he saw him, but that "[n]ow he's all better so … he wouldn't need any restrictions for that." (RX8, p.20). He indicated that for the shoulder he would presently still say no over chest lifting. (RX8, pp.21-22). He also opined that Petitioner's need for additional treatment and restrictions for the shoulder would not be related to his job activities. (RX8, p.22).

On cross examination, Dr. Li indicated that the IME was set up through his assistant, either through a third party or the Illinois Public Risk Fund. (RX8, p.23). He stated that he was provided with a list of questions to answer by defense counsel. (RX8, p.23).

Dr. Li agreed he saw Petitioner for an in-person exam on 1/7/19. (RX8, pp.23-24). He noted he was provided with and personally reviewed past medical records before the examination. (RX8, p.24). He agreed the records he reviewed started on 9/18/18 and ended on 12/18/18. (RX8, p.24). He agreed that after reviewing these past medical records and performing a physical exam, his diagnoses included rotator cuff strain, impingement syndrome for the left shoulder, and a lumbar strain for the back. (RX8, pp.24-25). He agreed his report does not mention any symptom magnification or malingering, and if he had observed any, he would have noted it in his report. (RX8, p.25). He agreed that at the time he believed Petitioner required some therapy and injections for the left shoulder, and if those had failed, he believed surgery would be the logical next step. (RX8, p.25). He also agreed that he believed Petitioner could return to work with no overhead lifting from floor to waist. (RX8, pp.25-26).

Dr. Li indicated that he was not provided with any medical records prior to 9/18/18 indicating that Petitioner was suffering from any left shoulder issues or previous back pains. (RX8, p.26).

When asked about his testimony regarding missing a few things in Dr. Rhode's records, Dr. Li stated "I don't know if I missed it or just got confused by it, but … I thought it said negative impingement test, but it said positive impingement test." (RX8, p.26). He also agreed that the 9/18/18 record by PA Murphy mentions positive impingement specifically with external rotation representing the anterior supraspinatus rotator cuff. (RX8, pp.26-27). He was willing to concede that he initially misinterpreted that, and that anything in his report about a negative impingement test would be inaccurate. (RX8, pp.27-28). He also agreed that there was a positive impingement sign noted in the 10/2/18 report and that his reference to a negative test was incorrect. (RX8, p.29).

He agreed he testified that the basis for his causation opinion was due to an inconsistent

history. (RX8, pp.29-30). When shown the history reflected in the 9/18/18 report – namely, presenting with left shoulder and low back pain with radiculopathy that began 8/2/18 after using machinery at work – Dr. Li stated: "I didn't quote that verbatim [in his report], but I gave my interpretation of that…" (RX8, p.30). He noted that "[t]here is no dispute that he thought it was a work injury and that he told Physician Assistant Murphy or Dr. Rhode that it occurred on August 2nd, 2018. I don't dispute that at all. I agree with that." (RX8, p.31). However, Dr. Li stated that Petitioner "… told me a very specific mechanism of injury, lifting up a 100 pound auger and he felt pain in his shoulder. That mechanism makes sense. He doesn't really talk about the type of work otherwise." (RX8, pp.31-32).

When asked how Petitioner could have had all these negative Speed's tests and then all of a sudden have a positive one, Dr. Li replied: "[t]he explanation would be that something happened in between the last negative Speed's test examination and the first positive Speed's test examination, something happened to his biceps tendon." (RX8, p.32). However, he noted that he saw Petitioner before the first positive Speed's test so "… it would have had to happen after he saw me." (RX8, pp.32-33). He also noted that there was nothing in the records of Dr. Rhode or PA Murphy indicating that a new injury occurred between 1/7/19, when Dr. Li saw him, and the date of the first positive Speed's test on 1/23/19. (RX8, p.33).

On re-direct examination, Dr. Li agreed that PA Murphy's 9/18/18 note also indicated that Petitioner denied ever having a shoulder injury. (RX8, p.35). He stated that "[t]hat was crucial. And it reads, ["]He denies every [sic] having a shoulder injury.["] I interpret that [as] he denies ever having a shoulder injury. Meaning that he didn't actually recall a specific event during his work. It was, I worked and I got shoulder pain. Therefore, it's a work related shoulder pain." (RX8, p.35). He agreed that when Petitioner was in his office he checked his phone and determined 9/10/18 was the date of injury. (RX8, pp.35-36). He indicated that Petitioner never gave him a history of anything happening on 8/2/18, noting that "… we were working backwards. He said, oh, it happened a couple of weeks after I – before I stopped working, which would have been like late September. But then he went back and checked his text messages, and it was mid September." (RX8, p.36). He also noted that his recollection was that Petitioner injured his lumbar spine prior to injuring his shoulder. (RX8, p.36).

On re-cross examination, when asked if there was any chance that PA Murphy meant that Petitioner denied any prior injury, Dr. Li stated: "I don't think I can answer that question. I mean, I read it as he didn't have a specific injury… I am not going to go interpret someone else I have never even met." (RX8, p.37).

When asked if he ever asked Petitioner about an 8/2/18 injury, Dr. Li responded: "I asked him for the date. I didn't say, well, was it August 2nd or what? I said, hey, give me approximately when you did it. If he said early August, I would have counted that. I asked him for a day… It wasn't a multiple choice question." (RX8, pp.37-38).

Conclusions of Law

The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of his claim, particularly the prerequisites that the injury complained of

arose out of and in the course of the employment. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d. 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977). It is the function of the Commission to decide questions of fact and causation, to judge the credibility of witnesses, and to resolve conflicting medical evidence. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980). The question of whether a claimant's injury arose out of his or her employment is typically a question of fact to be resolved by the commission, whose finding will not be disturbed unless it is against the manifest weight of the evidence. *Johnson Outboards v. Industrial Comm'n*, 77 Ill. 2d 67, 71 (1979); *Illinois Valley Irrigation, Inc. v. Industrial Comm'n*, 66 Ill. 2d 234, 239 (1977) (citing *Warren v. Industrial Comm'n*, 61 Ill. 2d 373, 376 (1975)).

In the present case, Petitioner claims that he injured his left shoulder as a result of a specific, identifiable incident on 8/2/18 – namely, using a two-man auger to dig holes for the installation of fencing around Respondent's putt-putt course. However, the record contains multiple inconsistencies with respect to this claimed injury, including the testimony of his supervisor, Terry Stoneking, who was present at the time these fence posts were dug, and who flatly denied being told by Petitioner that he had injured his shoulder at that time. Mr. Stoneking also credibly testified that he observed no visible signs of pain or discomfort on the part of Petitioner thereafter. Likewise, Neil Armstrong, Respondent's superintendent of support services, testified that Petitioner never made any such complaints to him and that he did not observe any signs of pain or discomfort by Petitioner at the time of his visits, and that he was not aware of the alleged accident until he received the Application for Adjustment of Claim. To add to the confusion, two separate Form 45: First Report of Injury forms dated 9/19/18 were submitted into evidence – one signed by Petitioner alleging a date of accident of "Sept, 2018 Aug 2" while "using gas powered trimmer/use of auger" and "holding trimmer for extended time" resulting in "left shoulder strain/tear in socket" (RX12), while another Form 45 prepared on that date alleged a date of accident of 9/10/18 as a result of "repetitive heavy lifting, left shoulder, back." (RX3). More importantly, Petitioner continued to work in his regular duty capacity for Respondent through the end of the 2018 season, and did not seek treatment until he visited Dr. Rhode's office on 9/18/18, at which time he finally reported left shoulder and low back pain which developed after using machinery at work. In addition, the initial Application for Adjustment of Claim (18 WC 26931) alleged an injury to his left shoulder and back on 9/10/18, not 8/2/18, due to "[r]epetitive lifting" (RX1), while an Application filed on 4/22/19 with respect to 19 WC 11909 alleged an injury to the left shoulder on "09/20/2018" while "[w]orking with auger" – although an Amended Application in claim 19 WC 11909 filed on 4/23/19 later changed the date of accident to 8/2/19. (RX6).

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 he sustained a distinct, identifiable accident on 8/2/18.

Furthermore, the Commission finds that Petitioner failed to prove that a causal relationship existed between said alleged accident and his current condition of ill-being, based on the opinion of Respondent's §12 examiner, Dr. Li.

Accordingly, the Arbitrator's decision is reversed and Petitioner's claim for compensation is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated 2/27/20 is vacated and Petitioner's claim for compensation is hereby denied.

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

July 2, 2021

o: 5/4/21
TJT/pmo
51

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

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

DISSENT

I dissent. I believe the evidence fully supports the Arbitrator's finding that Petitioner has proven by a preponderance of the credible evidence that he was injured in an accident that arose out of and in the course of his employment on August 2, 2018 and that his current condition of ill-being with respect to his left shoulder is directly related to his work-injury on that date.

The majority takes issue with several inconsistencies between Petitioner's testimony relative to his injury and the record, most notably the testimony of Mr. Stoneking and Mr. Armstrong as well as the differing dates of accident and alleged circumstances surrounding same found in the various Applications, Form 45s and medical histories. I would not dispute the fact that these differences do in fact exist. However, I believe that these discrepancies are minor and fail to take into consideration the fact that Petitioner is a lay-person, unfamiliar with the vagaries of Illinois workers' compensation law, and given that he suffered a traumatic brain injury while serving in the Marines, which he admits has resulted in difficulty remembering dates and, in his own words, "keep[ing] everything straight." (T.48).

Furthermore, I do not believe that the histories are really all that disparate. Indeed, the initial history recorded by Dr. Rhode's office on 9/18/18, or a little more than a month following the accident, clearly shows that he presented "… for evaluation of left shoulder, low back pain, and radiculopathy which began developing 08-02-18 after using machinery at work and which became significantly worse around 09-12-18." I would suggest that this history, to his treating orthopedic surgeon, should hold more sway than any mention of an accident and how it was caused contained in the legal filings of his attorneys, or in a form his employer either filled out or assisted him with.

Thus, I believe the inconsistencies are minimal and totally understandable under the circumstances, and by no means evidence of his lack of credibility. And as a result, I would affirm the Arbitrator's well-reasoned and thorough decision in its entirety.

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

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

WALLACE, NICHOLAS
Employee/Petitioner

Case# **19WC011909**
18WC026931

MACOMB PARK DISTRICT
Employer/Respondent

On 2/27/2020, 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 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
STEPHEN MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR
CHAMPAIGN, IL 61821

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nicholas Wallace
Employee/Petitioner
v.
Macomb Park District
Employer/Respondent

Case # **19** WC **11909**
Consolidated cases: **18 WC 26931**

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 Hinrichs**, Arbitrator of the Commission, in the city of **Peoria**, on **January 15, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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, **August 2, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,587.68**; the average weekly wage was $**222.84**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **1** dependent children.

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

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

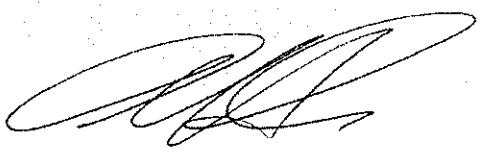
The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that an accident occurred on August 2, 2018 that arose out of and in the course of Petitioner's employment. The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he continues to suffer from left shoulder pain, and that this current condition of ill-being was caused by his work-injury on August 2, 2018 while employed by Respondent. Respondent shall pay the following reasonable, necessary and related medical bills; $10,238.41 for treatment rendered at Orland Park Orthopedics; $433.04 for treatment rendered at ATI Physical Therapy; $2,720.00 for treatment rendered at Orthopedics & Sports Enhancement Center; $14,890.35 for treatment rendered at RX Development, and $17,567.84 for treatment rendered at Persistent Labs. Respondent shall pay these medical bills directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act, and subject to reductions under the medical fee schedule.

The Arbitrator awards prospective reasonable medical care as prescribed by Petitioner's treating physician Dr. Blair Rhode, which is necessary to cure and relieve Petitioner's current condition of ill-being in his left shoulder from his work injury on August 2, 2018. The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from October 3, 2018 through March 25, 2019 and June 26, 2019 thru January 15, 2020. This represents 53 and 5/7th weeks of disability at a rate of $222.84 totaling $11,969.69.

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

February 25, 2020
Date

ICArbDec19(b)

Nicholas Wallace. Macomb Park District 19WC 11909 & 18WC 26931

FEB 27 2020

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS WALLACE	)	
	)	
Petitioner,	)	
vs.	)	
	)	No. 19 WC 11909
MACOMB PARK DISTRICT	)	18WC 26931 (Consolidated)
	)	
Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

On April 22, 2019 Petitioner filed an Application for Adjustment of Claim which was assigned case number 19 WC 11909. The Application alleges Petitioner sustained injuries to his left shoulder while working with an auger on September 10, 2018 (Rx 5). The following day, on April 23, 2019, an Amended Application for Adjustment of Claim was filed for this case, 19 WC 11909. The Amended Application changed the alleged accident date from September 10, 2018 to August 2, 2018. (Rx 6)

The parties stipulated Nicholas Wallace ("Petitioner") was employed by Macomb Park District ("Respondent") on August 2, 2018, that timely notice of an accident was given, that the Petitioner earned an average weekly wage of $222.84, was 34 years old, single, with one dependent child.

The parties proceeded to hearing on the following disputed issues: Accident, Causal Connection, Temporary Total Disability, Medical and Prospective Medical.

FINDINGS OF FACT

Petitioner testified he was employed by Respondent for two seasons doing landscaping and mechanical work (Tr. 14-16). His job duties included mowing, weeding, trimming hedges and mechanical work on machines like pitching machines (Tr. 16-17).

Prior to working for Respondent, Petitioner served as a United States Marine. He was injured during his service as a result of a large explosion. He was diagnosed with a traumatic brain injury and post-traumatic stress disorder (Tr. 34). Consequently, he suffers from headaches, memory loss, and has difficulty keeping things like dates straight, as they "get mixed up in [his] head" (Tr. 48-50). Petitioner testified that he never injured his left shoulder during his service with the Marines, or at any time prior to August 2, 2018 (Tr. 33-34).

Petitioner testified that on August 2, 2018 he and a co-worker, David Bainbridge, were assigned to tear out an old vinyl fence and replace it with a new one at a mini golf course (Tr. 18-19). This work involved using a two-man auger to dig holes which would then be filled with concrete to hold the fence poles (Tr. 19). The auger has diameter capacity between 2-inches and 18-inches, and can dig up to 45 inches deep. (Rx. 11). A picture and description of

the auger is included in Respondent's Exhibit 11. Petitioner's testimony confirmed that the auger could dig holes about three to four feet deep (Tr. 20-21). Petitioner testified that while operating the auger, first it would dig down, creating a hole, then they would have to pull the auger up several times to get the dirt out of the hole (Tr. 22). Petitioner reported the two-man auger full of dirt weighed approximately 100 pounds (Rx. 8 at 8). Petitioner testified that they had to dig through clay which was more difficult and would jostle the auger. (Tr. 21)

Petitioner testified that on August 2, 2018 while he was lifting the auger up out of a hole they were digging, he felt a pop in his left shoulder (Tr. 22). He noted that after feeling the pop, it was around lunchtime, so he stopped his work for about 30-45 minutes to eat lunch (Tr. 23). Petitioner testified that he told his co-worker, David Bainbridge, and his supervisor, Terry Stoneking, about the incident but did not fill out any paperwork (Tr. 23-24). Notice is not in dispute.

Petitioner continued working full duty for Respondent for several weeks as he hoped the shoulder would just heal up (Tr. 26). Petitioner's left shoulder pain did not resolve on its own, so Petitioner presented to Dr. Blair Rhode's office for an examination on September 18, 2018 (Tr. 26). Petitioner was initially seen by Physician Assistant ("PA") Savannah Murphy and she noted that "Mr. Wallace presents to our clinic for evaluation of left shoulder, low back pain, and radiculopathy which began developing 08-02-18 after using machinery at work and which became significantly worse around 09-12-18" (Px 1). She noted positive impingement in the left shoulder (*id.*). PA Murphy recommended he undergo an MRI of the left shoulder and return to work with no lifting over 20 pounds with the left arm and no heavy equipment use (*id.*).

During his evidence deposition, Dr. Blair Rhode clarified the September 18, 2018 note, testifying that Petitioner denied any left shoulder injury prior to August 2, 2018, but did report a work-related left shoulder and low back injury on August 2, 2018 while using machinery at work. Px. 2 at 9. Dr. Blair Rhode testified that it is not uncommon for someone to wait over a month to seek care following an injury (Px. 2 at 38). Dr. Rhode further opined that the low back strain was resolved and there was no permanent disability because of the low back strain at work on August 2, 2018 (Px. 2 at 28).

On September 19, 2018, after his first doctor's visit following the accident, Petitioner was asked to fill out an Illinois Form 45: Employer's First Report of Injury Report (Tr. 41-42). In that report, Rx 12, Petitioner noted left shoulder pain from the use of an auger and gas-powered trimmer. The alleged dates of injury are August 2, 2018 and September 12, 2018 (Tr. 43-44).

Petitioner underwent an MRI of the left shoulder on September 26, 2018 at the Orthopedics & Sports Enhancement Center (Px 4). The impression on the MRI report was "mild acromioclavicular arthrosis" and "no focal rotator cuff tear or discrete labral tear" (Px. 4). Petitioner then presented back to PA Murphy on October 2, 2018 and she recommended Petitioner return in a few weeks and see Dr. Rhode (Px1 and Px 2 at 11). Petitioner testified that October 2, 2018 was his final day of work at the Macomb Park District, as the season was over (Tr. 27-28).

On October 2, 2018, Petitioner reported for an initial evaluation with ATI Physical Therapy. The nature of injury is described as Petitioner was "using an agar [sic] to dig a hole in the ground. Patient reports doing all day for two days and having pain following. Patient went to MD after it didn't go away" (Px 3).

Dr. Rhode saw Petitioner on October 17, 2018 and noted that Petitioner sustained the left shoulder injury while operating an auger (Px 2 at 12). Dr. Rhode administered a left shoulder acromial steroid injection, for diagnostic and therapeutic purposes, and recommended Petitioner return work with no lifting over 20 lbs. (Px 2 at 12 & Px 1). PA Murphy saw Petitioner for a follow-up on November 13, 2018 and Petitioner reported that the injection significantly improved his symptoms (Px 2 at 13). Dr. Rhode testified that the improvement in Petitioner's symptoms supported the finding of a rotator cuff injury (*id.*). Petitioner saw PA Murphy again on December 18, 2018 and noted that Petitioner's symptoms were worsening (Px 2 at 13-14). As a result, Dr. Rhode opined Petitioner would require more treatment than just an injection (*id.*). Petitioner was kept on the same work restrictions (*id.*).

Petitioner followed up with Dr. Rhode on December 26, 2018. Dr. Rhode administered another subacromial injection and kept Petitioner on restricted work activity of no lifting over 20 lbs. with the left arm (Px 2 at 14-15 & Px 1).

Respondent scheduled Petitioner for a Section 12 examination with Dr. Lawrence Li on January 7, 2019 (Rx 8 at 6). The parties deposed Dr. Li on August 19, 2019 (Rx 8). Petitioner provided Dr. Li with a history consistent with his testimony (Rx 8 at 8). Dr. Li opined Petitioner suffered a left shoulder strain and impingement syndrome (Rx 8 at 11). Dr. Li did not find there to be causation because he felt there was an inconsistency in Petitioner's history of whether the incident was from using the auger or from repetitive work (Rx 8 at 13-14). However, Dr. Li agreed that Petitioner provided a consistent history of a work injury on August 2, 2018 that gradually worsened leading him to seek medical care in mid-September 2018 (Rx. 8 at 31). Moreover, Dr. Li agreed that in his initial Section 12 report he incorrectly noted there was no impingement sign found during Petitioner's initial visit to Dr. Rhode's office on September 18, 2018. (Rx 8 at 26-27). Notably, when Dr. Li was asked on cross-exam whether the mechanism of injury Petitioner described in using the auger to dig holes could cause the injuries Petitioner is suffering from in this matter, Dr Li replied, "that mechanism makes sense" (Rx. 8 at 31-32). Finally, Dr. Li agreed with the medical treatment rendered, the potential need for surgery, and Petitioner's need for work restrictions for his left shoulder (Rx 8 at 20-22, 25).

Dr. Rhode saw Petitioner again on January 23, 2019 and they discussed the possibility of left shoulder surgery including a left arthroscopic subacromial decompression and possible rotator cuff and biceps tenodesis (Px 2 at 15-16). The same restrictions were also kept in place (Px 2 at 16).

Dr. Rhode saw Petitioner again on February 20, 2019 and was formally recommending Petitioner undergo a biceps tenodesis versus SLAP repair (Px. 1, and Px 2 at 16-17). He also continued Petitioner's work restrictions (Px 2 at 17). Following this exam, Petitioner followed up with Dr. Rhode on April 16, 2019, May 15, 2019, June 12, 2019, August 7, 2019, September 4, 2019 and November 8, 2019 (Px 1). Dr. Rhode continued to recommend surgery

and kept Petitioner on a restriction of no lifting over 20 pounds with the left arm (*id.*). Petitioner testified that if Dr. Rhode's prescribed surgery were authorized, he would like to proceed with Dr. Rhode's prescribed course of care (Tr. 39).

Dr. Rhode testified that, based on his treatment of the Petitioner, it was his opinion that Petitioner suffered a left rotator cuff injury on August 2, 2018 while operating an auger developing sudden onset shoulder pain (Px. 2 at 23). Further, based on Petitioner's history, the subjective complaints, sequential physical exam findings, and Petitioner's positive response to the two injections but with symptom return, Dr. Rhode opined that Petitioner is a surgical candidate (Px. 2 at 24).

Petitioner testified that he continues to suffer extreme left shoulder pain when he tries to lift his arm up especially with getting dressed (Tr. 37). He noted pain with simple everyday tasks like driving (*id.*). To treat the pain, he takes Tramadol and Norco as prescribed by Dr. Rhode as well as uses lidocaine patches (Tr. 37-38). However, Petitioner also testified that he does not like to take pain medication as it is hard on his system (Tr. 60). This testimony is supported by Petitioner's negative drug testing (Rx. 9).

Testimony of Terry Stoneking & Petitioner's Rebuttal Testimony

Mr. Terry Stoneking testified that he was the manager of the facility where Petitioner worked and has been employed by the Respondent for about 8 to 10 years (Tr. 67-68). Mr. Stoneking testified that on August 2, 2018, the Respondent rented an auger because it did not own one (Tr. 70). The rental agreement for the auger was admitted in evidence as Respondent's Exhibit 10.

Mr. Stoneking testified he did not use the auger, but he was present when Petitioner and another worker were using it. Mr. Stoneking confirmed Petitioner's testimony about Petitioner's operation of the auger on August 2, 2018 to put up a vinyl fence, but he testified that Petitioner never advised him of injury from operating the auger (Tr. 69-74). Petitioner testified that he mentioned his left shoulder injury frequently to Mr. Stoneking, but he was not given the opportunity to fill out paperwork regarding the incident of August 2, 2018 (Tr. 112-113).

Mr. Stoneking testified that Petitioner could perform his regular job duties following the incident off August 2, 2018, including painting a large diesel tank (Tr. 75-77). Petitioner testified he was able to continue his everyday job duties like mowing and trimming along with painting figurines and obstacles on the mini golf course, the diesel tank, shelter houses, and parking lot blocks and spots (Tr. 53-54). Both Petitioner and Mr. Stoneking testified that the painting was a not a heavy lifting job (Tr. 61 & Tr. 84). Petitioner testified he would paint using his non-dominant right hand as he could paint with both hands (Tr. 63-64).

Mr. Stoneking testified that the Respondent did close for the season in October, but he believed Petitioner stopped showing up for work prior to the end of the season (Tr. 80).

Testimony of Neil Armstrong

Mr. Armstrong testified that he is the superintendent of support services for Respondent and deals with work-injuries (Tr. 88-89). He testified that he often saw Petitioner in the Summer of 2018 and did not observe Petitioner having any discomfort (Tr. 90). He testified he knew nothing about Petitioner's injury until he received the Application for Adjustment of Claim (Tr. 92-93). Moreover, he did not have any specific knowledge of Petitioner being injured (Tr. 92).

Petitioner's Employment with the City of Macomb, Video Surveillance, and Testimony of Mr. Jim Kasper

A few months after Petitioner's final day of work for Respondent, Petitioner did find work within his restrictions with the City of Macomb (Tr. 31). He started on March 25, 2019, working a labor job at the cemetery (*id.*). Petitioner testified he was terminated from that job on June 25, 2019 as he was struggling with the combination of the work, the sun, and his pain medications (Tr. 32-33). The employment records from the City of Macomb indicate Petitioner was terminated June 25, 2019 due to a poor attitude, not reporting to his supervisor, and leaving work without notifying his supervisor (Rx. 7). Petitioner testified he has been off work and looking for work within his restrictions since June 25, 2019 (Tr. 36).

For a period before and during Petitioner's employment with the City of Macomb, he was surveilled at the Respondent's request.

Mr. Jim Kasper testified he was a private investigator hired by Respondent to perform surveillance on Petitioner (Tr. 102). He followed Petitioner for a total of seven days, from March 21st to 23rd, and April 19th, 24th, 25th, and 26th (Tr. 107-108). The Arbitrator has reviewed all the sixty minutes of video from the seven dates of surveillance in Rx 13. Mr. Kasper testified that his surveillance did not show Petitioner doing anything strenuous with his arms (Tr. 105-106). The video does not show Petitioner performing any overhead activities, but he is observed operating the zero-turn mower, operating a weed whacker and driving. (Rx 13). Petitioner's testimony regarding his job duties at the City of Macomb is consistent with the surveillance. Petitioner testified that he adhered to his work restrictions while with the City of Macomb (Tr. 31). The surveillance video supports both Mr. Kasper's and Petitioner's testimony.

CONCLUSIONS OF LAW

Based on the foregoing facts, the Arbitrator finds as follows:

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

The Arbitrator concludes that the Petitioner has proven by a preponderance of the evidence that he was injured in an accident that arose out of and in the course of his employment by the

Respondent on August 2, 2018. This conclusion is based on the following:

Petitioner credibly testified that that on August 2, 2018 he was lifting an auger out of a hole he was digging with a co-worker and felt a pop in his left shoulder (Tr. 22). His testimony of regarding the accident of August 2, 2018, is corroborated by his treating medical records, his account to Respondent's Section 12 examiner, as well as by his hand-written accident report for Respondent (Px 1, Rx 8 at 8 & Rx 12). The Arbitrator observed the Petitioner, and found him to be sincere, consistent and credible.

While Petitioner did not seek immediate medial treatment, he credibly testified that he continued working full duty for Respondent for several weeks as he hoped his left shoulder would heal on its own. Because his left shoulder pain failed to abate in time, Petitioner presented to Dr. Rhode's office for treatment on September 18, 2018 (Tr. 26). Dr. Rhode testified that in his experience it is not uncommon for someone to wait over a month to seek care following an injury (Px. 2 at 38). The Arbitrator agrees.

The Petitioner testified he has difficulty remembering things, and things like dates get mixed up in his head due to suffering a traumatic brain injury ("TBI") while serving in the Marines. The Arbitrator finds that while Petitioner was sometimes confused about dates, he remained consistent on the larger issue regarding an accident while using an auger at work. Petitioner's consistency regarding a work-related accident is reflected throughout the record.

Petitioner did seek medical treatment on September 18, 2018, giving a history of left shoulder pain after using machinery at work on August 2, 2018 (Px 1). Petitioner's initial treatment visit noted that, "Mr. Wallace presents to our clinic for evaluation of left shoulder, low back pain, and radiculopathy which began developing 08-02-18 after using machinery at work and which became significantly worse around 09-12-18" (Px 1).

Petitioner also provided Dr. Li, Respondent's Section 12 examiner, with a consistent history of a left shoulder injury from using an auger when he pulled the auger up and jerked his shoulder (Rx 8 at 8). Dr. Li noted that "there is no dispute that [Petitioner] thought it was a work injury and that he told Physician Assistant Murphy or Dr. Rhode that it occurred on August 2, 2018. I don't dispute that at all" (Rx 8 at 31). Notably, Dr. Li testified that the mechanism of injury Petitioner described made sense given Petitioner's reported injury while using an auger (Rx. 8 at 31-32).

Petitioner testified that he told his co-worker, David Bainbridge, and his supervisor, Terry Stoneking, about the incident (Tr. 23-24). Mr. Stoneking testified that Petitioner did not mention being injured on August 2, 2018 (Tr. 74). Petitioner disputed this testimony and testified that he mentioned his left shoulder injury frequently to Mr. Stoneking, but Mr. Stoneking did not give the Petitioner an opportunity to fill out paperwork regarding the incident of August 2, 2018 (Tr. 112-113). Whether or not Petitioner reported this injury to Mr. Stoneking, the parties stipulated that the Petitioner gave timely notice of an accident to Respondent.

Petitioner and Mr. Stoneking agreed that a two-man auger was used by Petitioner and another employee on August 2, 2018 for digging holes for a fence (Tr. 18-19 & Tr. 70-73). The use of an auger was further corroborated by the Respondent's receipt for the auger rental on August 2, 2018 (Rx. 10).

Supporting Petitioner's testimony further is Petitioner's hand-written accident report dated September 19, 2018 reporting an injury from August 2, 2018 to the left shoulder with "use of auger" (Rx 12).

Given the evidence in the record, the Arbitrator finds that Petitioner has proven by a preponderance of the credible evidence that on August 2, 2018, he sustained an accident to his left shoulder that arose out of and in the course of his employment for Respondent.

Regarding the issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

Both Dr. Rhode and Dr. Li opined Petitioner has left shoulder complaints that require medical treatment (Px 1 & Rx 8). Both Dr. Rhode and Dr. Li agree that if a conservative course of care fails, then surgical intervention would be reasonable and necessary (Px 2 at 16-17 & Rx. 8 at 25).

Petitioner credibly testified that he had no left shoulder problems prior to his accident on August 2, 2018 (Tr. 33-34). Petitioner reported the same to his treating physician, Dr. Rhode (Px 2 at 9). Dr. Rhode credibly testified "It's my opinion that the patient sustained a left shoulder rotator cuff injury on August 2, 2018 while operating an auger and developed sudden onset of shoulder pain" (Px 2 at 23). He based his opinion on Petitioner's history of an "injury secondary to single event while operating an auger" as well as "the history, the subjective complaints, the sequential physical exam findings, [and] the positive response to the injections but yet symptom return" (Px 2 at 23-24).

Dr. Li did not explicitly find there to be causation due to his belief that there was an inconsistency in Petitioner's history of whether Petitioner's injury was from using the auger or from repetitive work (Rx 8 at 13-14). However, Dr. Li agreed that Petitioner provided a consistent history of a work injury on August 2, 2018 that gradually worsened leading him to seek medical care in mid-September 2018 (Rx. 8 at 31). Significantly, when asked on cross-exam whether the mechanism of injury Petitioner described in using the auger to dig holes could cause the injuries Petitioner is suffering from in this matter, Dr Li replied, "that mechanism makes sense" (Rx. 8 at 31-32).

Petitioner testified that he continues to suffer extreme left shoulder pain when he tries to lift his arm up especially with getting dressed (Tr. 37). He noted pain with simple everyday tasks like driving (*id.*). To treat the pain, he takes Tramadol and Norco as prescribed by Dr. Rhode as well as uses lidocaine patches (Tr. 37-38). Furthermore, there is no evidence of another injury to Petitioner's left shoulder either prior to, or subsequent to, August 2, 2018.

The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he continues to suffer from left shoulder pain, and that his current condition of ill-being in his left shoulder is directly related to his work-injury on August 2, 2018 while working for Respondent.

Regarding issue (J), were medical services provided reasonable and necessary, the Arbitrator finds the following:

Incorporating the above findings, the Arbitrator finds that all medical care provided to Petitioner in order to cure and relieve the effects of his August 2, 2018 work accident have been reasonable, necessary, and related to the August 2, 2019 work accident. Respondent shall pay the following medical bills; $10,238.41 for bills owed to Orland Park Orthopedics; $433.04 for bills owed to ATI Physical Therapy; $2,720.00 for bills owed to Orthopedics & Sports Enhancement Center; $14,890.35 owed to RX Development and $17,567.84 owed to Persistent Labs. Respondent shall pay these medical bill amounts directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act and subject to reductions under the medical fee schedule.

Regarding the issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

Both Petitioner's treating physician, Dr. Rhode, and Respondent's examiner, Dr. Li, believed that Petitioner has left shoulder complaints that would require a surgical intervention should a conservative course of care fail. Dr. Li opined Petitioner required some therapy and injections but would require surgery if those failed (Rx 8 at 25). Following two failed injections, Dr. Rhode saw Petitioner on February 20, 2019 and formally recommended Petitioner undergo left shoulder surgery (Px 2 at 16-17, 24).

In reliance on the Petitioner's treating surgeon, Dr. Blair Rhode, the Arbitrator finds that the Petitioner has yet to reach maximum medical improvement. Dr. Rhode prescribed a left shoulder surgery. The Petitioner indicated that were such care authorized he would seek said care.

The Arbitrator orders Respondent to provide and pay for Dr. Rhode's prescribed course of care, pursuant to Section 8(a) and 8.2 and subject to the medical fee schedule, which is reasonable and necessary to relieve Petitioner of his left shoulder pain.

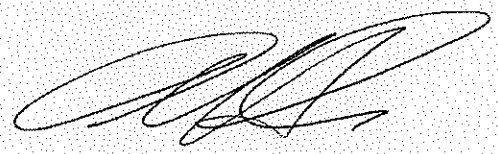
Regarding the issue (L), What temporary benefits are in dispute, the Arbitrator finds the following:

Incorporating the above findings, Petitioner should have been paid temporary total disability benefits for the dates he was released to perform restricted work if Respondent did not accommodate those restrictions. Since September 18, 2018, PA Murphy and Dr. Rhode placed Petitioner on a 20 lbs. lifting restriction as a result of his work-injury (Px 1). Dr. Li also testified that Petitioner required a work restriction of no overhead lifting (Rx 8 at 21).

Petitioner's last day of work for Respondent was October 2, 2018. On March 25, 2019, Petitioner began working within his restrictions for the City of Macomb (Tr. 31). Petitioner was terminated from that job on June 25, 2019. Petitioner has been off work looking for work since June 25, 2019 (Tr. 36).

The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from October 3, 2018 through March 25, 2019 and June 26, 2019 thru January 15, 2020. This represents 53 and 5/7th weeks of disability at a rate of $222.84 totaling $11,969.69.

IT IS SO ORDERED BY:



Adam Hinrichs, Arbitrator
Illinois Workers' Compensation Commission
February 25, 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC035469
Case Name	ALLISON, TRAVIS v. STATE OF ILLINOIS REHABILITATION DEPARTMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0341
Number of Pages of Decision	10
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Ryan Platt
Respondent Attorney	Alyssa Silvestri

DATE FILED: 7/6/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Travis Allison,

Petitioner,

vs. NO: 18 WC 35469

State of Illinois Rehabilitation Department,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, benefit rates and wages, medical expenses, temporary total 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 December 2, 2020, is hereby affirmed and adopted.

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

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

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.

July 6,2021

/s/ Barbara N. Flores
Barbara N. Flores

o: 6/17/21
BNF/wde
45

/s/ Marc Parker
Marc Parker

/s/ Christopher A. Harris
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0341
NOTICE OF ARBITRATOR DECISION

ALLISON, TRAVIS Case# **18WC035469**
Employee/Petitioner

ST OF IL DEPT OF REHABILITATON
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:

1315 DWORKIN AND MACIARIELLO
RYAN PLATT
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
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

DEC 2 - 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Travis Allison
Employee/Petitioner

v.

State of Illinois Dept. of Rehabilitation
Employer/Respondent

Case # **18** WC **35469**

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 **September 21, 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 **November 26, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**2,814.76**; the average weekly wage was $**428.42**.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $285.55 per week for 7-4/7 weeks, commencing November 30, 2018 through January 22, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services as outlined in Petitioner's Exhibit 3, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $257.05 per week for 10 weeks, because the injuries sustained caused the 2% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $257.05 per week for 12.7 weeks, because the injuries sustained caused the 4% loss of use of the left leg as provided in Section 8(e)12 of the Act and 2% loss of use of the right hand as provided in Section 8(e)9 of the Act.

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

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

Signature of Arbitrator

11/30/2020
Date

DEC 2 - 2020

STATEMENT OF FACTS

Petitioner was employed as a Personal Aide/Assistant for the Department of Human Services in October of 2018. Petitioner testified the job required him to cook and clean around the home, assist clients from point A to point B, including helping the client from his home to the Pace vehicles any time his client needed to leave his home, and grounds work such as shoveling stairs. Per the Home Services Provider Agreement, Petitioner's job duties consisted of cooking, cleaning and running errands. Petitioner testified his wage was $13 per hour.

On November 26, 2018, Petitioner fell while shoveling snow off of stairs for a client. He lost his footing and tumbled down the stairs. He injured his back, leg, neck and wrist. Petitioner testified he notified his supervisor of the accident by leaving a voicemail message. Petitioner testified that he did not work after he fell. He explained that he fell in the middle of his shift and went home to rest following the accident.

On November 28, 2018, Petitioner sought treatment at Little Company of Mary Hospital for pain on left side of chest and abdomen and right wrist pain. He reported falling while shoveling. Petitioner was diagnosed as having low back pain, prescribed pain medication and advised to follow up with his primary care doctor in 2-3 days if the pain did not improve.

On November 30, 2018, Petitioner sought treatment at AMCI-Beverly Park Medical Center (herein AMCI) for complaints of neck, back, right wrist, and left knee pain. Petitioner reported falling on ice and reporting the accident to his supervisor. Petitioner reported a prior accident in September 2018 where he suffered an injury to his right wrist. He was diagnosed with cervical sprain, thoracic sprain, lumbar sprain, right wrist sprain, left knee lower leg sprain and left knee contusion. The diagnoses were found to be casually related to and/or possibly exacerbated by the incident noted in the history. Petitioner was taken off work pending follow up with Dr. Foreman on December 4, 2018.

On December 4, 2018, Petitioner returned for a follow up visit for continued neck pain, upper and lower back pain, right wrist pain and left knee pain. Petitioner was referred for physical therapy and kept off work.

On January 2, 2019, Petitioner returned for re-evaluation and complained of neck, back, right wrist and left knee pain. Petitioner indicated that he wanted to return to work as tolerated if the employer allowed it.

On January 22, 2019, Petitioner returned for follow up with primary complaints of neck, back, right wrist and left knee pain. Petitioner indicated that he felt he was able to try returning to work. Petitioner was then discharged from care.

Petitioner testified he has "lost a step" since the accident and that he wakes up in pain. Petitioner further testified that weather changes cause stiffness in his left knee. On cross examination, Petitioner confirmed that the provider agreement outlines his job duties.

Further on cross examination, Petitioner testified that he has hurt both legs over the years because he is an athlete. Petitioner indicated that he had surgery on the right leg 15 years prior to the November 26, 2018 accident. Regarding his right wrist, Petitioner testified that in September 2018 he caught his right hand in an elevator door and that he sought treatment for his right hand following that incident. Petitioner explained that the September 2018 right hand injury healed quickly.

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 notes that Petitioner testified that his job consisted of cooking, cleaning, assisting clients and grounds work such as shoveling stairs. The Arbitrator further notes that the Home Services Provider Agreement indicates that Petitioner's job consisted of cooking, cleaning and running errands. The Arbitrator finds that "running errands" is very broad and would include any grounds work, such as shoveling snow from the client's stairs. Additionally, the Arbitrator notes that the Home Services Provider Agreement does not indicate that Petitioner's duties were limited to the things listed in the agreement. Further, Petitioner testified that one of his duties was to help his client from his home to Pace vehicles when the client would leave his home. The Arbitrator finds that while shoveling snow could reasonably be considered cleaning, it is also an errand incidental to helping his client safely exit his home.

The Arbitrator notes that in *McCalister v. Illinois Workers' Compensation Commission*, 2020 IL 124848, claimant, a sous-chef, sustained a knee injury while looking on his knees for a misplaced pan of carrots. The Illinois Supreme Court reversed the appellate court and found that the injury arose out of claimant's employment, reasoning that the claimant "was at work performing an act his employer might reasonably expect him to perform incident to his assigned job duties." *Id.* at ¶52. The Arbitrator finds the present situation analogous since in the instant case, shoveling snow is a task Petitioner could reasonably be expected to perform incident to his job duties.

Therefore, for the reasons set forth above, the Arbitrator finds that Petitioner injuries arose out of and in the course of his employment on November 26, 2018.

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

The Arbitrator adopts and incorporates the findings under Section C above. Additionally, the Arbitrator notes that Petitioner sought treatment following the November 26, 2018 accident and consistently reported a slip and fall on ice/snow to his medical providers. Further, there is nothing in the records indicating that Petitioner was dealing with any ongoing preexisting conditions prior to the November 26, 2018 accident.

Therefore, for the reasons set forth above, the Arbitrator finds that Petitioner's conditions are causally related to the November 26, 2018 work accident.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that wage records show that Petitioner began working for Respondent on October 11, 2018, and that he did not perform any work for Petitioner after his November 26, 2018 injury. Therefore, Petitioner worked for Respondent for 6 and 4/7 weeks. The W-2 form that the state provided Petitioner shows that during his term of employment, Petitioner earned a total of $2,814.76. Petitioner's total earnings of $2,814.76 divided by 6 and 4/7 weeks comes out to $428.33.

Therefore, the Arbitrator finds that Petitioner's average weekly wage is $428.33.

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 notes that Respondent has not paid any of the charges for reasonable and necessary medical services. The Arbitrator further notes that all the treatment provided was for Petitioner's injuries following the November 26, 2018 accident. Additionally, the Arbitrator notes that no evidence contradicting the diagnoses and Petitioner's need for treatment was presented.

Therefore, for the reasons set forth above, the Arbitrator finds that all the medical services rendered to Petitioner were reasonable, necessary and causally related to his work injury on November 26, 2018. As such, Petitioner is entitled to payment of all medical expenses per Petitioner's Exhibit 3, pursuant to the medical fee schedule.

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

The Arbitrator notes that Petitioner was taken off work from November 30, 2018 through January 22, 2019 by his treatment providers. As such, Petitioner was unable to work during those dates. Therefore, the Arbitrator finds that Petitioner was temporary and totally disabled from November 30, 2018 through January 22, 2019.

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

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

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

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

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

With regard to subsection (i) of Section 8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator places no weight on this factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Personal Aide/Assistant at the time of the accident and has been released to return to work full duty. The Arbitrator places great weight on this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 25 years old at the time of the accident. The Arbitrator places some weight on this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner's earning capacity has not been affected by the November 26, 2018 accident. The Arbitrator places substantial weight on this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the medical records corroborate Petitioner's testimony that he sustained injuries to his lumbar, thoracic, and cervical spine, left knee, and right wrist as a result of the November 26, 2018 work accident. The Arbitrator places great weight on 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 person as a whole pursuant to Section 8(d)2 of the Act. Additionally, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of a 4% loss of use of the left leg pursuant to Section 8(e)12 of the Act and a 2% loss of use of the right hand pursuant to Section 8(e)9 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC016586
Case Name	MERRICK, JOSHUA v. ABF FREIGHT LINES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0342
Number of Pages of Decision	16
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Jason Esmond
Respondent Attorney	John Campbell

DATE FILED: 7/6/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua Merrick,

Petitioner,

vs. NO: 18 WC 16586

ABF Freightlines,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under section 8(a) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on review, the Commission writes additionally to address the issue of prospective medical care.

Petitioner suffered a right foot injury at work on October 24, 2017, followed by immediate and ongoing pain which eventually led to medical treatment. He began treating with Dr. Bush on October 1, 2018. A CT scan performed October 5, 2018 revealed a nondisplaced fracture of the third metatarsal bone, which was consistent with the mechanism of injury. Conservative care consisting of an orthotic and a stiff-soled shoe was recommended. Dr. Bush also discussed surgery in the form of a third TMT arthrodesis with plate and screw fixation, and excision of the fourth metatarsal bone cyst with plate and screw with allograft.

In his deposition testimony given on June 20, 2019, Dr. Bush testified that the surgery discussed would be reasonable and necessary if Petitioner's pain persisted. Dr. Bush acknowledged Petitioner's underlying degenerative foot condition, but opined it was more likely than not that his consistent pain following the aggravating injury sustained at work led to the necessity of surgery. Dr. Bush testified that conservative care would mitigate Petitioner's pain, but that surgery would eliminate his pain and correct the problem. Following this testimony, Dr. Bush testified that he had not seen Petitioner since 2018 and indicated that he would need to re-examine Petitioner to determine if surgery remained necessary. On further cross-examination, Dr. Bush testified that if Petitioner continued to have pain, he would continue to recommend surgery to eliminate Petitioner's pain and correct the problem.

In the interim, Respondent had Petitioner evaluated by Dr. Neal on July 11, 2018 at which time he opined that Petitioner did not suffer an injury as claimed and no treatment was causally related or necessary. Dr. Neal subsequently authored an addendum report on March 6, 2019 in which he further opined that surgery was unnecessary.

Based upon the medical records and the testimony of Dr. Bush, the Commission agrees with the Arbitrator that Petitioner established that he sustained a compensable accident as well as a causal connection between his right foot condition and accident at work. However, the testimony of Dr. Bush in 2019 clarified that the propriety of surgery depended on a re-evaluation and Petitioner's ongoing medical condition. The Commission notes that such additional treatment very well could include the aforementioned surgery, which was already the subject of Respondent's section 12 examiner's evaluation and addendum reports. However, the record reflects that the prospective course of treatment at this juncture consists of a re-evaluation to determine if the previously recommended foot surgery remained necessary. Thus, the Commission modifies the Arbitrator's award of prospective medical care by awarding the recommended follow-up evaluation with Dr. Bush.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of right foot surgery is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for Petitioner's follow up evaluation with Dr. Bush.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 17, 2020 is hereby affirmed as modified herein.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,000.00. 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.

July 6,2021

o: 5/20/21
BNF/wde
45

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

/s/*Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0342
NOTICE OF ARBITRATOR DECISION
8(a) DECISION

MERRICK, JOSHUA Case# **18WC016586**
Employee/Petitioner

ABF FREIGHTLINES
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:

2489 BLACK & JONES AATY AT LAW
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2965 KEEFE CAMPBELL BIERY & ASSOC
JOHN CAMPBELL
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
8(a) Decision

Joshua Merrick Case # **18 WC 16586**

v.

ABF Freightlines
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 **Michael Glaub**, Arbitrator of the Commission, in the city of **Rockford**, on **September 14, 2020.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 24, 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 $61,365.20, yielding an average weekly wage of **$1,180.10.**

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

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

ORDER

- The Respondent shall pay $ **701.21** for necessary medical services, as provided in Section 8(a) and 8.2 of the Act and consistent with the medical fee schedule, in addition to the medical bills previously paid through Respondent's group plan.

- The Respondent shall authorize prospective medical care relative to Petitioner's right foot, specifically the surgery recommended by Dr. Bush, and postoperative care, until Petitioner reaches a state of maximum medical improvement.

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

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

Signature of Arbitrator

November 13, 2020
Date

ICArbDec

NOV 17 2020

STATEMENT OF FACTS

The parties appeared for hearing on September 14, 2020 before Arbitrator Glaub under the Illinois Workers' Compensation Act. The parties stipulated that Petitioner was an employee of Respondent on October 24, 2017. The parties stipulated that Petitioner earned $61,365.20 in the year prior to October 24, 2017, and that his average weekly wage was $1,180.10. The parties stipulated that Petitioner was 46 years of age, married, with 1 dependent child on October 24, 2017.

Petitioner testified that he had worked for Respondent for approximately 12 years prior to his October 24, 2017 injury and remained employed with Respondent. (T8). Petitioner works for Respondent as a truck driver on a full-time basis. (T8). On October 24, 2017, Petitioner was working at a Dollar General in Janesville, Wisconsin. (T9). He was unloading skids, sorting and segregating cartons on skids. (T9). Petitioner testified he was sorting products (or cartons) onto various skids all around on the floor. (T9). While holding two cartons in his hand, Petitioner turned and bumped one of the skids with his left foot, losing his balance. (T9). Petitioner came down on his right foot, at an angle, on top of a skid next to him. (T10). Petitioner testified that he experienced immediate pain on the top and side of his right foot. (T10). At that point, Petitioner stopped and sat down for a short period of time and finished sorting the products before leaving. (T10). Petitioner testified that this happened at around lunch time. (T11).

Petitioner did not seek medical care at the time of his injury. (T11). Petitioner testified that he called Andrew Breitbach, his supervisor/dispatcher, when he got back to the terminal. (T11). Petitioner testified that he filled out an accident report the next day with Mr. Breitbach. (T12). He testified that the written report was turned into the dispatcher and he did not get a copy of it. (T24).

Petitioner testified that the 1st Report of Injury form submitted as Petitioner's Exhibit 1 might have been what was completed by Andrew Breitbach the day after his injury. (T30). That form is not dated, but noted the injury occurred at Dollar General on October 24, 2017 and was reported on October 25, 2017. (Px. 1). It described twisting of the foot/leg when sorting cartons and stepping on a skid. (Px. 1).

Petitioner testified that he completed a second accident report on May 16, 2018. (T25-26, Rx. 1). This was required after he started treating for his injury. (T26). Respondent's Exhibit 2 noted an accident date of October 24, 2017 and noted that the incident was reported to the Supervisor on December 4, 2017. (Rx. 1). The Employee Statement noted that Petitioner was separating cartons of full skids onto empty skids. It noted he lost balance and had to step onto another skid to catch his balance, hurting his foot and ankle. (Rx. 1). Respondent's Exhibit 2 was the Supervisor Statement coinciding with the Incident Report. It was dated May 17, 2018 and signed by Andrew Breitbach, Supervisor Assistant. (Rx. 2). That form indicated that Mr. Breitbach had become aware of the incident on December 4, 2017, when Petitioner told him about it. (Rx. 2).

Respondent called Joseph Wehling, Respondent's Service Center Manager, to testify. (T45). Mr. Wehling confirmed that Andrew Breitbach was a supervisor that worked under him in 2017. (T47). Mr. Wehling testified that protocol is that supervisors will prepare handwritten and online forms immediately upon

becoming aware of a work-related injury. (T47-48). At that point, he would be informed of the injury. (T48). He testified that he had not received information regarding Petitioner's injury until May of 2018. (T49). However, Mr. Wehling agreed that Respondent's Exhibit 2, completed by Petitioner's supervisor, Mr. Breitbach, indicated he had become aware of Petitioner's injury on December 4, 2017. (T56).

Petitioner testified that he had undergone a DOT physical on February 10, 2018. (T39-40). He testified that he reported he cannot run in place, but they indicate he didn't need to do that for the physical. (T40). He indicated he had another DOT physical in February of 2020 as well. (T41).

Petitioner did not seek treatment for his foot until May 3, 2018. (T12-13). Petitioner testified that between October 24, 2017 and May 3, 2018, he had soreness in his foot, but he was able to walk on it. He thought he had bruised or sprained something but expected the pain would get better. (T13). Petitioner testified that the pain became worse over time. (T13). Petitioner indicated he noticed swelling in the foot after a month or two, which also got worse gradually. (T14). Prior to receiving treatment, Petitioner continued to work his regular job. (T14). He explained that he does not typically move freight at other docks. (T14). The location that he injured his foot was the only location that freight was moved after leaving Respondent's facility (T14-15).

On May 3, 2018, Petitioner was seen at Physician's Immediate Care. (Px. 2). That record noted that he had sustained an injury on November 15, 2017 after twisting his right foot after stepping on a skid. He indicated he had some knee pain as well, but that completely resolved. He described fairly constant discomfort in the mid dorsal foot, worse with prolonged weightbearing. Petitioner also described intermittent swelling in the dorsal mid foot area. He declined foot or ankle issues prior to the injury. X-rays were performed and interpreted to be normal. An MRI was recommended. (Px. 1).

Petitioner was questioned regarding the date of November 15, 2017 provided to Physician's Immediate Care. Petitioner testified that he must have given Physician's Immediate Care the wrong date. (T36). He noted that the incident reports with his employer contained the correct accident date of October 24, 2017. (Tr. p. 36). He noted that he had not been certain of the date of injury when he was seen at Physician's Immediate Care, approximately 6-7 months after the injury occurred. (Tr. p. 43).

Petitioner followed up at Physician's Immediate Care on May 17, 2018. (Px. 2). He continued to complaint of pain in his foot with prolonged weightbearing and noted he was working full duty. He was again recommended an MRI. (Px. 2).

Petitioner was then seen by Dr. Bryan Neal, at Respondent's request, for an independent medical examination, on July 18, 2018. (Rx. 5). Dr. Neal diagnosed osteoarthritis of the right proximal fourth metatarsal-tarsal joint. He did not believe Petitioner had sustained a work injury given that he did not treat for approximately 6 months. (Rx. 5).

Petitioner underwent the right foot MRI on September 15, 2018. (Px. 4). He saw Dr. Bush, an orthopedic surgeon, at Ortho IL on October 1, 2018. (Px. 4). The history provided was that Petitioner was experiencing right foot pain after a 10/2017 injury when his foot was caught in a skid when sorting cartons at work.

Petitioner reported that he had never had any pain in his foot prior to the injury. Dr. Bush reviewed the September 15, 2018 MRI and recommended a CT scan along with a stiff shoe and Meloxicam. (Px. 4).

Petitioner was seen in follow up by Dr. Bush on October 18, 2018, after having undergone the CT scan on October 5, 2018. (Px. 4). Dr. Bush recommended surgery in the form of a 3rd TMT arthrodesis with plate and screw fixation, along with excision of the 4th metatarsal bone cyst with plate and screw with allograft. Dr. Bush suggested blood work to first rule out inflammatory conditions or gout. (Px. 4). Petitioner testified that underwent the lab work recommended to rule out inflammatory conditions and those were negative. (T 17).

Dr. Neal completed an addendum report on June 17, 2019 after reviewing the diagnostics. (Rx. 6). Dr. Neal noted the MRI revealed cysts and degenerative spurring. He did not believe surgery was reasonable or necessary. (Rx. 6). At the time of his deposition, Dr. Neal agreed that Petitioner's symptoms had remained consistent and that there was no indication he was malingering or exaggerating his symptoms. (Rx. 7). Dr. Neal also agreed that x-rays taken of Petitioner's left foot did not reveal signs of the arthritis in his right foot. (Rx. 7).

Dr. Bush was deposed on June 20, 2019. (Px 5). Dr. Bush noted that the lab work performed on October 22, 2018 showed indications of inflammation, but no signs of any underlying inflammatory condition or gout. Dr. Bush opined there is a causal relationship between Petitioner's injury and his current condition. He opined that the injury aggravated the degenerative conditions in his foot, causing the need for surgery. Dr. Bush opined it is likely that Petitioner fractured through the preexistent cyst or aggravated the arthritis, causing the onset and ongoing symptoms in Petitioner's right foot. (Px. 5). Dr. Bush noted that a stiff soled shoe and a rigid shank would mitigate his symptoms but would not cure him. He opined that surgery would eliminate Petitioner's pain and correct the problem in his right foot. (Px. 5).

Petitioner testified that he has no problems with his left foot. (T17). He has continued on Meloxicam. (T 18). Petitioner noted that he takes it once a day and it helps with his pain. (T18). He testified that he tries to not take it on the weekends, because it is not good for the kidneys. (T18). When he does not take Meloxicam, he notices a lot of pain in his foot. (T18). By Sunday night, he can't stand on his foot due to a lot of sharp pain. (T18-19).

Petitioner has continued to work his regular job, missing time only to attend the examination with Dr. Neal, or his hearing. (T19). He testified his foot is sore, but he can do his job. (T19). His ongoing foot pain does impact the amount of time he spends on his feet. (T19-20). After three or four hours, his foot swells. (T 20). Petitioner testified that he takes a yearly trip to Disney World. (T20). Since his injury however, he has been unable to walk through the parks. (T20). He has had to rent a scooter to ride around in, something he did not have to do since he started taking that vacation on a yearly basis in 2000. (T20-21).

FINDINGS OF FACT AND CONCLUSIONS OF LAW ON THE DISPUTED ISSUES

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

The Arbitrator adopts the statement of facts detailed above and finds that Petitioner sustained an accident that arose out of an in the course of his employment with Respondent on October 24, 2017. The Arbitrator relies upon the treating records, the opinions of Dr. Bush, the accident reports, and Petitioner's credible testimony.

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 v. Industrial Commission, 207 Ill. 2d 193, 203, 797 N.E. 2d 665, 671-672 (2003). An injury occurs within the course of an employee's employment if the injury occurs within the time and space boundaries of the employment. Id. An injury "arises out" of an employee's employment when the employee was performing acts he was instructed to perform by his employer, acts which the employee might reasonably be expected to perform relating to his assigned duties. Id.

For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Trucker Company v. Industrial Commission, 129 Ill. 2d 52 (1989). A risk is incidental to employment where it belongs to or it is connected with what an employee has to do in fulfilling his duties. Id. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is said to arise out of this employment. Id.

Petitioner testified credibly to an injury while sorting products between skids and tripping over a skid. He testified to coming down on his right foot after stumbling with two cartons in his hands. The accident report completed by Petitioner and his supervisor provided a similar history of his injury. While the date the injury reports were completed is disputed, Petitioner's supervisor documented that Petitioner described hurting his foot stepping on the side of a skid on October 24, 2017 at least as early as December 4, 2017. (Rx. 1, 2). Petitioner's description of the accident to Physician's Immediate Care, Dr. Bush, and Dr. Neal are all consistent. While the date of the accident was noted as November 15, 2017 to Physician's Immediate Care, the visit was over 6 months after the injury and Petitioner testified that he was not certain of the date of his injury when he was seen on May 3, 2018. He testified that the date of the injury noted on the accident reports was correct.

As such, the Arbitrator finds that Petitioner sustained his burden of proving an injury occurred that arose out of and in the course of his employment on October 24, 2017. Petitioner's credible testimony regarding his injury and the consistent description of that accident to the medical providers and examining physicians is sufficient to prove that the accident occurred.

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

The Arbitrator finds that Petitioner provided timely notice of the accident to Respondent. Section 6 of the Act requires notice of an injury within 45 days of the accident. Petitioner testified that he called Andrew Breitbach, his dispatcher/supervisor on the day of the injury, when he returned to the terminal. He testified that he filled out an accident report the next day with Mr. Breitbach. Respondent's witness, Mr. Wehling, testified that he did not receive notice of Petitioner's alleged injury until May of 2018. He testified that should Mr. Breitbach have been informed of the injury, he should have completed paperwork at that time. However, Respondent's Supervisor Statement, signed by Mr. Breitbach, noted that he had been informed of Petitioner's injury on December 4, 2017. No injury report was completed or provided at that time. Regardless of whether Petitioner reported the injury the day it occurred or filled out an accident report the next day, Respondent's Exhibit 2 noted that Mr. Breitbach, Petitioner's supervisor, was made aware of the injury on December 4, 2017, 41 days after it occurred. As such, the Arbitrator finds that timely notice was given by Petitioner to Respondent.

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

The Arbitrator adopts the findings of fact stated above and incorporates them herein by this reference. The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his October 24, 2017 injury. The Arbitrator relies upon the treating records, the opinions of Dr. Bush, as well as Petitioner's credible testimony.

The Arbitrator relies upon the well-established rules set forth by the Illinois Supreme Court that "the fact that an employee may have suffered from a preexisting condition will not preclude an award if the condition was aggravated or accelerated by the employment. The employee need not prove employment was the sole causative factor or even that it was the principal causative factor, but only that it was **a causative factor** in the resulting injury." Williams v. Industrial Com., 85 Ill. 2d 117, 122 (1981).

Having found Petitioner sustained an injury on October 24, 2017, the issue is whether Petitioner's current condition of ill-being remains related to that injury. Dr. Neal offered the opinion that Petitioner did not sustain an injury and that he suffered from osteoarthritis. Dr. Bush agreed that Petitioner suffered from pre-existent degenerative conditions in his foot, but found the October 24, 2017 injury aggravated those conditions. Dr. Bush testified that as Petitioner was asymptomatic with no complaints to his foot prior to his injury, and had experienced consistent pain since, he had likely fractured through a dormant cyst or aggravated the preexisting arthritis.

There is no indication that Petitioner had any issue with his right foot prior to his injury on October 24, 2017. While Petitioner did not seek treatment for over 6 months after the injury, his testimony regarding the reasons he did not immediately treat were credible. Petitioner testified that he believed the pain would go away. It was not so intolerable that he was unable to work or missed time from work. He was able to continue his regular job, as he has continued to work without any lost time since he started treating. Petitioner credibly

testified to the onset of and continuation of symptoms in his right foot since October 24, 2017. Petitioner's treatment records are also consistent with his testimony. He initially reported increased discomfort with prolonged weightbearing. His job does not require prolonged weightbearing, so he was able to continue working.

The Arbitrator finds Petitioner's testimony regarding the description of his injury and his symptoms since the injury to be credible. There was no indication that Petitioner experienced issues with his right foot prior to October 24, 2017 and there is no indication he sustained any other injury to his foot since October 24, 2017. Based on the absence of any prior right foot issues, a consistent history of onset of symptoms, and Dr. Bush's credible opinion, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury he sustained on October 24, 2017.

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

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary for the injury sustained on October 24, 2017. The Arbitrator notes that the medical records, diagnoses, treatment carried out, and treatment recommendations are noted in the Statement of Facts. The dispute regarding medical bills was based on causal connection. Respondent's examining physician agreed that Petitioner's treatment had been reasonable and necessary. Finding that Petitioner's treatment was causally related to his repetitive work activities, the outstanding medical bills are Respondent's responsibility. The Arbitrator finds that Respondent is responsible for the outstanding medical bills, totaling $701.21:

The owed bills include: $288.43 at Ortho Illinois (dates of service 10/1/18, 10/5/18, and 10/18/18)
$412.78 at Physician's Immediate Care (dates of service 5/3/18 and 5/17/18).

As such, the Arbitrator finds that Respondent is liable for the unpaid medical bills, totaling $701.21, pursuant to the medical fee schedule.

O. Other Issues: Prospective Medical

The Arbitrator adopts the findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference.

As noted above, the Arbitrator has found that Petitioner's current condition of ill-being regarding his right foot is causally related to his October 24, 2017 work injury. Having found his condition causally related, Petitioner is entitled to prospective medical treatment, specifically the surgical procedure recommended by Dr. Bush. Petitioner's medical records and his testimony evidence that he has significant ongoing symptoms relative to his right foot warranting the surgery recommended by his treating orthopedic, Dr. Bush. While he has been able to continue working his regular job, he has required ongoing medication to deal with his daily pain. He has had to limit activities of daily living due to difficulty with prolonged weight-bearing. Dr. Bush noted that use of a stiff soled shoe and a rigid shank would mitigate his symptoms but would not cure him. Dr. Bush noted that surgery would eliminate Petitioner's pain and correct the problem in his foot.

Therefore, the Arbitrator finds that Respondent is responsible for providing prospective medical treatment hereafter, limited to that which is reasonably required to place Petitioner at maximum medical improvement.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC027233
Case Name	BALDWIN, COLTON v. AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0343
Number of Pages of Decision	11
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Michelle Rich
Respondent Attorney	Gregory Keltner

DATE FILED: 7/6/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Colton Baldwin,

Petitioner,

vs. NO: 15 WC 27233

American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2020, is hereby affirmed and adopted.

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

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

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

July 6,2021

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

o: 6/3/21
BNF/wde
45

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0343

BALDWIN, COLTON
Employee/Petitioner

Case# **15WC027233**
15WC027255

AMERICAN COAL COMPANY
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:

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

2999 LITCHFIELD CAVO LLP
GREG KELTNER
222 S CENTRAL AVE SUITE 110
ST LOUIS, MO 63105

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

Colton Baldwin
Employee/Petitioner

v.

American Coal Company
Employer/Respondent

Case # 15 WC 27233

Consolidated cases: 15 WC 27255

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 2, 2015, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $45,547.57; the average weekly wage was $1,260.35.

On the date of accident, Petitioner was 24 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $4,442.44 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $4,442.44.

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

ORDER

Based upon the Arbitrator's Conclusion of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

November 12, 2020
Date

NOV 17 2020

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case 15 WC 27255, Petitioner alleged that he sustained "Repetitive Trauma" which caused an injury to the "Neck/Man As A Whole." The application alleged a date of accident (manifestation) of June 21, 2015 (Arbitrator's Exhibit 3). In case 15 WC 27233, Petitioner alleged that on August 2, 2015, Petitioner was "Driving coal scoop and thrown into roof" and sustained an injury to the "Neck/Man As A Whole" (Arbitrator's Exhibit 2).

The cases were previously consolidated. In both cases, Respondent disputed liability on the basis of accident and causal relationship. Respondent disputed notice in case 15 WC 27255, but not in case 15 WC 27233 (Arbitrator's Exhibit 1).

Petitioner was employed by Respondent for approximately four years. At the time of both accidents, Petitioner worked as a coal scoop operator. The coal scoop was a piece of machinery used in the mines to load/deliver materials in the mine. It was on wheels and operated by levers located in the front of it. Petitioner faced forward while operating the coal scoop, but had to constantly turn his neck to the left or right. The coal scoop was driven on an uneven surface which caused a considerable amount of bouncing around.

On June 23, 2015, Petitioner sought medical treatment at Ferrell Hospital Family Practice and was evaluated by Andrew Hosman, a Physician Assistant. At that time, Petitioner complained of neck pain which had been present for approximately three months. Petitioner advised that he worked in a coal mine and his head was turned to the right when he operated heavy equipment. X-rays of the cervical spine were obtained which were normal. Petitioner was diagnosed with neck pain and prescribed medication (Petitioner's Exhibit 3).

Petitioner was seen by PA Hosman on July 20, 2015. Petitioner continued to have neck pain as well as radicular symptoms. PA Hosman ordered an MRI scan (Petitioner's Exhibit 3).

On July 23, 2015, Ferrell Hospital was notified by Petitioner's group insurance carrier that the request for an MRI had been denied. The reason given was that there had to be a trial of activity modification for at least six weeks before an MRI would be authorized. A telephone message was left with Petitioner for him to make an appointment with Dr. Jackson (Petitioner's Exhibit 3).

At trial, Petitioner testified that on August 2, 2015, he was driving the coal scoop and it ran over a piece of coal which caused his head to be slammed into the roof/canopy of the vehicle. Petitioner stated that between June 21, 2015, and August 2, 2015, his neck pain was mild. After the accident of August 2, 2015, Petitioner's neck pain was very intense.

Petitioner sought medical treatment at the ER of Harrisburg Medical Center on August 2, 2015. At that time, Petitioner advised that while he was driving over rocks at work, he bounced up and struck his head on the roof of a vehicle. Petitioner described a sudden onset of symptoms which he described as mild. CT scans of the cervical spine and head were obtained, both of which were

normal. Petitioner was diagnosed with a neck strain and directed to see Dr. James Alexander (Petitioner's Exhibit 5).

Dr. Alexander saw Petitioner the following day, August 3, 2015. At that time, Petitioner advised the scoop he was driving ran over a rib which caused him to bounce into the canopy. Petitioner complained of neck and right arm pain. Dr. Alexander diagnosed Petitioner with a neck strain and cervical radiculopathy at C6. He ordered physical therapy (Petitioner's Exhibit 6).

Petitioner testified that on August 3, 2015, he sent a letter to Respondent in regard to the repetitive trauma injury of June 21, 2015. Petitioner's letter of August 3, 2015, was received into evidence at trial. Petitioner claimed an injury to his neck because of the repetitive bouncing around while driving the scoop and having to turn his head/neck sideways. Petitioner indicated he was not allowed to be present on company property. There was no reference to Petitioner's accident of the preceding day, August 2, 2015 (Respondent's Exhibit 6).

Petitioner continued to be seen by Dr. Alexander from August, through November, 2015. Petitioner continued to complain of neck and right arm pain. Dr. Alexander ordered additional physical therapy as well as an MRI scan (Petitioner's Exhibit 7).

The MRI was performed on October 5, 2015. According to the radiologist, the MRI revealed small protrusions/bulges at C4-C5, C5-C6 and C6-C7 (Petitioner's Exhibit 9).

Petitioner was subsequently seen by Dr. Matthew Gornet, an orthopedic surgeon, on December 17, 2015. At that time, Petitioner informed Dr. Gornet of the accident of August 2, 2015, and the medical treatment he received thereafter. Petitioner complained primarily of neck pain. Dr. Gornet reviewed the MRI of October 5, 2015, and opined it was of poor quality, but that it revealed a small protrusion at C5-C6. Dr. Gornet ordered a high resolution MRI and imposed light duty work restrictions (Petitioner's Exhibit 8).

The MRI was performed on December 21, 2015. According to the radiologist, the MRI revealed disc protrusions at C4-C5, C5-C6 and C6-C7 (Petitioner's Exhibit 9).

Petitioner was seen by Dr. Gornet on December 21, 2015. At that time, Dr. Gornet reviewed the MRI scan. His interpretation of the scan was consistent with the radiologist. He recommended Petitioner undergo an injection at C4-C5 and C5-C6 (Petitioner's Exhibit 8).

Petitioner was seen by Dr. Kaylea Boutwell on January 14, and February 4, 2016. On those occasions, Dr. Boutwell administered epidural steroid injections at C5-C6 and C4-C5, respectively (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. James Coyle, an orthopedic surgeon, on February 15, 2016. In connection with his examination of Petitioner, Dr. Coyle reviewed medical records and the MRI scans which were provided to him by Respondent. Petitioner informed Dr. Coyle of the accident of August 2, 2015. Petitioner complained of constant neck pain (Respondent's Exhibit 2).

Dr. Coyle opined the MRI scans revealed disc bulges at multiple levels of the cervical spine, but no annular fissures, foraminal impingement or acute disc herniations. Dr. Coyle diagnosed Petitioner with cervicalgia secondary to multilevel cervical disc disease. Dr. Coyle opined Petitioner's cervical spine condition was not related to the accident of August 2, 2015, and noted Petitioner had neck symptoms prior to that date and an MRI had been recommended, but denied by insurance (Respondent's Exhibit 2).

Petitioner continued to be treated by Dr. Gornet. Ultimately, on October 7, 2016, Dr. Gornet performed disc replacement surgery at C5-C6. Dr. Gornet subsequently released Petitioner to return to work without restrictions on November 22, 2016 (Petitioner's Exhibits 8 and 13).

Petitioner testified that by April, 2015, he believed his neck symptoms were work-related. However, Petitioner did not inform Respondent until after the accident of August 2, 2015, because he was concerned about losing his job. Petitioner did not recall if he advised the medical providers at Harrisburg Medical Center or Dr. Alexander that he had neck complaints and that a cervical MRI had been recommended prior to August 2, 2015. Petitioner likewise did not recall if he informed Dr. Gornet if he had any neck symptoms prior to the accident of August 2, 2015.

Martha Gant testified on the half of Respondent pursuant to a subpoena. In August, 2015, Gant worked for Respondent as a laborer and she worked with Petitioner. Gant testified she reported to work on August 1, 2015, and was working the midnight shift. She testified that prior to the beginning of the shift, she was seated at a table with Petitioner, Scott Troxel and other employees. She testified Petitioner said he had hurt his neck and had gone to his doctor who ordered and MRI, but insurance would not pay for it. Petitioner said he was going to go below and claim it as an accident so he could get the MRI paid for.

Gant identified a handwritten statement she prepared on August 3, 2015. The statement was consistent with her testimony and also noted Petitioner admitted he did not know how he had hurt his neck (Respondent's Exhibit 8).

Scott Troxel testified on behalf of Respondent pursuant to a subpoena. Troxel testified he worked with Petitioner virtually every day. He said that, prior to the beginning of the shift on August 2, 2015, he was in the above ground staging area with Petitioner, Martha Gant and other employees. At that time, Petitioner said his neck was hurting and someone had to pay for it, which Troxel understood to be the Respondent.

Troxel prepared a handwritten statement on August 3, 2015, which was received into evidence at trial. The statement was consistent with his testimony at trial (Respondent's Exhibit 9).

Conclusion of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner did not sustain an accidental injury arising out of and in the course of his employment by Respondent on August 2, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner sent a letter to Respondent on August 3, 2015 (the day after the alleged accident), in which he reported having sustained a repetitive trauma injury on June 21, 2015. Petitioner made no reference to having sustained a work-related accident on the preceding day.

Petitioner informed the medical providers at Harrisburg Medical Center, Dr. Alexander and Dr. Gornet of the accident of August 2, 2015; however, he did not inform any of them that he had neck symptoms prior to the accident of August 2, 2015.

Martha Gant and Scott Troxel, two fellow employees of Petitioner, testified on the half of Respondent at trial. Both of them prepared written statements on August 3, 2015 which were received into evidence. Gant and Troxel both testified Petitioner complained of neck pain prior to commencing work on August 2, 2015. Gant testified Petitioner did not know how he had hurt his neck. Troxel testified Petitioner said his neck was hurting and someone, namely, the Respondent, was going to pay for it.

The Arbitrator finds the testimony of Gant and Troxel to be credible.

In regard to disputed issues (F), (J), (K) and (L), the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC009447
Case Name	MURDOCH, CORY v. VILLAGE OF FOREST PARK
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0344
Number of Pages of Decision	11
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Crystal B. Figueroa
Respondent Attorney	Daniel Arkin

DATE FILED: 7/6/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cory Murdoch,

Petitioner,

vs. NO: 18 WC 9447

Village of Park Forest,

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 credibility, causal connection 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 November 24, 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.

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 6, 2021

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

o: 6/3/21
BNF/wde
45

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0344
NOTICE OF ARBITRATOR DECISION

MURDOCH, CORY Case# **18WC009447**
Employee/Petitioner

VILLAGE OF PARK FOREST
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:

0926 LEONARD LAW GROUP LLC
CRYSTAL B FIGUEROA
325 S PAULINA ST SUITE 100
CHICAGO, IL 60612

0507 RUSIN & MACIOROWSKI LTD
DANIEL W ARKIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

Cory Murdoch v. Village of Park Forest, 18 WC 009447

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

Cory Murdoch
Employee/Petitioner

v.

Village of Park Forest
Employer/Respondent

Case # **18** WC **009447**

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 **Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **October 28, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/25/2018,** Petitioner ***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 $**74,865.96**; the average weekly wage was $**1,439.73**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner **Permanent Partial Disability benefits of $790.64/week for 64.5 weeks because the injuries sustained caused a loss of 30% loss of use 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 a 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

Signature of Arbitrator

November 19, 2020
Date

NOV 24 2020

FINDINGS OF FACT

The Parties stipulated to all issues except for nature and extent including that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on March 25, 2018. Petitioner testified he was working as a paramedic when he assisted a lady who was unresponsive in a car, and that he carried her up over the side of the car and pivoted on some ice and gravel. [PX 1, pg. 21] Petitioner testified he felt pain in his left knee but was able to continue to treat and care for the unresponsive woman. Thereafter, Petitioner testified he continued to feel pain in his left knee and that it began to swell such that he could not roll his pants up over his left knee.

Petitioner was first examined at Advocate South Suburban Hospital on the date of the work accident. [PX 1, pg. 21] Petitioner was diagnosed with acute pain of the left knee, and he was provided with a knee mobilizer and crutches. [PX 1, pg. 23] He was prescribed 800mg Ibuprophen and taken off from work. *Id.*

Thereafter, Petitioner treated with Dr. Bernard Bach at Midwest Orthopedics at Rush. [PX 3] Dr. Bach diagnosed Petitioner with a partial tear to his anterior cruciate ligament (ACL). [PX 3, pg. 17] Upon review of the Lachman test, the numbers on the KT-1000 and the MRI, Dr. Bach concluded they were consistent with a partial ACL injury. [PX 3, pg. 18]. Dr. Bach referred Petitioner to Independence Physical Therapy. [PX 4]

Petitioner underwent a left knee arthroscopic primary ACL reconstruction using Arthrex 2.9mm PushLock Technique on May 3, 2018. [PX 3, pg. 61-62] Petitioner's ACL was completely resected, and a #2 Fiber wire was placed in the PL bundle. [PX 3, pg. 62] Petitioner testified that two screws were inserted into his left leg at the time of surgery and both screws remain in his left leg. The operative report indicates that the ACL was completely resected and a formal ACL reconstruction was performed because Dr. Back found a pseudoglide pivot shift phenomenon. [PX3 at 62] Dr. Bach performed a microfracture with an angled awl with 4-5 perforations placed high in the ACL origin on the lateral intercondylar notch region. [Id.] Dr. Back also drilled a 2.9mm drill hole in the region of the PCL bundle. The sutures were then placed through the eyelets of the inserted Arthrex PushLock. [Id.]

Petitioner testified that he completed 29 sessions of physical therapy from April 11, 2018 through August 8, 2018. The medical records document Petitioner was compliant with physical therapy, as well as with his home exercise program. [PX 4, pg. 31]

Petitioner testified surgery was helpful, as he could not bend his left leg prior to surgery. When questioned as to why some medical records document Petitioner having no problems with his left knee and overall doing very well, Petitioner testified that the record indicated how he felt on that particular day and that he has both good and bad days. Petitioner testified that on bad days, his left knee stiffens up and he will rest, ice his knee, and/or take Ibuprophen.

Petitioner testified that he currently experiences pain and discomfort while kneeling on the job, but he pushes through and completes the task. Furthermore, Petitioner testified he is a Senior at the Village of Park Forest and, therefore, he does not complain to himself nor anyone else at work about his left knee. In order to alleviate any pain and discomfort, Petitioner testified he applies ice to his left knee and takes Motrin. The medical records document Petitioner was motivated to return to work regular duty. [PX 4, pg. 49]

Petitioner was released to light duty work on May 14, 2018 [PX 3, pg. 78]. On cross-examination, Petitioner testified he was not getting in and out of firetrucks during his light duty release. Petitioner was released to full duty work on July 27, 2018. [PX 3, pg. 21] Petitioner reached maximum medical improvement (MMI) on July 23, 2018. [PX 3, pg. 59] The medical records document that upon Petitioner's full duty release, there was a car fire and his left knee swelled up from hauling a firehouse. [PX 4, pg. 51] Petitioner testified that on his first full-duty day back he had a strenuous shift which involved advancing a fire hose line several dozen feet. Petitioner testified that after this first day back he went home with a sore and swollen left knee that he treated by elevating and icing.

Petitioner testified his job requires that he exercise every day, for at least an hour. The medical records document there is a gym at the firehouse, which Petitioner uses. [PX 4, pg. 48]

On cross-examination, Petitioner was asked about the truck he drives. Petitioner drives a full-size pickup truck with larger than stock wheels. [RX3] He testified that he is able to get in and out of the truck without difficulty although he is cautious when doing so.

Petitioner underwent his first Independent Medical Examination (IME) on July 3rd, 2018. [RX1] Petitioner underwent his 2nd IME on January 14, 2020. [RX2] Petitioner testified that his first IME examination (July 23rd, 2018) lasted 10-15 minutes, and his 2nd IME examination (January 14, 2020) lasted less than five minutes.

Petitioner testified at trial that he has not returned to Dr. Bach or his physical therapist, or received any other treatment for his left knee since being discharged from care approximately two and a half years prior to trial. Petitioner was examined by Dr. Karlsson at DMG Orthopaedics on January 14, 2020 pursuant to Section 12 of the Act. Dr. Karlsson's Section 12 report [RX 1] noted that Petitioner feels as though his knee is doing very well and that Petitioner advised that he has no pain and no complaints or instability to his knee. Dr. Karlsson further noted Petitioner was not taking any medications, either prescription or over the counter.

On examination, Dr. Karlsson's report compared the left knee and the right knee, and finds that they are identical with the exception of a trace of atrophy at the quadriceps in the left knee.

Dr. Karlsson further noted that Petitioner confirmed that he is continuing to work as a firefighter/paramedic in a full duty capacity with no restrictions, and further that he is having no complaints or problems performing his job. The Arbitrator also notes that this is consistent with the petitioner's testimony at trial.

In addition to the Section 12 report discussed above, Dr. Karlsson also prepared a separate report, also dated January 14, 2020, documenting his AMA Impairment Rating. This report [RX2] contains the Lower Limb Questionnaire form the petitioner completed. According to this questionnaire form, the petitioner denied having any stiffness or swelling within the last week, confirmed that he has not had any pain while walking on flat surfaces, going up or down stairs or lying in bed at night during the past week and further that he has not had any difficulties getting around or putting on socks. On cross-examination, Respondent asked Petitioner about a 7-question IME questionnaire, which documented Petitioner had no swelling and was overall doing well. In response to this inquiry, Petitioner testified that the questionnaire answers reflected how he felt on that particular day, as he has both good and bad days. On cross-examination, Respondent also asked Petitioner whether it was true his left injured knee felt better than his right knee (which he has not had problems with), as

Dr. Karlsson documented this in his report, dated January 14, 2020. In response to Respondent's question, Petitioner denied the allegation and mentioned he did not recall ever making that statement to the Dr. Karlsson. Petitioner testified that he modifies how he performs his job, sometimes ices his knee and takes Ibuprophen, and avoids certain physical activities to minimize the chance of reinjuring his knee.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980).

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was mostly credible. He answered questions quickly and spontaneously. His body mannerisms and tone of voice indicated sincerity. The only caveat is Petitioner's response to why a certain medical record indicated that he had no complaints about his knee after he had completed physical therapy and returned to work full-duty. Petitioner testified that he would have reported how his knee was feeling on a particular day and would not have elaborated beyond to include all days. Petitioner testified that his primary goal was to return to work full-duty as a paramedic because he loves the job and that his knee sometimes becomes swollen or sore after a long shift on the job. Petitioner also testified that he has difficulty squatting and changes the position of his knee while working because of its current condition. Petitioner testified that he has avoided certain physical activities outside of work to minimize the chance of reinjury. The Arbitrator finds that Petitioner's zeal to return to work combined with the Arbitrator's sense that Petitioner is the type to minimize any difficulty explains a general lack of subjective complaining on many of the medical records yield the overall impression that Petitioner was

credible. In short, the Arbitrator believes Petitioner's testimony regarding the nature and extent of the injury which is the only issue to be decided in this case.

In connection with the Arbitrator's Decision regarding [L] the Nature and Extent of the Injury, the Arbitrator concludes as follows:

Pursuant to §8.1b(b) of the Act, the Arbitrator addresses the issue of Petitioner's permanent partial disability as follows:

i. Respondent provided an AMA rating of 0%. The Arbitrator gives appropriate weight to this factor in determining PPD.

ii. Petitioner's occupation at the time of the accident was a Senior firefighter paramedic for the Village of Park Forest. Petitioner maintains the same job position with no loss of earnings. On the date of the hearing, Petitioner testified his job duties remain the same. Petitioner testified that his job duties vary depending on the shift; however, he often works 24 hour shifts and engages in fire suppression. Additionally, Petitioner testified he often kneels and crawls on the job. Petitioner's unrebutted testimony was also that he removes patients from their homes during fires. The Arbitrator gives this factor significant weight in determining PPD.

iii. Petitioner was 40 years of age at the time of his accident. Petitioner will likely remain in the workforce for many more years. Petitioner's job is physically demanding, and Petitioner continues to experience occasional pain and swelling. The Arbitrator gives significant weight to this factor in determining PPD.

iv. No evidence has been presented as to the lack of earning capacity. The Arbitrator gives some weight to this factor in determining PPD.

v. Petitioner's surgery was a success and physical therapy restored most of the function of his injured knee. Petitioner continues to experience pain and swelling on some days. In order to alleviate swelling and pain, Petitioner testified he ices and elevates his left leg, as well as takes Motrin. Petitioner also testified that his knee with its inserted hardware – the Arbitrator finds that the eyelet inserted in Petitioner's knee to which fiber is run through is in fact inserted hardware - is aggravated by weather changes. Petitioner's knee minimally affects how he performs his job because he has difficulty squatting and must adjust the position of his knee when rendering first aid or caring for persons in distress. Petitioner testified that he is more careful with physical activities so as not to reinjure his knee. For example, he no longer rides dirt bikes due to fear of injuring his left knee again. The Arbitrator gives this factor substantial weight in determining PPD.

After considering the evidence and the factors enumerated in §8.1b of the Act, the Arbitrator finds Petitioner has suffered 30% loss of use of the left leg.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	96WC001261
Case Name	ALEVISOS, JAMES v. RELCO ELECTRIC CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0345
Number of Pages of Decision	14
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Lawrence Stefani
Respondent Attorney	Martin Spiegel

DATE FILED: 7/6/2021

/s/Kathryn Doerries, Commissioner

Signature

21IWCC0345

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES ALEVIZOS,

Petitioner,

vs. NO: 96 WC 01261

RELCO ELECTRIC CO.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Illinois Workers' Compensation Commission ("Commission") pursuant to a Rule 23 Order of the First District Appellate Court Workers' Compensation Division, filed October 23, 2020, which reversed the decision of the circuit court of Cook County, which confirmed the January 4, 2019, Commission decision finding no causal connection between the Petitioner's December 1, 1995, work accident and his current condition of ill-being of his low back, reversed the Commission decision, and remanded the case to the Commission for further proceedings. (2020 IL App (1st) 200184WC-U) In light of the Rule 23 Order, the Commission is specifically tasked to: (1) determine what medical expenses incurred by claimant after April 28, 2004, were causally related to his work accident of December 1, 1995; (2) to make an appropriate award of medical expenses based upon that determination; and (3) assess whether claimant is entitled to additional temporary total disability and permanency benefits in light of this order.

Based upon the Appellate Court's finding of causal connection between the Petitioner's work injury and his current low back condition of ill-being, the Commission finds that the Petitioner sustained his burden of proving that he is entitled to 302-1/7 weeks of temporary total disability benefits commencing February 28, 2007, through December 12, 2012; that Petitioner is entitled to an award under §8(f) as his condition resulted in a material change in Petitioner's condition since his arbitration hearing resulting in permanent total disability commencing on December 13, 2012; and that Petitioner is entitled to medical expenses related to his low back

treatment itemized in Petitioner's exhibit one, to be paid under §8(a) and §8.2 of the Act and pursuant to the stipulation of the parties. (12/14/17 T, pp. 19-20, PX1)

Background

The following statement of facts is based upon the findings in the afore-referenced Rule 23 Remand Order of the First District Appellate Court and the entire record. (2020 IL App (1st) 200184WC-U) Petitioner sustained an accident arising out of and in the course of his employment on December 1, 1995. He injured his right ankle and subsequently developed an altered gait causing stress in his low back and eventually participated in a work-hardening program. While in work-hardening, Petitioner began treating for low back pain and eventually underwent two surgeries. The first surgery, on February 19, 1997, was an L5-S1 lumbar discectomy with foraminotomies bilaterally performed by Dr. Freitag. Petitioner developed lumbar instability. The second surgery was performed by Dr. DeFeo on February 22, 2000, consisting of a lumbar fusion at L5-S1 with Ray cages.

After Petitioner's April 28, 2004, arbitration hearing, the arbitrator filed a decision on July 7, 2004, and found a causal relationship between the condition of ill-being involving Petitioner's low back and the December 1, 1995, accident. The arbitrator also found Petitioner to be permanently disabled, relative to his lumbar spine, to the extent of 60% of a person as a whole. In so finding, the presiding arbitrator found surveillance footage of Petitioner bench pressing nine to ten repetitions with 135 pounds, eight repetitions with 185 pounds, five repetitions with 225 pounds, and, at least, a single repetition with 275 pounds well in excess of a 30-pound physician-imposed lifting restriction and Petitioner's physical appearance at the arbitration hearing, notably his being physically fit, belied Petitioner's claim of being unable to return to work as an electrician. (12/14/17 T, PX30)

During his testimony in support of his Petition for Review, Petitioner did not deny lifting the weights seen on the surveillance footage, he, instead, testified that he was working out but did not recall testifying that he could hold more than 100 pounds or lifting 45 pounds when working out. (12/14/17 T, PX27, pp. 50-51) Petitioner further testified that he was not sure if he could bench press 225 pounds five times and he was probably maxing out at 275 pounds two times. (12/14/17 T, PX27, p. 53) Nonetheless, the Commission affirmed and adopted the arbitrator's finding. Neither party sought judicial review of the Commission decision and, as the Appellate Court held, the decision therefore became the law of the case.

More than two years passed after Petitioner's April 28, 2004, arbitration hearing before Petitioner sought treatment for complaints traceable to his December 1, 1995, accident. On June 29, 2006, Petitioner presented to Dr. Gary Bennett of Chapman Medical Center with increasing symptoms in his back and right leg complaints. Prior to that, Petitioner testified that he stopped working as a security guard because that was too difficult for him to continue. (12/14/17 T, PX27, p. 9) His brother is an Orange County osteopathic medicine physician and has coordinated his medical care since his relocation to California on February 13, 1999, acted as his primary care physician for most of that time, and referred him to all the physicians he has seen in California. (12/14/17 T, PX27, p. 10-11)

Dr. Bennett recommended that Petitioner undergo conservative treatment, including epidural and transforaminal steroid injections, however, there is no evidence that Petitioner sought further medical care until he presented to Dr. Kamran Aflatoon of Southern California Spine and Orthopedic Oncology on February 28, 2007, eight months after treating with Dr. Bennett. Dr. Aflatoon ordered an EMG/NCV, performed on October 23, 2007, that confirmed lumbosacral nerve-root irritation, mostly at the L5-S1 level. He also ordered a CT myelogram of the lumbar spine, taken on November 6, 2007, which revealed that the left cage device used in Dr. DeFeo's fusion surgery, was extending into the L5-S1 neural foramen and compressing the exiting left L5 nerve root. Dr. Aflatoon opined that Petitioner had a non-union at L5-S1 and a disc herniation at L4-L5. Dr. Aflatoon also found Petitioner totally disabled and in need of additional back surgery and the position of the left cage device would need to be addressed. This finding led to a course of multiple additional surgeries. On May 16, 2007, Dr. Aflatoon authored an addendum to his February 28, 2007, evaluation causally relating Petitioner's current status to his 1995 accident.

Petitioner was referred by Respondent (Guaranty Fund) for a §12 evaluation with Dr. Stewart Shanfield. On March 4, 2008, Dr. Shanfield opined that the CT myelogram showed that the cage from Dr. DeFeo's February 2000 surgery was in the left neural foramen and impinging along the L5 and S1 nerve root. Dr. Shanfield found that Petitioner required surgery, including an extension of the lumbar fusion, and found it causally related to the February 2000 surgery and the and December 1, 1995, work accident. Dr. Shanfield opined that Petitioner was not capable of returning to gainful employment until the full resolution of his medical and pain issues. (PX4)

On April 23, 2008, Dr. Aflatoon recommended a spinal cord stimulator and second opinion from the Santa Monica Spine Institute. On July 23, 2008, Dr. Aflatoon documented that further surgery was not indicated, but that Petitioner was permanently disabled, could not be gainfully employed, and would require lifelong medication to control his chronic pain.

Petitioner saw Dr. Bennett for the second and last time on August 21, 2008. Dr. Bennett concluded that he was unable to treat Petitioner due to the complexity of his medical condition. Petitioner also treated with Dr. Miguel Dominguez of Intervention Pain Management between September 30, 2008, and June 14, 2011, for medications and injections. Petitioner underwent a trial for a spinal cord stimulator (SCS) on February 18, 2009, however, Dr. Dominguez did not proceed with a permanent implantation of a SCS. At subsequent visits, Dr. Dominguez observed behavior that he found inconsistent with Petitioner's office visits and described this behavior as an "amplication of his symptoms." (12/14/17 T, PX5)

Petitioner next consulted Dr. Rick Delamarter at the Spine Institute of Santa Monica on March 25, 2009, and was under his care through February 1, 2011. (12/14/17 T, PX6) Dr. Delamarter agreed that the left cage used in Dr. DeFeo's February 22, 2000, surgery was protruding into the canal. He recommended surgery to correct the malalignment and a revision at L5-S1 with extension to L4-L5 which was previously positive on a discogram. Dr. Delamarter also referred Petitioner to Dr. George Graf for detoxification because Petitioner was taking a high dosage of narcotics. (12/14/17 T, PX6 3/25/09)

Petitioner was again examined by Dr. Shanfield on May 28, 2009, pursuant to Respondent's request under §12 of the Act. Dr. Shanfield concurred with the diagnosis of

malalignment of the Ray cages and surgery was warranted. Dr. Shanfield estimated that recovery for the surgery would take six months to one year. He hoped that Petitioner would return to gainful employment, but likely in a sedentary position. (PX4)

Petitioner underwent a two-step surgery with Dr. Delamarter to trim the misaligned Ray cage on January 28, 2010, and also consisting of an anterior discectomy, L4-5 partial corpectomies in preparation for interbody fusion, L4-5; use of allograft femoral ring for interbody fusion, L5-S1; revision laminotomies L4-5, L5-S1; revision partial medial facetectomies, L4-5, L5-S1; removal of extensive epidural scar tissue; exploration of fusion mass; segmental instrumentation of L4 and L5 with pedical screws; posterolateral fusion, L4-5; use of local autograft for posterolateral fusion. The post-operative diagnosis was failed-back syndrome. (12/14/17 T, PX6)

When Petitioner followed up with Dr. Delamarter, he recommended a lumbar CT scan and EMG nerve conduction study (NCS). The EMG/NCS was abnormal. (12/14/17 T, PX6) The lumbar CT scan confirmed the metal spacer device at L5-S1 was protruding into the neural foramen by approximately 4 millimeters. (12/14/17 T, PX6) Dr. Delamarter wrote a "to whom it may concern" report on February 1, 2011 stating that he was releasing Petitioner from his care since he is no longer a surgical candidate. He referred Petitioner to Dr. Hormoz Zahiri for further care. (12/14/17 T, PX6) The pain management physician's office notes document that Dr. Dominguez reviewed the CT scan and Petitioner needed further evaluation by a surgeon. (12/14/17 T, PX5, 1/17/11 and 1/24/11) Dr. Zahiri, an orthopedic surgeon, reviewed the CT scan and the NCS and opined that the metal cage from the Dr. Delemarter's surgery was protruding into the left foramina causing left sided severe radiculopathy, confirmed by the NCS. Dr. Zahari's notes confirmed that Petitioner remained temporarily totally disabled and he recommended revision of the lumbar fusion.

Petitioner underwent the next surgery on June 28, 2011, to remove and replace the L5-Sl interbody cages and extend the fusion to L4-S1 performed by Dr. Gregory Carlson. Petitioner then treated with Dr. Albert Lai, consisting of medication management and multiple lumbar injections. A lumbar myelogram and CT scan on April 13, 2012, revealed possible pseudo meningocele, which Dr. Carlson explained is a persistent leakage of spinal fluid from the spinal canal, a risk that Dr. Carlson pre-operatively discussed with Petitioner as well as the risks of arachnoiditis and adjacent level disease. Another surgery was performed on May 31, 2012, to repair the leak, a dural defect at L4-5.

On November 1, 2012, Dr. Lai performed a dorsal column stimulator trial that was removed one week later. On June 6, 2013, Dr. Bradley Noblett implanted an intrathecal pain pump. On August 21, 2013, Petitioner returned to Dr. Carlson complaining of more pain caused by the implanted device. An EMG showed chronic neurogenic changes in the lumbar paraspinal muscle with no evidence of radiculopathy. Dr. Carlson released Petitioner from his care, indicating that there were no further surgical procedures he could offer, and recommended continuing pain management with Dr. Albert Lai. Petitioner underwent a lumbar myelogram and CT scan at his brother and primary care physician Dr. Alevizos's request. Dr. Carlson interpreted the studies as showing significant arachnoiditis, scarring within the thecal sac. Dr. Carlson explained that arachnoiditis is a risk associated with surgery and associated with back pain, leg pain, and sciatica and can be ongoing or additional cause for persistent pain. Dr. Carlson testified that there is no

cure for arachnoiditis. (12/14/17 T, PX29, p. 15) In Dr. Carlson's view, Petitioner was totally disabled and unable to obtain any gainful employment. (12/14/17 T, PX29, p.21) Dr. Carlson referred claimant to Dr. J. Patrick Johnson for a second opinion.

Petitioner saw Dr. Johnson on June 16, 2014. Dr. Johnson concurred with the diagnosis of arachnoiditis and referred Petitioner to Dr. Joshua Prager, a pain-management physician. Petitioner was under the care of Dr. Prager from July 2, 2014, through September 9, 2014. He was diagnosed with failed-back-surgery syndrome. On September 2, 2014, Dr. Prager performed further surgery involving revision of the placement of the pain pump to optimize medications.

On September 23, 2015, Dr. Steven Feinberg examined Petitioner at Respondent's request. Dr. Feinberg subsequently testified by evidence deposition on June 20, 2017. (RX1) Doctor Feinberg noted that Petitioner had a "major" lumbar pathology after all of his surgeries but found a lack of objective physical findings on evaluation. Dr. Feinberg felt that Petitioner suffered from considerable pain behavior and symptom magnification, citing Petitioner's report to him that he was suffering from moderate depression with frequent suicidal ideations and pain level at 10 on a 10- point scale. Dr. Feinberg's diagnosis was failed-back syndrome, psychiatric comorbidity (i.e. psychological factors affecting claimant's physical condition). Dr. Feinberg recommended that Petitioner participate in a functional restoration and chronic pain program with a detoxification component. Dr. Feinberg concluded there was a causal relationship between the December 1, 1995, work injury and Petitioner's current disability. From a purely physical standpoint Petitioner would be expected to work at a sedentary capacity, although his overall presentation would make engagement in work impossible. Dr. Feinberg agreed that arachnoiditis is a significant diagnosis that can result in severe back and leg pain with neurological problems. He acknowledged that it can be a debilitating condition and that there's no surgery or procedure to "get rid of" arachnoiditis.

Upon referral of Dr. Alevizos, Petitioner received additional pain management from multiple physicians consisting of medication management, including pain pump reprogramming, refills and injections. Petitioner testified Dr. Chang and Dr. Alsharif recommended reducing medication intake and weaning off the pain pump. To that end, use of the pain pump was discontinued on September 14, 2016, and the device was later surgically removed. In September 2016, Petitioner began treatment with Dr. Lai for pain management.

On September 28, 2016, Petitioner returned to Dr. Carlson. Dr. Carlson opined that there were new findings at the levels of L3 and L4 based upon new diagnostics. His diagnosis was adjacent segment progressive intervertebral collapse at L2-L3 and L3-L4, remote fusion at L4- S1 with retained segmental hardware. A lumbar MRI taken on November 1, 2016, revealed a disc bulge at L2- L3 and a small disc protrusion at L3-L4. Dr. Carlson indicated that at L2 and L3 there had been a progressive intervertebral collapse with left paracentral disc extrusion measuring 12 millimeters by 5 milliliters by 10 millimeters, which was a change compared to the previous MRI scans taken more than two years earlier. Upon referral of Dr. Carlson, Dr. Eric Chang performed an epidural injection at the L2-L3 levels.

On May 19, 2017, Dr. Carlson testified consistent with his report that adjacent level problems are causally related to the original work injuries. He further testified that Petitioner is at risk to require further surgeries at L2-L3 and L3-L4, that he also has residual new L2-L3

paracentral disc herniation and progressive intervertebral collapse at L2-L3 and L3-L4, lumbar radiculopathy, arachnoiditis and has a cervical condition. (12/14/17 T, PX29, p. 28) Petitioner testified, however, that he doesn't know why he had the cervical MRI. He was not having cervical symptoms. He currently does not have cervical symptoms. (12/14/17 T, PX27, pp 32) In Dr. Carlson's view, there is a psychological component to Petitioner's condition. (12/14/17 T, PX29, p. 28) He acknowledged there have been issues regarding the proper amount of medication. He testified that Petitioner would benefit from ongoing pain management, functional restoration care, mental health care, and psychological supports. The lumbar condition of ill being has reached a permanent state and Petitioner is unable to return to gainful employment, even if sedentary. (12/14/17 T, PX29, p. 29-30)

Conclusions of Law

§19(h) of the Act provides, in pertinent part, as follows:

> [A]s 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 or award may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished, or ended. 820 ILCS 305/19(h) (West 2014).

In order to prove a change in Petitioner's condition, there must be a material change in the Petitioner's condition as compared to at the time of the arbitration hearing. The Appellate Court explains how to determine the material change.

> In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.)

Gay v. Industrial Com., 178 Ill. App. 3d 129, 532 N.E.2d 1149, 1989 Ill. App. LEXIS 3, 127 Ill. Dec. 320.

The Petitioner testified at the arbitration hearing that he was limited on things that he could do as he had lower back pain with sometimes radiating pain. Sometimes it felt like he was walking on pins and needles. He could not feel his bladder as he was emptying it. (04/28/04 T, pp. 101-104). The arbitrator relied upon the entire record at arbitration to assess permanency of 60% loss of use of the person as whole for the Petitioner's low back injury. The arbitrator noted that the three video surveillance tapes showing Petitioner weight-lifting well beyond his 30 pound lifting restriction belied Petitioner's claims that he could not work as an electrician at the time. Petitioner further testified at the arbitration hearing that he would to the health club and lift weights five days per week. He would lift in excess of 45 pounds when lifting weights. (04/28/04 T, pp. 101-104)

However, the arbitrator also acknowledged the fact that Petitioner sustained a significant injury to his low back.

At the §19(h) hearing, Petitioner testified that his current pain is in his lower back and his legs. He feels weakness in both his legs, and severe low back weakness. (12/14/17 T, p. 36) He further testified that he uses a cane, and loses balance and cannot grab, twist or do things normal people do and has to change positions a lot. He can drive for 19 minutes. (12/14/17 T, pp 37-38) His day-to-day life is a nightmare because of his back injury. He is unable to take care of himself or his house. He hires gardeners to take care of outside. His 82 year old mother helps him on a daily basis. He finds it sometimes hard to concentrate when the pain spikes. He would not wish his condition on his worst enemy. (12/14/17 T, pp. 40-41)

Given the Appellate Court Remand Order, that the Petitioner's low back condition is causally related to the work accident, the Commission therefore finds that Petitioner's low back condition has materially changed and significantly worsened from the time of the arbitration hearing based upon Dr. Carlson's opinion regarding Petitioner's chronic pain and inability to work as a result of multiple subsequent lumbar surgeries, diagnosis of arachnoiditis, new L2-L3 paracentral disc herniation and progressive intervertebral collapse at L2-L3 and L3-L4.

Medical

> Under section 8(a) of the Act, 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 [*267] the effects of a claimant's injury. *University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164, 596 N.E.2d 823, 173 Ill. Dec. 199 (1992). The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534, 758 N.E.2d 18, 259 Ill. Dec. 173 (2001).

City of Chicago v. Ill. Workers' Comp. Comm'n, 409 Ill. App. 3d 258, 266-267, 947 N.E.2d 863, 870, 2011 Ill. App. LEXIS 327, *18, 349 Ill. Dec. 849, 856.

At the beginning of the December 14, 2017 §19(h) and §8(a) Commission hearing, the parties stipulated that if Petitioner was entitled to medical expenses, Respondent is responsible for any reasonable, related and necessary bills in the form of 1) reimbursement to Petitioner for out-of-pocket medical expenses; 2) outstanding balances; and 3) Respondent will hold Petitioner harmless from any Medicare-based reimbursement claims. (12/14/17 T, pp. 19-20) Given the finding that Petitioner's low back condition is causally related to the work accident on December 1, 1995, the Commission finds that the Respondent shall pay the medical bills itemized in Petitioner's exhibit one pursuant to §8(a) and §8.2 of the Act and pursuant to the stipulation of the parties excluding treatment with growth hormones or plasma-enriched injections and excluding psychiatric or psychological treatment, if any.

The arbitrator specifically noted that the Petitioner was voluntarily exceeding his work restrictions by weightlifting as per the video surveillance and that Petitioner was, therefore, capable

of working. After his consult on February 28, 2007, Dr. Aflatoon found Petitioner totally disabled. On December 12, 2012, Dr. Carlson completed a "Consulting Physician's Permanent and Stationary Report." He ultimately concluded Petitioner to be 100% disabled from performing any meaningful work. Dr. Carlson's opinion, according to the report, was based, in part, on mental issues. The Commission declines, however, to find the Petitioner's mental health condition, if any, is causally related to the December 1, 1995, work accident given the paucity of evidence in the medical records concerning a diagnosis by an expert psychological or psychiatric physician, or treatment for a psychological condition including anxiety or depression outside of his consult for the SCS with Dr. R. Wayne Brown, a PhD, Clinical Psychologist. Dr. Brown was referred by Dr. Aflatoon. Further, based on Petitioner's reporting to Dr. Shanfield, he was admitted to the hospital pre-injury in 1994 for a psychiatric evaluation. (12/14/17 T, PX4, 3/4/08, p. 3) The Commission infers that there were previous pre-existing mental health issues, however, no indication that Petitioner's condition was more or less impacted after the subject work accident.

Dr. Brown documented that Petitioner believed both his depression and anxiety levels were low. Petitioner reported that at that time, on December 12, 2008, he was using Cymbalta 15 milligrams for depression with Valium and Xanax listed as current medications. He reported that he had not treated with a psychologist or psychiatrist. (12/14/17 T, PX5, Dr. Brown report pp. 2-3) However, Petitioner testified that he recalled seeing Dr. Terry Roh, a psychiatrist, in late 2011. (12/1/4/17 T, PX27, p. 21) At the Petitioner's September 30, 2008, office visit with Dr. Dominguez, he reported he had not tried Cymbalta. On November 13, 2008, Dr. Dominiguez wrote that he would institute Cymbalta for pain as primary reason. (12/14/17 T, PX5, 11/13/2008)

Dr. Brown noted that psychiatric indications did not indicate significant psychiatric distress at the time of his evaluation. (12/14/17 T , PX 5, Dr. Brown report p. 4) Dr. Brown concluded that an invasive procedure was not contraindicated from a psychological perspective. Dr. Brown further concluded that his depression and anxiety levels are better than expected for a chronic pain patient and should not cause him to be at a heightened risk for having an exaggerated negative reaction to an invasive medical procedure. (12/14/17 T, PX5, Dr. Brown report p. 8) Petitioner saw Dr. Dominguez on December 11, 2008 and on January 12, 2009 and neither pain medication history noted by Dr. Dominguez reflects that Petitioner was taking Cymbalta, however, under the section "medical reasoning" Cymbalta was included. The history of Petitioner's taking Cymbalta was short lived. Petitioner reported to Dr. Lai that Cymbalta was of no benefit. (12/14/17 T, PX11, 3/9/12)

On July 5, 2011, Petitioner refused to participate in a neuropsychological evaluation at St. St. Jude Medical Center. (12/14/17 T, PX9)

Dr. Carlson first saw Petitioner on May 13, 2011, for a consultation concerning his low back condition and continued to see him thereafter as one of his treating physicians. On December 12, 2012, Dr. Carlson completed a "Consulting Physician's Permanent and Stationary Report." He ultimately concluded Petitioner to be 100% disabled from performing any meaningful work, having noted earlier in the report that Petitioner had developed "significant mental health issues" that impede him from both returning to a functional lifestyle and coping with his pain. In the approximately twelve visits Petitioner had with Dr. Carlson between the May 13, 2011, consultation and Dr. Carlson authoring the Consulting Physician's Permanent and Stationary

Report on December 12, 2012, Dr. Carlson had never made a diagnosis relative to Petitioner's mental health in any of the records memorializing those visits. The Commission finds Dr. Carlson's lack of significant psychiatric or psychological findings consistent with the records of Petitioner's previous treating physician, Dr. Dominguez, with whom Petitioner treated with from 2008 to 2011.

Dr. Dominguez authored a Pain Management Workers' Compensation Report following each visit and within each report was both a behavioral assessment and a cognitive assessment. These assessments noted Petitioner exhibited anxiousness and distress but, other than those findings, Dr. Dominguez detected no behavioral abnormalities and unremarkable cognitive assessments. Dr. Dominguez did not refer Petitioner to another physician to address his anxiousness and distress. (12/14/17 T, PX5)

Dr. Albert Lai succeeded Dr. Dominguez as Petitioner's pain medication physician, treating Petitioner from 2011 into 2014. His records include a section entitled Review of Systems and listed among the reviewed systems was "anxiety and depression." Dr. Lai's objective findings included only anxiety. Dr. Lai, like Dr. Dominguez before him, did not refer Petitioner to anyone to address either his anxiety or depression.

A review of Petitioner's medical records from 2008 through 2012 provides no indication of Petitioner's mental state demonstrating, as Dr. Carlson described, "significant mental health issues" at any time prior to him writing as much in his Consulting Physician's Permanent and Stationary Report from December 12, 2012. That Dr. Carlson, despite that diagnosis, did not subsequently refer Petitioner for psychiatric or psychological care undermines his diagnosis.

Further, although Dr. Carlson treated Petitioner intermittently for many years, the Commission does not wholly rely upon his opinion alone in making its findings. Dr. Carlson, on May 8, 2014, authored a "To Whom It May Concern" letter in which he concluded that Petitioner was unable to take a four-hour flight to be present for the hearing in support of his §19(h) petition. He testified that "someone" asked him to write a letter but was unable to recall who that was. More troubling was his explanation as to how he knew Petitioner was unable to make such a flight. He testified that he knew Petitioner could not handle a four-hour flight because Petitioner's condition hadn't changed from the last time he saw him. Dr. Carlson's records indicate that last time he saw Petitioner prior to writing the "To Whom It May Concern" letter on May 8, 2014, was on August 21, 2013. Dr. Carlson did not offer an explanation as to how he knew what Petitioner's condition was on May 8, 2014, when he hadn't seen Petitioner for more than nine months. How Dr. Carlson assessed Petitioner's ability to travel is consistent with how he came to assess Petitioner's mental health. Both were made without an examination or medical records that support his conclusions. Dr. Carlson also testified that Petitioner has a cervical condition that Petitioner denied altogether.

Petitioner's mental health status was revisited by Dr. Khang Lai, the pain management physician with whom Petitioner has been treating with since September 14, 2016. The diagnosis Dr. Lai made of Petitioner's condition as a result of his examination of Petitioner that day included recurrent major depressive disorder. The Commission is also not persuaded with Dr. Lai's diagnosis given that neither Petitioner's chief complaints nor his recounted history included any complaints that touched upon his mental health. More significantly, the Review of Symptoms

indicates Petitioner's mental status to be normal and without depression. Dr. Lai's subsequent visit records repeat the diagnosis of recurrent major depressive disorder and repeatedly recommend that Petitioner's primary care physician refer Petitioner for psychiatric/psychological treatment. As Petitioner testified to, his primary care physician is, in fact, his brother, Dr. John Alevizos, and Dr. Alevizos has coordinated his medical care ever since he moved to California in February 1999. There was no testimony or medical record in evidence that Dr. Alevizos ever made such a referral. Therefore, the Commission declines to find Petitioner's condition as it relates to his mental health, if any, related to the work accident.

The Commission further relies upon Dr. Feinberg's opinion that there is no scientific basis regarding the use of human growth hormones for treatment of low back conditions and that plasma-enriched injections into the spine is "ridiculous." Dr. Feinberg further testified that there is no scientific-based evidence to support those injections. (12/14/17 T, RX1, pp. 31-32)

Temporary Total Disability

> To be entitled to TTD benefits, the 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 at 1090, 666 N.E.2d at 828-29 (1996). It does not matter whether he could have looked for work. Even though a claimant may be entitled to permanent disability compensation under the Workers' Compensation Act (Act), once the injured employee's physical condition has stabilized, he is no longer eligible for TTD benefits because the disabling condition has reached a permanent condition. *Manis*, 230 Ill. App. 3d at 660, 595 N.E.2d at 160-61. [***13]

Freeman United Coal Mining Co. v. Industrial Comm'n, 318 Ill. App. 3d 170, 177, 741 N.E.2d 1144, 1150, 2000 Ill. App. LEXIS 1021, *12-13, 251 Ill. Dec. 966, 972.

With respect to Petitioner's lost time, the Commission notes that Petitioner testified that he had not worked since he left his job as a security guard prior to his return to Dr. Bennett. (12/14/17 T, PX27, p. 9) The Petitioner also testified that he has not returned to work since that time. (12/14/17 T, PX27, 35) The Petitioner testified that no treating physician has released him to return to work since Dr. Aflatoon took him off work on February 28, 2007. (12/14/17 T, PX27, 35; PX3) The Commission notes that Dr. Aflatoon opined on June 23, 2008, that Petitioner was permanently disabled and would not be able to have any gainful employment. (12/14/17 T, PX3) Subsequently Dr. Shanfield opined on May 28, 2009, that Petitioner should have the surgery recommended by Dr. Delamarter, and it would be unlikely Petitioner could return to work as an electrician or engage in heavy physical work but hoped he could return to some type of gainful employment, sedentary work as opposed to physical labor. This again represented a material change in Petitioner's condition as he previously demonstrated the ability to lift heavy weights. Petitioner underwent several additional procedures and pain management thereafter, and after the January 28, 2010, surgery had a new diagnosis of failed back surgery.

On December 12, 2012, Dr. Carlson issued a report stating that Petitioner had reached maximum medical improvement (MMI). Petitioner saw several medical providers since that date

for pain management, however, Dr. Carlson testified consistent with his report that Petitioner had reached a state of MMI on December 12, 2012.

Given the finding of causal connection to Petitioner's work injury of December 1, 1995, the Commission finds that Petitioner is entitled to temporary total disability (TTD) commencing from the date Dr. Aflatoon took Petitioner off work, February 28, 2007, through December 12, 2012, the date Dr. Carlson opined that he was at MMI.

Permanent Disability

> 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. *ABB C-E Services v. Industrial Comm'n,* 316 Ill. App. 3d 745, 750, 737 N.E.2d 682, 250 Ill. Dec. 60 (2000).

Fed. Marine Terminals, Inc. v. Ill. Workers' Comp. Comm'n (Buza), 371 Ill. App. 3d 1117, 1129, 864 N.E.2d 838, 848, 2007 Ill. App. LEXIS 189, *27, 309 Ill. Dec. 597, 607

In this case, on December 12, 2012, Dr. Carlson issued a report stating that Petitioner had reached maximum medical improvement and is 100% disabled from performing meaningful work. (12/14/17 T, PX29, PDepX3, 12/12/12)

Dr. Feinberg saw Petitioner at Respondent's request on September 23, 2015. In his report, Dr. Feinberg found a causal relationship between the December 1, 1995, work injury and the current disability. He recommended medication detoxification. Dr. Feinberg further opined that based on the totality of his presentation, Petitioner was unable to engage in the open labor market. (12/14/17T, RX1, DepX2, 9/23/15 rpt, p. 32) Dr. Feinberg also authored reports dated April 11, 2016, and November 21, 2016. Dr. Feinberg testified on June 20, 2017 that Petitioner could work in a sedentary capacity. (12/14/17 T, RX1, p. 23) This opinion was based on the fact that Petitioner's grip test of his right hand, his non-dominant hand, was quite good at 115 pounds. The grip test is an objective test. Except for his range of motion loss, Petitioner had a normal objective examination. (12/14/17 T, RX1, pp. 21-22) On a purely objective basis, Petitioner's examination was not grossly abnormal. He found no evidence of lower body musculature atrophy. Petitioner was not like others who have had multiple back surgeries with their foot drops, reflex changes, and positive straight leg raises. None of that was evident in Petitioner. There was no evidence of loss of muscle girth which occurs with radiculopathy or severe nerve damage. (12/14/17 T, RX1, pp. 23-24)

In his report from October 30, 2015, Dr. Feinberg recommended that Petitioner participate in a functional restoration and chronic pain program. A functional restoration and chronic pain program is to assist someone who is dysfunctional with chronic pain to become more functional and detoxify them by having them have a better life. The program he recommended is similar to the ones recommended by Dr. Delamarter, Dr. Lopez, and Dr. Prager. One part of the program is to teach the injured people how to mentally and physically deal with the pain. His

practice has a team that includes a full-time psychologist, a full-time physical therapist, himself and an associate. With someone with Petitioner's history, treatment would begin with a day-long interdisciplinary evaluation to assess if the subject is amenable to participating in the program. Some people are not amenable to the treatment, performing more surgery or being afraid. His practice will entice such people by having them meet their successful patients. He did recommend Petitioner needed to be weaned of his pain medications. He would consider Petitioner stopping his medication to be an extremely positive step. (12/14/17 T, RX1, pp. 27-29).

Dr. Feinberg wrote in his April 11, 2016, report that Petitioner engaged in significant pain behavior and symptom magnification. (12/14/17 T, RX1, pp. 33-34)

Dr. Carlson testified on May 19, 2017. He disagreed with Dr. Feinberg that Petitioner would have a better life, be on less medicine, and be capable of working a sedentary job if he participated in a comprehensive functional restoration pain program. Dr. Carlson testified that the basis of his opinion was his long-term association with Petitioner, seeing him multiple occasions and observing his impairment, his lack of ability to even be comfortable in a sitting or standing position for short periods of time, his need for assistive devices such as wheelchairs to mobilize get in and out of our office. His ability to not be able to even wait to for us for 30 minutes in one position without creating havoc due to his ongoing pain issues. (12/14/17 T, PX29, pp. 30-31)

Despite Dr. Feinberg's evaluation and testimony regarding the possibility that Petitioner could work in a sedentary job and Dr. Carlson's credibility issues, the Commission relies on Dr. Carlson's opinion that Petitioner is permanently and totally disabled pursuant to §8(f) of the Act, based on his testimony regarding Petitioner's chronic pain and inability to work as a result of multiple lumbar surgeries, residual lumbar radiculopathy, arachnoiditis, new L2-L3 paracentral disc herniation and progressive intervertebral collapse at L2-L3 and L3-L4. (12/14/17/T, PX29, DepX3, p. 28,)

Therefore, the Commission finds that based upon the material change in Petitioner's low back condition that is causally related to the work accident on December 1, 1995, Petitioner is entitled to TTD from February 28, 2007, through December 12, 2012, is permanently totally disabled commencing December 13, 2012, pursuant to §8(f) of the Act, and is entitled to medical expenses related to Petitioner's low back treatment that are itemized in Petitioner's exhibit one excluding treatment with growth hormones or plasma-enriched injections and excluding psychiatric or psychological treatment, if any, to be paid pursuant to §8(a) and §8.2 of the Act and per the terms of the parties' stipulation, i.e. that Respondent is responsible for any reasonable, related and necessary bills in the form of: 1) reimbursement to Petitioner for out-of-pocket medical expenses; 2) outstanding balances; and 3) Respondent will hold Petitioner harmless from any Medicare-based reimbursement claims. (12/14/17 T, pp. 19-20, PX1)

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $607.33 per week for a period of 302-1/7 weeks, commencing from February 28, 2007, through December 12, 2012, 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 for reasonable, related and necessary low back medical expenses under §8(a) and §8.2 of the Act as itemized in Petitioner's exhibit one excluding treatment with growth hormones or plasma-enriched injections and excluding psychiatric or psychological treatment, if any, and that Respondent shall reimburse Medicare and Medicare Health Plans for conditional payments made and that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is liable. To the extent any balances remain regarding the awarded bills which stem from Petitioner's out-of-pocket, deductible, co-payments and/or co-insurance, the Respondent shall reimburse Petitioner accordingly pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $607.33 per week for life as provided in §8(f) of the Act, commencing from December 13, 2012, for the reason that Petitioner sustained a material increase in his disability to the extent of the total permanent disability of Petitioner. The Petitioner is entitled to receive annual adjustments to this award under §8(g) of the Act. Total and permanent disability awards are subject to an annual rate adjustment on July 15 of each year beginning on the second year after the date the award is entered pursuant to §8(g). The weekly rate shall be proportionately increased by the same percentage increase in the State's average weekly wage, subject to the prevailing maximum rate. In the event of a decrease in such average weekly wage there shall be no change in the then existing compensation rate.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the Petitioner compensation that has accrued and shall pay Petitioner the remainder, if any, in weekly payments.

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 proceeding in the Circuit Court shell file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 6, 2021

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

KAD/bsd
O050421
42

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC003657
Case Name	FRITSCHE, CHRISTOPHER v. STATE OF ILLINOIS/MENARD CC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0346
Number of Pages of Decision	28
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Michelle Rich
Respondent Attorney	Kenton Owens

DATE FILED: 7/6/2021

/s/ Barbara Flores, 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

Christopher Fritsche,

Petitioner,

vs. NO: 18 WC 3657

State of IL/Menard C.C.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under section 19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary total disability and maintenance, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the changes made below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of maintenance. The decision of the Arbitrator delineates the facts relating to the issue in detail.

In addressing maintenance, the Arbitrator found that Petitioner has been unable to return to work as a Correctional Officer since the accident. In so doing, the Arbitrator noted that psychologist, Dr. Sky, opined that Petitioner reached maximum medical improvement ("MMI") with respect to his mental condition as of March 30, 2020. Accordingly, the Arbitrator found that Petitioner was entitled to temporary total disability ("TTD") benefits from January 25, 2018 through March 30, 2020. Thus, Petitioner is entitled to ongoing Maintenance benefits for his vocational rehabilitation plan beginning March 31, 2020.

Based on the record, the Commission affirms the Arbitrator's award of maintenance benefits. Petitioner reached MMI for his shoulder and knee conditions on December 31, 2018 per treating physician Dr. Mall. However, Petitioner has permanent restrictions on squatting, kneeling and sprinting which will not allow him to return to work as a Correctional Officer. Petitioner was taken off work for his mental condition on June 6, 2018 and reached MMI as of March 30, 2020, per Dr. Sky. Dr. Sky also opined that, due to Petitioner's mental condition he would not recommend Petitioner returning to work as a Correctional Officer or other jobs with potential exposure to danger. Adding credibility to Dr. Sky's opinions are results of tests he administered which revealed major depressive disorder, anxiety, and pronounced PTSD in Petitioner with no indication of dishonesty.

Respondent suggests that the maintenance award should be vacated, as the vocational rehabilitation award is predicated on Petitioner's mental condition, yet the rehabilitation plan itself is based on Petitioner's physical condition. Respondent argues that Petitioner merely suffered a knee strain during the instant accident, which does not override the existing 22% credit for a prior knee injury claim that was settled. Thus, Respondent suggests Petitioner's current physical condition in relation to the instant accident does not rise to the level of requiring a rehabilitation plan. The Commission is not so persuaded.

The Arbitrator's focus on Petitioner's mental condition in paragraph "L" of the Decision was to analyze and explain the extension of TTD benefits through March 30, 2020. The Arbitrator does not indicate that the maintenance award is exclusively based on Petitioner's mental condition. To the contrary, paragraph "K" of the Decision reflects the Arbitrator's observation that Petitioner is unable to return to work as a Correctional Officer "[d]ue to both his knee and his mental status…." Given the entirety of the record, the Commission affirms the Arbitrator's award and finds that either, or both, of Petitioner's physical and mental conditions precluded him from returning to his pre-accident employment through March 30, 2020.

Further, the Commission is unpersuaded by Respondent's assertion that Petitioner's current knee condition does not preclude him from working as a Correctional Officer, and preclude a maintenance award. Although Petitioner had end-stage arthritis prior to the accident, and had undergone a 1994 right knee surgery and an April 2000 right knee injury, he was still able to work full duty prior to the instant accident for years leading up to the accident. Indeed, Respondent's section 12 examiner, Dr. Nogalski, acknowledged a lack of evidence of knee complaints leading up to the accident. Immediately after the accident Petitioner had consistent right knee complaints. An MRI revealed a new meniscal tear, and subsequently Petitioner underwent a total right knee replacement. Petitioner's treating physician, Dr. Mall, opined that the accident at work aggravated and accelerated Petitioner's knee condition leading to the knee replacement. A "chain of events" analysis establishes causal connection in this case beyond a mere knee strain, and the evidence supports a finding of causal connection between Petitioner's accident and the necessity for knee replacement surgery.

The Commission notes, however, that the Arbitrator's Decision does not expressly state that the rehabilitation award, and the associated maintenance benefits, are related to Petitioner's knee condition. In the interest of clarity, the Commission herein changes the Arbitration Decision in order to denote this relationship. Accordingly, the Commission affirms the

Arbitrator's finding that the rehabilitation plan and associated maintenance benefits are supported by the evidence as Petitioner's causally connected knee condition precludes a return to his pre-accident employment.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 2020, is hereby affirmed and adopted, but changed with respect to the maintenance paragraph in the Order section of the Arbitrator's Decision. The Commission herein denotes that the rehabilitation award and maintenance benefits are related to Petitioner's current knee condition.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

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

Pursuant to §19(f)(l) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

July 6, 2021

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

o: 5/20/21
BNF/wde
45

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0346
NOTICE OF 19(b) ARBITRATOR DECISION

FRITSCHE, CHRISTOPHER Case# **18WC003657**

Employee/Petitioner

ST OF IL/MENARD CORRECTIONAL CENTER

Employer/Respondent

On 8/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commi ssion 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:

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
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

AUG 3 - 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTOPHER FRITSCHE
Employee/Petitioner

Case # **18** WC **03657**

v.

Consolidated cases: _____

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
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 **EDWARD LEE**, Arbitrator of the Commission, in the city of **COLLINSVILLE, ILLINOIS**, on **JUNE 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 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 **choice of physicians**

FINDINGS

On the date of accident, **01/24/2018**, 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 $**65,604.00**; the average weekly wage was $**1,261.62**.

On the date of accident, Petitioner was **41** 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 $**114,148.42 (+5 service conn. days +2 regular days off)** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**7,810.40** for other benefits, for a total credit of $**121,958.82**.

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, including vocational rehabilitation expenses, as provided in § 8(a) and § 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**841.08**/week for **113 4/7** weeks, commencing **1/25/18** through **3/30/20** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $**841.08**/week for **10 3/7** weeks, commencing **3/31/20** through **6/11/20**, as provided in Section 8(a) of the Act.

Respondent shall have credit for any amounts of medical or temporary benefits previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit. Respondent shall approve and pay for the vocational rehabilitation plan recommended by Mr. Kaver.

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

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

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

Signature of Arbitrator

7/28/20
Date

ICArbDec19(b)

AUG 3 - 2020

FINDINGS OF FACT

Background:

This matter comes before the Arbitrator on Petitioner's request for hearing pursuant to Sections 19(b) and 8(a). (T. 4) The issues in dispute are causal connection, payment of medical bills, temporary total disability benefits, whether Respondent is due a credit for prior claims and advance of permanent partial disability benefits, choice of physicians, and prospective medical care. (AX1; T. 4)

Petitioner is a 41-year-old Correctional Officer at Respondent's Menard Correctional Center, a maximum security prison, and had been employed by Respondent for nearly 20 years. (AX1; T. 26, 27, 33) The parties stipulated that Petitioner sustained accidental injuries on January 24, 2018, when he was attacked by an inmate who refused to get back in his cell. (T. 34-36) Petitioner turned so as to keep an eye on the inmate's cell mate, and at that time, the inmate hit Petitioner in the side of the head with a closed fist, causing Petitioner's head to strike the concrete floor. *Id.* A violent assault ensued that lasted two to three minutes. (T. 33) Petitioner testified that after the assault, his entire body was in pain, but particularly his head, left shoulder, and right knee. (T. 33, 34)

Medical History:

Immediately after the injury, Petitioner was seen at Workcare West. (PX3, 1/25/18) There, the history of the assault was taken. *Id.* Petitioner presented with chief complaints of head and left eye pain, difficulty with memory along with dizziness and concentration problems, pain throughout his left shoulder along with difficulty lifting, left sided neck pain down to his thoracic spine, and right knee pain accompanied by locking. *Id.* Physical examination revealed tenderness to palpation and swelling on Petitioner's head. *Id.* In his cervical spine, there was discomfort with forward flexion, pain with rotation to the left, and tenderness to palpation along the upper trapezius on the left. *Id.* The thoracic spine was also tender. *Id.* There was tenderness of the left shoulder along the medial border of the scapula, pain with apprehension testing, difficulty with shrugging due to pain; and he was unable to elevate his shoulder. *Id.* There was pain to palpation along the lateral joint line in the right knee along with decreased flexion when compared to the left. *Id.* Petitioner was sent for CT scans of his head and neck, as well as x-rays of his facial bones, thoracic spine, left shoulder and right knee, all of which were normal. (PX3, 1/25/18; PX4, 1/25/18) The diagnosis was a concussion without loss of consciousness, strain of muscle, fascia and tendon in the neck, strain of muscle and tendon in the thorax, and contusions of the left shoulder and right knee. (PX3, 1/25/18) Petitioner was instructed to use heat, ice, stretching, ibuprofen, and acetaminophen to manage his pain. *Id.* He was instructed not to drive, placed off of work, and told to see his primary care physician. *Id.*

He was seen at Workcare West again January 29, 2018, where it was noted that he had constant aching in his head and neck that was accompanied by tinnitus, photophobia, and

difficulty concentrating and remembering. (PX3, 1/29/18) He was also still having problems with his left shoulder, thoracic spine, and right knee, all of which he felt were not improving. *Id.* His diagnoses were the same as the prior visit, but with the added diagnosis of meniscus derangements of the right knee, and strain of muscle, fascia and tendons at the left shoulder. *Id.* He was given instructions to use ice, elevation, heat, and over-the-counter medication. *Id.* He was also given a prescription for Valium for muscle pain and kept off work. *Id.* It was noted that he had an appointment with an orthopedic physician, Dr. Mall. *Id.*

On February 1, 2018, Petitioner returned to Workcare West where he was seen for his concussion symptoms. (PX3, 2/1/18) Petitioner reported feeling extremely anxious. *Id.* It was noted that he had had anxiety in the past that was more situational, but had been doing fine until his recent injury. *Id.* Since the injury, however, his anxiety had been "through the roof." *Id.* He had been having recurrent nightmares, and a great deal of stress and anxiety because of the violent assault. (T. 38) Prior to his work injury, he never experienced nightmares and did not treat with any counselor or therapist for his mental health. *Id.* He was kept off work and referred to a mental health professional. (PX3, 2/1/18) He followed up with Workcare on February 8, 2018, and February 19, 2018, where continued concussion and anxiety symptoms were noted. (PX3, 2/8/19, 2/19/18)

On January 30, 2018, Petitioner was seen by Dr. Nathan Mall, a board certified orthopedic specialist. (PX5, 1/30/18) Dr. Mall took the history of Petitioner's assault at work and noted chief complaints of neck, left shoulder, and right knee pain. *Id.* Physical examination revealed left shoulder weakness with rotator cuff testing in the supraspinatus distribution, 4+/5 strength in the supraspinatus, 5-/5 in the subscapularis and infraspinatus distributions compared with 5/5 on the right side, pain with Neer and Hawkins maneuvers accompanied by popping in the subacromial space, positive O'Brien's test on the left shoulder, pain to palpation over the biceps tendon, tenderness to palpation along the cervical spine and the paraspinal muscles and trapezius area. *Id.* On the right knee, pain to palpation was noted over the medial joint line, along with positive McMurray's, pain with valgus test, and mild effusion. *Id.* X-rays were negative. *Id.* Dr. Mall's assessment was that Petitioner had a possible medial meniscus tear in the right knee and a possible rotator cuff tear in the left shoulder. *Id.* He recommended an MRI arthrogram for the shoulder and an MRI for the knee. *Id.* He also recommended Petitioner to undergo an evaluation of his cervical spine. *Id.* Petitioner was given a script for physical therapy and taken off of work. *Id.*

On February 7, 2018, Petitioner was seen again by Dr. Mall, who reviewed the right knee MRI and standing radiographs, which revealed arthrosis, bone-on-bone articulation, significant fluid in the joint with a loose body, a large amount of effusion, evidence of a prior partial meniscectomy, and a new meniscal tear were all noted. (PX5, 2/7/18; PX6, 2/7/18) The left shoulder MRI revealed fluid around the subacromial space, fluid around the biceps tendon, but no evidence of rotator cuff or superior labral tearing. *Id.* Dr. Mall's recommendation for Petitioner was a cortisone injection and physical therapy to treat the underlying osteoarthritis,

and if Petitioner's symptoms did not improve following conservative care, then he would require a total knee arthroplasty. *Id.* A cortisone injection was performed that day in his office, and Petitioner was kept off work. *Id.*

On February 27, 2018, Petitioner returned to Dr. Mall following his course of physical therapy and injection on his right knee. (PX5, 2/27/18) He had been unable to undergo physical therapy on the left shoulder. *Id.* Petitioner's condition had not improved with respect to the right knee and Dr. Mall recommended a total knee arthroplasty. *Id.* Petitioner was kept off of work. *Id.*

On April 27, 2018, Petitioner returned to Dr. Mall with continued symptoms in his right knee and left shoulder. (PX5, 4/27/18) Dr. Mall again examined the left shoulder MRI. *Id.* He noted that there appeared to be an acute cartilage defect with a loose body present, unseen because of the previous poor quality of the MRI screen. *Id.* On a better screen, the radiologist had also identified this pathology. (PX5, 4/27/18; PX6, 2/7/18) Dr. Mall noted that this may have been contributing to Petitioner's locking and catching in the left shoulder. (PX5, 4/27/18) He recommended a left shoulder injection, which was performed that same day in his office, along with physical therapy. *Id.* His continued recommendation for the right knee was a total arthroplasty, and he gave Petitioner another injection in his knee while waiting on workers' compensation approval. *Id.*

On June 8, 2018, Petitioner underwent surgery with Dr. Mall in the form of a right knee total arthroplasty. (PX9) Dr. Mall recommended that he undergo physical therapy and kept Petitioner off work with respect to the knee. (PX5, 6/12/18)

Petitioner continued to follow up with Dr. Mall for both the right knee and left shoulder, the latter of which Dr. Mall believed would likely require surgical intervention in the form of an arthroscopy, loose body removal, chondral debridement, and labral repair. (PX5, 6/26/18, 7/24/18, 8/21/18) Petitioner continued to be kept off work with respect to his right knee, and was given restrictions for his left shoulder. *Id.*

On October 4, 2018, Dr. Mall performed an arthroscopic labral repair, debridement and microfracture of the glenoid cartilage defect, and a synovectomy of the glenohumeral joint with respect to Petitioner's left shoulder. (PX12) Intraoperatively, synovitis was noted and a synovectomy was performed, and the anteroinferior labrum was repaired. *Id.* Petitioner was kept off of work and, at his follow up appointment, prescribed physical therapy. (PX5, 10/4/18, 10/16/18)

On his next visit, November 13, 2018, Petitioner was still having weakness, popping, crepitus, and swelling in his right knee. (PX5, 11/13/18) He was given work restrictions for both his knee and shoulder and prescribed additional physical therapy. *Id.*

On December 31, 2018, Petitioner saw Dr. Mall and reported that his shoulder was doing better, but with respect to his right knee, he struggled with the use of stairs, could not kneel, and

did not feel he could sprint. (PX5, 12/31/18) Dr. Mall believed that Petitioner was at maximum medical improvement for both the left shoulder and the right knee, and Petitioner was given permanent restrictions on the right knee of no sprinting, kneeling, or repetitive steps. *Id.* Petitioner followed up with Dr. Mall on July 30, 2019, and January 28, 2020, with continued symptoms of difficultly kneeling and running. (PX5, 7/30/19, 1/28/20) Dr. Mall recommended the continuation of the same permanent restrictions with regard to the right knee. *Id.*

During the time he was treating for his knee and shoulder injuries, Petitioner also sought treatment with Dr. Asif Habib, a physician at Mid-American Psychiatric Consultants. (PX8, 6/6/18) He was referred here by Workcare West. (PX3, 2/1/18; T. 40) On June 6, 2018, Dr. Habib noted that Petitioner had been assaulted by an inmate and did not receive help for several minutes, and that the inmates were yelling to kill Petitioner. *Id.* Dr. Habib noted that since then, Petitioner suffered from anxiety, depression, nightmares about the incident, fear of going back to work, and feeling uneasy. *Id.* He noted that Petitioner had no problems with depression of anxiety prior to this incident, and was not taking any medications, had not seen a psychiatrist in the past, and had only taken Xanax after his divorce in 2015. *Id.* Dr. Habib's primary diagnosis was P.T.S.D. *Id.* Petitioner was given a prescription for Lexapro, instructed to take melatonin to sleep, referred to a counselor, and taken off work. *Id.*

On August 1, 2018, Petitioner returned to Dr. Habib with continued complaints of anxiety, and nightmares that caused sleep disturbance. (PX8, 8/1/18) His medications were continued. *Id.* On October 3, 2018, Petitioner followed up with Dr. Habib, where it was noted that he had anxiety, but Lexapro was helping his mood and he had been seeing a counselor weekly, as Dr. Habib had recommended. (PX8, 10/3/18) He was still, however, having anxiety and depression symptoms, especially when thinking about being back around inmates. (PX8, 2/6/19) Petitioner continued to follow up with Dr. Habib, who gave him prescriptions for Seroquel, Lexapro, and Buspar. (PX8, 1/31/20) At the time of Arbitration, Petitioner was still taking these medications, which help his stress level and help get to sleep at night because his nightmares are not as intense while taking the medication. (T. 40, 41) These medications, however, make Petitioner drowsy. *Id.*

At Dr. Habib's referral, Petitioner saw Dale Budslick, a Licensed Clinical Professional Counselor. (PX11) Ms. Budslick's notes indicate that the primary issue for Petitioner was to get "out of the mode of remembering the incident or dreams of just being at the prison." (PX11, 7/23/18) She saw Petitioner for 10 counseling sessions from July 23, 2018 through October 12, 2018. (PX11)

Arbitration Testimony, Christopher Fritsche:

Petitioner testified that, prior to the assault at work, he had no prior problems or surgeries in relation to his left shoulder. (T. 34) He testified that he had surgery on his right knee to repair a torn meniscus in 1994 when he was in high school. (T. 34)

Respondent offered into evidence a settlement contract from Petitioner's prior employer, Compact International, which was dated June 19, 2000, wherein Petitioner received 22% PPD to his right leg. (T. 48, 49; RX12) The settlement contract was over 20 years old, which Petitioner vaguely recalled after he was shown the document. (T. 50, 51) When questioned as to why he didn't recall this injury initially, Petitioner testified that he remembered having the knee surgery which occurred in 1994, but simply could not recall the incident from 2000. (T. 64) According to the settlement contract, the date of injury was April 3, 2000. (RX12) The time period between Petitioner's date of injury and the date Petitioner signed the settlement contract, June 19, 2000, was two and a half months. (AX1; RX12)

Petitioner testified that he has a high school diploma and a minimal college education. (T. 27) In between high school and going to work for Respondent, for whom he has worked for nearly two decades, he worked at his family farm, but he does not currently work there nor does he receive any income from same. (T. 28)

He co-owns a company, Concealed Comfort Pits, which produces waterfowl hunting products. (T. 29-31) Petitioner testified that he subcontracts the manufacturing of the product to a local Amish welding shop. (T. 31) Petitioner and his business partner do not perform any of the manual labor, installation services, delivery, set up, or media associated with the products. (T. 31-33, 44) He estimates that he made approximately $70,000.00 per year in the past two years from the sales of this intellectual property. (T. 32) While he is thankful for the income this company has brought him, he admitted that "it could be over tomorrow." (T. 43)

Respondent's attorney questioned Petitioner at length regarding his co-ownership of Concealed Comfort Pits, including multiple inquiries as to whether or not Petitioner performed installations for different clients. (T. 54-59) Petitioner was consistent in that he does not perform any physical activity and Respondent produced no evidence to the contrary. *Id.*

Respondent's attorney also questioned Petitioner as to whether he told Dr. Habib in May 2019 that he would not be returning to work at the prison secondary to his knee injury. (T. 61, 62) Petitioner responded that it was the ADA administrator who told Petitioner that he would not be returning to employment at the prison. *Id.* Again, Respondent offered no contrary testimony.

When asked if he could perform the duties of a Correctional Officer while under his permanent restrictions, Petitioner stated: "Absolutely not." (T. 39) His testimony on this issue was also unrebutted.

Petitioner has looked for work within his restrictions, but this is difficult in the months prior to Arbitration because of the stay-at-home order relating to the Coronavirus pandemic, which was in effect in Illinois until June 1, 2020. (T. 42) Petitioner plans on continuing to look for work within his restrictions with the assistance of his vocational counselor, Tim Kaver. (T. 42, 43) Petitioner testified that he is eager to return to some type of work, and his goal is to return to employment with the State of Illinois. (T. 43, 44) He has enrolled in and been accepted

into the Alternative Employment Program (AEP) with the State of Illinois, and testified that if an employment offer with the State of Illinois came, he would happily accept same. (T. 44, 45)

Arbitration Testimony, Timothy Kaver:

Timothy Kaver testified at Arbitration. (T. 9-26) Mr. Kaver has been a certified rehabilitation counselor since 1986. (T. 10) He testified that he provided vocational counseling and rehabilitation to Petitioner with the goal of helping him gain successful employment. (T. 10, 11) At the time of Arbitration, his efforts with regard to same were ongoing. (T. 11) He testified that his efforts on behalf of Petitioner have been slowed down somewhat by the Coronavirus pandemic, but more so because Petitioner's vocational rehabilitation plan calls for college and computer training, and the funding for same has not been approved. (T. 11, 12) Mr. Kaver's reports regarding Petitioner and charges for his services were entered into evidence. (T. 12, 13, 67)

Mr. Kaver testified that Dr. Mall stated that Petitioner had light duty restrictions, which is what he followed when formulating his assessment. (T. 18) Mr. Kaver testified that he explored Petitioner's educational background, prior work history, vocational interests and vocational test scores, which were excellent, and developed a plan based upon same. (T. 19, 20) Mr. Kaver testified that Petitioner's income resulting from his intellectual property, Concealed Comfort Pits, would not cause him to change his vocational rehabilitation plan. (T. 24, 25) Petitioner testified that Tim Kaver's testimony was accurate as it pertained to his situation. (T. 41)

Independent Medical Examination and Deposition Testimony, Dr. Nogalski:

Respondent had Petitioner examined by Dr. Michael Nogalski on November 28, 2018. (RX2) Dr. Nogalski noted the history of the inmate assault and reviewed medical records from Workcare, Southern Illinois Healthcare, Dr. Mall, MRI Partners of Chesterfield, and the Orthopedic Institute of Southern Illinois Physical Therapy. *Id.* Dr. Nogalski's physical examination of the right knee revealed a well healed anterior knee incision, slightly lax ligament stability in extension, especially with respect to varus stress. *Id.* There was tenderness over the iliotibial band, 4+/5 extension and flexion strength, significant drop back in flexion with an endpoint present, grad three to four laxity to posterior drawer testing, mild antalgia in his gait with decreased stance on the right side. *Id.* Exam of the left shoulder revealed some end-capsular tightness, 4/5 strength, and generalized tenderness over the anterior portal site. *Id.* Shoulder stability was not tested or stressed. *Id.* X-rays were performed which were normal for the shoulder, and for the knee, showed a cemented right total knee replacement. *Id.*

With regard to Petitioner's left shoulder, Dr. Nogalski felt that there may be a causal relationship between the shoulder aggravation and Petitioner's subsequent need for arthroscopy, and felt that the treatment incurred had been reasonable and necessary. *Id.*

However, with regard to the right knee, he opined that there were no objective findings of injury, believed Petitioner's osteoarthritic symptoms to be preexisting, and could not identify specific objective documentation that supported that there was an injury to the knee other than a strain. *Id.* He opined that the medical treatment to Petitioner's right knee was excessive due to his belief that there was a lack of objective correlation of his findings and his knee complaints and a "specific injury." *Id.* He did not believe that his MRI findings supported an acute or severe injury or a severe aggravation. *Id.* He felt that further conservative treatment would have brought Petitioner back to baseline. *Id.* He testified that he believed that Petitioner had reached maximum medical improvement with respect to the right knee at one to two weeks after his initial injury. *Id.*

Dr. Nogalski prepared an addendum report dated January 16, 2019, in which he noted that he had received and reviewed Petitioner's operative report from October 2, 2018, but that the operative findings of same did not change his opinions on causation or need for treatment with respect to Petitioner's left shoulder. (RX3)

Dr. Nogalski testified by way of deposition on November 4, 2019. (RX4) Dr. Nogalski testified that Petitioner gave him the history of his work assault, including striking his right knee, feeling it pop, feeling pain, and being unable to straighten it out. *Id.* at 11. He also had pain in his left shoulder. *Id* at 11. Dr. Nogalski testified that the left shoulder surgery and treatment had been reasonable and necessary in relation to the January 24, 2018 accident. *Id.* at 11. With respect to the right knee, Dr. Nogalski testified that, at the time he examined Petitioner, he had already undergone his knee replacement. *Id.* at 12. He testified that Petitioner suffered a temporary aggravation of his osteoarthritis in the knee. *Id.* at 16, 43, 44.

Dr. Nogalski testified that around 90% of his medical/legal work is at the request of the defense, and he charges approximately $3,900 for an IME, addendum and deposition. *Id.* at 21, 22, 25. He testified that he only performs about five to 10 knee replacements per year, and regularly refers patients in need of knee replacements to other physicians. *Id.* at 28. Dr. Nogalski testified that he believed Petitioner's mechanism of injury for the shoulder injury was sufficient to contribute to that condition, and that the mechanism of injury with respect to the knee, as described in the medical records, could reasonably be reconciled to cause knee pain and irritation in conjunction with the event. *Id.* at 36, 37. He agreed that Petitioner stated that he had not had any problems with his knee for many years. *Id.* at 37, 38. Dr. Nogalski admitted that he had not reviewed any medical records that would suggest that Petitioner's right knee was symptomatic prior to the accident, or that another physician had recommended a knee replacement. *Id.* at 33, 37, 38.

Dr. Nogalski agreed that the Supervisor's Report of Injury of Illness documented right knee soreness and swelling and that this was consistent with findings of joint effusion on the MRI. (*Id.* at 44, 45; PX17) He did not believe that Petitioner's right knee replacement was reasonable and necessary, but when asked if same fell below the standard of care, he hesitated,

then stated that it was on the line before stating that he did not feel it met the standard of care due to the lack of conservative treatment. (RX4 at 44, 45) However, he admitted that Petitioner had undergone conservative care in the form of an injection, but that same did little to relieve his complaints. *Id.* at 46. He testified that a brace is a conservative form of treatment for a younger individual with Petitioner's type of knee condition, and that Petitioner would have been well-served to pursue brace wear, but that he was unsure if Petitioner would have been able to return to work as a Correctional Officer while wearing a brace. *Id.* at 46, 47. Last, he testified that he did not know if Petitioner's right knee symptoms ever returned to baseline, and he did not possess any documentation that that was the case. *Id.* at 54, 55.

Independent Medical Examinations and Deposition Testimony, Dr. Hartman:

Dr. Hartman examined Petitioner on June 5, 2018. (RX5) Dr. Hartman is a psychologist, not a medical doctor or surgeon, as stated in Section 12 of the Illinois Workers' Compensation Act. Dr. Hartman reviewed medical records, including those from St. Joseph's Hospital, Occupational Medicine/Workcare, and Dr. Mall. *Id.* He took the history of the assault and noted Petitioner's goal was to return to good health. *Id.* He administered several psychological tests, which he interpreted as though Petitioner was magnifying his symptoms. *Id.* He indicated that Petitioner's profile on the Structured Inventory of Malingered Symptomatology (SIMS) was below the cutoff for overall exaggeration, but over the subtest cutoff for unlikely depression/anxiety symptoms. *Id.* He also noted that Petitioner's objective test results did not rule out the possibility of psychological difficulty, but felt that Petitioner's answers were exaggerated. *Id.* Dr. Hartman indicated that Petitioner's symptoms were caused by a combination of factors, including exaggeration, anger and frustration, binge alcohol abuse, but also the work event. *Id.*

Dr. Hartman felt that Petitioner would benefit from psychiatric and psychological treatment to address binge drinking and injury-reactive adjustment features. *Id.* He indicated that binge drinking was not related to Petitioner's work injury since he had a pre-existing history of alcohol abuse 20 years earlier. *Id.* He did feel that Petitioner had psychological difficulties relating to an adjustment reaction to his work injury, and that Petitioner did require psychiatric and psychotherapeutic support to treat same. *Id.* He stated that malingering was not a primary diagnosis. *Id.* Lastly, he opined that Petitioner's symptoms were causally related to three factors, 1) his work assault, 2) binge drinking and 3) symptom magnification. *Id.*

Dr. Hartman also mentions multiple times that Petitioner's claim that he was assaulted absent help from other staff was not credible since other records indicate that a second officer was present almost immediately. *Id.*

Petitioner saw Dr. Hartman for another independent medical examination March 2, 2020. *Id.* He stated that the records from Petitioner's treating mental health professionals, Ms. Budslick

and Dr. Habib, were not available for his review. (RX6) He noted that Petitioner was taking Escitalopram, BuSpar, and Seroquel (Quetiapine). *Id.*

Dr. Hartman believed that Petitioner exaggerated cognitive defect on the Word Memory Test, as compared with the one administered during his first evaluation with Petitioner in 2018. *Id.* Dr. Hartman believed that Petitioner's results in 2018 were normal, although those normal findings were not noted in Dr. Hartman's June 5, 2018 report. *Id.* Dr. Hartman opined that Petitioner exaggerated his symptoms on several other tests, and that he did not suffer from PTSD or post-concussion syndrome. *Id.* He felt that Petitioner's prescriptions for Buspar and Escitalopram were reasonable and necessary, but Quetiapine was not. *Id.*

Dr. Hartman testified by way of deposition that he has degrees in psychology psychopharmacology, but he was "two-thirds of the way to the requirement for prescribing in the State of Illinois" due to the regulations here. (RX7, p.7-9) On direct examination, he testified to his psychological diagnosis of Petitioner, namely "adjustment disorder unspecified with anxiety and anger" and "alcohol dependence unspecified with anxiety and magnified cognitive impairment." *Id.* at 11-12. He also noted cognitive impairment, which he characterized as mild, and "features of malingering, in other words, exaggeration, but they did not predominant [sic] in his evaluation." *Id.* at 12. He again acknowledged that he believed Petitioner would benefit from some treatment as outlined in his report, and *Id.* at 13-14. In commenting on his March 2020 examination, Dr. Hartman stated that from a psychological perspective, the only thing that was preventing Petitioner from returning to work psychologically was a prescription that was sedating him, and he believed that Petitioner was psychologically at maximum medical improvement. *Id.* at 16.

On cross-examination, Dr. Hartman acknowledged that Petitioner had not received any psychological treatment prior to the workplace assault or Respondent's requested independent medical evaluation. *Id.* at 20. He also admitted that it had been 20 years since there had been any noted problems with Petitioner drinking. *Id.* at 21-23. He also admitted that Petitioner reported that he had stopped drinking. *Id.* at 23-24. However, he recommended that Petitioner "detoxify from alcohol and then get about a month of weekly cognitive behavioral therapy." *Id.* at 23-24. He was aware that Petitioner had seen a counselor, but he did not have said counselor's notes. *Id.* at 24-25.

Dr. Hartman testified that he recommended cognitive therapy for Petitioner; but if he had a "complicating mental disorder," he would recommend "some sort of medication to help smooth [his] mood a bit." *Id.* at 27. He acknowledged that the Quetiapine Petitioner was taking was in his belief likely related to a sleeping problem he was having as a result of the assault. *Id.* at 29. He acknowledged that he was a psychologist rather than a medical doctor, and that most if not all of his psychological evaluations were done at the request of respondents. *Id.* at 33-34. He charges $695 an hour with a 3 hour minimum for his deposition testimony. *Id.* at 34.

Independent Medical Examination and Deposition Testimony, Dr. Sky:

Petitioner was seen for an independent medical evaluation by Dr. Adam Sky on March 30, 2020. (PX14) Dr. Sky reviewed medical records from Workcare, St. Joseph's Memorial Hospital, Dr. Mall, MRI Partners, Orthopedic Institute of Southern Illinois, Dr. Habib, Missouri Baptist Medical Center, Residential Home Health and Hospice, Dale Budslick, Apex Physical Therapy, as well as the IME reports from Dr. David Hartman and Dr. Michael Nogalski. *Id.* Dr. Sky noted that Petitioner was in his usual state of physical and mental health when he was assaulted. *Id.* He noted the details of the assault, including that during the assault, Petitioner felt like he was "fighting for [his] life." *Id.* He had a distinct memory of other inmates cheering on the inmate who was assaulting him, and recalled that it took several minutes for other officers to arrive and get the altercation under control. *Id.* Dr. Sky noted that from a psychiatric standpoint, Petitioner had not been doing well since shortly after the assault. *Id.* He was anxious, had difficulty sleeping, had disturbing dreams, became more irritable and moody and noticed that his focus and memory were not the same. *Id.* Petitioner stated to Dr. Sky that he "[wanted] to be able to work." *Id.*

Petitioner's past medical history was unremarkable, and it was noted that Petitioner was in good health prior to the assault, and enjoyed working out regularly. *Id.* His psychiatric history prior to the assault included only some marriage counseling in 2014 or 2015, and indicated that his primary physician had prescribed alprazolam, but he had not been taking it for some time prior to the assault. *Id.*

Dr. Sky reviewed Dr. Hartman's IME and noted that Dr. Hartman stated that, despite Petitioner's prolonged symptoms and the nature of his symptoms that had an adjustment disorder with anxiety and anger, features of malingering, as well as alcohol dependence, although Petitioner had not been a drinker in over 20 years. *Id.* He noted that psychological assessments were performed, but there were no scales to measure mood and anxiety symptoms, and the brief P.T.S.D. section was inconclusive. *Id.* Dr. Sky also noted that Dr. Hartman's report indicated that Petitioner denied psychological problems related to his work injury assault and that he was psychiatrically functioning normally, although this is not what was conveyed to Dr. Sky by Dr. Habib or Ms. Budslick. *Id.*

Dr. Sky's mental status examination revealed that Petitioner reported very poor sleep with disturbing dreams of being assaulted. *Id.* He had feelings of hopelessness, helplessness, and worthlessness. *Id.* Psychological testing was performed, including a Montgomery-Asberg Depression Rating Scale (MADRS), in which Petitioner scored a 24, consistent with moderate major depressive disorder. *Id.* A Beck's Depression Inventory (BDI) was performed wherein Petitioner's score was consistent with borderline to moderate clinical depression. *Id.* A Hamilton Anxiety Rating Scale (HAM-A) was also performed and findings were consistent with moderate

anxiety. *Id.* A PCL-5 measure was also performed which revealed a score of 40, which was consistent with severe posttraumatic stress disorder. *Id.* His PCL-5 scores on criterion D and E were particularly elevated, indicative of pronounced PTSD involving cognitive changes, mood symptoms, arousal, and reactivity. *Id.*

Dr. Sky's diagnoses included post-traumatic stress disorder, major depressive disorder, single episode with anxious distress, and possible post-concussive syndrome. *Id.* It was Dr. Sky's opinion that the cause of Petitioner's current psychiatric symptoms, diagnoses, and need for treatment was the January 24, 2018 assault. *Id.* He opined that there were no preexisting psychiatric issues that could have been exacerbated, exaggerated, or accelerated by the assault. *Id.* He also felt that Dr. Hartman's opinion that Petitioner's alcoholism was "highly dubious given that [Petitioner's] has been for the most part a minimal drinker for the better part of twenty years. He has not received any kind of treatment for his alcohol use nor were issues of alcohol use/abuse documented in any of the reviewed medical records." *Id.* Dr. Sky's opinion was that Petitioner had reached maximum medical improvement, but would require ongoing psychiatric `focused therapies. *Id.* Dr. Sky noted that Petitioner's nearly identical presentations on his evaluation in comparison with his other treating physicians were consistent with a valid and truthful narrative. *Id.*

Dr. Sky also testified by way of deposition. (PX16) He is licensed and board certified in psychiatry and neurology with added qualifications in geriatric psychiatry. *Id.* at 4-5. In addition to treating patients, he also performs independent medical evaluations for both petitioners and respondents. *Id.* at 5-7. Dr. Sky testified that he found it significant that Petitioner reported that his intuition failed him in this incident, as Petitioner reported that he usually would have a feeling that something bad was going to happen. *Id.* at 10-11. In this instance, however, Petitioner was caught completely off guard. *Id.* at 10-11. He noted that only one colleague was in the vicinity to aid Petitioner, and it took time for others to arrive on the scene. *Id.* at 10-11. He noted that within a week, Petitioner found himself anxious and sleepless with disturbing and intrusive dreams. *Id.* at 11-12. Petitioner was anxious about going to work and found himself avoiding work colleagues and exhibiting a host of other symptoms including irritability and lack of concentration. *Id.* at 11-12. However, Petitioner was not one who aspired to "become dependent on handouts." *Id.* at 12. While Petitioner had a brief bout of anxiety related to his divorce in 2014 and 2015, he had recovered and ceased taking the prescribed medication, and same never restricted his ability to function or work. *Id.* at 13. Following the incident, however, Petitioner required treatment from both Dr. Arif and Dr. Habib in June of 2018. *Id.* at 13-14.

After detailing his physical examination, Dr. Sky testified that the multiple tests he performed led to diagnoses of depression, anxiety, and post-traumatic stress disorder. *Id.* at 16-17. Dr. Sky testified that Petitioner's diagnoses were consistent with the history of his occupational injury. *Id.* at 17-18. Dr. Sky stated that Petitioner's post-traumatic stress disorder and depressive disorder with anxious distress were the result of the workplace assault. *Id.* at 17-18. When asked for the basis of his opinion, he stated:

> He had none of these symptoms or minimal symptoms prior to the assault. He certainly had no symptoms involving posttraumatic stress disorder. Arguably he had some very mild anxiety symptoms, but these have long been resolved. And almost immediately after the assault he began to experience the anxiety, the, you know, the lack of interest in activities, the cognitive or memory worries, the disturbing and intrusive dreams. He found himself trying to avoid work colleagues. All of that started almost immediately after this assault. *Id.* at 18-19.

He thus opined that Petitioner's condition was causally related to his injury, and further testified that the treatment Petitioner required for said diagnoses was reasonable, necessary, and causally related to the work injury. *Id.* at 19. He believed that Petitioner continued to require treatment, but would also benefit from more focused posttraumatic stress disorder therapies such as cognitive behavioral therapy, eye movement association, or processing treatment. *Id.* at 19-20. He also testified that in his 20 plus years of clinical experience as a clinician, he has become adept at determining the candor of patients, and he testified that he had no impression whatsoever that Petitioner was being dishonest. *Id.* at 20-21. He also indicated that Petitioner's presentation to him was the same as it was to Dr. Habib and Ms. Budslick. *Id.* at 20-21.

Dr. Sky testified that he reviewed Dr. Hartman's reports and it was apparent that he was not qualified to prescribe in Illinois or be a treating practitioner. *Id.* at 22. He disagreed with Dr. Hartman's diagnosis of adjustment disorder, which by definition resolves within six (6) months, and is typically related to a grief reaction. *Id.* at 23. According to the Diagnostic Statistical Manual, which defines psychological diagnoses, a condition is no longer adjustment disorder if it lasts beyond six (6) months. *Id.* at 23. He also stated that Petitioner had not abused alcohol for years and his use had been markedly reduced since 2007. *Id.* at 23-24. He also digressed with his opinion on the use of the medication prescribed to Petitioner. *Id.* at 24. He stated that the dose of Quetiapine that Petitioner was taking, about 1/25th of the maximum dose, was prescribed as a sleep aid and would be unlikely to cause him to be sedated throughout the day. *Id.* at 24-25.

Dr. Sky also testified that the MMPI testing performed by Dr. Hartman was somewhat irrelevant to the problems Petitioner presented with in terms of his work injury. *Id.* at 26-27. He disagreed with Dr. Hartman's assessment that Petitioner was functioning normally from a psychiatric standpoint, especially given that Petitioner was having neurovegetative symptoms such as difficulty sleeping, persistent symptoms of post-traumatic stress disorder, and pronounced symptoms of anhedonia or absence of pleasure, all of which were classic symptoms of major depressive disorder. *Id.* at 29-30. He again disagreed that Petitioner presented with any signs of malingering, given that Petitioner's presentation at his office and with the other clinicians was virtually identical. *Id.* at 30.

When asked about Petitioner's ability to work as a Correctional Officer, he stated that he would be "very, very hesitant to let him do anything that would involve the potential exposure to danger." *Id.* at 31. He stated:

> I wouldn't want him, say, for example, being a correctional officer, a first responder, a policeman, even a fireman. I think that would absolutely worsen his symptoms markedly. That said, I am not a vocational rehabilitation expert, but if he were one of my regular patients I would strongly advise him to stay away from anything that would potentially put him in danger. *Id.* at 31.

Dr. Sky thus testified that Dr. Habib's off work recommendations were also reasonable and related to Petitioner's work injury. *Id.* at 32.

On cross-examination, Dr. Sky stated that he believed that Dr. Habib's records supported that Petitioner could not return to work as a Correctional Officer due to anxiety. *Id.* at 41-44. He also testified that he believed Petitioner's depression played a bigger factor in Petitioner's fatigue rather than his medication, given that he only took same three (3) times a week. *Id.* at 45. He also did not believe that it was the medication itself that prevented Petitioner from working. *Id.* at 45.

Deposition Testimony, Dr. Mall:

Dr. Mall also testified by way of deposition. (PX15) Dr. Mall is a board-certified orthopedic surgeon who specializes in shoulder and knee surgeries. *Id.* at 4, 5. He performs shoulder and knee arthroscopies and replacements. *Id.* at 5, 6. Approximately 35 to 40% of his practice involves treating shoulder injuries and the same percentage for knee injuries. *Id.* at 7, 8. Dr. Mall also performs several IME's per week, usually at the request of employers and insurance carriers. *Id.* at 9, 10.

Dr. Mall testified that he treated Petitioner for injuries to his right knee and left shoulder. *Id.* at 11, 12. With regard to the left shoulder, Dr. Mall's examination of Petitioner's shoulder produced significant findings, including weakness and positive O'Brien's test. *Id.* at 12. The shoulder MRI showed fluid in the subacromial space and biceps tendon, along with a loose body that was associated with a labral tear. *Id.* at 16, 17. Dr. Mall felt that Petitioner suffered from rotator cuff tendinitis and strain in the left shoulder. *Id.* at 18.

Dr. Mall testified that Petitioner had no left shoulder complaints prior to the accident. *Id.* at 20, 21. Due to Petitioner's ongoing locking and catching symptoms, he performed left shoulder surgery. *Id.* at 28, 29, 31. He testified that there was some tearing in the labrum, which was debrided, and the loose body was identified. *Id.* at 31. Dr. Mall kept Petitioner off work and ordered physical therapy. *Id.* at 32.

He opined within a reasonable degree of medical certainty that Petitioner's left shoulder condition was causally related to the assault of January 24, 2018. *Id.* at 19. Dr. Mall's opinions that the mechanism of the work injury caused Petitioner's shoulder complaints was based upon Petitioner's lack of prior shoulder complaints, the MRI which showed acute trauma, and Petitioner's clinical symptoms. *Id.* at 36, 37.

With regard to Petitioner's right knee condition, Dr. Mall testified that his physical examination revealed medial joint line pain, positive McMurray's examination, and pain with valgus stressing. *Id.* at 12. There was also mild effusion. *Id.* at 12. He explained that a positive McMurray's test means that there is a concern for a meniscal tear, which can be positive with an MCL sprain as well. *Id.* at 13. He testified that Petitioner's arthritis was lateral, but he had pain medially which could raise a concern for an acute injury to the MCL, medial meniscal tear, or medial fracture that would not be seen on an x-ray. *Id.* at 13, 14.

Dr. Mall found that Petitioner's physical exam findings were consistent with his complaints. *Id.* at 19. With regard to whether Petitioner's complaints were consistent with his described mechanism of injury, Dr. Mall testified:

> Again, when there's sort of altercations like that, it's really hard for someone to some [sic] of hone down on the very specific injury mechanism with that. So typically within altercations and sort of motor vehicle accidents and things that involve a significant amount of trauma that happens quickly, I tend to not harp quite as much on the injury mechanism, just because a lot of people don't remember that. Things were happening quickly, and it's hard for someone to say yeah, my arm was put into an abduction external rotation position or my knee was torqued and this and that. So in those situations of altercations, I care more about did he report this pain right away to his employer? What were the body parts that were reported within a reasonable time frame? So he came and saw me actually within a week or so of his injury and was complaining of neck, shoulder, and knee pain, so I think those things all would be reasonable at that point. *Id.* at 19, 20.

Petitioner's knee x-rays showed fairly significant lateral compartment arthritis, and the MRI showed a significant amount of fluid in the joints. *Id.* at 16. Meniscal tearing was seen along with loss of cartilage. *Id.* at 16. He also testified that Petitioner likely suffered an MCL sprain as well, but that same was not visualized on the MRI due to inflammation around the MCL. *Id.* at 16, 17.

The injection performed on Petitioner's right knee was used to treat symptoms of inflammation did not get relief, or long-lasting relief from the injection. *Id.* at 24. Due to his osteoarthritis, Dr. Mall did not feel that without surgery, Petitioner's condition was going to return to his previous asymptomatic baseline. *Id.* at 23.

Dr. Mall testified that he performs surgeries based upon symptoms and ability to control pain, and that treatments are limited when it comes to individuals with severe arthritis. *Id.* at 38. In someone with arthritis such as Petitioner's, Dr. Mall felt that gel injections, PRP, and knee arthroscopy would not be beneficial, and that they would either benefit from steroid injections, or a knee replacement would be necessary. *Id.* at 27. He testified that he does not wait as long to perform knee replacements in individuals with valgus knees, as Petitioner has, because waiting too long to perform same can result in damage to the peroneal nerve. *Id.* at 23, 24. Dr. Mall testified that Petitioner's need for knee replacement surgery was accelerated by the work accident. *Id.* at 61, 62.

Dr. Mall performed a total right knee arthroplasty, and following same, Dr. Mall ordered physical therapy. *Id.* at 27, 28. Petitioner continued to follow up with Dr. Mall, who recommended work restrictions and strengthening. *Id.* at 32. Dr. Mall testified that on December 31, 2018, Petitioner returned to Dr. Mall and reported that his left shoulder was doing well. *Id.* at 33. He testified that upon physical examination of Petitioner's right knee, it was noted that his motion, extension, and manual testing were good, but he was having difficulty kneeling and sprinting. *Id.* at 33, 34. Dr. Mall felt that Petitioner's right knee symptoms had been stable, he had good strength, and he had maximized the benefit that he would receive from therapy. *Id.* at 34. Based upon Petitioner's clinical examination and inability to kneel and sprint, which are typical complaints following a knee replacement, Dr. Mall assigned Petitioner permanent restrictions of no sprinting, no kneeling, and no repetitive steps. *Id.* at 34, 35, 55, 56. Dr. Mall testified that he saw Petitioner last on July 30, 2019, and that his recommendations for permanent restrictions remained the same. *Id.* at 36.

Dr. Mall opined within a reasonable degree of medical certainty that Petitioner's and right knee condition was causally related to the January 24, 2018 assault. *Id.* at 19. Dr. Mall testified that there is a differentiation between an exacerbation where someone is able to return to their prior level of pain and function, and an aggravation, wherein returning to baseline would not be achievable. *Id.* at 25. It was his opinion within a reasonable degree of medical certainty that Petitioner had suffered an aggravation of his right knee condition. *Id.* at 25. Dr. Mall was aware that Petitioner had had knee surgery 20 years prior, but no recent knee complaints and was working full-duty at the time of the accident. *Id.* at 21. Dr. Mall felt that Petitioner's right knee complaints were related to the work injury and constituted an aggravation due to the fact that Petitioner did not have knee complaints prior to the injury except for those many years prior, the fact that he reported knee pain at his initial visit just six days following the accident, and the fact that Petitioner failed conservative treatment. *Id.* at 37.

On cross examination, Dr. Mall maintained that Petitioner's joint effusion finding was significant, that he required an arthroplasty, and that Petitioner required permanent restrictions on his right knee. *Id.* at 50, 52, 55-57.

CONCLUSIONS OF LAW

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

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Comp. Comm'n*, 371 Ill. App. 3d 882, 888, 864 N.E.2d 266, 272 (2007). The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-

being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003). [Emphasis added]. 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*, 207 Ill. 2d 193, 797 N.E.2d 665 (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*, 359 Ill. App. 3d 582, 834 N.E.2d 583 (2005).

Additionally, Employers are to take their employees as they find them. *A.C.& S. v. Industrial Comm'n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982). 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), 37 Ill. 2d 123; see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

Causal connection between accident and claimant's condition may be established by chain of events including claimant's ability to perform manual duties before accident, decreased ability to still perform immediately after accident, and other circumstantial evidence. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979). A compensable aggravation occurs when a claimant's need for surgery is accelerated. *Judith Wheaton v. State of Illinois/Choate Mental Health Center*, 13 I.W.C.C. 0467; *Bowman v. Gateway Reg'l Med. Ctr.*, 14 I.W.C.C. 1022; *Clutterbuck v. UPS*, 15 I.W.C.C. 0046; *Howard v. St. Clair Hwy. Dept.*, 16 I.W.C.C. 0187, modified 16 MR 106.

Based upon the aforementioned law and the evidence, the Arbitrator finds that Petitioner met his burden of proof in establishing that his current condition of ill-being is causally related to his accidental work injury. The Arbitrator found Petitioner to be a credible witness at Arbitration. Though Respondent presented a settlement contract that Petitioner did not recall with respect to his right knee, given the relatively short duration of said case from beginning to end, the fact that it occurred over 20 years prior, and that it was overshadowed in Petitioner's mind by the surgery he had in high school in 1994, it is certainly reasonable to conclude that he simply did not recall this incident. (RX12) Additionally, the Arbitrator had the opportunity to view Petitioner for the better part of an hour and found him to be credible, honest, and forthcoming.

The record is clear that Petitioner's condition of ill-being in his left shoulder is causally related to the accident, as both Dr. Mall and Dr. Nogalski believed that Petitioner's shoulder condition and the requisite surgery was related to the assault. (PX15; RX2) However, Dr. Nogalski opined that there were no objective findings of injury in Petitioner's right knee and stated his belief that Petitioner's right knee complaints were solely the result of his preexisting osteoarthritic condition. (RX2) The Arbitrator does not find his opinion supported by the evidence.

While it is clear that Petitioner suffered from end-stage arthritis, he was able to work full duty prior to this attack and had not, as acknowledged by Dr. Nogalski, had any problems with his right knee for many years. (RX4, p.36-37). He also opined that Petitioner could have returned to baseline with conservative care, but admitted on cross-examination that Petitioner had already received conservative care that did little for his symptoms and had absolutely no documentation that Petitioner's complaints ever resolved despite operative intervention. *Id.* at 46-47. The Arbitrator therefore gives deference to the opinion of Dr. Mall. Dr. Mall placed permanent restrictions on Petitioner's right knee of no sprinting, kneeling, or repetitive steps. (PX5, 7/30/19, 1/28/20) Dr. Mall noted that Petitioner had no complaints up to the assault and has had persistent complaints following same due to permanent aggravation of his underlying condition. (PX15, p.19-21, 25, 37) The Arbitrator therefore finds Petitioner met his burden of proof on the issue of causal connection with respect to his right knee.

Petitioner also suffers from anxiety, depression, and PTSD following the work assault. Dr. Sky opined that these diagnoses were causally related to Petitioner's work assault, and the Arbitrator finds his opinion credible based on the histories and findings noted in the records of Dr. Habib and Ms. Budslick. The records consistently reflect that Petitioner's past anxiety had been purely situational rather than long standing, and Petitioner had not required any therapy or medication for some time prior to the inmate assault. Following the work-related assault in January of 2018, however, Petitioner has suffered from persistent anxiety, depression with anhedonia, avoidance behaviors, and lack of sleep, and required continuous psychiatric care and counseling. (PX8; PX11; PX14) Dr. Sky stated that Petitioner's current mental state did not permit him to return to work as a Correctional Officer. (PX16, p.31) The Arbitrator finds his opinion credible and consistent with the evidence.

The Arbitrator gives less weight to the opinion of Dr. Hartman, a psychologist who did not have the records from Dr. Habib or Ms. Budslick available for his review. (RX6). The Arbitrator also notes that he was only "two-thirds of the way to the requirement for prescribing in the State of Illinois." (RX7, p.7-9) Nevertheless, even he admitted that Petitioner's work assault played a role in his mental condition of ill-being, as he listed the work assault as the first of three factors to which he related Petitioner's symptoms in his first report. (RX6) He also testified on cross-examination during his deposition that the Quetiapine Petitioner was taking was, in his belief, likely related to a sleeping problem he was having as a result of the assault. (RX7, p.29) The Arbitrator does not find him qualified to opine as to the reasonableness and necessity of any prescribed psychiatric medication, as he does not have the requisite qualifications to prescribe medicine within the State of Illinois.

In his second report and in his deposition, Dr. Hartman stated that Petitioner did not suffer from PTSD, but suffered from "adjustment disorder" and "alcohol dependence," even though Petitioner had suffered from his symptoms beyond six (6) months and ceased abusing

alcohol for two decades. (RX6; RX7, p.21-24) Dr. Hartman admitted during his deposition that Petitioner had not received any psychological treatment prior to the workplace assault. *Id.* at 20. Dr. Hartman also believed Petitioner was exaggerating his symptoms, but the Arbitrator does not find this opinion persuasive given 1) his incomplete clinical picture of Petitioner without access to Petitioner's psychological treatment records, 2) his own admission that "features of malingering . . . did not predomina[te] in [Petitioner's] evaluation," and Dr. Sky's adamant disagreement with Dr. Hartmant's assessment. Given that Dr. Sky actually possessed records from Dr. Habib and Ms. Budslick, and Dr. Sky is a licensed clinical psychiatrist whose qualifications are superior to those of a forensic psychologist such as Dr. Hartman, the Arbitrator gives more weight to Dr. Sky's opinion that Petitioner suffers from work-related PTSD.

Based upon the foregoing, the Arbitrator finds that Petitioner met his burden of proof in establishing that his alleged condition of ill-being as a whole is causally related to his undisputed work accident.

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 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001). Additionally, the Act requires Respondent to pay for "instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). A claimant is entitled to vocational rehabilitation benefits when there has been a reduction in earning capacity and where there is evidence that rehabilitation will increase his earning capacity. *Nat'l Tea Co. v. Indus. Comm'n*, 97 Ill. 2d 424, 454 N.E.2d 672 (1983).

Based upon the above findings as to causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits. The record also demonstrates that Petitioner is entitled to vocational rehabilitation benefits. Due to both his knee and his mental status, Petitioner is unable to return to work as a Correctional Officer. Petitioner has been working with a vocational rehabilitation specialist and made a good faith effort to progress despite the ongoing pandemic impeding his effort. Dr. Sky also indicated that Petitioner would require maintenance care from Dr. Habib and Ms. Budslick to preserve "his current level of functioning." (PX14)

Respondent shall therefore pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, pursuant to the medical fee schedule or a PPO agreement (whichever is less) as provided in § 8(a) and § 8.2 of the Act.

Respondent shall be given credit for medical benefits that have been paid through its group carrier, 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.

Respondent shall also pay expenses for Petitioner's vocational rehabilitation program as recommended by Mr. Kaver.

Issue (L): What temporary benefits are in dispute? (State TPD, Maintenance, or TTD)

The record demonstrates that Petitioner has been unable to return to work as a Correctional Officer since the time of the injury. Dr. Sky opined that Petitioner reached maximum medical improvement with respect to his mental condition of ill-being on May 30, 2020. (PX14) Consequently, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from January 25, 2018, through May 30, 2020. Petitioner is entitled to ongoing maintenance benefits for his vocational rehabilitation plan beginning May 31, 2020. Respondent shall have credit for any benefits paid.

Issue (N): Is Respondent due any credit?

Respondent is entitled to the aforementioned credit for benefits paid towards the Arbitrator's award of temporary total disability and maintenance benefits. With regard to credit for the settlement contract, this case came to Arbitration on Petitioner's Petition under Sections 19(b) and 8(a), and Petitioner is receiving temporary benefits in the form of maintenance during his vocational rehabilitation. (PX19) As a result, the Arbitrator holds the issue of credit in abeyance until such time the final hearing is held. *See Freeman United Coal Min. Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 180, 741 N.E.2d 1144, 1152 (2000) (holding that TTD and maintenance are distinct benefits and that there may be instances where TTD benefits cease but maintenance benefits for vocational rehabilitation continue).

Issue (O): Other: Choice of Physicians:

Respondent objects to Dr. Sky's report based upon its belief that Petitioner has exceeded his choice of physicians. (T. 66, 67) However, the record is clear that Dr. Sky was a Section 12 examining physician. *Id.* The Act states, "An employee entitled to receive disability payments shall be required, if requested by the employer, to submit himself, at the expense of the employer, for examination to a duly qualified medical practitioner or surgeon selected by the employer, at any time and place reasonably convenient for the employee, either within or without the State of Illinois, for the purpose of determining the nature, extent and probable duration of the injury received by the employee, and for the purpose of ascertaining the amount of

compensation which may be due the employee from time to time for disability according to the provisions of this Act. (820 ILCS 305/12)

Petitioner is not seeking for any bills to be paid in connection with Dr. Sky's Section 12 examination. *Id.* Respondent's objection is therefore overruled, and the Arbitrator concludes that there is no choice of physician issue.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC019633
Case Name	MILLER, PHILIP v. WESTSIDE TRANSPORT
Consolidated Cases	17WC035761 19WC029339
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0347
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Joseph J. Leonard
Respondent Attorney	Brad Antonacci

DATE FILED: 7/7/2021

/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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Philip Miller,

Petitioner,

vs. No. 16 WC 19633

Westside Transport,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by Respondent Cedar Rapids Steel Transport (CRST) in consolidated cases Nos. 17 WC 35761 and 19 WC 29339, also referencing the instant case,[1] and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner's application for adjustment of claim in the instant case No. 16 WC 19633 alleges that on June 9, 2016, Petitioner injured his left knee while pulling a pin. Petitioner's application for adjustment of claim in case No. 17 WC 35761, brought against CRST, alleges that on November 13, 2017, Petitioner injured his left knee while stepping into a truck. Petitioner's application for adjustment of claim in case No. 19 WC 29339, brought against CRST, alleges that on October 1, 2019, Petitioner again injured his left knee at work. The three claims were consolidated and tried pursuant to section 19(b) on January 24, 2020. On June 23, 2020, the Arbitrator filed three decisions (one in each case), following which CRST and Petitioner filed cross-petitions for review. The main issue on review is which employer is liable for Petitioner's prospective medical care.

[1] The three cases are intertwined and have been properly consolidated. However, the Commission is presently unable to issue consolidated decisions.

Petitioner, a semi truck driver, testified on direct examination that he began working for Westside Transport on or about June 2, 2016, after passing a DOT physical. A medical certificate in evidence confirms Petitioner passed a DOT physical on June 2, 2016. On June 9, 2016, Petitioner sustained a work accident (case No. 16 WC 19633). Petitioner testified that after picking up a load in Chicago, he had to slide the tandems forward, which involved crouching and pulling a lever on the underside of the trailer. Petitioner described the accident as follows: "I gave [the lever] a good hard yank, and *** my feet are planted in place, but I twisted this left knee and I heard a pop and *** I felt like *** a jolt of pain in my knee, and I fell to the ground except *** my hands were able to catch my fall." Thinking it was just a sprain, Petitioner drove to Cedar Rapids. By the time he got there, the pain was intense. Petitioner denied prior problems with the left knee.

Petitioner's wife picked him up, and they went to Mercy Medical Center in Cedar Rapids, where Petitioner received emergency care. On June 16, 2016, Petitioner followed up with his family doctor, Dr. Lovell, who ordered an MRI. After the MRI, Petitioner came under the care of Dr. Li, who recommended surgery. At the request of Westside Transport, Petitioner was examined by Dr. Watson on August 22, 2016. Following the section 12 exam, the surgery was approved.

On September 14, 2016, Petitioner underwent the surgery. Petitioner's postoperative treatment included a Supartz injection, physical therapy and work conditioning. On February 9, 2017, Petitioner complained to Dr. Li of significant discomfort in the left knee with standing more than ten minutes or walking more than 50 yards. Dr. Li prescribed medication and discussed a knee replacement surgery. Petitioner opted against the knee replacement, and Dr. Li released him to return to work full duty.

Petitioner returned to work as a truck driver for Westside Transport for approximately four and a half months. His left knee felt better than before the surgery in September of 2016, but nowhere near how it was before the accident. Petitioner rated his pain at rest a 2/10 and with activity a 6-9/10.

In May of 2017, Petitioner went to work for CRST because that job was closer to home, paid more, and was less physically demanding. Petitioner explained that he was an in-house driving instructor, paired with a new driver. The new driver performed the physical duties, while Petitioner evaluated him.

On November 13, 2017, while working for CRST, Petitioner sustained another injury to the left knee (case No. 17 WC 35761). Petitioner explained that he injured his left knee while climbing into the cab of the truck. "[W]hile I'm pivoting, my foot didn't move but my knee did, and much like that day in June 2016, I felt my knee *** like, shear." The pain in the left knee increased after the accident.

On November 15, 2017, Petitioner returned to Dr. Li, who ordered an MRI. After the MRI, Dr. Li prescribed physical therapy and discussed arthroscopic surgery vs. injections. Petitioner had an injection. On December 13, 2017, Dr. Li recommended arthroscopic surgery. At the request of CRST, Petitioner was examined by Dr. Alpert on January 9, 2018. After the examination, the arthroscopy was denied and the temporary disability payments stopped. On January 25, 2018, Petitioner asked Dr. Li to release him to return to work full duty.

At the end of January of 2018, Petitioner returned to work for CRST. Petitioner described his left knee condition at the time as follows: "Sitting at rest with the weight off my knee either on a chair

or a seat *** or driver's seat at rest, the pain would be three to a three and a half, four. On some days it would even be more than that. It would be five or six. ¶ Getting up, moving around doing my duties getting out, walking in the building to get the paperwork, coming back out of the building to get the trailer undocked, shutting the doors, and then having to go fuel, the pain would be eight to nine and some days even a ten." The pain "increased on a permanent basis," compared to before the accident on November 13, 2017. "[I]t was a new baseline." CRST placed Petitioner into a less physically demanding job driving shorter routes. Petitioner continued to follow up with Dr. Li, who recommended arthroscopy vs. viscosupplementation. Neither was approved. The pain "remained consistent with the new baseline." Petitioner did not see Dr. Li after July 30, 2018, until the next accident.

On October 2, 2019, while working for CRST, Petitioner again injured his left knee—this time while getting out of the truck (case No. 19 WC 29339). Petitioner explained: "[I]t just happened to be a spot where two concrete pads, the expansion joint in between the two concrete pads, there was a gap and it's kind of like it's worn or chipped away, kind of like a little pothole *** literally a pothole there. *** [M]y [left] foot toe went in there and caught or grabbed the hole. *** When I went to step down altogether to be on the floor, *** my foot stayed in place but this knee (indicating) started to rotate, and I got unbalanced, literally got unbalanced, and I'm trying to get back, and I went to go grab the grip with my right hand, and I couldn't reach it in time, and I just went down." After Petitioner fell, the pain in the knee was a 10/10.

Petitioner underwent another MRI and followed up with Dr. Li, who recommended physical therapy and injections. Petitioner underwent a series of Supartz injections in October and November of 2019. At the request of CRST, Dr. Alpert reexamined Petitioner on November 1, 2019. On December 6, 2019, Petitioner reported to Dr. Li no significant improvement from the injections. Dr. Li recommended a total knee replacement and referred Petitioner to Dr. Mulvey. Petitioner believed the total knee replacement was the same procedure he had discussed with Dr. Li in January of 2017. As of the time of the arbitration hearing, the knee replacement had not been approved and Petitioner had not seen Dr. Mulvey. Dr. Li has not released Petitioner to return to work. Petitioner described the pain in his left knee as follows: "Here at rest with my weight off my knee, three, three and a half. Getting up, just going across the street from the parking deck to here, up the elevator and here, eight." The pain has increased since the last baseline. Petitioner has difficulty performing activities of daily living and relies on his wife. He would like to proceed with the knee replacement surgery.

On cross-examination by Westside Transport, Petitioner acknowledged that after returning to work following the arthroscopic surgery, he "was able to *** perform the duties very well, but not without pain. *** [T]he pain was tolerable." Petitioner worked regular duty and did not miss any time from work because of knee problems. In late May of 2017, Petitioner passed a DOT physical to go to work for CRST. Petitioner agreed that his pain progressively worsened after the second and third accidents. The first time Dr. Li referred Petitioner to Dr. Mulvey was after the accident on October 2, 2019.

On cross-examination by CRST, Petitioner testified that he understood from Dr. Li he would continue to have pain and limitations with the left knee as a result of the injury in June of 2016 and would eventually need a knee replacement. Petitioner rated his pain a 6-9/10 with activity when he returned to work for Westside Transport in February of 2017. He rated his pain 7-8/10 with activity when he returned to work for CRST in January of 2018.

The medical records in evidence show that on June 10, 2016, Petitioner presented at Mercy Medical Center with left knee pain, giving a history consistent with his testimony. Physical examination was notable for a decreased range of motion and tenderness. X-rays showed: "Moderate tricompartmental left knee degenerative change/osteoarthritis. Chronic medial collateral ligament dystrophic calcification near the tibial insertion. No evidence to suggest an acute injury." Petitioner was given a knee immobilizer and crutches. On June 16, 2016, Petitioner followed up with Dr. Lovell, who ordered an MRI.

On June 30, 2016, Petitioner consulted Dr. Li, who suspected a meniscal or chondral injury and also ordered an MRI. The MRI was interpreted by the radiologist as showing: "1. Multifocal fraying/tear of the body and posterior horn on the medial meniscus. 2. Small oblique tear of the anterior horn on the lateral meniscus reaching the inferior articular surface. 3. Grade 2 MCL sprain. 4. Tricompartmental degenerative joint disease, most notably in the medial compartment. 5. Small joint effusion with several intra-articular bodies." On July 5, 2016, Dr. Li recommended surgery and provided the following causation opinion: "[A]lthough [the patient] had pre-existing Osteoarthritis in his Left knee the injury suffered on 6/9/16 caused a Medial and lateral meniscus tears and also the loose bodies seen on the MRI. The need for surgery is a directly related cause to the 6/9/16 injury."

On September 14, 2016, Dr. Li performed: "1. Left knee arthroscopy with partial medial and lateral meniscectomy. 2. Abrasion chondroplasty medial femoral condyle, patella and femoral trochlea." Postoperatively, Petitioner underwent physical therapy and a Supartz injection on October 20, 2016. On December 9, 2016, Dr. Li noted: "The Supartz injection has worked well and he feels much better. He has completed his FCE and it shows that he has done relatively well and three weeks for work conditioning is recommended." On January 6, 2017, Dr. Li noted: "He has had his work conditioning and FCE and he has passed." Dr. Li released Petitioner to return to work full duty.

On February 9, 2017, Dr. Li noted: "He is able to drive and get into his truck without any significant discomfort. He does have significant discomfort with prolonged standing or walking. If he walks 50 yards or more he has discomfort. If he stands more than 10 minutes there is discomfort." Dr. Li assessed "residual pain from Osteoarthritis permanently aggravated by his work injury," further stating: "I explained to the patient that he will have permanent aggravation of his Osteoarthritis and he will need symptomatic treatment in the form of medications, injections, viscosupplementation, and possibly a knee replacement as a result of this in the future." Dr. Li declared Petitioner at maximum medical improvement and prescribed medication.

Petitioner returned on November 15, 2017, after the second work accident. "He reports he was doing well until this incident at work." An MRI performed November 17, 2017, was interpreted by the radiologist as follows: "1. Tricompartmental degenerative joint disease, most notably in the medial and patellofemoral compartments, slightly progressed since the prior exam. 2. Suspected recurrent tear of the medial meniscus." Dr. Li prescribed physical therapy. On December 13, 2017, Dr. Li noted: "Patient's Left knee continues to hurt with any standing over 15 minutes. He develops significant swelling and he cannot be as mobile as he was before. He is still using one crutch to ambulate. Patient's pain is aggravated by activities of daily living and limits lifestyle desired. Pain also interferes with sleep and wakes the patient up." Dr. Li recommended arthroscopic surgery.

On January 25, 2018, Dr. Li noted: "His IME states he needs to return to work full duty and his work comp payments have been cut off so he is here to discuss returning to work. His symptoms remain the same. Continues to have pain however cannot afford to remain off work." Dr. Li prescribed medication, allowed Petitioner to return to work, and advised him to call if the symptoms worsened. On February 26, 2018, Dr. Li noted: "He continues to have pain in his Left knee with prolonged standing and walking but he can tolerate driving." Dr. Li kept Petitioner on full duty. On April 20, 2018, Dr. Li noted: "He continues to have significant pain at the end of each week. Early in the week he can tolerate the pain but as he works more the pain gets intolerable." Dr. Li recommended viscosupplementation or arthroscopic surgery. On July 30, 2018, Dr. Li noted: "Continues to have pain over the anterior and medial aspect of his knee. He reports it has been catching on him." Dr. Li performed an injection into the knee.

On October 3, 2019, Petitioner returned after the third accident. Dr. Li noted: "[T]his is clearly a new injury. He cannot currently bear any weight on his Left knee." Dr. Li injected the knee. An MRI performed October 3, 2019, was interpreted by the radiologist as follows: "1. Findings raise the possibility of a recurrent medial meniscal tear, including a suspected horizontal tear of the anterior horn. 2. Degenerative joint disease, moderate to severe in the medial compartment." On October 4, 2019, Dr. Li stated: "There is a significant component of aggravation of his underlying osteoarthritis." Dr. Li recommended physical therapy. On October 21, 2019, Petitioner reported moderate improvement from the injection; however, he was unable to walk any significant distance. Dr. Li stated: "I believe the Osteoarthritis aggravation is the main source of his pain and I recommend supartz injections for that." Dr. Li performed a series of five Supartz injections from October 22 through November 19, 2019.

On December 6, 2019, Dr. Li noted: "[H]e feels that the injections have not helped him significantly and at this point his pain is beyond what he can tolerate." Dr. Li concluded: "Patient has failed non operative treatment. I will refer him to Dr. Mulvey for a total knee replacement."

Dr. Li testified by evidence deposition on October 29, 2018. Dr. Li provided the following causation opinions: "[E]ven though [the patient] didn't have any symptoms before his [first] accident, he had osteoarthritis. The accident didn't cause all of his osteoarthritis. But the accident did accelerate it beyond its normal progression. So accelerated by causing further fragmentation of the articular cartilage that needed to be addressed." But for the first accident, Petitioner might not have needed a knee replacement. "He might have been able to be treated conservatively for the rest of his life." In February of 2017, Petitioner was at maximum medical improvement and returned to work within his new baseline. Petitioner continued to work until the second accident, which caused new acute findings. The treatment Dr. Li provided after the second accident was necessitated by the new injury. The second accident caused a material aggravation of the left knee condition. In January of 2018, Dr. Li released Petitioner to return to work because his benefits were cut off. However, Petitioner needed further treatment. "[H]e was still worse than at the time I discharged him in February of 2017." After Petitioner returned to work, his condition was "going downhill."

As of the time of the deposition, Dr. Li proposed the following treatment: "I would probably get some updated X-rays and talk to him about all the options going from the most conservative, which would be visco supplementation, arthroscopy, all the way up to a total knee." The total knee replacement "would be a possibility. I think it's been a possibility all along." Dr. Li agreed the first accident permanently aggravated the preexisting osteoarthritis, and the second accident materially

aggravated that permanent aggravation. Dr. Li further opined: "It's my opinion that [CRST] and accident two would be the one that would be responsible for any further treatment *** including a total knee. The reason being [the patient] was definitely on a certain course of progression towards worsening osteoarthritis going to a total knee. I think that accident two increased the—or shortened the time distance to that and also most likely accelerated the progression so that it would come up sooner than if the accident two never happened." As of July of 2018, Petitioner was not at maximum medical improvement from the second accident.

On cross-examination, Dr. Li testified that in February of 2017, Petitioner was not a candidate for a total knee replacement. He became a candidate for a total knee replacement after the second accident. Dr. Li agreed that he discussed a total knee replacement in February of 2017. Dr. Li reiterated: "[I]t's my opinion that the second accident exacerbated and accelerated the need for a total knee. So any total knee in the future would still be related to the second accident because I think the second accident broke the chain of causation for the first." Dr. Li ultimately agreed the need for a total knee replacement started with the first accident.

Dr. Alpert, an orthopedic surgeon, testified by evidence deposition on March 8, 2019. Dr. Alpert began by testifying that on January 9, 2018, he examined Petitioner at the request of CRST. Petitioner and Westside Transport immediately interposed a *Ghere* objection to the opinions expressed in the addendum report, which was not timely provided to them. Petitioner subsequently withdrew his *Ghere* objection, while Westside Transport continued to object throughout the deposition.

Dr. Alpert affirmed that all of his opinions that took into account the first accident were expressed in the addendum report.[2] Dr. Alpert diagnosed a "left knee endstage osteoarthritis with degenerative meniscus tear in a patient who is six foot three and 355 pounds." Dr. Alpert initially "didn't believe that any kind of work-related injury caused or had anything to do with the condition as it relates to his left knee." Dr. Alpert opined the left knee condition was "pre-existing and degenerative," noting the imaging studies did not show any acute injury. Dr. Alpert therefore "didn't believe [Petitioner] needed any further care and treatment as related to the November 13, 2017 incident." Relative to the underlying condition, Dr. Alpert recommended conservative treatment and, if it failed, a knee replacement.

Dr. Alpert agreed that the first accident aggravated Petitioner's underlying degenerative arthritis. Dr. Alpert continued: "[I]t seems that all of the symptoms as it relates to this where he sought and needed medical treatment started from that first injury in June 9th of 2016. ¶ He was treated with some conservative measures including a knee arthroscopy, and from my perspective, the work injury on June 9th, 2016 sort of started him on this path of needing care and treatment as it relates to his left knee." Dr. Alpert believed the arthroscopy performed by Dr. Li was inappropriate. "Certainly a knee arthroscopy for this generally does not help which is what happened to [Petitioner] as an arthroscopy doesn't help arthritis." Based on the chain of events, Dr. Alpert related "any care and treatment" to the first accident.

[2]Dr. Alpert initially understood that Petitioner claimed a work accident on November 13, 2017, and had a "pre-existing condition with his left knee related to left knee injury that occurred in June 2016, which he reports was a torn meniscus."

On cross-examination, Dr. Alpert admitted that he never reviewed the medical records from Dr. Li from June of 2016 to January of 2017 or obtained a history from Petitioner of the first work accident. Dr. Alpert attributed Petitioner's ongoing left knee problems to the first accident and the *sequelae* of the arthroscopic surgery. Regarding the second accident, Dr. Alpert opined it was a mere manifestation of the advancement of the arthritic process. In terms of treatment, Dr. Alpert recommended conservative measures and, if they failed, a knee replacement.

Dr. Alpert's post-deposition addendum report, dated November 1, 2019, was admitted into evidence without objection. In the report, Dr. Alpert opined the third accident caused "a left knee strain that aggravated previously symptomatic knee arthritis." Dr. Alpert opined the aggravation would be temporary, requiring a three-month course of conservative treatment. "Any care and treatment after that three-month period would be [due] to the degenerative condition of his knee and not from any acute injury."

Dr. Herrin, an orthopedic surgeon who examined Petitioner at the request of Westside Transport, testified by evidence deposition on May 2, 2019. Dr. Herrin examined Petitioner on January 10, 2019, before the third accident. Regarding the first accident, Dr. Herrin opined: "[H]e may have aggravated some of the preexisting arthritis in the knee. And potentially could have injured the meniscus." Regarding the second accident, Dr. Herrin opined: "Again, he may have aggravated some degenerative changes within the knee at that time. I don't believe this MRI scan revealed any additional meniscal pathology that I can see. So that would be potentially aggravation of some arthritis in the knee." At the time of the examination, Petitioner "had severe degenerative arthritis of his knee and his exam was consistent with that. I didn't think it was significantly related to the accident at that point. * * * Based on progression of his osteoarthritis of his knee, which would be the natural history." Dr. Herrin did not believe the first accident caused or aggravated the preexisting arthritis in the left knee to the point Petitioner would require a total knee replacement. Rather, Dr. Herrin opined, based on the clinical and diagnostic findings in June of 2016, that Petitioner was already a candidate for a total knee replacement before the first accident. Dr. Herrin did not think the first accident "resulted in a permanent aggravation [of the underlying condition]. Temporary would be what my opinion would be." Dr. Herrin acknowledged that he was unaware of Petitioner having any symptoms or treatment for a left knee condition before the first accident. Dr. Herrin considered the surgery performed by Dr. Li on September 14, 2016, to be inappropriate and potentially harmful.

Following a section 19(b) hearing, the Arbitrator filed three decisions on June 23, 2020. In the instant case No. 16 WC 19633, the Arbitrator found "in favor of [Westside Transport] as to the disputed issues of causal connection related to current condition of ill being, with credit given to [Westside Transport] for any bills paid. ¶ [Westside Transport] is not liable to pay for any left total knee replacement surgery or approve the referral to Dr. Mulvey pursuant to section 8.2 of the Act and in accordance with the fee schedule."

In case No. 17 WC 35761, the Arbitrator found "in favor of Petitioner as to the disputed issues of causal connection, liability for unpaid medical bills-listed in PX 16 with credit given to [CRST] for any bills paid, and prospective medical. ¶ The Arbitrator awards Petitioner unpaid medical bills of Dr. Li pursuant to section 8.2 of the Act for service dates of 11/13/17 thru 7/30/18 as defined in PX16 with [CRST] to be given a credit for any bills paid as listed on RX4 and in accordance with the fee schedule as against Respondent CRST. ¶ [CRST] to approve and pay for left total knee replacement surgery and

related costs as recommended by Dr. Li and approve the referral to Dr. Mulvey pursuant to section 8.2 of the Act and in accordance with the fee schedule."

In case No. 19 WC 29339, the Arbitrator "denies that Petitioner's current condition of ill being is causally related to the accident of October 2, 2019, but finds a closed period of causal connection from 10/2/19 thru January 1, 2019, as per CRST IME physician Dr. Alpert (CRST EX#3) who provided a period of causation for three months after the October 2, 2019 accident. ¶ The Arbitrator finds in favor of Petitioner on the disputed issue of liability for unpaid medical bills-incurred from October 2, 2019 thru January 1, 2020 as that being the period of causation found by the Arbitrator for the accident date of 10/2/2019; and further awards Petitioner the bills listed in PX18 pursuant to section 8.2 with credit given to Respondent CRST for any bills paid as referenced on Arb EX. 6 and on CRST RX11. ¶ The Arbitrator denies liability as against CRST for the requested left total knee replacement for the accident date of 10/02/2019. ¶ The Arbitrator denies further TTD to Petitioner beyond 1/1/2020 as the condition of ill-being, that being a left knee replacement, is causally related to the accident of 11/13/2017." In the "Conclusions of Law," the Arbitrator awarded TTD "from the period 10/3/2019 thru 1/1/2020, a period of 13 weeks, that being the period of causal connection."

On review, CRST argues: "Petitioner's current condition of ill-being is causally related to the June 9, 2016, incident and *** therefore, Respondent, Westside Transport, is responsible for all medical treatment related to the 2016 incident including Petitioner's total left knee replacement and referral to Dr. Mulvey. * * * Petitioner's current condition of ill-being is unrelated to the November 13, 2017, and October 2, 2019, incidents and *** Cedar Rapids Steel Transport has paid for all medical care associated with said incidents and is not liable for any additional benefits or medical treatment requested by Petitioner." In sum, CRST argues "the 2016 incident permanently aggravated Petitioner's preexisting osteoarthritis; therefore, Respondent, Westside, should be held liable for any prospective care." CRST considers the accidents on November 13, 2017 and October 2, 2019 to have caused only "a [temporary] manifestation of [the] preexisting osteoarthritis" or a "sprain."

Petitioner filed a protective review. In his brief, Petitioner states: "[T]he Arbitrator could have found a causal relationship between the 1st accident that occurred on June 9, 2016 while in the employment of Westside Transportation, and the need for left knee arthroplasty. Arbitrator Kay could have awarded petitioner the left TKA as against respondent Westside Transportation rather than respondent CRST. However the petitioner takes no exception to the decision as it stands against CRST as written. Clearly either respondent Westside Transportation or respondent CRST is responsible for petitioner's left TKA. To state that neither is responsible would be against the preponderance of the overwhelming evidence. ¶ *** [P]etitioner takes no exceptions to the Arbitrator's orders and finding of fact and conclusions of law as to liability for unpaid medical bills awarded against Westside Transportation and CRST."

Westside Transport asks the Commission to affirm and adopt the Arbitrator's Decisions. As a protective argument, Westside Transport renews its *Ghere* objections.[3]

The Commission agrees with CRST that the first accident on June 9, 2016, set in motion a chain of events that ultimately resulted in Petitioner's need for a knee replacement. As a preliminary matter, the Commission sustains Westside Transport's *Ghere* objections to the causation opinions of Dr. Alpert.

[3]The Arbitrator relied on certain opinions of Dr. Alpert.

Rather, the Commission relies on the opinion of Dr. Li that the first accident accelerated Petitioner's underlying degenerative condition beyond its normal progression by causing further fragmentation of the articular cartilage; but for the first accident, Petitioner might not have needed a knee replacement and might have been able to be treated conservatively for the rest of his life. Dr. Li ultimately affirmed that the need for a total knee replacement started with the first accident. To the extent Dr. Li then ventured into the purely legal realm by placing legal liability for the knee replacement on the second accident and CRST, the Commission rejects that part of his opinion as outside the area of his professional expertise.

The Commission finds the Arbitrator properly relied on Dr. Alpert's third (unobjected to) report to the extent Dr. Alpert opined that Petitioner would reach maximum medical improvement after the third accident by January 1, 2020.

Accordingly, the Commission modifies the Arbitrator's Decision with respect to the benefits due to Petitioner after January 1, 2020. The Commission places the liability for those benefits on Respondent Westside Transport.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Westside Transport shall pay to Petitioner the sum of $449.37 per week for a period of 3 2/7 weeks, from January 2, 2020 through the date of the arbitration hearing on January 24, 2020, that being the period of temporary total incapacity for work under §8(b). 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 compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Westside Transport shall provide, pursuant to §§8(a) and 8.2 of the Act, prospective medical care consisting of a left total knee replacement and incidental care.

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 Westside Transport pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Westside Transport 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 Westside Transport 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.

July 7, 2021

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

SJM/sk
o-4/20/2021
44

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

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

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

MILLER, PHILIP
Employee/Petitioner

Case# **16WC019633**

17WC035761
19WC029339

WESTSIDE TRANSPORT
Employer/Respondent

On 6/23/2020, 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 0.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0926 LEONARD LAW GROUP LLC
JOE LEONARD
325 S PAULINA ST SUITE 100
CHICAGO, IL 60612

0532 HOLECEK & ASSOCIATES
KENNETH SMITH
161 N CLARK ST SUITE 800
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
19(b)

Phillip Miller
Employee/Petitioner

v.

Westside Transport
Employer/Respondent

Case # **16** WC **19633**

Consolidated cases: **17 WC 35761 and 19 WC 29339**

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 **Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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 _____

FINDINGS

On the date of accident, **June 9, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$35,051.12**; the average weekly wage was $**674.06**.

On the date of accident, Petitioner was **56** 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 $**17,386.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**31,534.31 for 8.2 medical paid to date** for other benefits, for a total credit of $**48,920.41**.

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

ORDER

SEE THE ATTACHED DECISION OF THE ARBITRATOR FOR FINDINGS OF FACT AND CONCLUSIONS OF LAW AS TO CAUSAL CONNECTION, LIABILITY FOR MEDICAL BILLS; AND LIABILITY FOR PROSPECTIVE MEDICAL; SAID DECISION IS INCORPORATED HEREIN AS IF FULLY SET FORTH HEREIN;

THE ARBITRATOR FINDS IN FAVOR OF RESPONDENT AS TO THE DISPUTED ISSUES OF CAUSAL CONNECTION RELATED TO CURRENT CONDITION OF ILL BEING, WITH CREDIT GIVEN TO RESPONDENT FOR ANY BILLS PAID;

RESPONDENT IS NOT LIABLE TO PAY FOR ANY LEFT TOTAL KNEE REPLACEMENT SURGERY OR APPROVE THE REFERRAL TO DR. MULVY PURSUANT TO SECTION 8.2 OF THE ACT AND IN ACCORDANCE WITH THE FEE SCHEDULE.

PENALTIES 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

06/05/2020
Date

ICArbDec19(b)

JUN 23 2020

PROCEDURAL HISTORY

This matter is consolidated with Case #17wc35761 and #19wc29339.

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on January 24, 2020 in Chicago, Illinois. this matter involves three separate dates of accident in which the petitioner alleges injuries to his left knee while working for two respondents. These accidents occurred on June 9, 2016, November 13, 2017, and October 2, 2019. The 2016 accident occurred while he was working for Respondent Westside Transportation the 2017 and 2019 accidents occurred while he was working for Respondent CSRT.

The parties went to hearing with the following issues in dispute: whether Mr. Phillip Miller's (hereinafter "Petitioner") current condition of ill-being is casually connected to his injury and whether Westside Transport (hereinafter "Westside") is liable for the total knee replacement (hereinafter "TKA") for the left knee and any unpaid ills listed in (PX16) for dates of service from 6/9/16 through 3/9/17 less any 8j credit due Respondent. (Arb.X1)

The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that he was hired by Westside Transportation on June 2, 2016. He underwent the required DOT physical prior to his employment and was cleared to work. He denied left knee pain prior to June 2, 2016 and denied ever being prescribed a left knee MRI, physical therapy, arthroscopy, or a left total knee replacement.

He testified that he was hired as a driver of semi tractors and trailers. His duties consisted of picking up and delivering freight, getting in and out of the truck, fueling, opening the trailer doors, docking the trailer, and maintaining the logbooks per DOT regulations. He did not have a set route. He testified that he would get his assignments through satellite communication inside the tractor cab.

On June 9, 2016 he was driving his truck in Cedar Rapids, Iowa. He arrived at a designated pick up site and docked the trailer. After loading, he shut the trailer doors and pulled the trailer away from the dock. He then proceeded to slide the tandems forward to be legal weight and legal length now that he was loaded. That required that he crouch in a baseball catcher position and grab a lever under the trailer and pull it out. He testified that the lever got stuck the first time due to the added weight of the load. On the second attempt he pulled hard and in doing so he twisted his left knee, heard a pop, and felt a jolt of pain in his left knee like lightning. He was able to catch himself with his hand and did not fall to the ground.

He continued to work but as time went on, he felt intense pain in the left knee and called dispatch. He eventually stopped working and called his wife the following morning. She arrived and drove him to Mercy Medical Center.

Petitioner was examined at Mercy Medical Center and provided crutches, medications of Toradol and Relafen, and instructed to follow up with his primary doctor. He followed up by his primary physician Dr. John Lovelle (hereinafter "Dr. Lovelle") on June 16, 2016 in Tremont, Illinois. Dr. Lovelle prescribed medication and ordered an MRI of the left knee.

He underwent an MRI on June 30, 2016 at Open MRI Center in Normal, Illinois and consulted with orthopedic physician Dr. Li that same day. He testified that Dr. Li recommended surgery to his left knee. Prior

to surgery being approved, he was examined by Dr. Watson by the insurance company for Westside on Aug 22, 2016. He testified that his surgery was then approved.

Petitioner underwent surgery at Ireland Grove Center on September 14, 2016. He followed up with doctor Li on September 22nd, and again on October 20, 2016. He underwent a suparts injection on November 17, 2016 by Dr. Li. He testified he participated in physical therapy at OSF from September 21st through December 6, 2016. His physical therapy progressed into a work conditioning program in December of 2016. He had a work capacity evaluation on December 9, 2016.

Petitioner testified that he was examined by doctor Li again on January 6, 2017. Dr. Li discussed the work capacity evaluation with him. He testified that he saw Dr. Li again February 9, 2017 and at that visit he was complaining of significant discomfort with prolonged standing or walking greater than 50 yards. He told Dr. Li that standing greater than 10 minutes at a time caused discomfort. He was given a 3-month supply of Mobic and Rabeprazole. **He testified doctor Li discussed knee replacement surgery at this visit. He did not have knee replacement surgery at that time. He testified Dr. Li released him to return to full duty work after this visit.**

Petitioner testified he returned to full duty work at Westside for approximately 4 1/2 months. He testified he continued to perform the job duties of a truck driver. **He testified his left knee felt better after surgery but that it was nowhere near as close to where it was before his injury.** He testified he had pain even at rest and on a scale of one to ten he rated it at a two to a two and a half. When he was sitting with his weight off his knee, he rated his pain a six to a nine. If he had to get up and move around and do his duties such as getting out of the truck to fuel, open the trailer door, walk into a building or get paperwork, the pain scale would be anywhere from a six to nine depending upon how far he would have to walk.

Petitioner testified he stopped working for Westside because he discovered a job opportunity in Morton, Illinois. It was only 3 1/2 miles from his house and involved working a dedicated account hauling Caterpillar freight for CRST. He testified he left Westside in May 2017 because the new job at CRST offered more money and was closer to his house. The job at CRST was less physical.

He testified he was initially hired at CRST to be a driver trainer. He was an experienced driver and they assigned him to train employees who had just completed in-house driving school. He would evaluate their performance over a five-week period. He testified the trainee performed all the major and minor physical duties to get experience including fuelling, opening the doors of the trailer, docking the trailer, and going into the building to get the paperwork. He testified he had this helper over a five-month period.

He testified that on November 13, 2017, he was getting into the cab of his truck on the driver side using a 3-point stance. He put his right foot up on the first step followed by his left and that in order to get his "bottom" into the driver seat he would swing his right foot into the floorboard underneath the seat, and in doing so, pivot with his left leg. While performing this activity his left leg did not pivot on the metal step and he felt a sheering action in his left knee with pain.

He testified he was still taking Mobic and the other medication prescribed to him by Dr. Li prior to this occurrence. In describing his level of pain to his left knee on a scale of one to ten, zero being no pain and ten being intense pain he testified his pain level increased at both sitting and with movement. He rated his sitting pain a three to a three and a half and his getting up and moving around pain a nine. He reviewed photographs (PX11) and identified them as the steps he was ascending when his left knee twisted. He testified he personally took the photos on his cell phone. He testified he reported this accident to CRST and returned to Dr. Li again for treatment.

He was examined by Dr. Li on November 15, 2017. Dr. Li ordered a new MRI of his left knee and prescribed crutches. Left knee MRI was performed on November 17th at Open MRI Center. Dr. Li discussed arthroscopic surgery versus injection treatment at the follow up appointment. Petitioner testified he underwent an injection and resumed physical therapy at OSF.

He was seen by Dr. Li again December 13, 2017 at which time Dr. Li recommended left knee arthroscopy. He testified that he was examined by the workers compensation carrier for CRST on January 9, 2018 by Dr. Joshua Alpert (hereinafter "Dr. Alpert"). He testified he gave Dr. Alpert a history of his injury and surgery in 2016 and the accident at CRST on November 13, 2017. He testified that after this examination his arthroscopic surgery was denied.

Petitioner saw Dr. Li again on January 25, 2018 at which time he requested Dr. Li to release him to return to work because his TTD benefits were cut off. He testified he returned to work for CRST. He testified that upon his return, sitting at rest with weight off his knee in a chair or the driver seat that his pain would be three and a half to a four and some days it would be more than that. Getting up and moving around to do his duties like getting out of his truck and walking into buildings to get paperwork, shutting trailer doors, and when fueling, his pain would be eight to a nine and some days a ten out of ten.

When asked if the pain he was describing after his 2nd injury at CRST was the same level of pain that he was dealing with after the 2016 surgery, he testified that after November 13, 2017 that it had increased on a permanent basis. He testified it was his new baseline.

He continued to work for CRST but testified that they changed his job to a less physical position and allowed him to make shorter runs between two dedicated points from Morton, Illinois to Mount Vernon, Illinois. He testified he only had to go in with an empty trailer and do a drop and hook, do the billing, and sign the paperwork.

He did see Dr. Li in consultation on February 26, 2018 at which time Dr. Li extended his Mobic and prescribed Prilosec. He was instructed to follow up as needed. He returned to Dr. Li on April 20, 2018 and he advised Dr. Li at that time that he was in more pain. He was prescribed Rabeprazole. Dr. Li recommended arthroscopy versus visco supplementation, but neither were approved. He continued to work at CRST and his pain to his left knee continued and remained consistent with a new baseline.

He testified that he saw Dr. Li on July 30, 2018. He was in much more pain and his left knee was catching. He was provided an injection and his prescriptions of Mobic and Rabeprazole were again renewed. He testified Dr. Li again recommended surgery, but it was again denied.

He continued to work for CRST without returning for medical treatment until October 2019. **On October 2, 2019 he was exiting his tractor** on the driver side door in a 3-point stance facing the inside of the cab . When he placed his right foot on the ground where 2 concrete pads joined there was a large gap where the expansion joint was worn and chipped away like a pothole. His right foot toe went in the hole and caught and when he went to step down his foot stayed in the hole he rotated and lost his balance. He tried to reach and grab the side handle of the truck but failed to reach it and he fell.

Petitioner described his left knee pain after the fall as a ten. He notified his employer immediately. He again consulted with Dr. Li who sent him for another MRI to his left knee on October 3, 2019. He was examined by Dr. Li on October 4, 2019 and he recommended physical therapy and injections. He told Dr. Li on October 21, 2019 that he was having difficulty walking although he noted moderate improvement with the injection. Dr. Li recommended supartz injections. Petitioner had the first of five supartz injections on October 22, 2019 and the last one on November 19, 2019.

Petitioner saw Dr. Li on December 6, 2019 after the last injection. He advised him that he did not get any significant improvement from the injections. He told Dr. Li he could not tolerate the pain anymore. He testified Dr. Li referred him to Dr. Mulvey for a left knee arthroplasty. He testified that left knee arthroplasty had not been approved as of the date of arbitration. He testified Dr. Li has not released him from his care and that he still has him off work. He has not seen Dr. Mulvey yet and has not received any approval to do so from the CRST workers compensation carrier.

He testified he saw doctor Joshua Alpert (hereinafter "Dr. Alpert") again at the request of CRST on November 1, 2019. He told Dr. Alpert again about the accident in 2016 at Westside, the second accident in 2017 at CRST, and about this new accident at CRST that occurred on October 2, 2019. At the time of arbitration he was waiting for authorization for left total knee replacement.

When asked about his baseline on a scale of one to ten zero being no pain and ten being excruciating pain, he testified at rest with his weight off his knee it's a three to a three and a half, and getting up, just going across the street from the parking deck to the courthouse up the elevator his pain was an eight. When asked about his baseline he testified there is yet another new baseline following the October 2, 2019 accident and that his left knee pain has increased.

He testified he lives with his wife and that he is unable to do most daily activities and that his wife does a vast majority of them. He testified he is waiting and hoping that his left knee replacement is awarded to him and if it were he would consult with Dr. Mulvey immediately and do everything in his power to get back to gainful employment after surgery.

On cross examination by Westside Transportation's attorney, Petitioner admitted the only surgery performed by Dr. Li was arthroscopy and that as of January 2017, Dr. Li had told him he can return to work full duty. Petitioner admitted that Dr. Li released him to maximum medical improvement on February 9, 2017 from the June 3, 2016 accident. He testified he was able to perform the duties at Westside Transportation very well but not without pain. He testified the pain was tolerable and that he did not miss any time off work because of left knee problems after he returned to work . He testified he had to pass a DOT exam in order to start working at CRST.

On cross examination by CRST's attorney, Petitioner admitted he had not undergone any treatment to his left knee prior to 2016. He admitted he had been treating with Dr. Li for his left knee since 2016. He admitted that after the arthroscopic surgery performed by Dr. Li that he continued to have pain in his knee and that Dr. Li injected that knee for that pain.

He admitted that when he went through work conditioning that he continued to have pain to the left knee namely with walking crouching and standing. He admitted that Dr. Li and he had discussions about his left knee condition and that the pain and limitations he was experiencing would be permanent in nature.

When provided an excerpt from doctor Li's medical records that read, *"I explained to the patient that he will have permanent aggravation of his osteoarthritis and he will need symptomatic treatment in the form of medications, injections, visco supplementation and possibly a total knee replacement as a result of this in the future,"* he did not dispute such conversation.

He admitted that Dr. Li had told him that he will be experiencing additional symptoms in the left knee in the future following the June 2016 injury that would require him to go back and see him again for future treatment. He admitted that Dr. Li gave him pain medication when he released him from his care in 2017 following the June 2016 accident.

He admitted that when he returned to work at Westside Transportation in February 2017, that his moving around pain was between a six and a nine out of ten. He attested that after the CRST work injury on November 13, 2017, that he went back to work for CRST after being off for 2 months. When asked if his left knee at any time ever felt as good as it did prior to June 2016 he replied, "absolutely not."

On being called as a witness for ***direct examination by Westside Transportation's*** attorney in their case in chief, he did admit that his pain had gotten progressively worse after the 2nd and 3rd accidents.

Neither respondent denied accidental injuries while petitioner was under their employment. Respondent Westside stipulated to accidental injuries occurring on June 9, 2016 and respondent CRST stipulated to accidental injuries to have occurred in their employ on November 13, 2017 and on October 2, 2019. However, both Westside and CRST denied causation as it related to petitioner's current need for a left total knee replacement seemingly attributing the need for same to the other.

No rebuttal witnesses were called by either respondent.

Medical Treatment

Petitioner received DOT clearance to work at Westside Transportation on June 2, 2016. PX1. Petitioner was seen at Mercy Medical Center located in Cedar Rapids Iowa on June 10, 2016. PX2 The chief complaint was that his left knee popped and swelled up yesterday while he was pulling a handle on a truck trailer.PX2 at p7 X-rays demonstrated moderate tricompartmental left knee degenerative osteoarthritis without evidence to suggest an acute injury. Id He was instructed to follow up with his primary physician if pain persisted and he was discharged. Id

Petitioner consulted his family physician Dr. John Lovell on June 16, 2016.PX4 He stated that he hurt his left knee moving a tandem slide lever as he squatted to move the lever while pushing and felt a pop in his left knee. Id. He was experiencing intense pain with weight bearing and had to have his wife pick him up in Cedar Rapids. Id He was ambulating with the crutch and using a left knee brace. Id He denied previous problems to his left knee. Dr. Lovell ordered an MRI of the left knee without contrast. Id

Petitioner was examined by Lawrence Li of Orthopedic and Shoulder Center on June 30, 2016. PX5 Dr. Li agreed that a left knee MRI was necessary. Dr. Li's diagnosis was suspected left knee acute injury consistent with medial meniscal or chondral injury.PX5 He was prescribed Mobic and Rabeprazole. PX5

The MRI of the left knee on June 30, 2016 demonstrated multi focal fraying/tear of the body and posterior horn of the medial meniscus; small oblique tear of the anterior horn of the lateral meniscus reaching the inferior articular surface ; Grade 2 MCL sprain; tricompartmental degenerative joint disease most notably in the medial compartment ; and a small joint effusion with several intra articular loose bodies .PX5 at p.8

Petitioner returned to Dr. Li on July 5, 2016. Dr. Li recommended left knee arthroscopic surgery.PX5 He stated to a reasonable degree of medical certainty that although Mr. Miller had pre-existing osteoarthritis in his left knee, the injury he suffered on June 9, 2016 caused a medial and lateral meniscal tear and also the loose bodies seen on the MRI.PX5 He stated the need for surgery was a direct result of the injury of June 9, 2016.PX5 at p. 14

Petitioner was examined at the request of the Respondent by Dr. Michael Watson of Watson Orthopedics on August 22, 2016. Dr. Watson stated that additional treatment including arthroscopic surgery was needed because of the work injury.PX5 at p.20. He also stated that Mr. Miller had pre-existing asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9, 2016.Id

Petitioner underwent left knee surgery at Ireland Grove Center on September 14th 2016.PX5 at p.22 The procedure performed was left knee arthroscopy with partial medial and lateral meniscectomy; abrasion chondroplasty medial femoral condyle, patella and femoral trochlea. PX5 at p.22-23 He was seen post operatively on September 22,2016 and again on October 20, 2016. Dr Li stated that he continued to complain of residual pain from his osteoarthritis aggravated by his work injury.PX5 at p.29 A Supartz injection was administered November 17th 2016 and worked well and petitioner felt better. PX5 at p.31

He was examined again by Dr. Li on December 9, 2016. Dr. Li commented that Petitioner had completed his FCE and it showed he had done relatively well and that 3 weeks of work conditioning were recommended. The WCA (work capacity assessment) report dated December 6, 2016 conducted at OSF Industrial Rehabilitation demonstrated limitations with climbing and low-level work. PX10 at p.2 Petitioner demonstrated difficulty with getting into and out of the low position such as kneeling or crouching to complete a task. Id

He was examined again by Dr. Li on January 6, 2017 and was instructed to return to work full duty and to follow up in 4 weeks for a final check.PX5 at pgs. 35-37 He was again examined by Dr. Li on February 9, 2017.PX5 at pgs. 38-41 He was able to drive and get into his truck without significant discomfort although he did have significant discomfort with prolonged standing and walking and if he walked 50 yards or more he had discomfort.PX5 at p.38 If he stood more than 10 minutes there was discomfort. Id Dr. Li opined that Petitioner had a permanent aggravation of his osteoarthritis and that he will need symptomatic treatment in the form of medications, injections, viscosupplementation, and possibly a knee replacement as a result of this in the future.PX5 at pgs.40-41 He was released at that time to maximum medical improvement. Id

2nd accident at CRST

Petitioner was seen again by Dr. Li on November 15, 2017. He reported a new injury to have occurred November 13, 2017.PX5 at p.43. He testified he was getting up into his semi cab and twisted his left knee. Id Dr. Li suspected meniscal tear and recommended an MRI and follow up to determine the appropriate treatment plan.PX5 at p.47 MRI testing of the left knee on November 17, 2017 demonstrated tricompartmental degenerative joint disease , most notably in the medial and patella femoral compartments, slightly progressed since the prior exam, and a suspected recurrent tear of the medial meniscus.PX5 at pgs.53-54

Petitioner was reexamined by Dr. Li on November 20, 2017 at which time Dr. Li reviewed the new MRI scan and diagnosed a new tear of the medial meniscus superimposed on underlying osteoarthritis.PX5 at p.58 Dr. Li noted relief from last week's previous injection. Id He instructed Petitioner to start physical therapy and to follow up in three weeks. Id

Petitioner was examined again on December 13, 2017 and complained that his left knee continued to hurt with any standing over 15 minutes and that he complained of significant swelling and could not be as mobile as he was before.PX5 at pgs.59-61 He was still using one crutch to ambulate. Id Dr. Li recommended left knee arthroscopic surgery. Id

Petitioner was examined again by Dr. Li on January 25, 2018. PX5 at pgs.63-64 Dr. Li noted that the IME stated that he needed to return to work full duty and that his workers compensation payments had been cut off so he was there to discuss returning to work. Id His symptoms remained the same and he continued to have pain however he could not afford to remain off work. Id He was provided prescriptions of Mobic and Prilosec and Rabeprazole. Id He was allowed to return to full duty work and advised to return if symptoms worsen.PX5 at p.65

Petitioner was seen again on February 26, 2018 with continued left knee pain with prolonged standing and walking.PX5 at pgs.66-68 He was able to tolerate driving. Id His medication was re dispensed and he was allowed to continue working full duty and instructed to follow up if his pain increased.PX5 p.68

Petitioner was seen on April 20, 2018 in follow up by Dr. Li.PX5 at pgs.69-71 His medication was continued and he was instructed to consider options of having viscosupplementation or arthroscopic knee surgery. Id He was seen again July 30th 2018. PX5 at p.72 He continued to have pain over the anterior and medial aspect of his knee. Id He reported that it had been catching on him. Id Dr Li administered an injection and advised petitioner to consider knee arthroscopy. Id

3rd accident at CRST

Petitioner returned to Dr. Li on October 3, 2019. Px6 pgs.12-16 He reported a third injury to have occurred in Morton, Illinois. Id He was getting out of his truck and as he was stepping down he put his left foot down on the damaged area of concrete causing him to twist his left ankle and twist his left knee. Id Since that time he has had constant severe pain. Id Dr. Li referenced the previous work-related injuries to his left knee back in 2016 and then again in 2017.Id He referenced that these cases were still in litigation but that this was clearly a new injury. Id Petitioner was unable to weight bear on his left knee. Id Dr. Li recommended an MRI and follow up to determine the treatment plan. Id

A left knee MRI was performed on October 3, 2019 at Open MRI Center demonstrated the possibility of a recurrent medial meniscal tear, including a suspected horizontal tear of the anterior horn, and degenerative joint disease, moderate to severe in the medial compartment.PX6 at p.17. Dr. Li evaluated Petitioner on October 4, 2019 and based on the MRI findings recommended physical therapy. Id He felt there was a significant component of aggravation of his underlying arthritis.PX6 at p.22

Petitioner was examined again on October 21, 2019.PX6 at p.23 He reported moderate improvement in his left knee pain with the injection and Mobic but he was still not near where he was before. Id He was unable to walk any significant distance. Id Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with a small medial meniscal tear.PX6 at p.25 He opined that the osteoarthritis aggravation was the main source of his pain and he recommended Supartz injections. Id Petitioner received the first of five supartz injections on October 22, 2019 and the last on November 19th 2019.PX6 at pgs.26-30. He was instructed to return to the clinic prn. Id

Petitioner returned to Dr. Li on December 6, 2019. He felt that the injections had not helped him significantly and at that point his pain was beyond what he can tolerate. PX6 at p.31-33 Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with medial meniscal tear. Id He was provided Mobic and Prilosec. Id Dr. Li felt he had failed all nonoperative treatment and referred him to doctor Mulvey for a total knee replacement. Id

Evidence deposition of Dr. Li

Dr. Lawrence Li was deposed on October 29, 2018.PX12. Dr. Li was read his office note from December 9, 2016 in which he stated that that his diagnosis was left knee arthroscopy with partial medial and lateral meniscectomy , abrasion chondroplasty, medial femoral condyle, patella and femoral trochlea with residual pain from osteoarthritis permanently aggravated by his work injury. PX12 at p.28.

He was questioned what he meant by permanently aggravated by his work injury. Id Doctor Li stated *"so even though Mr. Miller didn't have any symptoms before his accident, he had osteoarthritis. The accident didn't cause all of his osteoarthritis. But the accident did accelerate it beyond its normal progression. So accelerated by causing further fragmentation of the articular cartilage that needed to be addressed. So if we*

have a line that has a slope of let's say 10 degrees this then moved it, moved the line up the Y axis a certain amount it may have - and then made the slope let's say 12 degrees. That's just an example. That's not exact."

He was also asked about the significance of the November 13, 2017 accident. PX12 at pgs.47-48. Dr. Li testified *"it is my opinion that employer two that accident two would be responsible for any further treatment , you know, including a total knee. The reason being Mr. Miller was on a certain course of progression towards worsening osteoarthritis going to a total knee. I think that accident two increased the - -or shorten the time distance to that and also most likely accelerated the progression so that it would come up sooner than if accident two never happened."* He testified he felt accident two was a material aggravation of the permanent aggravation sustained in accident one. PX12 at pgs.48-49.

Regarding accident #3 that occurred on October 2, 2019, Dr. Li's records state that he felt that there was a significant component of aggravation of his underlying arthritis.PX6 at p.22.

IME report of Dr. Watson

Dr. Watson of Watson Orthopedics performed an independent medical evaluation on August 22, 2016 for Westside.PX5 at p.19-21 He answered questions posed by Westside transportation as follows:

1. My current diagnosis at this time is tricompartmental osteoarthritis with an acute medial collateral ligament sprain as well as tears of the medial meniscus in the lateral meniscus.
2. I do believe there are pre-existing medical conditions which are related to his current condition. I believe that most likely the tri-compartmental osteoarthritis noted on the MRI scan is likely preexisting before the injury of June 9th, 2016. The meniscal tearing may or may not be an acute finding as it would be impossible to date these lesions. The grade 2 MCL sprain appears to be acute . The small loose bodies noted on the MRI scan are likely chronic.
3. I do believe that the accident history relates to his current symptoms and some of the above mentioned acute diagnostic findings.
4. I believe that Mr. Miller has preexisting asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9th, 2016. Therefore, additional treatment, including arthroscopic surgery, is needed because of the work injury. The pre-existing condition of osteoarthritis in part has contributed to some of the acute findings in Mr. Miller's left knee. Were it not for the injury of June 9th 2016 , however, I do not feel that surgical treatment and subsequent postop care would be necessary at this time. For that reason, I believe that surgery being requested is causally related to the accident history provided by Mr. Miller.
5. I do not believe that Mr. Miller is currently capable of working full duty . I do not believe that he should do any lifting, climbing, or squatting,. He should not do any kneeling. Assuming that surgical treatment would be successful , that I would anticipate maximum medical improvement to be around 6 to 8 weeks post up and I would estimate that at that time he would likely reach his pre-accident condition as it relates to the left knee . If further treatment would be necessary in the future, and it likely will, I feel that additional treatment will be necessary because of the chronic conditions in Mr. Miller's knee . Finally I believe that the reduced work status is secondary to his acute injury rather than his pre-existing condition, which was obviously present prior to June 9th, 2016.

Deposition of Joshua Alpert

Dr. Joshua Alpert testified by way of evidence deposition March 8, 2019.PX14. Dr. Alpert compared the 2016 arthroscopic operative report of Dr. Li to the new MRI taken after Petitioner's second accident on November 13, 2017.PX12 at p.43 Dr. Albert agreed that the new MRI report showed a recurrent tear of the medial meniscus in the same area as the prior medial meniscectomy from 2016. He testified that finding supports his opinion today that the current condition of Petitioner after the second injury of November 13, 2017 clearly demonstrated a worsening of the arthritic condition in the surgical sites where he previously had arthroscopy, as opposed to an acute injury attributable to November 13, 2017.PX12 at p. 44. He agreed that the existence of the progression of the surgical areas where the prior meniscectomy was performed, where the articular cartilage was debrided and shaved, that those areas have progressed, and further deteriorated, indicative of an acceleration of the arthritic process. PX12 at 45. ***Dr. Alpert testified that the arthroscopic surgery that Dr. Li performed accelerated the timeframe in which Mr. Miller would go on to eventually require a total knee replacement. Id*** Dr. Alpert testified then he would define the event of November 13, 2017 as a manifestation of petitioners' arthritic condition rather than a new injury breaking the chain of causation.PX14 at p.46

Dr. Alpert also examined Petitioner after his 3rd injury on October 2, 2019.CRST RX5 While Dr. Alpert opined that Petitioner sustained an acute component in that accident and suggested rest, therapy, medication and Supartz injections, ***he further opined that the ultimate need for a left total knee replacement was not related to the October 2, 2019*** event but to rather his preexisting condition. Id

Deposition of Dr. Herrin

Dr. Rodney Herron testified on behalf of Westside Transportation on May 2, 2019.PX13 Dr. Herrin was asked the following question: PX13 at p.22

Q. The procedure that doctor Li performed in the petitioner's knee , meaning he removed the meniscus medially and laterally , or at least a portion of it, and also did a chondroplasty procedure, would you agree that that operation has the potential to accelerate the progression of arthritis in the Petitioner Mr. Miller's knee?

A. The removal of the meniscus I don't think necessarily would make a difference. It's nonfunctional. I'm uncertain about the chondroplasty. That potentially could aggravate things . I wouldn't do that procedure for that reason.

Q. Because of the potential for aggravation?

A. Potentially. Depends on what he means by chondroplasty too. If you just kind of smooth off the joint that's probably not going to make a big difference. If you actually do a true abrasion chondroplasty, which is kind of an outdated procedure , then that may make a difference.

CONCLUSIONS OF LAW:

With regard to issue (F) whether Petitioner's injury is casually connected to his injury while working for Respondent, the Arbitrator finds as follows:

The Petitioner's current condition of ill being is not casually connected to his injury while working for Westside Transport. Here, the Petitioner's current condition of ill -being is not related to the June 9, 2016 work accident because he was at Maximum Medical Improvement (hereinafter "MMI") for the aforementioned injury.

Courts have discussed when a claimant has reached MMI. Among the factors to be considered in determining whether a claimant has reached maximum medical improvement include 1) a release to return to work, with restrictions or otherwise, 2) medical testimony or evidence concerning claimant's injury, the extent thereof, the prognosis, and 3) whether the injury has stabilized. Beuse v. Industrial Commission, 299 Ill.App.3d at 183, 233 Ill.Dec. 453, 701 N.E.2d at 98.(1998 1ST. Dist). The medical records and testimony are clear that the petitioner was at MMI for the June 9, 2016 injury by February of 2017.

In using the MMI factors In *Beuse*, noted above, the Arbitrator notes that the Petitioner was placed back to work in his job as a truck driver, heavy duty, in January of 2017 (PX. 5 p. 34-34) and placed at MMI by Dr. Li on February 9, 2016. Second, and most persuasive is the testimony of Dr. Li. Dr. Li noted that the Petitioner did not treat for his knee from February 9, 2017, until his second accident in November of 2017. (PX.5 p 40). Third, Dr. Li noted that there was no indication the Petitioner requested any medical treatment from February 9, 2017, until he returned to treat with him in November of 2017. The Petitioner did not seek any medical treatment from the time he was placed at maximum medical until his second injury. Furthermore, the testimony notes he had to climb in and out of his truck upwards of 100 times a day and he was able to meet all the physical demands of a truck driver from February 2017 to November 2017. The medical records and testimony are clear that after the Petitioner's knee surgery in September of 2016 he made a full recovery and was at MMI in February of 2017 for his knee injury which occurred during the June 2016 accident.

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury." *Vogel v. Industrial Commission*, 354 Ill.App.3d 780, 786, 821 N.E.2d 807, 812 (2005). From the evidence in this case, it is clear that the November 2017 and October 2019 accidents broke the chain of causation for the 2016 accident.

The most compelling evidence in this case is the testimony of Dr. Li. Dr. Li's deposition occurred on October 29, 2018, which was after the June 2016 and November 2017 accidents but before the October 2019 accident. During his testimony Dr. Li was asked and noted the following:

Q. "If you performed the arthroscopy that you had recommended as part of an option for Mr. Miller and assuming Mr. Miller's meniscus tears that you identified or you described here in your deposition today were repaired following that procedure or as part of that procedure and he returned to his pre-November 2017 baseline, would it still be your opinion that any further treatment for the osteoarthritic condition, including a possible total knee replacement, would be related to my accident as opposed to the first one (accident)?"

> A. "Well, it's my opinion that the second accident exacerbated and accelerated the need for a total knee. So any total knee in the future would still be related to the second accident because I think the second accident broke the chain of causation for the first." (P. 76)

Respondent CRST might argue that the first date of loss caused the current recommendation for total knee replacement surgery and that the *International Harvester Co.*, line of cases would prove from a legal standpoint that the June 2016 accident caused the need for knee replacement surgery. However, in this case there is unrefuted evidence by, his treating doctor, Dr. Li that the November 13, 2017, accident broke the chain of causation of the first accident. He was clear that any additional treatment was not a result of the first accident. There was no evidence presented that the first knee injury put him at a greater predisposition for the second and third accidents. When questioned specifically Dr. Li noted to a reasonable degree of medical and surgical certainty that based on his review of the films, the operative report, and his treatment of this patient, if he were to progress to a total knee arthroplasty, the employer of accident two (CRST) should pay for it and it is his opinion that employer two (CRST) would be responsible for any further treatment, including a total knee. (Dr. Li. P. 71)

The Petitioner acknowledged after he saw Dr. Li on February 9, 2017, that the condition of his right knee did not warrant him returning to the doctor for treatment until "after" he suffered the November 13, 2017, injury while working at CRST. The Petitioner testified that his condition and symptoms worsened after the 2nd and 3rd accidents. It is important to note that he continued to treat with Dr. Li even after the second accident and that Dr. Li continued to recommend arthroscopic surgery up until and after the 3rd injury. He was not referred to the doctor that specializes in knee replacements until after the course of injections after his 3rd accident failed to alleviate his symptoms in December 2019.

The contention that first accident caused the current condition of ill being leading to the knee replacement surgery is further refuted by the November 1, 2019, IME by Dr. Albert. In this IME Dr. Albert noted that if the Petitioner was being truthful about his history, the October 2019 accident might have caused a need for about three months of conservative treatment, including injections and would require him to miss time off from work. It is illogical and improbable that CRST's own doctor noted a more recent knee injury regarding the October 2019 accident, acknowledge the need for some treatment after the most recent accident, then argues that his current condition of ill being is not related to the most recent accident.

Finally, the Arbitrator notes that no claim for ongoing temporary benefits were made at the hearing as a result of the June 2016 work injury. (Arb Ex 1). On-going temporary benefits that were requested were regarding the 2019 injury. (Arb Ex 3). This goes against any contention that the current state of ill being could be related to the 2016 accident when the only request for on-going benefits were made in regards to the 2019 injury.

With regard to issue (K) whether Petitioner is entitled to any prospective medical care from Respondent, the arbitrator finds as follows:

For the reasons noted in Subparagraph F, the Petitioner is not entitled to any prospective medical care as a result of the June 9, 2016 date of loss. It is well documented that the Petitioner suffered two additional separate distinct injuries in November 2017 and October 2019. Thus any on-going treatment over three years after he was found to be at maximum medical improvement for the June 2016, work injury is not related to the June 9, 2016, accident.

Signature of Arbitrator

06/05/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC035761
Case Name	MILLER, PHILLIP v. CEDAR RAPIDS STEEL TRANSPORT
Consolidated Cases	16WC019633 19WC029339
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0348
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commisioner

Petitioner Attorney	Joseph J. Leonard
Respondent Attorney	Brad Antonacci

DATE FILED: 7/7/2021

/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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Philip Miller,

Petitioner,

vs. No. 17 WC 35761

Cedar Rapids Steel Transport,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by Respondent Cedar Rapids Steel Transport (CRST) and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner's application for adjustment of claim in consolidated case No. 16 WC 19633, brought against Westside Transport,[1] alleges that on June 9, 2016, Petitioner injured his left knee while pulling a pin. Petitioner's application for adjustment of claim in the instant case No. 17 WC 35761, brought against CRST, alleges that on November 13, 2017, Petitioner injured his left knee while stepping into a truck. Petitioner's application for adjustment of claim in consolidated case No. 19 WC 29339, brought against CRST, alleges that on October 1, 2019, Petitioner again injured his left knee at work. The three claims were consolidated and tried pursuant to section 19(b) on January 24, 2020. On June 23, 2020, the Arbitrator filed three decisions (one in each case), following which CRST and Petitioner filed cross-petitions for review. The main issue on review is which employer is liable for Petitioner's prospective medical care.

[1] Petitioner's three cases are intertwined and have been properly consolidated. However, the Commission is presently unable to issue consolidated decisions.

Petitioner, a semi truck driver, testified on direct examination that he began working for Westside Transport on or about June 2, 2016, after passing a DOT physical. A medical certificate in evidence confirms Petitioner passed a DOT physical on June 2, 2016. On June 9, 2016, Petitioner sustained a work accident (case No. 16 WC 19633). Petitioner testified that after picking up a load in Chicago, he had to slide the tandems forward, which involved crouching and pulling a lever on the underside of the trailer. Petitioner described the accident as follows: "I gave [the lever] a good hard yank, and *** my feet are planted in place, but I twisted this left knee and I heard a pop and *** I felt like *** a jolt of pain in my knee, and I fell to the ground except *** my hands were able to catch my fall." Thinking it was just a sprain, Petitioner drove to Cedar Rapids. By the time he got there, the pain was intense. Petitioner denied prior problems with the left knee.

Petitioner's wife picked him up, and they went to Mercy Medical Center in Cedar Rapids, where Petitioner received emergency care. On June 16, 2016, Petitioner followed up with his family doctor, Dr. Lovell, who ordered an MRI. After the MRI, Petitioner came under the care of Dr. Li, who recommended surgery. At the request of Westside Transport, Petitioner was examined by Dr. Watson on August 22, 2016. Following the section 12 exam, the surgery was approved.

On September 14, 2016, Petitioner underwent the surgery. Petitioner's postoperative treatment included a Supartz injection, physical therapy and work conditioning. On February 9, 2017, Petitioner complained to Dr. Li of significant discomfort in the left knee with standing more than ten minutes or walking more than 50 yards. Dr. Li prescribed medication and discussed a knee replacement surgery. Petitioner opted against the knee replacement, and Dr. Li released him to return to work full duty.

Petitioner returned to work as a truck driver for Westside Transport for approximately four and a half months. His left knee felt better than before the surgery in September of 2016, but nowhere near how it was before the accident. Petitioner rated his pain at rest a 2/10 and with activity a 6-9/10.

In May of 2017, Petitioner went to work for CRST because that job was closer to home, paid more, and was less physically demanding. Petitioner explained that he was an in-house driving instructor, paired with a new driver. The new driver performed the physical duties, while Petitioner evaluated him.

On November 13, 2017, while working for CRST, Petitioner sustained another injury to the left knee (case No. 17 WC 35761). Petitioner explained that he injured his left knee while climbing into the cab of the truck. "[W]hile I'm pivoting, my foot didn't move but my knee did, and much like that day in June 2016, I felt my knee *** like, shear." The pain in the left knee increased after the accident.

On November 15, 2017, Petitioner returned to Dr. Li, who ordered an MRI. After the MRI, Dr. Li prescribed physical therapy and discussed arthroscopic surgery vs. injections. Petitioner had an injection. On December 13, 2017, Dr. Li recommended arthroscopic surgery. At the request of CRST, Petitioner was examined by Dr. Alpert on January 9, 2018. After the examination, the arthroscopy was denied and the temporary disability payments stopped. On January 25, 2018, Petitioner asked Dr. Li to release him to return to work full duty.

At the end of January of 2018, Petitioner returned to work for CRST. Petitioner described his left knee condition at the time as follows: "Sitting at rest with the weight off my knee either on a chair

or a seat *** or driver's seat at rest, the pain would be three to a three and a half, four. On some days it would even be more than that. It would be five or six. ¶ Getting up, moving around doing my duties getting out, walking in the building to get the paperwork, coming back out of the building to get the trailer undocked, shutting the doors, and then having to go fuel, the pain would be eight to nine and some days even a ten." The pain "increased on a permanent basis," compared to before the accident on November 13, 2017. "[I]t was a new baseline." CRST placed Petitioner into a less physically demanding job driving shorter routes. Petitioner continued to follow up with Dr. Li, who recommended arthroscopy vs. viscosupplementation. Neither was approved. The pain "remained consistent with the new baseline." Petitioner did not see Dr. Li after July 30, 2018, until the next accident.

On October 2, 2019, while working for CRST, Petitioner again injured his left knee—this time while getting out of the truck (case No. 19 WC 29339). Petitioner explained: "[I]t just happened to be a spot where two concrete pads, the expansion joint in between the two concrete pads, there was a gap and it's kind of like it's worn or chipped away, kind of like a little pothole *** literally a pothole there. *** [M]y [left] foot toe went in there and caught or grabbed the hole. *** When I went to step down altogether to be on the floor, *** my foot stayed in place but this knee (indicating) started to rotate, and I got unbalanced, literally got unbalanced, and I'm trying to get back, and I went to go grab the grip with my right hand, and I couldn't reach it in time, and I just went down." After Petitioner fell, the pain in the knee was a 10/10.

Petitioner underwent another MRI and followed up with Dr. Li, who recommended physical therapy and injections. Petitioner underwent a series of Supartz injections in October and November of 2019. At the request of CRST, Dr. Alpert reexamined Petitioner on November 1, 2019. On December 6, 2019, Petitioner reported to Dr. Li no significant improvement from the injections. Dr. Li recommended a total knee replacement and referred Petitioner to Dr. Mulvey. Petitioner believed the total knee replacement was the same procedure he had discussed with Dr. Li in January of 2017. As of the time of the arbitration hearing, the knee replacement had not been approved and Petitioner had not seen Dr. Mulvey. Dr. Li has not released Petitioner to return to work. Petitioner described the pain in his left knee as follows: "Here at rest with my weight off my knee, three, three and a half. Getting up, just going across the street from the parking deck to here, up the elevator and here, eight." The pain has increased since the last baseline. Petitioner has difficulty performing activities of daily living and relies on his wife. He would like to proceed with the knee replacement surgery.

On cross-examination by Westside Transport, Petitioner acknowledged that after returning to work following the arthroscopic surgery, he "was able to *** perform the duties very well, but not without pain. *** [T]he pain was tolerable." Petitioner worked regular duty and did not miss any time from work because of knee problems. In late May of 2017, Petitioner passed a DOT physical to go to work for CRST. Petitioner agreed that his pain progressively worsened after the second and third accidents. The first time Dr. Li referred Petitioner to Dr. Mulvey was after the accident on October 2, 2019.

On cross-examination by CRST, Petitioner testified that he understood from Dr. Li he would continue to have pain and limitations with the left knee as a result of the injury in June of 2016 and would eventually need a knee replacement. Petitioner rated his pain a 6-9/10 with activity when he returned to work for Westside Transport in February of 2017. He rated his pain 7-8/10 with activity when he returned to work for CRST in January of 2018.

The medical records in evidence show that on June 10, 2016, Petitioner presented at Mercy Medical Center with left knee pain, giving a history consistent with his testimony. Physical examination was notable for a decreased range of motion and tenderness. X-rays showed: "Moderate tricompartmental left knee degenerative change/osteoarthritis. Chronic medial collateral ligament dystrophic calcification near the tibial insertion. No evidence to suggest an acute injury." Petitioner was given a knee immobilizer and crutches. On June 16, 2016, Petitioner followed up with Dr. Lovell, who ordered an MRI.

On June 30, 2016, Petitioner consulted Dr. Li, who suspected a meniscal or chondral injury and also ordered an MRI. The MRI was interpreted by the radiologist as showing: "1. Multifocal fraying/tear of the body and posterior horn on the medial meniscus. 2. Small oblique tear of the anterior horn on the lateral meniscus reaching the inferior articular surface. 3. Grade 2 MCL sprain. 4. Tricompartmental degenerative joint disease, most notably in the medial compartment. 5. Small joint effusion with several intra-articular bodies." On July 5, 2016, Dr. Li recommended surgery and provided the following causation opinion: "[A]lthough [the patient] had pre-existing Osteoarthritis in his Left knee the injury suffered on 6/9/16 caused a Medial and lateral meniscus tears and also the loose bodies seen on the MRI. The need for surgery is a directly related cause to the 6/9/16 injury."

On September 14, 2016, Dr. Li performed: "1. Left knee arthroscopy with partial medial and lateral meniscectomy. 2. Abrasion chondroplasty medial femoral condyle, patella and femoral trochlea." Postoperatively, Petitioner underwent physical therapy and a Supartz injection on October 20, 2016. On December 9, 2016, Dr. Li noted: "The Supartz injection has worked well and he feels much better. He has completed his FCE and it shows that he has done relatively well and three weeks for work conditioning is recommended." On January 6, 2017, Dr. Li noted: "He has had his work conditioning and FCE and he has passed." Dr. Li released Petitioner to return to work full duty.

On February 9, 2017, Dr. Li noted: "He is able to drive and get into his truck without any significant discomfort. He does have significant discomfort with prolonged standing or walking. If he walks 50 yards or more he has discomfort. If he stands more than 10 minutes there is discomfort." Dr. Li assessed "residual pain from Osteoarthritis permanently aggravated by his work injury," further stating: "I explained to the patient that he will have permanent aggravation of his Osteoarthritis and he will need symptomatic treatment in the form of medications, injections, viscosupplementation, and possibly a knee replacement as a result of this in the future." Dr. Li declared Petitioner at maximum medical improvement and prescribed medication.

Petitioner returned on November 15, 2017, after the second work accident. "He reports he was doing well until this incident at work." An MRI performed November 17, 2017, was interpreted by the radiologist as follows: "1. Tricompartmental degenerative joint disease, most notably in the medial and patellofemoral compartments, slightly progressed since the prior exam. 2. Suspected recurrent tear of the medial meniscus." Dr. Li prescribed physical therapy. On December 13, 2017, Dr. Li noted: "Patient's Left knee continues to hurt with any standing over 15 minutes. He develops significant swelling and he cannot be as mobile as he was before. He is still using one crutch to ambulate. Patient's pain is aggravated by activities of daily living and limits lifestyle desired. Pain also interferes with sleep and wakes the patient up." Dr. Li recommended arthroscopic surgery.

On January 25, 2018, Dr. Li noted: "His IME states he needs to return to work full duty and his work comp payments have been cut off so he is here to discuss returning to work. His symptoms remain the same. Continues to have pain however cannot afford to remain off work." Dr. Li prescribed medication, allowed Petitioner to return to work, and advised him to call if the symptoms worsened. On February 26, 2018, Dr. Li noted: "He continues to have pain in his Left knee with prolonged standing and walking but he can tolerate driving." Dr. Li kept Petitioner on full duty. On April 20, 2018, Dr. Li noted: "He continues to have significant pain at the end of each week. Early in the week he can tolerate the pain but as he works more the pain gets intolerable." Dr. Li recommended viscosupplementation or arthroscopic surgery. On July 30, 2018, Dr. Li noted: "Continues to have pain over the anterior and medial aspect of his knee. He reports it has been catching on him." Dr. Li performed an injection into the knee.

On October 3, 2019, Petitioner returned after the third accident. Dr. Li noted: "[T]his is clearly a new injury. He cannot currently bear any weight on his Left knee." Dr. Li injected the knee. An MRI performed October 3, 2019, was interpreted by the radiologist as follows: "1. Findings raise the possibility of a recurrent medial meniscal tear, including a suspected horizontal tear of the anterior horn. 2. Degenerative joint disease, moderate to severe in the medial compartment." On October 4, 2019, Dr. Li stated: "There is a significant component of aggravation of his underlying osteoarthritis." Dr. Li recommended physical therapy. On October 21, 2019, Petitioner reported moderate improvement from the injection; however, he was unable to walk any significant distance. Dr. Li stated: "I believe the Osteoarthritis aggravation is the main source of his pain and I recommend supartz injections for that." Dr. Li performed a series of five Supartz injections from October 22 through November 19, 2019.

On December 6, 2019, Dr. Li noted: "[H]e feels that the injections have not helped him significantly and at this point his pain is beyond what he can tolerate." Dr. Li concluded: "Patient has failed non operative treatment. I will refer him to Dr. Mulvey for a total knee replacement."

Dr. Li testified by evidence deposition on October 29, 2018. Dr. Li provided the following causation opinions: "[E]ven though [the patient] didn't have any symptoms before his [first] accident, he had osteoarthritis. The accident didn't cause all of his osteoarthritis. But the accident did accelerate it beyond its normal progression. So accelerated by causing further fragmentation of the articular cartilage that needed to be addressed." But for the first accident, Petitioner might not have needed a knee replacement. "He might have been able to be treated conservatively for the rest of his life." In February of 2017, Petitioner was at maximum medical improvement and returned to work within his new baseline. Petitioner continued to work until the second accident, which caused new acute findings. The treatment Dr. Li provided after the second accident was necessitated by the new injury. The second accident caused a material aggravation of the left knee condition. In January of 2018, Dr. Li released Petitioner to return to work because his benefits were cut off. However, Petitioner needed further treatment. "[H]e was still worse than at the time I discharged him in February of 2017." After Petitioner returned to work, his condition was "going downhill."

As of the time of the deposition, Dr. Li proposed the following treatment: "I would probably get some updated X-rays and talk to him about all the options going from the most conservative, which would be visco supplementation, arthroscopy, all the way up to a total knee." The total knee replacement "would be a possibility. I think it's been a possibility all along." Dr. Li agreed the first accident permanently aggravated the preexisting osteoarthritis, and the second accident materially

aggravated that permanent aggravation. Dr. Li further opined: "It's my opinion that [CRST] and accident two would be the one that would be responsible for any further treatment *** including a total knee. The reason being [the patient] was definitely on a certain course of progression towards worsening osteoarthritis going to a total knee. I think that accident two increased the—or shortened the time distance to that and also most likely accelerated the progression so that it would come up sooner than if the accident two never happened." As of July of 2018, Petitioner was not at maximum medical improvement from the second accident.

On cross-examination, Dr. Li testified that in February of 2017, Petitioner was not a candidate for a total knee replacement. He became a candidate for a total knee replacement after the second accident. Dr. Li agreed that he discussed a total knee replacement in February of 2017. Dr. Li reiterated: "[I]t's my opinion that the second accident exacerbated and accelerated the need for a total knee. So any total knee in the future would still be related to the second accident because I think the second accident broke the chain of causation for the first." Dr. Li ultimately agreed the need for a total knee replacement started with the first accident.

Dr. Alpert, an orthopedic surgeon, testified by evidence deposition on March 8, 2019. Dr. Alpert began by testifying that on January 9, 2018, he examined Petitioner at the request of CRST. Petitioner and Westside Transport immediately interposed a *Ghere* objection to the opinions expressed in the addendum report, which was not timely provided to them. Petitioner subsequently withdrew his *Ghere* objection, while Westside Transport continued to object throughout the deposition.

Dr. Alpert affirmed that all of his opinions that took into account the first accident were expressed in the addendum report.[2] Dr. Alpert diagnosed a "left knee endstage osteoarthritis with degenerative meniscus tear in a patient who is six foot three and 355 pounds." Dr. Alpert initially "didn't believe that any kind of work-related injury caused or had anything to do with the condition as it relates to his left knee." Dr. Alpert opined the left knee condition was "pre-existing and degenerative," noting the imaging studies did not show any acute injury. Dr. Alpert therefore "didn't believe [Petitioner] needed any further care and treatment as related to the November 13, 2017 incident." Relative to the underlying condition, Dr. Alpert recommended conservative treatment and, if it failed, a knee replacement.

Dr. Alpert agreed that the first accident aggravated Petitioner's underlying degenerative arthritis. Dr. Alpert continued: "[I]t seems that all of the symptoms as it relates to this where he sought and needed medical treatment started from that first injury in June 9th of 2016. ¶ He was treated with some conservative measures including a knee arthroscopy, and from my perspective, the work injury on June 9th, 2016 sort of started him on this path of needing care and treatment as it relates to his left knee." Dr. Alpert believed the arthroscopy performed by Dr. Li was inappropriate. "Certainly a knee arthroscopy for this generally does not help which is what happened to [Petitioner] as an arthroscopy doesn't help arthritis." Based on the chain of events, Dr. Alpert related "any care and treatment" to the first accident.

[2]Dr. Alpert initially understood that Petitioner claimed a work accident on November 13, 2017, and had a "pre-existing condition with his left knee related to left knee injury that occurred in June 2016, which he reports was a torn meniscus."

On cross-examination, Dr. Alpert admitted that he never reviewed the medical records from Dr. Li from June of 2016 to January of 2017 or obtained a history from Petitioner of the first work accident. Dr. Alpert attributed Petitioner's ongoing left knee problems to the first accident and the *sequelae* of the arthroscopic surgery. Regarding the second accident, Dr. Alpert opined it was a mere manifestation of the advancement of the arthritic process. In terms of treatment, Dr. Alpert recommended conservative measures and, if they failed, a knee replacement.

Dr. Alpert's post-deposition addendum report, dated November 1, 2019, was admitted into evidence without objection. In the report, Dr. Alpert opined the third accident caused "a left knee strain that aggravated previously symptomatic knee arthritis." Dr. Alpert opined the aggravation would be temporary, requiring a three-month course of conservative treatment. "Any care and treatment after that three-month period would be [due] to the degenerative condition of his knee and not from any acute injury."

Dr. Herrin, an orthopedic surgeon who examined Petitioner at the request of Westside Transport, testified by evidence deposition on May 2, 2019. Dr. Herrin examined Petitioner on January 10, 2019, before the third accident. Regarding the first accident, Dr. Herrin opined: "[H]e may have aggravated some of the preexisting arthritis in the knee. And potentially could have injured the meniscus." Regarding the second accident, Dr. Herrin opined: "Again, he may have aggravated some degenerative changes within the knee at that time. I don't believe this MRI scan revealed any additional meniscal pathology that I can see. So that would be potentially aggravation of some arthritis in the knee." At the time of the examination, Petitioner "had severe degenerative arthritis of his knee and his exam was consistent with that. I didn't think it was significantly related to the accident at that point. * * * Based on progression of his osteoarthritis of his knee, which would be the natural history." Dr. Herrin did not believe the first accident caused or aggravated the preexisting arthritis in the left knee to the point Petitioner would require a total knee replacement. Rather, Dr. Herrin opined, based on the clinical and diagnostic findings in June of 2016, that Petitioner was already a candidate for a total knee replacement before the first accident. Dr. Herrin did not think the first accident "resulted in a permanent aggravation [of the underlying condition]. Temporary would be what my opinion would be." Dr. Herrin acknowledged that he was unaware of Petitioner having any symptoms or treatment for a left knee condition before the first accident. Dr. Herrin considered the surgery performed by Dr. Li on September 14, 2016, to be inappropriate and potentially harmful.

Following a section 19(b) hearing, the Arbitrator filed three decisions on June 23, 2020. In case No. 16 WC 19633, the Arbitrator found "in favor of [Westside Transport] as to the disputed issues of causal connection related to current condition of ill being, with credit given to [Westside Transport] for any bills paid. ¶ [Westside Transport] is not liable to pay for any left total knee replacement surgery or approve the referral to Dr. Mulvey pursuant to section 8.2 of the Act and in accordance with the fee schedule."

In the instant case No. 17 WC 35761, the Arbitrator found "in favor of Petitioner as to the disputed issues of causal connection, liability for unpaid medical bills-listed in PX 16 with credit given to [CRST] for any bills paid, and prospective medical. ¶ The Arbitrator awards Petitioner unpaid medical bills of Dr. Li pursuant to section 8.2 of the Act for service dates of 11/13/17 thru 7/30/18 as defined in PX16 with [CRST] to be given a credit for any bills paid as listed on RX4 and in accordance with the fee schedule as against Respondent CRST. ¶ [CRST] to approve and pay for left total knee

replacement surgery and related costs as recommended by Dr. Li and approve the referral to Dr. Mulvey pursuant to section 8.2 of the Act and in accordance with the fee schedule."

In case No. 19 WC 29339, the Arbitrator "denies that Petitioner's current condition of ill being is causally related to the accident of October 2, 2019, but finds a closed period of causal connection from 10/2/19 thru January 1, 2019, as per CRST IME physician Dr. Alpert (CRST EX#3) who provided a period of causation for three months after the October 2, 2019 accident. ¶ The Arbitrator finds in favor of Petitioner on the disputed issue of liability for unpaid medical bills-incurred from October 2, 2019 thru January 1, 2020 as that being the period of causation found by the Arbitrator for the accident date of 10/2/2019; and further awards Petitioner the bills listed in PX18 pursuant to section 8.2 with credit given to Respondent CRST for any bills paid as referenced on Arb EX. 6 and on CRST RX11. ¶ The Arbitrator denies liability as against CRST for the requested left total knee replacement for the accident date of 10/02/2019. ¶ The Arbitrator denies further TTD to Petitioner beyond 1/1/2020 as the condition of ill-being, that being a left knee replacement, is causally related to the accident of 11/13/2017." In the "Conclusions of Law," the Arbitrator awarded TTD "from the period 10/3/2019 thru 1/1/2020, a period of 13 weeks, that being the period of causal connection."

On review, CRST argues: "Petitioner's current condition of ill-being is causally related to the June 9, 2016, incident and *** therefore, Respondent, Westside Transport, is responsible for all medical treatment related to the 2016 incident including Petitioner's total left knee replacement and referral to Dr. Mulvey. * * * Petitioner's current condition of ill-being is unrelated to the November 13, 2017, and October 2, 2019, incidents and *** Cedar Rapids Steel Transport has paid for all medical care associated with said incidents and is not liable for any additional benefits or medical treatment requested by Petitioner." In sum, CRST argues "the 2016 incident permanently aggravated Petitioner's preexisting osteoarthritis; therefore, Respondent, Westside, should be held liable for any prospective care." CRST considers the accidents on November 13, 2017 and October 2, 2019 to have caused only "a [temporary] manifestation of [the] preexisting osteoarthritis" or a "sprain."

Petitioner filed a protective review. In his brief, Petitioner states: "[T]he Arbitrator could have found a causal relationship between the 1st accident that occurred on June 9, 2016 while in the employment of Westside Transportation, and the need for left knee arthroplasty. Arbitrator Kay could have awarded petitioner the left TKA as against respondent Westside Transportation rather than respondent CRST. However the petitioner takes no exception to the decision as it stands against CRST as written. Clearly either respondent Westside Transportation or respondent CRST is responsible for petitioner's left TKA. To state that neither is responsible would be against the preponderance of the overwhelming evidence. ¶ *** [P]etitioner takes no exceptions to the Arbitrator's orders and finding of fact and conclusions of law as to liability for unpaid medical bills awarded against Westside Transportation and CRST."

Westside Transport asks the Commission to affirm and adopt the Arbitrator's Decisions. As a protective argument, Westside Transport renews its *Ghere* objections.[3]

The Commission agrees with CRST that the first accident on June 9, 2016, set in motion a chain of events that ultimately resulted in Petitioner's need for a knee replacement. As a preliminary matter, the Commission sustains Westside Transport's *Ghere* objections to the causation opinions of Dr. Alpert.

[3]The Arbitrator relied on certain opinions of Dr. Alpert.

Rather, the Commission relies on the opinion of Dr. Li that the first accident accelerated Petitioner's underlying degenerative condition beyond its normal progression by causing further fragmentation of the articular cartilage; but for the first accident, Petitioner might not have needed a knee replacement and might have been able to be treated conservatively for the rest of his life. Dr. Li ultimately affirmed that the need for a total knee replacement started with the first accident. To the extent Dr. Li then ventured into the purely legal realm by placing legal liability for the knee replacement on the second accident and CRST, the Commission rejects that part of his opinion as outside the area of his professional expertise.

The Commission finds the Arbitrator properly relied on Dr. Alpert's third (unobjected to) report to the extent Dr. Alpert opined that Petitioner would reach maximum medical improvement after the third accident by January 1, 2020.

Accordingly, the Commission modifies the Arbitrator's Decision with respect to the benefits due to Petitioner after January 1, 2020. The Commission places the liability for those benefits on Westside Transport.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent CRST shall pay the medical bills in evidence as delineated by the Arbitrator, pursuant to §§8(a) and 8.2 of the Act and subject to appropriate credit.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated against Respondent CRST.

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 CRST pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent CRST 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.

July 7, 2021

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

SJM/sk
o-4/20/2021
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0348
NOTICE OF 19(b) ARBITRATOR DECISION

MILLER, PHILLIP
Employee/Petitioner

Case# **17WC035761**

16WC019633
19WC029339

WESTSIDE TRANSPORT/CEDAR RAPIDS STEEL TRANSPORT
Employer/Respondent

On 6/23/2020, 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 0.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0926 LEONARD LAW GROUP LLC
JOE LEONARD
325 S PAULINA ST SUITE 100
CHICAGO, IL 60601

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
300 HAMILTON BLVD
PEORIA, IL 61601

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)

PHILLIP MILLER
Employee/Petitioner

v.

WESTSIDE TRANSPORT/ CEDAR RAPIDS STEEL TRANSPORT
Employer/Respondent

Case # **17** WC **35761**

Consolidated cases: **16 WC 19633 and 19 WC 29339**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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 **Prospective Medical Care**

FINDINGS

On the date of accident, **November 13, 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 $**46,982.52**; the average weekly wage was $**903.51**.

On the date of accident, Petitioner was **58** 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 $**6,026.40** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**4,591.10** for other benefits, for a total credit of $**10,617.50**.

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

ORDER

SEE THE ATTACHED DECISION OF THE ARBITRATOR FOR FINDINGS OF FACT AND CONCLUSIONS OF LAW AS TO CAUSAL CONNECTION, LIABILITY FOR MEDICAL BILLS; AND LIABILITY FOR PROSPECTIVE MEDICAL; SAID DECISION IS INCORPORATED HEREIN AS IF FULLY SET FORTH HEREIN;

THE ARBITRATOR FINDS IN FAVOR OF PETITIONER AS TO THE DISPUTED ISSUES OF CAUSAL CONNECTION, LIABILITY FOR UNPAID MEDICAL BILLS-LISTED IN PX 16 WITH CREDIT GIVEN TO RESPONDENT FOR ANY BILLS PAID, AND PROSPECTIVE MEDICAL;

THE ARBITRATOR AWARDS PETITIONER UNPAID MEDICAL BILLS OF DR. LI PURSUANT TO SECTION 8.2 OF THE ACT FOR SERVICE DATES OF 11/13/17 THRU 7/30/18 AS DEFINED IN PX16 WITH RESPONDENT TO BE GIVEN A CREDIT FOR ANY BILLS PAID AS LISTED ON RX4 AND IN ACCORDANCE WITH THE FEE SCHEDULE AS AGAINST RESPONDENT CRST.

RESPONDENT TO APPROVE AND PAY FOR LEFT TOTAL KNEE REPLACEMENT SURGERY AND RELATED COSTS AS RECOMMENDED BY DR. LI AND APPROVE THE REFERRAL TO DR. MULVY PURSUANT TO SECTION 8.2 OF THE ACT AND IN ACCORDANCE WITH THE FEE SCHEDULE.

PENALTIES 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

06/05/2020
Date

ICArbDec19(b)

JUN 23 2020

PROCEDURAL HISTORY

This matter is consolidated with Case #16wc19633 and #19wc29339.

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on January 24, 2020 in Chicago, Illinois. this matter involves three separate dates of accident in which the petitioner alleges injuries to his left knee while working for two respondents. These accidents occurred on June 9, 2016, November 13, 2017, and October 2, 2019. The 2016 accident occurred while he was working for Respondent Westside Transportation the 2017 and 2019 accidents occurred while he was working for Respondent CSRT.

The parties went to hearing with the following issues in dispute: whether Mr. Phillip Miller's (hereinafter "Petitioner") current condition of ill-being is casually connected to his injury on November 13, 2017 and whether CRST is liable for the total knee replacement (hereinafter "TKA") for the left knee and any unpaid bills listed in (PX16) for dates of service from 11/13/17 through 7/30/18 less any 8j credit due Respondent. (Arb.X1)

The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that he was hired by Westside Transportation on June 2, 2016. He underwent the required DOT physical prior to his employment and was cleared to work. He denied left knee pain prior to June 2, 2016 and denied ever being prescribed a left knee MRI, physical therapy, arthroscopy, or a left total knee replacement.

He testified that he was hired as a driver of semi tractors and trailers. His duties consisted of picking up and delivering freight, getting in and out of the truck, fueling, opening the trailer doors, docking the trailer, and maintaining the logbooks per DOT regulations. He did not have a set route. He testified that he would get his assignments through satellite communication inside the tractor cab.

On June 9, 2016 he was driving his truck in Cedar Rapids, Iowa. He arrived at a designated pick up site and docked the trailer. After loading, he shut the trailer doors and pulled the trailer away from the dock. He then proceeded to slide the tandems forward to be legal weight and legal length now that he was loaded. That required that he crouch in a baseball catcher position and grab a lever under the trailer and pull it out. He testified that the lever got stuck the first time due to the added weight of the load. On the second attempt he pulled hard and in doing so he twisted his left knee, heard a pop, and felt a jolt of pain in his left knee like lightning. He was able to catch himself with his hand and did not fall to the ground.

He continued to work but as time went on, he felt intense pain in the left knee and called dispatch. He eventually stopped working and called his wife the following morning. She arrived and drove him to Mercy Medical Center.

Petitioner was examined at Mercy Medical Center and provided crutches, medications of Toradol and Relafen, and instructed to follow up with his primary doctor. He followed up by his primary physician Dr. John Lovelle (hereinafter "Dr. Lovelle") on June 16, 2016 in Tremont, Illinois. Dr. Lovelle prescribed medication and ordered an MRI of the left knee.

He underwent an MRI on June 30, 2016 at Open MRI Center in Normal, Illinois and consulted with orthopedic physician Dr. Li that same day. He testified that Dr. Li recommended surgery to his left knee. Prior

to surgery being approved, he was examined by Dr. Watson by the insurance company for Westside on Aug 22, 2016. He testified that his surgery was then approved.

Petitioner underwent surgery at Ireland Grove Center on September 14, 2016. He followed up with doctor Li on September 22nd, and again on October 20, 2016. He underwent a suparts injection on November 17, 2016 by Dr. Li. He testified he participated in physical therapy at OSF from September 21st through December 6, 2016. His physical therapy progressed into a work conditioning program in December of 2016. He had a work capacity evaluation on December 9, 2016.

Petitioner testified that he was examined by doctor Li again on January 6, 2017. Dr. Li discussed the work capacity evaluation with him. He testified that he saw Dr. Li again February 9, 2017 and at that visit he was complaining of significant discomfort with prolonged standing or walking greater than 50 yards. He told Dr. Li that standing greater than 10 minutes at a time caused discomfort. He was given a 3-month supply of Mobic and Rabeprazole. **He testified doctor Li discussed knee replacement surgery at this visit. He did not have knee replacement surgery at that time. He testified Dr. Li released him to return to full duty work after this visit.**

Petitioner testified he returned to full duty work at Westside for approximately 4 1/2 months. He testified he continued to perform the job duties of a truck driver. **He testified his left knee felt better after surgery but that it was nowhere near as close to where it was before his injury.** He testified he had pain even at rest and on a scale of one to ten he rated it at a two to a two and a half. When he was sitting with his weight off his knee, he rated his pain a six to a nine. If he had to get up and move around and do his duties such as getting out of the truck to fuel, open the trailer door, walk into a building or get paperwork, the pain scale would be anywhere from a six to nine depending upon how far he would have to walk.

Petitioner testified he stopped working for Westside because he discovered a job opportunity in Morton, Illinois. It was only 3 1/2 miles from his house and involved working a dedicated account hauling Caterpillar freight for CRST. He testified he left Westside in May 2017 because the new job at CRST offered more money and was closer to his house. The job at CRST was less physical.

He testified he was initially hired at CRST to be a driver trainer. He was an experienced driver and they assigned him to train employees who had just completed in-house driving school. He would evaluate their performance over a five-week period. He testified the trainee performed all the major and minor physical duties to get experience including fuelling, opening the doors of the trailer, docking the trailer, and going into the building to get the paperwork. He testified he had this helper over a five-month period.

He testified that on November 13, 2017, he was getting into the cab of his truck on the driver side using a 3-point stance. He put his right foot up on the first step followed by his left and that in order to get his "bottom" into the driver seat he would swing his right foot into the floorboard underneath the seat, and in doing so, pivot with his left leg. While performing this activity his left leg did not pivot on the metal step and he felt a sheering action in his left knee with pain.

He testified he was still taking Mobic and the other medication prescribed to him by Dr. Li prior to this occurrence. In describing his level of pain to his left knee on a scale of one to ten, zero being no pain and ten being intense pain he testified his pain level increased at both sitting and with movement. He rated his sitting pain a three to a three and a half and his getting up and moving around pain a nine. He reviewed photographs (PX11) and identified them as the steps he was ascending when his left knee twisted. He testified he personally took the photos on his cell phone. He testified he reported this accident to CRST and returned to Dr. Li again for treatment.

He was examined by Dr. Li on November 15, 2017. Dr. Li ordered a new MRI of his left knee and prescribed crutches. Left knee MRI was performed on November 17th at Open MRI Center. Dr. Li discussed arthroscopic surgery versus injection treatment at the follow up appointment. Petitioner testified he underwent an injection and resumed physical therapy at OSF.

He was seen by Dr. Li again December 13, 2017 at which time Dr. Li recommended left knee arthroscopy. He testified that he was examined by the workers compensation carrier for CRST on January 9, 2018.by Dr. Joshua Alpert (hereinafter "Dr. Alpert"). He testified he gave Dr. Alpert a history of his injury and surgery in 2016 and the accident at CRST on November 13, 2017. He testified that after this examination his arthroscopic surgery was denied.

Petitioner saw Dr. Li again on January 25, 2018 at which time he requested Dr. Li to release him to return to work because his TTD benefits were cut off. He testified he returned to work for CRST. He testified that upon his return, sitting at rest with weight off his knee in a chair or the driver seat that his pain would be three and a half to a four and some days it would be more than that. Getting up and moving around to do his duties like getting out of his truck and walking into buildings to get paperwork, shutting trailer doors, and when fueling, his pain would be eight to a nine and some days a ten out of ten.

When asked if the pain he was describing after his 2nd injury at CRST was the same level of pain that he was dealing with after the 2016 surgery, he testified that after November 13, 2017 that it had increased on a permanent basis. He testified it was his new baseline.

He continued to work for CRST but testified that they changed his job to a less physical position and allowed him to make shorter runs between two dedicated points from Morton, Illinois to Mount Vernon, Illinois. He testified he only had to go in with an empty trailer and do a drop and hook, do the billing, and sign the paperwork.

He did see Dr. Li in consultation on February 26, 2018 at which time Dr. Li extended his Mobic and prescribed Prilosec. He was instructed to follow up as needed. He returned to Dr. Li on April 20, 2018 and he advised Dr. Li at that time that he was in more pain. He was prescribed Rabeprazole. Dr. Li recommended arthroscopy versus visco supplementation, but neither were approved. He continued to work at CRST and his pain to his left knee continued and remained consistent with a new baseline.

He testified that he saw Dr. Li on July 30, 2018. He was in much more pain and his left knee was catching. He was provided an injection and his prescriptions of Mobic and Rabeprazole were again renewed. He testified Dr. Li again recommended surgery, but it was again denied.

He continued to work for CRST without returning for medical treatment until October 2019. **On October 2, 2019 he was exiting his tractor** on the driver side door in a 3-point stance facing the inside of the cab . When he placed his right foot on the ground where 2 concrete pads joined there was a large gap where the expansion joint was worn and chipped away like a pothole. His right foot toe went in the hole and caught and when he went to step down his foot stayed in the hole he rotated and lost his balance. He tried to reach and grab the side handle of the truck but failed to reach it and he fell.

Petitioner described his left knee pain after the fall as a ten. He notified his employer immediately. He again consulted with Dr. Li who sent him for another MRI to his left knee on October 3, 2019. He was examined by Dr. Li on October 4, 2019 and he recommended physical therapy and injections. He told Dr. Li on October 21, 2019 that he was having difficulty walking although he noted moderate improvement with the injection. Dr. Li recommended supartz injections. Petitioner had the first of five supartz injections on October 22, 2019 and the last one on November 19, 2019.

Petitioner saw Dr. Li on December 6, 2019 after the last injection. He advised him that he did not get any significant improvement from the injections. He told Dr. Li he could not tolerate the pain anymore. He testified Dr. Li referred him to Dr. Mulvey for a left knee arthroplasty. He testified that left knee arthroplasty had not been approved as of the date of arbitration. He testified Dr. Li has not released him from his care and that he still has him off work. He has not seen Dr. Mulvey yet and has not received any approval to do so from the CRST workers compensation carrier.

He testified he saw doctor Joshua Alpert (hereinafter "Dr. Alpert") again at the request of CRST on November 1, 2019. He told Dr. Alpert again about the accident in 2016 at Westside, the second accident in 2017 at CRST, and about this new accident at CRST that occurred on October 2, 2019. At the time of arbitration he was waiting for authorization for left total knee replacement.

When asked about his baseline on a scale of one to ten zero being no pain and ten being excruciating pain, he testified at rest with his weight off his knee it's a three to a three and a half, and getting up, just going across the street from the parking deck to the courthouse up the elevator his pain was an eight. When asked about his baseline he testified there is yet another new baseline following the October 2, 2019 accident and that his left knee pain has increased.

He testified he lives with his wife and that he is unable to do most daily activities and that his wife does a vast majority of them. He testified he is waiting and hoping that his left knee replacement is awarded to him and if it were he would consult with Dr. Mulvey immediately and do everything in his power to get back to gainful employment after surgery.

On cross examination by Westside Transportation's attorney, Petitioner admitted the only surgery performed by Dr. Li was arthroscopy and that as of January 2017, Dr. Li had told him he can return to work full duty. Petitioner admitted that Dr. Li released him to maximum medical improvement on February 9, 2017 from the June 3, 2016 accident. He testified he was able to perform the duties at Westside Transportation very well but not without pain. He testified the pain was tolerable and that he did not miss any time off work because of left knee problems after he returned to work . He testified he had to pass a DOT exam in order to start working at CRST.

On cross examination by CRST's attorney, Petitioner admitted he had not undergone any treatment to his left knee prior to 2016. He admitted he had been treating with Dr. Li for his left knee since 2016. He admitted that after the arthroscopic surgery performed by Dr. Li that he continued to have pain in his knee and that Dr. Li injected that knee for that pain.

He admitted that when he went through work conditioning that he continued to have pain to the left knee namely with walking crouching and standing. He admitted that Dr. Li and he had discussions about his left knee condition and that the pain and limitations he was experiencing would be permanent in nature.

When provided an excerpt from doctor Li's medical records that read, *"I explained to the patient that he will have permanent aggravation of his osteoarthritis and he will need symptomatic treatment in the form of medications, injections, visco supplementation and possibly a total knee replacement as a result of this in the future,"* he did not dispute such conversation.

He admitted that Dr. Li had told him that he will be experiencing additional symptoms in the left knee in the future following the June 2016 injury that would require him to go back and see him again for future treatment. He admitted that Dr. Li gave him pain medication when he released him from his care in 2017 following the June 2016 accident.

He admitted that when he returned to work at Westside Transportation in February 2017, that his moving around pain was between a six and a nine out of ten. He attested that after the CRST work injury on November 13, 2017, that he went back to work for CRST after being off for 2 months. When asked if his left knee at any time ever felt as good as it did prior to June 2016 he replied, "absolutely not."

On being called as a witness for ***direct examination by Westside Transportation's*** attorney in their case in chief, he did admit that his pain had gotten progressively worse after the 2nd and 3rd accidents.

Neither respondent denied accidental injuries while petitioner was under their employment. Respondent Westside stipulated to accidental injuries occurring on June 9, 2016 and respondent CRST stipulated to accidental injuries to have occurred in their employ on November 13, 2017 and on October 2, 2019. However, both Westside and CRST denied causation as it related to petitioner's current need for a left total knee replacement seemingly attributing the need for same to the other.

No rebuttal witnesses were called by either respondent.

Medical Treatment

Petitioner received DOT clearance to work at Westside Transportation on June 2, 2016. PX1. Petitioner was seen at Mercy Medical Center located in Cedar Rapids Iowa on June 10, 2016. PX2 The chief complaint was that his left knee popped and swelled up yesterday while he was pulling a handle on a truck trailer.PX2 at p7 X-rays demonstrated moderate tricompartmental left knee degenerative osteoarthritis without evidence to suggest an acute injury. Id He was instructed to follow up with his primary physician if pain persisted and he was discharged. Id

Petitioner consulted his family physician Dr. John Lovell on June 16, 2016.PX4 He stated that he hurt his left knee moving a tandem slide lever as he squatted to move the lever while pushing and felt a pop in his left knee. Id. He was experiencing intense pain with weight bearing and had to have his wife pick him up in Cedar Rapids. Id He was ambulating with the crutch and using a left knee brace. Id He denied previous problems to his left knee. Dr. Lovell ordered an MRI of the left knee without contrast. Id

Petitioner was examined by Lawrence Li of Orthopedic and Shoulder Center on June 30, 2016. PX5 Dr. Li agreed that a left knee MRI was necessary. Dr. Li's diagnosis was suspected left knee acute injury consistent with medial meniscal or chondral injury.PX5 He was prescribed Mobic and Rabeprazole. PX5

The MRI of the left knee on June 30, 2016 demonstrated multi focal fraying/tear of the body and posterior horn of the medial meniscus; small oblique tear of the anterior horn of the lateral meniscus reaching the inferior articular surface ; Grade 2 MCL sprain; tricompartmental degenerative joint disease most notably in the medial compartment ; and a small joint effusion with several intra articular loose bodies .PX5 at p.8

Petitioner returned to Dr. Li on July 5, 2016. Dr. Li recommended left knee arthroscopic surgery.PX5 He stated to a reasonable degree of medical certainty that although Mr. Miller had pre-existing osteoarthritis in his left knee, the injury he suffered on June 9, 2016 caused a medial and lateral meniscal tear and also the loose bodies seen on the MRI.PX5 He stated the need for surgery was a direct result of the injury of June 9, 2016.PX5 at p. 14

Petitioner was examined at the request of the Respondent by Dr. Michael Watson of Watson Orthopedics on August 22, 2016. Dr. Watson stated that additional treatment including arthroscopic surgery was needed because of the work injury.PX5 at p.20. He also stated that Mr. Miller had pre-existing asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9, 2016.Id

Petitioner underwent left knee surgery at Ireland Grove Center on September 14th 2016.PX5 at p.22 The procedure performed was left knee arthroscopy with partial medial and lateral meniscectomy; abrasion chondroplasty medial femoral condyle, patella and femoral trochlea. PX5 at p.22-23 He was seen post operatively on September 22,2016 and again on October 20, 2016. Dr Li stated that he continued to complain of residual pain from his osteoarthritis aggravated by his work injury.PX5 at p.29 A Supartz injection was administered November 17th 2016 and worked well and petitioner felt better. PX5 at p.31

He was examined again by Dr. Li on December 9, 2016. Dr. Li commented that Petitioner had completed his FCE and it showed he had done relatively well and that 3 weeks of work conditioning were recommended. The WCA (work capacity assessment) report dated December 6, 2016 conducted at OSF Industrial Rehabilitation demonstrated limitations with climbing and low-level work. PX10 at p.2 Petitioner demonstrated difficulty with getting into and out of the low position such as kneeling or crouching to complete a task. Id

He was examined again by Dr. Li on January 6, 2017 and was instructed to return to work full duty and to follow up in 4 weeks for a final check.PX5 at pgs. 35-37 He was again examined by Dr. Li on February 9, 2017.PX5 at pgs. 38-41 He was able to drive and get into his truck without significant discomfort although he did have significant discomfort with prolonged standing and walking and if he walked 50 yards or more he had discomfort.PX5 at p.38 If he stood more than 10 minutes there was discomfort. Id Dr. Li opined that Petitioner had a permanent aggravation of his osteoarthritis and that he will need symptomatic treatment in the form of medications, injections, viscosupplementation, and possibly a knee replacement as a result of this in the future.PX5 at pgs.40-41 He was released at that time to maximum medical improvement. Id

2nd accident at CRST

Petitioner was seen again by Dr. Li on November 15, 2017. He reported a new injury to have occurred November 13, 2017.PX5 at p.43. He testified he was getting up into his semi cab and twisted his left knee. Id Dr. Li suspected meniscal tear and recommended an MRI and follow up to determine the appropriate treatment plan.PX5 at p.47 MRI testing of the left knee on November 17, 2017 demonstrated tricompartmental degenerative joint disease , most notably in the medial and patella femoral compartments, slightly progressed since the prior exam, and a suspected recurrent tear of the medial meniscus.PX5 at pgs.53-54

Petitioner was reexamined by Dr. Li on November 20, 2017 at which time Dr. Li reviewed the new MRI scan and diagnosed a new tear of the medial meniscus superimposed on underlying osteoarthritis.PX5 at p.58 Dr. Li noted relief from last week's previous injection. Id He instructed Petitioner to start physical therapy and to follow up in three weeks. Id

Petitioner was examined again on December 13, 2017 and complained that his left knee continued to hurt with any standing over 15 minutes and that he complained of significant swelling and could not be as mobile as he was before.PX5 at pgs.59-61 He was still using one crutch to ambulate. Id Dr. Li recommended left knee arthroscopic surgery. Id

Petitioner was examined again by Dr. Li on January 25, 2018. PX5 at pgs.63-64 Dr. Li noted that the IME stated that he needed to return to work full duty and that his workers compensation payments had been cut off so he was there to discuss returning to work. Id His symptoms remained the same and he continued to have pain however he could not afford to remain off work. Id He was provided prescriptions of Mobic and Prilosec and Rabeprazole. Id He was allowed to return to full duty work and advised to return if symptoms worsen.PX5 at p.65

Petitioner was seen again on February 26, 2018 with continued left knee pain with prolonged standing and walking.PX5 at pgs.66-68 He was able to tolerate driving. Id His medication was re dispensed and he was allowed to continue working full duty and instructed to follow up if his pain increased.PX5 p.68

Petitioner was seen on April 20, 2018 in follow up by Dr. Li.PX5 at pgs.69-71 His medication was continued and he was instructed to consider options of having viscosupplementation or arthroscopic knee surgery. Id He was seen again July 30th 2018. PX5 at p.72 He continued to have pain over the anterior and medial aspect of his knee. Id He reported that it had been catching on him. Id Dr Li administered an injection and advised petitioner to consider knee arthroscopy. Id

3rd accident at CRST

Petitioner returned to Dr. Li on October 3, 2019. Px6 pgs.12-16 He reported a third injury to have occurred in Morton, Illinois. Id He was getting out of his truck and as he was stepping down he put his left foot down on the damaged area of concrete causing him to twist his left ankle and twist his left knee. Id Since that time he has had constant severe pain. Id Dr. Li referenced the previous work-related injuries to his left knee back in 2016 and then again in 2017.Id He referenced that these cases were still in litigation but that this was clearly a new injury. Id Petitioner was unable to weight bear on his left knee. Id Dr. Li recommended an MRI and follow up to determine the treatment plan. Id

A left knee MRI was performed on October 3, 2019 at Open MRI Center demonstrated the possibility of a recurrent medial meniscal tear, including a suspected horizontal tear of the anterior horn, and degenerative joint disease, moderate to severe in the medial compartment.PX6 at p.17. Dr. Li evaluated Petitioner on October 4, 2019 and based on the MRI findings recommended physical therapy. Id He felt there was a significant component of aggravation of his underlying arthritis.PX6 at p.22

Petitioner was examined again on October 21, 2019.PX6 at p.23 He reported moderate improvement in his left knee pain with the injection and Mobic but he was still not near where he was before. Id He was unable to walk any significant distance. Id Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with a small medial meniscal tear.PX6 at p.25 He opined that the osteoarthritis aggravation was the main source of his pain and he recommended Supartz injections. Id Petitioner received the first of five supartz injections on October 22, 2019 and the last on November 19th 2019.PX6 at pgs.26-30. He was instructed to return to the clinic prn. Id

Petitioner returned to Dr. Li on December 6, 2019. He felt that the injections had not helped him significantly and at that point his pain was beyond what he can tolerate. PX6 at p.31-33 Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with medial meniscal tear. Id He was provided Mobic and Prilosec. Id Dr. Li felt he had failed all nonoperative treatment and referred him to doctor Mulvey for a total knee replacement. Id

Evidence deposition of Dr. Li

Dr. Lawrence Li was deposed on October 29, 2018.PX12. Dr. Li was read his office note from December 9, 2016 in which he stated that that his diagnosis was left knee arthroscopy with partial medial and lateral meniscectomy , abrasion chondroplasty, medial femoral condyle, patella and femoral trochlea with residual pain from osteoarthritis permanently aggravated by his work injury. PX12 at p.28.

He was questioned what he meant by permanently aggravated by his work injury. Id Doctor Li stated *"so even though Mr. Miller didn't have any symptoms before his accident, he had osteoarthritis. The accident didn't cause all of his osteoarthritis. But the accident did accelerate it beyond its normal progression. So accelerated by causing further fragmentation of the articular cartilage that needed to be addressed. So if we*

have a line that has a slope of let's say 10 degrees this then moved it, moved the line up the Y axis a certain amount it may have - and then made the slope let's say 12 degrees. That's just an example. That's not exact."

He was also asked about the significance of the November 13, 2017 accident. PX12 at pgs.47-48. Dr. Li testified *"it is my opinion that employer two that accident two would be responsible for any further treatment , you know, including a total knee. The reason being Mr. Miller was on a certain course of progression towards worsening osteoarthritis going to a total knee. I think that accident two increased the - -or shorten the time distance to that and also most likely accelerated the progression so that it would come up sooner than if accident two never happened."* He testified he felt accident two was a material aggravation of the permanent aggravation sustained in accident one. PX12 at pgs.48-49.

Regarding accident #3 that occurred on October 2, 2019, Dr. Li's records state that he felt that there was a significant component of aggravation of his underlying arthritis.PX6 at p.22.

IME report of Dr. Watson

Dr. Watson of Watson Orthopedics performed an independent medical evaluation on August 22, 2016 for Westside.PX5 at p.19-21 He answered questions posed by Westside transportation as follows:

1. My current diagnosis at this time is tricompartmental osteoarthritis with an acute medial collateral ligament sprain as well as tears of the medial meniscus in the lateral meniscus.
2. I do believe there are pre-existing medical conditions which are related to his current condition. I believe that most likely the tri-compartmental osteoarthritis noted on the MRI scan is likely preexisting before the injury of June 9th, 2016. The meniscal tearing may or may not be an acute finding as it would be impossible to date these lesions. The grade 2 MCL sprain appears to be acute . The small loose bodies noted on the MRI scan are likely chronic.
3. I do believe that the accident history relates to his current symptoms and some of the above mentioned acute diagnostic findings.
4. I believe that Mr. Miller has preexisting asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9th, 2016. Therefore, additional treatment, including arthroscopic surgery, is needed because of the work injury. The pre-existing condition of osteoarthritis in part has contributed to some of the acute findings in Mr. Miller's left knee. Were it not for the injury of June 9th 2016 , however, I do not feel that surgical treatment and subsequent postop care would be necessary at this time. For that reason, I believe that surgery being requested is causally related to the accident history provided by Mr. Miller.
5. I do not believe that Mr. Miller is currently capable of working full duty . I do not believe that he should do any lifting, climbing, or squatting,. He should not do any kneeling. Assuming that surgical treatment would be successful , that I would anticipate maximum medical improvement to be around 6 to 8 weeks post up and I would estimate that at that time he would likely reach his pre-accident condition as it relates to the left knee . If further treatment would be necessary in the future, and it likely will, I feel that additional treatment will be necessary because of the chronic conditions in Mr. Miller's knee . Finally I believe that the reduced work status is secondary to his acute injury rather than his pre-existing condition, which was obviously present prior to June 9th, 2016.

Deposition of Joshua Alpert

Dr. Joshua Alpert testified by way of evidence deposition March 8, 2019.PX14. Dr. Alpert compared the 2016 arthroscopic operative report of Dr. Li to the new MRI taken after Petitioner's second accident on November 13, 2017.PX12 at p.43 Dr. Albert agreed that the new MRI report showed a recurrent tear of the medial meniscus in the same area as the prior medial meniscectomy from 2016. He testified that finding supports his opinion today that the current condition of Petitioner after the second injury of November 13, 2017 clearly demonstrated a worsening of the arthritic condition in the surgical sites where he previously had arthroscopy, as opposed to an acute injury attributable to November 13, 2017.PX12 at p. 44. He agreed that the existence of the progression of the surgical areas where the prior meniscectomy was performed, where the articular cartilage was debrided and shaved, that those areas have progressed, and further deteriorated, indicative of an acceleration of the arthritic process. PX12 at 45. ***Dr. Alpert testified that the arthroscopic surgery that Dr. Li performed accelerated the timeframe in which Mr. Miller would go on to eventually require a total knee replacement. Id*** Dr. Alpert testified then he would define the event of November 13, 2017 as a manifestation of petitioners' arthritic condition rather than a new injury breaking the chain of causation.PX14 at p.46

Dr. Alpert also examined Petitioner after his 3rd injury on October 2, 2019.CRST RX5 While Dr. Alpert opined that Petitioner sustained an acute component in that accident and suggested rest, therapy, medication and Supartz injections, ***he further opined that the ultimate need for a left total knee replacement was not related to the October 2, 2019*** event but to rather his preexisting condition. Id

Deposition of Dr. Herrin

Dr. Rodney Herron testified on behalf of Westside Transportation on May 2, 2019.PX13 Dr. Herrin was asked the following question: PX13 at p.22

Q. The procedure that doctor Li performed in the petitioner's knee , meaning he removed the meniscus medially and laterally , or at least a portion of it, and also did a chondroplasty procedure, would you agree that that operation has the potential to accelerate the progression of arthritis in the Petitioner Mr. Miller's knee?

A. The removal of the meniscus I don't think necessarily would make a difference. It's nonfunctional. I'm uncertain about the chondroplasty. That potentially could aggravate things . I wouldn't do that procedure for that reason.

Q. Because of the potential for aggravation?

A. Potentially. Depends on what he means by chondroplasty too. If you just kind of smooth off the joint that's probably not going to make a big difference. If you actually do a true abrasion chondroplasty, which is kind of an outdated procedure , then that may make a difference.

CONCLUSIONS OF LAW:

With regard to issue (F) whether Petitioner's injury is casually connected to his injury while working for Respondent, the Arbitrator finds as follows:

The Petitioner's current condition of ill being is casually connected to his injury while working for CRST. Here, the Petitioner's current condition of ill -being is related to the November 13, 2017 work accident. Courts have discussed when a claimant has reached MMI. Among the factors to be considered in determining whether a claimant has reached maximum medical improvement include 1) a release to return to work, with restrictions or otherwise, 2) medical testimony or evidence concerning claimant's injury, the extent thereof, the

prognosis, and 3) whether the injury has stabilized. Beuse v. Industrial Commission, 299 Ill.App.3d at 183, 233 Ill.Dec. 453, 701 N.E.2d at 98.(1998 1ST. Dist). The medical records and testimony are clear that the petitioner was at MMI for the June 9, 2016 injury by February of 2017.

In using the MMI factors In *Beuse,* noted above, the Arbitrator notes that the Petitioner was placed back to work in his job as a truck driver, heavy duty, in January of 2017 (PX. 5 p. 34-34) and placed at MMI by Dr. Li on February 9, 2016. Second, and most persuasive is the testimony of Dr. Li. Dr. Li noted that the Petitioner did not treat for his knee from February 9, 2017, until his second accident in November of 2017. (PX.5 p 40). Third, Dr. Li noted that there was no indication the Petitioner requested any medical treatment from February 9, 2017, until he returned to treat with him in November of 2017. The Petitioner did not seek any medical treatment from the time he was placed at maximum medical until his second injury. Furthermore, the testimony notes he had to climb in and out of his truck upwards of 100 times a day and he was able to meet all the physical demands of a truck driver from February 2017 to November 2017. The medical records and testimony are clear that after the Petitioner's knee surgery in September of 2016 he made a full recovery and was at MMI in February of 2017 for his knee injury which occurred during the June 2016 accident.

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury." *Vogel v. Industrial Commission,* 354 Ill.App.3d 780, 786, 821 N.E.2d 807, 812 (2005). From the evidence in this case, it is clear that the November 2017 and October 2019 accidents broke the chain of causation for the 2016 accident.

The most compelling evidence in this case is the testimony of Dr. Li. Dr. Li's deposition occurred on October 29, 2018, which was after the June 2016 and November 2017 accidents but before the October 2019 accident. During his testimony Dr. Li was asked and noted the following:

Q. "If you performed the arthroscopy that you had recommended as part of an option for Mr. Miller and assuming Mr. Miller's meniscus tears that you identified or you described here in your deposition today were repaired following that procedure or as part of that procedure and he returned to his pre-November 2017 baseline, would it still be your opinion that any further treatment for the osteoarthritic condition, including a possible total knee replacement, would be related to my accident as opposed to the first one (accident)?"

> A. "Well, it's my opinion that the second accident exacerbated and accelerated the need for a total knee. So any total knee in the future would still be related to the second accident because I think the second accident broke the chain of causation for the first." (P. 76)

Respondent CRST argues that the first date of loss caused the current recommendation for total knee replacement surgery and that the *International Harvester Co.,* line of cases would prove from a legal standpoint that the June 2016 accident caused the need for knee replacement surgery. However, in this case there is unrefuted evidence by, his treating doctor, Dr. Li that the November 13, 2017, accident broke the chain of causation of the first accident. He was clear that any additional treatment was not a result of the first accident. There was no evidence presented that the first knee injury put him at a greater predisposition for the second and third accidents. When questioned specifically Dr. Li noted to a reasonable degree of medical and surgical certainty that based on his review of the films, the operative report, and his treatment of this patient, if he were to progress to a total knee arthroplasty, the employer of accident two (CRST) should pay for it and it is his opinion that employer two (CRST) would be responsible for any further treatment, including a total knee. (Dr. Li. P. 71)

The Petitioner acknowledged after he saw Dr. Li on February 9, 2017, that the condition of his right knee did not warrant him returning to the doctor for treatment until "after" he suffered the November 13, 2017, injury while working at CRST. The Petitioner testified that his condition and symptoms worsened after the 2nd

and 3rd accidents. It is important to note that he continued to treat with Dr. Li even after the second accident and that Dr. Li continued to recommend arthroscopic surgery up until and after the 3rd injury. He was not referred to the doctor that specializes in knee replacements until after the course of injections after his 3rd accident failed to alleviate his symptoms in December 2019.

The contention that first accident caused the current condition of ill being leading to the knee replacement surgery is further refuted by the November 1, 2019, IME by Dr. Albert. In this IME Dr. Albert noted that if the Petitioner was being truthful about his history, the October 2019 accident might have caused a need for about three months of conservative treatment, including injections and would require him to miss time off from work. It is illogical and improbable that CRST's own doctor noted a more recent knee injury regarding the October 2019 accident, acknowledge the need for some treatment after the most recent accident, then argues that his current condition of ill being is not related to the most recent accident.

With regard to issue (K) whether Petitioner is entitled to any prospective medical care from Respondent, the arbitrator finds as follows:

For the reasons noted in Subparagraph F and Case # 16wc19633, the Petitioner is entitled to prospective medical care as a result of the November 13, 2017 date of loss and not the work injury related to the June 9, 2016, accident.

Signature of Arbitrator

06/05/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC029339
Case Name	MILLER, PHILIP v. CEDAR RAPIDS STEEL TRANSPORT
Consolidated Cases	16WC019633 17WC035761
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0349
Number of Pages of Decision	19
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Joseph J. Leonard
Respondent Attorney	Brad Antonacci

DATE FILED: 7/7/2021

/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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Philip Miller,

Petitioner,

vs. No. 19 WC 29339

Cedar Rapids Steel Transport,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by Respondent Cedar Rapids Steel Transport (CRST) and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.[1] The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 23, 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.

[1] Petitioner's three cases on review are intertwined and have been properly consolidated. However, the Commission is presently unable to issue consolidated decisions.

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.

July 7, 2021

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

SJM/sk
o-4/20/2021
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0349
NOTICE OF 19(b) ARBITRATOR DECISION

MILLER, PHILIP
Employee/Petitioner

Case# **19WC029339**

16WC019633
17WC035761

CRST
Employer/Respondent

On 6/23/2020, 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 0.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0926 LEONARD LAW GROUP LLC
JOE LEONARD
325 S PAULINA ST SUITE 100
CHICAGO, IL 60612

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
300 HAMILTON BLVD
PEORIA, IL 61601

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)

Phillip Miller
Employee/Petitioner

v.

CRST
Employer/Respondent

Case # **19** WC **29339**

Consolidated cases: **16 WC 19633 and 17 WC 35761**

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 **Kay**, Arbitrator of the Commission, in the city of **Chicago**, on January 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **October 2, 2019**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**53,464.84**; the average weekly wage was $**1,028.17**.

On the date of accident, Petitioner was **59** 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 $**8,915.29** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,386.51** for other benefits, for a total credit of $**10,301.80**.

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

ORDER

SEE THE CONSOLIDATED DECISIONS OF THE ARBITRATOR IN 16 WC 19633 AND 17 WC 35761 CONSOLIDATED WITH 19 WC 29339; SAID DECISIONS ARE MADE A PART OF THE DECISION IN THIS CASE, AS IF FULLY SET FORTH HEREIN;

SEE THE ATTACHED DECISION OF THE ARBITRATOR FOR FINDINGS OF FACT AND CONCLUSIONS OF LAW AS TO CAUSAL CONNECTION, LIABILITY FOR MEDICAL BILLS; AND LIABILITY FOR PROSPECTIVE MEDICAL; SAID DECISION IS INCORPORATED HEREIN AS IF FULLY SET FORTH HEREIN;

THE ARBITRATOR DENIES THAT PETITIONER'S CURRENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE ACCIDENT OF OCTOBER 2, 2019, BUT FINDS A CLOSED PERIOD OF CAUSAL CONNECTION FROM 10/2/19 THRU JANUARY 1, 2019, AS PER CRST IME PHYSICIAN DR. ALPERT (CRST EX#3) WHO PROVIDED A PERIOD OF CAUSATION FOR THREE MONTHS AFTER THE OCTOBER 2, 2019 ACCIDENT;

THE ARBITRATOR FINDS IN FAVOR OF PETITIONER ON THE DISPUTED ISSUE OF LIABILITY FOR UNPAID MEDICAL BILLS-INCURRED FROM OCTOBER 2, 2019 THRU JANUARY 1, 2020 AS THAT BEING THE PERIOD OF CAUSATION FOUND BUY THE ARBITRATOR FOR THE ACCIDENT DATE OF 10/2/2019; AND FURTHER AWARDS PETITIONER THE BILLS LISTED IN PX18 PURSUANT TO SECTION 8.2 WITH CREDIT GIVEN TO RESPONDENT CRST FOR ANY BILLS PAID AS REFERENCED ON ARB EX. 6 AND ON CRST RX11;

THE ARBITRATOR DENIES LIABILITY AS AGAINST CRST FOR THE REQUESTED LEFT TOTAL KNEE REPLACEMENT FOR THE ACCIDENT DATE OF 10/02/2019;

THE ARBITRATOR DENIES FURTHER TTD TO PETITIONER BEYOND 1/1/2020 AS THE CONDITION OF ILL-BEING, THAT BEING A LEFT KNEE REPLACEMENT, IS CAUSALLY RELATED TO THE ACCIDENT OF 11/13/2017.

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

06/05/2020
Date

ICArbDec19(b)

JUN 23 2020

PROCEDURAL HISTORY

This matter is consolidated with Case #16wc19633 and #17wc35761.

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on January 24, 2020 in Chicago, Illinois. this matter involves three separate dates of accident in which the petitioner alleges injuries to his left knee while working for two respondents. These accidents occurred on June 9, 2016, November 13, 2017, and October 2, 2019. The 2016 accident occurred while he was working for Respondent Westside Transportation the 2017 and 2019 accidents occurred while he was working for Respondent CSRT.

The parties went to hearing with the following issues in dispute: whether Mr. Phillip Miller's (hereinafter "Petitioner") current condition of ill-being is casually connected to his injury on October 2, 2019 and whether CRST is liable for the total knee replacement (hereinafter "TKA") for the left knee and any unpaid bills listed in (PX18) incurred after 10/2/19 less any 8j credit due Respondent, and TTD for the period of 10/3/19 to present or 10/13/19 through 1/1/2020. (Arb.X3)

The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that he was hired by Westside Transportation on June 2, 2016. He underwent the required DOT physical prior to his employment and was cleared to work. He denied left knee pain prior to June 2, 2016 and denied ever being prescribed a left knee MRI, physical therapy, arthroscopy, or a left total knee replacement.

He testified that he was hired as a driver of semi tractors and trailers. His duties consisted of picking up and delivering freight, getting in and out of the truck, fueling, opening the trailer doors, docking the trailer, and maintaining the logbooks per DOT regulations. He did not have a set route. He testified that he would get his assignments through satellite communication inside the tractor cab.

On June 9, 2016 he was driving his truck in Cedar Rapids, Iowa. He arrived at a designated pick up site and docked the trailer. After loading, he shut the trailer doors and pulled the trailer away from the dock. He then proceeded to slide the tandems forward to be legal weight and legal length now that he was loaded. That required that he crouch in a baseball catcher position and grab a lever under the trailer and pull it out. He testified that the lever got stuck the first time due to the added weight of the load. On the second attempt he pulled hard and in doing so he twisted his left knee, heard a pop, and felt a jolt of pain in his left knee like lightning. He was able to catch himself with his hand and did not fall to the ground.

He continued to work but as time went on, he felt intense pain in the left knee and called dispatch. He eventually stopped working and called his wife the following morning. She arrived and drove him to Mercy Medical Center.

Petitioner was examined at Mercy Medical Center and provided crutches, medications of Toradol and Relafen, and instructed to follow up with his primary doctor. He followed up by his primary physician Dr. John Lovelle (hereinafter "Dr. Lovelle") on June 16, 2016 in Tremont, Illinois. Dr. Lovelle prescribed medication and ordered an MRI of the left knee.

He underwent an MRI on June 30, 2016 at Open MRI Center in Normal, Illinois and consulted with orthopedic physician Dr. Li that same day. He testified that Dr. Li recommended surgery to his left knee. Prior

to surgery being approved, he was examined by Dr. Watson by the insurance company for Westside on Aug 22, 2016. He testified that his surgery was then approved.

Petitioner underwent surgery at Ireland Grove Center on September 14, 2016. He followed up with doctor Li on September 22nd, and again on October 20, 2016. He underwent a suparts injection on November 17, 2016 by Dr. Li. He testified he participated in physical therapy at OSF from September 21st through December 6, 2016. His physical therapy progressed into a work conditioning program in December of 2016. He had a work capacity evaluation on December 9, 2016.

Petitioner testified that he was examined by doctor Li again on January 6, 2017. Dr. Li discussed the work capacity evaluation with him. He testified that he saw Dr. Li again February 9, 2017 and at that visit he was complaining of significant discomfort with prolonged standing or walking greater than 50 yards. He told Dr. Li that standing greater than 10 minutes at a time caused discomfort. He was given a 3-month supply of Mobic and Rabeprazole. **He testified doctor Li discussed knee replacement surgery at this visit. He did not have knee replacement surgery at that time. He testified Dr. Li released him to return to full duty work after this visit.**

Petitioner testified he returned to full duty work at Westside for approximately 4 1/2 months. He testified he continued to perform the job duties of a truck driver. **He testified his left knee felt better after surgery but that it was nowhere near as close to where it was before his injury.** He testified he had pain even at rest and on a scale of one to ten he rated it at a two to a two and a half. When he was sitting with his weight off his knee, he rated his pain a six to a nine. If he had to get up and move around and do his duties such as getting out of the truck to fuel, open the trailer door, walk into a building or get paperwork, the pain scale would be anywhere from a six to nine depending upon how far he would have to walk.

Petitioner testified he stopped working for Westside because he discovered a job opportunity in Morton, Illinois. It was only 3 1/2 miles from his house and involved working a dedicated account hauling Caterpillar freight for CRST. He testified he left Westside in May 2017 because the new job at CRST offered more money and was closer to his house. The job at CRST was less physical.

He testified he was initially hired at CRST to be a driver trainer. He was an experienced driver and they assigned him to train employees who had just completed in-house driving school. He would evaluate their performance over a five-week period. He testified the trainee performed all the major and minor physical duties to get experience including fuelling, opening the doors of the trailer, docking the trailer, and going into the building to get the paperwork. He testified he had this helper over a five-month period.

He testified that on November 13, 2017, he was getting into the cab of his truck on the driver side using a 3-point stance. He put his right foot up on the first step followed by his left and that in order to get his "bottom" into the driver seat he would swing his right foot into the floorboard underneath the seat, and in doing so, pivot with his left leg. While performing this activity his left leg did not pivot on the metal step and he felt a sheering action in his left knee with pain.

He testified he was still taking Mobic and the other medication prescribed to him by Dr. Li prior to this occurrence. In describing his level of pain to his left knee on a scale of one to ten, zero being no pain and ten being intense pain he testified his pain level increased at both sitting and with movement. He rated his sitting pain a three to a three and a half and his getting up and moving around pain a nine. He reviewed photographs (PX11) and identified them as the steps he was ascending when his left knee twisted. He testified he personally took the photos on his cell phone. He testified he reported this accident to CRST and returned to Dr. Li again for treatment.

He was examined by Dr. Li on November 15, 2017. Dr. Li ordered a new MRI of his left knee and prescribed crutches. Left knee MRI was performed on November 17th at Open MRI Center. Dr. Li discussed arthroscopic surgery versus injection treatment at the follow up appointment. Petitioner testified he underwent an injection and resumed physical therapy at OSF.

He was seen by Dr. Li again December 13, 2017 at which time Dr. Li recommended left knee arthroscopy. He testified that he was examined by the workers compensation carrier for CRST on January 9, 2018 by Dr. Joshua Alpert (hereinafter "Dr. Alpert"). He testified he gave Dr. Alpert a history of his injury and surgery in 2016 and the accident at CRST on November 13, 2017. He testified that after this examination his arthroscopic surgery was denied.

Petitioner saw Dr. Li again on January 25, 2018 at which time he requested Dr. Li to release him to return to work because his TTD benefits were cut off. He testified he returned to work for CRST. He testified that upon his return, sitting at rest with weight off his knee in a chair or the driver seat that his pain would be three and a half to a four and some days it would be more than that. Getting up and moving around to do his duties like getting out of his truck and walking into buildings to get paperwork, shutting trailer doors, and when fueling, his pain would be eight to a nine and some days a ten out of ten.

When asked if the pain he was describing after his 2nd injury at CRST was the same level of pain that he was dealing with after the 2016 surgery, he testified that after November 13, 2017 that it had increased on a permanent basis. He testified it was his new baseline.

He continued to work for CRST but testified that they changed his job to a less physical position and allowed him to make shorter runs between two dedicated points from Morton, Illinois to Mount Vernon, Illinois. He testified he only had to go in with an empty trailer and do a drop and hook, do the billing, and sign the paperwork.

He did see Dr. Li in consultation on February 26, 2018 at which time Dr. Li extended his Mobic and prescribed Prilosec. He was instructed to follow up as needed. He returned to Dr. Li on April 20, 2018 and he advised Dr. Li at that time that he was in more pain. He was prescribed Rabeprazole. Dr. Li recommended arthroscopy versus visco supplementation, but neither were approved. He continued to work at CRST and his pain to his left knee continued and remained consistent with a new baseline.

He testified that he saw Dr. Li on July 30, 2018. He was in much more pain and his left knee was catching. He was provided an injection and his prescriptions of Mobic and Rabeprazole were again renewed. He testified Dr. Li again recommended surgery, but it was again denied.

He continued to work for CRST without returning for medical treatment until October 2019. **On October 2, 2019 he was exiting his tractor** on the driver side door in a 3-point stance facing the inside of the cab . When he placed his right foot on the ground where 2 concrete pads joined there was a large gap where the expansion joint was worn and chipped away like a pothole. His right foot toe went in the hole and caught and when he went to step down his foot stayed in the hole he rotated and lost his balance. He tried to reach and grab the side handle of the truck but failed to reach it and he fell.

Petitioner described his left knee pain after the fall as a ten. He notified his employer immediately. He again consulted with Dr. Li who sent him for another MRI to his left knee on October 3, 2019. He was examined by Dr. Li on October 4, 2019 and he recommended physical therapy and injections. He told Dr. Li on October 21, 2019 that he was having difficulty walking although he noted moderate improvement with the injection. Dr. Li recommended supartz injections. Petitioner had the first of five supartz injections on October 22, 2019 and the last one on November 19, 2019.

Petitioner saw Dr. Li on December 6, 2019 after the last injection. He advised him that he did not get any significant improvement from the injections. He told Dr. Li he could not tolerate the pain anymore. He testified Dr. Li referred him to Dr. Mulvey for a left knee arthroplasty. He testified that left knee arthroplasty had not been approved as of the date of arbitration. He testified Dr. Li has not released him from his care and that he still has him off work. He has not seen Dr. Mulvey yet and has not received any approval to do so from the CRST workers compensation carrier.

He testified he saw doctor Joshua Alpert (hereinafter "Dr. Alpert") again at the request of CRST on November 1, 2019. He told Dr. Alpert again about the accident in 2016 at Westside, the second accident in 2017 at CRST, and about this new accident at CRST that occurred on October 2, 2019. At the time of arbitration he was waiting for authorization for left total knee replacement.

When asked about his baseline on a scale of one to ten zero being no pain and ten being excruciating pain, he testified at rest with his weight off his knee it's a three to a three and a half, and getting up, just going across the street from the parking deck to the courthouse up the elevator his pain was an eight. When asked about his baseline he testified there is yet another new baseline following the October 2, 2019 accident and that his left knee pain has increased.

He testified he lives with his wife and that he is unable to do most daily activities and that his wife does a vast majority of them. He testified he is waiting and hoping that his left knee replacement is awarded to him and if it were he would consult with Dr. Mulvey immediately and do everything in his power to get back to gainful employment after surgery.

On cross examination by Westside Transportation's attorney, Petitioner admitted the only surgery performed by Dr. Li was arthroscopy and that as of January 2017, Dr. Li had told him he can return to work full duty. Petitioner admitted that Dr. Li released him to maximum medical improvement on February 9, 2017 from the June 3, 2016 accident. He testified he was able to perform the duties at Westside Transportation very well but not without pain. He testified the pain was tolerable and that he did not miss any time off work because of left knee problems after he returned to work . He testified he had to pass a DOT exam in order to start working at CRST.

On cross examination by CRST's attorney, Petitioner admitted he had not undergone any treatment to his left knee prior to 2016. He admitted he had been treating with Dr. Li for his left knee since 2016. He admitted that after the arthroscopic surgery performed by Dr. Li that he continued to have pain in his knee and that Dr. Li injected that knee for that pain.

He admitted that when he went through work conditioning that he continued to have pain to the left knee namely with walking crouching and standing. He admitted that Dr. Li and he had discussions about his left knee condition and that the pain and limitations he was experiencing would be permanent in nature.

When provided an excerpt from doctor Li's medical records that read, *"I explained to the patient that he will have permanent aggravation of his osteoarthritis and he will need symptomatic treatment in the form of medications, injections, visco supplementation and possibly a total knee replacement as a result of this in the future,"* he did not dispute such conversation.

He admitted that Dr. Li had told him that he will be experiencing additional symptoms in the left knee in the future following the June 2016 injury that would require him to go back and see him again for future treatment. He admitted that Dr. Li gave him pain medication when he released him from his care in 2017 following the June 2016 accident.

He admitted that when he returned to work at Westside Transportation in February 2017, that his moving around pain was between a six and a nine out of ten. He attested that after the CRST work injury on

November 13, 2017, that he went back to work for CRST after being off for 2 months. When asked if his left knee at any time ever felt as good as it did prior to June 2016 he replied, "absolutely not."

On being called as a witness for ***direct examination by Westside Transportation's*** attorney in their case in chief, he did admit that his pain had gotten progressively worse after the 2nd and 3rd accidents.

Neither respondent denied accidental injuries while petitioner was under their employment. Respondent Westside stipulated to accidental injuries occurring on June 9, 2016 and respondent CRST stipulated to accidental injuries to have occurred in their employ on November 13, 2017 and on October 2, 2019. However, both Westside and CRST denied causation as it related to petitioner's current need for a left total knee replacement seemingly attributing the need for same to the other.

No rebuttal witnesses were called by either respondent.

Medical Treatment

Petitioner received DOT clearance to work at Westside Transportation on June 2, 2016. PX1. Petitioner was seen at Mercy Medical Center located in Cedar Rapids Iowa on June 10, 2016. PX2 The chief complaint was that his left knee popped and swelled up yesterday while he was pulling a handle on a truck trailer.PX2 at p7 X-rays demonstrated moderate tricompartmental left knee degenerative osteoarthritis without evidence to suggest an acute injury. Id He was instructed to follow up with his primary physician if pain persisted and he was discharged. Id

Petitioner consulted his family physician Dr. John Lovell on June 16, 2016.PX4 He stated that he hurt his left knee moving a tandem slide lever as he squatted to move the lever while pushing and felt a pop in his left knee. Id. He was experiencing intense pain with weight bearing and had to have his wife pick him up in Cedar Rapids. Id He was ambulating with the crutch and using a left knee brace. Id He denied previous problems to his left knee. Dr. Lovell ordered an MRI of the left knee without contrast. Id

Petitioner was examined by Lawrence Li of Orthopedic and Shoulder Center on June 30, 2016. PX5 Dr. Li agreed that a left knee MRI was necessary. Dr. Li's diagnosis was suspected left knee acute injury consistent with medial meniscal or chondral injury.PX5 He was prescribed Mobic and Rabeprazole. PX5

The MRI of the left knee on June 30, 2016 demonstrated multi focal fraying/tear of the body and posterior horn of the medial meniscus; small oblique tear of the anterior horn of the lateral meniscus reaching the inferior articular surface ; Grade 2 MCL sprain; tricompartmental degenerative joint disease most notably in the medial compartment ; and a small joint effusion with several intra articular loose bodies .PX5 at p.8

Petitioner returned to Dr. Li on July 5, 2016. Dr. Li recommended left knee arthroscopic surgery.PX5 He stated to a reasonable degree of medical certainty that although Mr. Miller had pre-existing osteoarthritis in his left knee, the injury he suffered on June 9, 2016 caused a medial and lateral meniscal tear and also the loose bodies seen on the MRI.PX5 He stated the need for surgery was a direct result of the injury of June 9, 2016.PX5 at p. 14

Petitioner was examined at the request of the Respondent by Dr. Michael Watson of Watson Orthopedics on August 22, 2016. Dr. Watson stated that additional treatment including arthroscopic surgery was needed because of the work injury.PX5 at p.20. He also stated that Mr. Miller had pre-existing asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9, 2016.Id

Petitioner underwent left knee surgery at Ireland Grove Center on September 14th 2016.PX5 at p.22 The procedure performed was left knee arthroscopy with partial medial and lateral meniscectomy; abrasion

chondroplasty medial femoral condyle, patella and femoral trochlea. PX5 at p.22-23 He was seen post operatively on September 22,2016 and again on October 20, 2016. Dr Li stated that he continued to complain of residual pain from his osteoarthritis aggravated by his work injury.PX5 at p.29 A Supartz injection was administered November 17th 2016 and worked well and petitioner felt better. PX5 at p.31

He was examined again by Dr. Li on December 9, 2016. Dr. Li commented that Petitioner had completed his FCE and it showed he had done relatively well and that 3 weeks of work conditioning were recommended. The WCA (work capacity assessment) report dated December 6, 2016 conducted at OSF Industrial Rehabilitation demonstrated limitations with climbing and low-level work. PX10 at p.2 Petitioner demonstrated difficulty with getting into and out of the low position such as kneeling or crouching to complete a task. Id

He was examined again by Dr. Li on January 6, 2017 and was instructed to return to work full duty and to follow up in 4 weeks for a final check.PX5 at pgs. 35-37 He was again examined by Dr. Li on February 9, 2017.PX5 at pgs. 38-41 He was able to drive and get into his truck without significant discomfort although he did have significant discomfort with prolonged standing and walking and if he walked 50 yards or more he had discomfort.PX5 at p.38 If he stood more than 10 minutes there was discomfort. Id Dr. Li opined that Petitioner had a permanent aggravation of his osteoarthritis and that he will need symptomatic treatment in the form of medications, injections, viscosupplementation, and possibly a knee replacement as a result of this in the future.PX5 at pgs.40-41 He was released at that time to maximum medical improvement. Id

2nd accident at CRST

Petitioner was seen again by Dr. Li on November 15, 2017. He reported a new injury to have occurred November 13, 2017.PX5 at p.43. He testified he was getting up into his semi cab and twisted his left knee. Id Dr. Li suspected meniscal tear and recommended an MRI and follow up to determine the appropriate treatment plan.PX5 at p.47 MRI testing of the left knee on November 17, 2017 demonstrated tricompartmental degenerative joint disease , most notably in the medial and patella femoral compartments, slightly progressed since the prior exam, and a suspected recurrent tear of the medial meniscus.PX5 at pgs.53-54

Petitioner was reexamined by Dr. Li on November 20, 2017 at which time Dr. Li reviewed the new MRI scan and diagnosed a new tear of the medial meniscus superimposed on underlying osteoarthritis.PX5 at p.58 Dr. Li noted relief from last week's previous injection. Id He instructed Petitioner to start physical therapy and to follow up in three weeks. Id

Petitioner was examined again on December 13, 2017 and complained that his left knee continued to hurt with any standing over 15 minutes and that he complained of significant swelling and could not be as mobile as he was before.PX5 at pgs.59-61 He was still using one crutch to ambulate. Id Dr. Li recommended left knee arthroscopic surgery. Id

Petitioner was examined again by Dr. Li on January 25, 2018. PX5 at pgs.63-64 Dr. Li noted that the IME stated that he needed to return to work full duty and that his workers compensation payments had been cut off so he was there to discuss returning to work. Id His symptoms remained the same and he continued to have pain however he could not afford to remain off work. Id He was provided prescriptions of Mobic and Prilosec and Rabeprazole. Id He was allowed to return to full duty work and advised to return if symptoms worsen.PX5 at p.65

Petitioner was seen again on February 26, 2018 with continued left knee pain with prolonged standing and walking.PX5 at pgs.66-68 He was able to tolerate driving. Id His medication was re dispensed and he was allowed to continue working full duty and instructed to follow up if his pain increased.PX5 p.68

Petitioner was seen on April 20, 2018 in follow up by Dr. Li.PX5 at pgs.69-71 His medication was continued and he was instructed to consider options of having viscosupplementation or arthroscopic knee surgery. Id He was seen again July 30th 2018. PX5 at p.72 He continued to have pain over the anterior and medial aspect of his knee. Id He reported that it had been catching on him. Id Dr Li administered an injection and advised petitioner to consider knee arthroscopy. Id

3rd accident at CRST

Petitioner returned to Dr. Li on October 3, 2019. Px6 pgs.12-16 He reported a third injury to have occurred in Morton, Illinois. Id He was getting out of his truck and as he was stepping down he put his left foot down on the damaged area of concrete causing him to twist his left ankle and twist his left knee. Id Since that time he has had constant severe pain. Id Dr. Li referenced the previous work-related injuries to his left knee back in 2016 and then again in 2017.Id He referenced that these cases were still in litigation but that this was clearly a new injury. Id Petitioner was unable to weight bear on his left knee. Id Dr. Li recommended an MRI and follow up to determine the treatment plan. Id

A left knee MRI was performed on October 3, 2019 at Open MRI Center demonstrated the possibility of a recurrent medial meniscal tear, including a suspected horizontal tear of the anterior horn, and degenerative joint disease, moderate to severe in the medial compartment.PX6 at p.17. Dr. Li evaluated Petitioner on October 4, 2019 and based on the MRI findings recommended physical therapy. Id He felt there was a significant component of aggravation of his underlying arthritis.PX6 at p.22

Petitioner was examined again on October 21, 2019.PX6 at p.23 He reported moderate improvement in his left knee pain with the injection and Mobic but he was still not near where he was before. Id He was unable to walk any significant distance. Id Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with a small medial meniscal tear.PX6 at p.25 He opined that the osteoarthritis aggravation was the main source of his pain and he recommended Supartz injections. Id Petitioner received the first of five supartz injections on October 22, 2019 and the last on November 19th 2019.PX6 at pgs.26-30. He was instructed to return to the clinic prn. Id

Petitioner returned to Dr. Li on December 6, 2019. He felt that the injections had not helped him significantly and at that point his pain was beyond what he can tolerate. PX6 at p.31-33 Dr. Li's diagnosis was aggravation of underlying osteoarthritis left knee with medial meniscal tear. Id He was provided Mobic and Prilosec. Id Dr. Li felt he had failed all nonoperative treatment and referred him to doctor Mulvey for a total knee replacement. Id

Evidence deposition of Dr. Li

Dr. Lawrence Li was deposed on October 29, 2018.PX12. Dr. Li was read his office note from December 9, 2016 in which he stated that that his diagnosis was left knee arthroscopy with partial medial and lateral meniscectomy , abrasion chondroplasty, medial femoral condyle, patella and femoral trochlea with residual pain from osteoarthritis permanently aggravated by his work injury. PX12 at p.28.

He was questioned what he meant by permanently aggravated by his work injury. Id Doctor Li stated *"so even though Mr. Miller didn't have any symptoms before his accident, he had osteoarthritis. The accident didn't cause all of his osteoarthritis. But the accident did accelerate it beyond its normal progression. So accelerated by causing further fragmentation of the articular cartilage that needed to be addressed. So if we have a line that has a slope of let's say 10 degrees this then moved it, moved the line up the Y axis a certain amount it may have - and then made the slope let's say 12 degrees. That's just an example. That's not exact."*

He was also asked about the significance of the November 13, 2017 accident. PX12 at pgs.47-48. Dr. Li testified *"it is my opinion that employer two that accident two would be responsible for any further treatment ,*

you know, including a total knee. The reason being Mr. Miller was on a certain course of progression towards worsening osteoarthritis going to a total knee. I think that accident two increased the - -or shorten the time distance to that and also most likely accelerated the progression so that it would come up sooner than if accident two never happened." He testified he felt accident two was a material aggravation of the permanent aggravation sustained in accident one. PX12 at pgs.48-49.

Regarding accident #3 that occurred on October 2, 2019, Dr. Li's records state that he felt that there was a significant component of aggravation of his underlying arthritis.PX6 at p.22.

IME report of Dr. Watson

Dr. Watson of Watson Orthopedics performed an independent medical evaluation on August 22, 2016 for Westside.PX5 at p.19-21 He answered questions posed by Westside transportation as follows:

1. My current diagnosis at this time is tricompartmental osteoarthritis with an acute medial collateral ligament sprain as well as tears of the medial meniscus in the lateral meniscus.
2. I do believe there are pre-existing medical conditions which are related to his current condition. I believe that most likely the tri-compartmental osteoarthritis noted on the MRI scan is likely preexisting before the injury of June 9th, 2016. The meniscal tearing may or may not be an acute finding as it would be impossible to date these lesions. The grade 2 MCL sprain appears to be acute . The small loose bodies noted on the MRI scan are likely chronic.
3. I do believe that the accident history relates to his current symptoms and some of the above mentioned acute diagnostic findings.
4. I believe that Mr. Miller has preexisting asymptomatic osteoarthritis of his left knee that was aggravated or accelerated by the work injury of June 9th, 2016. Therefore, additional treatment, including arthroscopic surgery, is needed because of the work injury. The pre-existing condition of osteoarthritis in part has contributed to some of the acute findings in Mr. Miller's left knee. Were it not for the injury of June 9th 2016 , however, I do not feel that surgical treatment and subsequent postop care would be necessary at this time. For that reason, I believe that surgery being requested is causally related to the accident history provided by Mr. Miller.
5. I do not believe that Mr. Miller is currently capable of working full duty . I do not believe that he should do any lifting, climbing, or squatting,. He should not do any kneeling. Assuming that surgical treatment would be successful , that I would anticipate maximum medical improvement to be around 6 to 8 weeks post up and I would estimate that at that time he would likely reach his pre-accident condition as it relates to the left knee . If further treatment would be necessary in the future, and it likely will, I feel that additional treatment will be necessary because of the chronic conditions in Mr. Miller's knee . Finally I believe that the reduced work status is secondary to his acute injury rather than his pre-existing condition, which was obviously present prior to June 9th, 2016.

Deposition of Joshua Alpert

Dr. Joshua Alpert testified by way of evidence deposition March 8, 2019.PX14. Dr. Alpert compared the 2016 arthroscopic operative report of Dr. Li to the new MRI taken after Petitioner's second accident on November 13, 2017.PX12 at p.43 Dr. Albert agreed that the new MRI report showed a recurrent tear of the medial meniscus in the same area as the prior medial meniscectomy from 2016. He testified that finding

supports his opinion today that the current condition of Petitioner after the second injury of November 13, 2017 clearly demonstrated a worsening of the arthritic condition in the surgical sites where he previously had arthroscopy, as opposed to an acute injury attributable to November 13, 2017.PX12 at p. 44. He agreed that the existence of the progression of the surgical areas where the prior meniscectomy was performed, where the articular cartilage was debrided and shaved, that those areas have progressed, and further deteriorated, indicative of an acceleration of the arthritic process. PX12 at 45. ***Dr. Alpert testified that the arthroscopic surgery that Dr. Li performed accelerated the timeframe in which Mr. Miller would go on to eventually require a total knee replacement. Id*** Dr. Alpert testified then he would define the event of November 13, 2017 as a manifestation of petitioners' arthritic condition rather than a new injury breaking the chain of causation.PX14 at p.46

Dr. Alpert also examined Petitioner after his 3rd injury on October 2, 2019.CRST RX5 While Dr. Alpert opined that Petitioner sustained an acute component in that accident and suggested rest, therapy, medication and Supartz injections, ***he further opined that the ultimate need for a left total knee replacement was not related to the October 2, 2019*** event but to rather his preexisting condition. Id

Deposition of Dr. Herrin

Dr. Rodney Herron testified on behalf of Westside Transportation on May 2, 2019.PX13 Dr. Herrin was asked the following question: PX13 at p.22

Q. The procedure that doctor Li performed in the petitioner's knee , meaning he removed the meniscus medially and laterally , or at least a portion of it, and also did a chondroplasty procedure, would you agree that that operation has the potential to accelerate the progression of arthritis in the Petitioner Mr. Miller's knee?

A. The removal of the meniscus I don't think necessarily would make a difference. It's nonfunctional. I'm uncertain about the chondroplasty. That potentially could aggravate things . I wouldn't do that procedure for that reason.

Q. Because of the potential for aggravation?

A. Potentially. Depends on what he means by chondroplasty too. If you just kind of smooth off the joint that's probably not going to make a big difference. If you actually do a true abrasion chondroplasty, which is kind of an outdated procedure , then that may make a difference.

CONCLUSIONS OF LAW:

With regard to issue (F) whether Petitioner's injury is casually connected to his injury while working for Respondent, the Arbitrator finds as follows:

The Petitioner's current condition of ill being is casually connected to his injury while working for CRST for the period of October 2, 2019, covering the acute period of treatment from October 2, 2019 thru January 1, 2020; the Arbitrator denies causation as against CRST beyond this date.

With regard to issue (J) whether Respondent is liable for the following unpaid medical bills in (PX18) incurred after 10/2/19, the Arbitrator finds as follows:

The Arbitrator awards petitioner medical bills listed in PX18 incurred for the period October 2, 2019 thru January 1, 2020, and awards respondent CRST a credit for payments made as itemized in RX11.

With regard to issue (K) whether Petitioner is entitled to any prospective medical care from Respondent, the arbitrator finds as follows:

For the reasons noted in Subparagraph F and Case # 16wc19633, the Petitioner is entitled to prospective medical care as a result of the November 13, 2017 date of loss and not the work injury related to the October 2, 2019, accident.

With respect to issue (L) whether Petitioner is entitled to TTD for the period of 10/3/19 to the present or 10/3/19 through 1/1/2020, the Arbitrator finds as follows:

The Arbitrator awards petitioner TTD from the period 10/3/2019 thru 1/1/2020, a period of 13 weeks, that being the period of causal connection.

Signature of Arbitrator

06/05/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	07WC036523
Case Name	WEBB, MARGARET v. HARRAH'S ILLINOIS CORP
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	21IWCC0350
Number of Pages of Decision	6
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mark Weissburg
Respondent Attorney	Dennis Noble

DATE FILED: 7/7/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Webb,

Petitioner,

vs. No. 07 WC 36523

Harrah's Illinois Corp.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. On December 1, 2017, the circuit court entered an order finding against the manifest weight of the evidence the Commission's decision denying Petitioner's claim. The circuit court ruled: "The manifest weight of the evidence plainly shows that the Plaintiff suffered a work related injury to her lower back on July 9, 2007, and that as a result of that injury, she is now totally disabled from pursuing any meaningful work." The circuit court ordered:

> "A. The decision of the Arbitrator and the Commission, finding no accident arising out of and in the course of employment, is reversed and set aside;
>
> B. This matter is remanded to the Commission for further proceedings consistent with this order."

On October 19, 2018, the appellate court dismissed Respondent's appeal, finding the circuit court's order interlocutory.

In accordance with the circuit court's directions, the Commission has considered the pertinent parts of the record *de novo* to determine the benefits due to Petitioner.

Petitioner, a buffet server, testified on direct examination that she worked for Respondent since 1997. Petitioner stated the job involved "[a] lot of lifting, a lot of walking, plates that we had were rather heavy and we had bus tubs that we used when we got busy and it could get rather full at times." Petitioner testified she sustained a work accident on July 9, 2007, that caused chest and back pain. Petitioner promptly notified her supervisor and sought emergency treatment.

After a brief hospitalization, Petitioner mainly treated with Dr. Vera and Dr. Templin. Dr. Templin did not think Petitioner was a surgical candidate. Petitioner denied that any of her doctors ever released her to return to work full duty. Rather, she was released to return to work with restrictions and kept on restricted duty. Respondent did not accommodate the restrictions. At some point, Petitioner underwent a functional capacity evaluation (FCE), and Dr. Rivera imposed permanent restrictions based on the FCE. Respondent did not offer vocational rehabilitation or accommodate the permanent restrictions.

Petitioner further testified that she held a GED certificate and had completed one year of college. Petitioner's only work experience aside from working for Respondent was working as a babysitter. For three months, Petitioner looked for babysitting work and also applied at Wendy's, Silver Spoon, Subway and K-Mart. The brief job search was unsuccessful. Petitioner then applied for and was awarded Social Security disability benefits. Regarding her condition at the time of the arbitration hearing, Petitioner testified to significant back pain and functional limitations. Petitioner did not believe she could work at all.

On cross-examination, Petitioner clarified that she returned to work for Respondent for at least a week after the hospital stay. On July 22 or 24, 2007, Respondent terminated Petitioner's employment for participating in an argument/altercation. Petitioner looked for another job for approximately three months in the second half of 2007. She has not looked for work since 2007. Petitioner has been receiving Social Security disability benefits since 2012.

The medical records in evidence show Petitioner was hospitalized at Silver Cross Hospital from July 9 through July 11, 2007, for chest and back pain.

On July 13, 2007, Petitioner followed up at Primary Care of Joliet. The attending physician's assistant prescribed physical therapy and imposed work restrictions. On July 25, 2007, Petitioner related that she returned to work on regular duty because no light duty was available; working full duty aggravated her back pain. Dr. Vera took Petitioner off work.

On September 12, 2007, Petitioner returned to Dr. Vera, reporting no improvement. Thereafter, Petitioner followed up approximately monthly through January of 2008, complaining of persistent pain. Dr. Vera prescribed physical therapy and kept Petitioner off work.

A lumbar MRI performed January 31, 2008, was interpreted by the radiologist as showing facet arthropathy bilaterally at L5-S1 with resultant moderate to severe bilateral foraminal stenosis and mild central spinal stenosis.

On February 7, 2008, Petitioner consulted Dr. Templin at Hinsdale Orthopedics. Petitioner complained of pain across the lumbosacral junction radiating to the buttocks and up the back. Dr. Templin noted Petitioner was morbidly obese. Dr. Templin reviewed the lumbar MRI, noting "significant facet hypertrophy at the L4-L5 level as well as at the L3-L4 level; however, at 5-1, she has very significant facet arthropathy, which impinges on the neuro foramina bilaterally resulting in moderate to severe foraminal stenosis where the nerve roots appear to be effaced. There is no evidence of acute disk herniation, but there is desiccation of the disk space at this level." Dr. Templin recommended physical therapy and injections.

On February 26, 2008, Petitioner consulted Dr. Rivera, a pain management specialist, at the referral of Dr. Templin. Dr. Rivera initially prescribed medication.

On March 18, 2008, Dr. Templin imposed a 5-pound lifting restriction with sitting and standing as tolerated. On April 15, 2008, Petitioner followed up, reporting some improvement with physical therapy. Dr. Templin increased the lifting restrictions to 10 pounds with sitting and standing as tolerated, and encouraged Petitioner to seek employment.

On June 3, 2008, Petitioner returned to Dr. Templin, reporting no change in her condition. Dr. Templin recommended injections and continued Petitioner's restrictions. In June and July of 2008, Dr. Rivera performed facet joint injections. On July 22, 2008, Petitioner followed up with Dr. Templin, reporting a 25 percent improvement in her back pain. Dr. Templin recommended additional injections. Dr. Templin increased the lifting restriction to 20 pounds with bending, squatting and kneeling as tolerated. On August 25, 2008, Petitioner followed up with Dr. Rivera, likewise reporting a significant improvement. Dr. Rivera recommended an FCE and released Petitioner to return to work with a 30-pound lifting restriction. On September 2, 2008, Dr. Templin agreed with Dr. Rivera's recommendation to obtain an FCE.

On September 15, 2008, Petitioner underwent the FCE, which concluded she could return to her usual occupation as a waitress, but with restrictions on walking, stooping/crouching and balancing.

Petitioner followed up with Dr. Rivera in September and November of 2008, reporting stable symptoms.

On March 5, 2009, Petitioner returned to Dr. Templin, rating her back pain a 6/10 and complaining that nothing gave her relief. Dr. Templin opined: "I think the patient is a poor candidate for surgical intervention given the majority of her pain is axial low-back pain and given her morbid obesity, I do not think she would fare well with surgical intervention." Dr. Templin recommended continued pain management and vocational rehabilitation, and instructed Petitioner to follow up as needed.

On April 8, 2009, Petitioner returned to Dr. Rivera, reporting stable symptoms. Dr. Rivera imposed the restrictions pursuant to the FCE, increasing the lifting restriction to 35 pounds, and instructed Petitioner to follow up as needed.

Both Dr. Templin and Dr. Rivera causally connected Petitioner's low back condition to the work accident. Respondent's section 12 examiner, Dr. Lieber, disagreed.

Petitioner's vocational expert, Susan Entenberg, opined in a report dated January 21, 2010, that Petitioner could not return to her full duties as a buffet server, and recommended positions as a cashier or counter attendant, opining Petitioner's earning capacity was approximately $8.00 per hour.

On remand, the Commission is bound to comply with the order of the circuit court, which as noted found: "The manifest weight of the evidence plainly shows that the Plaintiff suffered a work related injury to her lower back on July 9, 2007, and that as a result of that injury, she is now totally disabled from pursuing any meaningful work." Implicit in the order of the circuit court are the findings of accident, notice, causation and odd-lot permanent total disability benefits. The Commission's task on remand is to determine all the benefits due to Petitioner and calculate the benefit rates. The Commission awards the following benefits, as supported by the record: temporary total disability benefits of $340.33[1] per week from July 25, 2007 through April 8, 2009; interim wage differential benefits[2] of $127.00[3] per week from January 21, 2010, the date of the vocational evaluation report, through April 8, 2016, the date of the arbitration hearing; the medical bills in evidence that Petitioner incurred through April 8, 2009, pursuant to §§8(a) and 8.2 of the Act; and odd-lot permanent total disability benefits of $430.69[4] per week, commencing April 9, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $340.33 per week for a period of 89 1/7 weeks, from July 25, 2007 through April 8, 2009, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $127.00 per week for a further period of 324 2/7 weeks, from January 21, 2010 through April 8, 2016, as provided in §8(d)1 of the Act, for the reason that the injuries sustained caused Petitioner to become partially incapacitated from pursuing her usual and customary line of employment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in evidence that Petitioner incurred through April 8, 2009, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent total disability benefits of $430.69 per week for life, commencing April 9, 2016, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry to 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.

---

[1] The parties stipulated to an average weekly wage of $510.50.
[2] See the request for hearing form.
[3] ($510.50 - $8.00 x 40) x 2/3 = $127.00.
[4] The minimum permanent total disability rate.

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.

July 7, 2021

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

SJM/sk
o-05/05/2021
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC030079
Case Name	CORTEZ, PEDRO v. SOURCE ONE STAFFING
Consolidated Cases	19WC024022
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0351
Number of Pages of Decision	22
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Julio Costa
Respondent Attorney	Torrie Poplin

DATE FILED: 7/8/2021

/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

PEDRO CORTEZ,

Petitioner,

vs. NO: 18 WC 30079

SOURCE ONE STAFFING,

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, prospective medical care, temporary total disability, and penalties and fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes noted herein, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Commission writes additionally in this case to clarify that Respondent is entitled to a credit for any amounts already paid regarding the medical expenses awarded in this matter. The Commission also corrects a clerical error to state that the temporary total disability benefits for the period from September 21, 2018 through September 16, 2020 is a period of 103 and 6/7ths weeks rather than 103 and 5/7ths weeks as stated in the Decision of the Arbitrator. The Commission further notes that the awards of prospective medical care and penalties and fees are affirmed in our Decision and Opinion on Review in this case and that prospective medical care and penalties and fees were not awarded in the Decision of the Arbitrator in the consolidated case of 19 WC 24022.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 21, 2020 is hereby affirmed and adopted in all other respects with

the changes stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner's reasonable and necessary outstanding medical bills pursuant to the fee schedule and §§8(a) and 8.2 of the Act for the services provided by: Suburban Orthopedics, Athletico, ATI Physical Therapy, and Alexian Brothers Medical Center. Respondent shall receive a credit for medical benefits that have been paid regarding these expenses, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided by §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $453.33 per week for the period from September 21, 2018 through September 16, 2020, for a period of 103 and 6/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit for benefits already paid.

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

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

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

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

July 8, 2021

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

o: 6/17/21
BNF/kcb
045

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

/s/ *Marc Parker*
Marc Parker

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

CORTEZ, PEDRO
Employee/Petitioner

Case# **18WC030079**

19WC024022

SOURCE ONE STAFFING INC
Employer/Respondent

On 12/21/2020, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Pedro Cortez,
Employee/Petitioner,

v.

Source One Staffing, Inc.,
Employer/Respondent.

Case # **18** WC **030079**

Consolidated cases: **19 WC 024022**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah J. Baker**, Arbitrator of the Commission, in the city of **Chicago**, on **September 16, 2020 and October 21, 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: **Prospective Medical Care**

FINDINGS

On the dates of accident, **September 20, 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 $**35,360.00**; the average weekly wage was $**680.00**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**21,319.36** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,914.00** for other benefits, for a total credit of $**23,233.36**.

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

ORDER

Petitioner's current condition of ill-being to his lumbar spine is causally related to the undisputed September 20, 2018 work accident.

Respondent shall pay Petitioner temporary total disability benefits of **$453.33**/week for the periods of **September 21, 2018 through September 16, 2020** representing **103-5/7 weeks** as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act, to the following providers: Suburban Orthopedics, Athletico, ATI Physical Therapy, and Alexian Brothers Medical Center.

Respondent shall authorize and pay for post-operative medical treatment, including physical therapy, for the lumbar spine that is recommended and prescribed by physicians at Suburban Orthopedics (Dr. McNally).

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.

Respondent shall pay to Petitioner penalties of **$2,527.61**, as provided in Section 16 of the Act; **$6,638.05**, as provided in Section 19(k) of the Act; and **$6,000.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

December 21, 2020
Date

ICArbDec19(b)

DEC 21 2020

FINDINGS OF FACT

The Parties agreed to proceed to hearing on September 16, 2020, with the understanding the hearing would be bifurcated with proofs left open only to allow Respondent additional time to admit an addendum from Dr. Zelby's medical records review which Respondent had requested. The Parties further stipulated to admitting no other evidence, including additional depositions, opinions, reports, or addendums, beyond the addendum from Dr. Zelby that Respondent had already requested and was waiting to be completed. The Parties agreed to close proofs on October 21, 2020, at 9:30 am.

On October 21, 2020, the Parties presented before the Arbitrator to admit Dr. Zelby's medical records review addendum and close proofs. At that time, it was brought to the Arbitrator's attention that Dr. Zelby had been given the transcript from the September 16, 2020 hearing and had opined as to Petitioner's testimony in his medical records review addendum. Petitioner's Counsel moved to strike any opinions in Dr. Zelby's addendum referencing Petitioner's subjective complaints at the time of hearing on September 16, 2020, and/or any opinions elicited from reviewing the September 16, 2020, trial transcript. Accordingly, the Arbitrator admitted Dr. Zelby's Addendum report but granted Petitioner's *instanter* motion to strike any opinions derived from the trial transcript contained therein. The Arbitrator ruled that based on the parties' prior agreements and representations, any opinions in Dr. Zelby's addendum referencing Petitioner's subjective complaints at the time of hearing on September 16, 2020 would not be referenced in the Arbitrator's decision.

TESTIMONY

The parties stipulated that Petitioner sustained work-related accidents on June 7, 2018 (19WC024022) and September 20, 2018 (18WC030079) while employed by Respondent as a "Picker" at Greco & Sons, Inc., a company that provides food to restaurants.

Prior 2017 Accident

Pedro Cortez (Petitioner) testified, through a qualified Spanish-language interpreter, that he previously sustained an injury on May 3, 2017, while employed by Source One Staffing, Inc. (Respondent). (Transcript "TX" at 26) (PX2). Petitioner testified he felt a pull in his lumbar area after lifting a bag of flour. (TX at 26). Medical records show that Petitioner treated at Tyler Medical Services for a lumbar strain from May 4, 2017, for a total of three visits, until he was released full duty on May 17, 2017. (PX2). Petitioner testified he underwent no physical therapy for this

minor injury and worked full duty from the day he was released on May 17, 2017, until his recent accident on June 7, 2018. (TX at 63).

June 7, 2018 Undisputed Accident

Petitioner testified that on June 7, 2018, he was employed by Respondent for approximately one year. (TX at 20). Respondent operates as a staffing agency. (*Id.*). Petitioner testified that he was assigned to work for Greco & Sons, Inc., a company that provides food to restaurants. (*Id.*). Petitioner worked as a "picker." (*Id.*). His duties included picking materials for orders, placing the materials on pallets, and moving the pallets to a truck using an electric cart jack. (*Id.* at 20-21).

Petitioner testified that on June 7, 2018, he was using a cart jack to pick an order in the produce section when six boxes, containing lettuce and weighing 60 to 80 pounds, fell off a pallet and struck his left, posterior rib and lumbar area. (TX at 23-24) (Petitioner's Exhibit 2 "PX2"). Petitioner reported his injury to "Pepe," a supervisor at Greco, and to a female manager at Source One Staffing, with whom Petitioner filed a written report. (TX at 24-25).

September 20, 2018 Undisputed Accident

After returning back to work full duty from his previous June 2018 accident, Petitioner sustained another work injury on September 20, 2018, while still working for Respondent. (TX at 30). This time, Petitioner was assisting "Ruben" with deliveries to various restaurants. (TX at 30). Petitioner testified he slipped while going down a ramp using a dolly to unload boxes from a truck. (*Id.* at 31) (PX2). The dolly then fell on Petitioner's right shin. (*Id.* at 31). Petitioner reported this injury to Respondent. (*Id.*)

Additionally, Petitioner testified that following his September 20, 2018, injury, physical therapy and injections provided pain relief for some time, but his pain always returned. (TX at 35). Before his surgery, Petitioner experienced pain on a 7/10 or 8/10 scale on his worst days. (*Id.* at 41). Petitioner admitted to being in "a lot of pain" after his surgery for a month and then it started "going down." (Id. at 39). At hearing, Petitioner rated his current pain at a 1/10 scale and when asked how he felt on his worst says after his surgery, he testified at "three or four level." (*Id.* at 41). When asked how his symptoms have improved since his surgery, Petitioner admitted to still having a low degree of back pain but testified he experienced full resolution of his leg pain. (*Id.*). Overall, Petitioner testified he considers his surgery a success and adamantly expressed his eagerness to return to work. (*Id.* at 43). Petitioner takes pride in being a hardworking person ever since he came to the U.S. and expressed sadness over not being capable of being the breadwinner of his family for his wife and children. (*Id.* at 44). Petitioner started crying at hearing when testifying about feeling dependent on his wife and being

unable to carry or play with his young son. (*Id.*). Petitioner testified the insurance stopped paying him his weekly benefits in May 2019. (*Id.* at 47).

On cross-examination, Petitioner testified that he disclosed his prior work injuries to Dr. Pelinkovic and Dr. Mardjetko. (TX AT 50-53). Petitioner testified he stopped treating at Tyler Medical Services following his September 20, 2018, injury because he felt he was not receiving adequate medical care. (*Id.* at 55). Petitioner reiterated his leg pain resolved about a month after his surgery and indicated a willingness to move around and work, albeit less than 100%. (*Id.* at 60). Additionally, Petitioner testified that he has two small children who are two years old and six years old. (*Id.* at 61).

MEDICAL TREATMENT

Treatment for June 7, 2018 Injury

On June 8, 2018, Respondent presented to Dr. Robert Long at Tyler Medical Services at the direction of Respondent. (TX at 27) (PX2). Petitioner reported pain with motion or direct pressure. (PX2). Following a physical examination and review of x-rays of the left ribs and lumbar spine, Dr. Long diagnosed Petitioner with left rib contusions and lumbar contusions. (*Id.*). Petitioner's x-ray of the left ribs indicated a finding that was highly suspicious for a left, eighth rib fracture and small, left pleural effusion. (*Id.*). Petitioner's x-ray of the lumbar spine noted no acute, bony abnormalities. (*Id.*). Dr. Long instructed Petitioner to ice the affected area over the course of the next two days and to take over-the-counter ibuprofen and Tylenol as needed. (*Id.*). Dr. Long placed Petitioner on ten-pound work restrictions but Petitioner testified that he was not capable of returning to work. (TX at 28).

After several follow-ups at Tyler Medical Services, Petitioner returned to Dr. Pappas at Tyler Medical Services on June 21, 2018, with persistent pain, numbness, and tingling in the back of his left leg. (PX2). Petitioner reported no pain improvement after taking Prednisone Dosepak and only some relief after taking Flexeril. (*Id.*). Dr. Pappas recommended an MRI scan of the lumbar spine to address Petitioner's persistent radiculopathy. (*Id.*). Dr. Pappas prescribed Naproxen and advised Petitioner to continue taking Flexeril. (*Id.*). Dr. Pappas continued Petitioner's 10-pound work restrictions. (*Id.*).

On July 6, 2018, Petitioner presented at Preferred Open MRI to undergo an MRI of the lumbar spine. (PX2) (Respondent Exhibit 9 "RX9"). The MRI revealed lumbar spondylosis, mild chronic compression deformity of the L5 vertebral body, mild diffuse and a generalized bilobed disc bulge at the L3-L4 level, a 3.5 mm generalized posterior disc bulge at the L4-L5 level, and a 4 mm generalized posterior disc bulge at the L5-S1 level. (*Id.*).

On July 10, 2018, Petitioner returned to Dr. Pappas for a follow-up visit. (PX2). Petitioner reported no rib pain but reported continued back pain radiating into the gluteal region and reaching his thigh and posterior calf region. (*Id.*). After reviewing the lumbar MRI, Dr. Pappas refilled Petitioner's prescriptions for Naproxen and Cyclobenzaprine and continued Petitioner's 10-pound work restrictions. (*Id.*). Given Petitioner's ongoing back complaints, on July 24, 2018, Dr. Pappas recommended he undergo six sessions of physical therapy at Athletico. (*Id.*).

On July 27, 2018, Petitioner presented to Athletico Physical Therapy, on referral from Dr. Pappas. (Petitioner Exhibit 5 "PX5"). There, Petitioner presented with pain on a 2/10 scale at best, 5/10 at worst, and complaints of aggravated low back pain with bed mobility, when taking his first steps in the morning and with bending and twisting activities. (*Id.*). Petitioner attended physical therapy sessions at Athletico until September 5, 2018, with some improvements of low back pain aggravated with bending and deep squatting but at a much lower pain level than when Petitioner first began physical therapy, as indicated by a 2/10 pain level at worst. (*Id.*).

On September 7, 2018, Dr. Pappas released Petitioner to return to work full duty. (PX2) (TX at 29).

Treatment for September 20, 2018 Injury

Following his second injury on September 20, 2018, Petitioner immediately presented to the Emergency Department at Northwest Community Hospital via ambulance with low back pain and severe leg pain. (TX at 31-33) (Petitioner Exhibit 1 "PX1"). Following a physical examination and x-rays of the lumbar spine, Petitioner was diagnosed with contusion of right calf and degenerative disc changes of the L5-S1 levels. (PX1). Petitioner was given crutches, discharged from care, and directed to follow-up with a primary care physician. (*Id.*).

On September 21, 2018, Petitioner presented to Dr. Pappas at Tyler Medical Services at Respondent's direction with low back pain on a 6/10 scale and right, lower shin pain on a 4/10 scale. (PX2). Following a physical examination, Petitioner was diagnosed with a lumbar contusion with sprain and spasms and a right lower leg anterior tibia/shin contusion. (*Id.*). Dr. Pappas prescribed Naproxen and Cyclobenzaprine. (*Id.*). Additionally, Dr. Pappas placed Petitioner off work for the remainder of his shift on September 21, 2018, and then placed him on ten-pound work restrictions beginning on September 24, 2018. (*Id.*). Petitioner testified that when he returned to work, he worked less than one full shift because he could not stand or sit for long periods of time and experienced a lot of pain. (TX at 33).

On September 24, 2018, at the recommendation of a friend, Petitioner came under the care of orthopedic spine surgeon, Dr. Dalip Pelinkovic, at Suburban Orthopedics. (Petitioner Exhibit 3 "PX3") (TX at 56). There, Petitioner reported constant low back pain that radiates down his legs, reaching his bilateral calves, and posterior right leg pain. (PX3). Additionally, Petitioner presented with pain on a 7/10 scale. (*Id.*). After a physical examination and x-rays of the lumbar spine, which revealed decreased disk height, Dr. Pelinkovic diagnosed Petitioner with lumbar strain and S1 radiculopathy. (*Id.*). Dr. Pelinkovic recommended that Petitioner undergo an MRI of the lumbar spine. (*Id.*). Additionally, Dr. Pelinkovic placed Petitioner off work for four weeks. (*Id.*)

On October 4, 2018, Petitioner underwent MRI of the lumbar spine at Suburban Orthopedics. (PX3). The MRI revealed a narrow spinal canal and mild degenerative disc disease at the L4-L5 and L5-S1 levels. (*Id.*). Specifically, the MRI revealed mild disc bulge causing ventral thecal sac deformity without significant canal narrowing of the L4-L5 level, moderate loss of disc space height at the L5-S1 level, and mild disc bulge without canal narrowing at the L5-S1 levels. (*Id.*).

On October 5, 2018, Petitioner presented to Athletico Physical Therapy, on a previous referral from Dr. Pappas. (Petitioner's Exhibit 4 "PX4"). Petitioner presented with sharp lumbar spine pain on a 6/10 scale accompanied by radicular symptoms. (*Id.*). Upon physical examination, Petitioner was assessed with exhibiting bilateral SI dysfunction, deficits in lumbar AROM, antalgic-like gait, and exacerbation of symptoms upon flexion of the lumbar. (*Id.*). Petitioner attended physical therapy at Athletico until January 8, 2019, with continued complaints of low back pain that at times radiates to the lower, left extremities and is aggravated with bending, ascending stairs, hip flexing. (*Id.*).

On October 8, 2018, Petitioner returned to Dr. Pelinkovic for a follow-up visit. (PX3). Petitioner reported low back pain, right and left leg pain, and pain when doing exercise during physical therapy. (*Id.*). Upon review of Petitioner's October 4, 2018, lumbar spine MRI, Dr. Pelinkovic modified his diagnosis to lumbar strain, disc bulges at the L4-L5 and L5-S1 levels with patent central canal and foraminal stenosis. (*Id.*). Dr. Pelinkovic referred Petitioner for a pain management evaluation for possible treatment with injections. (*Id.*). Dr. Pelinkovic continued Petitioner's off work restrictions. (*Id.*).

On October 22, 2018, Petitioner presented to pain management physician Dr. Dmitry Novoseletsky at Suburban Orthopedics. (PX3). Petitioner presented with sharp pain across his lower back that radiates to both lower extremities and is accompanied by numbness and tingling. (*Id.*). Dr. Novoseletsky diagnosed Petitioner with lumbar radiculopathy and sacroiliitis. (*Id.*). Dr. Novoseletsky instructed Petitioner to continue taking Naxproxen and prescribed Pantoprazole. (*Id.*). Dr. Novoseletsky placed Petitioner off work. (*Id.*).

On November 14, 2018, pursuant to Respondent's request, Petitioner presented for a section 12 examination with Dr. Steven M. Mardjetko at Illinois Bone and Joint Institute. (Petitioner's Exhibit 6 "PX6"). Petitioner reported to Dr. Mardjetko that he sustained a previous work injury that involved predominantly the left chest wall but that he fully recovered and returned to work full duty. (*Id.*). Dr. Mardjetko's report states that no pertinent past medical or surgical history was reported. Following a physical examination, a review of diagnostic scans, and a review of Petitioner's medical records from Northwest Community Hospital, Tyler Medical Center, Suburban Orthopedics, and Athletico, Dr. Mardjetko indicated that Petitioner's pre-existing conditions include the presence of congenital lumbar spinal stenosis. (*Id.*). Dr. Mardjetko concluded that Petitioner's symptoms are causally related to his September 20, 2018, injury. (*Id.*). Dr. Mardjetko recommended a decompression and stabilization procedure of the L4-L5 and L5-S1 levels should Petitioner fail to improve with injections and conservative treatment. (*Id.*).

After his initial evaluation in October 2018, Petitioner treated with Dr. Novoseletsky over the course of the next nine months. (PX3). During this time, and pursuant to Dr. Mardjetko's November 2018 section 12 opinion, Petitioner underwent a lumbar epidural steroid injection on February 26, 2019, an SI joint injection on April 3, 2019, and continued physical therapy at Athletico and ATI. (*Id.*). During this time, Dr. Novoseletsky placed Petitioner off work. (*Id.*). Petitioner testified that the injections and physical therapy helped his pain for a short period of time before returning to baseline pain levels. (TX at 35).

On July 23, 2019, Petitioner underwent an Electromyography and Nerve Conduction Study (EMG/NCS), performed by Dr. Aleksandr Goldvekht. (PX3). The EMG indicated prolonged latencies of the left tibial H-reflexes for Petitioner's height and evidence supporting a mild, left L5 radiculopathy, with possible L5 radicular disease. (*Id.*).

On August 14, 2019, after exhausting all efforts at conservative treatment with Dr. Novoseletsky, Petitioner returned to Dr. Pelinkovic for surgical evaluation. (PX3). Petitioner reported that pain management with Dr. Novoseletsky, including an LESI, SI joint injection, and physical therapy provided temporary relief. (*Id.*). Following a physical examination, Dr. Pelinkovic diagnosed Petitioner with lumbar strain, disc bulges at the L4-L5 and L5-S1 levels with patent central canal and foraminal stenosis, and recalcitrant left L5 radiculopathy. (*Id.*). Dr. Pelinkovic referred Petitioner to undergo an updated MRI for pre-operative planning, as the section 12 physician suggested a two-level fusion surgery at the L4-L5 and L5-S1 levels. (*Id.*). Additionally, Dr. Pelinkovic placed Petitioner off work. (*Id.*).

On August 27, 2019, Petitioner presented to Suburban Orthopedics for a second MRI of the lumbar spine. (PX3). The MRI revealed a narrow lumbar spinal

canal, disc desiccation and mild loss of disc space height at the L4-5 and L5-S1 levels, disc bulge at the L4-L5 level causing mild to moderate left subarticular zone narrowing, and a stable mild disc bulge at the L5-S1 level. (*Id.*).

On August 28, 2019, Petitioner returned to Dr. Pelinkovic to review the updated MRI results. (PX3). Based on the MRI and Petitioner's persistent symptoms of back pain and lower extremity radiculopathy, Dr. Pelinkovic recommended decompressive L4-5 and L5-S1 microdiscectomy and foraminotomy surgery. (*Id.*). Over the course of the next six months, Petitioner continued treating while awaiting surgical approval. (*Id.*). Dr. Pelinkovic continued Petitioner's off work restrictions. (Id.). During this time, Petitioner did not receive any TTD benefits. (Petitioner Exhibit 10 "PX10").

On February 13, 2020, pursuant to Respondent's request, Dr. Mardjetko generated an addendum report to his initial November 11, 2018, section 12 report. (Petitioner Exhibit 7 "PX7") In doing so, Dr. Mardjetko was asked to review additional medical records from Petitioner's May 3, 2017, June 7, 2018, and September 20, 2018, injuries and opine regarding causal connection. (*Id.*). Dr. Mardjetko concluded Petitioner fully recovered from his May 2017 and June 2018 work injuries and that his low back current condition of ill-being was causally related to his September 20, 2018 work injury, which was the "current trigger for the aggravation of his current lumbar pain syndrome." (PX7). Furthermore, Dr. Mardjetko's reiterated his recommendation for L4-L5 and L5-S1 fusion surgery and disagreed with Dr. Pelinkovic's recommendation for decompressive surgery, citing that a discectomy was unlikely to provide relief to Petitioner's back pain or address his radicular pain. (PX7).

On March 3, 2020, pursuant to Respondent's request, Dr. Andrew S. Zelby generated a Medical Records Review report. (Respondents Exhibit 3 "RX3"). In doing do, Dr. Zelby reviewed all of Petitioner's medical records pertaining to his injuries but did not physically examine Petitioner. (TX at 47). Dr. Zelby opined that the only diagnosis supported by the records is a temporary exacerbation of Petitioner's pre-existing degenerative condition and denied the need for any surgery at all. (RX3). On one hand, Dr. Zelby disagreed with Dr. Mardjetko's recommendation for fusion surgery because according to Dr. Zelby, Petitioner had mild, degenerative disc disease. (*Id.*). On the other hand, Dr. Zelby disagreed with Dr. Pelinkovic's recommendation for decompressive surgery because Petitioner's radiating leg pain "does not represent a radiculopathy." (*Id.*). Finally, Dr. Zelby concluded Petitioner had reached maximum medical improvement (MMI) within four to six months of his September 20, 2018, work injury and requires no further treatment. (*Id.*).

Petitioner's microdiscectomy surgery was originally scheduled for March 2020 but cancelled due to restrictions on elective surgeries during COVID-19. (PX3)

(TX at 36). During Petitioner's last follow-up visit with Dr. Pelinkovic on June 3, 2020, his opinion that Petitioner would benefit from decompressive surgery did not change; specifically an L4-L5 and L5-S1 microdiscectomy, laminectomy, and foraminotomy. (PX3).

On June 30, 2020, Petitioner came under the care of orthopedic spine surgeon Dr. Thomas A. McNally, a colleague of Dr. Pelinkovic at Suburban Orthopedics. (PX3). Petitioner testified he began treating with Dr. McNally because Dr. Pelinkovic moved out of state. (TX at 37). Petitioner reported sharp back pain and numbness/ tingling of his left, outer leg. (PX3). Petitioner underwent a physical examination and x-rays of the lumbar spine. (*Id.*). Upon review of the x-rays, which revealed decreased disc height space at the L4-L5 and L5-S1 levels, previous MRIs, and EMG/NCS of the bilateral lower extremities, Dr. McNally agreed with Dr. Pelinkovic's recommendation for left, L4-L5 and L5-S1 decompressive surgery. (*Id.*). Dr. McNally placed Petitioner off work and recommended an updated lumbar MRI for pre-operative planning. *(Id.*).

On July 10, 2020, Petitioner presented to Suburban Orthopedics for updated MRI of the lumbar spine. (PX3). The MRI indicated a bulging disc at the L4-L5 level and a left paramedian disc herniation at the L5-S1 level, both of which appeared similar to previous MRIs. (*Id.*)

On July 13, 2020, Petitioner underwent a decompressive left L4-L5 laminotomy, partial facetectomy, foraminotomy, and discectomy with decompression of the neural elements; and a decompressive left L5-S1 laminotomy, partial facetectomy, and foraminotomy with decompression of the neural elements at AMITA Alexian Brothers Medical Center, performed by Dr. McNally. (Petitioner Exhibit 8 "PX8"). Petitioner testified the surgery performed by Dr. McNally was the same decompressive procedure Dr. Pelinkovic had recommended. (TX at 38).

On July 28, 2020, Petitioner returned to Dr. McNally for post-operative care. (PX3). Petitioner reported pain and numbness behind the left calf, pain to his left, big toe, and pain that radiates from his left thigh to his knee. (*Id.*). Following a physical examination, Dr. McNally recommended that Petitioner wait to begin physical therapy and ordered a closed MRI of the lumbar spine. (*Id.*). Dr. McNally placed Petitioner off work. *(Id.*).

On August 6, 2020, Petitioner presented to Suburban Orthopedics for a post-operative MRI of the lumbar spine. (PX3). The MRI indicated post-operative changes at the L4-5 and L5-S1 levels with residual bulging discs but no stenosis or nerve root compression. (*Id.*). Petitioner testified that Dr. McNally reviewed his post-operative MRI and indicated "everything looked normal." (TX at 40).

On August 21, 2020, and September 10, 2020, Petitioner returned to Dr. McNally, each time reporting improved symptoms. (PX3). As a result, Dr. McNally recommended Petitioner begin physical therapy. (*Id.*). Petitioner testified that his first therapy session was scheduled for September 16, 2020, at ATI. (TX at 42).

On October 19, 2020, Dr. Zelby issued an addendum to his original Medical Records Review report, indicating that the July 2020 surgery and subsequent treatment was not reasonable or necessary. (Respondent Exhibit 12 "RX12")

Deposition of Dr. Dalip Pelinkovic (June 15, 2020)

Prior to Petitioner's surgery, the Parties presented for Dr. Pelinkovic's evidence deposition on June 15, 2020. (Petitioner Exhibit 9 "PX9"). Dr. Pelinkovic testified he personally reviewed all diagnostics, including lumbar MRI films and EMG, and diagnosed Petitioner with a left L4-5 disk protrusion with narrowing (pinched nerves) at both L4-L5 and L5-S1 levels. (*Id.* at 18). In Dr. Pelinkovic's opinion, the MRI findings had a strong correlation with Petitioner's EMG and physical exam findings. (*Id.*). Specifically, Dr. Pelinkovic testified EMG and Petitioner's physical exam confirmed that an L5 nerve root is compressed on the left side, thereby corroborating his MRI which confirmed nerve root impingement in the lateral recess at L4-5 and at the exit of L5-S1. (*Id.* at 21). Accordingly, Dr. Pelinkovic felt Petitioner would obtain sufficient relief from a smaller operation with less risk, such as a decompression, in contrast to the two-level fusion recommended by Dr. Mardjetko. (*Id.*). When asked why he originally recommended a microdiskektomy surgery and then added laminectomy and foraminotomies, Dr. Pelinkovic admitted feeling misunderstood and testified that when "you do a microdiskektomy, you routinely perform a laminectomy and foraminotomy anyway." (*Id.* at 25).

With respect to Dr. Zelby's Medical Records Review report, Dr. Pelinkovic disagreed with his opinion that Petitioner did not have radiculopathy, citing: 1) MRI report which states Petitioner may have L5 radiculopathy from the compromised nerve root; 2) EMG confirming L5 radiculopathy; and 3) Petitioner's subjective symptoms of shooting pain down his leg in a dermatomal distribution. (*Id.* at 30). Dr. Pelinkovic was adamant that since the ultimate goal of surgery was to make Petitioner better and reintegrate him back into his working environment, he could do so best with a decompression surgery only without the fusion. (*Id.* at 28-29). Dr. Pelinkovic added if Petitioner's symptoms persisted beyond the routine healing time for a decompression, that a fusion surgery would still be an option down the line; although he was confident it would not be necessary. (*Id.* at 29). Dr. Pelinkovic opined that Petitioner's current condition of ill-being is causally related to his September 20, 2018, work injury. (*Id.* at 32).

On cross-examination, Dr. Pelinkovic reiterated his main goal for treatment is to significantly improve a patient and restore his ability to go back to work. (PX9 at 45). When asked if he thought Petitioner's MRI findings were degenerative or traumatic, Dr. Pelinkovic testified there was a disk protrusion and injury to disk which he thought was an acute injury. (*Id.* at 39). Additionally, Dr. Pelinkovic emphasized that addressing the L5 nerve root at both levels via decompression surgery would likely resolve Petitioner's back and leg pain. (*Id.* at 45-46). Dr. Pelinkovic maintained, in accordance with Dr. Mardjetko's section 12 opinion, that there were no pre-existing issues that would materially alter his causation opinion. (*Id.* at 32-33).

On redirect examination, Dr. Pelinkovic emphasized the risks of undergoing a two-level fusion, which included foot drop, spinal fluid leakage, nonunion of the fusion, and potentially bleeding out if the aorta and/or the vena cava were to get "nicked." (PX9 at 45).

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the (September 20, 2018) injury?

The Arbitrator finds that the undisputed June 7, 2018 work accident caused injuries to Petitioner's lumbar spine and ribs, which resolved on September 7, 2018.

The Arbitrator finds that Petitioner's current lumbar spine condition of ill-being is causally related to the undisputed September 20, 2018 work accident.

The Arbitrator finds Petitioner's testimony about his June 7 and September 20, 2018 work injuries, subsequent treatment, and preexisting 2017 injury to be credible. The accident histories in all of the medical records submitted into evidence describe an almost identical mechanism of injury corroborative of Petitioner's testimony at trial; specifically, that Petitioner permanently injured his low back on September 20, 2018, after slipping on a ramp while using a dolly to unload items from a truck.

Petitioner's candor in his testimony regarding the minor 2017 accident is also determinative of Petitioner's credibility. While working for Respondent on May 3, 2017, Petitioner suffered an unrelated low back injury picking up a heavy bag of flour. Petitioner credibly testified, and the medical records support his testimony, that he treated for a total of three visits at Tyler Medical Services for a lumbar strain and was released to full duty work two weeks later on May 17, 2017. Afterwards, Petitioner returned to work for Respondent in a full duty capacity with no back complaints until his injury the following year on June 7, 2018, and then again on September 20, 2018. The Arbitrator finds that based on Dr. Pelinkovic's

credible and persuasive testimony, the March 2017 injury was not significant enough to be the cause of Petitioner's current lumbar spine condition.

The Arbitrator finds Dr. Pelinkovic and Dr. McNally's recommendations for decompressive spine surgery to be highly credible and consistent with the medical records. The Arbitrator also finds it significant that Dr. Mardjetko, Respondent's section 12 examining physician, concluded Petitioner fully recovered from both his May 2017 and June 2018 work injuries and that his current need for spine surgery was causally related to his September 20, 2018, work injury, which was the "current trigger for the aggravation of his current lumbar pain syndrome." Even though Dr. Mardjetko recommended a more surgically invasive lumbar fusion procedure, the Arbitrator still gives weight to his causation opinion given his thorough review of Petitioner's medical records and consistency with Dr. Pelinkovic's testimony regarding causation. The Arbitrator does not find Dr. Zelby's opinions, which were based on a review of medical records only, to be credible or persuasive in this case based on the opinions of Dr. Pelinkovic and Dr. Mardjetko and the medical records.

Further, it is undisputed that Petitioner was working full duty at the time of his September 20, 2018, work accident. In fact, records from Tyler Medical reveal Petitioner had been discharged for his June 2018 work accident on September 7, 2018. Petitioner testified he returned to work full duty for Respondent assisting drivers on deliveries until he sustained the undisputed accident going down a ramp on September 20, 2018. After this injury, Petitioner required extensive medical treatment. Ultimately, Dr. Pelinkovic, and his successor Dr. McNally, and even Respondent's own section 12 examining physician, Dr. Mardjetko, recommended surgery once all conservative measures were exhausted.

Reviewing the evidence in its entirety, the Arbitrator finds that the undisputed September 20, 2018 accident aggravated Petitioner's preexisting lumbar spine condition, which has not resolved and requires additional treatment.

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 parties' stipulation that a work-related accident occurred on June 7, 2018 and the above finding of causal connection, Respondent shall pay reasonable and necessary medical services for the lumbar spine and rib conditions as provided in Sections 8(a) and 8.2 of the Act to providers for treatment from June 7, 2018 through September 7, 2018, the date Petitioner reached maximum medical improvement for the lumbar spine and rib conditions.

Based on the parties' stipulation that a work-related accident occurred on September 20, 2018 and the above finding of causal connection, Respondent is required to pay reasonable and necessary medical bills for treatment to Petitioner's lumbar spine pursuant to section 8(a) and section 8.2 of the Workers' Compensation Act, to the following providers:

1.	Suburban Orthopedics	$19,119.00
2.	Athletico	$1,667.00
3.	ATI Physical Therapy	$24,446.18
4.	Alexian Brothers Medical Center	$37,680.50

L. What temporary (temporary total disability) benefits are in dispute?

With respect to the undisputed June 7, 2018 work accident, the Arbitrator finds that Petitioner was temporarily and totally disabled from June 8, 2018 through September 7, 2018, the date when Petitioner reached maximum medical improvement and was released to full duty work.

With respect to the undisputed September 20, 2018 work accident, the Arbitrator finds that Petitioner has been temporarily and totally disabled from September 21, 2018 to September 16, 2020, the date of the arbitration hearing.

The dispositive inquiry in deciding whether a Petitioner is entitled to temporary total disability (TTD) is whether his condition has stabilized, i.e. whether he has reached maximum medical improvement. *Interstate Scaffolding, Inc. Illinois Workers' Comp. Comm'm*, 236 Ill.2d 132, 142 (2010). When an injured Petitioner demonstrates that he continues to be temporarily totally disabled as a result of his work-related injury, he is entitled to TTD benefits. *Id.* at 149.

The Arbitrator relies on the opinions of Petitioner's treating physicians and Respondent's section 12 examining physician, Dr. Mardjetko, as convincing evidence that Petitioner's condition had not yet stabilized as of September 16, 2020. The Arbitrator gives no weight to Dr. Zelby's opinion that Petitioner reached maximum medical improvement within four to six months of his September 20, 2018, work injury, and required no further medical treatment. (RX3).

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator awards penalties on Petitioner's Petition for Penalties pursuant to section 19(l) and 19(k), and attorney's fees pursuant to section 16 of the Worker's Compensation Act.

Section 19(l) penalties

Section 19(l) provides, in pertinent part:

> If the employee has made [a] written demand for payment of benefits under Section 8(a) or 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. 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 . . . shall allow . . . 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. (emphasis added).

820 ILCS 305/19(l).

Penalties imposed under section 19(l) are in the nature of a late fee. Therefore, the award of section 19(l) penalties is mandatory if the payment is late, and the employer or its carrier cannot show an adequate justification for the delay. Specifically, when the employer "without good and just cause" fails to pay or delays payment of medical expenses (section 8(a)) and TTD benefits (section 8(b)). *McMahan v. Indus. Comm'n.*, 289 Ill.3d 1090, 1093 (1996); *Theis v. Ill. Workers' Comp. Comm'n.*, 2017 IL App (1st) 161237WC, ¶ 20. Under section 19(l)'s reasonableness standard, an employer's delay is justified only "if the facts which a reasonable person in the employer's position would have, would justify [the delay]." *Bd. of Educ. v. Indus. Comm'n*, 93 Ill. 2d 1, 10 (1982). The employer bears the burden of justifying the delay, and its justification is sufficient only if a reasonable person in the employer's position would have believed the delay was justified.

The Arbitrator finds that Respondent has not satisfied section 19(l)'s reasonableness standard. A reasonable person in Respondent's position would not have terminated and delayed unreasonably Petitioner's TTD benefits based on the existing medical records and medical opinions. The Arbitrator finds that, after Dr. Mardjetko's section 12 report was tendered, which found that Petitioner's lumbar spine condition was causally related to the undisputed September 20, 2018 work accident, Respondent had no reasonable basis to continue to delay and deny Petitioner TTD benefits. Respondent's Exhibit 6 shows that Respondent has not paid TTD benefits since February 25, 2020 and the reason for this unclear based on the evidence. On February 13, 2020, Dr. Mardjetko issued a section 12 addendum report in which he reviewed Petitioner's May 2017 medical records and acknowledged that Petitioner had preexisting lumbar disc degeneration, but opined it did not change his opinion that Petitioner's lumbar spine condition was causally

related to the September 20, 2018 work accident. Further, Dr. Zelby did not issue his (incredible and unpersuasive) opinion until March 3, 2020 so it is unclear why Respondent has not paid TTD benefits since February 24, 2020.

Section 19(k) penalties and Section 16 attorney's fees

Section 19(k) provides, in pertinent part:

> [W]here there has been any unreasonable or vexatious delay in payment or intentional payment of compensation . . . the Commission may award compensation additional compensation additional to that otherwise payable . . . 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 [an] unreasonable delay. (emphasis added). 820 ILCS 305/19(k).

Further, section 16 provides, in pertinent part:

> Whenever the Commission [finds] that the employer, his or her agent, service company or insurance carrier . . . has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy . . . the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. 820 ILCS 305/16.

The assessment of penalties under sections 19(k) and 16 are discretionary. *McMahan*, 183 Ill 2d. at 515. Penalties under sections 19(k) and 16 may be warranted if a claimant demonstrates that a delay in benefit payment is deliberate or results from bad faith or an improper purpose – a much higher standard than section 19(l)'s reasonableness standard. *Mech. Devices v. Indus. Comm'n.*, 344 Ill App. 3d 752, 764 (2003). *Id.* "Compensation" in section 19(k) includes compensation for lost wages and payment for medical services. *McMahan*, 183 Ill 2d. at 513.

Illinois courts have refused to assess penalties under sections 19(k) and 16 where there is sufficient evidence indicating that the employer could have *reasonably believed* that the employee was not entitled to compensation. *Bd. of Educ.*, 93 Ill. at 11. *See also Avon Products v. Indus. Comm'n*, 82 Ill. 2d 297, 304 (1980) (no penalties for delay of TTD and medical expenses when Respondent relied on existing inconsistencies in medical records regarding Petitioner's injury and a three-day delay in reporting injury to employer) and *Mech. Devices*, 344 Ill. at 764 (no penalties for non-payment of back-related TTD and medical expenses when Respondent relied on an existing medical expert's opinion disputing causation).

For the reasons set forth in the Arbitrators section 19(l) analysis, the Arbitrator also approves Petitioner's Petition for Penalties pursuant to section 19(k) and attorney's fees pursuant to section 16. Additionally, the Arbitrator finds Respondent's defenses in justifying its unreasonable and vexatious delay to be without merit and amount to the sort of frivolous defenses which do not present a real controversy that is contemplated by the statute.

Calculation of Penalties

Section 19(l) Penalties

Penalties under section 19(l) are equal to the sum of $30 per day for each day that TTD benefits under section 8(b) have been withheld or refused. The Arbitrator finds that from February 25, 2020, the day after Respondent terminated TTD benefits (RX6) based on Dr. Mardjetko's section 12 report which found Petitioner's condition to be causally related to the undisputed September 20, 2018 work accident, to September 16, 2020, the date of the arbitration hearing. The Arbitrator finds that Respondent shall pay section 19(l) penalties at a rate of $30.00 per day, equal to $6,000.00 for Respondent's unreasonable delay in paying benefits.

Section 19(k) Penalties

Penalties under section 19(k) are equal to 50% of the amount payable at the time of such award. "Payable at the time of such award" means the amount of an award at the time the award is paid, as determined by the arbitrator, less any timely payments paid by Respondent prior to the award. The amount of TTD benefits that are owed from February 25, 2020 to September 16, 2020 is $13,276.09. Fifty percent of the amount of TTD owed is $6,638.05. The Arbitrator finds that Respondent shall pay to Petitioner $6,638.05 in penalties pursuant to section 19(k) for the unreasonable and vexatious delay in paying benefits.

Section 16 Attorney's Fees

The Arbitrator finds that Respondent shall pay attorney fees pursuant to section 16 in the amount of $2,527.61 (20% of $6,000 + $6,638.05).

O. Prospective Medical Care

The Arbitrator finds Petitioner is entitled to prospective medical care. Petitioner has not reached MMI as Dr. McNally has prescribed medical treatment, including post-operative physical therapy and follow-up care, that Petitioner has yet to complete. (PX3). At trial, Petitioner testified he was recently approved to begin physical therapy with his first appointment being on September 16, 2020, the date

of the hearing. (TX at 42-43). Respondent shall authorize and pay for post-operative medical treatment, including physical therapy, for the lumbar spine that is recommended and prescribed by physicians at Suburban Orthopedics, including Dr. McNally.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC024022
Case Name	CORTEZ, PEDRO v. SOURCE ONE STAFFING
Consolidated Cases	18WC030079
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0352
Number of Pages of Decision	22
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Julio Costa
Respondent Attorney	Torrie Poplin

DATE FILED: 7/8/2021

/s/ Barbara Flores, Commissioner

Signature

19STATE 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 CORTEZ,

Petitioner,

vs. NO: 19 WC 24022

SOURCE ONE STAFFING,

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, prospective medical care, temporary total disability, and penalties and fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes noted herein, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Commission writes additionally in this case to clarify that Respondent is entitled to a credit for any amounts already paid regarding the medical expenses awarded in this matter. The Commission also corrects a clerical error to state that the temporary total disability benefits for the period from June 8, 2018 through September 7, 2018 is a period of 13 and 1/7ths weeks rather than 13 weeks as stated in the Decision of the Arbitrator. The Commission further notes that the awards of prospective medical care and penalties and fees are affirmed in our Decision and Opinion on Review in the consolidated case of 18 WC 30079 and that prospective medical care and penalties and fees were not awarded in the Decision of the Arbitrator in this case.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 21, 2020 is hereby affirmed and adopted in all other respects with the changes stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay reasonable and necessary medical bills of providers for Petitioner's lumbar spine and rib conditions, pursuant to the fee schedule and §§8(a) and 8.2 of the Act for treatment from June 7, 2018 through September 7, 2018, the date Petitioner reached maximum medical improvement for the lumbar spine and rib conditions. Respondent shall receive a credit for medical benefits that have been paid regarding these expenses, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided by §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $453.33 per week for the period from June 8, 2018 through September 7, 2018, for a period of 13 and 1/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit for benefits already paid.

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

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

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

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

July 8, 2021

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

o: 6/17/21
BNF/kcb
045

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

/s/ *Marc Parker*
Marc Parker

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

CORTEZ, PEDRO
Employee/Petitioner

Case# **19WC024022**

18WC030079

SOURCE ONE STAFFING INC
Employer/Respondent

On 12/21/2020, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Pedro Cortez,
Employee/Petitioner,

v.

Source One Staffing, Inc.
Employer/Respondent.

Case # **19** WC **024022**

Consolidated cases: **18 WC 030079**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah J. Baker**, Arbitrator of the Commission, in the city of **Chicago**, on **September 16, 2020 and October 21, 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: **Prospective Medical Care**

FINDINGS

On the date of accident, **June 7, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**35,360.00**; the average weekly wage was $**680.00**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**5,504.86** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,504.86**.

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

ORDER

Respondent shall pay reasonable and necessary medical services for the lumbar spine and rib conditions as provided in Sections 8(a) and 8.2 of the Act to providers for treatment from June 7, 2018 through September 7, 2018, the date Petitioner reached maximum medical improvement for the lumbar spine and rib conditions.

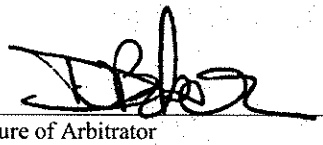
Respondent shall pay Petitioner temporary total disability benefits of **$453.33**/week for the periods of **June 8, 2018 through September 7, 2018** representing **13 weeks** as provided in Section 8(b) of the Act.

Respondent is entitled to a credit for temporary total disability benefits paid to Petitioner for the periods of June 13, 2018 through September 7, 2018.

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

December 21, 2020
Date

ICArbDec19(b)

DEC 21 2020

FINDINGS OF FACT

The Parties agreed to proceed to hearing on September 16, 2020, with the understanding the hearing would be bifurcated with proofs left open only to allow Respondent additional time to admit an addendum from Dr. Zelby's medical records review which Respondent had requested. The Parties further stipulated to admitting no other evidence, including additional depositions, opinions, reports, or addendums, beyond the addendum from Dr. Zelby that Respondent had already requested and was waiting to be completed. The Parties agreed to close proofs on October 21, 2020, at 9:30 am.

On October 21, 2020, the Parties presented before the Arbitrator to admit Dr. Zelby's medical records review addendum and close proofs. At that time, it was brought to the Arbitrator's attention that Dr. Zelby had been given the transcript from the September 16, 2020 hearing and had opined as to Petitioner's testimony in his medical records review addendum. Petitioner's Counsel moved to strike any opinions in Dr. Zelby's addendum referencing Petitioner's subjective complaints at the time of hearing on September 16, 2020, and/or any opinions elicited from reviewing the September 16, 2020, trial transcript. Accordingly, the Arbitrator admitted Dr. Zelby's Addendum report but granted Petitioner's *instanter* motion to strike any opinions derived from the trial transcript contained therein. The Arbitrator ruled that based on the parties' prior agreements and representations, any opinions in Dr. Zelby's addendum referencing Petitioner's subjective complaints at the time of hearing on September 16, 2020 would not be referenced in the Arbitrator's decision.

TESTIMONY

The parties stipulated that Petitioner sustained work-related accidents on June 7, 2018 (19WC024022) and September 20, 2018 (18WC030079) while employed by Respondent as a "Picker" at Greco & Sons, Inc., a company that provides food to restaurants.

Prior 2017 Accident

Pedro Cortez (Petitioner) testified, through a qualified Spanish-language interpreter, that he previously sustained an injury on May 3, 2017, while employed by Source One Staffing, Inc. (Respondent). (Transcript "TX" at 26) (PX2). Petitioner testified he felt a pull in his lumbar area after lifting a bag of flour. (TX at 26). Medical records show that Petitioner treated at Tyler Medical Services for a lumbar strain from May 4, 2017, for a total of three visits, until he was released full duty on May 17, 2017. (PX2). Petitioner testified he underwent no physical therapy for this

minor injury and worked full duty from the day he was released on May 17, 2017, until his recent accident on June 7, 2018. (TX at 63).

June 7, 2018 Undisputed Accident

Petitioner testified that on June 7, 2018, he was employed by Respondent for approximately one year. (TX at 20). Respondent operates as a staffing agency. (*Id.*). Petitioner testified that he was assigned to work for Greco & Sons, Inc., a company that provides food to restaurants. (*Id.*). Petitioner worked as a "picker." (*Id.*). His duties included picking materials for orders, placing the materials on pallets, and moving the pallets to a truck using an electric cart jack. (*Id.* at 20-21).

Petitioner testified that on June 7, 2018, he was using a cart jack to pick an order in the produce section when six boxes, containing lettuce and weighing 60 to 80 pounds, fell off a pallet and struck his left, posterior rib and lumbar area. (TX at 23-24) (Petitioner's Exhibit 2 "PX2"). Petitioner reported his injury to "Pepe," a supervisor at Greco, and to a female manager at Source One Staffing, with whom Petitioner filed a written report. (TX at 24-25).

September 20, 2018 Undisputed Accident

After returning back to work full duty from his previous June 2018 accident, Petitioner sustained another work injury on September 20, 2018, while still working for Respondent. (TX at 30). This time, Petitioner was assisting "Ruben" with deliveries to various restaurants. (TX at 30). Petitioner testified he slipped while going down a ramp using a dolly to unload boxes from a truck. (*Id.* at 31) (PX2). The dolly then fell on Petitioner's right shin. (*Id.* at 31). Petitioner reported this injury to Respondent. (*Id.*)

Additionally, Petitioner testified that following his September 20, 2018, injury, physical therapy and injections provided pain relief for some time, but his pain always returned. (TX at 35). Before his surgery, Petitioner experienced pain on a 7/10 or 8/10 scale on his worst days. (*Id.* at 41). Petitioner admitted to being in "a lot of pain" after his surgery for a month and then it started "going down." (Id. at 39). At hearing, Petitioner rated his current pain at a 1/10 scale and when asked how he felt on his worst says after his surgery, he testified at "three or four level." (*Id.* at 41). When asked how his symptoms have improved since his surgery, Petitioner admitted to still having a low degree of back pain but testified he experienced full resolution of his leg pain. (*Id.*). Overall, Petitioner testified he considers his surgery a success and adamantly expressed his eagerness to return to work. (*Id.* at 43). Petitioner takes pride in being a hardworking person ever since he came to the U.S. and expressed sadness over not being capable of being the breadwinner of his family for his wife and children. (*Id.* at 44). Petitioner started crying at hearing when testifying about feeling dependent on his wife and being

unable to carry or play with his young son. (*Id.*). Petitioner testified the insurance stopped paying him his weekly benefits in May 2019. (*Id.* at 47).

On cross-examination, Petitioner testified that he disclosed his prior work injuries to Dr. Pelinkovic and Dr. Mardjetko. (TX AT 50-53). Petitioner testified he stopped treating at Tyler Medical Services following his September 20, 2018, injury because he felt he was not receiving adequate medical care. (*Id.* at 55). Petitioner reiterated his leg pain resolved about a month after his surgery and indicated a willingness to move around and work, albeit less than 100%. (*Id.* at 60). Additionally, Petitioner testified that he has two small children who are two years old and six years old. (*Id.* at 61).

MEDICAL TREATMENT

Treatment for June 7, 2018 Injury

On June 8, 2018, Respondent presented to Dr. Robert Long at Tyler Medical Services at the direction of Respondent. (TX at 27) (PX2). Petitioner reported pain with motion or direct pressure. (PX2). Following a physical examination and review of x-rays of the left ribs and lumbar spine, Dr. Long diagnosed Petitioner with left rib contusions and lumbar contusions. (*Id.*). Petitioner's x-ray of the left ribs indicated a finding that was highly suspicious for a left, eighth rib fracture and small, left pleural effusion. (*Id.*). Petitioner's x-ray of the lumbar spine noted no acute, bony abnormalities. (*Id.*). Dr. Long instructed Petitioner to ice the affected area over the course of the next two days and to take over-the-counter ibuprofen and Tylenol as needed. (*Id.*). Dr. Long placed Petitioner on ten-pound work restrictions but Petitioner testified that he was not capable of returning to work. (TX at 28).

After several follow-ups at Tyler Medical Services, Petitioner returned to Dr. Pappas at Tyler Medical Services on June 21, 2018, with persistent pain, numbness, and tingling in the back of his left leg. (PX2). Petitioner reported no pain improvement after taking Prednisone Dosepak and only some relief after taking Flexeril. (*Id.*). Dr. Pappas recommended an MRI scan of the lumbar spine to address Petitioner's persistent radiculopathy. (*Id.*). Dr. Pappas prescribed Naproxen and advised Petitioner to continue taking Flexeril. (*Id.*). Dr. Pappas continued Petitioner's 10-pound work restrictions. (*Id.*).

On July 6, 2018, Petitioner presented at Preferred Open MRI to undergo an MRI of the lumbar spine. (PX2) (Respondent Exhibit 9 "RX9"). The MRI revealed lumbar spondylosis, mild chronic compression deformity of the L5 vertebral body, mild diffuse and a generalized bilobed disc bulge at the L3-L4 level, a 3.5 mm generalized posterior disc bulge at the L4-L5 level, and a 4 mm generalized posterior disc bulge at the L5-S1 level. (*Id.*).

On July 10, 2018, Petitioner returned to Dr. Pappas for a follow-up visit. (PX2). Petitioner reported no rib pain but reported continued back pain radiating into the gluteal region and reaching his thigh and posterior calf region. (*Id.*). After reviewing the lumbar MRI, Dr. Pappas refilled Petitioner's prescriptions for Naproxen and Cyclobenzaprine and continued Petitioner's 10-pound work restrictions. (*Id.*). Given Petitioner's ongoing back complaints, on July 24, 2018, Dr. Pappas recommended he undergo six sessions of physical therapy at Athletico. (*Id.*).

On July 27, 2018, Petitioner presented to Athletico Physical Therapy, on referral from Dr. Pappas. (Petitioner Exhibit 5 "PX5"). There, Petitioner presented with pain on a 2/10 scale at best, 5/10 at worst, and complaints of aggravated low back pain with bed mobility, when taking his first steps in the morning and with bending and twisting activities. (*Id.*). Petitioner attended physical therapy sessions at Athletico until September 5, 2018, with some improvements of low back pain aggravated with bending and deep squatting but at a much lower pain level than when Petitioner first began physical therapy, as indicated by a 2/10 pain level at worst. (*Id.*).

On September 7, 2018, Dr. Pappas released Petitioner to return to work full duty. (PX2) (TX at 29).

Treatment for September 20, 2018 Injury

Following his second injury on September 20, 2018, Petitioner immediately presented to the Emergency Department at Northwest Community Hospital via ambulance with low back pain and severe leg pain. (TX at 31-33) (Petitioner Exhibit 1 "PX1"). Following a physical examination and x-rays of the lumbar spine, Petitioner was diagnosed with contusion of right calf and degenerative disc changes of the L5-S1 levels. (PX1). Petitioner was given crutches, discharged from care, and directed to follow-up with a primary care physician. (*Id.*).

On September 21, 2018, Petitioner presented to Dr. Pappas at Tyler Medical Services at Respondent's direction with low back pain on a 6/10 scale and right, lower shin pain on a 4/10 scale. (PX2). Following a physical examination, Petitioner was diagnosed with a lumbar contusion with sprain and spasms and a right lower leg anterior tibia/shin contusion. (*Id.*). Dr. Pappas prescribed Naproxen and Cyclobenzaprine. (*Id.*). Additionally, Dr. Pappas placed Petitioner off work for the remainder of his shift on September 21, 2018, and then placed him on ten-pound work restrictions beginning on September 24, 2018. (*Id.*). Petitioner testified that when he returned to work, he worked less than one full shift because he could not stand or sit for long periods of time and experienced a lot of pain. (TX at 33).

On September 24, 2018, at the recommendation of a friend, Petitioner came under the care of orthopedic spine surgeon, Dr. Dalip Pelinkovic, at Suburban Orthopedics. (Petitioner Exhibit 3 "PX3") (TX at 56). There, Petitioner reported constant low back pain that radiates down his legs, reaching his bilateral calves, and posterior right leg pain. (PX3). Additionally, Petitioner presented with pain on a 7/10 scale. (*Id.*). After a physical examination and x-rays of the lumbar spine, which revealed decreased disk height, Dr. Pelinkovic diagnosed Petitioner with lumbar strain and S1 radiculopathy. (*Id.*). Dr. Pelinkovic recommended that Petitioner undergo an MRI of the lumbar spine. (*Id.*). Additionally, Dr. Pelinkovic placed Petitioner off work for four weeks. (*Id.*)

On October 4, 2018, Petitioner underwent MRI of the lumbar spine at Suburban Orthopedics. (PX3). The MRI revealed a narrow spinal canal and mild degenerative disc disease at the L4-L5 and L5-S1 levels. (*Id.*). Specifically, the MRI revealed mild disc bulge causing ventral thecal sac deformity without significant canal narrowing of the L4-L5 level, moderate loss of disc space height at the L5-S1 level, and mild disc bulge without canal narrowing at the L5-S1 levels. (*Id.*).

On October 5, 2018, Petitioner presented to Athletico Physical Therapy, on a previous referral from Dr. Pappas. (Petitioner's Exhibit 4 "PX4"). Petitioner presented with sharp lumbar spine pain on a 6/10 scale accompanied by radicular symptoms. (*Id.*). Upon physical examination, Petitioner was assessed with exhibiting bilateral SI dysfunction, deficits in lumbar AROM, antalgic-like gait, and exacerbation of symptoms upon flexion of the lumbar. (*Id.*). Petitioner attended physical therapy at Athletico until January 8, 2019, with continued complaints of low back pain that at times radiates to the lower, left extremities and is aggravated with bending, ascending stairs, hip flexing. (*Id.*).

On October 8, 2018, Petitioner returned to Dr. Pelinkovic for a follow-up visit. (PX3). Petitioner reported low back pain, right and left leg pain, and pain when doing exercise during physical therapy. (*Id.*). Upon review of Petitioner's October 4, 2018, lumbar spine MRI, Dr. Pelinkovic modified his diagnosis to lumbar strain, disc bulges at the L4-L5 and L5-S1 levels with patent central canal and foraminal stenosis. (*Id.*). Dr. Pelinkovic referred Petitioner for a pain management evaluation for possible treatment with injections. (*Id.*). Dr. Pelinkovic continued Petitioner's off work restrictions. (*Id.*).

On October 22, 2018, Petitioner presented to pain management physician Dr. Dmitry Novoseletsky at Suburban Orthopedics. (PX3). Petitioner presented with sharp pain across his lower back that radiates to both lower extremities and is accompanied by numbness and tingling. (*Id.*). Dr. Novoseletsky diagnosed Petitioner with lumbar radiculopathy and sacroiliitis. (*Id.*). Dr. Novoseletsky instructed Petitioner to continue taking Naxproxen and prescribed Pantoprazole. (*Id.*). Dr. Novoseletsky placed Petitioner off work. (*Id.*).

On November 14, 2018, pursuant to Respondent's request, Petitioner presented for a section 12 examination with Dr. Steven M. Mardjetko at Illinois Bone and Joint Institute. (Petitioner's Exhibit 6 "PX6"). Petitioner reported to Dr. Mardjetko that he sustained a previous work injury that involved predominantly the left chest wall but that he fully recovered and returned to work full duty. (*Id.*). Dr. Mardjetko's report states that no pertinent past medical or surgical history was reported. Following a physical examination, a review of diagnostic scans, and a review of Petitioner's medical records from Northwest Community Hospital, Tyler Medical Center, Suburban Orthopedics, and Athletico, Dr. Mardjetko indicated that Petitioner's pre-existing conditions include the presence of congenital lumbar spinal stenosis. (*Id.*). Dr. Mardjetko concluded that Petitioner's symptoms are causally related to his September 20, 2018, injury. (*Id.*). Dr. Mardjetko recommended a decompression and stabilization procedure of the L4-L5 and L5-S1 levels should Petitioner fail to improve with injections and conservative treatment. (*Id.*).

After his initial evaluation in October 2018, Petitioner treated with Dr. Novoseletsky over the course of the next nine months. (PX3). During this time, and pursuant to Dr. Mardjetko's November 2018 section 12 opinion, Petitioner underwent a lumbar epidural steroid injection on February 26, 2019, an SI joint injection on April 3, 2019, and continued physical therapy at Athletico and ATI. (*Id.*). During this time, Dr. Novoseletsky placed Petitioner off work. (*Id.*). Petitioner testified that the injections and physical therapy helped his pain for a short period of time before returning to baseline pain levels. (TX at 35).

On July 23, 2019, Petitioner underwent an Electromyography and Nerve Conduction Study (EMG/NCS), performed by Dr. Aleksandr Goldvekht. (PX3). The EMG indicated prolonged latencies of the left tibial H-reflexes for Petitioner's height and evidence supporting a mild, left L5 radiculopathy, with possible L5 radicular disease. (*Id.*).

On August 14, 2019, after exhausting all efforts at conservative treatment with Dr. Novoseletsky, Petitioner returned to Dr. Pelinkovic for surgical evaluation. (PX3). Petitioner reported that pain management with Dr. Novoseletsky, including an LESI, SI joint injection, and physical therapy provided temporary relief. (*Id.*). Following a physical examination, Dr. Pelinkovic diagnosed Petitioner with lumbar strain, disc bulges at the L4-L5 and L5-S1 levels with patent central canal and foraminal stenosis, and recalcitrant left L5 radiculopathy. (*Id.*). Dr. Pelinkovic referred Petitioner to undergo an updated MRI for pre-operative planning, as the section 12 physician suggested a two-level fusion surgery at the L4-L5 and L5-S1 levels. (*Id.*). Additionally, Dr. Pelinkovic placed Petitioner off work. (*Id.*).

On August 27, 2019, Petitioner presented to Suburban Orthopedics for a second MRI of the lumbar spine. (PX3). The MRI revealed a narrow lumbar spinal

canal, disc desiccation and mild loss of disc space height at the L4-5 and L5-S1 levels, disc bulge at the L4-L5 level causing mild to moderate left subarticular zone narrowing, and a stable mild disc bulge at the L5-S1 level. (*Id.*).

On August 28, 2019, Petitioner returned to Dr. Pelinkovic to review the updated MRI results. (PX3). Based on the MRI and Petitioner's persistent symptoms of back pain and lower extremity radiculopathy, Dr. Pelinkovic recommended decompressive L4-5 and L5-S1 microdiscectomy and foraminotomy surgery. (*Id.*). Over the course of the next six months, Petitioner continued treating while awaiting surgical approval. (*Id.*). Dr. Pelinkovic continued Petitioner's off work restrictions. (Id.). During this time, Petitioner did not receive any TTD benefits. (Petitioner Exhibit 10 "PX10").

On February 13, 2020, pursuant to Respondent's request, Dr. Mardjetko generated an addendum report to his initial November 11, 2018, section 12 report. (Petitioner Exhibit 7 "PX7") In doing so, Dr. Mardjetko was asked to review additional medical records from Petitioner's May 3, 2017, June 7, 2018, and September 20, 2018, injuries and opine regarding causal connection. (*Id.*). Dr. Mardjetko concluded Petitioner fully recovered from his May 2017 and June 2018 work injuries and that his low back current condition of ill-being was causally related to his September 20, 2018 work injury, which was the "current trigger for the aggravation of his current lumbar pain syndrome." (PX7). Furthermore, Dr. Mardjetko's reiterated his recommendation for L4-L5 and L5-S1 fusion surgery and disagreed with Dr. Pelinkovic's recommendation for decompressive surgery, citing that a discectomy was unlikely to provide relief to Petitioner's back pain or address his radicular pain. (PX7).

On March 3, 2020, pursuant to Respondent's request, Dr. Andrew S. Zelby generated a Medical Records Review report. (Respondents Exhibit 3 "RX3"). In doing do, Dr. Zelby reviewed all of Petitioner's medical records pertaining to his injuries but did not physically examine Petitioner. (TX at 47). Dr. Zelby opined that the only diagnosis supported by the records is a temporary exacerbation of Petitioner's pre-existing degenerative condition and denied the need for any surgery at all. (RX3). On one hand, Dr. Zelby disagreed with Dr. Mardjetko's recommendation for fusion surgery because according to Dr. Zelby, Petitioner had mild, degenerative disc disease. (*Id.*). On the other hand, Dr. Zelby disagreed with Dr. Pelinkovic's recommendation for decompressive surgery because Petitioner's radiating leg pain "does not represent a radiculopathy." (*Id.*). Finally, Dr. Zelby concluded Petitioner had reached maximum medical improvement (MMI) within four to six months of his September 20, 2018, work injury and requires no further treatment. (*Id.*).

Petitioner's microdiscectomy surgery was originally scheduled for March 2020 but cancelled due to restrictions on elective surgeries during COVID-19. (PX3)

(TX at 36). During Petitioner's last follow-up visit with Dr. Pelinkovic on June 3, 2020, his opinion that Petitioner would benefit from decompressive surgery did not change; specifically an L4-L5 and L5-S1 microdiscectomy, laminectomy, and foraminotomy. (PX3).

On June 30, 2020, Petitioner came under the care of orthopedic spine surgeon Dr. Thomas A. McNally, a colleague of Dr. Pelinkovic at Suburban Orthopedics. (PX3). Petitioner testified he began treating with Dr. McNally because Dr. Pelinkovic moved out of state. (TX at 37). Petitioner reported sharp back pain and numbness/ tingling of his left, outer leg. (PX3). Petitioner underwent a physical examination and x-rays of the lumbar spine. (*Id.*). Upon review of the x-rays, which revealed decreased disc height space at the L4-L5 and L5-S1 levels, previous MRIs, and EMG/NCS of the bilateral lower extremities, Dr. McNally agreed with Dr. Pelinkovic's recommendation for left, L4-L5 and L5-S1 decompressive surgery. (*Id.*). Dr. McNally placed Petitioner off work and recommended an updated lumbar MRI for pre-operative planning. *(Id.*).

On July 10, 2020, Petitioner presented to Suburban Orthopedics for updated MRI of the lumbar spine. (PX3). The MRI indicated a bulging disc at the L4-L5 level and a left paramedian disc herniation at the L5-S1 level, both of which appeared similar to previous MRIs. (*Id.*)

On July 13, 2020, Petitioner underwent a decompressive left L4-L5 laminotomy, partial facetectomy, foraminotomy, and discectomy with decompression of the neural elements; and a decompressive left L5-S1 laminotomy, partial facetectomy, and foraminotomy with decompression of the neural elements at AMITA Alexian Brothers Medical Center, performed by Dr. McNally. (Petitioner Exhibit 8 "PX8"). Petitioner testified the surgery performed by Dr. McNally was the same decompressive procedure Dr. Pelinkovic had recommended. (TX at 38).

On July 28, 2020, Petitioner returned to Dr. McNally for post-operative care. (PX3). Petitioner reported pain and numbness behind the left calf, pain to his left, big toe, and pain that radiates from his left thigh to his knee. (*Id.*). Following a physical examination, Dr. McNally recommended that Petitioner wait to begin physical therapy and ordered a closed MRI of the lumbar spine. (*Id.*). Dr. McNally placed Petitioner off work. *(Id.*).

On August 6, 2020, Petitioner presented to Suburban Orthopedics for a post-operative MRI of the lumbar spine. (PX3). The MRI indicated post-operative changes at the L4-5 and L5-S1 levels with residual bulging discs but no stenosis or nerve root compression. (*Id.*). Petitioner testified that Dr. McNally reviewed his post-operative MRI and indicated "everything looked normal." (TX at 40).

On August 21, 2020, and September 10, 2020, Petitioner returned to Dr. McNally, each time reporting improved symptoms. (PX3). As a result, Dr. McNally recommended Petitioner begin physical therapy. (*Id.*). Petitioner testified that his first therapy session was scheduled for September 16, 2020, at ATI. (TX at 42).

On October 19, 2020, Dr. Zelby issued an addendum to his original Medical Records Review report, indicating that the July 2020 surgery and subsequent treatment was not reasonable or necessary. (Respondent Exhibit 12 "RX12")

Deposition of Dr. Dalip Pelinkovic (June 15, 2020)

Prior to Petitioner's surgery, the Parties presented for Dr. Pelinkovic's evidence deposition on June 15, 2020. (Petitioner Exhibit 9 "PX9"). Dr. Pelinkovic testified he personally reviewed all diagnostics, including lumbar MRI films and EMG, and diagnosed Petitioner with a left L4-5 disk protrusion with narrowing (pinched nerves) at both L4-L5 and L5-S1 levels. (*Id.* at 18). In Dr. Pelinkovic's opinion, the MRI findings had a strong correlation with Petitioner's EMG and physical exam findings. (*Id.*). Specifically, Dr. Pelinkovic testified EMG and Petitioner's physical exam confirmed that an L5 nerve root is compressed on the left side, thereby corroborating his MRI which confirmed nerve root impingement in the lateral recess at L4-5 and at the exit of L5-S1. (*Id.* at 21). Accordingly, Dr. Pelinkovic felt Petitioner would obtain sufficient relief from a smaller operation with less risk, such as a decompression, in contrast to the two-level fusion recommended by Dr. Mardjetko. (*Id.*). When asked why he originally recommended a microdiskektomy surgery and then added laminectomy and foraminotomies, Dr. Pelinkovic admitted feeling misunderstood and testified that when "you do a microdiskektomy, you routinely perform a laminectomy and foraminotomy anyway." (*Id.* at 25).

With respect to Dr. Zelby's Medical Records Review report, Dr. Pelinkovic disagreed with his opinion that Petitioner did not have radiculopathy, citing: 1) MRI report which states Petitioner may have L5 radiculopathy from the compromised nerve root; 2) EMG confirming L5 radiculopathy; and 3) Petitioner's subjective symptoms of shooting pain down his leg in a dermatomal distribution. (*Id.* at 30). Dr. Pelinkovic was adamant that since the ultimate goal of surgery was to make Petitioner better and reintegrate him back into his working environment, he could do so best with a decompression surgery only without the fusion. (*Id.* at 28-29). Dr. Pelinkovic added if Petitioner's symptoms persisted beyond the routine healing time for a decompression, that a fusion surgery would still be an option down the line; although he was confident it would not be necessary. (*Id.* at 29). Dr. Pelinkovic opined that Petitioner's current condition of ill-being is causally related to his September 20, 2018, work injury. (*Id.* at 32).

On cross-examination, Dr. Pelinkovic reiterated his main goal for treatment is to significantly improve a patient and restore his ability to go back to work. (PX9 at 45). When asked if he thought Petitioner's MRI findings were degenerative or traumatic, Dr. Pelinkovic testified there was a disk protrusion and injury to disk which he thought was an acute injury. (*Id.* at 39). Additionally, Dr. Pelinkovic emphasized that addressing the L5 nerve root at both levels via decompression surgery would likely resolve Petitioner's back and leg pain. (*Id.* at 45-46). Dr. Pelinkovic maintained, in accordance with Dr. Mardjetko's section 12 opinion, that there were no pre-existing issues that would materially alter his causation opinion. (*Id.* at 32-33).

On redirect examination, Dr. Pelinkovic emphasized the risks of undergoing a two-level fusion, which included foot drop, spinal fluid leakage, nonunion of the fusion, and potentially bleeding out if the aorta and/or the vena cava were to get "nicked." (PX9 at 45).

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the (September 20, 2018) injury?

The Arbitrator finds that the undisputed June 7, 2018 work accident caused injuries to Petitioner's lumbar spine and ribs, which resolved on September 7, 2018.

The Arbitrator finds that Petitioner's current lumbar spine condition of ill-being is causally related to the undisputed September 20, 2018 work accident.

The Arbitrator finds Petitioner's testimony about his June 7 and September 20, 2018 work injuries, subsequent treatment, and preexisting 2017 injury to be credible. The accident histories in all of the medical records submitted into evidence describe an almost identical mechanism of injury corroborative of Petitioner's testimony at trial; specifically, that Petitioner permanently injured his low back on September 20, 2018, after slipping on a ramp while using a dolly to unload items from a truck.

Petitioner's candor in his testimony regarding the minor 2017 accident is also determinative of Petitioner's credibility. While working for Respondent on May 3, 2017, Petitioner suffered an unrelated low back injury picking up a heavy bag of flour. Petitioner credibly testified, and the medical records support his testimony, that he treated for a total of three visits at Tyler Medical Services for a lumbar strain and was released to full duty work two weeks later on May 17, 2017. Afterwards, Petitioner returned to work for Respondent in a full duty capacity with no back complaints until his injury the following year on June 7, 2018, and then again on September 20, 2018. The Arbitrator finds that based on Dr. Pelinkovic's

credible and persuasive testimony, the March 2017 injury was not significant enough to be the cause of Petitioner's current lumbar spine condition.

The Arbitrator finds Dr. Pelinkovic and Dr. McNally's recommendations for decompressive spine surgery to be highly credible and consistent with the medical records. The Arbitrator also finds it significant that Dr. Mardjetko, Respondent's section 12 examining physician, concluded Petitioner fully recovered from both his May 2017 and June 2018 work injuries and that his current need for spine surgery was causally related to his September 20, 2018, work injury, which was the "current trigger for the aggravation of his current lumbar pain syndrome." Even though Dr. Mardjetko recommended a more surgically invasive lumbar fusion procedure, the Arbitrator still gives weight to his causation opinion given his thorough review of Petitioner's medical records and consistency with Dr. Pelinkovic's testimony regarding causation. The Arbitrator does not find Dr. Zelby's opinions, which were based on a review of medical records only, to be credible or persuasive in this case based on the opinions of Dr. Pelinkovic and Dr. Mardjetko and the medical records.

Further, it is undisputed that Petitioner was working full duty at the time of his September 20, 2018, work accident. In fact, records from Tyler Medical reveal Petitioner had been discharged for his June 2018 work accident on September 7, 2018. Petitioner testified he returned to work full duty for Respondent assisting drivers on deliveries until he sustained the undisputed accident going down a ramp on September 20, 2018. After this injury, Petitioner required extensive medical treatment. Ultimately, Dr. Pelinkovic, and his successor Dr. McNally, and even Respondent's own section 12 examining physician, Dr. Mardjetko, recommended surgery once all conservative measures were exhausted.

Reviewing the evidence in its entirety, the Arbitrator finds that the undisputed September 20, 2018 accident aggravated Petitioner's preexisting lumbar spine condition, which has not resolved and requires additional treatment.

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 parties' stipulation that a work-related accident occurred on June 7, 2018 and the above finding of causal connection, Respondent shall pay reasonable and necessary medical services for the lumbar spine and rib conditions as provided in Sections 8(a) and 8.2 of the Act to providers for treatment from June 7, 2018 through September 7, 2018, the date Petitioner reached maximum medical improvement for the lumbar spine and rib conditions.

Based on the parties' stipulation that a work-related accident occurred on September 20, 2018 and the above finding of causal connection, Respondent is required to pay reasonable and necessary medical bills for treatment to Petitioner's lumbar spine pursuant to section 8(a) and section 8.2 of the Workers' Compensation Act, to the following providers:

1.	Suburban Orthopedics	$19,119.00
2.	Athletico	$1,667.00
3.	ATI Physical Therapy	$24,446.18
4.	Alexian Brothers Medical Center	$37,680.50

L. What temporary (temporary total disability) benefits are in dispute?

With respect to the undisputed June 7, 2018 work accident, the Arbitrator finds that Petitioner was temporarily and totally disabled from June 8, 2018 through September 7, 2018, the date when Petitioner reached maximum medical improvement and was released to full duty work.

With respect to the undisputed September 20, 2018 work accident, the Arbitrator finds that Petitioner has been temporarily and totally disabled from September 21, 2018 to September 16, 2020, the date of the arbitration hearing.

The dispositive inquiry in deciding whether a Petitioner is entitled to temporary total disability (TTD) is whether his condition has stabilized, i.e. whether he has reached maximum medical improvement. *Interstate Scaffolding, Inc. Illinois Workers' Comp. Comm'm*, 236 Ill.2d 132, 142 (2010). When an injured Petitioner demonstrates that he continues to be temporarily totally disabled as a result of his work-related injury, he is entitled to TTD benefits. *Id.* at 149.

The Arbitrator relies on the opinions of Petitioner's treating physicians and Respondent's section 12 examining physician, Dr. Mardjetko, as convincing evidence that Petitioner's condition had not yet stabilized as of September 16, 2020. The Arbitrator gives no weight to Dr. Zelby's opinion that Petitioner reached maximum medical improvement within four to six months of his September 20, 2018, work injury, and required no further medical treatment. (RX3).

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator awards penalties on Petitioner's Petition for Penalties pursuant to section 19(l) and 19(k), and attorney's fees pursuant to section 16 of the Worker's Compensation Act.

Section 19(l) penalties

Section 19(l) provides, in pertinent part:

> If the employee has made [a] written demand for payment of benefits under Section 8(a) or 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. 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 . . . shall allow . . . 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. (emphasis added).
>
> 820 ILCS 305/19(l).

Penalties imposed under section 19(l) are in the nature of a late fee. Therefore, the award of section 19(l) penalties is mandatory if the payment is late, and the employer or its carrier cannot show an adequate justification for the delay. Specifically, when the employer "without good and just cause" fails to pay or delays payment of medical expenses (section 8(a)) and TTD benefits (section 8(b)). *McMahan v. Indus. Comm'n.*, 289 Ill.3d 1090, 1093 (1996); *Theis v. Ill. Workers' Comp. Comm'n.*, 2017 IL App (1st) 161237WC, ¶ 20. Under section 19(l)'s reasonableness standard, an employer's delay is justified only "if the facts which a reasonable person in the employer's position would have, would justify [the delay]." *Bd. of Educ. v. Indus. Comm'n*, 93 Ill. 2d 1, 10 (1982). The employer bears the burden of justifying the delay, and its justification is sufficient only if a reasonable person in the employer's position would have believed the delay was justified.

The Arbitrator finds that Respondent has not satisfied section 19(l)'s reasonableness standard. A reasonable person in Respondent's position would not have terminated and delayed unreasonably Petitioner's TTD benefits based on the existing medical records and medical opinions. The Arbitrator finds that, after Dr. Mardjetko's section 12 report was tendered, which found that Petitioner's lumbar spine condition was causally related to the undisputed September 20, 2018 work accident, Respondent had no reasonable basis to continue to delay and deny Petitioner TTD benefits. Respondent's Exhibit 6 shows that Respondent has not paid TTD benefits since February 25, 2020 and the reason for this unclear based on the evidence. On February 13, 2020, Dr. Mardjetko issued a section 12 addendum report in which he reviewed Petitioner's May 2017 medical records and acknowledged that Petitioner had preexisting lumbar disc degeneration, but opined it did not change his opinion that Petitioner's lumbar spine condition was causally

related to the September 20, 2018 work accident. Further, Dr. Zelby did not issue his (incredible and unpersuasive) opinion until March 3, 2020 so it is unclear why Respondent has not paid TTD benefits since February 24, 2020.

Section 19(k) penalties and Section 16 attorney's fees

Section 19(k) provides, in pertinent part:

> [W]here there has been any unreasonable or vexatious delay in payment or intentional payment of compensation . . . the Commission may award compensation additional compensation additional to that otherwise payable . . . 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 [an] unreasonable delay. (emphasis added). 820 ILCS 305/19(k).

Further, section 16 provides, in pertinent part:

> Whenever the Commission [finds] that the employer, his or her agent, service company or insurance carrier . . . has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy . . . the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. 820 ILCS 305/16.

The assessment of penalties under sections 19(k) and 16 are discretionary. *McMahan*, 183 Ill 2d. at 515. Penalties under sections 19(k) and 16 may be warranted if a claimant demonstrates that a delay in benefit payment is deliberate or results from bad faith or an improper purpose – a much higher standard than section 19(l)'s reasonableness standard. *Mech. Devices v. Indus. Comm'n.*, 344 Ill App. 3d 752, 764 (2003). *Id.* "Compensation" in section 19(k) includes compensation for lost wages and payment for medical services. *McMahan*, 183 Ill 2d. at 513.

Illinois courts have refused to assess penalties under sections 19(k) and 16 where there is sufficient evidence indicating that the employer could have *reasonably believed* that the employee was not entitled to compensation. *Bd. of Educ.*, 93 Ill. at 11. *See also Avon Products v. Indus. Comm'n*, 82 Ill. 2d 297, 304 (1980) (no penalties for delay of TTD and medical expenses when Respondent relied on existing inconsistencies in medical records regarding Petitioner's injury and a three-day delay in reporting injury to employer) and *Mech. Devices*, 344 Ill. at 764 (no penalties for non-payment of back-related TTD and medical expenses when Respondent relied on an existing medical expert's opinion disputing causation).

For the reasons set forth in the Arbitrators section 19(l) analysis, the Arbitrator also approves Petitioner's Petition for Penalties pursuant to section 19(k) and attorney's fees pursuant to section 16. Additionally, the Arbitrator finds Respondent's defenses in justifying its unreasonable and vexatious delay to be without merit and amount to the sort of frivolous defenses which do not present a real controversy that is contemplated by the statute.

Calculation of Penalties

Section 19(l) Penalties

Penalties under section 19(l) are equal to the sum of $30 per day for each day that TTD benefits under section 8(b) have been withheld or refused. The Arbitrator finds that from February 25, 2020, the day after Respondent terminated TTD benefits (RX6) based on Dr. Mardjetko's section 12 report which found Petitioner's condition to be causally related to the undisputed September 20, 2018 work accident, to September 16, 2020, the date of the arbitration hearing. The Arbitrator finds that Respondent shall pay section 19(l) penalties at a rate of $30.00 per day, equal to $6,000.00 for Respondent's unreasonable delay in paying benefits.

Section 19(k) Penalties

Penalties under section 19(k) are equal to 50% of the amount payable at the time of such award. "Payable at the time of such award" means the amount of an award at the time the award is paid, as determined by the arbitrator, less any timely payments paid by Respondent prior to the award. The amount of TTD benefits that are owed from February 25, 2020 to September 16, 2020 is $13,276.09. Fifty percent of the amount of TTD owed is $6,638.05. The Arbitrator finds that Respondent shall pay to Petitioner $6,638.05 in penalties pursuant to section 19(k) for the unreasonable and vexatious delay in paying benefits.

Section 16 Attorney's Fees

The Arbitrator finds that Respondent shall pay attorney fees pursuant to section 16 in the amount of $2,527.61 (20% of $6,000 + $6,638.05).

O. Prospective Medical Care

The Arbitrator finds Petitioner is entitled to prospective medical care. Petitioner has not reached MMI as Dr. McNally has prescribed medical treatment, including post-operative physical therapy and follow-up care, that Petitioner has yet to complete. (PX3). At trial, Petitioner testified he was recently approved to begin physical therapy with his first appointment being on September 16, 2020, the date

of the hearing. (TX at 42-43). Respondent shall authorize and pay for post-operative medical treatment, including physical therapy, for the lumbar spine that is recommended and prescribed by physicians at Suburban Orthopedics, including Dr. McNally.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC035380
Case Name	VAUGHN, SHERI v. SECRETARY OF STATE ILLINOIS STATE LIBRARY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0353
Number of Pages of Decision	19
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	Richard Glisson

DATE FILED: 7/9/2021

/s/ Deborah Baker, 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

SHERI VAUGHN,

Petitioner,

vs. NO: 16 WC 35380

SECRETARY OF STATE - ILLINOIS STATE LIBRARY,

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 whether Petitioner sustained accidental injuries arising out of her employment, causal connection of her right thumb and bilateral hand and elbow conditions of ill-being, entitlement to medical expenses, entitlement to Temporary Total Disability benefits, and the nature and extent of Petitioner's 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 of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects Page 12 to reflect the employee's burden of proof for obtaining compensation under the Act is set forth in Section 1(d) (*820 ILCS 305/1(d)*).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2020, as corrected above, is hereby affirmed and adopted.

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

July 9, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/22/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0353

VAUGHN, SHERI
Employee/Petitioner

Case# **16WC035380**

SECRETARY OF STATE-IL STATE LIBRARY
Employer/Respondent

On 3/16/2020, 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 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICE OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0514 ASSISTANT ATTORNEY GENERAL
RICHARD C GLISSON
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

MAR 16 2020

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

S. Vaughn v. Secy. of St.- IL State Library, 16 WC 035380

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

Sheri Vaughn
Employee/Petitioner

v.

Secretary of State-IL State Library
Employer/Respondent

Case # **16** WC **035380**

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 **Springfield**, on **December 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

S. Vaughn v. Secy. of St.- IL State Library, 16 WC 035380

FINDINGS

On **August 24, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$47,003.84**; the average weekly wage was **$903.92**.

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 is entitled to a credit of **$N/A** under Section 8(j) of the Act.

ORDER

Claim for Compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on August 24, 2015 and failed to prove a causal connection between her work activities for Respondent and any condition of ill-being regarding her upper extremities.

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 16, 2020
Date

ICArbDec p. 2

MAR 16 2020

PROLOGUE

The Arbitrator redacted Petitioner's SSN information from PX 1, RX 5 and RX 6 to bring the said Exhibits into compliance with Supreme Court Rule 138.

FINDINGS OF FACT

Testimony:

Petitioner is 61 years old and works for the Secretary of State at the Illinois State Library. She has been so employed since 2001. Petitioner currently works as a library technical specialist and her work is mostly clerical in nature. She has worked at this position for nearly 2 years at the time of trial. At the time of the claimed injury in 2015, Petitioner was working for the Respondent as a library technician. Petitioner started the library technician job in 2005 and worked at that position until around late 2015. Petitioner testified that her scheduled job hours were from 8:00am to 4:30pm with two fifteen minute breaks and an hour lunch. Petitioner is right handed.

As a library technician, Petitioner's primary duties were to help with the mail. She testified that she would process six to seven hampers full of containers of audiobooks a day. She would unload the hampers and open up the book containers (PX 7A and 7B) with a tool (PX 8). To open the container, Petitioner would insert the tool under the straps shown on PX 7A and push down. After she checked the contents of the container, she would close it by using her thumbs to push down the straps. Petitioner testified that she performed this task "hundreds of time a day." Some of the cases required force to make them snap closed. Petitioner testified that she noticed pain from her wrist into the palm of her hand when doing this job task. It was first in her right hand and then later in her left hand, as well.

Petitioner stated that prior to August 24, 2015, she problems with her hands going back four to five years. In fact, prior to Petitioner's claimed injury date, she had been diagnosed with right hand carpal tunnel syndrome. Petitioner testified she did not pursue surgery at that time. A 2009 EMG conducted by Dr. Becker demonstrated that Petitioner suffered from right carpal tunnel syndrome. The patient related this to a 2001 car accident. No evidence of right cubital tunnel was reported, nor was there reported cervical radiculopathy at that time. Petitioner said that she had numbness in both hands a couple of years before 2015.

Petitioner had an auto accident in 2001 where she hurt her neck. She testified as a result of this accident she had tingling in her hands, so she went to a physician.

Petitioner testified she had numbness in both hands a couple of years before 2015. This did not interfere with her ability to do her job.

Shortly before August 2015 Petitioner had a catheter inserted in her right wrist. When they took it out her entire arm went numb.

Petitioner testified PX1 is the accident/injury report form (Workers' Compensation Employee's Notice of Injury) she filled out stating she sustained an injury putting containers of books on the shelves. The date of the accident was August 24, 2015. "Shifting shelves of new books – grabbed several containers between thumb and fingers and reached up to place on shelf-I felt the tendon in my right hand just below my thumb pop." Petitioner testified she reported this incident to her primary care doctor who then referred her to Dr. Ma, an orthopedist. She documented no notice to her supervisor. The bills were paid through Healthlink

(Respondent's group carrier) for this incident. Petitioner testified that if her PCP's records did not contain a history of this incident, they would be incorrect or inaccurate. (PX 1)

Petitioner testified she first saw Dr. Ma on October 21, 2015. Petitioner testified that she told Dr. Ma that she was having problems at work with her hands. She did not have an explanation for Dr. Ma not documenting this. She did not plan on putting her claim through workers' compensation because "nobody witnessed it" (the thumb popping incident).

Petitioner testified using the tool (PX 8) caused her symptoms to be exasperated or made worse. She would feel pain from her wrist down through the palm of her hand. She testified she is right handed, so she did everything with her right hand. Dr. Ma performed a right carpal tunnel release in February 11, 2016 that went well, resolving her numbness and tingling.

Petitioner then underwent left carpal and cubital tunnel release by Dr. Ma on February 11, 2017. Her last treatment for her hands was in February of 2018. Petitioner testified that her hands were fine at the time of hearing. She a little weakness but no numbness. She has problems with her right arm (tingling and numbness) when she uses a mouse at work.

Petitioner testified her work tasks are similar to LBPH (Library for the Blind and Physically Handicapped) library workers job tasks in other states and they use identical book container formats to the ones the State of Illinois uses. She is on a list serve for LBPH library workers.

On cross examination, Petitioner agreed the cases portrayed Exhibit 7 are light weight and she used her right hand exclusively to open the plastic containers. Petitioner stated she only used her left hand to close the container.

On cross, Petitioner was asked about the E.M.G. she had in March 2009 when she told Dr. Becker all her problems started in 2001 following an automobile accident. Petitioner admitted having pain in her wrist for a long period of time dating back to 2001 when Dr. Becker diagnosed her with carpal tunnel syndrome.

Petitioner was asked further about a visit to Dr. Becker in 2016 for numbness and tingling in her hands, mostly on the left, even though she is right handed that awoke her at night. Petitioner also complained to Dr. Becker about numbness and tingling in her toes and feet.

Petitioner was asked if she was diabetic. Petitioner testified she took medication for one day but did not like the way it made her feel and asked to see an endocrinologist. Petitioner testified both her mother and father both bad diabetic peripheral neuropathy. Petitioner stated she was no longer pre-diabetic.

Petitioner testified that on June 15, 2016, she complained to her PCP about tingling in feet, legs with pins & needles and numbness in her arms and hands when raised, while driving or reading or laying on side. She further referenced on that visit neck pain that started after the car accident in 2001. She testified she was rear-ended by about three or four cars.

Petitioner testified she did not recall the visit to her PCP on October 16, 2015, wherein she told her physician she cancelled her orthopedic appointment because Dr. Ahmed told her that her symptoms were from the heart catheterization.

Petitioner was examined by Dr. Sudekum for an IME and testified that she answered all of his questions to the best of her ability. On cross examination, Petitioner affirmed Respondent's IME doctor inquired about the jobs she performed, the tasks involved with those jobs, as well as the years she performed those jobs.

Petitioner was asked about the chart note of August 27, 2015, three days after the claimed date of accident of August 24, 2015, wherein Dr. Richards' note states "underwent cardiac catheterization last month. After the procedure when they removed the catheter from right radial artery her right hand momentarily went completely numb. Sensation returned within seconds. Since that time she has had ongoing right wrist pain overlying the distal radius." Petitioner recalled the conversation and the doctor's visit. Petitioner said she had pain in her right wrist for well over a month after the catheterization. When asked why nothing was in the note about the tendon popping while she was shelving books three days after the August 24, 2015 alleged accident date in the Application, Petitioner's response was she talked to the nurse practitioner about that.

Petitioner was asked about the e-mail in PX 4 inquiring about a container opening tool dated March 8, 2017. Petitioner testified that tool had been in use and existence since she started her technician job.

On cross examination, Petitioner was asked about PX1, the workers' compensation notice of injury which was dated 10-6-16, listing her date of injury of 8-24-15. Petitioner testified about 13 months after her injury she filled out the report. The Application for Adjustment of Claim is dated November 1, 2016 and contains nothing about her tendon popping while shelving books. (ArbX 2)

On redirect examination, Petitioner agreed that she had ongoing right hand problems going back for years. She agreed that her employment with Respondent brought on pain symptoms in her hands.

The Parties agreed that photos of PX7 and PX8 would be made part of the record and PX 8 was described for the Record.

Petitioner called Cheryl Johnson as a witness. Ms. Johnson testified she is retired from the Illinois State Library and Secretary of State. Ms. Johnson testified she worked with Petitioner for six or seven years in the talking book and braille section. Ms. Johnson testified she would open hundreds of the items depicted in Px7 everyday using the tool Px8. Ms. Johnson testified this activity caused her problems with her hands. She testified she transfered to another department because she was having problems and pain in her hands. She further stated she was diagnosed with rheumatoid arthritis since 2007 or 2008. Ms. Johnson testified she never filed a workers' compensation claim against the Illinois Secretary of State as a result of doing this job.

Respondent called Sharon Ruda as a witness. Ms. Ruda has been employed at the Illinois State Library since January of 2000 as Associate Director. She has been Petitioner's supervisor for a number of years. In that capacity she is familiar with the tasks the Petitioner performs each day at work and has performed those tasks herself over the years. She also assigns the tasks performed by Petitioner each day.

Ms. Ruda said on average they would get about three hampers of book containers a day and four on a heavy day. On an average they would get in about 3,000 to 4,000 books on average. There are 9 part-time and 2 full time employees opening the boxes. In 2014, they began doing circulation for the entire state. Prior to that time, they were considered back up. Prior to 2014, they had significantly less book containers coming in to the library. Ms. Ruda testified Petitioner opened the book containers back in 2013 when there were significantly less boxes to open. Ms. Ruda testified to a weekly report prepared by Petitioner outlining her duties from August 3rd through August 14, 2015. The report stated that she received new books, verified what was received, what was ordered by the library, contacted the Library of Congress if there was a discrepancy, put outside labels on the books, labeled the books, worked on attendance, worked on duplication, pulled new books, scanned

applications, was attendance clerk & performed clerical duties. Ms. Ruda identified RX 6 (Supervisor's Report of Injury or Illness), which she prepared on 10-30-16 because she was asked to. She testified that she never received any notification of injury from Petitioner.

On cross examination, Ms. Ruda testified some of the hampers could be half filled, some could be three quarters filled and others could be filled to the top. She testified usually on a daily basis it would be from 2,000 to 4,000 audiobooks processed, depending on the day of the week or time of year. Ms. Ruda identified Px8 as a book opener which some people use and others do not. It's a personal choice. Ms. Ruda said she uses the tool since it's easier to use it to open the container. They can also use the tool or their hands to close Px7. Once again she said it's the worker's choice. Ms. Ruda testified no one came to her, and said they were having problems performing these tasks nor was she aware of anyone filing a workers' compensation claim for performing these tasks.

Medical Records

Petitioner's medical records date back to 2009. On March 3, 2009, she was evaluated by Dr. Cecile Becker M.D. for complaints of "numbness in her RIGHT arm". Dr. Becker performed RIGHT upper extremity nerve conduction studies and her note from that date states: "She states that this started in 2001 following a motor vehicle accident. She also admits to neck pain. She states her hands become numb. Her symptoms worsened when she lifts her arm up... Electrodiagnostic interpretation: These findings are consistent with: 1. A mild to median neuropathy at the RIGHT wrist (carpal tunnel syndrome)." (RX 3)

In 2013, she was diagnosed with pre-diabetes based on elevated blood glucose. She was also diagnosed with vitamin D deficiency, obesity, and hyperlipidemia at that time.

On March 27, 2013, she was evaluated by her primary care provider, Ms. Jamey Whitmer FNP, for a rash and lightheadedness and her note from that date states,

> "Chief complaint: Patient here for possible shingles on her back that started a couple of days ago.
> Current Meds: vitamin b12, vitamin D, atenolol, Nexuim, hydrochlorothiazide...
> Active Problems: Benign essential hypertension, carpal tunnel syndrome, cervicalgia, conjoined pain localized in the hip, joint pain localized to the shoulder, restless leg syndrome.
> Assessment: 1. Rash and urticarial back 2. Lightheadedness and dizziness that seems to resolve with food.
> Plan:... I am going to have her obtain labs in the morning while fasting, possibly to see what her blood glucoses in the morning before meals. I will follow up with the patient in 1 week to assess her for possible need for oral glucose tolerance test. It does sound like the patient could be having some periods of hypoglycemia." (RX 2)

On the basis of her blood work she was diagnosed with pre-diabetes and prescribed diet and exercise and was given a referral to a "Certified Diabetes Educator". She was subsequently evaluated and treated by Dr. Jennifer Richards M.D. at the Springfield Diabetes and Endocrine Center. Repeat blood work revealed continued elevation of the hemoglobin A1c. A thyroid ultrasound was performed on August 1, 2013, which revealed thyroid nodules and enlarged cervical lymph nodes. A thyroid biopsy was attempted on August 19, 2013, which was nondiagnostic. (RX 2)

On July 2, 2015, Petitioner underwent a cardiac catheterization, apparently for evaluation of possible coronary artery disease. She was seen the following day, on July 3, 2015 at the Springfield Clinic by Jennifer Richards M.D. and her note from that date states,

> "Patient had cardiac cath yesterday. She has bruising and discomfort in the RIGHT wrist at the insertion site. Swelling reduced since yesterday. Thumb is tingling at times." (RX 2)

On August 27, 2015, Petitioner presented to her PCP, 3 days after the claimed accident date, and it is noted:

> "Underwent cardiac catheterization last month. After the procedure, when they removed the catheter from RIGHT radial artery, her RIGHT hand momentarily went completely numb. Sensation returned within seconds. Since that time she has had ongoing RIGHT wrist pain, overlying distal radius. Has had no swelling or skin color changes. Sensation has been normal. Pain is not worsening, but also not improving."

It was also noted on this date August 27, 2015, 3 days after the accident,

> "Pre-diabetes: A1c 6.0; has a long-standing history of pre-diabetes, current A1C worse than previous. Recommended diabetic diet, exercise. We will recheck A1c in 6 months. (RX 2)

On October 16, 2015, she presented to Dr. Richards' nurse practitioner still having wrist pain, unchanged from when I saw her last, noting Dr. Ahmed told her that her symptoms were from the heart catheterization.

On October 21, 2015, Petitioner was evaluated by Dr. Jian Jun Ma and his clinical note from that date states:

> "Reason for visit is: RIGHT wrist de Quervain's... The patient was a 57-year-old right-hand-dominant Caucasian female who presented to the clinic for evaluation of pain the RIGHT wrist. The patient has an office job. The patient has a history of numbness and tingling in both hands. The patient was diagnosed with carpal tunnel syndrome several years ago. The patient has been treating with bracing over the past several years. Recently the patient developed pain as intermittent, sharp and throbbing, 6/10 on the pain intensity scale. The patient has been wearing a brace over the past few years. She said that the brace did help with the pain, however, she could not do anything with the brace on the RIGHT wrist... It was noted that the patient has a significant medical history of prediabetic condition.
> Assessment: De Quervain's tenosynovitis and carpal tunnel syndrome
> Plan:... The nature of carpal tunnel syndrome and de Quervain's release was discussed. We discussed about nonsurgical measures, including activity modification, bracing, nonsteroidal anti-inflammatory medications, and steroid injection. I did not feel that the patient is a good candidate for steroid injection given her significant history of prediabetic condition. After extensive discussion the patient decided to proceed with surgical intervention. The patient was advised for RIGHT wrist first extensor compartment release and carpal tunnel release..." (PX 2)

On February 11, 2016, Petitioner underwent surgical treatment by Dr. Ma, including a RIGHT open carpal tunnel release and RIGHT wrist first dorsal extensor compartment release. Postoperatively, her numbness and tingling improved significantly, however she continued complaining of RIGHT wrist pain. She was released back to full, unrestricted duty after her surgery by Dr. Ma on April 26, 2016. (PX 2)

On June 15, 2016, Petitioner was evaluated at the Springfield Clinic by Ms. Jamey Whitmer FNP for tingling in her upper and lower extremities. Ms. Whitmer's note from that date states,

> "...Tingling started in arms years ago; occurs if arms raised (driving, reading) or laying on side; can feel in neck down to hands, LEFT side worse than RIGHT, has history of carpal tunnel. When laying, arms have to be straight out, not down at sides, or they fall asleep. Tingling started in toes a few years ago. Past year, progressed to the feet and anterior legs. Tingling is worse in her feet. Legs seem weaker with activity (going upstairs) past several weeks. Standing, walking, any type of pressure makes worse. The tingling sometimes last all day; ibuprofen seems to help. Tingling in the feet occurs approximately 4 days per week, in legs approximately 1 day per 7-14 days. Sometimes has neck pain; ongoing for years, seems more frequent past 6 months or so. Pain started after accident 2001. And the posterior neck, is a nagging ache. The pain doesn't travel, but the tingling does. Thinks has a disc bulge in spine." (RX 2)

On June 13, 2016, she underwent x-rays of her cervical spine, which revealed,

> "Moderate to severe degenerative disc disease at C6-7".

On June 18, 2016, she repeated blood studies, which revealed an elevated hemoglobin A1c at 5.9.

On June 30, 2016, she was reevaluated by Dr. Cecile Becker at the Springfield clinic, who performed bilateral upper extremity nerve conduction studies. Dr. Becker's note from that date states,

> "...Complains of numbness and tingling in her hands bilaterally. This is worse on the LEFT than on the RIGHT. It awakens her at night. It is worse when she bends her LEFT elbow. She also admits to neck pain. She had a RIGHT carpal tunnel release earlier this year. That was helpful. She also complains of numbness and tingling in her toes and feet. She has had some falls.
> Electrodiagnostic interpretation: These findings are consistent with:
> 1. A mild median mononeuropathy at the RIGHT wrist, carpal tunnel syndrome
> 2. A mild median mononeuropathy at the LEFT wrist, carpal tunnel syndrome
> 3. A mild ulnar mononeuropathy at the RIGHT elbow
> 4. A mild-to-moderate ulnar mononeuropathy at the LEFT elbow
> 5. Evidence for bilateral brachial plexopathy or cervical radiculopathies is not found
> 6. There is a mild sensory axonal polyneuropathy. Possible etiologies include diabetes, uremia or certain vitamin deficiencies...." (RX 3)

Only July 18, 2016, she was reevaluated by Dr. Richards and her note from that date states,

> "...Had been to Becker for EMG-NCS and got results: There was mild CT where she had surgery on the RIGHT wrist, ulnar tunnel bilaterally, and neuropathy at

the feet mild. When she reads or drives these are worse...We reviewed diet guidelines."

On September 28, 2016, she was reevaluated by Dr. Becker and her note from that date states,

"In June she had an EMG/NCV. It shows bilateral carpal tunnel syndrome and bilateral ulnar entrapments at the elbows, mild on the RIGHT and mild-to-moderate on the LEFT. She had a carpal tunnel release earlier this year by Dr. Ma. The EMG also revealed a mild sensory axonal peripheral neuropathy. The patient states that she is a prediabetic. She denies any exposure to chemicals or chemotherapy. She denies any history of cancer... Her mom had diabetic peripheral neuropathy. Her dad has peripheral neuropathy. The pain in her feet comes and goes. Usually occurs after she has been walking or standing for long time. She denies any numbness. She denies any pain at night. She has a history of vitamin B12 deficiency. She takes oral vitamin B12 supplementation... Hemoglobin A1c was 5.9 but her 2 hour glucose tolerance test was normal...
Assessment:
Polyneuropathy, idiopathic, progressive

1. Mild peripheral neuropathy...
2. Prediabetes
3. History B12 deficiency
4. Bilateral ulnar neuropathies at the elbows. We will refer her back to Dr. Ma" (RX 2)

On November 8, 2016, she was reevaluated by Dr. Ma and his not from that date states,

"...The patient state that her RIGHT wrist has been doing well. Recently the patient has been complaining of worsening pain in the LEFT wrist and arm. She also complained of numbness and tingling in the LEFT hand... She stated that the pain in the LEFT wrist was aggravated with certain motion. She stated that every time she holds an I-pad, her LEFT hand will fall asleep and gets numb... After verbal consent was given, a mixture of 1ml of 1% pain lidocaine mixed with 1 ml of 6mg/ml of betamethasone was injected to the LEFT carpal tunnel successfully...The patient will return to clinic in 6-8 weeks for reevaluation." (PX 2)

On January 6, 2017, she was reevaluated by Dr. Ma and his note from that date states,

"...She had steroid injection of the LEFT carpal tunnel several weeks ago which provided limited relief... She felt that something needs to be done in the LEFT wrist to relieve her symptoms... It appeared that she did not respond to a steroid injection well. We discussed about the risks of carpal tunnel and cubital tunnel release. After an extensive discussion, the patient decided to proceed with surgical intervention. LEFT carpal tunnel release, cubital tunnel release, with ulnar nerve transposition were recommended. It appeared that the ulnar nerve on the medial aspect of the LEFT elbow was unstable. I do feel that the patient will benefit from an ulnar nerve anterior transposition as well." (PX 2)

On February 16, 2017, Dr. Ma performed a LEFT open carpal tunnel release and a LEFT cubital tunnel release, including an anterior ulnar nerve transposition. (PX 2)

Petitioner was seen on several occasions by Dr. Ma postoperatively. She was released back to full, unrestricted duty on May 12, 2017. Dr. Ma's clinical note from October 17, 2017 states,

> "She is 8 months out from surgery. She has been doing well except for some numbness and tingling to her RIGHT ring and small fingers mostly with prolonged periods of elbow flexion. Her LEFT hand numbness and tingling have improved significantly... She has a history of mild carpal tunnel syndrome on the RIGHT side. She is unsure if her symptoms have progressed."

On February 13, 2018, Petitioner was reevaluated by Dr. Ma and his note from that date states,

> "She is 1 year out from surgery. She is doing well. She is doing well in the LEFT hand. She has occasional numbness and tingling in the RIGHT hand. She is pleased with the recovery." (PX 2)

Medical Testimony

Petitioner submitted the evidence deposition of Dr. Ma, taken on June 5, 2018. (PX 5) Dr. Ma testified that the last time he saw Petitioner was February 13, 2018, at which point she was doing great. She filled out a form at Dr. Ma's office where they asked if her condition was work related and the Petitioner said no. Dr. Ma further testified she had a history of diabetes and diabetes will not cause carpal tunnel syndrome, but diabetes makes people more vulnerable and at an increased risk to suffer this type of problem. Dr. Ma further testified he released Petitioner without restrictions on May 12, 2017. After a hypothetical questions from Petitioner's counsel concerning Petitioner's job duties and reviewing a variety of pictures, Dr. Ma stated "we did not go over detail, say how I do the job... it is definitely possible it aggravated her symptoms."(Px5p26) During cross examination, Dr. Ma testified there was nothing in all of his notes reflecting or documenting Petitioner ever complaining about having symptoms while she was at work (Px5p29, 30). Prior to his deposition on June 5, 2018, Dr. Ma had no documentation of Petitioner complaining her medical issues were due to working for the State of Illinois (id). Further, prior to the deposition, Dr. Ma did not know what agency she worked for or of the job duties Petitioner performed. Dr. Ma also testified Petitioner never conveyed to him she was injured shelving books (Px5p40).

Respondent had Dr. Sudekum perform an I.M.E on Petitioner on September 18, 2018. Respondent submitted Dr. Sudekum's evidence deposition, taken on February 14, 2019. (RX 1)

Unlike Dr. Ma, Dr. Sudekum had reviewed Petitioner's medical records dating back to 2009. Dr. Sudekum elicited extensive details about Petitioner's job duties over the years, directly from Petitioner, consisting of almost two pages in his report going back all the way to 2001, when she first started working for the State of Illinois. Dr. Sudekum further reviewed past medical history and surgeries, medications, hobbies and performed a physical exam. Dr. Sudekum was somewhat surprised Petitioner did not volunteer any information regarding the initial onset of her upper extremity paresthesia due to the 2001 motor vehicle accident where she was first diagnosed with right carpal tunnel syndrome in association with that accident. She told Dr. Sudekum that the accident at work occurred in July 2015 when she was shelving books and felt pop and sharp pain in her right wrist. The medical records are completely void of this incident but do show Petitioner underwent a cardiac catheterization and first developed wrist pain in July of 2015. Dr. Sudekum also noted:

> "Ms. Vaughan neglected to mention or recall that her right radial wrist pain and Dequervain's tendonitis developed immediately after a right wrist cardiac catheterization where a large bore needle was inserted into the RIGHT radial wrist, instead citing an alternative "work related" narrative.
> Nowhere in the medical records that I received is there any statement or indication by Ms. Vaughn or any treating provider and that her right radial wrist pain and/or numbness in either upper extremity develop or occurred as a result of the "work related incident" that she described to me today.(RX 1, Ex2)

Dr. Sudekum was asked if there was a causal relationship. His response after discussing the medical records was as follows:

> Despite the known history (documented in clinical notes by Dr. Ma's colleagues at the Springfield Clinic) that Ms. Vaughan developed RIGHT wrist pain and inflammatory tendinitis immediately after undergoing cardiac catheterization, which involves inserting a large catheter into the radial artery directly adjacent to the first dorsal extensor compartment (where DeQuervains tendonitis occurs) and injecting intra-arterial contrast material into the artery, Dr. Ma failed to recognize and/or acknowledge the causal connection between the cardiac catheterization insult and the development of her RIGHT De Quervain's tendinitis.
> De Quervain's tendinitis is a known complication of radial artery catheterization of the LEFT wrist radial artery catheterization and Ms. Vaughan's LEFT wristDde Quervain's tendinitis was a direct result of the cardiac catheterization.
> It is also notable that Ms. Vaughn was first diagnosed with right carpal tunnel syndrome in 2009 and that she first developed carpal tunnel symptoms in 2001, in association with the motor vehicle accident.
>
> On March 3, 2009, she was evaluated by Dr. Cecile Becker M.D. for complaints of "numbness in her RIGHT arm". Dr. Becker's performed RIGHT upper extremity nerve conduction studies at that time and her note from that date states,
> "She states that this started in 2001 following a motor vehicle accident. She also admits to neck pain. She states her hands become numb. Her symptoms worsened when she lifts her arm up... Electrodiagnostic interpretation: These findings are consistent with:
> 1. A mild to median neuropathy at the RIGHT wrist (carpal tunnel syndrome)."
> I do not find any statement or indication and any of Dr. Ma's notes that Ms. Vaughan or Dr. Ma himself stated, suggested, indicated or opined that her work activities had caused or aggravated any of her upper extremity conditions.
> I have received and reviewed full transcription of the deposition of Dr. Ma on June 5, 2018. In the deposition, on page 25, Dr. Ma was asked,
> "Question: (by Ms. Vaughan's attorney)... Now, doctor, based on the description I just present to you and the hypothetical facts and the pictures you reviewed, could these activities either aggravate, cause or accelerate and underlying De Quervain's disease suffered by the Petitioner in her RIGHT hand.
> Answer: (by Dr. Ma) I think it ---while we did not---when every time, you know, we saw Ms. Vaughan, we did not go over detail, say how I do the job. Most of the time she said like with a certain motion, if I am like lifting stuff, testing stuff,

was causing my pain. I think if this is correct, she is doing such amount of work on a daily basis that it is definitely possible aggravated her symptoms.
Question: So, you would say for De Quervain's disease?
Answer: De Quervain's, carpal tunnel, cubital tunnel syndrome.
Question: All 3 symptoms?
Answer: If this is true."
Dr. Ma's equivocal and uncertain answer above may suggest that Ms. Vaughan may have experienced some symptoms referral to her upper extremity conditions while at work. While it is possible that Ms. Vaughan may have experienced some of the symptoms associated with her upper extremity conditions while at home, at night, while driving, and/or while at work this would be analogous to a situation where an individual with established preexisting arthritis of the knee or hip may experience knee or hip pain whenever walking, whether that be at work, at home or elsewhere.
It is well documented that Ms. Vaughan suffers from generalized bilateral upper and lower extremity peripheral neuropathies. Possible etiologies and/or factors which may have contributed to the development or her peripheral neuropathies include diabetes/chronically elevated glucose, vitamin B-12 deficiency, body habitus/obesity, female sex, age over 59 years, genetic predisposition (both or her parents also suffered from peripheral neuropathies), hypertension, hypercholesterolemia/peripheral vascular disease, cervical radiculopathy, thoracic outlet syndrome, and/or a neck injury secondary to a motor vehicle accident in 2001. (RX1, Rx2p19,20)

Dr. Sudekum opined that Petitioner's work activities did not cause or aggravate her upper extremity conditions. Her work activities did not accelerate Petitioner's UE conditions. On cross examination, Dr. Sudekum said that about half of the 50 or so IME's he does a year involve carpal tunnel syndrome and about 2/3 of those examinations are done at the request of the State of Illinois.

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 her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

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

E. DID PETITIONER GIVE NOTICE OF THE ACCIDENT WITHIN THE TIME LIMITS OF THE ACT?

Petitioner gave timely Notice of the accident.

The Record in this case does not establish that Petitioner gave Respondent notice of the accident within 45 days of the claimed accident date of August 24, 2015, as required by §6(c) of the Act. Generally, this would operate to bar Petitioner's claim, as Notice is jurisdictional. Ristow v. Industrial Commission, 39 Ill.2d 410 (1968), White v. The Workers' Compensation Commission, 374 Ill. App. 3d 907 (2007)

In the present case, Petitioner gave Notice when the Notice of Injury (PX 1) was prepared on October 6, 2016, considerably more than 45 days from the accident date of August 24, 2015.

Respondent claimed a §8(j) credit for medical expenses. The last date of treatment was February 13, 2018, when Petitioner was seen by Dr. Ma. The bill for that service was paid by Respondent's group carrier on August 31, 2018 (PX 6) §8(j) provides that the period of time for giving notice of the accidental injury does not commence to run until the termination of the group payments. As the last payment made by group was on August 31, 2018, Petitioner was required to give Notice within 45 days after August 31, 2018. Thus, the giving of Notice in October of 2016 was timely.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, AND F. IS PETITIONER'S CURRENT CONDION OF ILL BEING CAUSALLY RELATED TO THE INJURY?

Petitioner failed to prove that she sustained accidental injuries which arose out of an in the course of her employment by Respondent on August 24, 2015.

First, all of the medical records are void of any history of an injury sustained when shelving books and hearing a pop in her thumb (as is alleged in PX 1), even though Petitioner testified this history was both communicated to both her PCP and Dr. Ma. "It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Commission, 2 Ill. 2d 590, 602 (1954) No history and no timely reporting of any such injury defeats any claim for this incident.

Petitioner's claim for repetitive trauma injuries to both hands and both elbows, as is alleged in the Application (ArbX2), fails as well.

The medical records do not support causation or a finding that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent. Petitioner had longstanding problems with her hands which she never related to her work throughout all her medical visits. She related her problems to other sources, including a car accident and a cardiac catheterization procedure.

Petitioner called Cheryl Johnson as a witness. Ms. Johnson testified she had rheumatoid arthritis. This is an autoimmune chronic inflammatory disorder that causes pain, swelling and deformity unlike the wear and tear damage of osteoarthritis. The Arbitrator is not surprised Ms. Johnson described having pain in her hands while performing similar tasks to the Petitioner. The Arbitrator finds it telling that she never filed a workers' compensation claim for an injury to her hands.

Petitioner's testimony regarding her workload (6 to 7 hampers of books a day) was not supported by her supervisor, Ruda (3 to 4 hampers a day). Petitioner's complaints of numbness and tingling in her hands and feet are certainly consistent with a systemic disease, not repetitive hand activities.

The opinions of Respondent's expert, Dr. Anthony Sudekum, MD are more persuasive on the issue of causation than those of Petitioner's expert, Dr. Jianjun Ma, MD.

Dr. Sudekum specializes in the evaluation and treatment of upper extremity conditions. He is board certified in plastic and reconstructive surgery, with a sub-specialty board in surgery of the upper extremity. Petitioner's job did not cause or aggravate Petitioner's upper extremity conditions. Petitioner's job activities did not accelerate any condition of ill-being in her upper extremities. Her job activities did not have repetitive impact and vibration. Petitioner's co-morbidities were significant (obesity, female, age). It is also noted that Petitioner was not forthcoming in the history she gave Dr. Sudekum, neglecting to mention the prior MVA, the prior positive NCV and the problems she had after the cardiac cath procedure. (RX 2)

Dr. Ma's causation opinions are not persuasive in this case. His causation opinion was that it was definitely possible that the hypothetically described work activities aggravated her symptoms related to De Quervain's, carpal tunnel and cubital tunnel syndrome, such that surgery became necessary and proper. If the described activities were accurate, Petitioner's work activities could be an aggravating factor. Dr. Ma did not document that Petitioner experienced any problems performing her work activities. He did not have knowledge of Petitioner's work activities until he talked with Petitioner's attorney before his deposition. Dr. Ma's testimony regarding Petitioner's co-morbidities did not concur with the testimony of Dr. Sudekum and are not consistent with generally accepted medical thought as to the etiology of carpal tunnel syndrome. He did not provide Petitioner with an injection at the first visit, as she was pre-diabetic. He did not agree that diabetes is a risk factor for CTS (diabetics are more vulnerable). He would not agree that being a female, age and obesity are risk factors for CTS.

Considering the expert testimony, Petitioner's testimony and the testimony of Johnson and Ruda, the demonstrative exhibits (PX 3, PX 7A and 7B and PX8) and the medical records both before and after the date of the alleged accident, the Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on August 24, 2015 and has failed to prove a causal connection between her work activities for Respondent and any condition of ill-being regarding her upper extremities.

J. MEDICAL EXPENSES AND L. NATURE AND EXTENT

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on August 24, 2015 and failed to prove her current condition of ill-being is causally related to the alleged accident, the Arbitrator needs not decide the above issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC018301
Case Name	MAYE, CRYSTAL M v. MT VERNON WALMART SUPERCENTER STORE #224
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0354
Number of Pages of Decision	10
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Joshua Humbrecht
Respondent Attorney	Michael Scully

DATE FILED: 7/9/2021

/s/ Deborah Baker, 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 TTD rate; §19(l), §19(k) Penalties and §16 Fees	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRYSTAL MAYE,

Petitioner,

vs. NO: 18 WC 18301

MT. VERNON WALMART SUPERCENTER STORE #224,

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 Petitioner's entitlement to Temporary Total Disability benefits and whether Respondent proved its refusal to pay benefits was reasonable such that §19(l) and §19(k) penalties and §16 attorney's fees were not warranted, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

The Commission, like the Arbitrator, finds the evidence clearly establishes Petitioner is entitled to Temporary Total Disability benefits from December 21, 2019 through February 5, 2020, and Respondent failed to prove its refusal to pay those benefits was reasonable. *See*, *Board of Education of the City of Chicago v. Industrial Commission*, 93 Ill.2d 1, 9-10, 442 N.E.2d 861, 865 (1982). The Commission emphasizes that Respondent's position is not only contrary to law regarding the employer's obligation to pay benefits when an employee is terminated while under restrictions, but it is also inconsistent with the facts and incompatible with the prior final §19(b) Decision. The Commission observes, however, the award is miscalculated. The parties stipulated

that Petitioner's average weekly wage is $616.51 (Arb.'s Ex. 1), which yields a Temporary Total Disability rate of $411.01 ($616.51 ÷ 3 x 2 = $411.01). The period at issue is 6 5/7 weeks, so the accrued Temporary Total Disability benefit totals $2,759.64. The Commission calculates the penalties and fees as follows:

§19(l):	$30.00 x 47 days = $1,410.00
§19(k):	$2,759.64 (accrued TTD) x 50% = $1,379.82
§16:	$2,759.64 (accrued TTD) x 20% = $551.93

Additionally, the Commission corrects the Notice of the Decision of the Arbitrator to reflect the interest rate is 0.10%.

All else is affirmed.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $411.01 per week for a period of 6 5/7 weeks, representing December 21, 2019 through February 5, 2020, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(l) penalties in the amount of $1,410.00.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(k) penalties in the amount of $1,379.82.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §16 attorney's fees in the amount of $551.93.

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

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

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

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

July 9, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/22/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0354
NOTICE OF 19(b) ARBITRATOR DECISION

MAYE, CRYSTAL M Case# **18WC018301**

Employee/Petitioner

MT VERNON WALMART SUPERCENTER STORE #224

Employer/Respondent

On 4/2/2020, 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 0,10% 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:

4689 HASSAKIS & HASSAKIS PC
JOSHUA A HUMBRECHT
206 S 9TH ST SUITE 201
MT VERNON, IL 62864

5074 QUINTAIROS PRIETO WOOD & BOYER
JAMES MAGIERA
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Crystal M. Maye
Employee/Petitioner

v.

Mt. Vernon Walmart Supercenter Store #224
Employer/Respondent

Case # 18 WC 018301

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 Thomas L. Ciecko, Arbitrator of the Commission, in the City of Mt. Vernon, on February 5, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, March 19, 2018, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $30,825.35; the average weekly wage was $616.51.

On the date of accident, Petitioner was 38 years of age, married with 2 dependent children.

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

Respondent shall be given no credit for TTD, TPD, maintenance, or other benefits.

Respondent is entitled to no credit under Section 8(j) of the Act.

ORDER

TEMPORARY TOTAL DISABILITY BENEFITS

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $413.06/WEEK FOR 6 4/7 WEEKS COMMENCING DECEMBER 21, 2019 THROUGH FEBRUARY 5, 2020, AS PROVIDED IN SECTION 8(B) OF THE ACT.

PENALTIES

RESPONDENT SHALL PAY TO PETITIONER, PENALTIES OF $542.88 AS PROVIDED IN SECTION 16 OF THE ACT; $1357.19, AS PROVIDED IN SECTION 19(K) OF THE ACT; AND $1380.00 AS PROVIDED IN SECTION 19(L) OF THE ACT.

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

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

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

Signature of Arbitrator

4-1-2020
Date

APR 2 - 2020

PREFACE

The parties proceeded to hearing February 5, 2020 on a Petition For an Immediate Hearing Under Section 19(b) of the Act, and a Request for Hearing indicating the following disputed issues: whether Petitioner is entitled to a period of temporary total disability; and whether Petitioner is entitled to penalties/attorney's fees under Sections 19(k), (l), and 16 of the Act. Crystal M. Maye v. Mt Vernon Walmart Supercenter, No. 18 WC 18301 Transcript of Proceeding on Arbitration at 8; Arbitrator's Exhibit 1; Arbitrator's Exhibit 2. This case has previously been tried on a prior 19(b) Petition before Arbitrator Nowak who found an accident occurred that arose out of and in the course of Petitioner's employment by Respondent; timely notice of the accident was given to Respondent; Petitioner's current condition of ill-being was causally related to the injury; and Petitioner was entitled to prospective medical care. Petitioner's Exhibit 1; Petitioner's Exhibit 2. Petitioner testified as well as Gary Wyman.

FINDINGS OF FACT

Petitioner, Crystal M. Maye, filed her Application for Adjustment of Claim alleging she sustained injuries to her low back and bilateral lower extremities while employed with Respondent on March 19, 2018. This matter proceeded to a 19(b) hearing on November 7, 2019 and a decision was subsequently rendered on January 7, 2020. That Arbitrator's decision dated January 7, 2020 concluded that Petitioner's current state of ill-being was causally related to the incident; Petitioner had not reached MMI; and awarded Petitioner prospective medical in the form of an SI joint surgery. Accordingly, the law of this case is that Petitioner's current condition of ill-being is causally related to the incident; Petitioner is not at MMI and she is entitled to prospective surgery. Arbitrator's Exhibit 3; Petitioner's Exhibit 1.

After the parties first 19(b) trial on November 7, 2019 and while the parties awaited receipt of the Arbitrator's 19(b) decision, Petitioner was terminated by Respondent on December 20, 2019. Petitioner testified that as of December 20, 2019, she was working light duty per the restrictions imposed by her treating physician. Respondent's Section 12 examiner, Dr. Chabot, imposed restrictions on Petitioner as well. Respondent's witness Gary Wyman, testified that at the time of Petitioner's termination she was working with a five pound restriction with no repetitive bending, twisting, lifting or stooping. The unrebutted evidence at trial is that Petitioner was under restrictions related to her work injury at the time of her termination and Respondent was accommodating her restrictions. Maye at 15, 76.

In December, 2019 Petitioner's counsel sent an email to Respondent's counsel notifying Respondent's counsel that Petitioner had been terminated and requested that Respondent issue bi-weekly TTD benefits. Petitioner's counsel advised that Petitioner was terminated while on restrictions. Petitioner's counsel then followed-up on multiple occasions in January, 2020. Respondent did not respond to the requests for TTD, nor set forth a basis for nonpayment until January 24, 2020. On January 24, 2020, Respondent's counsel sent an email stating that Petitioner had abandoned her job and accordingly, no TTD benefits would be paid. Petitioner's Exhibit 3. Petitioner's counsel immediately responded and advised that the allegation of job abandonment was erroneous, not consistent with the facts and amounted to vexatious and unreasonable conduct. At trial, the evidence showed that Petitioner worked every assigned shift the week leading up to her termination. Petitioner in fact worked her standard overnight shift of December 19, 2019 into the

morning of December 20, 2019. Respondent's witness, Gary Wyman, who terminated Petitioner, testified that Petitioner was not present at the time she was terminated "because she was actually working at the time." Maye at 87. It was not until the last five minutes of her shift, that Petitioner was terminated by Respondent. At trial, there was no evidence that demonstrated "job abandonment" as alleged in the January 24, 2020 email.

Evidence was presented surrounding the reasons and circumstances of Petitioner's termination. Petitioner testified that after her accident on March 19, 2018 she utilized intermittent Family Medical Leave Act ("FMLA") which permitted her to miss three days a month and two additional two hour intervals per month related to her ongoing pain and to attend doctor's visits. Shortly following work injury in March, 2018 and up through October, 2019, Petitioner's physician properly addressed the FMLA paperwork. However, when Petitioner's FMLA required recertification at the end of October, 2019, there had been a clerical error with the extent of her leave. This clerical error led several absences which Petitioner believed were covered through FMLA being retroactively removed and assessed as points. This led to Petitioner, as a matter of Respondent's policy, "pointing out" and her termination. Petitioner and Respondent's witness, Gary Wyman, confirmed a substantial portion of Petitioner's points she accrued were secondary to FMLA dates not being approved through its third-party administrator, Sedgwick. These dates were retroactively assessed as points when the third-party administer determined they were not consistent with her current FMLA paperwork. Maye at 92-10; Respondent's Exhibits 5, 7.

Petitioner testified that at the time of her termination her physician's office had corrected its paperwork and resubmitted it to the third-party administrating company, Sedgwick, and that she was working with both Sedgwick and her physician's office to rectify the error in her FMLA paperwork when terminated.

CONCLUSIONS OF LAW

Disputed issue **L** is whether Petitioner is entitled to temporary total disability benefits from December 21, 2019 to the date of hearing. A claimant is temporarily totally disabled from the time an injury incapacitates her from work until the time as she is recovered or restored as the permanent character of her injury will permit. The dispositive inquiry is whether the claimant's condition has stabilized, reached maximum medical improvement as an example. Considerations are given to a release to return to work, medical testimony, and evidence concerning the injury and extent of the injury. Interstate Scaffolding, Inc. v. Workers' Compensation Commission, 385 Ill. App. 3d 1040, 1043 (2008).

Petitioner was terminated on December 20, 2019 while under restrictions related to her work-injury. Petitioner testified to her restrictions. Respondent's own Section 12 examiner imposed restrictions. Gary Wyman, Respondent's witness testified that Petitioner was working under restrictions at the time of her termination. The law of this case, as well, is that Petitioner had restrictions as well.

Petitioner's condition was not stable and had not reached MMI. Respondent had authorized the surgery following receipt of the 19(b) decision on January 7, 2020 and never appealed the Arbitrator's Findings of Facts and Conclusions of Law. An employer's obligation to pay temporary total disability benefits to an injured employee does not cease because the employee has been discharged, whether or not for cause. That is the law in a case with precisely this issue in this Petition. Interstate Scaffolding, Inc v. Illinois Workers'

Compensation Commission, 236 Ill. 2nd 132, 149 (2010); See also Matuszczak v. Illinois Workers' Compensation Commission (Wal-Mart), 2014 Il App (2d) 130532 WC.

I find as a conclusion of law, Petitioner is entitled to temporary total disability from December 21, 2019 to the date of hearing February 5, 2020, 6 and 4/7 weeks at the rate of $413.06 ($616.51 x 0.67) per week.

Disputed issue **M** is whether penalties or fees should be imposed on Respondent.

Petitioner's counsel made demand for the initiation of TTD in writing. Petitioner's counsel called and emailed Respondent on multiple occasions without any response. Respondent never provided a basis, in writing, for the non-payment of benefits within 14 days of Petitioner's written request, as set forth in the Act. When Respondent finally did respond, 36 days after the demand for benefits had been made, it alleged that Petitioner "abandoned her job." Even if that were a proper basis to deny paying benefits, at trial Respondent failed to offer any evidence that Petitioner had abandoned her job as it set forth in its January 24, 2020 email. The evidence is the opposite. Petitioner worked every shift she was scheduled for in the five days leading up to her termination. At the time she was in fact terminated, Respondent's witness, said that she was not present for her termination "because she was working." She was in the building finishing her regularly scheduled shift from 10:00 p.m. December 19, 2019 to 7:00 a.m. December 20, 2019. Termination seemingly stemmed from a clerical error in her FMLA paperwork and from retroactive application of unexcused absences.

Respondent had no good-faith basis to withhold TTD benefits.

Accordingly, Respondent shall pay $30.00 per day, from December 20, 2019 through February 5, 2020, 46 days, or $1380.00 pursuant to Section 19(l).

Sections 16 and 19(k) require a finding that an employer's denial of benefits was unreasonable or vexatious. That is, the refusal to pay must result from bad faith or improper purpose. While the burden is higher, this Arbitrator in listening to the manner in which Petitioner was treated and in the face of the crystal clear state of the law in that situation, finds that Respondent's action and conduct in light of the underlying facts, were to put it kindly, vexatious and unreasonable.

Accordingly, the Arbitrator concludes that Petitioner is entitled to penalties and fees under Section 19(k) and Section 16 in the amount of $1,357.19 (50% of the TTD withheld) and $542.88 in fees (20% of the TTD withheld as attorneys' fees).

Arbitrator

4-1-2021
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC001689
Case Name	LEDEZMA, JUAN v. LEGGETT & PLATT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0355
Number of Pages of Decision	23
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Craig Bucy

DATE FILED: 7/9/2021

/s/ Stephen Mathis, Commissioner

Signature

21IWCC0355

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

JUAN LEDEZMA,

Petitioner,

vs. NO: 15 WC 01689

LEGGETT & PLATT,

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, temporary total disability, and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Permanent Disability

The Commission views the evidence differently with respect to Section 8.1b(b) factor (v).

(v) evidence of disability corroborated by the treating medical records

In analyzing the evidence of disability as corroborated by the treating medical records, the Commission notes that a Functional Capacity Evaluation was performed by Athletico on November 18, 2015 per order of Dr. Zelby. The FCE documented several functional limitations that gravitate in favor of increased permanent disability.

At the time of the FCE the examiner was unable to elicit a left patellar reflex and noted diminished sensation in Petitioner's left lower extremity which correlated with the L 3-4 dermatome which is adjacent to the level of the L4-5 fusion performed by Dr. Zelby on June 11, 2015. Additionally, Petitioner was found to have moderate limitation of left hip flexion.

Dr. Zelby's final clinical note of November 18, 2015 documents that Petitioner was post left L4-L5 fusion with placement of lateral plate and screws. Petitioner reported weakness in the left lower extremity, and occasional low back pain. Dr. Zelby prescribed Tramadol, a narcotic pain medication and Gabapentin. At trial Petitioner testified that he always wears a back brace.

Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds Petitioner sustained a 7.5 % loss of the person as a whole under Section 8(d)2.

All else is affirmed.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being of the lumbar spine is not causally related to the accident of December 5, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for reasonable and necessary medical service related to the lumbar spine is denied. Petitioner reached MMI by April 9, 2015. Respondent has paid all reasonable and necessary medical services related to the lumbar spine and any award for further dates of service is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $346.32 per week for a period of 37.5 weeks, as provided in §8 (e) of the Act, for the reason that the injuries sustained caused the loss of 7.5% of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,000.00. 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.

July 9, 2021

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

SJM/msb
o-05/05/2021
44

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

DISSENT

I disagree with the majority's decision to affirm the Arbitrator's finding that Petitioner's current condition of ill-being to the lumbar spine is not causally related to the undisputed December 5, 2014 accident. In my view, Petitioner established by the preponderance of the evidence that his lumbar spine condition was causally related to the December 5, 2014 work accident, which aggravated and accelerated his degenerative disc disease such that he required a lumbar fusion at L4-L5.

It is undisputed that Petitioner sustained a work accident on December 5, 2014 when he lifted a heavy box while working as an "order picker" for Respondent. It is also undisputed that Petitioner had pre-existing lumbar spine conditions for which he had treated with Dr. Zelby prior to the undisputed accident. However, 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).

In May 2012, prior to the December 5, 2014 accident, Petitioner treated with Dr. Zelby for lumbar spine complaints that radiated into the right lower extremity after a work injury which is not the subject of this instant case. At this time, Dr. Zelby diagnosed Petitioner with an extruded L4-L5 disc with radiculopathy and recommended that Petitioner undergo an L4-L5 microdiscectomy. Petitioner did not undergo this surgery.

In March 2014, Petitioner settled his workers' compensation claims for three injuries to the lumbar spine which occurred in 2012 and 2013. Petitioner testified that he had some continued trouble to his back after March 2014, however he was able to perform his job full job duties without restrictions. It was not until after the undisputed December 5, 2014 work accident that Petitioner's lumbar spine symptoms changed and worsened. After this December 5, 2014 accident, Petitioner was unable to return to his job with Respondent until undergoing a lumbar spine fusion surgery.

On January 19, 2015, Petitioner was evaluated by Dr. Zelby after treating at the Clearing Clinic and undergoing physical therapy for approximately 6 weeks. At this visit, Dr. Zelby documented that on December 5, 2014, *Petitioner "developed an exacerbation of low back pain" and presented with lumbar spine pain that radiated into both lower extremities.* Dr. Zelby specifically noted Petitioner now required a more extensive surgical intervention: *"We explained that surgery to treat his low back pain will involve a lumbar fusion, not a discectomy or decompression,"* and he recommended a lumbar spine MRI. Petitioner followed up with Dr. Zelby on February 16, 2015. On that date, Dr. Zelby reviewed both Petitioner's 2012 MRI and Petitioner's February 7, 2015 MRI and noted that *the MRIs were different*. Dr. Zelby opined that

the 2015 MRI showed degenerative disc disease at L4-L5 with partial loss of disc space height, but the "previously seen L4-5 disc extrusion [was] not seen on the current study." Dr. Zelby diagnosed Petitioner with degenerative disc disease, recommended that Petitioner undergo a lateral interbody fusion at L4-L5, and noted that Petitioner would likely require permanent restrictions following surgery. Petitioner underwent the lumbar fusion surgery on June 11, 2015 at Adventist LaGrange Memorial Hospital ("LaGrange Hospital"). Of note, the discharge summary from LaGrange Hospital dated June 15, 2015 states: "*This is a 42-year-old man who had a work-related injury.* The patient works as a forklift operator. After he was carrying something, he developed severe back pain."

On November 18, 2015, Petitioner followed up with Dr. Zelby and reported having only occasional low back pain and no pain in his legs. Petitioner did however experience intermittent left thigh numbness and some left leg weakness. Petitioner indicated that he used a single-post cane occasionally and primarily for security. Dr. Zelby noted that Petitioner had made "a nice recovery" and that *"he would like to make a return to full duty work beginning Monday"* driving a forklift. Dr. Zelby released Petitioner to work full duty without restrictions. Petitioner's unrebutted testimony was that he initially worked light duty but then resumed his full duty job duties. I find it significant that despite Dr. Zelby's predictions and at Petitioner's request, Petitioner returned to his full duty job as an order picker for Respondent where he worked until July 2019 when he was laid off due to the plant closing.

Based on a chain of events analysis, I find that Petitioner's lumbar spine condition of ill-being and need for a lumbar fusion at L4-L5 is causally related to the undisputed December 5, 2014 work accident. In *Price v. Industrial Comm'n*, the appellate court considered the applicability of a "chain of events" analysis to a case involving a preexisting condition and reasoned as follows:

> The employer also contends that the facts of the present case do not support the Commission's 'chain of events' analysis because [the claimant] had a preexisting condition. The employer cites no authority for the proposition that a 'chain of events' analysis cannot be used to demonstrate the aggravation of a preexisting injury, nor do we see any logical reason why it should not. *The rationale justifying the use of the 'chain of events' analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury*. (Emphasis added.)

Price v. Industrial Comm'n, 278 Ill. App. 3d 848, 853-54, 663 N.E.2d 1057, 1060-061 (4th Dist. 1996).

Similarly, the appellate court in *Schroeder v. IWCC* found that in such cases, "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.

In the instant case, Petitioner credibly[1] testified he had pre-existing lower back problems that worsened after the December 5, 2014 accident. The medical records support and corroborate Petitioner's testimony. In 2012, Petitioner had a herniation at L4-L5 and radicular symptoms *into the right leg*. In contrast, after the December 5, 2014 accident, an MRI showed Petitioner's L4-L5 herniation had resolved; however, Petitioner had a loss of disc space height at L4-L5 with radicular symptoms into *both legs*. The medical records clearly show that Petitioner had radiculopathy into the right lower extremity in 2012, but after the December 5, 2014 accident, Petitioner developed radiculopathy into both lower extremities. Further, Dr. Zelby's records indicate that Petitioner experienced an exacerbation of pain after the December 5, 2014 accident.

It is evident from both Petitioner's testimony and the medical records that he was able to perform his job duties prior to the accident, although he had some trouble, but after the undisputed accident, he was unable to perform his full job duties until undergoing a lumbar fusion. It is also significant that Petitioner's treating physician, Dr. Zelby, performed a different, more extensive surgical procedure (a lumbar fusion) than what was previously recommended before the December 5, 2014 accident (a microdiscectomy). Although Petitioner's pre-existing lumbar degenerative disc disease may have been a factor of his need for surgery, it is evident that the undisputed December 5, 2014 work accident, was also a causative factor of his need for surgery. To analyze this point using the court's language in *Schroeder*, Petitioner was in a certain condition and had some preexisting back trouble but was able to perform his full job duties without restrictions; Petitioner injured his lumbar spine in a work accident on December 5, 2014; and following the accident, Petitioner's lumbar spine condition deteriorated so much that he could not perform his full job duties anymore and Dr. Zelby recommended a more extensive surgical procedure, a lumbar fusion. In this case, it is plainly inferable that the December 5, 2014 accident caused the deterioration to Petitioner's lumbar spine.

Respondent attempts to argue that Petitioner's credible and honest testimony, that he had a pre-existing lumbar spine condition and some trouble with his back while performing his job duties prior to the December 5, 2014 accident, undermines Petitioner's claim. I find that Respondent's arguments are without merit in light of the fact that Petitioner was able to perform his job duties until the December 5, 2014 work accident. Additionally, Respondent's arguments are contrary to the Supreme Court's holdings in *Sisbro*, 207 Ill.2d at 205, and *Schroeder*, 2017 IL App (4th) ¶ 26, as stated above.

Respondent also attempts to argue that the medical records and Dr. Singh's section 12 report undermine Petitioner's claim. I find these arguments are also without merit and are contradicted by the evidence. Respondent claims that Petitioner's current lumbar spine condition is the same as it was before the December 5, 2014 accident. However, in his report, Dr. Singh agreed that a comparison of the 2013 MRI and 2015 MRI revealed the two MRIs were in fact different. The 2013 MRI showed a herniation at L4-L5. The 2015 MRI showed the herniation at

1 There is no dispute that Petitioner's testimony was credible as Respondent relies on Petitioner's testimony in making its arguments, and there is no evidence in the treating medical records that Petitioner exaggerated or displayed any signs of symptom magnification.

L4-L5 had "decreased" but there was a loss of disk signal and height density at L4-L5. Dr. Singh opined that Petitioner's lumbar spine condition was not related to his work injury and proceeded to detail Petitioner's previous work accidents in 2011 (this date appears to be an error based on the settlement contract in evidence), 2012, and 2013. Dr. Singh opined that Petitioner's condition was related to his prior lumbar spine injuries, which I note, Respondent disputed and denied at the time the parties settled those claims. Respondent's reliance on Dr. Singh's report (also relied on by the Arbitrator and the majority), which states that Petitioner's condition is related to his previous work injuries that were resolved via settlement contract in March 2014, is undermined by the fact the settlement contract in evidence states that causation for the 2012 and 2013 accidents was "Disputed and Denied," per Dr. Soriano's 2013 section 12 report. Interestingly, in 2013, Dr. Soriano opined that Petitioner had a herniated disc at L4-L5 and degenerative disc disease, but opined that Petitioner's complaints were unrelated to the 2012 and 2013 injuries (despite Petitioner's radiculopathy and Dr. Zelby's opinion that Petitioner required a microdiscectomy). I find it unreasonable and contrary to the evidence for Respondent to first argue that Petitioner's lumbar spine condition was not causally related to the three lumbar spine injuries in 2012 and 2013, completely dispute and deny the 2012 and 2013 cases at the time of settlement, and then after the December 5, 2014 accident, argue that Petitioner's current lumbar spine condition is actually related to the prior three injuries that took place in 2012 and 2013, which were disputed and denied by Respondent.

Further, Dr. Singh's report mentions a note where "Dr. Erickson" recommended Petitioner undergo surgery to the L4-L5 level at some point prior to December 5, 2014, however, I note that this report was not admitted into evidence. Further, Petitioner did not undergo surgery at that time and was able to perform his full job duties until the December 5, 2014 accident. Finally, Dr. Singh's opinion that Petitioner had five-out-of-five positive Waddell's signs and demonstrated "nonanatomic" pain complaints is contradicted by the fact that Petitioner significantly improved after undergoing the lumbar spine fusion performed by Dr. Zelby and following the surgery, Petitioner even requested to be released to full duty work without restrictions where he worked for Respondent until the plant closed. Based on the above, I find Dr. Singh's section 12 report and opinions to be unpersuasive and not credible.

I find that Petitioner proved causal connection and Respondent is liable for all medical bills related to Petitioner's lumbar spine treatment through November 18, 2015. Additionally, Petitioner is entitled to temporary total disability benefits from June 11, 2015 through November 18, 2015. The medical records indicate that Petitioner had a generally good result from the lumbar fusion surgery except for some occasional left thigh numbness and left leg weakness. Admirably, Petitioner requested that Dr. Zelby release him to full duty work with no restrictions and he continued to work for Respondent from November 2015 to July 2019 when the plant closed. I find that Petitioner is entitled to permanent partial disability benefits pursuant to section 8(d)(2) of the Workers' Compensation Act to the extent of 25% of the person as a whole.

For all the above reasons, I respectfully dissent.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0355
NOTICE OF ARBITRATOR DECISION

LEDEZMA, JUAN Case# **15WC001689**
Employee/Petitioner

LEGGETT & PLATT
Employer/Respondent

On 6/23/2020, 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 0.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
CRAIG BUCY
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

Juan Ledezma
Employee/Petitioner

v.

Leggett & Platt
Employer/Respondent

Case # 15 WC 1689

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **February 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 **December 5, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, the average weekly wage was **$577.20**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **4** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,296.95** for short term disability benefits, for a total credit of **$5,296.95**.

Respondent is entitled to a credit of **$78,190.25** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that petitioner's current condition of ill-being of the lumbar spine is not causally related to the accident of 12/5/14.

The Arbitrator denies petitioner's claim for reasonable and necessary medical services related to the lumbar spine. The Arbitrator finds that petitioner reached MMI by April 9, 2015. The Arbitrator further finds that Respondent has paid all reasonable and necessary medical services related to the lumbar spine and declines to award any further dates of service.

Respondent shall pay Petitioner permanent partial disability benefits of $346.32/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

6/05/2020
Date

ICArbDec p.

JUN 23 2020

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on February 26, 2020 in Chicago, Illinois. This matter was originally assigned to Arbitrator David Kane. However, Arbitrator Kay was covering Arbitrator's call on the day of the hearing and the parties agreed to Arbitrator Kay hearing the matter.

The parties went to hearing with the following issues in dispute: whether Mr. Juan Ledezma's (hereinafter "Petitioner") condition of ill-being is casually connected to his injury, whether Leggett & Platt (hereinafter "Respondent") is liable for unpaid medical bills, whether Petitioner is entitled to temporary total disability for the period of 6/11/15 through 11/24/15 and the nature and extent of Petitioner's injury. (Arb.X1)

The parties stipulated that on 12/5/14 Petitioner and Respondent were operating under the Illinois Workers' Compensation Act, and their relationship was one of employee and employer, that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, and that Petitioner gave notice of the accident to Respondent within the time limits stated in the act. (Arb.X1) The average weekly wage for the record was $577.20, Petitioner was 41 years old at the time of the accident, married, and had 4 dependent children. (Arb.X1)

Petitioner was the only witness to testify at trial. Petitioner testified with the use of an interpreter. Noel Cortez was the interpreter and testified he had interpreted before the Illinois Workers' Compensation Commission for the past 16 years. He testified that he had not met petitioner prior to the date of the trial.

The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that on December 5, 2014, he was employed by Respondent, Leggett & Platt. Respondent's business is furniture, and Petitioner worked in the warehouse. He testified he was hired on September 3, 2001 and worked to pick orders in the distribution part of warehouse. Petitioner testified that he would be given a "pick list" and would then go pick orders to place onto a skid before bringing the skid back to a central location. Petitioner testified that the items he picked weighed between 15 – 90 pounds.

Petitioner testified that on December 5, 2014 he went to pick up an order, which weighed approximately 75 pounds. Petitioner testified that when he bent to lift the item from the shelf he felt a pulling sensation in his lower back and radiating pain down his legs. Petitioner testified that he immediately told his supervisor about the incident and filled out an accident report before seeking treatment at the company clinic.

Petitioner testified that he underwent a drug test at the clinic and was given medication for pain before he underwent physical therapy at the Clearing Clinic. Petitioner testified that physical therapy was not helpful and he was referred to Dr. Andrew Zelby for further evaluation.

Petitioner testified that he first saw Dr. Zelby on January 19, 2015, at which time he was prescribed an MRI of the lower back. Petitioner testified that he underwent that MRI on February 7, 2015. Petitioner testified that returned to see Dr. Zelby after completing the MRI and was recommended surgery to the L4-L5 level. He testified that he underwent a fusion surgery on June 11, 2015.

Petitioner testified that he continued to work for Leggett & Platt after the initial accident date and prior to his lumbar surgery on June 11, 2015. Petitioner testified that he continued to experience lower back pain in the month after his surgery, but that physical therapy helped resolve those pain complaints.

Petitioner testified that he underwent post-operative physical therapy at Athletico until he was discharged in November of 2015. He testified he returned to work for Respondent in his pre-acccident position in November of 2015. Petitioner testified he performed light duty work for a bit when he first returned, but eventually resumed full duty work without restrictions.

Petitioner testified that he continued working for Leggett & Platt until the company warehouse closed. Petitioner testified he was laid off as of July 19, 2019. Petitioner testified that at the time of trial, he was working in another distribution facility sorting tortillas. Petitioner testified that he had been working in this specific location for the past 10 days. He alleged that he had difficulty finding a regular job due to his back condition.

Petitioner testified that he notices some lower back pain when he bends to lift items at work or when changing diapers at home. He stated that he wears a belt to help with his back issues and takes Tylenol as needed.

Petitioner testified that he had suffered injuries to the lower back in 2012 and 2013 for which he missed time from work. Petitioner testified that he used vacation days in order to not lose money as a result of these incidents. Petitioner testified that he had undergone an injection to the lumbar spine as a result of those pre-December 2014 injuries, which he stated was not helpful. Petitioner testified that he settled those prior claims in March of 2014 and returned to work full duty.

Petitioner testified that after he settled the pre-accident claims and returned to work, **he missed several days of work due to lumbar spine conditions prior to the December 5, 2014 accident. Petitioner testified that he had continued to experience issues in his lumbar spine prior to the December 5, 2014 accident. Petitioner testified he had difficulty performing his job duties as a result of his ongoing lumbar spine complaints prior the accident date of December 5, 2014.** Petitioner testified that he continued to experience difficulty when bending over to pick items up and experienced lumbar spine pain while performing these activities prior to the December 5, 2014 accident. Petitioner testified that his lower back never resolved after the prior accidents.

Cross-Examination Testimony of Petitioner

On cross examination, Petitioner testified that he had previously claimed accident dates of January 12, 2011, April 17, 2012 and April 22, 2013. He testified that he suffered injuries to the lumbar spine as a result of those prior accidents.

With respect to the January 12, 2011 accident, petitioner initially denied that he was pulling a heavy box from a ledge at chest height before placing the box onto a skid located on the ground. Despite reviewing Dr. Soriano's September 19, 2013 IME report, which contained a detailed description of the injury and was entered into evidence as Respondent's Exhibit #5, petitioner continued to insist that the description was incorrect. Petitioner testified that the IME report correctly detailed the April 17, 2012 and April 22, 2013 accident. Petitioner then confirmed that he suffered injury to the lumbar spine as a result of the January 12, 2011 accident but disagreed with the description of the accident contained in the IME report. Petitioner testified that he was unable to work full duty until March of 2012 after that initial January 12, 2011 accident.

With respect to the April 17, 2012 accident, Petitioner testified that he suffered an injury to the lower back while lifting freight at work. He testified that he experienced **lower back pain which radiated into both of his legs after the April 17, 2012 accident**. He testified that he treated with Dr. Zelby after the April 17, 2012 accident and **had been recommended surgery for the lumbar spine**. Petitioner confirmed that the surgical recommendation was to the L4-L5 level. Petitioner testified that the surgical recommendation was first made on May 10, 2012, over two years prior to the December 5, 2014 accident date.

With respect to the April 22, 2013 accident, Petitioner testified he suffered yet another injury to the lumbar spine. **Petitioner testified that he continued to experience radiating lumbar spine pain into both legs after the April 22, 2013 accident.** Petitioner conceded that he saw Dr. Erickson after that accident and **was again prescribed surgery for the lumbar spine**. Petitioner confirmed that he underwent an MRI and EMG as a result of these accidents. Petitioner testified that he was diagnosed with L4-L5 radiculopathies after these three prior accidents.

Petitioner testified that he was seen by Dr. Soriano on September 19, 2013 for an independent medical examination. He confirmed that he was diagnosed with degenerative disc disease and a herniated disc as a result of the prior accidents. Petitioner testified that both Dr. Zelby and Dr. Erickson diagnosed him with degenerative disc disease. **He confirmed that both doctors recommended surgery to the L4-L5 level as a result of the accidents prior to December 5, 2014.** Petitioner testified that he reached a settlement agreement which was approved on March 12, 2014 to resolve the prior accidents.

Petitioner testified that he suffered another injury on December 5, 2014. He testified that he sought treatment at the Clearing Clinic the same day. Petitioner testified he told the Clearing Clinic that he had injured his back at work lifting a 50 pound box. Petitioner conceded that he did not tell the Clearing Clinic about his prior back injuries.

Petitioner testified that he sought treatment with Dr. Andrew Zelby on January 19, 2015. Petitioner confirmed that he had previously treated with Dr. Andrew Zelby in May 2012 for his prior work injuries to the lumbar spine. Petitioner testified he had previously obtained a surgical recommendation for the L4-L5 level from Dr. Zelby. Petitioner confirmed that Dr. Zelby reviewed an MRI from May 22, 2013 at the initial visit, which showed degenerative disc disease at the L4-L5 level. Petitioner testified that Dr. Zelby again diagnosed him with lumbar degenerative disc disease. He confirmed Dr. Zelby again recommended surgery at the L4-L5 level.

Petitioner testified that he underwent an independent medical examination with Dr. Kern Singh of Midwest Orthopedics at Rush on April 9, 2015. Petitioner denied ever telling Dr. Singh that he had experienced similar back problems prior to the accident, in direct contradiction of the IME report. After being presented with a copy of Dr. Singh's IME report, petitioner continued to deny that he had ever told Dr. Singh that he had experienced similar back issues in the past. Petitioner confirmed that Dr. Singh diagnosed him with degenerative disc disease and did not feel his surgery was related to the work accident.

Petitioner testified that he eventually obtained a full duty release from Dr. Zelby and returned to work. He confirmed that he had not sought treatment with Dr. Zelby since November of 2015 and did not have any follow up appointments scheduled with Dr. Zelby at the time of trial. Petitioner testified that he had returned to work in his pre-accident position full duty without restrictions. Petitioner testified that he was laid off in July of 2019 as a result of the plant closing. He confirmed that he was not terminated from employment due to any kind of medical condition.

Petitioner testified that he obtained health insurance through his employment with Respondent. He testified that he put all of his medical bills through this group health insurance carrier. Petitioner also confirmed that he received short-term disability benefits for the entire time period he was off work - June 19, 2015 through November 24, 2015.

Re-direct Examination

On re-direct examination, Petitioner confirmed that the surgery he underwent was an L4-L5 fusion. He confirmed this was a different surgery then initially prescribed by Dr. Zelby in 2012.

Re-cross Examination

On re-cross, petitioner testified that the level of the lumbar spine that he eventually underwent surgery on was **the exact same level that he was recommend surgery for by Dr. Zelby in 2012**. He conceded that Dr. Zelby's diagnosis of degenerative disc disease did not change in any way between the May 2012 office visit and his initial post December 5, 2014 office visit with Dr. Zelby.

Pre-Accident Medical Records

The records from petitioner's pre-accident medical treatment with Dr. Zelby were entered into evidence as part of Respondent's Exhibit #7.

The records from Dr. Zelby contained the report from a lumbar MRI petitioner underwent on February 7, 2012 at MacNeal Hospital. (RX7). That MRI documented a small right paracentral disk protrusion at the L4-L5 level, with the disk material abutting the right nerve root as it exited the thecal sac. (RX7). It additionally documented narrowing of the neural foramina bilaterally at the L4-L5 level. (RX7).

Petitioner was first seen by Dr. Andrew Zelby on May 10, 2012. (RX7). Petitioner reported an injury occurring at work in February of 2012. (RX7). As result of that accident, petitioner complained of pain to his lower back, which went into his right leg. (RX7). Petitioner reported that he suffered another injury on April 17, 2012 while moving a 90-pound box from a shelf to his skid. (RX7). Petitioner reported that developed an exacerbation of his prior low back pain and right leg pain as a result. (RX7). Petitioner reported that his back pain slightly improved with physical therapy, but he continued to experience low back pain. (RX7).

At the time of his initial evaluation with Dr. Zelby, petitioner complained of low back pain which radiated from his right buttock, down the posterolateral aspect of his right leg and into the ankle. (RX7). Petitioner complained of numbness in his right foot but denied any weakness. (RX7). He reported his pain was constant in nature. (RX7).

A physical examination noted reduced range of motion of the lumbar spine. (RX7). Petitioner demonstrated a positive Lying and Sitting Straight Leg Raise Test on the right. (RX7). He also had difficulty heel-toe walking on the right side. (RX7). Dr. Zelby noted diminished sensation to light touch in the right lower extremity. (RX7). Dr. Zelby diagnosed petitioner with lumbar degenerative disc disease and a herniated disc. (RX7). Dr. Zelby opined that petitioner's pain complaints were emanating from an extruded L4-L5 disc, with petitioner's symptoms consistent with a right L5 radiculopathy. (RX7). Dr. Zelby reviewed petitioner's February 7, 2012 MRI and recommended petitioner undergo a right sided L4-L5 discectomy. (RX7). After petitioner confirmed he wanted to proceed, surgery was scheduled. (RX7).

IME with Dr. Soriano

Petitioner did not follow up with Dr. Zelby thereafter. Instead, he suffered a new accident on April 22, 2013. After that accident, petitioner was evaluated by Dr. Marc Soriano, a neurosurgeon, for a Section 12 Independent Medical Exam. Dr. Soriano's report was entered into evidence as Respondent's Exhibit # 5.

Dr. Sorianos' report contained detailed descriptions of petitioner's mechanisms of injury for the January 12, 2011, April 17, 2012 and April 22, 2013 accidents. (RX5). With respect to the January 12, 2011 injury, petitioner reported that he was "unable to get out of bed" the morning after the accident due to his low back pain. (RX5). Petitioner reported that he did not return to regular duty work until March 1, 2012, over a year after the initial accident date. (RX5).

With respect to the April 17, 2012 injury, petitioner told Dr. Soriano that he was lifting freight when he began experiencing low back pain that radiated into both legs. (RX5). Petitioner reported he was recommended surgery for the L4-L5 level. (RX5). Petitioner stated that after the surgical recommendation, he began treating with a chiropractor. (RX5).

With respect to the April 22, 2013 injury, petitioner reported that he had undergone injections, which were of minor help. (RX5). Petitioner old Dr. Soriano that he was also seen by Dr. Erickson, another neurosurgeon, who opined that petitioner needed a fusion surgery. (RX5).

Dr. Soriano reviewed medical records, which included an EMG performed on June 7, 2013 which documented acute denervation at the L5-S1 level. (RX5). He also reviewed an MRI report dated May 22, 2013 which documented a 4-millimeter broad-based disc bulge at the L4-L5 level, with a central annular tear. (RX5). The MRI also showed hypertrophic facet with moderate central stenosis at the L4-L5 level. (RX5). Dr. Soriano reviewed a pain management evaluation from Dr. Engel, who opined that petitioner's MRI documented a worsening spinal condition. (RX5).

Dr. Soriano diagnosed petitioner with degenerative disc disease of the lumbar spine and a herniated disc. (RX5). He opined that petitioner had pre-existing and ongoing degeneration of the lumbar spine. (RX5).

Post-Accident Medical Treatment

Petitioner was initially seen at the Clearing Clinic on December 5, 2014. (RX6). HE reported that was lifting boxes when he felt pain in his lower back. (RX6). Petitioner complained of lower back with radiated into his bilateral legs. (RX6). Petitioner was diagnosed with a lumbar strain and instructed to attend physical therapy. (RX6). He was also given light duty restrictions. (RX6).

Petitioner subsequently underwent physical therapy at the Clearing Clinic from December 10, 2014 through January 15, 2015. (RX6).

Petitioner saw Dr, Andrew Zelby, the neurosurgeon who had previously recommended surgery in 2012, on January 19, 2015. (RX7). Petitioner provided a history of his injury to Dr. Zelby. (RX7). He told Dr. Zelby that had undergone a series of lumbar epidural steroids injections prior to the accident of December 5, 2014. (RX7). Petitioner reported that the most recent injection was a few months prior to the evaluation, but it had provided only temporary relief. (RX7). Petitioner complained of low back pain which intermittently radiated into both legs. (RX7).

Dr. Zelby reviewed x-rays taken on December 5, 2014 which he opined showed a loss of disc space height at the L4-L5 level. (RX7). Dr. Zelby opined that the x-rays did not show any acute findings. (RX7). He also reviewed an MRI of the lumbar spine taken on May 22, 2013. (RX7). Dr. Zelby opined that the MRI showed degenerative disc disease at the L4-L5 level with partial loss of disc space height. (RX7). He further opined that the MRI showed a broad-based bulging disc with mild to moderate bilateral recess stenosis. (RX7).

Dr. Zelby diagnosed petitioner with lumbar degenerative disc disease and a herniated disc. (RX7). Dr. Zelby noted that petitioner had tried lumbar epidural steroid injections in the past without relief. (RX7). He renewed his recommendation for surgery, but now wanted to proceed with a fusion due to the progression of petitioner's condition. (RX7). Dr. Zelby recommended an updated MRI and x-rays to prepare for surgery. (RX7).

Petitioner returned to see Dr. Zelby on February 16, 2015 after undergoing the updated imaging. (RX7). His symptoms were unchanged. (RX7). Dr. Zelby reviewed the updated x-rays and opined they showed loss of disc height at the L4-L5 level. (RX7). He reviewed the updated MRI and opined it showed degenerative disc disease at the L4-L5 level with partial loss of disc height space, as demonstrated on the May 22, 2013 MRI. (RX7). Dr. Zelby further noted degenerative endplate changes. (RX7). Dr. Zelby updated his diagnosis to lumbar degenerative disc disease only and maintained his recommendation for surgery. (RX7).

IME with Dr. Kern Singh

Petitioner was seen by Dr. Kern Singh for a Section 12 Independent Medical Examination on April 9, 2015. The IME report was entered into evidence as Respondent's Exhibit #8.

Dr. Singh reviewed petitioner's medical records dating back to May 4, 2012, in connection his examination. (RX8). He noted that petitioner had undergone treatment with Dr. Erickson after his April 23, 2013 accident and was recommended a lumbar fusion. (RX8).

At the time of the IME, Petitioner complained of whole-body pain, which he rated at a 7-9/10 level. (RX8). Petitioner told Dr. Singh that he had experienced similar episodes of back pain in the past. (RX8). Petitioner reported he had undergone physical therapy and injections after his April 2013 accident with moderate relief. (RX8).

On examination, Petitioner had self-limited range of motion of the lumbar spine. (RX8). Monofilament testing was symmetric and within normal limits in the bilateral lower extremities. (RX8). Petitioner had full strength of the lower extremities. Petitioner had 5/5 positive Waddell Findings, including pain with percussion, pain with simulated axial loading, pain with simulated axial rotation, a distracted straight leg raise and symptom magnification. (RX8).

Dr. Singh reviewed Petitioner's lumbar MRI film from May 22, 2013 and February 7, 2015. (RX8). He opined the 2015 MRI was unchanged from the 2013 MRI, with the exception of the disc protrusion actually decreasing in size. (RX8).

Dr. Singh diagnosed Petitioner with a lumbar strain and degenerative disc disease. (RX8). He noted that petitioner had complained of ongoing lumbar spine symptoms since 2011. (RX8). Dr. Singh opined petitioner had long-standing disk degeneration that was unrelated to the December 5, 2014 accident. (RX8). Dr. Singh further opined that petitioner's disk degeneration at the L4-L5 level was clearly pre-existing in nature, as evidence by his 2013 MRI. (RX8). He placed petitioner at MMI for the lumbar strain and opined that any further medical treatment was unrelated to the December 5, 2014 accident. (RX8).

Dr. Singh further noted that petitioner's pain complaints on examination did not appear to have any anatomical basis. (RX8). He did not believe that petitioner's pain complaints correlated to any L4-L5 pathology. (RX8).

Medical Treatment Resumed

Petitioner returned to see Dr. Zelby on June 1, 2015. (RX7). Petitioned denied any change in symptoms and wished to proceed with surgery. (RX7).

Dr. Zelby performed an L4-L5 fusion and discectomy on June 1, 2015 at Adventist La Grange Hospital. (RX7). The pre and post-operative diagnoses were lumbosacral spondylosis and degenerative disc disease at the L4-L5 level. (RX7).

Petitioner returned to see Dr. Zelby on July 1, 2015. (RX7). He was recovering well from surgery. Dr. Zelby recommended that petitioner begin physical therapy and kept petitioner off work. (RX7).

Petitioner subsequently underwent a course of physical therapy before returning to see Dr. Zelby on September 9, 2015. (RX7). Petitioner was three months post-op and was slowly improving. (RX7). Dr. Zelby opined that petitioner was making slow but steady improvement and recommended an additional six weeks of physical therapy. (RX7).

Petitioner next saw Dr. Zelby on October 21, 2015. (RX7). Petitioner reported his therapy was going well. (RX7). He had no pain in his low back or legs. Petitioner stated that he felt ready to return to work. (RX7). Dr. Zelby recommended a further four weeks of physical therapy and allowed petitioner to work driving a forklift and with a 10-pound lifting restriction. (RX7).

Petitioner was last seen by Dr. Zelby on November 18, 2015. (RX7). Petitioner was five and a half months post-surgery and doing well. (RX7). A physical examination was grossly normal. Updated x-rays of the lumbar spine showed well-maintained spinal alignment with a solid arthrodesis through the fusion cage. (RX7). Dr. Zelby released petitioner to return to work full duty without restrictions as of November 23, 2015. (RX7).

Petitioner thereafter underwent no additional medical treatment to his lumbar spine.

CONCLUSIONS OF LAW:

With regard to issue (F) whether Petitioner's injury is casually connected to his injury while working for Respondent, the Arbitrator finds as follows:

It is the claimant's burden to prove by a preponderance of the evidence that he 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 (Ill. 2003). The claimant must show that his condition of ill-being is causally related to the accident at issue.

There is no dispute that Petitioner suffered a work accident on December 5, 2014. The dispute centers around whether Petitioner's current condition of ill-being with respect to the lumbar spine is causally connected to that accident. Petitioner's argument that his lumbar fusion surgery was the result of the December 5, 2014 accident is directly rebutted by the medical records and his testimony at trial.

The medical records confirm that Petitioner was diagnosed with degenerative disc disease at the L4-L5 level prior to the December 5, 2014 work accident by multiple surgeons. (RX5, RX7, RX8). Petitioner was first

seen by Dr. Zelby on May 10, 2012. At that visit, Dr. Zelby diagnosed Petitioner with degenerative disc disease at the L4-L5 level and recommended that petitioner undergo spinal surgery at the L4-L5 level. (RX7). This was the same level that Petitioner would later undergo the fusion in June of 2015. Dr. Zelby's diagnosis was based in part on an MRI from February 7, 2012, which documented degenerative findings.

Petitioner also was evaluated by Dr. Erickson after his April 2013 accident. Dr. Erickson recommended that Petitioner undergo a lumbar fusion at the L4-L5 level. (RX8). This was over a year and half before Petitioner's December 5, 2014 accident and over two years before he would undergo the exact same procedure with Dr. Zelby. It is clear that petitioner's lumbar spine degenerative condition and need for surgery pre-existed the December 5, 2014 work accident. Petitioner documented multiple lumbar spine accidents prior to December 5, 2014 and had two separate physicians recommended surgical intervention at the L4-L5 level.

Petitioner was seen by Dr. Marc Soriano on September 19, 2013 for an independent medical examination, over a year prior to the December 5, 2014 accident. At that IME, Petitioner reported that his lumbar spine pain was so bad that he "was unable to get out of bed." Dr. Soriano reviewed an MRI from May 22, 2013, which continued to document degenerative findings at the L4-L5 level. Dr. Soriano opined that Petitioner had degenerative disc disease, which was pre-existing and ongoing in nature. Dr. Soriano noted that Petitioner had been prescribed an L4-L5 surgery by two different surgeons at the time of the IME.

After the December 5, 2014 accident, Petitioner returned to see Dr. Zelby, the same surgeon who had previously recommended surgery to the L4-L5 level. Petitioner's pain complaints were grossly unchanged from his prior visit in May of 2012. Dr. Zelby's diagnosis was completely unchanged from Petitioner's pre-accident visit in May of 2012. He continued to diagnose petitioner with degenerative disc disease at the L4-L5 level. Dr. Zelby again recommended surgery to the L4-L5 level, the exact same level that he had recommended surgery to in 2012. Dr. Zelby recommended a fusion to petitioner at the January 15, 2015 examination. Petitioner had previously been prescribed the exact same procedure by Dr. Erickson after his April 23, 2013 accident, over a year and a half prior to the December 5, 2014 incident.

Dr. Zelby reviewed Petitioner's pre-accident MRIs as well as an updated MRI from February 7, 2015. Dr. Zelby opined that all of the MRIs demonstrated degenerative disc disease at the L4-L5 level. Dr. Zelby opined that the February 7, 2015 MRI was largely unchanged from the pre-accident MRI's.

Petitioner was also evaluated by Dr. Kern Singh on April 9, 2015 for another IME. Petitioner told Dr. Singh that he had "experienced similar episodes of back pain" prior to the December 5, 2014 incident. Dr. Singh reviewed Petitioner's MRI films from May 22, 2013 and February 7, 2015. Dr. Singh opined that both MRIs documented degenerative disc disease at the L4-L5 level. Dr. Singh opined that the MRIs were largely unchanged. He opined that the February 7, 2015 actually documented a slight improvement of the disc bulge noted on the May 22, 2013 MRI.

During his examination, Dr. Singh noted that Petitioner had a completely normal neurological exam, with 5/5 Waddell Findings. Dr. Singh diagnosed Petitioner with lumbar degenerative disc disease at the L4-L5 level, which clearly pre-existed the work accident radiographically. Dr. Singh diagnosed Petitioner with a lumbar strain and opined petitioner had reached MMI by the time of the IME.

In addition to the medical evidence, petitioner confirmed at trial that his lumbar spine pain complaints as a result of his prior accidents never resolved. At trial, petitioner confirmed that he had suffered three separate accidents to the lumbar spine, all of which pre-dated the December 5, 2014 accident. He confirmed that the last accident occurred on April 22, 2013. Petitioner testified that those prior accidents resulted in complaints of lower back pain that radiated into his legs. He confirmed that he was recommended surgery to the L4-L5 level

by two different surgeons as a result of those accidents. Those pre-accident surgical recommendations included a recommendation for the exact same procedure petitioner later underwent with Dr. Zelby.

Despite settling the prior cases, Petitioner testified that his lumbar spine pain never resolved. He testified that after settling his prior claims, he continued to miss work due to his back pain. He testified that he continued to experience ongoing lower back pain, which made his job duties difficult. He testified that he struggled with and altered some of his job duties due to his continued lumbar spine complaints.

Petitioner's testimony is consistent with his medical records, which document continued physical therapy and epidural steroid injections to the lumbar spine in the period leading up to the December 5, 2014 accident. Petitioner told Dr. Zelby at his first visit after the December 5, 2014 accident that he had undergone an injection a few months prior, which did not offer any significant relief to his lumbar spine pain. Petitioner told Dr. Singh that he had experienced similar episodes of lumbar spine pain prior to the work accident.

Petitioner's diagnosis, from his first accident on January 12, 2011 through the December 5, 2014, never changed. Every doctor who examined petitioner diagnosed him with degenerative disc disease at the L4-L5 level. Petitioner was first recommended surgery to the L4-L5 level by Dr. Zelby on May 10, 2012. Petitioner was subsequently recommended an L4-L5 fusion by Dr. Erickson after the April 22, 2013 accident. Petitioner testified at trial that his pain complaints never resolved prior to the December 5, 2014 accident, that he continued to miss work prior to the December 5, 2014 accident for his continued back issues, and that he had to alter his job duties due to his continued lumbar spine complaints. It is clear that petitioner failed to meet his burden of proof that his lumbar fusion procedure of June 1, 2015 was related to the December 5, 2014 accident.

The Arbitrator finds the opinion of Respondent's Section 12 Medical Examiner, Dr. Singh, to be credible. The Arbitrator finds that petitioner reached MMI by the time of Dr. Singh's IME on April 9, 2015. The Arbitrator finds that Petitioner's current condition of ill-being with respect to the lumbar spine is not causally related to the work accident of December 5, 2014.

With regard to issue (J) 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 adopts and incorporates herein the findings set forth in Section F above. The Arbitrator finds that petitioner suffered a lumbar spine sprain/strain as a result of the accident. The Arbitrator therefore declines to award any medical bills related to Petitioner's lumbar spine past the IME with Dr. Singh on April 9, 2015.

With regard to whether Petitioner is entitled to TTD for the period of 6/11/2015 through 11/24/15, the Arbitrator finds as follows:

Based upon the findings in Sections F and J above, the Arbitrator finds that Petitioner is not entitled to any TTD. Petitioner alleged entitlement to TTD benefits from June 11, 2015 through November 24, 2015. Based upon the findings set forth in Section F above, petitioner reached MMI for his lumbar spine condition by April 9, 2015. As such, the Arbitrator finds that petitioner is not entitled to any TTD benefits.

With regard to issue (L) the nature and extent of Petitioner's injury the Arbitrator finds as follows:

The Arbitrator finds that Petitioner suffered a soft tissue injury to the lumbar spine. Under Section 8.1b of the Act, there are five factors for evaluating a claimant's permanent partial disability: (i) the level of impairment per an impairment rating under Section 8.1b(a), (ii) the occupation of the injured employee, (iii) the age of the employee at the time of the alleged injury, (iv) the employee's future earning capacity, and (v) the evidence of the disability corroborated by the treatment records.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a warehouse picker at the time of the accident. This position required petitioner to occasionally lift boxes up to 90 pounds. The Arbitrator takes note of the physical requirements of petitioner's job and therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of the accident. Petitioner suffered only soft tissue injuries and will not have to live with any significant disability. Therefore, the Arbitrator awards this factor little weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that petitioner underwent an unrelated lumbar fusion before obtaining a full duty release. Petitioner thereafter returned to his pre-accident position where he continued to work for another three and a half years. The Arbitrator gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, Arbitrator finds that petitioner suffered a lumbar spine strain. Dr. Singh opined petitioner reached MMI by the time of the his IME on April 9, 2015. 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 5 % loss of use of the person as a whole or 25 weeks of benefits at a PPD rate of $346.32 per week pursuant to §8(e) of the Act.

With regard to issue (N), whether Respondent is due any credit, the Arbitrator finds as follows:

At trial, Respondent submitted into evidence proof of payment of short-term disability benefits as well as a records from petitioner's group health insurance carrier which he obtained through his employment. Respondent is self-insured.

The records regarding the short-term disability benefits were entered into evidence as Respondent's Exhibit # 9. The exhibit documents that petitioner received $5,296.95 in short-term disability benefits from his employer for the time period June 19, 2015 through November 24, 2015.

The records regarding the group health insurance carrier payments were entered into evidence as Respondent's Exhibit #10. Petitioner confirmed at trial that he obtained his group health insurance through his employment with Respondent. The records document that the group health carrier paid $78,190.25 in medical bills for petitioner's treatment through his return to work on November 25, 2015.

The Arbitrator finds that Respondent is entitled to an 8(j) credit of $78,190.25 for medical bills paid by the group health insurance carrier and a further credit of $5,296.95 for short-term disability benefits.

Signature of Arbitrator

6/05/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC032834
Case Name	DEL BOSQUE, HECTOR v. EMPLOYCO USA
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0356
Number of Pages of Decision	30
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Steven Seidman
Respondent Attorney	David Poulos

DATE FILED: 7/12/2021

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HECTOR DEL BOSQUE,

Petitioner,

vs. NO: 18 WC 32834

EMPLOYCO USA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, benefit rate, wage calculation, temporary total disability benefits, medical expenses, and prospective medical treatment 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 affirms the Arbitrator as to accident, causation, and prospective medical treatment. However, the Commission vacates the award for temporary total disability benefits from October 23, 2018 through November 4, 2018 and also modifies the award of temporary total disability benefits from November 20, 2018 through December 26, 2018 to the period beginning on November 26, 2018 through January 7, 2019.

In regard to the average weekly wage, the Commission modifies the Arbitrator's average weekly wage calculation of $505.07 and finds the correct average weekly wage to be $1,894.00 with a corresponding temporary total disability rate of $1,262.67 per week.

Finally, the Commission clarifies that the only medical expenses awarded are for treatment rendered to the back and left ankle. Any expenses related to treatment for the right ankle are denied.

Although Petitioner proved accident and causation, Petitioner's claim for temporary total disability benefits must be modified as it was not supported by the records. Following his accident, Petitioner returned to work. He testified he left work on October 23, 2018 because the show was over and he was in pain. Petitioner testified he went back to work light duty from November 4, 2018 through November 20, 2018. However, there are no off work slips in evidence corroborating lost time for the period from October 23, 2018 through November 4, 2018.

Petitioner further testified that on November 20, 2018 he went off work again until December 26, 2018. (T. 75) However, there is no evidence in the record that Petitioner was taken off work as of November 20, 2018. The evidence indicates Petitioner was taken off work by Dr. Clay beginning November 26, 2018 through January 7, 2019. (Px4)

Accordingly, the Commission vacates the Arbitrator's award of temporary total disability benefits for the period beginning October 23, 2018 through November 4, 2018. The Commission also modifies the Arbitrator's temporary total disability award for the period from November 20, 2018 through December 26, 2018 and awards temporary total disability benefits for the period beginning November 26, 2018 through January 7, 2019.

The Commission also modifies the benefit rates and wage calculations. Although the Arbitrator correctly found that Petitioner's wage should be determined based on a weeks and parts calculation as Petitioner worked less than 52 weeks, the calculation of dividing the total number of hours by the alleged 3 weeks worked was incorrect.

The unrebutted testimony was that Petitioner worked for Employco for approximately 3 weeks prior to the accident. There was overtime, but it was not mandatory. (T. 49-50) Rx5 reflects the hours that the Petitioner worked. Most days Petitioner worked 8 hours. (T. 50)

In reviewing Rx5, the Commission finds that Petitioner worked 24 hours and 8 doubletime hours. His rate of pay was $47.35. As the only testimony that is in evidence are 8-hour workdays, and this evidence is unrebutted, it appears that Petitioner earned $1,136.40 of regular pay for the equivalent of 3 days' work over the 3-week period of time. Applying the weeks and parts analysis, that would be the equivalent of 3/5 weeks for a correct average weekly wage of $1,894.00. Based on that analysis, Petitioner is awarded temporary disability benefits at a rate of $1,262.67 per week.

Finally, the Commission clarifies that no medical expenses are awarded for any treatment regarding Petitioner's right ankle. Petitioner had a pre-existing condition that was not aggravated as a result of his work accident. As such, no medical treatment related to the right ankle is causally connected to the work accident of October 9, 2018 and is therefore denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,262.67 per week for a period of 6 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 $27,812.18 in medical bills as they pertain to the back and left ankle only, and

$31,848.93 in related benefits from Petitioner's significant other's Blue Cross/Blue Shield of Illinois policy, only as they pertain to the back and left ankle, 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 $67,518.00. 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.

July 12,2021

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

MEP/dmm
O: 050421
49

DISSENT

I respectfully dissent from the majority opinion regarding the causal connection of Petitioner's left ankle to the subject work accident, and therefore for the award of medical bills for treatment for his left ankle at Illinois Bone and Joint. I further dissent from the majority's award for any and all treatment at Suburban Orthopedics based upon Petitioner exceeding his two doctor chain of referral choice pursuant to §8(a) of the Act. Even if, arguendo, Petitioner did not exceed his two physician and chain of referral choice, I would deny the medical expenses from Suburban Orthopedics for his left ankle based upon causal connection and I would find Petitioner reached MMI for his low back condition on March 14, 2019, and that he could return to work full-duty for his low back based upon Dr. Graf's opinion and bolstered by Dr. Clay's February 20, 2019 opinion that Petitioner's "MRI of the lumbar spine was unremarkable for pathology which could explain his constellation of symptoms." (PX4)

With respect to the related medical bills that were paid by his spouse's group insurance, I would not award those medical expenses to Petitioner, instead the language of the award should read: Respondent shall hold Petitioner harmless from any claim by Blue Cross Blue Shield in related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the Petitioner's low back and excluding those bills from Suburban Orthopaedics and referrals therefrom, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

Further, I would find that the Arbitrator's calculation of AWW was correct based upon Petitioner's failure to prove any additional entitlement per the strictures of §10. Finally, I find that Petitioner lacks credibility. These opinions and my dissent are based on the factors set forth below.

Background

Jason Sauls was called as a witness for Petitioner. Sauls testified that he was eating lunch with Petitioner and that they were sitting next to a crate that was close to the aisle. A forklift hit the crate lid that was open, and it pushed the crate and Petitioner about two feet, two to three feet. (T. 12-13) Sauls testified the crate was open. The lid was about 120 degrees, facing the aisle that the forklift was in. The crate was parallel to the red tape that was on the floor for the red warning lane for the forklifts to drive through. They were both sitting against the crate having lunch. Petitioner was leaning against the crate, which was about 18 to 24 inches tall, with his shoulder blades up against it. When the forklift hit, Sauls believed it hit the lid and it pushed the crate forward and at an angle to where it made Petitioner slide forward about two feet. Sauls did not see the forklift hit the crate because his back was to it. He heard a loud noise when the forklift hit the crate. Sauls was sitting about 4 feet to the right of Petitioner. (T. 17-18)

Sauls further testified that he saw what happened to Petitioner's body when he heard the noise. "Well, as the crate was struck, his head whipped back, and he started to – as the crate moved forward, it started to sit him up and it pushed him in seated position

with his legs straight out about two and a half to three feet." Sauls testified that the crate that was struck was about 4 foot by 8 foot by 18 inches tall and weighed an easy three, 400 pounds. (T. 19) The crate had chains to hold the lid open. And they had it open to pull graphics out of it. The graphics were like panels that the Petitioner and his coworkers were putting on the booths made of plastic, one eighth-inch thick pieces. The graphics were 3 foot by 8 foot tall. Sauls testified that the graphics were not real heavy but when you have 30 or 40 of them in the box, it could become a little heavy. (T. 20-21)

Sauls testified that he did not see the forklift hit the crate. He did not remember if the top of the crate fell down or not. (T. 26) Sauls did not recall seeing Petitioner's head against the box at any time. (T. 27) Sauls further testified that he spoke to Petitioner two times about the accident. When Sauls last talked to him in June 2019, Petitioner talked about the accident and what happened in his words. (T. 28, 30)

Sauls further testified that "it hit him as like if he was on the open ice and somebody checked him. He got hit hard. It whipped his head back like whiplash and then pushed him forward. And as it moved, you could see his back, like, slide up the crate to the sitting-up position because he was leaning on it like as if he was in a chair, lounge chair, leaning back on it. So it sat him up and it moved him. It moved him hard. It moved him fast. It moved him violently." (T. 36-37)

On recross-examination Sauls testified that Petitioner was sitting on the last 18 inches of the crate, and that Sauls was seated side by side with Petitioner along this crate using it to recline while we had lunch. Petitioner was leaning against the flat part, relaxing. (T. 38-39)

Petitioner testified that he was eating lunch with his coworkers while sitting with his back up against a shipping crate. (T. 53) Something hit from behind him as he was talking to his "buddy Jason." Something launched him forward, pressing him against the floor, moving forward. Petitioner testified that he did not know what it was at first. Something hit him in the back of the head. It was like a jolt. (T. 53-54) His coworkers flagged the forklift driver and both the driver and Petitioner's supervisors were called and then the insurance people were also called. Thomas Johnson was Petitioner's lead supervisor on that group. (T. 54-55) Petitioner testified that Johnson asked if he was okay and whether he needed to go to the hospital. Petitioner replied no, testifying that he said he was "going to try to work through it. I need the money." (T. 55-56)

Petitioner continued to work and refused to go in an ambulance despite one being called. Petitioner testified that after the incident his lower back and his head were bothering him. (T. 57-58) Despite that testimony, Petitioner completed a Medical Treatment Refusal Form, provided by Respondent, on which he indicated he sustained injuries to the head and back. He refused treatment and wrote, "Want to go back to work I feel I am OK to go back." Petitioner signed the form and dated it October 9, 2018. (RX3)

To clarify, Petitioner testified that PX9B shows the forklift hit that corner forcing the other corner in like this. So when he hit the corner, the corner Petitioner was on, was

pushed forward. The corner on PX9A, that is to the left of where he was sitting, was the corner that got pushed forward, and that was the corner that struck Petitioner. (T. 69-70) He filled out reports and questionnaires on October 9, 2018. (T. 70) He also saw a doctor on October 16, 2018. Petitioner noticed that he had a lot of physical pain in his back, his left ankle and he had head pain. (T. 72) Petitioner testified that his back pain was sharp, stinging, stiff, and he was not able to keep his back arched straight up. The ankle was very painful and stressful. He testified that he could not turn it certain ways without hurting. He further testified that he had sharp pains and also numbness. (T. 73)

However, Petitioner had noted that he had only head and back pain on the Medical Treatment and Refusal form; there was no mention of ankle pain. Petitioner also completed a Workers' Compensation Injury Questionnaire dated October 9, 2018 as well. Petitioner indicated on that form, that he felt pain to the "head and back." (RX4)

On cross-examination Petitioner testified that the lid on the crate was open and "when it came down and I launched forward, it hit the back of my head coming closed." Further, Petitioner conceded that the lid did not hit him straight on, though, it grazed him. He testified, "Grazed is a good term." (T. 85-86) He worked the rest of the day until at least 8:00 or 8:30 the day of the incident. (T. 90) Petitioner also testified that he vomited twice at approximately 6:30 and then 7:00 or 7:30. He had conversations with Medcor, a medical triage company about the accident and he told them the truth about his physical condition. (T. 90-91) The initial treating medical records are devoid of any mention of a left ankle injury.

Petitioner further testified on cross-examination that there was no blood in the pictures that were taken at the scene, nor did his clothes have blood on them. He was pushed forward by the crate and slid on carpeting that had a protective plastic covering on it and worked the rest of the day. (T. 92) Petitioner then testified that he did not see any medical consult until one week later. (T. 92-93) He conceded that he had a personal injury lawsuit pending and at the time of the work incident, he was getting treatment for an unrelated injury to his right ankle. (T. 94)

He worked until the show was over, and was seeking TTD thereafter, testifying he was in pain. He was off work until November 4, 2018, and then off again on November 20, 2018. (T, 75)

Petitioner testified that Dr. Chorba was prescribing Norco for his right ankle injury despite the fact that he was treating with Dr. Peterson. He had both doctors prescribing Norco for the same ankle. (T. 107) When Dr. Chorba tried to wean him off Norco, however, Petitioner received the Norco from both doctors, subsequently obtaining it solely from Dr. Peterson. *Id.* Petitioner testified that he continues to take six to eight Norco up to the date of the Arbitration hearing. (T, 108) Petitioner testified that he was using marijuana as a recreational drug, and that he informed Dr. Chorba and Dr. Peterson of that fact, however, the records are devoid of that history. (T. 110-111; RX7)

Petitioner's Credibility

I find that by referencing Jason Sauls as his "buddy" (T. 53) Petitioner conceded an inherent bias in Sauls' testimony. Petitioner testified that he spoke with Jason Sauls one or two weeks before the March 11, 2020, arbitration hearing whereas Sauls testified that the last time he spoke with Petitioner was June 2019. I find it implausible that Petitioner only asked Sauls if he was going to testify but they had no conversation as to the content of that testimony and Sauls testified Petitioner "talked about the accident and what happened in his words." (T. 28) At the end of the day, Jason Sauls testified that he did not see the forklift hit the crate because his back was to it. (T. 18,

Further, Petitioner testified the lid of the crate "grazed" him (T. 86) and he refused medical treatment that day, continued working and did not seek a medical consult for a week, then continued to work thereafter until the exposition show was over. (RX3)

On direct examination Petitioner neglected to mention that he spoke with the forklift driver, Kevin Ward, when he was filling out his incident report with Employco. He testified only to a conversation eight months later. (T. 89) On cross-examination, Petitioner admitted to a second conversation on the day of the accident. (T. 88-89) Petitioner never sought any medical treatment for a week and in fact, only complained of head and back pain at the time of the accident and at the initial medical consult. When he saw Dr. Peterson for his unrelated right ankle on November 1, 2018, less than a month after the work accident, there was no mention of left ankle pain. In fact the left ankle examination was normal. (RX7)

On November 26, 2018, Petitioner's accident history in his consult with Dr. Brian Clay was described as follows, "Patient reports that he was in a seated position having lunch when he was struck by a forklift. At which point, he was thrown onto his back entrapping his left ankle underneath him." (PX4)

When Petitioner saw Dr. Pelinkovic on March 13, 2019, he described the work accident as, "being pushed from behind by the crate he was leaning against because the crate was hit by a forklift. Then he was hit again by the crate when he was…trying to get up." (PX6)

I note the various inconsistent descriptions of the work accident do not comport with the Petitioner's testimony or his initial accident reports or medical histories.

On February 20, 2019, Dr. Brian Clay saw Petitioner at Illinois Bone & Joint Institute for his low back. In Dr. Clay's Impression and Plan he stated that he was unclear as to what is driving Petitioner's left knee pain. "His MRI of the lumbar spine was unremarkable for pathology which could explain his constellation of symptoms." Dr. Clay referred Petitioner to Dr. Breslow for his left knee. (PX4)

Finally, on March 18, 2019, the video surveillance showed Petitioner carrying a case of bottled water on his left side, and his right arm to carry three bags and was seen

without the back brace he had been wearing at the doctor's appointment shortly before and with no apparent discomfort. I find this surveillance persuasive and the totality of the evidence suggests that Petitioner is not credible, is malingering or, at minimum, misrepresenting the extent of his pain to the medical providers.

Average Weekly Wage Rate

I agree with the Arbitrator's analysis and would find that Petitioner is a part-time worker and failed to prove that he is entitled to the "weeks and parts thereof" benefit of §10 of the Act.

Section 10 of the Workers' Compensation Act provides in pertinent part:

> The basis for computing the compensation provided for in Sections 7 and 8 of the Act shall be as follows:
> The compensation shall be computed on the basis of the 'Average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Ill. Rev. Stat. 1981, ch. 48, par. 138.10.

Petitioner testified that on October 9, 2018, he was employed by The Expo Group. (T. 41) He thought his hourly rate was $48.55 per hour. (T. 41) He was paid by Employco. When asked by his attorney on direct examination how long he was working for Employco USA, Petitioner responded, "I had done two prior shows." (T. 43) He figured he worked for Expo Group directly. (T. 44) His understanding of his relationship on October 9, 2018 with Employco USA was that he worked for them. He basically subcontracted with the company …and he worked for Employco. (T. 46) He agreed that it would be fair to say he worked for them for three weeks although he testified initially he worked for them for "around about two months." (T. 48) He testified that he was called out every day for the trade show. He agreed that RX5 showed the hours that he worked for the three weeks preceding October 9, 2018, for Employco. (T. 49)

Petitioner was asked on direct examination, "Now, with regard to this employee pay history, does this reflect you worked eight hours a day or certain hours that are reflected on here?" (T. 50) Petitioner replied, "To answer the question, the certain hours that are reflected on there. However, I ---most of the days I worked eight hours a day." (T, 50)

Petitioner did not specifically testify to his job duties at the time of the accident, only to what he was doing at the time of the arbitration hearing. With regard to how he got his hours he testified only that he "would get a talk at the end of the day for the next day

what time to come in." (T. 51) "The supervisors would tell us that we needed to work a certain amount of hours to get a job done. And then, therefore, if I only worked three hours one day, it was because we got cut because there was either too many guys or not enough guys, and you had to be placed somewhere else." (T. 51)

I would find that RX5 shows that Petitioner worked for only 32 hours over three weeks and that Petitioner has failed to show that he was more than a part-time worker for three weeks. There was no testimony or payroll history evidence regarding Petitioner's prior 52 week work history submitted by Petitioner. The only credible evidence before the Commission regarding the 52 weeks prior to the subject accident is RX5. Section 10 is not designed to provide a windfall for part-time workers. There is no evidence that at the time of the injury, Petitioner was prevented from working by anything but his own design despite his testimony regarding the possibility he could get cut. His testimony was inconclusive and he did not sustain his burden of proof. Therefore, I would agree with the Arbitrator's calculation that Petitioner's total wages of $1,515.20 should be divided by three weeks and his AWW should be $505.07 because of failure of proof.

Causal Connection

Left Ankle

I disagree with the majority and would find that Petitioner's left ankle condition is not causally related to the subject work accident relying on the opinion of Dr. Holmes. As referenced above, there was no left ankle injury or pain complaints reported on the date of accident on the Workers' Compensation Injury Questionnaire dated October 9, 2018. Although Petitioner contacted Respondent later that day stating his left ankle hurt, he did not report it on the questionnaire. Further, beginning November 1, 2018, Petitioner treated with Dr. Peterson at Suburban Orthopaedics for his unrelated right ankle condition and Dr. Peterson's records contain statements of examination of Petitioner's left ankle condition indicating the left ankle was normal. (RX7) The first mention of left ankle pain and complaints were x-rays taken at Good Samaritan Hospital on November 15, 2018. The radiology Impression was a small osseous fragment along the lateral aspect of the talus may represent a small avulsion fracture. No additional osseous abnormalities. The ankle mortise is intact.

He next documented left ankle pain complaints in a questionnaire at Illinois Bone and Joint Institute on November 26, 2018. (PX4, RX6)

Petitioner consulted Dr. Alan League for the first and only time on November 27, 2018 for his alleged left ankle injury. Dr. League reviewed the x-rays and ordered an MRI.

Beginning in April 2019, Petitioner switched his treatment of the alleged work-related left ankle injury from Illinois Bone and Joint/Dr. League to Dr. Peterson at Suburban Orthopaedics, who had been treating Petitioner for his unrelated right ankle injury.

Petitioner saw Dr. George Holmes at Respondent's request on May 2, 2019. Petitioner's history to Dr. Holmes reflects that during therapy for his right ankle, Petitioner developed left ankle pain. (RX2)

Dr. George Holmes is both the Director of Orthopaedic Foot and Ankle surgery at Midewest Orthopaedics at Rush and the Program Director of the Foot & Ankle Fellowship program. (RX2)

In response to specific interrogatories, Dr. Holmes opined as follows:

- Petitioner's condition of ill-being with regard to the left ankle is related to findings of an MRI scan which demonstrated evidence of some fibrosis and scarring in the lateral ligaments, a small subtalar effusion, some fluid around the posterior tibial tendon. Otherwise, this was a normal x-ray. These findings were relatively benign and did not represent any specific injury or trauma to the ankle.
- Petitioner's subjective complaints are lateral ankle pain, posterior ankle pain, and anterolateral ankle pain. He also has complaints of stiffness and painful weightbearing and dorsiflexion of the ankle.
- There does not appear to be any specific mechanism of injury with regard to the left ankle. The injury reports indicate that initial treatment demonstrated and reported no evidence of any ankle injury whatsoever.
- The objective exam is not consistent with the petitioner's subjective complaints at this time. That is to say, the MRI scan findings are not consistent with the areas of discomfort noted on exam today.
- At this point, I cannot draw any causal relationship between the alleged accident of October 9, 2018, and Petitioner's current left ankle condition.
- The medical treatment to date with regard to the left ankle is more likely than not appropriate for his doctors to treat his subjective complaints, but those treatment options provided to him have not been related to the injury reported on 10/9/18.
- From the standpoint of the injury of October 9, 2018, no further treatment is recommended for the Petitioner's left ankle.
  Regardless of the causation issue, I see nothing on the x-ray or the exam that would warrant the procedure outlined by his podiatrist.
- With regard to the work injury of October 9, 2018, he can return to full duty. If he is unable to return to full duty with respect to the left ankle, it would not be related to the reported work injury.
- Petitioner has reached MMI with regard to the work injury of October 9, 2018.

I find Dr. Holmes' opinion more persuasive than Dr. Peterson, the podiatrist, because on November 1, 2018, when Petitioner treated with Dr. Peterson at Suburban Orthopaedics for his unrelated right ankle condition, Dr. Peterson's records contain statements of examination of Petitioner's left ankle condition indicating the left ankle was normal.

(RX7) Dr. Holmes is both the Director of Orthopaedic Foot and Ankle surgery at Midwest Orthopaedics at Rush and the Program Director of the Foot & Ankle Fellowship program.

Further, Petitioner never testified about an injury to his left ankle at the time of the incident. Also, on the initial injury form there was no injury to the left ankle documented. Dr. League noted that he was looking for an AITF ligament tear, OCD lesion, bony contusion on the left ankle MRI. The left ankle MRI showed evidence of fibrosis or scarring of the AITF and calcaneal fibular ligament without additional signal consistent with healed moderate grade sprains, small tibiotalar and posterior subtalar joint effusions, and fluid but otherwise normal high-field MRI of the left ankle with no evidence of peroneal tendon pathology, osteochondritis dissecans, or other significant pathology. (PX4)

Low Back

I find that Petitioner sustained a lumbar back strain and was at MMI as of March 14, 2019, and I would deny further medical treatment based on Dr. Graf's opinion. On January 7, 2019, Petitioner's treating doctor. Dr. Clay, documented that the lumbar spine MRI "did not reveal anything significant aside from mild disc bulging at L5-S1." (PX4, 1/07/19) Dr. Clay further opined that Petitioner's MRI of the lumbar spine was "unremarkable for pathology which could explain his constellation of symptoms." (PX4, 2/20/19)

On March 14, 2019, Respondent's §12 expert, Dr. Graf, opined that Petitioner demonstrated non-organic pain signs on evaluation in the form of pain out of proportion to the evaluation. He further opined as follows:

> Petitioner is a 29-year-old male who claims injury on 10/9/18. He currently complains of low back pain rating it to a level of 9/10 and further self-rates his pain and disability in the "severe disability" category. While stating such, he demonstrates a normal neurologic exam and demonstrates a normal MRI scan of the low back.
> Regarding a diagnosis, I would consider Petitioner's diagnosis to be a possible muscular strain, though I am unable to objectively substantiate his current subjective complaints of pain given the lack of objective findings.
>
> To a reasonable degree of medical and surgical certainty, it is my opinion Petitioner is at MMI. It is further my opinion that no further care or treatment is reasonable nor medically necessary as it relates to the claimed injury in question.
>
> There is no objective reason why Petitioner cannot return to his full duty level job as described.
>
> In answer to specific interrogatories, Dr. Graf opined:

- Current condition of ill-being – lumbar spine: Petitioner claims severe low back pain and rates himself into the "severe disability" category. While stating such he demonstrates a normal neurologic exam and has a normal MRI scan of the lumbar spine.
- Subjective complaints – low back: Petitioner essentially complains of pain in the low back rated up to levels of a 9/10.
- Mechanism of injury on October 9, 2018: Described in body of report
- Objective exam findings consistent with subjective complaints: Petitioner has no objective findings on physical exam. Further, he demonstrates a normal MRI scan of the lumbar spine.
- Causation: I question causation as a whole given Petitioner's current subjective complaints which lack an objective basis.
- Medical treatment reasonable and necessary: The initial medical care and treatment, in my opinion, would be considered reasonable though I am unable to objectively substantiate the need for further care given the physical exam and imaging studies.
- Further medical treatment: N/A
- Petitioner capable of working full capacity: there is no objective reason why Petitioner cannot return to full duty level work.
- MMI: It is my opinion Petitioner has reached MMI.

Medical Bills

Medical Expenses

The majority awards medical bills of $31,848.93 payable to Petitioner that have been paid by Petitioner's significant other's group insurance under Blue Cross/Blue Shield (BCBS). The balance on the Petitioner's bill exhibit for those bills paid by BCBS is zero. The Appellate Court has been very specific in its analysis regarding the amount owed by Respondent when the Petitioner's bills were paid by insurance other than his own group plan. An award over and above the amount paid by the other group plan results in a windfall for Petitioner, thus the reimbursement award must be limited to the amount paid. As the second district Appellate Court held in *Perez,*

> The Illinois Administrative Code provides, in pertinent part:
> "Under the fee schedule, the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge. If an employer *or* insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail." (Emphasis added.) 50 Ill. Adm. Code 7110.90(d), amended at 36 Ill. Reg. 17108 (eff. Nov. 20, 2012).
> Here, again, [***9] the language cited by claimant is devoid of any limitation that only the employer's own insurance carrier may negotiate the reduced rate. The disjunctive term "or" indicates that either the employer *or* insurance carrier—any insurance carrier—may negotiate a

reduced rate.

Perez v. Ill. Workers' Comp. Comm'n, 2018 IL App (2d) 170086WC, P19-P21, 96 N.E.3d 524, 527, 2018 Ill. App. LEXIS 10, *6-9, 420 Ill. Dec. 439, 442

While I agree with the majority that based upon the holding, in *Perez,* Petitioner would owe only the amount of the negotiated rate paid by Blue Cross Blue Shield in related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, I do not agree Respondent is liable for those payments except as they pertain to the low back prior to March 14, 2019. Further, I would have Respondent hold Petitioner harmless from any claim by Blue Cross Blue Shield for related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the low back prior to March 14, 2019, excluding any treatment at Suburban Orthopaedics, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

Petitioner Exceeded Two Physician Chain of Referral

Section 8(a) of the Illinois Workers' Compensation Act provides in relevant part:

> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense.
> *820 ILCS 305/8*

Prior to the subject work accident, Petitioner was treating with Suburban Orthopedics for an unrelated right foot injury. After the work accident Petitioner continued to treat with Suburban Orthopaedics for his right ankle. Petitioner then chose to treat with his primary care physician (PCP), Dr. Chorba, and subsequently chose Illinois Bone and Joint to treat for his "back and ankle pain" as described on the Medical History Form dated November 26, 2018. (Px4, Rx6) He then chose to transfer his treatment for his left ankle and his low back to Suburban Orthopedics. Therefore, I find that all

Petitioner's medical bills for treatment at Suburban Orthopaedics should be denied because Petitioner exceeded his two choice of physicians.

Conclusions of Law

Based on a careful review of the evidence, I would specifically find that Petitioner is not credible, deny all medical treatment for the left foot based upon the initial histories and Dr. Holmes' opinion, deny medical treatment after March 14, 2019, for the low back based upon Dr. Graf's opinion and the surveillance and deny all medical treatment at Suburban Orthopaedics because Petitioner exceeded his two physician chain of referral maximum as dictated by §8(a)2 of the Act. Further, I would find that Respondent shall hold Petitioner harmless from any claim by Blue Cross Blue Shield for related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the low back prior to March 14, 2019, excluding any treatment at Suburban Orthopaedics, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

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

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

21IWCC0356

DEL BOSQUE, HECTOR
Employee/Petitioner

Case# **18WC032834**

EMPLOYCO USA
Employer/Respondent

On 5/12/2020, 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 J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

4696 POULOS & DiBENEDETTO LAW
DAVID POULOS
850 W JACKSON BLVD SUITE 405
CHICAGO, IL 60607

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Hector Del Bosque
Employee/Petitioner

v.

Employco USA
Employer/Respondent

Case # **18** WC **32834**

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 **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 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 9, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**1,515.20**; the average weekly wage was $**505.07**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $336.71 per week for 7-1/7 weeks, commencing October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $27,812.18 in related medical bills that remain outstanding and $31,848.93 in related benefits from Petitioner's significant other's Blue Cross/Blue Shield of Illinois policy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall provide prospective medical care for Petitioner's conditions of ill being in accordance with the recommendations of Dr. Peterson and Dr. Novoseletsky, as provided in Section 8(a) of the act.

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

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

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

Elaine K Lee

Signature of Arbitrator

May 7, 2020

Date

ICArbDec19(b)

MAY 12 2020

STATEMENT OF FACTS:

The parties stipulated that on October 9, 2018, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. (AX1) Petitioner was a 27-year old Carpenter for Respondent Employco USA on October 9, 2018. *Id.* Employco USA is the mother company of The Expo Group, for whom Petitioner was working for on October 9, 2018. (T. 41-42) Petitioner testified that prior to October 9, 2018, he had worked two shows and had been working for Respondent for approximately three weeks. (T. 43, 48) Petitioner testified that he worked every day while shows were going on. (T. 48) According to Petitioner, at the end of each day, the supervisors would tell workers their hours for the following day. (T. 50-51) Petitioner indicated that, on most days, he worked eight hours, but his regular assigned hours are reflected on his employee pay history. (T. 50; RX5) Petitioner testified that overtime was not mandatory. (T. 50)

Petitioner testified that on October 9, 2018 at about 12:20 p.m. he was eating lunch with his coworkers Jason, Javier and Sean while sitting on the floor with his back up against a shipping crate. (T. 53) Petitioner testified the crate was flush with the aisle, just past the red tape. (T. 61) According to Petitioner, crates were allowed to project about one foot into the aisle, with their lids open, to allow for forklifts to continue up and down the aisles. (T. 61-62) Petitioner explained that he suddenly felt a jolt, and something launched him forward, hitting him in the back of the head. (T. 53) Petitioner testified that Jason and Sean flagged down a nearby forklift driver and notified him that he had hit Petitioner. *Id.* Petitioner stated that the forklift driver came over and told him he was fine, however Petitioner responded that he was not fine. (T. 54-55) Petitioner testified that his lower back and head were bothering him. (T. 57-58) He further testified that he tried to stand up but was unable to do so and ended up sitting back down against the crate as suggested by Sean. (T. 65) Petitioner explained that Sean asked to use Petitioner's phone to take a few pictures documenting the incident, which he did. (T. 58) Petitioner testified that those pictures—contained in Petitioner's Exhibits 11A through 11D—truly and accurately represent him sitting there after the accident when Sean took the pictures. (T. 58-59, 162) The crate had not been moved following the accident. (T. 66)

Petitioner testified that they all called over their respective supervisors and Respondent's insurance people showed up. (T. 55) Petitioner stated that Thomas Johnson (Johnson), also known as TJ, was Petitioner's lead supervisor. (T. 55) According to Petitioner, Johnson asked him if he was okay and if he needed to go to the hospital, to which Petitioner responded that he did not want to go to the hospital and that he was going to try to work through the pain. (T. 56) Petitioner believed an ambulance was called, but Petitioner refused to take it. (T. 57) Petitioner testified that he had a family to support and he figured that he was young and strong, and that he could work through his discomfort. *Id.* Petitioner testified that he continued to work and vomited twice over the course of the evening. (T. 90)

Petitioner was required to fill out accident reports and questionnaires that day. (T. 70) One report, the Medcor Workplace Injury Triage and Reporting Form, states: "employee alleges about 4 ½ hours ago while sitting on the floor to eat his lunch and leaning against a shipping crate a forklift driver struck the crate which struck the back of his head and lower back. Employee is calling back complaining of left ankle pain and offers he vomited twice." (RX1)

Jason Sauls (Sauls), Petitioner's co-worker, testified that he was working with Petitioner on October 9, 2018 and that he remembered an accident with Petitioner occurring on that day. (T. 10-12) Sauls testified that he was eating lunch with Petitioner while they were both sitting against a crate. (T. 17-18) Sauls explained that the crate was made of wood and easily weighed 300-400 pounds. (T. 19) According to Sauls, Petitioner was leaning back against the crate with his shoulder blades up against it. (T. 17-18) Sauls testified that he was seated about four feet to Petitioner's right. (T. 18) Sauls explained that the aisle was lined with red tape demarcating

lanes for the forklifts to drive through and the crate was parallel to the red tape with its lid open about 120 degrees facing out into the aisle. (T. 17) Saul testified that as they were eating, a forklift hit the open crate lid, pushing the crate forward and at an angle into Petitioner. (T. 13, 18.) Sauls explained that due to the angle in which the forklift hit the crate, the crate moved away from him rather than into him, so Sauls was not hit. (T. 33-34) Sauls testified that as the crate was struck, Petitioner's head whipped back in a whiplash motion. (T. 19, 36) According to Sauls, the corner of the crate hit Petitioner hard, as if he was on open ice and somebody body checked him. (T. 36) Sauls explained that the force of the impact pushed Petitioner into more of an upright seated position and shoved him two to three feet along the floor with his legs straight out in front of him. (T. 13, 18-19) Sauls testified that the hit moved Petitioner hard, fast and violently. (T. 36-37) Sauls testified that following the accident, Petitioner complained of pain so Sauls told him to stay still until they could call someone over. (T. 21) Sauls testified that he called their supervisor, Johnson. (T. 22) Sauls stated that he informed Johnson that a forklift hit a crate and that the crate hit Petitioner. (T 32.) According to Sauls, several higher-ups came by and they brought in a paramedic crew to check Petitioner out, as well as a lot of carpenters who came over and were talking. (T. 31-32.) Sauls explained that ultimately, Petitioner continued to work until about 8:00 p.m. (T. 29)

Kevin Ward (Ward), the forklift driver, also testified at the arbitration hearing. (T. 121) Ward testified that he worked for McCormick Place Teamsters 727 and that on October 9, 2018, he was working at McCormick Place as a forklift driver. (T. 121-122) Ward testified that he had just gotten off his lunch break and was driving his forklift down the aisle when he hit a crate after failing to notice that its top was flipped up. (T. 122-123) Ward explained that forklifts can travel approximately 15 to 20 miles per hour. (T. 130) Ward testified that he was shocked and that, at first, he didn't realize that he had hit something—he just felt his forklift suddenly stop. (T. 122- 123) Ward testified that he did not talk to Petitioner until later that day, after Petitioner was taken away on a stretcher of some sort and Ward was taken away for a urinalysis drug screening. (T. 123-24, 131) Ward testified that he later saw Petitioner, and there was a conversation, but he could not remember exactly what was said. (T. 125) Ward testified that he thought Petitioner either said he was okay or that he didn't want anything to happen to Ward or to himself, and that he just wanted to get back to work. *Id.* Ward could not recall whether Petitioner was saying that he wasn't hurt or whether he was okay. (T. 128)

Petitioner first sought medical attention with his primary care physician (PCP), Dr. Thomas Chorba, on October 16, 2018. (PX2, T.70) Petitioner testified that was the first available time Petitioner could get in to see him. (T. 92-93) Petitioner testified that he related his history of injury to Dr. Chorba and complained of pain in his back, head, and left ankle. (T. 72) Petitioner stated that he indicated that his back pain was sharp and stinging, his back felt stiff and he could not keep it fully upright. (T. 72-73) Petitioner testified that he described his left ankle pain as severe and sharp, complained of numbness in the left ankle and reported that he could not turn it certain ways without it hurting. (T. 73) Dr. Chorba ordered x-rays of Petitioner's lumbar spine and left ankle. (T. 73; PX3)

Petitioner testified that he continued to work until October 23, 2018, when the show ended. (T. 74-75) Petitioner testified that he was also in physical pain. (T. 75) Petitioner indicated that he remained off work until November 4, 2018, at which point he returned to work light duty. (T. 75)

Petitioner underwent the lumbar spine and left ankle x-rays on November 15, 2018. (PX3.) The lumbar spine x-ray showed no acute fracture or dislocation and that the sacroiliac joints were intact. *Id.* The left ankle x-ray revealed a small osseous fragment along the lateral aspect of the talus which may represent a small avulsion fracture. *Id.*

Petitioner testified that he continued working light duty until November 20, 2018 and then remained off work until December 26, 2018. (T. 75)

On November 26, 2018, Petitioner followed up with Dr. Brian Clay at Illinois Bone and Joint Institute. (PX4) Dr. Clay noted Dr. Chorba as Petitioner's PCP and cc'd him in his report. *Id.* Petitioner complained of constant moderate-to-severe lower back and left ankle pain at 8/10, which he described as sharp, throbbing, aching, and cramping, aggravated by most activities of daily living as well as lifting, prolonged walking, or standing. *Id.* Petitioner related his history of injury and noted that he had seen Dr. Chorba for the problem and had gotten x-rays, but otherwise described his prior treatment for the condition as toughing it out. *Id.* Petitioner reported that he had continued working since the accident, but that he was suffering from increased pain, muscle spasms and radicular symptoms into his left leg. *Id.* On examination, Dr. Clay noted that straight leg raise and slump tests were positive on the left leg but negative on the right leg. *Id.* The left ankle revealed tenderness over the lateral malleolus with light palpation with passive inversion and eversion of the left ankle provoking pain through the subtalar joint. *Id.* Dr. Clay took x-rays and opined that they showed no significant osseous abnormalities in the lumbar spine except for disc space height loss at T12-L1, and that nonweightbearing left ankle x-rays showed no evidence of fracture or dislocation. *Id.* Dr. Clay diagnosed Petitioner as having lumbar radiculopathy, a chronic lumbar strain, sciatica of the left leg and left ankle pain. *Id.* Dr. Clay ordered physical therapy and an MRI for the lumbar spine. *Id.* Dr. Clay also kept Petitioner off work until February 11, 2019 and instructed Petitioner to continue taking Norco, as needed, and prescribed him Robaxin 750 mg for low back pain and muscle tightness. *Id.* Dr. Clay referred Petitioner to foot and ankle specialist Dr. Alan League regarding his ankle condition and instructed Petitioner to return for follow up regarding his back on January 7, 2019. *Id.*

Petitioner saw Dr. League on November 27, 2018 at Illinois Bone and Joint Institute. *Id.* Petitioner related his history of injury and complained of ongoing pain. *Id.* On physical examination, Dr. League noted left ankle tenderness diffusely with active guarding, as well as restricted motion and strength with active inversion, eversion, dorsiflexion, and plantar flexion. *Id.* He observed no such strength reduction in the right ankle. *Id.* Dr. League diagnosed Petitioner as having left ankle sprain/strain and with residual pain for more than a month and a half since the injury. *Id.* Dr. League ordered a left ankle MRI to look for structural injuries. *Id.*

The December 7, 2018 lumbar spine MRI revealed slight straightening of the normal lumbar spine lordosis; mild right foraminal narrowing, a borderline early annular bulge and end-plate spurring, and minimal spondylotic change at L5-S1; and at T12-L1, mild to moderate disc desiccation, mild spondylotic change, Schmorl node development along the inferior T12 end-plate with adjacent marrow signal heterogeneity, and a mild annular bulge causing slight impression upon the thecal sac. *Id.*

Petitioner returned to Dr. Clay on January 7, 2019 complaining of persistent low back and left ankle pain. *Id.* Dr. Clay recommended that Petitioner continue outpatient physical therapy and opined that he would respond well to physical therapy for ongoing pain and symptom management for a chronic lumbar strain. *Id.* He further opined that Petitioner was not an appropriate candidate for spine interventions at that point. *Id.*

On February 20, 2019, Petitioner followed up with Dr. Clay once more, reporting continued low back pain as well as developing worsening left knee pain. *Id.* Dr. Clay referred Petitioner to Dr. Marc Breslow to evaluate Petitioner's knee and for a spine surgery consultation. *Id.*

Petitioner testified that sometime thereafter, he decided to switch treaters to Suburban Orthopaedics. (T. 77) Petitioner explained that Illinois Bone and Joint Institute were not friendly about scheduling around Petitioner's parenting duties, so he switched to a treater with a closer location. *Id.*

On March 13, 2019, Petitioner saw to Dr. Dalip Pelinkovic at Suburban Orthopaedics complaining of left ankle pain of 5/10, less severe left knee pain and low back pain at 7/10 with shooting pain and tingling

radiating into his left hip and down his leg. (PX6) Petitioner related his history of injury and explained that he continued working for two weeks thereafter due to financial concerns, but that his pain worsened until it became intolerable. *Id.* During examination of Petitioner's lower back, Dr. Pelinkovic noted a positive FABER test on the left, midline tenderness along the lumbosacral junction and left lumbar paraspinal tenderness. *Id.* Dr. Pelinkovic further noted that Petitioner was negative for Waddell signs. *Id.* Dr. Pelinkovic diagnosed Petitioner as having a lumbar sprain/strain, lumbar facet joint syndrome and left ankle pain. *Id.* Dr. Pelinkovic opined that Petitioner's current lumbar spine and left lower extremity conditions were causally related to the work injury on October 9, 2018. *Id.* Dr. Pelinkovic noted that Petitioner was pain free and working full duty as a Carpenter prior to the injury. *Id.* Dr. Pelinkovic recommended physical therapy for the lower back and opined that Petitioner could return to work with restrictions. *Id.* Petitioner reported that Respondent would not allow him to return to work with restrictions. *Id.*

Petitioner testified that on the morning of March 14, 2019, he was scheduled for an independent medical examination (IME), at Respondent's request, with Dr. George Holmes. (T. 80) Petitioner testified that he was on the highway when he received a call from his children's' school informing him that they were sick and needed to be picked up. (T. 80, 98; PX10) Petitioner testified that he went to pick up his children and called his attorney to report that he was going to miss the appointment with Dr. Holmes. (T. 98-99)

Later that day, Petitioner underwent an IME with Dr. Carl Graf at the Illinois Spine Institute. (RX1) Petitioner described the October 9, 2018 accident and complained of low back pain to his left leg following the accident. *Id.* During physical examination, Dr. Graf noted that Petitioner exhibited decreased sensation in the dorsal and lateral aspects of his left foot and normal sensation in the right foot. *Id.* Dr. Graf further noted that a supine straight leg raise test produced left-sided hamstring pain on the left leg and that the test was negative on the right. *Id.* Dr. Graf further noted that Petitioner's reported pain was out of proportion to the evaluation. *Id.* Dr. Graf diagnosed Petitioner as having a possible muscular strain and opined that it was not causally related to the accident because he could not identify osseous abnormalities or disc herniation in the spine MRI or objective findings on physical examination. *Id.* Dr. Graf opined that Petitioner was at maximum medical improvement (MMI), that no further care or treatment was reasonable or necessary and that Petitioner could return to work full duty. *Id.*

On March 15, 2019, Petitioner saw Dr. Kyle Peterson at Suburban Orthopaedics for his left ankle. (PX6) Petitioner reported that his left ankle pain was constant but worse when physically active and located on the lateral aspect of the ankle along with the Achilles area. *Id.* Petitioner related his history of injury and indicated that his left ankle symptoms began on October 9, 2018 following his work accident. *Id.* On physical examination, Dr. Peterson noted that Petitioner had an antalgic gait with moderate swelling of the left ankle and none on the right ankle. *Id.* He further noted that Petitioner exhibited moderate tenderness to palpation over the anterolateral gutter and peroneal tendons of the left ankle and no tenderness over the right ankle. *Id.* Petitioner had positive results for the anterior drawer test and varus tilt test on the left ankle and negative on the right ankle. *Id.* Dr. Peterson noted that Petitioner had a great deal of pain about the ankle joint line, especially in the anterolateral corner. *Id.* Dr. Peterson also noted that the joint felt fairly unstable with an anterior drawer and talar tilting evident. *Id.* Dr. Peterson found mild crepitus and slight tenderness in the peroneal tendons. *Id.* Dr. Peterson diagnosed Petitioner as having a left chronic lateral ankle sprain, an ATFL tear, peroneal tendinitis with possible tear and ankle instability. *Id.* Dr. Peterson listed the cause/mechanism of Petitioner's condition as traumatic work. *Id.* Dr. Peterson issued Petitioner restrictions of weight-bearing, range of motion and sports as tolerated and instructed Petitioner to return after undergoing his left ankle MRI. *Id.*

On March 16, 2019, Petitioner underwent the left ankle MRI, the results of which revealed small tibiotalar and posterior subtalar joint effusions; a small amount of fluid distending the tibialis posterior and flexor digitorum longus sheaths; and evidence of fibrosis/scarring of the anterior talofibular ligament and

calcaneal fibular ligament without additional altered signal, which the radiologist opined were consistent with healed moderate-grade sprains. (PX4)

On March 19, 2019, Petitioner returned to Dr. Peterson, who reviewed the left ankle MRI. (PX6) Dr. Peterson opined that Petitioner was suffering from a chronic lateral sprain to his left ankle, an ATFL tear, peroneal tendinitis with no tear, and left ankle instability. *Id.* Dr. Peterson discussed the possibility of a future left ankle arthroscopy with open Brostrom/Gould and Petitioner elected to undergo the procedure. *Id.*

On March 22, 2019, Petitioner began physical therapy at Suburban Physical Therapy. *Id.* During his initial evaluation, Petitioner related his history of injury and reported that he could stand for 10 to 15 minutes before he began to feel fatigue and heaviness in his back, that he could walk approximately 1 mile, that he got increased pain when climbing more than 30 stairs, and that he was waking up 5 to 6 times per night. *Id.* Petitioner reported that his pain could reach 7-10/10 at times. *Id.* Petitioner stated that he had not been experiencing radicular pain or tingling down into his left thigh for a while. *Id.* On examination, physical therapist Michele Branka observed reduced strength in Petitioner's left hip and left leg relative to the right; tenderness to palpation throughout the lumbar paravertebral muscles, left greater than right; hypomobility with PA glides; and muscle guarding at L1 through L5. *Id.* Brank opined that the findings were consistent with a back injury at work. *Id.*

On May 2, 2019, Petitioner underwent the IME with Dr. George B. Holmes regarding his left ankle. (RX2) Petitioner related his history of injury and Dr. Holmes reviewed Petitioner's medical records and diagnostic exams. *Id.* Dr. Holmes opined that Petitioner's left ankle MRI scan showed some fibrosis and scarring in the lateral ligaments, a small subtalar effusion and some fluid around the posterior tibial tendon. *Id.* He opined that these findings were relatively benign and did not indicate trauma to the ankle. *Id.* He opined that Petitioner's treatment to date had been reasonable. *Id.* He further opined that there was no causal relationship between Petitioner's accident of October 9, 2018 and his left ankle condition, that Petitioner was at MMI with regard to his left ankle and that his left ankle condition was not preventing him from returning to work. *Id.*

On May 3, 2019, Petitioner returned to Dr. Peterson for follow-up on his left ankle. (PX6.) Dr. Peterson noted that Petitioner's symptoms continued to persist despite treatment. *Id.* Dr. Peterson continued to recommend a left ankle arthroscopy with open Brostrom/Gould. *Id.*

On May 6, 2019, Petitioner returned to Dr. Pelinkovic for follow-up regarding his back. *Id.* Petitioner complained of continued constant dull back pain, varying in intensity between 5/10 and 9/10. *Id.* Petitioner reported that he could walk 5-20 minutes before needing to stop. *Id.* Dr. Pelinkovic referred Petitioner to Dr. Dmitry Novoseletsky for a back pain management consultation, had Petitioner continue to see Dr. Peterson for his ankle issues and continued Petitioner's physical therapy while recommending he wean himself off narcotics. *Id.*

Petitioner saw Dr. Novoseletsky on May 13, 2019. *Id.* Petitioner complained of constant lower back stiffness and pain at 6-10/10. *Id.* Dr. Novoseletsky examined Petitioner and diagnosed him as having lumbar facet syndrome and lumbar spine strain/sprain. *Id.* He continued Petitioner on Norco, Cyclobenzaprine and Meloxicam. *Id.* Dr. Novoseletsky ordered left L2, L3, L4, and L5 lumbar medial branch blocks for diagnostic purposes. *Id.* Dr. Novoseletsky indicated that if Petitioner found temporary relief, then he would order a second set of blocks with different anesthetic medication to rule out a placebo response. *Id.* With significant relief from a second set of blocks, Dr. Novoseletsky noted, Petitioner would be a good candidate for radiofrequency neurotomy. *Id.*

Petitioner followed up with Dr. Novoseletsky on June 10, 2019 and returned to Dr. Peterson again on June 11, 2019. *Id.* Petitioner complained to Dr. Peterson of worsening ankle pain, sharp in nature, at 7-10/10. *Id.* Dr. Peterson noted that Petitioner remained unchanged on examination. *Id.* Dr. Peterson continued to recommend an arthroscopy and recommended that Petitioner go off of work in the meantime. *Id.*

On June 12, 2019, Dr. Novoseletsky administered a left-sided prognostic lumbar medial branch block at L2, L3, L4, and L5 with Dr. Novoseletsky. *Id.*

On June 24, 2019, Petitioner followed up Dr. Novoseletsky and reported that his back pain that day was worse than the pre-injection baseline pain, sharp and at 7/10. *Id.* Petitioner reported obtaining 50% relief of his symptoms within 30 minutes of the June 12th medial branch block and that said relief lasted 3 hours. *Id.* Dr. Novoseletsky noted that Petitioner's axial low back pain had persisted since the October 2018 injury and opined that, with a reasonable degree of medical certainty, it was a direct result of the work accident of October 2018. *Id.* Dr. Novoseletsky opined that Petitioner's mechanism of injury was consistent with facet joint syndrome (forceful extension with trunk rotation). *Id.* Dr. Novoseletsky explained that the MRI did not reliably confirm or rule out facet joint syndrome and that the gold standard method of diagnosis is diagnostic lumbar medial branch blocks. *Id.*

On July 8, 2019, Petitioner returned to Dr. Pelinkovic, who noted that Petitioner's physical exam remained unchanged, as did his recommendations. *Id.*

On July 23, 2019, Petitioner underwent a second prognostic lumbar medial branch block at L2, L3, L4, and L5. *Id.*

Petitioner was discharged from physical therapy on July 30, 2019 due to recommended surgery for a different body part. *Id.* On that day, Petitioner demonstrated diminished left leg strength compared to the right, with tenderness to palpation in the lumbar paravertebral muscles, left side greater than right. *Id.* Petitioner demonstrated restricted trunk range of motion with flexion, extension and side bending, as well as a decreased standing tolerance of 15 minutes. *Id.*

On August 1, 2019, Petitioner returned to Dr. Novoseletsky. *Id.* Petitioner reported that his back pain had returned to its pre-injection baseline level. *Id.* He reported obtaining greater than 75% relief of his symptoms within 30 minutes of the July 23rd medial branch block and that said relief lasted 2 hours. *Id.* He reported that he felt much better when performing activities that would ordinarily elicit back pain. *Id.*

On August 14, 2019, Dr. Novoseletsky authored a letter of medical necessity opining that a left L2, L3, L4 and L5 lumbar medial branch radiofrequency neurotomy is medically necessary to treat Petitioner's facetogenic back pain. *Id.* Dr. Novoseletsky noted that Petitioner experienced 50% relief of his back pain after his initial medial branch block of June 12th and that he experienced greater than 75% relief of his back pain after the second medial branch block procedure. *Id.* Dr. Novoseletsky opined that each was a positive diagnostic block when combined with Petitioner's reports of significant functional improvement during the time the blocks were in effect and that this rendered him a good candidate for lumbar medial branch radiofrequency neurotomy of the affected nerves. *Id.*

Petitioner continued to follow up with Dr. Peterson for his left ankle symptoms through November 2019. *Id.* Petitioner reported highly variable pain from 4/10 to 10/10, achy throbbing and stiffness that could sometimes radiate up into his shin. *Id.* Dr. Peterson noted that Petitioner's left ankle was positive for popping and cracking with movement. *Id.* Dr. Peterson noted that Petitioner's symptoms were severe and persisted with treatment. *Id.*

At the arbitration hearing, Respondent called Juan Herrera (Herrera) as a witness. (T. 134) Herrera is a private investigator that Respondent hired to surveil Petitioner. (T. 135-136) Herrera presented a little over three minutes of surveillance footage from March 14, 2019, depicting Petitioner leaving the IME, driving to Walmart and buying some small items. (T. 138-140; RX9) Herrera testified that he did not know if Petitioner had purchased Ibuprofen there or if he had visited the pharmacy. (T. 146-147) Herrera then presented a surveillance video, running time of one minute and 11 seconds, from May 2, 2019, which showed Petitioner entering his residence with a document in his hand. (T. 141; RX9) Herrera testified that he selected these clips from out of two 8-hour days of surveillance because those were the only times he saw Petitioner. (T. 143) Herrera explained that the computer playing the video during the arbitration hearing was buffering during playback, causing the video to stutter and making it difficult to tell how accurately it depicted Petitioner's gait or walking ability. (T. 144-145, 153-154) Herrera testified that he was not informed as to Petitioner's work status at the time surveillance was conducted. (T. 148-149)

Petitioner testified that as of the day of hearing, he was still having difficulty sitting up straight for long periods of time, his back gets stiff and stings and he is no longer able to turn left and right without pain. (T. 82-83) Petitioner stated that he still sometimes gets shooting pain down his left leg and that his left ankle pain continues, reaching up to his mid-calf at times. (T. 83) Petitioner testified that he cannot sit in the car and use his leg up high at all nor can he go downstairs or use ladders without constant pain. *Id.* Petitioner further testified that sometimes he gets stinging and numbness when standing for long periods of time. *Id.* Petitioner indicated that he takes Hydrocodone, Methocarbamol, Naproxen and over-the-counter Aleve for his symptoms. (T. 83-84) Petitioner testified that if his left ankle surgery were authorized, he would undergo it. (T. 84-85)

Petitioner testified that he did not have any treatment for his left ankle prior to October 9, 2018. (T. 78) Petitioner explained that around 2014, he pulled a muscle in his back while he was working as a mover, but the condition resolved within one week with rest and Ibuprofen. (T. 77-78) According to Petitioner, other than that, he had no treatment for any back problems between 2014 and 2018. (T. 78) Prior to October 9, 2018, Petitioner suffered an injury to his right ankle. (RX2) Petitioner was carrying boxes and walking down the sidewalk on June 29, 2014 when he damaged the ankle. *Id.* Treating doctors identified microfractures to the talus and calcaneus of the right ankle and Dr. Thomas Chorba recommended surgery, but Petitioner was unable to afford the procedure. *Id.* Instead, Petitioner treated his right ankle pain with Norco, Naproxen, Lidocaine and Lidocaine patches. *Id.*

Petitioner testified that he currently works for Freeman at McCormick Place. (T. 41) Petitioner explained that his job is to dismantle and set up booth works or furniture pieces for booth works for trade shows. *Id.* Petitioner indicated that at the time of the accident, Petitioner made $48.55 an hour working for Respondent. *Id.*

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:

In order for an accident to arise in the course of employment, it generally must occur within the time and space boundaries of the employment; and for an accident to arise out of one's employment, 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. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 672 (2003). In *Pintur v. Germann*, 183 Ill. App. 3d 763, 765-766 (1989), the court explained that:

> "The Illinois Supreme Court has defined the phrase 'in the course of the employment' as that within the period of employment at a place where the employee may reasonably be in the performance of his duties or engaged in something incidental thereto....As to the requirement that the injury 'arise out of' the employment, the Illinois Supreme Court has defined such an injury as one having its origin in some risk connected with, or incidental to, the employment....Among the injuries found not to be incidental to the employment are those which result from a personal risk, as opposed to a risk inherent in the claimant's work or work place."

In *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill. 2d 52, 58-59 (1989), the court explained:

> "Typically, 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. 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. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable." (Internal citations omitted.)

In this case, Respondent has stipulated that Petitioner was its employee on October 9, 2018. The fact that Petitioner was on his lunch break at the time of the accident does not change this result. "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2D 331, 339 (1980). Here, Petitioner remained on Respondent's premises while eating lunch; pursuant to *Eagle Discount*, eating lunch was therefore incidental to his employment. Furthermore, Petitioner's decision to sit against a crate during his lunch break is an act which an employee might reasonably be expected to do while working at McCormick Place setting up a show.

Additionally, the Arbitrator finds that Petitioner's testimony as to how the accident occurred credible and supported by the testimony of the other witnesses and the consistent histories of the accident provided to medical providers and examiners throughout Petitioner's treatment.

For the above reasons, the Arbitrator finds that Petitioner's accident arose both out of and in the course of Petitioner's employment with Respondent on October 9, 2018.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that all three witnesses to the accident testified that supervisors were notified of the accident immediately. Therefore, the Arbitrator finds that notice of the October 9, 2018 accident was provided in a timely manner.

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

Respondent disputes that Petitioner's current condition of ill-being is causally related to his work injury. The Arbitrator addresses each condition in turn.

Left Ankle

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

The Arbitrator finds that both Petitioner's credible testimony and the medical record establish a causal nexus between the October 9, 2018 accident and Petitioner's ongoing left ankle condition. The Arbitrator notes that Petitioner did not have any treatment for his left ankle prior to October 9, 2018, save for a left ankle fracture he had sustained as a child. Following the accident, by contrast, the evidence establishes that he was experiencing a lot of physical pain in his back, head, and left ankle. Petitioner's left ankle symptoms were substantial and he could not turn his left ankle certain ways without pain.

Additionally, the treating records consistently detail Petitioner's left ankle symptoms and problems following the October 9, 2018 accident, as do the diagnostic exams. Furthermore, Petitioner's treating physicians consistently opined that his left ankle condition was causally related to his work accident. At every visit, Dr. Peterson noted the cause/mechanism of Petitioner's left ankle condition as "traumatic work." Dr. League related Petitioner's ankle conditions to his injury a month-and-a-half prior. Dr. Pelinkovic opined to a reasonable degree of medical and surgical certainty that Petitioner's left lower extremity conditions were causally related to the work injury.

The Arbitrator notes that the Dr. Holmes was less clear in his opinions, finding that Petitioner's left ankle condition was related to findings on the MRI scan which demonstrating some fibrosis and scarring in the lateral ligaments, a small subtalar effusion and some fluid around the posterior tibial tendon. Ultimately, Dr. Holmes opined that these findings did not indicate trauma to the left ankle. The Arbitrator notes that the radiologist who took this MRI opined that these findings were consistent with healed moderate-grade sprains. The Arbitrator also notes that Dr. Holmes's opinion is not supported by Dr. Peterson's findings of positive results for an anterior drawer test and varus tilt test on the left ankle and observed mild crepitus. Therefore, the Arbitrator finds the findings and opinions of Petitioner's treating physicians more persuasive than the opinions of Dr. Holmes in this matter.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being in his left ankle is causally related to October 9, 2018 work accident.

Lower Back

The Arbitrator notes that Petitioner's back had been in good health for approximately four years prior to the date of accident, the last incident being a pulled muscle that resolved within one week. During the accident, a forklift smashed into the crate that Petitioner's back was braced against, causing his head to whip back and strike the crate. Coworker Jason Sauls testified that the corner of the crate hit Petitioner hard, as if he was on open ice and somebody body checked him. Immediately following the accident, Petitioner was in pain. Multiple

contemporaneous documents submitted into evidence show that Petitioner felt intense pain in his head and back following the accident and that he vomited twice after the accident.

The Arbitrator further notes that when Petitioner was able to see his PCP, Dr. Chorba, on October 16, 2018, Petitioner was still experiencing a lot of physical pain in his back, head, and left ankle. Petitioner described his back pain as sharp and stinging and indicated that his back felt stiff and he could not keep it fully upright. Subsequent medical records establish that Petitioner's back pain continued following the accident. Additionally, Dr. Pelinkovic opined that Petitioner's lower back condition was more likely than not causally related to the work injury and Dr. Novoseletsky opined that Petitioner's ongoing low back pain was a direct result of the work accident of October 2018.

The Arbitrator notes that while Dr. Graf opined that Petitioner's lumbar strain was not causally related, the reasoning for this conclusion was not adequately explained. Dr. Graf assessed Petitioner with a possible muscular strain but opined that it was not causally related because Petitioner had no objective findings on physical examination and had a normal MRI. Yet, Dr. Graf does not offer any explanation as to how muscle strain would appear on a spine MRI, nor does he address his own physical examination findings which included abnormalities of decreased sensation in the dorsal and lateral aspects of Petitioner's left foot versus normal sensation in his right foot and a supine straight leg raise test which produced left-sided hamstring pain on the left leg. As such, the Arbitrator finds the opinions of Dr. Graf less persuasive than the findings and opinions of Petitioner's treating physicians Dr. Pelinkovic and Dr. Novoseletsky in this matter.

Finally, the Arbitrator notes that Ward testified that he thought Petitioner said he was fine following the accident; however, the Arbitrator gives this testimony little weight. Ward testified that he could not remember exactly what Petitioner said and could not recall whether Petitioner was saying that he was not hurt or whether he was okay in some other sense. The Arbitrator will not speculate as to what Ward meant to say or convey.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding his lower back is causally related to the October 9, 2018 work accident.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims that he earned $98,488.00 in the year prior to the accident, with an average weekly wage of $1,894.00. Respondent asserts that Petitioner's average weekly wage is $505.07.

The Arbitrator notes that a printed Employee Pay History, entered as Respondent's Exhibit 5, from January 1, 2018 to October 9, 2018 showed Petitioner earning $1,894.00 across 32 total hours of work, from September 3, 2018 through September 23, 2018, a period totaling 21 days or three weeks. The document also indicates that Petitioner earned $757.60 during 8 hours of double time pay. Finally, the document reveals that Petitioner earned $47.35 per hour.

Pursuant to Section 10 of the Act, overtime and double-time pay should be excluded from calculation of Petitioner's average weekly wage. Petitioner testified that overtime was not mandatory for his work with Respondent and Petitioner did not provide any evidence regarding the number of hours he was required to work in a given day or week. Thus, the Petitioner's overtime pay is excluded from the average weekly wage calculation.

The Employee Pay History shows Petitioner worked 24 hours of regular hourly time and 8 hours of double-time. Taking Petitioner's $47.35 hourly rate and applying that rate to the 32 hours Petitioner worked, the total is $1,515.20.

The Arbitrator notes that the Employee Pay History does not indicate how many days Petitioner actually worked during the three-week period from September 3 through September 23, 2018. However, the document does establish that Petitioner appears to have lost five or more calendar days in the 52-week period preceding the alleged injury. Pursuant to the *Sylvester* decision, if an employee lost five or more calendar days during the 52 weeks preceding the injury, whether or not in the same week, his earnings for that year are divided by the number of weeks and parts thereof that he actually worked after the lost time has been deducted. *Sylvester v. Industrial Com'n,* 197 Ill.2d 225 (2001).

The Arbitrator notes that the evidence establishes that Petitioner lost more than five calendar days in the 52-week period preceding the accident and that he only worked for Respondent from September 3rd to September 23, 2018. As previously noted, the Employee Pay History shows wages earned for Respondent from January 1st to October 9, 2018. Thus, the second method of average weekly wage calculation pursuant to Section 10 of the Act is appropriate in this case.

Based on the evidence set forth above, the Arbitrator finds that, dividing Petitioner's earnings of $1,515.20 by the total weeks and parts thereof (three weeks), Petitioner's average weekly wage comes to $505.07.

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

Petitioner has $27,812.18 in outstanding medical bills and $31,848.93 paid by his significant other's Blue Cross/Blue Shield of Illinois policy. Respondent has not paid any medical expenses on this case.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records, the Arbitrator finds that Petitioner's medical services were reasonable and necessary. The Arbitrator finds that Respondent is liable for the $27,812.18 in related medical bills that remain outstanding, as well as $31,848.93 in related benefits from his significant other's Blue Cross/Blue Shield of Illinois policy.

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

The Arbitrator notes that on March 19, 2019, Dr. Peterson opined that Petitioner was suffering from a chronic lateral sprain to his left ankle, an ATFL tear, peroneal tendinitis with no tear and left ankle instability The Arbitrator also notes that Dr. Peterson discussed and recommended a left ankle arthroscopy with open Brostrom/Gould. Petitioner testified that he wishes to undergo the recommended surgery.

The Arbitrator notes that on August 14, 2019, Dr. Novoseletsky authored a letter of medical necessity opining that a left L2, L3, L4, and L5 lumbar medial branch radiofrequency neurotomy is medically necessary to treat Petitioner's facetogenic back pain and that each lumbar medial branch provided a positive diagnostic result when combined with Petitioner's reports of significant functional improvement, rendering him a good candidate for the procedure.

The Arbitrator further notes that Petitioner testified and the medical records indicate that Petitioner continues to suffer from left ankle and low back problems as a result of the October 9, 2018 accident.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records and Petitioner's credible testimony, the Arbitrator finds that Petitioner is entitled to prospective medical care, at Respondent's expense, for his conditions of ill being in accordance with the recommendations of Dr. Peterson and Dr. Novoseletsky

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

The Arbitrator notes that Petitioner was unable to work from October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018, totaling 7-1/7 weeks.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records and Petitioner's credible testimony, the Arbitrator finds that Petitioner is entitled to temporary total disability (TTD) benefits from October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018 (7-1/7 weeks). As such, the Arbitrator finds that Petitioner's TTD benefits owed total $2,405.07 (7-1/7 weeks x 2/3 x $505.07).

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

HECTOR DEL BOSQUE,	)	
Petitioner,	)	
	)	No. 18WC 32834
vs.	)	21 IWCC0356
	)	
EMPLOYCO USA,	)	
Respondent.	)	

ORDER

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

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated July 21, 2021, is hereby vacated and recalled pursuant to Section 19(f) of the Act.

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

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

July 14,2021

MEP/yp
049

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

HECTOR DEL BOSQUE,

Petitioner,

vs. NO: 18 WC 32834
21IWCC0356

EMPLOYCO USA,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, benefit rate, wage calculation, temporary total disability benefits, medical expenses, and prospective medical treatment 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 affirms the Arbitrator as to accident, causation, and prospective medical treatment. However, the Commission vacates the award for temporary total disability benefits from October 23, 2018 through November 4, 2018 and also modifies the award of temporary total disability benefits from November 20, 2018 through December 26, 2018 to the period beginning on November 26, 2018 through January 7, 2019.

In regard to the average weekly wage, the Commission modifies the Arbitrator's average weekly wage calculation of $505.07 and finds the correct average weekly wage to be $1,894.00 with a corresponding temporary total disability rate of $1,262.67 per week.

Finally, the Commission clarifies that the only medical expenses awarded are for treatment rendered to the back and left ankle. Any expenses related to treatment for the right ankle are denied.

Although Petitioner proved accident and causation, Petitioner's claim for temporary total disability benefits must be modified as it was not supported by the records. Following his accident, Petitioner returned to work. He testified he left work on October 23, 2018 because the show was over and he was in pain. Petitioner testified he went back to work light duty from November 4, 2018 through November 20, 2018. However, there are no off work slips in evidence corroborating lost time for the period from October 23, 2018 through November 4, 2018.

Petitioner further testified that on November 20, 2018 he went off work again until December 26, 2018. (T. 75) However, there is no evidence in the record that Petitioner was taken off work as of November 20, 2018. The evidence indicates Petitioner was taken off work by Dr. Clay beginning November 26, 2018 through January 7, 2019. (Px4)

Accordingly, the Commission vacates the Arbitrator's award of temporary total disability benefits for the period beginning October 23, 2018 through November 4, 2018. The Commission also modifies the Arbitrator's temporary total disability award for the period from November 20, 2018 through December 26, 2018 and awards temporary total disability benefits for the period beginning November 26, 2018 through January 7, 2019.

The Commission also modifies the benefit rates and wage calculations. Although the Arbitrator correctly found that Petitioner's wage should be determined based on a weeks and parts calculation as Petitioner worked less than 52 weeks, the calculation of dividing the total number of hours by the alleged 3 weeks worked was incorrect.

The unrebutted testimony was that Petitioner worked for Employco for approximately 3 weeks prior to the accident. There was overtime, but it was not mandatory. (T. 49-50) Rx5 reflects the hours that the Petitioner worked. Most days Petitioner worked 8 hours. (T. 50)

In reviewing Rx5, the Commission finds that Petitioner worked 24 hours and 8 doubletime hours. His rate of pay was $47.35. As the only testimony that is in evidence are 8-hour workdays, and this evidence is unrebutted, it appears that Petitioner earned $1,136.40 of regular pay for the equivalent of 3 days' work over the 3-week period of time. Applying the weeks and parts analysis, that would be the equivalent of 3/5 weeks for a correct average weekly wage of $1,894.00. Based on that analysis, Petitioner is awarded temporary disability benefits at a rate of $1,262.67 per week.

Finally, the Commission clarifies that no medical expenses are awarded for any treatment regarding Petitioner's right ankle. Petitioner had a pre-existing condition that was not aggravated as a result of his work accident. As such, no medical treatment related to the right ankle is causally connected to the work accident of October 9, 2018 and is therefore denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,262.67 per week for a period of 6 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 $27,812.18 in medical bills as they pertain to the back and left ankle only, and $31,848.93 in related benefits from Petitioner's significant other's Blue Cross/Blue Shield of Illinois policy, only as they pertain to the back and left ankle, 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 $67,518.00. 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.

July 14, 2021

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

MEP/dmm
O: 050421
49

Del Bosque v. Employco USA
18 WC 32834

DISSENT

I respectfully dissent from the majority opinion regarding the causal connection of Petitioner's left ankle to the subject work accident, and therefore for the award of medical bills for treatment for his left ankle at Illinois Bone and Joint. I further dissent from the majority's award for any and all treatment at Suburban Orthopedics based upon Petitioner exceeding his two doctor chain of referral choice pursuant to §8(a) of the Act. Even if, arguendo, Petitioner did not exceed his two physician and chain of referral choice, I would deny the medical expenses from Suburban Orthopedics for his left ankle based upon causal connection and I would find Petitioner reached MMI for his low back condition on March 14, 2019, and that he could return to work full-duty for his low back based upon Dr. Graf's opinion and bolstered by Dr. Clay's February 20, 2019 opinion that Petitioner's "MRI of the lumbar spine was unremarkable for pathology which could explain his constellation of symptoms." (PX4)

With respect to the related medical bills that were paid by his spouse's group insurance, I would not award those medical expenses to Petitioner, instead the language of the award should read: Respondent shall hold Petitioner harmless from any claim by Blue Cross Blue Shield in related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the Petitioner's low back and excluding those bills from Suburban Orthopaedics and referrals therefrom, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

Further, I would find that the Arbitrator's calculation of AWW was correct based upon Petitioner's failure to prove any additional entitlement per the strictures of §10. Finally, I find that Petitioner lacks credibility. These opinions and my dissent are based on the factors set forth below.

Background

Jason Sauls was called as a witness for Petitioner. Sauls testified that he was eating lunch with Petitioner and that they were sitting next to a crate that was close to the aisle. A forklift hit the crate lid that was open, and it pushed the crate and Petitioner about two feet, two to three feet. (T. 12-13) Sauls testified the crate was open. The lid was about 120 degrees, facing the aisle that the forklift was in. The crate was parallel to the red tape that was on the floor for the red warning lane for the forklifts to drive through. They were both sitting against the crate having lunch. Petitioner was leaning against the crate, which was about 18 to 24 inches tall, with his shoulder blades up against it. When the forklift hit, Sauls believed it hit the lid and it pushed the crate forward and at an angle to where it made Petitioner slide forward about two feet. Sauls did not see the forklift hit the crate because his back was to it. He heard a loud noise when the forklift hit the crate. Sauls was sitting about 4 feet to the right of Petitioner. (T. 17-18)

Sauls further testified that he saw what happened to Petitioner's body when he heard the noise. "Well, as the crate was struck, his head whipped back, and he started to – as the crate moved forward, it started to sit him up and it pushed him in seated position

with his legs straight out about two and a half to three feet." Sauls testified that the crate that was struck was about 4 foot by 8 foot by 18 inches tall and weighed an easy three, 400 pounds. (T. 19) The crate had chains to hold the lid open. And they had it open to pull graphics out of it. The graphics were like panels that the Petitioner and his coworkers were putting on the booths made of plastic, one eighth-inch thick pieces. The graphics were 3 foot by 8 foot tall. Sauls testified that the graphics were not real heavy but when you have 30 or 40 of them in the box, it could become a little heavy. (T. 20-21)

Sauls testified that he did not see the forklift hit the crate. He did not remember if the top of the crate fell down or not. (T. 26) Sauls did not recall seeing Petitioner's head against the box at any time. (T. 27) Sauls further testified that he spoke to Petitioner two times about the accident. When Sauls last talked to him in June 2019, Petitioner talked about the accident and what happened in his words. (T. 28, 30)

Sauls further testified that "it hit him as like if he was on the open ice and somebody checked him. He got hit hard. It whipped his head back like whiplash and then pushed him forward. And as it moved, you could see his back, like, slide up the crate to the sitting-up position because he was leaning on it like as if he was in a chair, lounge chair, leaning back on it. So it sat him up and it moved him. It moved him hard. It moved him fast. It moved him violently." (T. 36-37)

On recross-examination Sauls testified that Petitioner was sitting on the last 18 inches of the crate, and that Sauls was seated side by side with Petitioner along this crate using it to recline while we had lunch. Petitioner was leaning against the flat part, relaxing. (T. 38-39)

Petitioner testified that he was eating lunch with his coworkers while sitting with his back up against a shipping crate. (T. 53) Something hit from behind him as he was talking to his "buddy Jason." Something launched him forward, pressing him against the floor, moving forward. Petitioner testified that he did not know what it was at first. Something hit him in the back of the head. It was like a jolt. (T. 53-54) His coworkers flagged the forklift driver and both the driver and Petitioner's supervisors were called and then the insurance people were also called. Thomas Johnson was Petitioner's lead supervisor on that group. (T. 54-55) Petitioner testified that Johnson asked if he was okay and whether he needed to go to the hospital. Petitioner replied no, testifying that he said he was "going to try to work through it. I need the money." (T. 55-56)

Petitioner continued to work and refused to go in an ambulance despite one being called. Petitioner testified that after the incident his lower back and his head were bothering him. (T. 57-58) Despite that testimony, Petitioner completed a Medical Treatment Refusal Form, provided by Respondent, on which he indicated he sustained injuries to the head and back. He refused treatment and wrote, "Want to go back to work I feel I am OK to go back." Petitioner signed the form and dated it October 9, 2018. (RX3)

To clarify, Petitioner testified that PX9B shows the forklift hit that corner forcing the other corner in like this. So when he hit the corner, the corner Petitioner was on, was

pushed forward. The corner on PX9A, that is to the left of where he was sitting, was the corner that got pushed forward, and that was the corner that struck Petitioner. (T. 69-70) He filled out reports and questionnaires on October 9, 2018. (T. 70) He also saw a doctor on October 16, 2018. Petitioner noticed that he had a lot of physical pain in his back, his left ankle and he had head pain. (T. 72) Petitioner testified that his back pain was sharp, stinging, stiff, and he was not able to keep his back arched straight up. The ankle was very painful and stressful. He testified that he could not turn it certain ways without hurting. He further testified that he had sharp pains and also numbness. (T. 73)

However, Petitioner had noted that he had only head and back pain on the Medical Treatment and Refusal form; there was no mention of ankle pain. Petitioner also completed a Workers' Compensation Injury Questionnaire dated October 9, 2018 as well. Petitioner indicated on that form, that he felt pain to the "head and back." (RX4)

On cross-examination Petitioner testified that the lid on the crate was open and "when it came down and I launched forward, it hit the back of my head coming closed." Further, Petitioner conceded that the lid did not hit him straight on, though, it grazed him. He testified, "Grazed is a good term." (T. 85-86) He worked the rest of the day until at least 8:00 or 8:30 the day of the incident. (T. 90) Petitioner also testified that he vomited twice at approximately 6:30 and then 7:00 or 7:30. He had conversations with Medcor, a medical triage company about the accident and he told them the truth about his physical condition. (T. 90-91) The initial treating medical records are devoid of any mention of a left ankle injury.

Petitioner further testified on cross-examination that there was no blood in the pictures that were taken at the scene, nor did his clothes have blood on them. He was pushed forward by the crate and slid on carpeting that had a protective plastic covering on it and worked the rest of the day. (T. 92) Petitioner then testified that he did not see any medical consult until one week later. (T. 92-93) He conceded that he had a personal injury lawsuit pending and at the time of the work incident, he was getting treatment for an unrelated injury to his right ankle. (T. 94)

He worked until the show was over, and was seeking TTD thereafter, testifying he was in pain. He was off work until November 4, 2018, and then off again on November 20, 2018. (T, 75)

Petitioner testified that Dr. Chorba was prescribing Norco for his right ankle injury despite the fact that he was treating with Dr. Peterson. He had both doctors prescribing Norco for the same ankle. (T. 107) When Dr. Chorba tried to wean him off Norco, however, Petitioner received the Norco from both doctors, subsequently obtaining it solely from Dr. Peterson. *Id.* Petitioner testified that he continues to take six to eight Norco up to the date of the Arbitration hearing. (T, 108) Petitioner testified that he was using marijuana as a recreational drug, and that he informed Dr. Chorba and Dr. Peterson of that fact, however, the records are devoid of that history. (T. 110-111; RX7)

Petitioner's Credibility

I find that by referencing Jason Sauls as his "buddy" (T. 53) Petitioner conceded an inherent bias in Sauls' testimony. Petitioner testified that he spoke with Jason Sauls one or two weeks before the March 11, 2020, arbitration hearing whereas Sauls testified that the last time he spoke with Petitioner was June 2019. I find it implausible that Petitioner only asked Sauls if he was going to testify but they had no conversation as to the content of that testimony and Sauls testified Petitioner "talked about the accident and what happened in his words." (T. 28) At the end of the day, Jason Sauls testified that he did not see the forklift hit the crate because his back was to it. (T. 18,

Further, Petitioner testified the lid of the crate "grazed" him (T. 86) and he refused medical treatment that day, continued working and did not seek a medical consult for a week, then continued to work thereafter until the exposition show was over. (RX3)

On direct examination Petitioner neglected to mention that he spoke with the forklift driver, Kevin Ward, when he was filling out his incident report with Employco. He testified only to a conversation eight months later. (T. 89) On cross-examination, Petitioner admitted to a second conversation on the day of the accident. (T. 88-89) Petitioner never sought any medical treatment for a week and in fact, only complained of head and back pain at the time of the accident and at the initial medical consult. When he saw Dr. Peterson for his unrelated right ankle on November 1, 2018, less than a month after the work accident, there was no mention of left ankle pain. In fact the left ankle examination was normal. (RX7)

On November 26, 2018, Petitioner's accident history in his consult with Dr. Brian Clay was described as follows, "Patient reports that he was in a seated position having lunch when he was struck by a forklift. At which point, he was thrown onto his back entrapping his left ankle underneath him." (PX4)

When Petitioner saw Dr. Pelinkovic on March 13, 2019, he described the work accident as, "being pushed from behind by the crate he was leaning against because the crate was hit by a forklift. Then he was hit again by the crate when he was…trying to get up." (PX6)

I note the various inconsistent descriptions of the work accident do not comport with the Petitioner's testimony or his initial accident reports or medical histories.

On February 20, 2019, Dr. Brian Clay saw Petitioner at Illinois Bone & Joint Institute for his low back. In Dr. Clay's Impression and Plan he stated that he was unclear as to what is driving Petitioner's left knee pain. "His MRI of the lumbar spine was unremarkable for pathology which could explain his constellation of symptoms." Dr. Clay referred Petitioner to Dr. Breslow for his left knee. (PX4)

Finally, on March 18, 2019, the video surveillance showed Petitioner carrying a case of bottled water on his left side, and his right arm to carry three bags and was seen

without the back brace he had been wearing at the doctor's appointment shortly before and with no apparent discomfort. I find this surveillance persuasive and the totality of the evidence suggests that Petitioner is not credible, is malingering or, at minimum, misrepresenting the extent of his pain to the medical providers.

Average Weekly Wage Rate

I agree with the Arbitrator's analysis and would find that Petitioner is a part-time worker and failed to prove that he is entitled to the "weeks and parts thereof" benefit of §10 of the Act.

Section 10 of the Workers' Compensation Act provides in pertinent part:

> The basis for computing the compensation provided for in Sections 7 and 8 of the Act shall be as follows:
> The compensation shall be computed on the basis of the 'Average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Ill. Rev. Stat. 1981, ch. 48, par. 138.10.

Petitioner testified that on October 9, 2018, he was employed by The Expo Group. (T. 41) He thought his hourly rate was $48.55 per hour. (T. 41) He was paid by Employco. When asked by his attorney on direct examination how long he was working for Employco USA, Petitioner responded, "I had done two prior shows." (T. 43) He figured he worked for Expo Group directly. (T. 44) His understanding of his relationship on October 9, 2018 with Employco USA was that he worked for them. He basically subcontracted with the company …and he worked for Employco. (T. 46) He agreed that it would be fair to say he worked for them for three weeks although he testified initially he worked for them for "around about two months." (T. 48) He testified that he was called out every day for the trade show. He agreed that RX5 showed the hours that he worked for the three weeks preceding October 9, 2018, for Employco. (T. 49)

Petitioner was asked on direct examination, "Now, with regard to this employee pay history, does this reflect you worked eight hours a day or certain hours that are reflected on here?" (T. 50) Petitioner replied, "To answer the question, the certain hours that are reflected on there. However, I ---most of the days I worked eight hours a day." (T, 50)

Petitioner did not specifically testify to his job duties at the time of the accident, only to what he was doing at the time of the arbitration hearing. With regard to how he got his hours he testified only that he "would get a talk at the end of the day for the next day

what time to come in." (T. 51) "The supervisors would tell us that we needed to work a certain amount of hours to get a job done. And then, therefore, if I only worked three hours one day, it was because we got cut because there was either too many guys or not enough guys, and you had to be placed somewhere else." (T. 51)

I would find that RX5 shows that Petitioner worked for only 32 hours over three weeks and that Petitioner has failed to show that he was more than a part-time worker for three weeks. There was no testimony or payroll history evidence regarding Petitioner's prior 52 week work history submitted by Petitioner. The only credible evidence before the Commission regarding the 52 weeks prior to the subject accident is RX5. Section 10 is not designed to provide a windfall for part-time workers. There is no evidence that at the time of the injury, Petitioner was prevented from working by anything but his own design despite his testimony regarding the possibility he could get cut. His testimony was inconclusive and he did not sustain his burden of proof. Therefore, I would agree with the Arbitrator's calculation that Petitioner's total wages of $1,515.20 should be divided by three weeks and his AWW should be $505.07 because of failure of proof.

Causal Connection

Left Ankle

I disagree with the majority and would find that Petitioner's left ankle condition is not causally related to the subject work accident relying on the opinion of Dr. Holmes. As referenced above, there was no left ankle injury or pain complaints reported on the date of accident on the Workers' Compensation Injury Questionnaire dated October 9, 2018. Although Petitioner contacted Respondent later that day stating his left ankle hurt, he did not report it on the questionnaire. Further, beginning November 1, 2018, Petitioner treated with Dr. Peterson at Suburban Orthopaedics for his unrelated right ankle condition and Dr. Peterson's records contain statements of examination of Petitioner's left ankle condition indicating the left ankle was normal. (RX7) The first mention of left ankle pain and complaints were x-rays taken at Good Samaritan Hospital on November 15, 2018. The radiology Impression was a small osseous fragment along the lateral aspect of the talus may represent a small avulsion fracture. No additional osseous abnormalities. The ankle mortise is intact.

He next documented left ankle pain complaints in a questionnaire at Illinois Bone and Joint Institute on November 26, 2018. (PX4, RX6)

Petitioner consulted Dr. Alan League for the first and only time on November 27, 2018 for his alleged left ankle injury. Dr. League reviewed the x-rays and ordered an MRI.

Beginning in April 2019, Petitioner switched his treatment of the alleged work-related left ankle injury from Illinois Bone and Joint/Dr. League to Dr. Peterson at Suburban Orthopaedics, who had been treating Petitioner for his unrelated right ankle injury.

Petitioner saw Dr. George Holmes at Respondent's request on May 2, 2019. Petitioner's history to Dr. Holmes reflects that during therapy for his right ankle, Petitioner developed left ankle pain. (RX2)

Dr. George Holmes is both the Director of Orthopaedic Foot and Ankle surgery at Midewest Orthopaedics at Rush and the Program Director of the Foot & Ankle Fellowship program. (RX2)

In response to specific interrogatories, Dr. Holmes opined as follows:

- Petitioner's condition of ill-being with regard to the left ankle is related to findings of an MRI scan which demonstrated evidence of some fibrosis and scarring in the lateral ligaments, a small subtalar effusion, some fluid around the posterior tibial tendon. Otherwise, this was a normal x-ray. These findings were relatively benign and did not represent any specific injury or trauma to the ankle.
- Petitioner's subjective complaints are lateral ankle pain, posterior ankle pain, and anterolateral ankle pain. He also has complaints of stiffness and painful weightbearing and dorsiflexion of the ankle.
- There does not appear to be any specific mechanism of injury with regard to the left ankle. The injury reports indicate that initial treatment demonstrated and reported no evidence of any ankle injury whatsoever.
- The objective exam is not consistent with the petitioner's subjective complaints at this time. That is to say, the MRI scan findings are not consistent with the areas of discomfort noted on exam today.
- At this point, I cannot draw any causal relationship between the alleged accident of October 9, 2018, and Petitioner's current left ankle condition.
- The medical treatment to date with regard to the left ankle is more likely than not appropriate for his doctors to treat his subjective complaints, but those treatment options provided to him have not been related to the injury reported on 10/9/18.
- From the standpoint of the injury of October 9, 2018, no further treatment is recommended for the Petitioner's left ankle.
  Regardless of the causation issue, I see nothing on the x-ray or the exam that would warrant the procedure outlined by his podiatrist.
- With regard to the work injury of October 9, 2018, he can return to full duty. If he is unable to return to full duty with respect to the left ankle, it would not be related to the reported work injury.
- Petitioner has reached MMI with regard to the work injury of October 9, 2018.

I find Dr. Holmes' opinion more persuasive than Dr. Peterson, the podiatrist, because on November 1, 2018, when Petitioner treated with Dr. Peterson at Suburban Orthopaedics for his unrelated right ankle condition, Dr. Peterson's records contain statements of examination of Petitioner's left ankle condition indicating the left ankle was normal.

(RX7) Dr. Holmes is both the Director of Orthopaedic Foot and Ankle surgery at Midwest Orthopaedics at Rush and the Program Director of the Foot & Ankle Fellowship program.

Further, Petitioner never testified about an injury to his left ankle at the time of the incident. Also, on the initial injury form there was no injury to the left ankle documented. Dr. League noted that he was looking for an AITF ligament tear, OCD lesion, bony contusion on the left ankle MRI. The left ankle MRI showed evidence of fibrosis or scarring of the AITF and calcaneal fibular ligament without additional signal consistent with healed moderate grade sprains, small tibiotalar and posterior subtalar joint effusions, and fluid but otherwise normal high-field MRI of the left ankle with no evidence of peroneal tendon pathology, osteochondritis dissecans, or other significant pathology. (PX4)

Low Back

I find that Petitioner sustained a lumbar back strain and was at MMI as of March 14, 2019, and I would deny further medical treatment based on Dr. Graf's opinion. On January 7, 2019, Petitioner's treating doctor. Dr. Clay, documented that the lumbar spine MRI "did not reveal anything significant aside from mild disc bulging at L5-S1." (PX4, 1/07/19) Dr. Clay further opined that Petitioner's MRI of the lumbar spine was "unremarkable for pathology which could explain his constellation of symptoms." (PX4, 2/20/19)

On March 14, 2019, Respondent's §12 expert, Dr. Graf, opined that Petitioner demonstrated non-organic pain signs on evaluation in the form of pain out of proportion to the evaluation. He further opined as follows:

> Petitioner is a 29-year-old male who claims injury on 10/9/18. He currently complains of low back pain rating it to a level of 9/10 and further self-rates his pain and disability in the "severe disability" category. While stating such, he demonstrates a normal neurologic exam and demonstrates a normal MRI scan of the low back.
> Regarding a diagnosis, I would consider Petitioner's diagnosis to be a possible muscular strain, though I am unable to objectively substantiate his current subjective complaints of pain given the lack of objective findings.
>
> To a reasonable degree of medical and surgical certainty, it is my opinion Petitioner is at MMI. It is further my opinion that no further care or treatment is reasonable nor medically necessary as it relates to the claimed injury in question.
>
> There is no objective reason why Petitioner cannot return to his full duty level job as described.
>
> In answer to specific interrogatories, Dr. Graf opined:

- Current condition of ill-being – lumbar spine: Petitioner claims severe low back pain and rates himself into the "severe disability" category. While stating such he demonstrates a normal neurologic exam and has a normal MRI scan of the lumbar spine.
- Subjective complaints – low back: Petitioner essentially complains of pain in the low back rated up to levels of a 9/10.
- Mechanism of injury on October 9, 2018: Described in body of report
- Objective exam findings consistent with subjective complaints: Petitioner has no objective findings on physical exam. Further, he demonstrates a normal MRI scan of the lumbar spine.
- Causation: I question causation as a whole given Petitioner's current subjective complaints which lack an objective basis.
- Medical treatment reasonable and necessary: The initial medical care and treatment, in my opinion, would be considered reasonable though I am unable to objectively substantiate the need for further care given the physical exam and imaging studies.
- Further medical treatment: N/A
- Petitioner capable of working full capacity: there is no objective reason why Petitioner cannot return to full duty level work.
- MMI: It is my opinion Petitioner has reached MMI.

Medical Bills

Medical Expenses

The majority awards medical bills of $31,848.93 payable to Petitioner that have been paid by Petitioner's significant other's group insurance under Blue Cross/Blue Shield (BCBS). The balance on the Petitioner's bill exhibit for those bills paid by BCBS is zero. The Appellate Court has been very specific in its analysis regarding the amount owed by Respondent when the Petitioner's bills were paid by insurance other than his own group plan. An award over and above the amount paid by the other group plan results in a windfall for Petitioner, thus the reimbursement award must be limited to the amount paid. As the second district Appellate Court held in *Perez,*

> The Illinois Administrative Code provides, in pertinent part:
> "Under the fee schedule, the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge. If an employer *or* insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail." (Emphasis added.) 50 Ill. Adm. Code 7110.90(d), amended at 36 Ill. Reg. 17108 (eff. Nov. 20, 2012).
> Here, again, [***9] the language cited by claimant is devoid of any limitation that only the employer's own insurance carrier may negotiate the reduced rate. The disjunctive term "or" indicates that either the employer *or* insurance carrier—any insurance carrier—may negotiate a

reduced rate.

Perez v. Ill. Workers' Comp. Comm'n, 2018 IL App (2d) 170086WC, P19-P21, 96 N.E.3d 524, 527, 2018 Ill. App. LEXIS 10, *6-9, 420 Ill. Dec. 439, 442

While I agree with the majority that based upon the holding, in *Perez,* Petitioner would owe only the amount of the negotiated rate paid by Blue Cross Blue Shield in related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, I do not agree Respondent is liable for those payments except as they pertain to the low back prior to March 14, 2019. Further, I would have Respondent hold Petitioner harmless from any claim by Blue Cross Blue Shield for related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the low back prior to March 14, 2019, excluding any treatment at Suburban Orthopaedics, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

Petitioner Exceeded Two Physician Chain of Referral

Section 8(a) of the Illinois Workers' Compensation Act provides in relevant part:

> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense.
> *820 ILCS 305/8*

Prior to the subject work accident, Petitioner was treating with Suburban Orthopedics for an unrelated right foot injury. After the work accident Petitioner continued to treat with Suburban Orthopaedics for his right ankle. Petitioner then chose to treat with his primary care physician (PCP), Dr. Chorba, and subsequently chose Illinois Bone and Joint to treat for his "back and ankle pain" as described on the Medical History Form dated November 26, 2018. (Px4, Rx6) He then chose to transfer his treatment for his left ankle and his low back to Suburban Orthopedics. Therefore, I find that all

Del Bosque v. Employco USA
18 WC 32834

Petitioner's medical bills for treatment at Suburban Orthopaedics should be denied because Petitioner exceeded his two choice of physicians.

Conclusions of Law

Based on a careful review of the evidence, I would specifically find that Petitioner is not credible, deny all medical treatment for the left foot based upon the initial histories and Dr. Holmes' opinion, deny medical treatment after March 14, 2019, for the low back based upon Dr. Graf's opinion and the surveillance and deny all medical treatment at Suburban Orthopaedics because Petitioner exceeded his two physician chain of referral maximum as dictated by §8(a)2 of the Act. Further, I would find that Respondent shall hold Petitioner harmless from any claim by Blue Cross Blue Shield for related benefits from Petitioner's significant other's Blue Cross Blue Shield of Illinois policy, only as they pertain to the low back prior to March 14, 2019, excluding any treatment at Suburban Orthopaedics, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act or the negotiated rate.

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

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

DEL BOSQUE, HECTOR
Employee/Petitioner

Case# **18WC032834**

EMPLOYCO USA
Employer/Respondent

On 5/12/2020, 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 J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

4696 POULOS & DiBENEDETTO LAW
DAVID POULOS
850 W JACKSON BLVD SUITE 405
CHICAGO, IL 60607

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Hector Del Bosque
Employee/Petitioner

v.

Employco USA
Employer/Respondent

Case # **18** WC **32834**

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 **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 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 9, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**1,515.20**; the average weekly wage was $**505.07**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $336.71 per week for 7-1/7 weeks, commencing October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $27,812.18 in related medical bills that remain outstanding and $31,848.93 in related benefits from Petitioner's significant other's Blue Cross/Blue Shield of Illinois policy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall provide prospective medical care for Petitioner's conditions of ill being in accordance with the recommendations of Dr. Peterson and Dr. Novoseletsky, as provided in Section 8(a) of the act.

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

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

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

Elaine K Lee

Signature of Arbitrator

May 7, 2020

Date

ICArbDec19(b)

MAY 12 2020

STATEMENT OF FACTS:

The parties stipulated that on October 9, 2018, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. (AX1) Petitioner was a 27-year old Carpenter for Respondent Employco USA on October 9, 2018. *Id.* Employco USA is the mother company of The Expo Group, for whom Petitioner was working for on October 9, 2018. (T. 41-42) Petitioner testified that prior to October 9, 2018, he had worked two shows and had been working for Respondent for approximately three weeks. (T. 43, 48) Petitioner testified that he worked every day while shows were going on. (T. 48) According to Petitioner, at the end of each day, the supervisors would tell workers their hours for the following day. (T. 50-51) Petitioner indicated that, on most days, he worked eight hours, but his regular assigned hours are reflected on his employee pay history. (T. 50; RX5) Petitioner testified that overtime was not mandatory. (T. 50)

Petitioner testified that on October 9, 2018 at about 12:20 p.m. he was eating lunch with his coworkers Jason, Javier and Sean while sitting on the floor with his back up against a shipping crate. (T. 53) Petitioner testified the crate was flush with the aisle, just past the red tape. (T. 61) According to Petitioner, crates were allowed to project about one foot into the aisle, with their lids open, to allow for forklifts to continue up and down the aisles. (T. 61-62) Petitioner explained that he suddenly felt a jolt, and something launched him forward, hitting him in the back of the head. (T. 53) Petitioner testified that Jason and Sean flagged down a nearby forklift driver and notified him that he had hit Petitioner. *Id.* Petitioner stated that the forklift driver came over and told him he was fine, however Petitioner responded that he was not fine. (T. 54-55) Petitioner testified that his lower back and head were bothering him. (T. 57-58) He further testified that he tried to stand up but was unable to do so and ended up sitting back down against the crate as suggested by Sean. (T. 65) Petitioner explained that Sean asked to use Petitioner's phone to take a few pictures documenting the incident, which he did. (T. 58) Petitioner testified that those pictures—contained in Petitioner's Exhibits 11A through 11D—truly and accurately represent him sitting there after the accident when Sean took the pictures. (T. 58-59, 162) The crate had not been moved following the accident. (T. 66)

Petitioner testified that they all called over their respective supervisors and Respondent's insurance people showed up. (T. 55) Petitioner stated that Thomas Johnson (Johnson), also known as TJ, was Petitioner's lead supervisor. (T. 55) According to Petitioner, Johnson asked him if he was okay and if he needed to go to the hospital, to which Petitioner responded that he did not want to go to the hospital and that he was going to try to work through the pain. (T. 56) Petitioner believed an ambulance was called, but Petitioner refused to take it. (T. 57) Petitioner testified that he had a family to support and he figured that he was young and strong, and that he could work through his discomfort. *Id.* Petitioner testified that he continued to work and vomited twice over the course of the evening. (T. 90)

Petitioner was required to fill out accident reports and questionnaires that day. (T. 70) One report, the Medcor Workplace Injury Triage and Reporting Form, states: "employee alleges about 4 ½ hours ago while sitting on the floor to eat his lunch and leaning against a shipping crate a forklift driver struck the crate which struck the back of his head and lower back. Employee is calling back complaining of left ankle pain and offers he vomited twice." (RX1)

Jason Sauls (Sauls), Petitioner's co-worker, testified that he was working with Petitioner on October 9, 2018 and that he remembered an accident with Petitioner occurring on that day. (T. 10-12) Sauls testified that he was eating lunch with Petitioner while they were both sitting against a crate. (T. 17-18) Sauls explained that the crate was made of wood and easily weighed 300-400 pounds. (T. 19) According to Sauls, Petitioner was leaning back against the crate with his shoulder blades up against it. (T. 17-18) Sauls testified that he was seated about four feet to Petitioner's right. (T. 18) Sauls explained that the aisle was lined with red tape demarcating

lanes for the forklifts to drive through and the crate was parallel to the red tape with its lid open about 120 degrees facing out into the aisle. (T. 17) Saul testified that as they were eating, a forklift hit the open crate lid, pushing the crate forward and at an angle into Petitioner. (T. 13, 18.) Sauls explained that due to the angle in which the forklift hit the crate, the crate moved away from him rather than into him, so Sauls was not hit. (T. 33-34) Sauls testified that as the crate was struck, Petitioner's head whipped back in a whiplash motion. (T. 19, 36) According to Sauls, the corner of the crate hit Petitioner hard, as if he was on open ice and somebody body checked him. (T. 36) Sauls explained that the force of the impact pushed Petitioner into more of an upright seated position and shoved him two to three feet along the floor with his legs straight out in front of him. (T. 13, 18-19) Sauls testified that the hit moved Petitioner hard, fast and violently. (T. 36-37) Sauls testified that following the accident, Petitioner complained of pain so Sauls told him to stay still until they could call someone over. (T. 21) Sauls testified that he called their supervisor, Johnson. (T. 22) Sauls stated that he informed Johnson that a forklift hit a crate and that the crate hit Petitioner. (T 32.) According to Sauls, several higher-ups came by and they brought in a paramedic crew to check Petitioner out, as well as a lot of carpenters who came over and were talking. (T. 31-32.) Sauls explained that ultimately, Petitioner continued to work until about 8:00 p.m. (T. 29)

Kevin Ward (Ward), the forklift driver, also testified at the arbitration hearing. (T. 121) Ward testified that he worked for McCormick Place Teamsters 727 and that on October 9, 2018, he was working at McCormick Place as a forklift driver. (T. 121-122) Ward testified that he had just gotten off his lunch break and was driving his forklift down the aisle when he hit a crate after failing to notice that its top was flipped up. (T. 122-123) Ward explained that forklifts can travel approximately 15 to 20 miles per hour. (T. 130) Ward testified that he was shocked and that, at first, he didn't realize that he had hit something—he just felt his forklift suddenly stop. (T. 122- 123) Ward testified that he did not talk to Petitioner until later that day, after Petitioner was taken away on a stretcher of some sort and Ward was taken away for a urinalysis drug screening. (T. 123-24, 131) Ward testified that he later saw Petitioner, and there was a conversation, but he could not remember exactly what was said. (T. 125) Ward testified that he thought Petitioner either said he was okay or that he didn't want anything to happen to Ward or to himself, and that he just wanted to get back to work. *Id.* Ward could not recall whether Petitioner was saying that he wasn't hurt or whether he was okay. (T. 128)

Petitioner first sought medical attention with his primary care physician (PCP), Dr. Thomas Chorba, on October 16, 2018. (PX2, T.70) Petitioner testified that was the first available time Petitioner could get in to see him. (T. 92-93) Petitioner testified that he related his history of injury to Dr. Chorba and complained of pain in his back, head, and left ankle. (T. 72) Petitioner stated that he indicated that his back pain was sharp and stinging, his back felt stiff and he could not keep it fully upright. (T. 72-73) Petitioner testified that he described his left ankle pain as severe and sharp, complained of numbness in the left ankle and reported that he could not turn it certain ways without it hurting. (T. 73) Dr. Chorba ordered x-rays of Petitioner's lumbar spine and left ankle. (T. 73; PX3)

Petitioner testified that he continued to work until October 23, 2018, when the show ended. (T. 74-75) Petitioner testified that he was also in physical pain. (T. 75) Petitioner indicated that he remained off work until November 4, 2018, at which point he returned to work light duty. (T. 75)

Petitioner underwent the lumbar spine and left ankle x-rays on November 15, 2018. (PX3.) The lumbar spine x-ray showed no acute fracture or dislocation and that the sacroiliac joints were intact. *Id.* The left ankle x-ray revealed a small osseous fragment along the lateral aspect of the talus which may represent a small avulsion fracture. *Id.*

Petitioner testified that he continued working light duty until November 20, 2018 and then remained off work until December 26, 2018. (T. 75)

On November 26, 2018, Petitioner followed up with Dr. Brian Clay at Illinois Bone and Joint Institute. (PX4) Dr. Clay noted Dr. Chorba as Petitioner's PCP and cc'd him in his report. *Id.* Petitioner complained of constant moderate-to-severe lower back and left ankle pain at 8/10, which he described as sharp, throbbing, aching, and cramping, aggravated by most activities of daily living as well as lifting, prolonged walking, or standing. *Id.* Petitioner related his history of injury and noted that he had seen Dr. Chorba for the problem and had gotten x-rays, but otherwise described his prior treatment for the condition as toughing it out. *Id.* Petitioner reported that he had continued working since the accident, but that he was suffering from increased pain, muscle spasms and radicular symptoms into his left leg. *Id.* On examination, Dr. Clay noted that straight leg raise and slump tests were positive on the left leg but negative on the right leg. *Id.* The left ankle revealed tenderness over the lateral malleolus with light palpation with passive inversion and eversion of the left ankle provoking pain through the subtalar joint. *Id.* Dr. Clay took x-rays and opined that they showed no significant osseous abnormalities in the lumbar spine except for disc space height loss at T12-L1, and that nonweightbearing left ankle x-rays showed no evidence of fracture or dislocation. *Id.* Dr. Clay diagnosed Petitioner as having lumbar radiculopathy, a chronic lumbar strain, sciatica of the left leg and left ankle pain. *Id.* Dr. Clay ordered physical therapy and an MRI for the lumbar spine. *Id.* Dr. Clay also kept Petitioner off work until February 11, 2019 and instructed Petitioner to continue taking Norco, as needed, and prescribed him Robaxin 750 mg for low back pain and muscle tightness. *Id.* Dr. Clay referred Petitioner to foot and ankle specialist Dr. Alan League regarding his ankle condition and instructed Petitioner to return for follow up regarding his back on January 7, 2019. *Id.*

Petitioner saw Dr. League on November 27, 2018 at Illinois Bone and Joint Institute. *Id.* Petitioner related his history of injury and complained of ongoing pain. *Id.* On physical examination, Dr. League noted left ankle tenderness diffusely with active guarding, as well as restricted motion and strength with active inversion, eversion, dorsiflexion, and plantar flexion. *Id.* He observed no such strength reduction in the right ankle. *Id.* Dr. League diagnosed Petitioner as having left ankle sprain/strain and with residual pain for more than a month and a half since the injury. *Id.* Dr. League ordered a left ankle MRI to look for structural injuries. *Id.*

The December 7, 2018 lumbar spine MRI revealed slight straightening of the normal lumbar spine lordosis; mild right foraminal narrowing, a borderline early annular bulge and end-plate spurring, and minimal spondylotic change at L5-S1; and at T12-L1, mild to moderate disc desiccation, mild spondylotic change, Schmorl node development along the inferior T12 end-plate with adjacent marrow signal heterogeneity, and a mild annular bulge causing slight impression upon the thecal sac. *Id.*

Petitioner returned to Dr. Clay on January 7, 2019 complaining of persistent low back and left ankle pain. *Id.* Dr. Clay recommended that Petitioner continue outpatient physical therapy and opined that he would respond well to physical therapy for ongoing pain and symptom management for a chronic lumbar strain. *Id.* He further opined that Petitioner was not an appropriate candidate for spine interventions at that point. *Id.*

On February 20, 2019, Petitioner followed up with Dr. Clay once more, reporting continued low back pain as well as developing worsening left knee pain. *Id.* Dr. Clay referred Petitioner to Dr. Marc Breslow to evaluate Petitioner's knee and for a spine surgery consultation. *Id.*

Petitioner testified that sometime thereafter, he decided to switch treaters to Suburban Orthopaedics. (T. 77) Petitioner explained that Illinois Bone and Joint Institute were not friendly about scheduling around Petitioner's parenting duties, so he switched to a treater with a closer location. *Id.*

On March 13, 2019, Petitioner saw to Dr. Dalip Pelinkovic at Suburban Orthopaedics complaining of left ankle pain of 5/10, less severe left knee pain and low back pain at 7/10 with shooting pain and tingling

radiating into his left hip and down his leg. (PX6) Petitioner related his history of injury and explained that he continued working for two weeks thereafter due to financial concerns, but that his pain worsened until it became intolerable. *Id.* During examination of Petitioner's lower back, Dr. Pelinkovic noted a positive FABER test on the left, midline tenderness along the lumbosacral junction and left lumbar paraspinal tenderness. *Id.* Dr. Pelinkovic further noted that Petitioner was negative for Waddell signs. *Id.* Dr. Pelinkovic diagnosed Petitioner as having a lumbar sprain/strain, lumbar facet joint syndrome and left ankle pain. *Id.* Dr. Pelinkovic opined that Petitioner's current lumbar spine and left lower extremity conditions were causally related to the work injury on October 9, 2018. *Id.* Dr. Pelinkovic noted that Petitioner was pain free and working full duty as a Carpenter prior to the injury. *Id.* Dr. Pelinkovic recommended physical therapy for the lower back and opined that Petitioner could return to work with restrictions. *Id.* Petitioner reported that Respondent would not allow him to return to work with restrictions. *Id.*

Petitioner testified that on the morning of March 14, 2019, he was scheduled for an independent medical examination (IME), at Respondent's request, with Dr. George Holmes. (T. 80) Petitioner testified that he was on the highway when he received a call from his children's' school informing him that they were sick and needed to be picked up. (T. 80, 98; PX10) Petitioner testified that he went to pick up his children and called his attorney to report that he was going to miss the appointment with Dr. Holmes. (T. 98-99)

Later that day, Petitioner underwent an IME with Dr. Carl Graf at the Illinois Spine Institute. (RX1) Petitioner described the October 9, 2018 accident and complained of low back pain to his left leg following the accident. *Id.* During physical examination, Dr. Graf noted that Petitioner exhibited decreased sensation in the dorsal and lateral aspects of his left foot and normal sensation in the right foot. *Id.* Dr. Graf further noted that a supine straight leg raise test produced left-sided hamstring pain on the left leg and that the test was negative on the right. *Id.* Dr. Graf further noted that Petitioner's reported pain was out of proportion to the evaluation. *Id.* Dr. Graf diagnosed Petitioner as having a possible muscular strain and opined that it was not causally related to the accident because he could not identify osseous abnormalities or disc herniation in the spine MRI or objective findings on physical examination. *Id.* Dr. Graf opined that Petitioner was at maximum medical improvement (MMI), that no further care or treatment was reasonable or necessary and that Petitioner could return to work full duty. *Id.*

On March 15, 2019, Petitioner saw Dr. Kyle Peterson at Suburban Orthopaedics for his left ankle. (PX6) Petitioner reported that his left ankle pain was constant but worse when physically active and located on the lateral aspect of the ankle along with the Achilles area. *Id.* Petitioner related his history of injury and indicated that his left ankle symptoms began on October 9, 2018 following his work accident. *Id.* On physical examination, Dr. Peterson noted that Petitioner had an antalgic gait with moderate swelling of the left ankle and none on the right ankle. *Id.* He further noted that Petitioner exhibited moderate tenderness to palpation over the anterolateral gutter and peroneal tendons of the left ankle and no tenderness over the right ankle. *Id.* Petitioner had positive results for the anterior drawer test and varus tilt test on the left ankle and negative on the right ankle. *Id.* Dr. Peterson noted that Petitioner had a great deal of pain about the ankle joint line, especially in the anterolateral corner. *Id.* Dr. Peterson also noted that the joint felt fairly unstable with an anterior drawer and talar tilting evident. *Id.* Dr. Peterson found mild crepitus and slight tenderness in the peroneal tendons. *Id.* Dr. Peterson diagnosed Petitioner as having a left chronic lateral ankle sprain, an ATFL tear, peroneal tendinitis with possible tear and ankle instability. *Id.* Dr. Peterson listed the cause/mechanism of Petitioner's condition as traumatic work. *Id.* Dr. Peterson issued Petitioner restrictions of weight-bearing, range of motion and sports as tolerated and instructed Petitioner to return after undergoing his left ankle MRI. *Id.*

On March 16, 2019, Petitioner underwent the left ankle MRI, the results of which revealed small tibiotalar and posterior subtalar joint effusions; a small amount of fluid distending the tibialis posterior and flexor digitorum longus sheaths; and evidence of fibrosis/scarring of the anterior talofibular ligament and

calcaneal fibular ligament without additional altered signal, which the radiologist opined were consistent with healed moderate-grade sprains. (PX4)

On March 19, 2019, Petitioner returned to Dr. Peterson, who reviewed the left ankle MRI. (PX6) Dr. Peterson opined that Petitioner was suffering from a chronic lateral sprain to his left ankle, an ATFL tear, peroneal tendinitis with no tear, and left ankle instability. *Id.* Dr. Peterson discussed the possibility of a future left ankle arthroscopy with open Brostrom/Gould and Petitioner elected to undergo the procedure. *Id.*

On March 22, 2019, Petitioner began physical therapy at Suburban Physical Therapy. *Id.* During his initial evaluation, Petitioner related his history of injury and reported that he could stand for 10 to 15 minutes before he began to feel fatigue and heaviness in his back, that he could walk approximately 1 mile, that he got increased pain when climbing more than 30 stairs, and that he was waking up 5 to 6 times per night. *Id.* Petitioner reported that his pain could reach 7-10/10 at times. *Id.* Petitioner stated that he had not been experiencing radicular pain or tingling down into his left thigh for a while. *Id.* On examination, physical therapist Michele Branka observed reduced strength in Petitioner's left hip and left leg relative to the right; tenderness to palpation throughout the lumbar paravertebral muscles, left greater than right; hypomobility with PA glides; and muscle guarding at L1 through L5. *Id.* Brank opined that the findings were consistent with a back injury at work. *Id.*

On May 2, 2019, Petitioner underwent the IME with Dr. George B. Holmes regarding his left ankle. (RX2) Petitioner related his history of injury and Dr. Holmes reviewed Petitioner's medical records and diagnostic exams. *Id.* Dr. Holmes opined that Petitioner's left ankle MRI scan showed some fibrosis and scarring in the lateral ligaments, a small subtalar effusion and some fluid around the posterior tibial tendon. *Id.* He opined that these findings were relatively benign and did not indicate trauma to the ankle. *Id.* He opined that Petitioner's treatment to date had been reasonable. *Id.* He further opined that there was no causal relationship between Petitioner's accident of October 9, 2018 and his left ankle condition, that Petitioner was at MMI with regard to his left ankle and that his left ankle condition was not preventing him from returning to work. *Id.*

On May 3, 2019, Petitioner returned to Dr. Peterson for follow-up on his left ankle. (PX6.) Dr. Peterson noted that Petitioner's symptoms continued to persist despite treatment. *Id.* Dr. Peterson continued to recommend a left ankle arthroscopy with open Brostrom/Gould. *Id.*

On May 6, 2019, Petitioner returned to Dr. Pelinkovic for follow-up regarding his back. *Id.* Petitioner complained of continued constant dull back pain, varying in intensity between 5/10 and 9/10. *Id.* Petitioner reported that he could walk 5-20 minutes before needing to stop. *Id.* Dr. Pelinkovic referred Petitioner to Dr. Dmitry Novoseletsky for a back pain management consultation, had Petitioner continue to see Dr. Peterson for his ankle issues and continued Petitioner's physical therapy while recommending he wean himself off narcotics. *Id.*

Petitioner saw Dr. Novoseletsky on May 13, 2019. *Id.* Petitioner complained of constant lower back stiffness and pain at 6-10/10. *Id.* Dr. Novoseletsky examined Petitioner and diagnosed him as having lumbar facet syndrome and lumbar spine strain/sprain. *Id.* He continued Petitioner on Norco, Cyclobenzaprine and Meloxicam. *Id.* Dr. Novoseletsky ordered left L2, L3, L4, and L5 lumbar medial branch blocks for diagnostic purposes. *Id.* Dr. Novoseletsky indicated that if Petitioner found temporary relief, then he would order a second set of blocks with different anesthetic medication to rule out a placebo response. *Id.* With significant relief from a second set of blocks, Dr. Novoseletsky noted, Petitioner would be a good candidate for radiofrequency neurotomy. *Id.*

Petitioner followed up with Dr. Novoseletsky on June 10, 2019 and returned to Dr. Peterson again on June 11, 2019. *Id.* Petitioner complained to Dr. Peterson of worsening ankle pain, sharp in nature, at 7-10/10. *Id.* Dr. Peterson noted that Petitioner remained unchanged on examination. *Id.* Dr. Peterson continued to recommend an arthroscopy and recommended that Petitioner go off of work in the meantime. *Id.*

On June 12, 2019, Dr. Novoseletsky administered a left-sided prognostic lumbar medial branch block at L2, L3, L4, and L5 with Dr. Novoseletsky. *Id.*

On June 24, 2019, Petitioner followed up Dr. Novoseletsky and reported that his back pain that day was worse than the pre-injection baseline pain, sharp and at 7/10. *Id.* Petitioner reported obtaining 50% relief of his symptoms within 30 minutes of the June 12th medial branch block and that said relief lasted 3 hours. *Id.* Dr. Novoseletsky noted that Petitioner's axial low back pain had persisted since the October 2018 injury and opined that, with a reasonable degree of medical certainty, it was a direct result of the work accident of October 2018. *Id.* Dr. Novoseletsky opined that Petitioner's mechanism of injury was consistent with facet joint syndrome (forceful extension with trunk rotation). *Id.* Dr. Novoseletsky explained that the MRI did not reliably confirm or rule out facet joint syndrome and that the gold standard method of diagnosis is diagnostic lumbar medial branch blocks. *Id.*

On July 8, 2019, Petitioner returned to Dr. Pelinkovic, who noted that Petitioner's physical exam remained unchanged, as did his recommendations. *Id.*

On July 23, 2019, Petitioner underwent a second prognostic lumbar medial branch block at L2, L3, L4, and L5. *Id.*

Petitioner was discharged from physical therapy on July 30, 2019 due to recommended surgery for a different body part. *Id.* On that day, Petitioner demonstrated diminished left leg strength compared to the right, with tenderness to palpation in the lumbar paravertebral muscles, left side greater than right. *Id.* Petitioner demonstrated restricted trunk range of motion with flexion, extension and side bending, as well as a decreased standing tolerance of 15 minutes. *Id.*

On August 1, 2019, Petitioner returned to Dr. Novoseletsky. *Id.* Petitioner reported that his back pain had returned to its pre-injection baseline level. *Id.* He reported obtaining greater than 75% relief of his symptoms within 30 minutes of the July 23rd medial branch block and that said relief lasted 2 hours. *Id.* He reported that he felt much better when performing activities that would ordinarily elicit back pain. *Id.*

On August 14, 2019, Dr. Novoseletsky authored a letter of medical necessity opining that a left L2, L3, L4 and L5 lumbar medial branch radiofrequency neurotomy is medically necessary to treat Petitioner's facetogenic back pain. *Id.* Dr. Novoseletsky noted that Petitioner experienced 50% relief of his back pain after his initial medial branch block of June 12th and that he experienced greater than 75% relief of his back pain after the second medial branch block procedure. *Id.* Dr. Novoseletsky opined that each was a positive diagnostic block when combined with Petitioner's reports of significant functional improvement during the time the blocks were in effect and that this rendered him a good candidate for lumbar medial branch radiofrequency neurotomy of the affected nerves. *Id.*

Petitioner continued to follow up with Dr. Peterson for his left ankle symptoms through November 2019. *Id.* Petitioner reported highly variable pain from 4/10 to 10/10, achy throbbing and stiffness that could sometimes radiate up into his shin. *Id.* Dr. Peterson noted that Petitioner's left ankle was positive for popping and cracking with movement. *Id.* Dr. Peterson noted that Petitioner's symptoms were severe and persisted with treatment. *Id.*

At the arbitration hearing, Respondent called Juan Herrera (Herrera) as a witness. (T. 134) Herrera is a private investigator that Respondent hired to surveil Petitioner. (T. 135-136) Herrera presented a little over three minutes of surveillance footage from March 14, 2019, depicting Petitioner leaving the IME, driving to Walmart and buying some small items. (T. 138-140; RX9) Herrera testified that he did not know if Petitioner had purchased Ibuprofen there or if he had visited the pharmacy. (T. 146-147) Herrera then presented a surveillance video, running time of one minute and 11 seconds, from May 2, 2019, which showed Petitioner entering his residence with a document in his hand. (T. 141; RX9) Herrera testified that he selected these clips from out of two 8-hour days of surveillance because those were the only times he saw Petitioner. (T. 143) Herrera explained that the computer playing the video during the arbitration hearing was buffering during playback, causing the video to stutter and making it difficult to tell how accurately it depicted Petitioner's gait or walking ability. (T. 144-145, 153-154) Herrera testified that he was not informed as to Petitioner's work status at the time surveillance was conducted. (T. 148-149)

Petitioner testified that as of the day of hearing, he was still having difficulty sitting up straight for long periods of time, his back gets stiff and stings and he is no longer able to turn left and right without pain. (T. 82-83) Petitioner stated that he still sometimes gets shooting pain down his left leg and that his left ankle pain continues, reaching up to his mid-calf at times. (T. 83) Petitioner testified that he cannot sit in the car and use his leg up high at all nor can he go downstairs or use ladders without constant pain. *Id.* Petitioner further testified that sometimes he gets stinging and numbness when standing for long periods of time. *Id.* Petitioner indicated that he takes Hydrocodone, Methocarbamol, Naproxen and over-the-counter Aleve for his symptoms. (T. 83-84) Petitioner testified that if his left ankle surgery were authorized, he would undergo it. (T. 84-85)

Petitioner testified that he did not have any treatment for his left ankle prior to October 9, 2018. (T. 78) Petitioner explained that around 2014, he pulled a muscle in his back while he was working as a mover, but the condition resolved within one week with rest and Ibuprofen. (T. 77-78) According to Petitioner, other than that, he had no treatment for any back problems between 2014 and 2018. (T. 78) Prior to October 9, 2018, Petitioner suffered an injury to his right ankle. (RX2) Petitioner was carrying boxes and walking down the sidewalk on June 29, 2014 when he damaged the ankle. *Id.* Treating doctors identified microfractures to the talus and calcaneus of the right ankle and Dr. Thomas Chorba recommended surgery, but Petitioner was unable to afford the procedure. *Id.* Instead, Petitioner treated his right ankle pain with Norco, Naproxen, Lidocaine and Lidocaine patches. *Id.*

Petitioner testified that he currently works for Freeman at McCormick Place. (T. 41) Petitioner explained that his job is to dismantle and set up booth works or furniture pieces for booth works for trade shows. *Id.* Petitioner indicated that at the time of the accident, Petitioner made $48.55 an hour working for Respondent. *Id.*

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:

In order for an accident to arise in the course of employment, it generally must occur within the time and space boundaries of the employment; and for an accident to arise out of one's employment, 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. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 672 (2003). In *Pintur v. Germann*, 183 Ill. App. 3d 763, 765-766 (1989), the court explained that:

> "The Illinois Supreme Court has defined the phrase 'in the course of the employment' as that within the period of employment at a place where the employee may reasonably be in the performance of his duties or engaged in something incidental thereto....As to the requirement that the injury 'arise out of' the employment, the Illinois Supreme Court has defined such an injury as one having its origin in some risk connected with, or incidental to, the employment....Among the injuries found not to be incidental to the employment are those which result from a personal risk, as opposed to a risk inherent in the claimant's work or work place."

In *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill. 2d 52, 58-59 (1989), the court explained:

> "Typically, 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. 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. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable." (Internal citations omitted.)

In this case, Respondent has stipulated that Petitioner was its employee on October 9, 2018. The fact that Petitioner was on his lunch break at the time of the accident does not change this result. "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2D 331, 339 (1980). Here, Petitioner remained on Respondent's premises while eating lunch; pursuant to *Eagle Discount*, eating lunch was therefore incidental to his employment. Furthermore, Petitioner's decision to sit against a crate during his lunch break is an act which an employee might reasonably be expected to do while working at McCormick Place setting up a show.

Additionally, the Arbitrator finds that Petitioner's testimony as to how the accident occurred credible and supported by the testimony of the other witnesses and the consistent histories of the accident provided to medical providers and examiners throughout Petitioner's treatment.

For the above reasons, the Arbitrator finds that Petitioner's accident arose both out of and in the course of Petitioner's employment with Respondent on October 9, 2018.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that all three witnesses to the accident testified that supervisors were notified of the accident immediately. Therefore, the Arbitrator finds that notice of the October 9, 2018 accident was provided in a timely manner.

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

Respondent disputes that Petitioner's current condition of ill-being is causally related to his work injury. The Arbitrator addresses each condition in turn.

Left Ankle

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

The Arbitrator finds that both Petitioner's credible testimony and the medical record establish a causal nexus between the October 9, 2018 accident and Petitioner's ongoing left ankle condition. The Arbitrator notes that Petitioner did not have any treatment for his left ankle prior to October 9, 2018, save for a left ankle fracture he had sustained as a child. Following the accident, by contrast, the evidence establishes that he was experiencing a lot of physical pain in his back, head, and left ankle. Petitioner's left ankle symptoms were substantial and he could not turn his left ankle certain ways without pain.

Additionally, the treating records consistently detail Petitioner's left ankle symptoms and problems following the October 9, 2018 accident, as do the diagnostic exams. Furthermore, Petitioner's treating physicians consistently opined that his left ankle condition was causally related to his work accident. At every visit, Dr. Peterson noted the cause/mechanism of Petitioner's left ankle condition as "traumatic work." Dr. League related Petitioner's ankle conditions to his injury a month-and-a-half prior. Dr. Pelinkovic opined to a reasonable degree of medical and surgical certainty that Petitioner's left lower extremity conditions were causally related to the work injury.

The Arbitrator notes that the Dr. Holmes was less clear in his opinions, finding that Petitioner's left ankle condition was related to findings on the MRI scan which demonstrating some fibrosis and scarring in the lateral ligaments, a small subtalar effusion and some fluid around the posterior tibial tendon. Ultimately, Dr. Holmes opined that these findings did not indicate trauma to the left ankle. The Arbitrator notes that the radiologist who took this MRI opined that these findings were consistent with healed moderate-grade sprains. The Arbitrator also notes that Dr. Holmes's opinion is not supported by Dr. Peterson's findings of positive results for an anterior drawer test and varus tilt test on the left ankle and observed mild crepitus. Therefore, the Arbitrator finds the findings and opinions of Petitioner's treating physicians more persuasive than the opinions of Dr. Holmes in this matter.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being in his left ankle is causally related to October 9, 2018 work accident.

Lower Back

The Arbitrator notes that Petitioner's back had been in good health for approximately four years prior to the date of accident, the last incident being a pulled muscle that resolved within one week. During the accident, a forklift smashed into the crate that Petitioner's back was braced against, causing his head to whip back and strike the crate. Coworker Jason Sauls testified that the corner of the crate hit Petitioner hard, as if he was on open ice and somebody body checked him. Immediately following the accident, Petitioner was in pain. Multiple

contemporaneous documents submitted into evidence show that Petitioner felt intense pain in his head and back following the accident and that he vomited twice after the accident.

The Arbitrator further notes that when Petitioner was able to see his PCP, Dr. Chorba, on October 16, 2018, Petitioner was still experiencing a lot of physical pain in his back, head, and left ankle. Petitioner described his back pain as sharp and stinging and indicated that his back felt stiff and he could not keep it fully upright. Subsequent medical records establish that Petitioner's back pain continued following the accident. Additionally, Dr. Pelinkovic opined that Petitioner's lower back condition was more likely than not causally related to the work injury and Dr. Novoseletsky opined that Petitioner's ongoing low back pain was a direct result of the work accident of October 2018.

The Arbitrator notes that while Dr. Graf opined that Petitioner's lumbar strain was not causally related, the reasoning for this conclusion was not adequately explained. Dr. Graf assessed Petitioner with a possible muscular strain but opined that it was not causally related because Petitioner had no objective findings on physical examination and had a normal MRI. Yet, Dr. Graf does not offer any explanation as to how muscle strain would appear on a spine MRI, nor does he address his own physical examination findings which included abnormalities of decreased sensation in the dorsal and lateral aspects of Petitioner's left foot versus normal sensation in his right foot and a supine straight leg raise test which produced left-sided hamstring pain on the left leg. As such, the Arbitrator finds the opinions of Dr. Graf less persuasive than the findings and opinions of Petitioner's treating physicians Dr. Pelinkovic and Dr. Novoseletsky in this matter.

Finally, the Arbitrator notes that Ward testified that he thought Petitioner said he was fine following the accident; however, the Arbitrator gives this testimony little weight. Ward testified that he could not remember exactly what Petitioner said and could not recall whether Petitioner was saying that he was not hurt or whether he was okay in some other sense. The Arbitrator will not speculate as to what Ward meant to say or convey.

Based on the evidence set forth above, the Arbitrator finds that Petitioner's current condition of ill-being regarding his lower back is causally related to the October 9, 2018 work accident.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims that he earned $98,488.00 in the year prior to the accident, with an average weekly wage of $1,894.00. Respondent asserts that Petitioner's average weekly wage is $505.07.

The Arbitrator notes that a printed Employee Pay History, entered as Respondent's Exhibit 5, from January 1, 2018 to October 9, 2018 showed Petitioner earning $1,894.00 across 32 total hours of work, from September 3, 2018 through September 23, 2018, a period totaling 21 days or three weeks. The document also indicates that Petitioner earned $757.60 during 8 hours of double time pay. Finally, the document reveals that Petitioner earned $47.35 per hour.

Pursuant to Section 10 of the Act, overtime and double-time pay should be excluded from calculation of Petitioner's average weekly wage. Petitioner testified that overtime was not mandatory for his work with Respondent and Petitioner did not provide any evidence regarding the number of hours he was required to work in a given day or week. Thus, the Petitioner's overtime pay is excluded from the average weekly wage calculation.

The Employee Pay History shows Petitioner worked 24 hours of regular hourly time and 8 hours of double-time. Taking Petitioner's $47.35 hourly rate and applying that rate to the 32 hours Petitioner worked, the total is $1,515.20.

The Arbitrator notes that the Employee Pay History does not indicate how many days Petitioner actually worked during the three-week period from September 3 through September 23, 2018. However, the document does establish that Petitioner appears to have lost five or more calendar days in the 52-week period preceding the alleged injury. Pursuant to the *Sylvester* decision, if an employee lost five or more calendar days during the 52 weeks preceding the injury, whether or not in the same week, his earnings for that year are divided by the number of weeks and parts thereof that he actually worked after the lost time has been deducted. *Sylvester v. Industrial Com'n,* 197 Ill.2d 225 (2001).

The Arbitrator notes that the evidence establishes that Petitioner lost more than five calendar days in the 52-week period preceding the accident and that he only worked for Respondent from September 3rd to September 23, 2018. As previously noted, the Employee Pay History shows wages earned for Respondent from January 1st to October 9, 2018. Thus, the second method of average weekly wage calculation pursuant to Section 10 of the Act is appropriate in this case.

Based on the evidence set forth above, the Arbitrator finds that, dividing Petitioner's earnings of $1,515.20 by the total weeks and parts thereof (three weeks), Petitioner's average weekly wage comes to $505.07.

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

Petitioner has $27,812.18 in outstanding medical bills and $31,848.93 paid by his significant other's Blue Cross/Blue Shield of Illinois policy. Respondent has not paid any medical expenses on this case.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records, the Arbitrator finds that Petitioner's medical services were reasonable and necessary. The Arbitrator finds that Respondent is liable for the $27,812.18 in related medical bills that remain outstanding, as well as $31,848.93 in related benefits from his significant other's Blue Cross/Blue Shield of Illinois policy.

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

The Arbitrator notes that on March 19, 2019, Dr. Peterson opined that Petitioner was suffering from a chronic lateral sprain to his left ankle, an ATFL tear, peroneal tendinitis with no tear and left ankle instability The Arbitrator also notes that Dr. Peterson discussed and recommended a left ankle arthroscopy with open Brostrom/Gould. Petitioner testified that he wishes to undergo the recommended surgery.

The Arbitrator notes that on August 14, 2019, Dr. Novoseletsky authored a letter of medical necessity opining that a left L2, L3, L4, and L5 lumbar medial branch radiofrequency neurotomy is medically necessary to treat Petitioner's facetogenic back pain and that each lumbar medial branch provided a positive diagnostic result when combined with Petitioner's reports of significant functional improvement, rendering him a good candidate for the procedure.

The Arbitrator further notes that Petitioner testified and the medical records indicate that Petitioner continues to suffer from left ankle and low back problems as a result of the October 9, 2018 accident.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records and Petitioner's credible testimony, the Arbitrator finds that Petitioner is entitled to prospective medical care, at Respondent's expense, for his conditions of ill being in accordance with the recommendations of Dr. Peterson and Dr. Novoseletsky

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

The Arbitrator notes that Petitioner was unable to work from October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018, totaling 7-1/7 weeks.

Based on the findings on issues "C," "E" and "F" above and the Arbitrator's review of the medical records and Petitioner's credible testimony, the Arbitrator finds that Petitioner is entitled to temporary total disability (TTD) benefits from October 23, 2018 to November 4, 2018 and from November 20, 2018 to December 26, 2018 (7-1/7 weeks). As such, the Arbitrator finds that Petitioner's TTD benefits owed total $2,405.07 (7-1/7 weeks x 2/3 x $505.07).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC010975
Case Name	SMITH, DEBBY B v. CARILLON AT CAMBRIDGE LAKES
Consolidated Cases	19WC026973
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0357
Number of Pages of Decision	27
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Michael Rothmann
Respondent Attorney	Kelly Kamstra

DATE FILED: 7/14/2021

/s/Marc Parker, 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debby Smith,

Petitioner,

vs.

No. 19 WC 10975, consolidated w/ 19 WC 26973

Carillon at Cambridge Lakes,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

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

Petitioner, a 63-year-old part-time fitness instructor employed by Respondent, filed two separate Applications for Adjustment of Claim. In claim #19 WC 10975 (this claim), she alleged that on October 30, 2018, she dropped an 8-lb. weight on her left foot. In claim #19 WC 26973, Petitioner alleged she sustained repetitive injuries on, "11/27/2018 TBD." Both claims were consolidated and tried together. At arbitration, Petitioner offered only one Request for Hearing

sheet (arbitration exhibit, AX1), in which she alleged sustaining accidental injuries on, "10/30/18 & prior."

The Arbitrator issued only one decision for both claims, finding that Petitioner's multiple conditions of ill-being were causally related to both of her claims. The Commission affirms that causation finding, but now issues a separate decision for each of Petitioner's claims.

The Arbitrator found Petitioner's average weekly wage (AWW) to be $303.79, which included Petitioner's stipulated AWW from Respondent of $158.65. However, the Arbitrator also included in Petitioner's AWW calculation an additional $145.14 per week, which she was paid while concurrently working part-time for another entity, the Center of Elgin.

Section 10 of the Workers' Compensation Act states in pertinent part, "when an employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation."

The Arbitrator expressly acknowledged that Petitioner's income from Center of Elgin was paid to her as an independent contractor, but believed the Appellate Court case, *Paoletti v. Industrial Comm'n,* 279 Ill. App. 3d 988 (1996), provided an exception to the provision that concurrent income must be from a concurrent "employer," and that the income be "wages."

The Commission views this issue differently than the Arbitrator. First, the plain language of Section 10 of the Act allows only wages from two or more employers to be considered in the AWW calculation. The Appellate Court has held that, when calculating the AWW of claimants having income from other sources, Section 10 of the WC Act protects, "persons who earn income from more than one job – as long as both jobs meet the definition of employer/employee under the Act." In *Dolce v. Industrial Comm'n,* 286 Ill. App. 3d 117 (1st Dist., 1996), the court ruled that the claimant therein was not considered an employee under the Act because of his independent contractor status with Post.

In addition, the Appellate Court in *Mansfield v. Ill. Workers' Comp. Comm'n,* 2013 IL App (2d) 120909 WC (2nd Dist., 2013), refused to include a claimant's earnings from self-employment in that claimant's AWW calculation. That court stated, "The employer contends claimant's business income should not be included in the calculation of the average weekly wage because it does not represent 'wages' earned while working for an 'employer.' We agree."

The *Mansfield* court considered the Tennessee decision *P&L Construction Co. v. Lankford, 559 S.W.2d 793 (Tenn. 1978),* which the *Paoletti* court relied upon to suggest an exception might exist which would allow concurrent earnings from work as an independent contractor to be included in the average weekly wage calculation. *Paoletti* suggested that such an exception might apply where, as in the present case, a claimant presents evidence of the wages earned by another employee of that company who performed duties similar to the claimant. However, the *Mansfield*

court ultimately rejected such an exception, stating, "we decline to further recognize an exception to this holding based on *Lankford*."

In the present case, there is no question that the income Petitioner received from the Center of Elgin was not wages paid to her as an employee. Given the *Mansfield* holding, the Commission finds the Arbitrator's reliance upon *Paoletti* misplaced, and that Petitioner's earnings from Center of Elgin should not have been used in the calculation of her average weekly wage. Accordingly, the Commission finds Petitioner's average weekly wage in this claim to be $158.65.

Finally, with regard to Petitioner's medical expenses, the Commission finds that the evidence supports a conclusion that all of the treatment Petitioner received for her causally related conditions was provided by Dr. Kazmer (Petitioner's first choice physician), Dr. Daniels (Petitioner's second choice physician), or treaters referred by them. Therefore, the Commission finds that none of Petitioner's treaters were outside the two-doctor chain of referral.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 17, 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 $158.65.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $158.65 per week for 65-5/7 weeks, for the periods commencing on December 1, 2018 through May 7, 2019, and from July 11, 2019 through May 8, 2020, those being the periods of temporary total incapacity from work under §8(b) 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 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.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is this case is remanded 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).

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,900.00. 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.

July 14, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-5/20/21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0357
NOTICE OF 19(b) ARBITRATOR DECISION

SMITH, DEBBY
Employee/Petitioner

Case# **19WC010975**
19WC026973

CARILLON OF CAMBRIDGE LAKES
Employer/Respondent

On 6/17/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2652 LAW OFFICE OF MARTIN L GLINK
MICHAEL ROTHMAN
1655 N ARLINGTON HEIGHTS RD
ARLINGTON HEIGHTS, IL 60010

1120 BRADY CONNOLLY & MASUDA PC
KELLY KAMSTRA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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
19(b)

Debby Smith
Employee/Petitioner

v.

Carillon of Cambridge Lakes
Employer/Respondent

Case # **19** WC **10975**

Consolidated cases: **19 WC 26973**

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, under emergency provisions and procedures enacted by the Commission and after pretrial with the parties failed to resolve the issues, by the Honorable **Paul Seal**, Arbitrator of the Commission in the city of **Chicago** on **5/8/2020**. 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. ☒ 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, prior to and **10/30/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,346.00**; the average weekly wage was **$303.79**.

On the date of accident, Petitioner was **63** 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 **$3,300** for TTD, $ for TPD, $ for maintenance, and **$529.90** for other benefits, for a total credit of **$3,829.90**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following medical providers, as set forth in Sections 8(a) and 8.2 of the Act: Illinois Bone and Joint: $400; Loyola Hospital: $4,025; Loyola Physician: $1,117.00; Ill. Pain Institute: $9,968.00; Pinnacle Anesthesia: $2,231.00; OrthoIllinois: $1,497.00; Midwest Bone & Joint: $2,376.00; Zimmer BioMet: $5,270.00; Progressive Radiology $1,210.00; Access Neurocare $2,420.00; Northern Ill. Foot and Ankle: $6,197.51; Northwestern $386.00; Shirley Ryan Lab $2,128.00; Sherman Hospital: $1,499.00; Midwest Anesthesia and Pain $1,075.00; and shall reimburse Petitioner for copays for Osco drugs $72.30 and Dick Pond Athletics: $478.28.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 65 5/7 weeks, commencing on December 1, 2018-May 7, 2019, and again July 11, 2019-May 8, 2020, for a total of $14,457.14 as provided in Section 8(b) of the Act. Respondent shall be given a credit of $3,829.90 for temporary total disability benefits that have been paid.

Penalties and attorneys fees 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

June 14, 2020
Date

ICArbDec19(b)

FINDINGS OF FACTS

On October 30, 2018, Petitioner, Debby Smith, (Smith) was an employee of Respondent, Carillon of Cambridge Lakes (Carillon). She started working for Carillon on April 4, 2017 as the fitness coordinator and physical fitness trainer through January 2018 and as a fitness trainer between January 2018 and December 1, 2018. Her duties included setting up the fitness classes, moving chairs and equipment in and out of the room, as well as instructing the classes in low and high impact classes, ranging from kick classes, pilates, yoga, dance and cardio mix classes, aqua classes (on the concrete around the pool), boot camp, etc.. Trx at 21-33. Even when teaching chair classes, she was required to push off with her feet and toes and perform exercises while standing. *Id.* at 29. The parties stipulated that Smith's AWW at Carillon for the year prior to October 30, 2018 was $158.65.

During this time, Smith also was worked as an independent contractor, at the Centre of Elgin, teaching similar classes. For the year prior to October 30, 2018, she worked 49 weeks, made $7,112, which equates to an AWW of $145.14. Trx, at 34-41; PEx.24. She was paid hourly at a rate consistent with what employees at Elgin with her experience and certifications would get paid. She was paid as an individual and not as a business. Trx at 34-41.

Preexisting conditions:

In 1974, Smith had a left knee meniscectomy. Trx at 41. She worked as a fitness trainer from 1984 through October 30, 2018. *Id.* at 18. No doctor restricted her from teaching classes through October 30, 2018. *Id.* at 41-42. On July 26, 2018 she saw Dr. Daniels for intermittent mild left knee pain with activity, which she attributed to playing tennis. She has some knee swelling, varus test was stable and x-rays shows she had bone on bone arthritis. PEx 9 at 11. He diagnosed her with unilateral osteoarthritis of the left knee and prescribed over the counter pain medication. PEx. 8 at 26, PEx 9, 8-9. Since she had bone on bone arthritis, she was a candidate for a knee replacement. Surgery would only become necessary based on her symptoms and limitations; she did not schedule surgery. PEx 9 at 12-13. He recommended activity modification, which meant that if it hurt, she should not do it. *Id.* at 32. On August 2, 2018, Smith told Dr. Daniel's office that she was considering left knee surgery but, wanted to hold off as long as possible and continue to be active, teach classes, and play tennis. PEx. 8 at 24. On August 2, 2018, Dr. Daniels did not restrict her from teaching classes. PEx. 9 at 14. She had a second opinion with Dr. Berger who gave her the same recommendations. Trx at 87. She played tennis and was able to teach and perform daily activities, despite intermittent mild knee pain through October 30, 2018. *Id.* at 45.

On July 26, 2018, she also complained of left ankle and left foot pain to the outside of her foot and only when wearing a shoe, not with activity. Ex. 8 at 26. Dr. Daniels did not treat or make any recommendations. PEx. 9 at 10. No other records show any left foot complaints prior to October 30, 2018. There is no evidence she had any preexisting back problems or right hip pain or conditions.

Accident:

On October 30, 2018, while working at Carillon, an eight pound weight fell on Smith's left foot and big toe. She reported the injury to her supervisors and filed an incident report. PEx27; Trx at 52. On October 31, 2018, she went to OrthoIllinois emergency clinic and was diagnosed with a left foot and

big toe joint contusion, prescribed a ridged sole shoe and to perform activities as tolerated. PEx. 8 at 20-22; PEx9 at 31. She continued to teach classes for Respondent through December 1, 2018. Trx 57-58.

On November 7, 2018, she saw Dr. Kazmer, complaining that weightbearing and walking caused increased foot pain and swelling. He diagnosed a left foot contusion and prescribed an orthotic walker for her back and left knee pain, a boot, reduce activity and minimal weight bearing. PEx6 at 6-7. On November 14, 2018, he diagnosed a metatarsal injury with swelling, tenderness and clicking and prescribed a boot and MRI. *Id.* at 8. A November 21, 2018 left foot MRI showed a nondisplaced fracture of the medial base of the big toe. PEx11 at 2. On November 28, 2018, Dr. Kazmer prescribed orthotics, a boot for 4-8 weeks, and minimize weight bearing. PEx.6 at 11. He excused her from work. *Id.* at 19.

On December 27, 2018, Smith complained to Dr. Daniels of the work injury and worsening knee pain with activity and pain with rest (4/10). PEx.8 at 17; PEx9 at 15-16. On exam, varus test was unstable with pain (lateral collateral ligament pain), and she was limping, which she had not been on the July 26, 2018 visit. PEx. 9 at 16, 38. He prescribed a medial unloader brace and to follow up with Dr. Kazmer. PEx.8 at 18. He testified that patients with osteoarthritis who limp could have increased collateral ligament pain. PEx9 at 17. He recommended a medial unloader brace for the increased pain, which was not prescribed prior to October 30, 2018. *Id.* at 18. The brace was not approved by workers compensation and she never received it. Trx at 106, 111. Dr. Daniels advised her to hold off knee surgery until the foot injury resolved. P.Ex. 8 at 18; PEx9 at 19.

On January 2, 2019, Dr. Kazmer noted she fell going into the shower. PEx6 at 21. Smith testified she was getting into her shower and when she stepped down with her left foot, she felt sharp pain in her left foot through to her knee. She did not slip or fall down to the ground but fell forward onto the seat in the shower. Trx 59-60. Dr. Kazmer did not believe x-rays were necessary and diagnosed her with the initial foot contusion and toe fracture, with no mention of aggravation by the shower incident, and recommended therapy and for her to be off work. PEx.6 at 21, 23. She did not have knee instability before the October 30, 2018 work injury. *Id.* at 27.

Smith treated at Huntley physical therapy from January 16, 2019 through February 1, 2019 and had the following complaints and symptoms: 1) increased pain with difficulty maintaining balance; 2) abnormal gait, decreased balance, strength, and ability to walk; 3) use of boot increased knee pain; 4) big toe and foot pain with numbness and burning; 5) on neuro exam, left foot Tinel's and Tarsal tunnel test were positive with pain; 6) numbness and tingling during therapy along the great toe, metatarsal joint and plantar fascia; 7) foot pain with activity and getting into and out of her bath, difficulty going up and down stairs, walking, standing, sit to stand, carrying objects three or more feet, and pulling and pushing; and 8) increased sensitization in the forefoot with positive Tinel's sign. The therapist advised Dr. Kazmer that Smith was not responding to desensitization therapy, therefore, on February 4, 2019, Dr. Kazmer diagnosed her with toe and neuritic (shooting/burning) pain which had increased with therapy and discharged her from therapy. PEx2 at 5, 8, 9, 15, 17, 19, 21 23, 28; PEx.6 at 31.

On February 21, 2019, Dr. Holmes performed an IME for Respondent. X-rays confirmed that the toe remained fractured and he diagnosed her with a work related big toe fracture, recommended bigger shoes, return back to work with no jumping and that she would be MMI in two weeks.

On March 13, 2019, Dr. Kazmer diagnosed her with chronic pain and continued her off work until further notice. PEx.6 at 29, 43. On April 3, 2019, he referred her to Dr. Schiff. *Id.* at 32.

On March 13, 2019, Respondent terminated Petitioner's TTD and medical benefits. Trx at 63.

On April 9, 2019, she saw Dr. Schiff, an orthopedic foot surgeon at Loyola, for left foot, big toe and 2nd toe pain. He suspected a plantar plate injury, indicated that the plantar plates were hard to visualize on the November 21, 2018 MRI, and therefore prescribed an ultrasound. Indication was foot trauma. PEx.3 at 3, 6. The April 24, 2019 ultrasound showed a neuroma bursal complex and 2nd and 3rd digit plantar plate tears. *Id.* at 5-6. Dr. Schiff diagnosed her with 2nd and 3rd plantar plate tears and recommended orthotics, a brace, and if conservative treatment failed, plantar pate surgery. He diagnosed her with a left plantar plate injury and kept her off work. *Id.* at 13.

On April 26, 2019, Dr. Daniels noted she had worsening knee pain and was using a lidocaine patch and tramadol. He recommended conservative treatment, advised her to return in a year and referred her to Dr. Vora for foot pain. PEx.8 at 8-9. On May 6, 2019, Smith saw Dr. Vora, at Illinois Bone and Joint, complaining of persistent burning, pain, numbness and tingling in her foot which started after the October injury. Dr. Vora diagnosed left metatarsalgia, 2nd and 3rd plantar plate injury and recommended a metatarsal pad to offload the foot, anti-inflammatories, symptomatic management, and possible surgery. PEx.1 at 3-4.

Dr. Schiff's May 7, 2019 notes referenced the October 30, 2018 work incident and plantar plate left foot injury. PEx.3 at 18, 19. He believed some of her pain was nerve related and recommended pain management. *Id.* at 19. Smith asked to be returned to modified duty because workers compensation had terminated her benefits. Trx at 65. Dr. Schiff returned her to work with restrictions of no barefoot work and to sit as needed. PEx.3 at 19.

Since Dr. Vora was in Libertyville, an hour from Smith's home, on May 30, 2019, Dr. Daniels referred her to Dr. Fliman, at Northwestern Huntley, for pain management. Trx at 66-67. On June 5, 2019, she advised Dr. Fliman that since October 30, 2018 she began to have low back, thigh and buttock pain and worse knee pain. PEx.19 at 1. She reported new right upper buttock pain since returning to work. *Id.* at 1. Dr. Fliman opined that the work related toe fracture caused her to limp, which exacerbated the preexisting left knee arthritis and caused lumbar and bilateral hip pain, which should resolve once the foot recovered. Dr. Fliman referred her back to Dr. Schiff for the foot and recommended no weightbearing for the knee. *Id.* at 2.

Dr. Fliman left her practice the day after she saw Smith (Trx at 67), therefore, on June 14, 2019, Dr. Daniels referred her to Dr. Dickey. PEx.8 at 7-8. Dr. Dickey's June 20, 2019 records indicate that Smith used her toes at work. PEx16 at 9-10. The June 20, 2019 x-rays showed a big toe fracture and abnormality at the ball of her foot. *Id.* at 11. Dr. Dickey referred her to Dr. Daniels for left knee pain and to pain management for left foot nerve damage. PEx15 at 10-13, PEx.16 at 12. Dr. Dickey prescribed a left foot MRI, EMG, and CAM walker boot. PEx15 at 13.

The June 21, 2019 left foot MRI showed a bone contusion with nondisplaced great toe fracture extending to the medial and plantar surface, and a Morton's neuroma 2nd interspace extending to plantar. PEx.15 at 1-2. Dr. Dickey explained that a Morton's neuroma is a thickening of the nerves

between the bones of the feet and can cause numbness, radiating and tingling pain. PEx16 at 18-19. On July 3, 2019, Dr. Dickey noted Smith was struggling and increased her restrictions to non-weight bearing and only chair/bench ball exercises until further notice. PEx15 at 20, 53.

On July 11, 2019, Smith complained of new right hip pain. Dr. Dickey noted that despite restricting her from standing at work she had to stand and was limping. PEx.15 at 24. Dr. Dickey testified that if Smith was able to perform seated work, that would have met her restrictions. PEx16 at 47. However, Smith testified that even with chair exercise restrictions, she was required to stand, walk, set up the exercise room, and perform exercises involving pushing up with her foot and ankle and had to favor her right leg over her left. Trx at 69-70.

On July 11, 2019, Dr. Dickey diagnosed her with right sided sciatica, left foot pain, edema, and a nonunion left big toe fracture. PEx.16 at 22-23; PEx15 at 26. She recommended a bone stimulator, immobilization, and CAM boot. PEx16 at 23. As a result of the exacerbation of back and knee pain and sciatica, she prescribed a surgical shoe and carbon fiber plate, Medrol Dose Pak, took her off work, and referred her to Dr. Prunskis for foot, back and hip pain. *Id.* at 23-24.

On July 18, 2019, Dr. Daniels noted increased knee pain at rest (6/10), with weakness, clicking, instability, popping and swelling, and recommended therapy. PEx.8 at 3-4. On July 18, 2019, Dr. Dickey noted that the bone stimulator and Medrol dose pack was helping. PEx.15 at 27-28.

On July 23, 2019, after reviewing the left foot MRI, Dr. Schiff diagnosed a non-healed big toe fracture and neuroma, and noted continued pain, numbness, and tingling in her foot. PEx.3 at 27. He opined she had a left plantar plate injury and referred Smith to Dr. Dickey. *Id.*

On July 30, 2019, she saw Dr. Prunskis at Illinois Pain Institute, for left foot and left knee pain with a history of a work accident crush injury on October 30, 2018. PEx.5 at 32. He noted that weightbearing increased her pain. *Id.* She had an antalgic gait, straight leg raise was positive on right. *Id.* at 33. He diagnosed a Morton's neuroma, right leg radiculitis and prescribed a left Morton's neuroma injection, lumbar MRI, left leg EMG. *Id.*

An August 1, 2019 x-ray showed the toe fracture healing. An August 16, 2019 EMG, prescribed by Dr. Dickey, showed L5 radiculopathy. PEx16 at 25-27; PEx.15 at 32; PEx14. An August 2, 2019 lumbar MRI showed an L4-5 broad based disc bulge with minimal bilateral neural foraminal narrowing and lumbar spondylosis. PEx18.

On August 20, 2019, Dr. Holmes provided an addendum IME report, noting that Smith's current foot complaints as seen in the MRIs are consistent with her activities as a 63 year old fitness instructor. He opined that the current condition with the great toe was related to the injury and that treatment for it was causally related to the October injury. However, he found she could return to work full duty and noted that, contrary to MRI and x-ray's actual findings, the new MRI and x-rays did not demonstrate structural problems. He recommended she purchase larger size orthotic shoes which was related to the injury.

On August 27, 2019, Dr. Prunskis noted continued constant burning, tingling low back pain radiating down her right leg, made worse by walking, as well as knee and foot pain. He recommended lumbar epidural nerve blocks on the right and left knee MRI. PEx.5 at 31.

On September 26, 2019, Dr. Dickey noted increased knee pain and continued left foot pain; a healing left great toe fracture (per the September 25, 2019 MRI), and recommended compression, rest, surgical shoe and carbon fiber plate, and bone stimulator. PEx15 at 44-46.

On October 3, 2019, Dr. Prunskis noted low back pain radiating down the right leg, and constant left foot pain aggravated by walking. He performed L4 and L5 nerve block and recommended a Morton's neuroma injection. PEx.5 at 25-26. On October 17, 2019, Dr. Prunskis noted she was in constant pain which was affecting her right and left hip, made worse with walking and exercise. He diagnosed her with lumbar radiculitis and low back pain, left foot Morton's neuroma and recommended an L4 and L5 epidural nerve root blocks. *Id.* at 19. He noted that the last knee MRI showed "further" degenerative changes. *Id.* at 19. On October 28, 2019, he kept her off work until further notice. *Id.* at 97.

On October 31, 2019, Dr. Dickey prescribed a CT scan, ultrasound, and kept her off work. PEx15 at 47-49, 54, 60. The November 14, 2019 ultrasound showed a neuroma and 2nd and 3rd digit plantar plate tears. PEx3 at 59; PEx16 at 35-36. Dr. Dickey testified that the plantar plate ligament connects the toe to the foot metatarsal and stabilizes the toe and since it has not healed, she was a candidate for plantar plate surgery. *Id.* at 36-37.

The November 14, 2019 left foot CT scan showed a healed big toe fracture which now had sclerosis of the hallux sesamoids. PEx 3 at 46-47. Dr. Dickey testified that as a result of the toe fracture, the big toe joint experienced increased pressure and inflammation and is starting to show signs of arthritis. PEx16 at 38-39.

On November 21, 2019, Dr. Prunskis noted continued knee and foot pain and back pain, while improved, was aggravated by standing and walking. PEx5 at 13. He diagnosed her with lumbar radiculitis, left Morton's neuroma, and performed a L4 and L5 epidural nerve blocks. He recommended a fourth lumbar epidural and a Morton's left foot neuroma injection, and a left knee MRI. *Id.* A December 7, 2019 left knee MRI confirmed left knee osteoarthritis. PEx.7.

On December 19, 2019, Dr. Pontinen, at Midwest Anesthesia Pain Specialist, saw her per referral from Dr. Dickey, to rule out RSD. Rx.11 at 6. He opined she had left foot, left knee and low back pain following a work injury but did not suffer from CRPS and kept her off work. *Id.* at 9. On December 23, 2019, Dr. Rakic from the same office, opined she did not have CRPS and that she had great toe and Morton's neuroma pain. *Id.* at 14. While he noted the dumbbell falling on her foot did not cause left knee arthritis or sciatica, he did not indicate whether or not limping could have aggravated or increased her pain. *Id.* at 15.

On January 17, 2020, Dr. Dickey referred her to Dr. Margolis at Shirley Ryan. PEx15 at 67-69. February 7, 2020 records note the October 30, 2018 work injury with gradual increase in limping and increase in knee and ankle pain and that wearing the boot increased back and hip pain. PEx. 20 at 1. She complained of big toe pain, numbness and swelling and pain to the top of her foot. *Id.* at 3. Dr. Margolis opined she did not have CPRS, but diagnosed central sensitization, knee pain, low back pain with a history of work related crush injury and neuroma. *Id.* at 5. He prescribed therapy, off work and Lyrica and lidocaine patches. *Id.*

On March 27, 2020, Dr. Dickey noted Smith's purchase of shoes for orthotics. PEx.15 at 73, PEx17. On April 14, 2020, Dr. Dickey referred her to Shirley Ryan and prescribed a gate analysis. *Id.* at 76, 83-84. On May 6, 2020, Dr. Dickey noted continued left foot, knee and right hip pain and that Smith suffered a crush injury that likely damaged some nerves in her foot and kept her off work. *Id.* at 85.

Dr. Dickey's testimony

Dr. Dickey, a board certified podiatrist and foot and ankle surgeon, explained that if the big toe is injured, balance, propulsion, and gait is altered. PEx16 at 4-6, 16. She related the left foot pain and big toe fracture to the October 30, 2018 accident and opined that Smith's years of fitness instruction through June 20, 2019 could have caused or contributed to the Morton's neuroma and plantar plate tears. *Id.* at 17, 19, 37. She opined that her bills were reasonable, necessary, and related to the October 30, 2018 work injury. *Id.* at 37.

Dr. Dickey testified that Smith had a lot of wear and tear from the years of fitness training through June 20, 2019 which contributed to the findings of the June 26, 2019 left ankle MRI which showed peroneal tendinitis, mild peroneal tenosynovitis, myotendinous of the Achilles tendon, superficial and deep retrocalcaneal bursitis, and increased fluid posterior and plantar heel pads. PEx15 at 3-5; PEx16 at 20-21, 55. Smith's peroneal tendinitis was an overuse injury. PEx.16 at 21. Respondent objected to these opinions per *Ghere,* however, they were consistent with the notice of evidence deposition, which stated that her years of teaching fitness contributed to the foot pain and diagnosed conditions. PEx15A.

Dr. Dickey also opined that the boot and abnormal gait secondary to the toe fracture contributed to her back pain, radiculopathy, and left knee pain. PEx15 at 13, 29-30, 34, 54. The basis for her opinion was her training in biomechanics and orthotics and how they apply to reactive forces. She explained that wearing orthotics helps send forces straight up and down the legs to the back which reduces back and knee pain and provide better alignment. *Id.* at 28, 33. She has treated patients with leg and feet misalignment with resultant back and knee pain and radiculopathy, for whom she has prescribed orthotics. *Id.* at 28-29, 33.

While Dr. Dickey admitted Smith's left leg was shorter than the right, which could cause her to limp and that the orthotic were to address both the fracture and misalignment, she testified that the foot and toe injuries could have aggravated her preexisting left leg discrepancy and increased her pain. *Id.* at 45, 47, 60. Dr. Dickey opined that Smith was a compliant patient who wanted to get better and return to work. PEx16 at 30, 58.

Dr. Holmes' testimony.

Dr. Holmes, an orthopedic surgeon, performed an IME on February 21, 2019. Rx5 at 4, 6. He took x-rays which showed a minimally displaced great toe fracture, meaning it had not healed. *Id.* at 11, 35, 50. She had swelling and pain over the top of her foot, was using Tramadol and Advil, and orthotics. *Id.* at 34. He diagnosed her with a fracture of the great toe related to the October 30, 2018 accident. *Id.* at 12-13. He returned her back to work with no restrictions, despite not knowing

what fitness classes she was teaching. *Id.* at 13, 46. He prescribed shoe modifications to fit the orthotics better and related it to her work injury. *Id.* at 13, 35.

On February 21, 2019, Dr. Holmes also noted positive Tinel's sign, tingling nerve pain in the left foot. *Id.* at 37-38. In a report to the adjuster, he indicated she was restricted from jumping for two weeks because of continued big toe pain. *Id.* at 39. In addition to the bigger shoe recommendation, he recommended that she needed a stiff sole for more support, since her current orthotics were inadequate. *Id.* at 40. He also recommended a plus/minus Morton's extension. *Id.* at 41. The Morton's extension, also recommended on August 20, 2019, helps toe fractures heal. *Id.* at 45-46.

On August 20, 2019, Dr. Holmes opined she was suffering from metatarsalgia, bursitis, neuroma, and plantar plate tears. *Id.* at 14-15. The metatarsalgia was related to the plantar plate tears and neuroma. *Id.* at 16. Dr. Holmes opined that the October 30, 2018 injury did not cause the plantar plate tears because her initial complaints of pain were limited to the great toe, not the metatarsals. *Id.* He admitted Respondent never sent him the physical therapy records. *Id.* at 41.

Dr. Homes opined she had a Morton's neuroma, inflamed nerve between the metatarsals, which causes numbness, burning and sharp pain, which worsened with walking. *Id.* at 17. He opined that the plantar plate tears, the neuroma, the peroneal tendon tenosynovitis, the retro calcaneus bursitis were not related to the October 30, 2018 work injury, but instead related to her occupation as physical fitness instructor. *Id.* at 19, 42-43, 49. The outer foot pain she complained of on February 21, 2019, could be peroneal tendonitis. *Id.* at 34. He opined the treatment for the big toe fracture through the date of his 2nd report was reasonable and related to the work injury. *Id.* at 19.

Despite Dr. Holmes' February 21, 2019 x-rays showing a big toe fracture and his admission it was fractured, Dr. Holmes also testified the toe was not fractured, otherwise he would not have sent her back to work, and that he was just "being a nice guy by saying no jumping for two weeks." *Id.* at 39-40. Dr. Holmes admitted that the June 21, 2019 MRI showed a nondisplaced fracture and that as of August 20, 2019 he could not state whether the big toe fracture had healed. *Id.* at 43-44. He admitted that if x-rays showed the fracture had not healed, a bone stimulator could be helpful, but that Respondent did not provide him with x-rays to review. *Id.* at 44. He also admitted that CAM walker boots also help treat broken big toes. *Id.* at 46.

Dr. Holmes agreed that an injured great toe could compromise balance and cause someone to limp, which can cause excessive force and increase plantar plate loading. *Id.* at 21, 24-27.

Dr. Mark Levin' testimony:

Dr. Mark Levin, a board-certified orthopedic surgeon, testified that he saw Smith on February 26, 2019. She worked 6-12 hours per week as personal trainer at Carillon and 4-10 hours per week at Centre of Elgin. *Id.* at 10. She complained that the knee pain increased a month after the October 2018 injury because of her antalgic gait. *Id.* at 10-11. She had preexisting knee issues and reported that her knee buckled in the bathroom. *Id.* at 11, 52.

Dr. Levin opined that she had degenerative left knee arthritic pain which predated the October 30, 2018 injury and that her limping did not cause the pain. *Id.* at 19. The basis for his opinion was that she required a knee replacement prior to October 30, 2018. *Id.* at 19. He opined that the films

do not show an aggravation of her osteoarthritis. *Id.* at 20. However, he admitted that knees are vulnerable to stress and wear and tear. *Id.* at 31. He admitted that running, jumping, squatting, high intensity aerobics or other physical activities stresses the knees. *Id.* 35, 37. Knee osteoarthritis can arise from overuse. *Id.* at 41. While he testified, she did not have a repetitive injury to her knee, he did not know how long she had been a personal trainer. *Id.* at 46. He opined that work restrictions would be based on her pain level. *Id.* at 21, 58.

He opined she was a candidate for total knee replacement before and after October 30, 2018, and it would be up to her when to have it done, since patients delay surgery if not in pain. *Id.* at 22, 49-51. He admitted that despite the surgery recommendation, prior to October 30, 2018 the pain was mild, and she was able to teach her physical fitness classes, bend, run, and play tennis through October 30, 2018. *Id.* at 52. No doctor prior to October 30, 2018 restricted her from working as a physical fitness trainer or playing tennis; significantly, he had no problem with her doing those activities prior to October 30, 2018. *Id.* at 56. Dr. Levin admitted she never scheduled knee surgery before October 30, 2018 and that surgery has to wait until after her foot recovers. *Id.* at 49, 57.

Dr. Daniel's testimony:

Dr. Daniels, an orthopedic surgeon specializing in hip and knee reconstruction, and who has performed approximately 7,000 knee replacements as well as treating back, spine and hip complaints, noted that Smith's October 30, 2018 work injury caused a gait abnormality which aggravated her preexisting knee osteoarthritis. PEx. 9 at 5-6, 19, 26. He explained that patients usually do well with arthritic joints, but that a change in gait can cause increased pain; and in her situation, she was maintaining her preexisting knee arthritis but that the injury, boot and limping aggravated her arthritic knee. PEx9 at 20. When he saw her prior to the October 30, 2018 injury, she was not limping and did not have varus instability. *Id.* at 38. The left foot and knee pain caused her to limp, and along with use of the boots, could affect the hips and back. *Id.* at 25-26. He also opined that her activities as a personal trainer since 1984 through the date he first saw her, July 2018, contributed to her left knee arthritis. *Id.* at 22- 23. Dr. Daniels referred her to Dr. Kazmer, Dr. Fliman and Dr. Vora. *Id.* at 31, 38. The bills were reasonable customary and necessary. *Id.* at 26.

CONCLUSIONS OF LAW:

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (C) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts as if stated herein. This Arbitrator finds that on and prior to October 30, 2018, Petitioner suffered an accident which arose out of and in the course of Petitioner's employment by Respondent. In support thereof:

An injury "arises out of" one's employment if, at the time of the occurrence, the employee was performing which the employee might reasonably be expected to perform incident to her assigned duties. *Sisbro, Inc. v. Industrial Com'n,* 207 Ill.2d 193, 204 (2003), *citing Caterpillar Tractor Co. v. Industrial Com'n,* 129 Ill.2d 52, 58 (1989). 'Arising out of' refers to the origin or cause of the

accident and presuppose a causal connection between the employment and the accidental injury and in order for an injury to come within the act it must have had its origin in some risk connected with, or incidental to, the employment, so that there is a causal connection between the employment and the injury. *Chmelik v. Vanna,* 31 Ill.2d 272 (1964). "In the course of the employment,' refers to time, place and circumstances under which the accident occurred, and it is stated generally that an accidental injury is received in the course of the employment when it occurs. within the period of employment at a place where the employee may reasonably be in the performance of her duties, and while she is fulfilling those duties or engaged in something incidental thereto. *Id.* "When workers' physical structures 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, 434 (1982).

On October 30, 2018, while setting up a fitness class for Respondent, a weight fell on Petitioner's left foot and big toe. Respondent's dispute on this point is unreasonable. As to the repetitive nature of her claim, Petitioner taught low and high impact classes for Respondent from April 4, 2017 through December 1, 2019. Dr. Holmes opined that the findings in the foot and ankle MRIs were a result of the repetitive nature of her occupation as a physical fitness trainer. Dr. Daniels and Dr. Dickey agreed these findings were a result of her occupation through the dates they first saw her, in July 2018 and June 2019, respectively. Dr. Daniels also opined that the left knee osteoarthritis was aggravated and contributed to by her occupation through June 2018. Moreover, Petitioner's left foot, left knee, low back and right leg radiculopathy were aggravated by her return to work for Respondent, between May 7, 2019 and July 11, 2019, as set forth above. Thus, Petitioner's duties for Respondent contributed to the left knee, back and foot conditions that she treated for after October 30, 2018.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (E) WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. This Arbitrator finds that Petitioner gave timely notice to Respondent. In support thereof:

Petitioner reported the October 30, 2018 work injury to her supervisors both orally and in writing. PEx 27; Trx. at 52-53. As to the repetitive complaints, her medical records from October 31, 2018 through February 21, 2019, which Respondent were in possession of and provided to Dr. Holmes, demonstrate that Petitioner's left foot, big toe and left knee worsened while she worked in November 2018 and thereafter. While Dr. Holmes disputed that the October 30, 2018 work injury caused the other foot injuries, in his August 20, 2019 supplemental report he opined they were related to the repetitive nature of her occupation as a fitness trainer. Petitioner filed a 2nd Application for Adjustment of Claim on September 17, 2019.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F) WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. This Arbitrator finds that Petitioner's present conditions of a fractured left big toe and sclerosis and

posttraumatic arthritis of the big toe hallux sesamoids, chronic left big toe and left foot pain and central sensitization, aggravation of left knee osteoarthritis, low back pain, right sided radiculopathy, and bilateral hip pain are related to the work related crush injury on October 30, 2018. This Arbitrator further finds that Petitioner's left knee osteoarthritis, peroneal tendinitis, peroneal tenosynovitis, myotendinous of Achilles tendon, retrocalcaneal bursitis, left foot Morton's neuroma, left foot 2nd and 3rd plantar plate tears are related to her increased limping as a result of the October 30, 2018 work injury and her years of being a personal trainer, including while working for Respondent.

Left big toe:

The treating physicians and Dr. Holmes opined that the October 30, 2018 injury caused the left big toe fracture. The fracture did not heal until November 2019. Recent films show arthritic changes in the big toe. Dr. Dickey's uncontradicted opinion was that the arthritic changes are related to the long term pressure that the big toe experienced during the delayed healing. For these reasons, this Arbitrator finds that the left big toe fracture and hallux sclerosis shown in the November 2019 CT are related to the October 30, 2018 work injury.

Left foot:

Per the June 26, 2019 MRI, Petitioner also suffers from peroneal tendinitis and tenosynovitis, myotendinous of Achilles Tendon, retrocalcaneal bursitis, left foot Morton's neuroma, and left foot 2nd and 3rd plantar plate tears. Dr. Dickey and Dr. Holmes opined that Petitioner's occupation as a physical fitness trainer, including her work duties through June 2019, which includes working for Respondent, caused or contributed to these findings. Dr. Schiff and Dr. Vora, who noted the October 30, 2018 work injury, indicated she suffered plantar plate tear injury. No doctor related the injuries to any other cause, including the December 24, 2018 shower incident. She did not slip or fall to the ground. Regardless, having increased pain while stepping into the shower, with a broken big toe, foot pain and decreased balance and ability to bear weight, does not rise to the level of an intervening accident. *International Harvester Co. v. Industrial Com'n*, 46 Ill.2d 238, 245 (1970); *Lasley Construction Co. v. Industrial Com'n,* 274 Ill.App.3d 890, 893 (1995); *Teska, v. Industrial Com'n,* 266 Ill.App.3d 740, 742 (1994). Based on Dr. Holmes' and Dr. Dickey's opinion, this Arbitrator finds that the conditions are related to the October 30, 2018 work injury and her occupation with Respondent.

Petitioner's foot pain continued to get worse since the October 30, 2018 injury, including the month she worked between October 30, 2018 and December 1, 2018. Dr. Kazmer, Dr. Vora and Dr. Holmes diagnosed metatarsalgia, as early as November 7, 2018. Physical therapy, Dr. Kazmer and Dr. Holmes noted nerve pain. Dr. Prunskis, Dr. Margolis at Shirley Ryan, Dr. Pontinen, Dr. Rakic, Dr. Dickey indicate continued chronic foot pain. While the doctors did not diagnose CRPS, they diagnosed crush injury, chronic left foot pain from central sensitization, plantar plate tears, metatarsalgia, and Morton's neuroma. For these reasons, and those above, this Arbitrator finds that the left foot 2nd and 3rd plantar plate tears, metatarsalgia, Morton's neuroma, chronic left foot pain, central sensitization, and left big toe and 2nd toe pain are related to the October 30, 2018 work injury and her duties as a physical fitness trainer for Respondent.

Left Knee:

Petitioner's left knee osteoarthritis preexisted the October 30, 2018 work injury. Yet, despite being a candidate for a left total knee replacement prior to October 30, 2018, Petitioner was managing with mild knee pain, and continued to teach her high and low impact fitness classes, play tennis, and perform daily activities. She had no knee instability and her varus test was negative. After the October 30, 2018 work injury, she continued to set up and teach fitness classes until December 1, 2018. Petitioner began to limp more, had difficulty walking and maintaining balance. Her knee pain worsened after the October 30, 2018 work injury through present. Petitioner began taking Tramadol, Lidocaine patches and other prescription medication, whereas previously the knee pain was controlled by ice and Advil. She began having lateral collateral ligament pain and was prescribed a medial knee brace, whereas prior to October 30, 2018 it had not been prescribed.

This Arbitrator finds Dr. Daniels' opinions more persuasive than Dr. Levin's. Dr. Daniels opined that Petitioner was managing her symptoms but that the October 30, 2018 injury and the limping and wearing of a boot aggravated her left knee pain. He also opined that her years of being a fitness trainer through June 2018 when he first saw her, contributed to her left knee arthritis. He explained that, while prior to the accident she was a candidate for knee surgery, when surgery became necessary would be based on her symptoms and functioning. Prior to the accident, surgery was not necessary, given her mild pain levels and ability to perform work and life activities.

Dr. Levin opined that her limping did not increase her knee pain, which is contradicted by the records. While he opined the accident did not aggravate her osteoarthritis, he admitted that knees are vulnerable to stress and wear and tear, that running, jumping, squatting, high intensity aerobics or physical activities can put stress on the knees, and that osteoarthritis can arise from overuse. While he opined that she did not have a repetitive knee injury, he did not know how long she had been a personal trainer.

Dr. Levin admitted her work restrictions and when surgery became necessary was based on her pain level. He admitted, that despite surgical recommendation, prior to October 30, 2018, the pain was mild, and she was able to teach her physical fitness classes, bend, run, and play tennis through October 30, 2018. He admitted that prior to October 30, 2018, no doctor restricted her from working as a physical fitness trainer or playing tennis, that he had no problem with her doing these activities, and that knee surgery was never scheduled. Despite referencing the December 2018 bathroom incident, neither he, nor any other doctor opined she suffered any injuries as a result of it. He did not dispute that Petitioner had increased pain and symptoms since October 30, 2018.

In preexisting condition cases, liability depends on whether 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 causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro v. Industrial Com'n,* 207 Ill.2d 193, 205 (2003); *Caterpillar Tractor v. Industrial Com'n,* 92 Ill.2d 30, 36–37 (1982). Just because the aggravation of a preexisting condition could have been caused by normal daily activity; that does not bar recovery. *Sisbro,* 207 Ill.2d at 212-13. If an accident, which arose out of work, aggravated the preexisting condition, regardless if it could have been aggravated by normal daily activity, such an injury is compensable. *Id.*

Employers take their employees as they find them. *Baggett,* 201 Ill.2d 187, 199 (2002). Even though an employee has a preexisting condition which makes 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,* 92 Ill.2d at 36. Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Com'n,* 37 Ill.2d 123, 127 (1967); *Teska,* 266 Ill.App.3d at 742.

Causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the accident and inability to perform the same duties afterward. *Darling v. Industrial Com'n,* 176 Ill.App.3d 186, 193 (1988). Compensability is required if the work injury is a factor of his current condition, even if subsequent aggravating factors take place. *Sommers v. Industrial Com'n,* 2013 IL App (4th) 111053WC-U, ¶43-50; *Teska,* 266 Ill. App. 3d at 742. Even if a claimant had a recommendation for surgery prior to the work injury, causation is satisfied if the work injury increased the pain and symptoms. *Elgin Bd. Of Educ. School Dist. U-45 v. Illinois Workers Compensation Com'n,* 409 Ill.App.3d 943, 949 (1st Dist. 2011).

Given the increase in Petitioner's left knee pain, symptoms, weakness and findings on exam after the October 30, 2018 work injury, this Arbitrator finds that the October 30, 2018 work injury aggravated Petitioner's left knee osteoarthritis.

Right radiculopathy, back and bilateral hip pain.

Given that Petitioner did not have back pain prior to the accident, that back pain was noted on November 7, 2018 which increased when she returned back to work between May 7, 2018 and July 11, 2018 and was required to favor one leg over the other and during which time she continued to limp, this Arbitrator finds that her low back pain, bilateral hip pain and L5 radiculopathy is causally related to the sequella from the October 30, 2018 work injury. This finding is based on Dr. Fliman's, Dr. Daniels and Dr. Dickey's opinions that the limping aggravated her back, which went unrebutted.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (G) WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. The parties stipulate that Petitioner's AWW for the year prior to the accident while working for Respondent was $158.65. The parties disagree as to whether her concurrent income from Centre of Elgin should be included in her AWW.

During the time Petitioner worked for Respondent, she also worked, as an independent contractor, teaching physical fitness at Centre of Elgin. Her AWW for the year prior to October 30, 2018, was $145.14 ($7,112 divided by 49 weeks). Respondent argues these wages should not be included in the AWW.

In *Paoletti v. Industrial Com'n,* 279 Ill.App.3d 988, 996 (1996), claimant's concurrent employment was from business income and business profit. Claimant owed a S-Corp business, for which he was paid net profits. As Professor Larson stated:

> "Generally, profits from a business, whether commercial or farm, are not considered as wages for purposes of establishing average wage. But close questions have arisen in connection with corporate officers, who may be stockholders, whose remuneration is not fixed but depends to some extent on the fortunes of the business. One court has held [*P & L Const. Co. v. Lankford,* 559 S.W.2d 793 (Tenn.1978)] the employee's share of profits was not the correct measure, but that the test should be the wage of another employee performing similar duties." Arthur Larson, *Workmen's Compensation Law,* sec. 60.12(e), pages 10–684–85." *Paoletti,* 279 Ill.App.3d at 996.

The Court in *Poaletti* note that the reasoning in *Lankford* may, under certain circumstances, apply in calculating a claimant's average weekly wage, but because claimant did not present evidence of what other employees would have been making performing similar duties, the court declined to include those wages. *Id.*

In the case at bar, Centre of Elgin paid Petitioner weekly. She was provided a 1099 and she paid her own taxes. She testified that her pay was consistent with the amount Centre of Elgin employees made given her years of experience and certifications. There was no evidence that the income was business profits and Petitioner testified she was paid as an individual, not as a business, LLC or corporation. For these reasons, this Arbitrator finds that the AWW from Centre of Elgin should be included in the AWW.

In cases of concurrent employment, determining the average weekly wage is done by adding the AWW of each job. *Mason Mfg., Inc. v. Industrial Com'n,* 331 Ill.App.3d 575, 579 (2002). Thus, adding the $158.65 plus $145.14 equals $303.79 as her AWW.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) REASONABLENESS OR NECESSITY OF MEDICAL, SURGICAL OR HOSPITAL BILLS OR SERVICES, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions, as if stated herein. Respondent has not paid for all reasonable and necessary medical services.

Petitioner's treating physicians and Dr. Holmes agree that her treatment for her great toe has been related to the October 30, 2018 injury. Despite Dr. Holmes indicating that the bone stimulator was not necessary, Respondent failed to provide him with x-rays which showed a nonunion fracture and Dr. Holmes admitted if the toe remained fractured, the bone stimulator would be beneficial. Dr. Dickey testified it was. This Arbitrator finds that all treatment for the great left toe is reasonable and necessary and related to the October 30, 2018 injury.

Incorporating the causation conclusions related to her foot, including Dr. Kazmer's, Dr. Holmes' and Dr. Vora's diagnosis of metatarsalgia, increased pain while walking and during therapy, the Morton's neuroma and plantar plate tears, Dr. Holmes' recorded nerve pain on February 21, 2019, Dr. Margolis' diagnosis of central sensitization, and Dr. Dickey's May 6, 2020 note of continued

nerve pain, this Arbitrator finds that all the treatment for the left foot since October 30, 2018 to present has been reasonable and necessary and related to the October 30, 2018 crush injury and/or her occupation as a fitness trainer for Respondent.

The Arbitrator further finds that the left knee treatment and MRIs are reasonable, and customary and related to the October 30, 2018 work injury and/or her occupation as a fitness trainer for Respondent. While Dr. Rakic noted that the weight falling on her foot did not cause her knee arthritis, he did not indicate whether it was aggravated or made more painful.

This Arbitrator further finds that the treatment for the low back pain and right leg radiculopathy, and bilateral hip pain, including but not limited to the injections and medication are reasonable, necessary and related to the October 30, 2018 work injury and/or her occupation as a fitness trainer for Respondent. While Dr. Rakic noted that the weight falling on her foot did not cause her sciatica, he did not indicate whether it could have been aggravated or made more painful.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following medical providers, as set forth in Sections 8(a) and 8.2 of the Act:

Provider:	Bill	Medical Fee Schedule
Illinois Bone and Joint: (PEx1 at 1)	$400.00	**$287.29**
Loyola Hospital: (PEx3 at 65-70)	$4,025.00	**$1,438.7**
Loyola Physician: (PEx4)	$1,117.00	**$861.51**
Ill. Pain Institute (PEx5 (1st 5 pages)	$9,968.00	**$6,166.90**
Pinnacle Anesthesia (PEx5 at 3)	$ 2,231.00	**$ 535.62**
OrthoIllinois: (PEx8 last 3 pages)	$1,497.00	**$743.27**
Midwest Bone & Joint (PEx18)	$2,376.00	**$1,457.68**
Zimmer BioMet (PEx.12, bone stimulator)	$5,270.00	**$3,916.21**
Progressive Radiology (PEx13)	$1,210.00	**$1,210.47**
Access Neurocare (PEx14)	$2,420.00	**$987.09**
Northern Ill. Foot and Ankle: (PEx15 at 88-106)	$6,197.51	**$3,536.69**
Dick Pond Athletics: (PEx17)	$478.28	**$478.28**
Northwestern (Fliman) (PEx19)	$386.00	**$231.40**
Shirley Ryan Lab (PEx20 at 6-9)	$516.00	**$245.31**
	$1,612.00	**$567.01**
Sherman Hospital (PEx 7)	$1,499.00	**$1,227.62**
Osco drugs (PEx23, copays for Kazmer and Dickey)		**$72.30**
Midwest Anesthesia and Pain (REx 11 at 126)	$1,075.00	**$430.19**
Total:		**$24,394.00**

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) IS PETITIONER ENTITLE TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein.

Petitioner's physicians have recommended continued conservative care for the foot pain and if that fails, plantar plate surgery and Morton's Neuroma surgery. Therefore, this Arbitrator finds that Petitioner is entitled to undergo, and Respondent is liable for, continued conservative care, including therapy at Athletico/ATI and Shirley Ryan, gait training, pain management, and Morton Neuroma injections, as prescribed by her physicians and should that fail, plantar plate and Morton's neuroma surgery.

This Arbitrator finds that despite the preexisting left knee condition and her being a candidate for left knee surgery, surgery was not necessary prior to October 30, 2018. Since October 30, 2018, her left knee symptoms have increased. Dr. Levin and Dr. Daniels both opined that Petitioner should hold off from a total knee replacement surgery until her foot treatment is completed. Therefore, this Arbitrator finds that Petitioner is entitled to continue with conservative treatment for the knee while treating the foot injury, and if conservative treatment fails, then Petitioner is entitled to, and Respondent is liable for, left knee replacement surgery.

As to low back, bilateral hip and right leg radiculopathy, this Arbitrator finds that Petitioner is entitled to continue to receive treatment for these conditions, for which Respondent remains liable.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein.

Petitioner's physician kept Petitioner off work from December 1, 2018 through May 7, 2019, and then from July 11, 2019 through May 8, 2019. Petitioner returned back to work on modified duty on May 7, 2019, because workers compensation terminated her benefits on March 13, 2019. She returned to work performing chair exercises, however despite this restriction, she was still required to stand, walk, set up the exercise room with chairs and matts, and perform exercises which aggravated her left toe, foot, left knee and right hip, after which Dr. Dickey took her off work again from July 11, 2019 through present.

Dr. Holmes returned her to work as of February 26, 2019, and as of August 20, 2019. However, he testified that if her toe remained fractured, he would not have returned her to work. X-rays he took on February 21, 2019 confirmed the toe was still fractured and it remained fractured through November 2019. Respondent failed to provide Dr. Holmes with the x-rays for his review and he admitted he does not know when the fracture healed. Dr. Holmes' opinions are not credible. This Arbitrator places more weight in all Petitioner's treating physicians who continued to keep Petitioner off work through present compared to Dr. Holmes' opinions.

Moreover, no doctor contradicted the treaters' opinions that she should remain off work due to her increased left knee pain, central sensitization, Morton's neuroma, plantar plate tears, low back pain and right sided radiculopathy.

For the above reasons, Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 65 5/7 weeks, commencing on December 1, 2018-May 7, 2019, and again July 11, 2019-May 8, 2020, for a total of $14,457.14 as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $3,829.90 for temporary total disability benefits that have been paid.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (M) SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS:

Petitioner failed to prove by a preponderance of the evidence that Respondent's conduct warrants penalties and attorneys fees. The Arbitrator denies penalties and fees.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC026973
Case Name	SMITH, DEBBY v. CARILLON OF CAMBRIDGE LAKES
Consolidated Cases	19WC010975
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0358
Number of Pages of Decision	27
Decision Issued By	Marc Parker, Commisioner

Petitioner Attorney	Michael Rothmann
Respondent Attorney	Kelly Kamstra

DATE FILED: 7/14/2021

/s/Marc Parker, 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debby Smith,

Petitioner,

vs.

No. 19 WC 26973, consolidated w/ 19 WC 10975

Carillon at Cambridge Lakes,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

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

Petitioner, a 63-year-old part-time fitness instructor employed by Respondent, filed two separate Applications for Adjustment of Claim. In claim #19 WC 10975, Petitioner alleged that on October 30, 2018, she dropped an 8-lb. weight on her left foot. In claim #19 WC 26973 (this claim), Petitioner alleged she sustained repetitive injuries on, "11/27/2018 TBD." Both claims were consolidated and tried together. At arbitration, Petitioner offered only one Request for Hearing sheet (arbitration exhibit, AX1). In it, she alleged sustaining accidental injuries on, "10/30/18 & prior."

The Arbitrator issued only one decision for both claims, finding that Petitioner's multiple conditions of ill-being were causally related to both of her claims. The Commission affirms that causation finding, but now issues a separate decision for each of Petitioner's claims.

Petitioner learned of the causal relationship between her multiple conditions of ill-being and her repetitive activities as a fitness trainer. on August 20, 2019 – the date of Dr. Holmes' addendum report. The Commission finds that to be the manifestation date of Petitioner's second claim, and modifies the date of accident in this claim, #19 WC 26973, to be August 20, 2019. Because Petitioner filed her Application for Adjustment of Claim on September 17, 2019, timely notice of that accident was given to Respondent.

The Arbitrator found Petitioner's average weekly wage (AWW) to be $303.79, which included Petitioner's stipulated AWW from Respondent of $158.65. However, the Arbitrator also included in Petitioner's AWW calculation an additional $145.14 per week, which she was paid while concurrently working part-time for another entity, the Center of Elgin.

Section 10 of the Workers' Compensation Act states in pertinent part, "when an employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation."

The Arbitrator expressly acknowledged that Petitioner's income from Center of Elgin was paid to her as an independent contractor, but believed the Appellate Court case, *Paoletti v. Industrial Comm'n,* 279 Ill. App. 3d 988 (1996), provided an exception to the provision that concurrent income must be from a concurrent "employer," and that the income be "wages."

The Commission views this issue differently than the Arbitrator. First, the plain language of Section 10 of the Act allows only wages from two or more employers to be considered in the AWW calculation. The Appellate Court has held that, when calculating the AWW of claimants having income from other sources, Section 10 of the WC Act protects, "persons who earn income from more than one job – as long as both jobs meet the definition of employer/employee under the Act." In *Dolce v. Industrial Comm'n,* 286 Ill. App. 3d 117 (1st Dist., 1996), the court ruled that the claimant therein was not considered an employee under the Act because of his independent contractor status with Post.

In addition, the Appellate Court in *Mansfield v. Ill. Workers' Comp. Comm'n,* 2013 IL App (2d) 120909 WC (2nd Dist., 2013), refused to include a claimant's earnings from self-employment in that claimant's AWW calculation. That court stated, "The employer contends claimant's business income should not be included in the calculation of the average weekly wage because it does not represent 'wages' earned while working for an 'employer.' We agree."

The *Mansfield* court considered the Tennessee decision *P&L Construction Co. v. Lankford, 559 S.W.2d 793 (Tenn. 1978),* which the *Paoletti* court relied upon to suggest an exception might exist which would allow concurrent earnings from work as an independent contractor to be included in the average weekly wage calculation. *Paoletti* suggested that such an exception might apply where, as in the present case, a claimant presents evidence of the wages earned by another employee of that company who performed duties similar to the claimant. However, the *Mansfield* court ultimately rejected such an exception, stating, "we decline to further recognize an exception to this holding based on *Lankford*."

In the present case, there is no question that the income Petitioner received from the Center of Elgin was not wages paid to her as an employee. Given the *Mansfield* holding, the Commission finds the Arbitrator's reliance upon *Paoletti* misplaced, and that Petitioner's earnings from Center of Elgin should not have been used in the calculation of her average weekly wage. Accordingly, the Commission finds Petitioner's average weekly wage in this claim to be $158.65.

Finally, with regard to Petitioner's medical expenses, the Commission finds that the evidence supports a conclusion that all of the treatment Petitioner received for her causally related conditions was provided by Dr. Kazmer (Petitioner's first choice physician), Dr. Daniels (Petitioner's second choice physician), or treaters referred by them. Therefore, the Commission finds that none of Petitioner's treaters were outside the two-doctor chain of referral.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 17, 2020, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the accident/manifestation date of Petitioner's claim in this matter, 19 WC 26973, is modified to be August 20, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is modified to $158.65.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $158.65 per week for 65-5/7 weeks, for the periods commencing on December 1, 2018 through May 7, 2019, and from July 11, 2019 through May 8, 2020, those being the periods of temporary total incapacity from work under §8(b) 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 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.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is this case is remanded 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).

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,900.00. 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.

July 14, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-5/20/21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0358
NOTICE OF 19(b) ARBITRATOR DECISION

SMITH, DEBBY
Employee/Petitioner

Case# **19WC010975**
19WC026973

CARILLON OF CAMBRIDGE LAKES
Employer/Respondent

On 6/17/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2652 LAW OFFICE OF MARTIN L GLINK
MICHAEL ROTHMAN
1655 N ARLINGTON HEIGHTS RD
ARLINGTON HEIGHTS, IL 60010

1120 BRADY CONNOLLY & MASUDA PC
KELLY KAMSTRA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Debby Smith
Employee/Petitioner

v.

Carillon of Cambridge Lakes
Employer/Respondent

Case # **19** WC **10975**

Consolidated cases: **19 WC 26973**

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, under emergency provisions and procedures enacted by the Commission and after pretrial with the parties failed to resolve the issues, by the Honorable **Paul Seal**, Arbitrator of the Commission in the city of **Chicago** on **5/8/2020**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, prior to and **10/30/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,346.00**; the average weekly wage was **$303.79**.

On the date of accident, Petitioner was **63** 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 **$3,300** for TTD, $ for TPD, $ for maintenance, and **$529.90** for other benefits, for a total credit of **$3,829.90**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following medical providers, as set forth in Sections 8(a) and 8.2 of the Act: Illinois Bone and Joint: $400; Loyola Hospital: $4,025; Loyola Physician: $1,117.00; Ill. Pain Institute: $9,968.00; Pinnacle Anesthesia: $2,231.00; OrthoIllinois: $1,497.00; Midwest Bone & Joint: $2,376.00; Zimmer BioMet: $5,270.00; Progressive Radiology $1,210.00; Access Neurocare $2,420.00; Northern Ill. Foot and Ankle: $6,197.51; Northwestern $386.00; Shirley Ryan Lab $2,128.00; Sherman Hospital: $1,499.00; Midwest Anesthesia and Pain $1,075.00; and shall reimburse Petitioner for copays for Osco drugs $72.30 and Dick Pond Athletics: $478.28.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 65 5/7 weeks, commencing on December 1, 2018-May 7, 2019, and again July 11, 2019-May 8, 2020, for a total of $14,457.14 as provided in Section 8(b) of the Act. Respondent shall be given a credit of $3,829.90 for temporary total disability benefits that have been paid.

Penalties and attorneys fees 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

June 14, 2020
Date

ICArbDec19(b)

FINDINGS OF FACTS

On October 30, 2018, Petitioner, Debby Smith, (Smith) was an employee of Respondent, Carillon of Cambridge Lakes (Carillon). She started working for Carillon on April 4, 2017 as the fitness coordinator and physical fitness trainer through January 2018 and as a fitness trainer between January 2018 and December 1, 2018. Her duties included setting up the fitness classes, moving chairs. and equipment in and out of the room, as well as instructing the classes in low and high impact classes, ranging from kick classes, pilates, yoga, dance and cardio mix classes, aqua classes (on the concrete around the pool), boot camp, etc.. Trx at 21-33. Even when teaching chair classes, she was required to push off with her feet and toes and perform exercises while standing. *Id.* at 29. The parties stipulated that Smith's AWW at Carillon for the year prior to October 30, 2018 was $158.65.

During this time, Smith also was worked as an independent contractor, at the Centre of Elgin, teaching similar classes. For the year prior to October 30, 2018, she worked 49 weeks, made $7,112, which equates to an AWW of $145.14. Trx, at 34-41; PEx.24. She was paid hourly at a rate consistent with what employees at Elgin with her experience and certifications would get paid. She was paid as an individual and not as a business. Trx at 34-41.

Preexisting conditions:

In 1974, Smith had a left knee meniscectomy. Trx at 41. She worked as a fitness trainer from 1984 through October 30, 2018. *Id.* at 18. No doctor restricted her from teaching classes through October 30, 2018. *Id.* at 41-42. On July 26, 2018 she saw Dr. Daniels for intermittent mild left knee pain with activity, which she attributed to playing tennis. She has some knee swelling, varus test was stable and x-rays shows she had bone on bone arthritis. PEx 9 at 11. He diagnosed her with unilateral osteoarthritis of the left knee and prescribed over the counter pain medication. PEx. 8 at 26, PEx 9, 8-9. Since she had bone on bone arthritis, she was a candidate for a knee replacement. Surgery would only become necessary based on her symptoms and limitations; she did not schedule surgery. PEx 9 at 12-13. He recommended activity modification, which meant that if it hurt, she should not do it. *Id.* at 32. On August 2, 2018, Smith told Dr. Daniel's office that she was considering left knee surgery but, wanted to hold off as long as possible and continue to be active, teach classes, and play tennis. PEx. 8 at 24. On August 2, 2018, Dr. Daniels did not restrict her from teaching classes. PEx. 9 at 14. She had a second opinion with Dr. Berger who gave her the same recommendations. Trx at 87. She played tennis and was able to teach and perform daily activities, despite intermittent mild knee pain through October 30, 2018. *Id.* at 45.

On July 26, 2018, she also complained of left ankle and left foot pain to the outside of her foot and only when wearing a shoe, not with activity. Ex. 8 at 26. Dr. Daniels did not treat or make any recommendations. PEx. 9 at 10. No other records show any left foot complaints prior to October 30, 2018. There is no evidence she had any preexisting back problems or right hip pain or conditions.

Accident:

On October 30, 2018, while working at Carillon, an eight pound weight fell on Smith's left foot and big toe. She reported the injury to her supervisors and filed an incident report. PEx27; Trx at 52. On October 31, 2018, she went to OrthoIllinois emergency clinic and was diagnosed with a left foot and

big toe joint contusion, prescribed a ridged sole shoe and to perform activities as tolerated. PEx. 8 at 20-22; PEx9 at 31. She continued to teach classes for Respondent through December 1, 2018. Trx 57-58.

On November 7, 2018, she saw Dr. Kazmer, complaining that weightbearing and walking caused increased foot pain and swelling. He diagnosed a left foot contusion and prescribed an orthotic walker for her back and left knee pain, a boot, reduce activity and minimal weight bearing. PEx6 at 6-7. On November 14, 2018, he diagnosed a metatarsal injury with swelling, tenderness and clicking and prescribed a boot and MRI. *Id.* at 8. A November 21, 2018 left foot MRI showed a nondisplaced fracture of the medial base of the big toe. PEx11 at 2. On November 28, 2018, Dr. Kazmer prescribed orthotics, a boot for 4-8 weeks, and minimize weight bearing. PEx.6 at 11. He excused her from work. *Id.* at 19.

On December 27, 2018, Smith complained to Dr. Daniels of the work injury and worsening knee pain with activity and pain with rest (4/10). PEx.8 at 17; PEx9 at 15-16. On exam, varus test was unstable with pain (lateral collateral ligament pain), and she was limping, which she had not been on the July 26, 2018 visit. PEx. 9 at 16, 38. He prescribed a medial unloader brace and to follow up with Dr. Kazmer. PEx.8 at 18. He testified that patients with osteoarthritis who limp could have increased collateral ligament pain. PEx9 at 17. He recommended a medial unloader brace for the increased pain, which was not prescribed prior to October 30, 2018. *Id.* at 18. The brace was not approved by workers compensation and she never received it. Trx at 106, 111. Dr. Daniels advised her to hold off knee surgery until the foot injury resolved. P.Ex. 8 at 18; PEx9 at 19.

On January 2, 2019, Dr. Kazmer noted she fell going into the shower. PEx6 at 21. Smith testified she was getting into her shower and when she stepped down with her left foot, she felt sharp pain in her left foot through to her knee. She did not slip or fall down to the ground but fell forward onto the seat in the shower. Trx 59-60. Dr. Kazmer did not believe x-rays were necessary and diagnosed her with the initial foot contusion and toe fracture, with no mention of aggravation by the shower incident, and recommended therapy and for her to be off work. PEx.6 at 21, 23. She did not have knee instability before the October 30, 2018 work injury. *Id.* at 27.

Smith treated at Huntley physical therapy from January 16, 2019 through February 1, 2019 and had the following complaints and symptoms: 1) increased pain with difficulty maintaining balance; 2) abnormal gait, decreased balance, strength, and ability to walk; 3) use of boot increased knee pain; 4) big toe and foot pain with numbness and burning; 5) on neuro exam, left foot Tinel's and Tarsal tunnel test were positive with pain; 6) numbness and tingling during therapy along the great toe, metatarsal joint and plantar fascia; 7) foot pain with activity and getting into and out of her bath, difficulty going up and down stairs, walking, standing, sit to stand, carrying objects three or more feet, and pulling and pushing; and 8) increased sensitization in the forefoot with positive Tinel's sign. The therapist advised Dr. Kazmer that Smith was not responding to desensitization therapy, therefore, on February 4, 2019, Dr. Kazmer diagnosed her with toe and neuritic (shooting/burning) pain which had increased with therapy and discharged her from therapy. PEx2 at 5, 8, 9, 15, 17, 19, 21 23, 28; PEx.6 at 31.

On February 21, 2019, Dr. Holmes performed an IME for Respondent. X-rays confirmed that the toe remained fractured and he diagnosed her with a work related big toe fracture, recommended bigger shoes, return back to work with no jumping and that she would be MMI in two weeks.

On March 13, 2019, Dr. Kazmer diagnosed her with chronic pain and continued her off work until further notice. PEx.6 at 29, 43. On April 3, 2019, he referred her to Dr. Schiff. *Id.* at 32.

On March 13, 2019, Respondent terminated Petitioner's TTD and medical benefits. Trx at 63.

On April 9, 2019, she saw Dr. Schiff, an orthopedic foot surgeon at Loyola, for left foot, big toe and 2nd toe pain. He suspected a plantar plate injury, indicated that the plantar plates were hard to visualize on the November 21, 2018 MRI, and therefore prescribed an ultrasound. Indication was foot trauma. PEx.3 at 3, 6. The April 24, 2019 ultrasound showed a neuroma bursal complex and 2nd and 3rd digit plantar plate tears. *Id.* at 5-6. Dr. Schiff diagnosed her with 2nd and 3rd plantar plate tears and recommended orthotics, a brace, and if conservative treatment failed, plantar pate surgery. He diagnosed her with a left plantar plate injury and kept her off work. *Id.* at 13.

On April 26, 2019, Dr. Daniels noted she had worsening knee pain and was using a lidocaine patch and tramadol. He recommended conservative treatment, advised her to return in a year and referred her to Dr. Vora for foot pain. PEx.8 at 8-9. On May 6, 2019, Smith saw Dr. Vora, at Illinois Bone and Joint, complaining of persistent burning, pain, numbness and tingling in her foot which started after the October injury. Dr. Vora diagnosed left metatarsalgia, 2nd and 3rd plantar plate injury and recommended a metatarsal pad to offload the foot, anti-inflammatories, symptomatic management, and possible surgery. PEx.1 at 3-4.

Dr. Schiff's May 7, 2019 notes referenced the October 30, 2018 work incident and plantar plate left foot injury. PEx.3 at 18, 19. He believed some of her pain was nerve related and recommended pain management. *Id.* at 19. Smith asked to be returned to modified duty because workers compensation had terminated her benefits. Trx at 65. Dr. Schiff returned her to work with restrictions of no barefoot work and to sit as needed. PEx.3 at 19.

Since Dr. Vora was in Libertyville, an hour from Smith's home, on May 30, 2019, Dr. Daniels referred her to Dr. Fliman, at Northwestern Huntley, for pain management. Trx at 66-67. On June 5, 2019, she advised Dr. Fliman that since October 30, 2018 she began to have low back, thigh and buttock pain and worse knee pain. PEx.19 at 1. She reported new right upper buttock pain since returning to work. *Id.* at 1. Dr. Fliman opined that the work related toe fracture caused her to limp, which exacerbated the preexisting left knee arthritis and caused lumbar and bilateral hip pain, which should resolve once the foot recovered. Dr. Fliman referred her back to Dr. Schiff for the foot and recommended no weightbearing for the knee. *Id.* at 2.

Dr. Fliman left her practice the day after she saw Smith (Trx at 67), therefore, on June 14, 2019, Dr. Daniels referred her to Dr. Dickey. PEx.8 at 7-8. Dr. Dickey's June 20, 2019 records indicate that Smith used her toes at work. PEx16 at 9-10. The June 20, 2019 x-rays showed a big toe fracture and abnormality at the ball of her foot. *Id.* at 11. Dr. Dickey referred her to Dr. Daniels for left knee pain and to pain management for left foot nerve damage. PEx15 at 10-13, PEx.16 at 12. Dr. Dickey prescribed a left foot MRI, EMG, and CAM walker boot. PEx15 at 13.

The June 21, 2019 left foot MRI showed a bone contusion with nondisplaced great toe fracture extending to the medial and plantar surface, and a Morton's neuroma 2nd interspace extending to plantar. PEx.15 at 1-2. Dr. Dickey explained that a Morton's neuroma is a thickening of the nerves

between the bones of the feet and can cause numbness, radiating and tingling pain. PEx16 at 18-19. On July 3, 2019, Dr. Dickey noted Smith was struggling and increased her restrictions to non-weight bearing and only chair/bench ball exercises until further notice. PEx15 at 20, 53.

On July 11, 2019, Smith complained of new right hip pain. Dr. Dickey noted that despite restricting her from standing at work she had to stand and was limping. PEx.15 at 24. Dr. Dickey testified that if Smith was able to perform seated work, that would have met her restrictions. PEx16 at 47. However, Smith testified that even with chair exercise restrictions, she was required to stand, walk, set up the exercise room, and perform exercises involving pushing up with her foot and ankle and had to favor her right leg over her left. Trx at 69-70.

On July 11, 2019, Dr. Dickey diagnosed her with right sided sciatica, left foot pain, edema, and a nonunion left big toe fracture. PEx.16 at 22-23; PEx15 at 26. She recommended a bone stimulator, immobilization, and CAM boot. PEx16 at 23. As a result of the exacerbation of back and knee pain and sciatica, she prescribed a surgical shoe and carbon fiber plate, Medrol Dose Pak, took her off work, and referred her to Dr. Prunskis for foot, back and hip pain. *Id.* at 23-24.

On July 18, 2019, Dr. Daniels noted increased knee pain at rest (6/10), with weakness, clicking, instability, popping and swelling, and recommended therapy. PEx.8 at 3-4. On July 18, 2019, Dr. Dickey noted that the bone stimulator and Medrol dose pack was helping. PEx.15 at 27-28.

On July 23, 2019, after reviewing the left foot MRI, Dr. Schiff diagnosed a non-healed big toe fracture and neuroma, and noted continued pain, numbness, and tingling in her foot. PEx.3 at 27. He opined she had a left plantar plate injury and referred Smith to Dr. Dickey. *Id.*

On July 30, 2019, she saw Dr. Prunskis at Illinois Pain Institute, for left foot and left knee pain with a history of a work accident crush injury on October 30, 2018. PEx.5 at 32. He noted that weightbearing increased her pain. *Id.* She had an antalgic gait, straight leg raise was positive on right. *Id.* at 33. He diagnosed a Morton's neuroma, right leg radiculitis and prescribed a left Morton's neuroma injection, lumbar MRI, left leg EMG. *Id.*

An August 1, 2019 x-ray showed the toe fracture healing. An August 16, 2019 EMG, prescribed by Dr. Dickey, showed L5 radiculopathy. PEx16 at 25-27; PEx.15 at 32; PEx14. An August 2, 2019 lumbar MRI showed an L4-5 broad based disc bulge with minimal bilateral neural foraminal narrowing and lumbar spondylosis. PEx18.

On August 20, 2019, Dr. Holmes provided an addendum IME report, noting that Smith's current foot complaints as seen in the MRIs are consistent with her activities as a 63 year old fitness instructor. He opined that the current condition with the great toe was related to the injury and that treatment for it was causally related to the October injury. However, he found she could return to work full duty and noted that, contrary to MRI and x-ray's actual findings, the new MRI and x-rays did not demonstrate structural problems. He recommended she purchase larger size orthotic shoes which was related to the injury.

On August 27, 2019, Dr. Prunskis noted continued constant burning, tingling low back pain radiating down her right leg, made worse by walking, as well as knee and foot pain. He recommended lumbar epidural nerve blocks on the right and left knee MRI. PEx.5 at 31.

On September 26, 2019, Dr. Dickey noted increased knee pain and continued left foot pain; a healing left great toe fracture (per the September 25, 2019 MRI), and recommended compression, rest, surgical shoe and carbon fiber plate, and bone stimulator. PEx15 at 44-46.

On October 3, 2019, Dr. Prunskis noted low back pain radiating down the right leg, and constant left foot pain aggravated by walking. He performed L4 and L5 nerve block and recommended a Morton's neuroma injection. PEx.5 at 25-26. On October 17, 2019, Dr. Prunskis noted she was in constant pain which was affecting her right and left hip, made worse with walking and exercise. He diagnosed her with lumbar radiculitis and low back pain, left foot Morton's neuroma and recommended an L4 and L5 epidural nerve root blocks. *Id.* at 19. He noted that the last knee MRI showed "further" degenerative changes. *Id.* at 19. On October 28, 2019, he kept her off work until further notice. *Id.* at 97.

On October 31, 2019, Dr. Dickey prescribed a CT scan, ultrasound, and kept her off work. PEx15 at 47-49, 54, 60. The November 14, 2019 ultrasound showed a neuroma and 2nd and 3rd digit plantar plate tears. PEx3 at 59; PEx16 at 35-36. Dr. Dickey testified that the plantar plate ligament connects the toe to the foot metatarsal and stabilizes the toe and since it has not healed, she was a candidate for plantar plate surgery. *Id.* at 36-37.

The November 14, 2019 left foot CT scan showed a healed big toe fracture which now had sclerosis of the hallux sesamoids. PEx 3 at 46-47. Dr. Dickey testified that as a result of the toe fracture, the big toe joint experienced increased pressure and inflammation and is starting to show signs of arthritis. PEx16 at 38-39.

On November 21, 2019, Dr. Prunskis noted continued knee and foot pain and back pain, while improved, was aggravated by standing and walking. PEx5 at 13. He diagnosed her with lumbar radiculitis, left Morton's neuroma, and performed a L4 and L5 epidural nerve blocks. He recommended a fourth lumbar epidural and a Morton's left foot neuroma injection, and a left knee MRI. *Id.* A December 7, 2019 left knee MRI confirmed left knee osteoarthritis. PEx.7.

On December 19, 2019, Dr. Pontinen, at Midwest Anesthesia Pain Specialist, saw her per referral from Dr. Dickey, to rule out RSD. Rx.11 at 6. He opined she had left foot, left knee and low back pain following a work injury but did not suffer from CRPS and kept her off work. *Id.* at 9. On December 23, 2019, Dr. Rakic from the same office, opined she did not have CRPS and that she had great toe and Morton's neuroma pain. *Id.* at 14. While he noted the dumbbell falling on her foot did not cause left knee arthritis or sciatica, he did not indicate whether or not limping could have aggravated or increased her pain. *Id.* at 15.

On January 17, 2020, Dr. Dickey referred her to Dr. Margolis at Shirley Ryan. PEx15 at 67-69. February 7, 2020 records note the October 30, 2018 work injury with gradual increase in limping and increase in knee and ankle pain and that wearing the boot increased back and hip pain. PEx. 20 at 1. She complained of big toe pain, numbness and swelling and pain to the top of her foot. *Id.* at 3. Dr. Margolis opined she did not have CPRS, but diagnosed central sensitization, knee pain, low back pain with a history of work related crush injury and neuroma. *Id.* at 5. He prescribed therapy, off work and Lyrica and lidocaine patches. *Id.*

On March 27, 2020, Dr. Dickey noted Smith's purchase of shoes for orthotics. PEx.15 at 73, PEx17. On April 14, 2020, Dr. Dickey referred her to Shirley Ryan and prescribed a gate analysis. *Id.* at 76, 83-84. On May 6, 2020, Dr. Dickey noted continued left foot, knee and right hip pain and that Smith suffered a crush injury that likely damaged some nerves in her foot and kept her off work. *Id.* at 85.

Dr. Dickey's testimony

Dr. Dickey, a board certified podiatrist and foot and ankle surgeon, explained that if the big toe is injured, balance, propulsion, and gait is altered. PEx16 at 4-6, 16. She related the left foot pain and big toe fracture to the October 30, 2018 accident and opined that Smith's years of fitness instruction through June 20, 2019 could have caused or contributed to the Morton's neuroma and plantar plate tears. *Id.* at 17, 19, 37. She opined that her bills were reasonable, necessary, and related to the October 30, 2018 work injury. *Id.* at 37.

Dr. Dickey testified that Smith had a lot of wear and tear from the years of fitness training through June 20, 2019 which contributed to the findings of the June 26, 2019 left ankle MRI which showed peroneal tendinitis, mild peroneal tenosynovitis, myotendinous of the Achilles tendon, superficial and deep retrocalcaneal bursitis, and increased fluid posterior and plantar heel pads. PEx15 at 3-5; PEx16 at 20-21, 55. Smith's peroneal tendinitis was an overuse injury. PEx.16 at 21. Respondent objected to these opinions per *Ghere,* however, they were consistent with the notice of evidence deposition, which stated that her years of teaching fitness contributed to the foot pain and diagnosed conditions. PEx15A.

Dr. Dickey also opined that the boot and abnormal gait secondary to the toe fracture contributed to her back pain, radiculopathy, and left knee pain. PEx15 at 13, 29-30, 34, 54. The basis for her opinion was her training in biomechanics and orthotics and how they apply to reactive forces. She explained that wearing orthotics helps send forces straight up and down the legs to the back which reduces back and knee pain and provide better alignment. *Id.* at 28, 33. She has treated patients with leg and feet misalignment with resultant back and knee pain and radiculopathy, for whom she has prescribed orthotics. *Id.* at 28-29, 33.

While Dr. Dickey admitted Smith's left leg was shorter than the right, which could cause her to limp and that the orthotic were to address both the fracture and misalignment, she testified that the foot and toe injuries could have aggravated her preexisting left leg discrepancy and increased her pain. *Id.* at 45, 47, 60. Dr. Dickey opined that Smith was a compliant patient who wanted to get better and return to work. PEx16 at 30, 58.

Dr. Holmes' testimony.

Dr. Holmes, an orthopedic surgeon, performed an IME on February 21, 2019. Rx5 at 4, 6. He took x-rays which showed a minimally displaced great toe fracture, meaning it had not healed. *Id.* at 11, 35, 50. She had swelling and pain over the top of her foot, was using Tramadol and Advil, and orthotics. *Id.* at 34. He diagnosed her with a fracture of the great toe related to the October 30, 2018 accident. *Id.* at 12-13. He returned her back to work with no restrictions, despite not knowing

what fitness classes she was teaching. *Id.* at 13, 46. He prescribed shoe modifications to fit the orthotics better and related it to her work injury. *Id.* at 13, 35.

On February 21, 2019, Dr. Holmes also noted positive Tinel's sign, tingling nerve pain in the left foot. *Id.* at 37-38. In a report to the adjuster, he indicated she was restricted from jumping for two weeks because of continued big toe pain. *Id.* at 39. In addition to the bigger shoe recommendation, he recommended that she needed a stiff sole for more support, since her current orthotics were inadequate. *Id.* at 40. He also recommended a plus/minus Morton's extension. *Id.* at 41. The Morton's extension, also recommended on August 20, 2019, helps toe fractures heal. *Id.* at 45-46.

On August 20, 2019, Dr. Holmes opined she was suffering from metatarsalgia, bursitis, neuroma, and plantar plate tears. *Id.* at 14-15. The metatarsalgia was related to the plantar plate tears and neuroma. *Id.* at 16. Dr. Holmes opined that the October 30, 2018 injury did not cause the plantar plate tears because her initial complaints of pain were limited to the great toe, not the metatarsals. *Id.* He admitted Respondent never sent him the physical therapy records. *Id.* at 41.

Dr. Homes opined she had a Morton's neuroma, inflamed nerve between the metatarsals, which causes numbness, burning and sharp pain, which worsened with walking. *Id.* at 17. He opined that the plantar plate tears, the neuroma, the peroneal tendon tenosynovitis, the retro calcaneus bursitis were not related to the October 30, 2018 work injury, but instead related to her occupation as physical fitness instructor. *Id.* at 19, 42-43, 49. The outer foot pain she complained of on February 21, 2019, could be peroneal tendonitis. *Id.* at 34. He opined the treatment for the big toe fracture through the date of his 2nd report was reasonable and related to the work injury. *Id.* at 19.

Despite Dr. Holmes' February 21, 2019 x-rays showing a big toe fracture and his admission it was fractured, Dr. Holmes also testified the toe was not fractured, otherwise he would not have sent her back to work, and that he was just "being a nice guy by saying no jumping for two weeks." *Id.* at 39-40. Dr. Holmes admitted that the June 21, 2019 MRI showed a nondisplaced fracture and that as of August 20, 2019 he could not state whether the big toe fracture had healed. *Id.* at 43-44. He admitted that if x-rays showed the fracture had not healed, a bone stimulator could be helpful, but that Respondent did not provide him with x-rays to review. *Id.* at 44. He also admitted that CAM walker boots also help treat broken big toes. *Id.* at 46.

Dr. Holmes agreed that an injured great toe could compromise balance and cause someone to limp, which can cause excessive force and increase plantar plate loading. *Id.* at 21, 24-27.

Dr. Mark Levin' testimony:

Dr. Mark Levin, a board-certified orthopedic surgeon, testified that he saw Smith on February 26, 2019. She worked 6-12 hours per week as personal trainer at Carillon and 4-10 hours per week at Centre of Elgin. *Id.* at 10. She complained that the knee pain increased a month after the October 2018 injury because of her antalgic gait. *Id.* at 10-11. She had preexisting knee issues and reported that her knee buckled in the bathroom. *Id.* at 11, 52.

Dr. Levin opined that she had degenerative left knee arthritic pain which predated the October 30, 2018 injury and that her limping did not cause the pain. *Id.* at 19. The basis for his opinion was that she required a knee replacement prior to October 30, 2018. *Id.* at 19. He opined that the films

do not show an aggravation of her osteoarthritis. *Id.* at 20. However, he admitted that knees are vulnerable to stress and wear and tear. *Id.* at 31. He admitted that running, jumping, squatting, high intensity aerobics or other physical activities stresses the knees. *Id.* 35, 37. Knee osteoarthritis can arise from overuse. *Id.* at 41. While he testified, she did not have a repetitive injury to her knee, he did not know how long she had been a personal trainer. *Id.* at 46. He opined that work restrictions would be based on her pain level. *Id.* at 21, 58.

He opined she was a candidate for total knee replacement before and after October 30, 2018, and it would be up to her when to have it done, since patients delay surgery if not in pain. *Id.* at 22, 49-51. He admitted that despite the surgery recommendation, prior to October 30, 2018 the pain was mild, and she was able to teach her physical fitness classes, bend, run, and play tennis through October 30, 2018. *Id.* at 52. No doctor prior to October 30, 2018 restricted her from working as a physical fitness trainer or playing tennis; significantly, he had no problem with her doing those activities prior to October 30, 2018. *Id.* at 56. Dr. Levin admitted she never scheduled knee surgery before October 30, 2018 and that surgery has to wait until after her foot recovers. *Id.* at 49, 57.

Dr. Daniel's testimony:

Dr. Daniels, an orthopedic surgeon specializing in hip and knee reconstruction, and who has performed approximately 7,000 knee replacements as well as treating back, spine and hip complaints, noted that Smith's October 30, 2018 work injury caused a gait abnormality which aggravated her preexisting knee osteoarthritis. PEx. 9 at 5-6, 19, 26. He explained that patients usually do well with arthritic joints, but that a change in gait can cause increased pain; and in her situation, she was maintaining her preexisting knee arthritis but that the injury, boot and limping aggravated her arthritic knee. PEx9 at 20. When he saw her prior to the October 30, 2018 injury, she was not limping and did not have varus instability. *Id.* at 38. The left foot and knee pain caused her to limp, and along with use of the boots, could affect the hips and back. *Id.* at 25-26. He also opined that her activities as a personal trainer since 1984 through the date he first saw her, July 2018, contributed to her left knee arthritis. *Id.* at 22- 23. Dr. Daniels referred her to Dr. Kazmer, Dr. Fliman and Dr. Vora. *Id.* at 31, 38. The bills were reasonable customary and necessary. *Id.* at 26.

CONCLUSIONS OF LAW:

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (C) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts as if stated herein. This Arbitrator finds that on and prior to October 30, 2018, Petitioner suffered an accident which arose out of and in the course of Petitioner's employment by Respondent. In support thereof:

An injury "arises out of" one's employment if, at the time of the occurrence, the employee was performing which the employee might reasonably be expected to perform incident to her assigned duties. *Sisbro, Inc. v. Industrial Com'n,* 207 Ill.2d 193, 204 (2003), *citing Caterpillar Tractor Co. v. Industrial Com'n,* 129 Ill.2d 52, 58 (1989). 'Arising out of' refers to the origin or cause of the

accident and presuppose a causal connection between the employment and the accidental injury and in order for an injury to come within the act it must have had its origin in some risk connected with, or incidental to, the employment, so that there is a causal connection between the employment and the injury. *Chmelik v. Vanna,* 31 Ill.2d 272 (1964). "In the course of the employment,' refers to time, place and circumstances under which the accident occurred, and it is stated generally that an accidental injury is received in the course of the employment when it occurs. within the period of employment at a place where the employee may reasonably be in the performance of her duties, and while she is fulfilling those duties or engaged in something incidental thereto. *Id.* "When workers' physical structures 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, 434 (1982).

On October 30, 2018, while setting up a fitness class for Respondent, a weight fell on Petitioner's left foot and big toe. Respondent's dispute on this point is unreasonable. As to the repetitive nature of her claim, Petitioner taught low and high impact classes for Respondent from April 4, 2017 through December 1, 2019. Dr. Holmes opined that the findings in the foot and ankle MRIs were a result of the repetitive nature of her occupation as a physical fitness trainer. Dr. Daniels and Dr. Dickey agreed these findings were a result of her occupation through the dates they first saw her, in July 2018 and June 2019, respectively. Dr. Daniels also opined that the left knee osteoarthritis was aggravated and contributed to by her occupation through June 2018. Moreover, Petitioner's left foot, left knee, low back and right leg radiculopathy were aggravated by her return to work for Respondent, between May 7, 2019 and July 11, 2019, as set forth above. Thus, Petitioner's duties for Respondent contributed to the left knee, back and foot conditions that she treated for after October 30, 2018.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (E) WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. This Arbitrator finds that Petitioner gave timely notice to Respondent. In support thereof:

Petitioner reported the October 30, 2018 work injury to her supervisors both orally and in writing. PEx 27; Trx. at 52-53. As to the repetitive complaints, her medical records from October 31, 2018 through February 21, 2019, which Respondent were in possession of and provided to Dr. Holmes, demonstrate that Petitioner's left foot, big toe and left knee worsened while she worked in November 2018 and thereafter. While Dr. Holmes disputed that the October 30, 2018 work injury caused the other foot injuries, in his August 20, 2019 supplemental report he opined they were related to the repetitive nature of her occupation as a fitness trainer. Petitioner filed a 2nd Application for Adjustment of Claim on September 17, 2019.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F) WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. This Arbitrator finds that Petitioner's present conditions of a fractured left big toe and sclerosis and

posttraumatic arthritis of the big toe hallux sesamoids, chronic left big toe and left foot pain and central sensitization, aggravation of left knee osteoarthritis, low back pain, right sided radiculopathy, and bilateral hip pain are related to the work related crush injury on October 30, 2018. This Arbitrator further finds that Petitioner's left knee osteoarthritis, peroneal tendinitis, peroneal tenosynovitis, myotendinous of Achilles tendon, retrocalcaneal bursitis, left foot Morton's neuroma, left foot 2nd and 3rd plantar plate tears are related to her increased limping as a result of the October 30, 2018 work injury and her years of being a personal trainer, including while working for Respondent.

Left big toe:

The treating physicians and Dr. Holmes opined that the October 30, 2018 injury caused the left big toe fracture. The fracture did not heal until November 2019. Recent films show arthritic changes in the big toe. Dr. Dickey's uncontradicted opinion was that the arthritic changes are related to the long term pressure that the big toe experienced during the delayed healing. For these reasons, this Arbitrator finds that the left big toe fracture and hallux sclerosis shown in the November 2019 CT are related to the October 30, 2018 work injury.

Left foot:

Per the June 26, 2019 MRI, Petitioner also suffers from peroneal tendinitis and tenosynovitis, myotendinous of Achilles Tendon, retrocalcaneal bursitis, left foot Morton's neuroma, and left foot 2nd and 3rd plantar plate tears. Dr. Dickey and Dr. Holmes opined that Petitioner's occupation as a physical fitness trainer, including her work duties through June 2019, which includes working for Respondent, caused or contributed to these findings. Dr. Schiff and Dr. Vora, who noted the October 30, 2018 work injury, indicated she suffered plantar plate tear injury. No doctor related the injuries to any other cause, including the December 24, 2018 shower incident. She did not slip or fall to the ground. Regardless, having increased pain while stepping into the shower, with a broken big toe, foot pain and decreased balance and ability to bear weight, does not rise to the level of an intervening accident. *International Harvester Co. v. Industrial Com'n*, 46 Ill.2d 238, 245 (1970); *Lasley Construction Co. v. Industrial Com'n,* 274 Ill.App.3d 890, 893 (1995); *Teska, v. Industrial Com'n,* 266 Ill.App.3d 740, 742 (1994). Based on Dr. Holmes' and Dr. Dickey's opinion, this Arbitrator finds that the conditions are related to the October 30, 2018 work injury and her occupation with Respondent.

Petitioner's foot pain continued to get worse since the October 30, 2018 injury, including the month she worked between October 30, 2018 and December 1, 2018. Dr. Kazmer, Dr. Vora and Dr. Holmes diagnosed metatarsalgia, as early as November 7, 2018. Physical therapy, Dr. Kazmer and Dr. Holmes noted nerve pain. Dr. Prunskis, Dr. Margolis at Shirley Ryan, Dr. Pontinen, Dr. Rakic, Dr. Dickey indicate continued chronic foot pain. While the doctors did not diagnose CRPS, they diagnosed crush injury, chronic left foot pain from central sensitization, plantar plate tears, metatarsalgia, and Morton's neuroma. For these reasons, and those above, this Arbitrator finds that the left foot 2nd and 3rd plantar plate tears, metatarsalgia, Morton's neuroma, chronic left foot pain, central sensitization, and left big toe and 2nd toe pain are related to the October 30, 2018 work injury and her duties as a physical fitness trainer for Respondent.

Left Knee:

Petitioner's left knee osteoarthritis preexisted the October 30, 2018 work injury. Yet, despite being a candidate for a left total knee replacement prior to October 30, 2018, Petitioner was managing with mild knee pain, and continued to teach her high and low impact fitness classes, play tennis, and perform daily activities. She had no knee instability and her varus test was negative. After the October 30, 2018 work injury, she continued to set up and teach fitness classes until December 1, 2018. Petitioner began to limp more, had difficulty walking and maintaining balance. Her knee pain worsened after the October 30, 2018 work injury through present. Petitioner began taking Tramadol, Lidocaine patches and other prescription medication, whereas previously the knee pain was controlled by ice and Advil. She began having lateral collateral ligament pain and was prescribed a medial knee brace, whereas prior to October 30, 2018 it had not been prescribed.

This Arbitrator finds Dr. Daniels' opinions more persuasive than Dr. Levin's. Dr. Daniels opined that Petitioner was managing her symptoms but that the October 30, 2018 injury and the limping and wearing of a boot aggravated her left knee pain. He also opined that her years of being a fitness trainer through June 2018 when he first saw her, contributed to her left knee arthritis. He explained that, while prior to the accident she was a candidate for knee surgery, when surgery became necessary would be based on her symptoms and functioning. Prior to the accident, surgery was not necessary, given her mild pain levels and ability to perform work and life activities.

Dr. Levin opined that her limping did not increase her knee pain, which is contradicted by the records. While he opined the accident did not aggravate her osteoarthritis, he admitted that knees are vulnerable to stress and wear and tear, that running, jumping, squatting, high intensity aerobics or physical activities can put stress on the knees, and that osteoarthritis can arise from overuse. While he opined that she did not have a repetitive knee injury, he did not know how long she had been a personal trainer.

Dr. Levin admitted her work restrictions and when surgery became necessary was based on her pain level. He admitted, that despite surgical recommendation, prior to October 30, 2018, the pain was mild, and she was able to teach her physical fitness classes, bend, run, and play tennis through October 30, 2018. He admitted that prior to October 30, 2018, no doctor restricted her from working as a physical fitness trainer or playing tennis, that he had no problem with her doing these activities, and that knee surgery was never scheduled. Despite referencing the December 2018 bathroom incident, neither he, nor any other doctor opined she suffered any injuries as a result of it. He did not dispute that Petitioner had increased pain and symptoms since October 30, 2018.

In preexisting condition cases, liability depends on whether 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 causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro v. Industrial Com'n,* 207 Ill.2d 193, 205 (2003); *Caterpillar Tractor v. Industrial Com'n,* 92 Ill.2d 30, 36–37 (1982). Just because the aggravation of a preexisting condition could have been caused by normal daily activity; that does not bar recovery. *Sisbro,* 207 Ill.2d at 212-13. If an accident, which arose out of work, aggravated the preexisting condition, regardless if it could have been aggravated by normal daily activity, such an injury is compensable. *Id.*

Employers take their employees as they find them. *Baggett,* 201 Ill.2d 187, 199 (2002). Even though an employee has a preexisting condition which makes 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,* 92 Ill.2d at 36. Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Com'n,* 37 Ill.2d 123, 127 (1967); *Teska,* 266 Ill.App.3d at 742.

Causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the accident and inability to perform the same duties afterward. *Darling v. Industrial Com'n,* 176 Ill.App.3d 186, 193 (1988). Compensability is required if the work injury is a factor of his current condition, even if subsequent aggravating factors take place. *Sommers v. Industrial Com'n,* 2013 IL App (4th) 111053WC-U, ¶43-50; *Teska,* 266 Ill. App. 3d at 742. Even if a claimant had a recommendation for surgery prior to the work injury, causation is satisfied if the work injury increased the pain and symptoms. *Elgin Bd. Of Educ. School Dist. U-45 v. Illinois Workers Compensation Com'n,* 409 Ill.App.3d 943, 949 (1st Dist. 2011).

Given the increase in Petitioner's left knee pain, symptoms, weakness and findings on exam after the October 30, 2018 work injury, this Arbitrator finds that the October 30, 2018 work injury aggravated Petitioner's left knee osteoarthritis.

Right radiculopathy, back and bilateral hip pain.

Given that Petitioner did not have back pain prior to the accident, that back pain was noted on November 7, 2018 which increased when she returned back to work between May 7, 2018 and July 11, 2018 and was required to favor one leg over the other and during which time she continued to limp, this Arbitrator finds that her low back pain, bilateral hip pain and L5 radiculopathy is causally related to the sequella from the October 30, 2018 work injury. This finding is based on Dr. Fliman's, Dr. Daniels and Dr. Dickey's opinions that the limping aggravated her back, which went unrebutted.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (G) WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein. The parties stipulate that Petitioner's AWW for the year prior to the accident while working for Respondent was $158.65. The parties disagree as to whether her concurrent income from Centre of Elgin should be included in her AWW.

During the time Petitioner worked for Respondent, she also worked, as an independent contractor, teaching physical fitness at Centre of Elgin. Her AWW for the year prior to October 30, 2018, was $145.14 ($7,112 divided by 49 weeks). Respondent argues these wages should not be included in the AWW.

In *Paoletti v. Industrial Com'n,* 279 Ill.App.3d 988, 996 (1996), claimant's concurrent employment was from business income and business profit. Claimant owed a S-Corp business, for which he was paid net profits. As Professor Larson stated:

> "Generally, profits from a business, whether commercial or farm, are not considered as wages for purposes of establishing average wage. But close questions have arisen in connection with corporate officers, who may be stockholders, whose remuneration is not fixed but depends to some extent on the fortunes of the business. One court has held [*P & L Const. Co. v. Lankford,* 559 S.W.2d 793 (Tenn.1978)] the employee's share of profits was not the correct measure, but that the test should be the wage of another employee performing similar duties." Arthur Larson, *Workmen's Compensation Law,* sec. 60.12(e), pages 10–684–85." *Paoletti,* 279 Ill.App.3d at 996.

The Court in *Poaletti* note that the reasoning in *Lankford* may, under certain circumstances, apply in calculating a claimant's average weekly wage, but because claimant did not present evidence of what other employees would have been making performing similar duties, the court declined to include those wages. *Id.*

In the case at bar, Centre of Elgin paid Petitioner weekly. She was provided a 1099 and she paid her own taxes. She testified that her pay was consistent with the amount Centre of Elgin employees made given her years of experience and certifications. There was no evidence that the income was business profits and Petitioner testified she was paid as an individual, not as a business, LLC or corporation. For these reasons, this Arbitrator finds that the AWW from Centre of Elgin should be included in the AWW.

In cases of concurrent employment, determining the average weekly wage is done by adding the AWW of each job. *Mason Mfg., Inc. v. Industrial Com'n,* 331 Ill.App.3d 575, 579 (2002). Thus, adding the $158.65 plus $145.14 equals $303.79 as her AWW.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) REASONABLENESS OR NECESSITY OF MEDICAL, SURGICAL OR HOSPITAL BILLS OR SERVICES, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions, as if stated herein. Respondent has not paid for all reasonable and necessary medical services.

Petitioner's treating physicians and Dr. Holmes agree that her treatment for her great toe has been related to the October 30, 2018 injury. Despite Dr. Holmes indicating that the bone stimulator was not necessary, Respondent failed to provide him with x-rays which showed a nonunion fracture and Dr. Holmes admitted if the toe remained fractured, the bone stimulator would be beneficial. Dr. Dickey testified it was. This Arbitrator finds that all treatment for the great left toe is reasonable and necessary and related to the October 30, 2018 injury.

Incorporating the causation conclusions related to her foot, including Dr. Kazmer's, Dr. Holmes' and Dr. Vora's diagnosis of metatarsalgia, increased pain while walking and during therapy, the Morton's neuroma and plantar plate tears, Dr. Holmes' recorded nerve pain on February 21, 2019, Dr. Margolis' diagnosis of central sensitization, and Dr. Dickey's May 6, 2020 note of continued

nerve pain, this Arbitrator finds that all the treatment for the left foot since October 30, 2018 to present has been reasonable and necessary and related to the October 30, 2018 crush injury and/or her occupation as a fitness trainer for Respondent.

The Arbitrator further finds that the left knee treatment and MRIs are reasonable, and customary and related to the October 30, 2018 work injury and/or her occupation as a fitness trainer for Respondent. While Dr. Rakic noted that the weight falling on her foot did not cause her knee arthritis, he did not indicate whether it was aggravated or made more painful.

This Arbitrator further finds that the treatment for the low back pain and right leg radiculopathy, and bilateral hip pain, including but not limited to the injections and medication are reasonable, necessary and related to the October 30, 2018 work injury and/or her occupation as a fitness trainer for Respondent. While Dr. Rakic noted that the weight falling on her foot did not cause her sciatica, he did not indicate whether it could have been aggravated or made more painful.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following medical providers, as set forth in Sections 8(a) and 8.2 of the Act:

Provider:	Bill	Medical Fee Schedule
Illinois Bone and Joint: (PEx1 at 1)	$400.00	**$287.29**
Loyola Hospital: (PEx3 at 65-70)	$4,025.00	**$1,438.7**
Loyola Physician: (PEx4)	$1,117.00	**$861.51**
Ill. Pain Institute (PEx5 (1st 5 pages)	$9,968.00	**$6,166.90**
Pinnacle Anesthesia (PEx5 at 3)	$ 2,231.00	**$ 535.62**
OrthoIllinois: (PEx8 last 3 pages)	$1,497.00	**$743.27**
Midwest Bone & Joint (PEx18)	$2,376.00	**$1,457.68**
Zimmer BioMet (PEx.12, bone stimulator)	$5,270.00	**$3,916.21**
Progressive Radiology (PEx13)	$1,210.00	**$1,210.47**
Access Neurocare (PEx14)	$2,420.00	**$987.09**
Northern Ill. Foot and Ankle: (PEx15 at 88-106)	$6,197.51	**$3,536.69**
Dick Pond Athletics: (PEx17)	$478.28	**$478.28**
Northwestern (Fliman) (PEx19)	$386.00	**$231.40**
Shirley Ryan Lab (PEx20 at 6-9)	$516.00	**$245.31**
	$1,612.00	**$567.01**
Sherman Hospital (PEx 7)	$1,499.00	**$1,227.62**
Osco drugs (PEx23, copays for Kazmer and Dickey)		**$72.30**
Midwest Anesthesia and Pain (REx 11 at 126)	$1,075.00	**$430.19**
Total:		**$24,394.00**

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) IS PETITIONER ENTITLE TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein.

Petitioner's physicians have recommended continued conservative care for the foot pain and if that fails, plantar plate surgery and Morton's Neuroma surgery. Therefore, this Arbitrator finds that Petitioner is entitled to undergo, and Respondent is liable for, continued conservative care, including therapy at Athletico/ATI and Shirley Ryan, gait training, pain management, and Morton Neuroma injections, as prescribed by her physicians and should that fail, plantar plate and Morton's neuroma surgery.

This Arbitrator finds that despite the preexisting left knee condition and her being a candidate for left knee surgery, surgery was not necessary prior to October 30, 2018. Since October 30, 2018, her left knee symptoms have increased. Dr. Levin and Dr. Daniels both opined that Petitioner should hold off from a total knee replacement surgery until her foot treatment is completed. Therefore, this Arbitrator finds that Petitioner is entitled to continue with conservative treatment for the knee while treating the foot injury, and if conservative treatment fails, then Petitioner is entitled to, and Respondent is liable for, left knee replacement surgery.

As to low back, bilateral hip and right leg radiculopathy, this Arbitrator finds that Petitioner is entitled to continue to receive treatment for these conditions, for which Respondent remains liable.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS:

The Arbitrator incorporates the Findings of Facts and above conclusions as if stated herein.

Petitioner's physician kept Petitioner off work from December 1, 2018 through May 7, 2019, and then from July 11, 2019 through May 8, 2019. Petitioner returned back to work on modified duty on May 7, 2019, because workers compensation terminated her benefits on March 13, 2019. She returned to work performing chair exercises, however despite this restriction, she was still required to stand, walk, set up the exercise room with chairs and matts, and perform exercises which aggravated her left toe, foot, left knee and right hip, after which Dr. Dickey took her off work again from July 11, 2019 through present.

Dr. Holmes returned her to work as of February 26, 2019, and as of August 20, 2019. However, he testified that if her toe remained fractured, he would not have returned her to work. X-rays he took on February 21, 2019 confirmed the toe was still fractured and it remained fractured through November 2019. Respondent failed to provide Dr. Holmes with the x-rays for his review and he admitted he does not know when the fracture healed. Dr. Holmes' opinions are not credible. This Arbitrator places more weight in all Petitioner's treating physicians who continued to keep Petitioner off work through present compared to Dr. Holmes' opinions.

Moreover, no doctor contradicted the treaters' opinions that she should remain off work due to her increased left knee pain, central sensitization, Morton's neuroma, plantar plate tears, low back pain and right sided radiculopathy.

For the above reasons, Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 65 5/7 weeks, commencing on December 1, 2018-May 7, 2019, and again July 11, 2019-May 8, 2020, for a total of $14,457.14 as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $3,829.90 for temporary total disability benefits that have been paid.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (M) SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS:

Petitioner failed to prove by a preponderance of the evidence that Respondent's conduct warrants penalties and attorneys fees. The Arbitrator denies penalties and fees.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC012058
Case Name	CARR, KARONJI v. STATE OF ILLINOIS DEPARTMENT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0359
Number of Pages of Decision	14
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jean Swee
Respondent Attorney	David Christensen

DATE FILED: 7/14/2021

/s/ Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF McLean)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Karonji Carr,

Petitioner,

vs. NO: 19WC 12058

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 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 September 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.

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.

July 14, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 7/1/21
68

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

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

21IWCC0359

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARR, KARONJI
Employee/Petitioner

Case# **19WC012058**

ST OF IL/ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 9/8/2020, 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

6079 ASSISTANT ATTORNEY GENERAL
BRADLEY DeFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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 62703

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

SEP -8 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Karanji Carr
Employee/Petitioner

v.

State of Illinois/Illinois Department of Transportation
Employer/Respondent

Case # **19** WC **12058**

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Springfield**, on **July 28, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and 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 27, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$55,680.04**; the average weekly wage was **$1,070.77**.

On the date of accident, Petitioner was **47** years of age, ***single,*** with **0** dependent children.

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

Respondent shall be given a credit of **$ALL AMOUNTS PAID** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$ALL AMOUNTS PAID.**

Respondent is entitled to a credit for medical bills paid in the amount of **$0** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$642.46/week** for a period of **47.3 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **20% loss of use of the right leg and 2% loss of use of the left leg.**

Respondent shall pay reasonable and necessary medical services as contained in Petitioner's Exhibit 9 as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

8/25/2020
Date

SEP 8 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Karonji Carr
Employee/Petitioner

Case # **19** WC **12058**

v.

Consolidated cases: N/A

State of Illinois/Illinois
Department of Transportation
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he had been employed by Respondent as a highway maintenance worker for approximately four years. Petitioner testified that while he was working on November 27, 2018, he was picking up debris on I-55 when the ground gave in and his right leg sank into the hole up to his hip. He testified that he also twisted his right knee in the accident. He testified that he struggled to get out of the hole for several minutes, and that he felt immediate right knee and left hip pain. Petitioner testified that he reported his injury to his employer on November 27, 2018.

Petitioner testified that Respondent referred him to Dr. Braun at BroMenn Occupational Health on November 27, 2018. He testified that after Dr. Braun released him, he continued to experience right knee and left hip pain. He testified that his right knee continued to worsen, and that he returned to Dr. Braun on January 8, 2019. Petitioner further testified at the time of arbitration as to the medical treatment that he underwent following the accident at issue.

Petitioner testified that prior to his November 27, 2018 work accident, he had never experienced any left hip pain and that he had never treated for his left hip. He further testified that prior to his November 27, 2018 accident, he had a previous right knee injury for which Dr. Keller performed surgery in approximately 2016. He testified that Dr. Keller released him from his care shortly after the knee surgery, and that after Dr. Keller released him, he did not have any ongoing right knee pain.

At the time of arbitration, Petitioner testified that he has continued to experience right knee pain with some swelling since his November 27, 2018 accident. He testified that if he performs a lot of bending or digging in holes at work, his right knee swells and flares up for a period of time. He testified that when his knee flares up, he takes Ibuprofen to help with the swelling and pain. He further testified that he has continued to experience right knee pain when kneeling, squatting, and going up and down stairs. He testified that when he works in the cold weather, his right knee hurts. Petitioner also testified that his left hip gets stiff and sore at work on a regular basis.

Petitioner testified that on and before his November 27, 2018 accident, he was employed full-time as an IDOT worker for Respondent and that he was also in the Navy Reserves. He testified that he has continued to work in both occupations. He further testified that he has received cost of living and contractual raises since his work accident.

On cross examination, Petitioner testified that he was last seen by Dr. Li when he was released in July 2019.

The report of Dr. Li dated November 5, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report noted that Petitioner injured his right knee on November 27, 2018 while working as a highway maintainer, that he suffered tears of the medial and lateral meniscus as well as a chondral fracture of the patella in his right knee, and that the condition required surgery, vasopneumatic compression, extensive therapy, medications, and follow-up. It was noted that it was Dr. Li's opinion that Petitioner would occasionally have anterior knee pain as a result of the chondral injury of his patella, that this would most likely occur when he was kneeling, squatting, going up and down stairs or climbing, and that he was also likely to experience discomfort when working outside during the cold weather. (PX1).

The medical records of Dr. Braun dated November 27, 2018 were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was on "rural patrol" walking along the shoulder to pick up debris when he stepped into a deep hole with his left leg causing his right knee on the surface to twist awkwardly and his left posterior hip area to impact the ground. It was noted that Petitioner previously had right knee meniscus injury and surgery a year ago but otherwise no previous injuries to either area, and that the pain in the right knee was worse and increased with walking. The diagnosis was noted to be that of (1) sprain of unspecified site of right knee, initial encounter; (2) contusion of left hip, initial encounter; (3) encounter for examination and observation following work accident. It was noted that Petitioner did not appear have a knee or hip internal derangement, that Dr. Braun was going to have him take the rest of the day off to ice and rest, and that he was then to use a flexible-type knee brace he had at home and prevent re-injury while he did activity as tolerated before a re-check in one week. It was also noted that Petitioner's recommended work status was that of regular duty. (PX2).

The Interpretive Report for an MRI of the right knee dated March 11, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that the films were interpreted as revealing (1) inferior articular surface horizontal tear of the posterior horn and posterior body portions of the medial meniscus with mild diminution; mild extrusion of the medial meniscus; small meniscal cysts contiguous with the posterior horn of the medial meniscus; (2) possible small inferior articular surface tear at posterior body portion of the lateral meniscus; (3) no ligamentous tear; (4) additional findings as described. It was noted that the reason for the exam was that of a sprain of the right knee, and that Petitioner related a history of twisting the right knee in December 2018. (PX3).

The Operative Report dated April 30, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the patella for a diagnosis of right knee medial and lateral meniscus tear, grade 2 chondral injury to the patella. (PX4).

Additional medical records of Dr. Braun were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on November 30, 2018, at which time it was noted that his left hip symptoms had resolved, that the right knee was better but still sore, and that there were no mechanical symptoms of the right knee. The diagnosis was noted to be that of (1) sprain of unspecified site of right knee, subsequent encounter; (2) contusion of left hip, subsequent encounter; (3) encounter for examination and observation following work accident. It was noted that Petitioner was recovering as well as expected, that he was to follow-up PRN, and that his recommended work status was regular duty. (PX5).

The records of Dr. Braun reflect that Petitioner was seen on January 8, 2019, at which time it was noted that he had had some persistent medial symptoms at certain times like stepping down on uneven surfaces, that there was no locking or catching, that the pain was not interfering with his work, and that he had been doing his usual leg exercises at the gym. It was noted that Petitioner thought that the pain would

have been gone by now so he was there for a re-check, and that he denied any new injury to his right knee. The diagnosis was noted to be that of (1) sprain of unspecified site of right knee, subsequent encounter; (2) contusion of left hip, subsequent encounter; (3) encounter for examination and observation following work accident. It was noted that Petitioner still had some persistent but improved right knee pain, that he had no signs or symptoms of an internal derangement that would require a surgery at that point, and that he was recommended to undergo therapy. It was further noted that Petitioner was also to "back off" his home leg exercises he did at the gym and was to focus on the therapy, and that if he was not better in 2-3 weeks with therapy an MRI would be requested. It was also noted that Petitioner was to deploy with the Guard for a month starting February 10, 2019, and that his recommended work status was that of regular duty. (PX5).

The records of Dr. Braun reflect that Petitioner was seen on January 29, 2019, at which time it was noted that he was seen for follow-up of his right knee, that there was no locking or catching, that the pain was not interfering with his work, and that there had been no approval of therapy yet. It was noted that there was no change in Petitioner's symptoms, that he was to deploy for a month with his reserve unit February 10th, and that there was no new injury to his right knee. The diagnosis was noted to be that of (1) sprain of unspecified site of right knee, subsequent encounter; (2) contusion of left hip, subsequent encounter; (3) encounter for examination and observation following work accident. It was noted that it would be good to get an MRI before Petitioner deployed to evaluate the anatomy and that if he had a normal MRI of the right knee he would be at maximum medical improvement, and if not then he would need an Orthopedic evaluation. It was noted that Petitioner's recommended work status was that of regular duty. At the time of the March 19, 2019 visit, it was noted that Petitioner's primary problem was that of stiffness, weakness, a loss of range of motion, a strain, a sprain, inflammation/swelling, pain, and swelling located in the right medial knee, right patellar area, right medial joint line, right hip, and left hip. It was noted that Petitioner considered it to be intense, localized, and seemed to be variable depending on the activity level, and that he had noticed that it was made worse by crawling, exertion, using it, walking, and moving it. It was further noted that it was improved by rest, fewer work hours, heat, and cold, and that Petitioner felt it was improving slightly. It was noted that Petitioner had been able to work if he was careful on uneven surfaces and reduced excess walking, that the pain was not interfering with his work, that physical therapy had been approved, that he had a month of deployment with his reserve unit, and that he reported that he tolerated it okay. It was noted that Petitioner was open to a trial of physical therapy and then was getting a referral for Orthopedic evaluation depending on the results. The diagnosis was noted to be that of (1) sprain of unspecified site of the right knee, subsequent encounter; (2) contusion of left hip, subsequent encounter; (3) encounter for examination and observation following work accident; (4) other tear of medial meniscus, current injury, right knee, subsequent encounter; (5) pain in right knee. Petitioner was recommended to start physical therapy and was referred to Orthopedics. It was noted that Petitioner's recommended work status was that of regular duty. (PX5).

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on March 28, 2019, at which time it was noted that he was seen for a right knee problem. It was noted that Petitioner stated that his pain began in November 2018 after he twisted and fell into a hole that was waist-deep while working, that he had been seen by another provider and recently underwent an MRI that showed a medial meniscus tear, and that he stated that he was scheduled to start therapy in the near future. It was noted that Petitioner stated that his overall condition had not improved since the onset, that he located the pain over the medial aspect of the knee, that he described it as an ache that was sharp, that he rated it at mild to moderate without radiation, and that he stated that bending, squatting, twisting, and prolonged walking aggravated his pain, while rest, activity modification, ice, and Tylenol had provided minimal relief. It was noted that Petitioner denied any numbness or tingling, that he noted intermittent swelling, that he noted a painful popping sensation with intermittent catching, and that he had a slight decrease in range of motion and weakness due to pain. It was noted that Petitioner had undergone a previous right knee arthroscopy and was doing quite well until the recent work injury. The assessment was noted to be that of (1) pain in right knee; (2) tear of

medial meniscus of right knee. It was noted that Petitioner had symptoms consistent with a symptomatic medial meniscus tear shown on MRI that was obtained on March 11, 2019. It was noted that a discussion was had regarding proceeding with a right knee arthroscopy with partial medial meniscectomy, and that Petitioner wished to proceed pending approval. It was also noted that Petitioner was to use ice as needed for pain relief, as well as Tylenol for additional pain relief. (PX6).

The medical records of Dr. Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on March 28, 2019, at which time it was noted that he worked as a highway maintainer and was walking, that his left leg went into a hole, and that as he went down into the hole he twisted his right knee and had had right knee pain ever since. It was noted that Petitioner had been treating with Occ Med and finally got an MRI that showed that he had a medial meniscus tear, and that he was referred to Dr. Li by a friend. It was noted that Petitioner's pain was worse with any type of uneven ground and any type of twisting, that he continued to work, that his pain was aggravated by activities of daily living and limited his desired lifestyle, and that the pain also interfered with sleep and woke him up. It was noted that Petitioner denied numbness and tingling, that he had had a previous knee arthroscopy in 2017 by Dr. Keller and did "magnificent" afterwards, and that he did not have any issues until this accident. The diagnosis was noted to be that of right medial meniscus tear causing all the pain, and it was noted that Petitioner also had a small lateral meniscus tear that did not appear to be symptomatic. Petitioner was dispensed Mobic and was given a prescription for Rabeprazole for gastrointestinal protection. Petitioner was recommended to undergo right knee arthroscopic surgery. (PX7).

The records of Dr. Li reflect that Petitioner was seen on April 25, 2019, at which time it was noted that he returned for follow-up of the right knee. It was noted that Petitioner's surgery had been approved and that he continued to have pain in his right knee with any type of pivoting or twisting. The diagnosis was noted to be that of right knee medial and lateral meniscus tear. Petitioner was recommended to undergo right arthroscopic knee surgery and informed consent was obtained. Petitioner underwent a Physical Therapy Initial Evaluation on May 3, 2019, at which time it was noted that he was to be evaluated and treated status/post right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the patella. It was noted that Petitioner reported that he had a surgery in high school and then again in 2017, that he had been doing great until 2017, that recently he was working in the snow and a sink hole opened up, and that he twisted his leg as he dropped. It was noted that Petitioner worked for IDOT, that he did pushing and pulling, that he had to be able to lift and carry 35# for an extended period of time, and that he needed to be 100% before he could go back to work. It was noted that Petitioner would benefit from skilled physical therapy at that time to address current deficits and to return him to full functional mobility. (PX7).

The records of Dr. Li reflect that Petitioner was seen on May 7, 2019, at which time it was noted that he had typical post-op pain, that the Game Ready vasopneumatic compression therapy decreased pain, swelling, and narcotic use, and that he had discomfort over the anterior aspect of the knee, particularly the patella tendon. It was noted that Petitioner's surgical incision was "excellent," that the incisions were healed, and that the sutures were removed. The diagnosis was noted to be that of right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the patella. It was noted that Voltaren gel was prescribed because Petitioner had pain, and that other non-narcotic options were not controlling the pain adequately. It was noted that narcotics and opiates should be avoided to minimize the risk of addiction and prolonged recovery. It was noted that a Reparel compression sleeve was prescribed to reduce swelling, inflammation, and pain, and that the sleeve would also accelerate recovery and restoration of function. Petitioner was also recommended to continue physical therapy and to remain off work. Petitioner was further recommended to return in four weeks for follow-up. (PX7).

The records of Dr. Li reflect that Petitioner was seen for physical therapy on May 8, 2019, at which time it was noted that he reported that he had been doing all of his home exercise program without a problem. It was noted that Petitioner had no new complaints during the session on that date, and that his range of motion was doing great. At the time of the May 6, 2019 physical therapy visit, it was noted that Petitioner had some pain in the knee on that date, that he rated in at a 4/10 but sometimes reached a 6/10, and that he iced the knee regularly (every couple of hours). It was noted that Petitioner's knee range of motion was progressing nicely, and that soft tissue mobilization was performed to address the soreness at the anterior knee. The Operative Report from Ireland Grove Center for Surgery dated April 30, 2019 noted that Petitioner underwent right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the patella on that date by Dr. Li for a diagnosis of right knee medial and lateral meniscus tear, and grade 2 chondral injury to the patella. (PX7).

The records of Dr. Li reflect that Petitioner underwent physical therapy on May 15, 2019, at which time it was noted that he reported that his knee was more sore in the back of the knee. It was noted that Petitioner had increased soreness on that date, so they did other therapeutic exercises to strengthen his core and lower extremity but with less weight bearing. It was noted that they also trialed low level laser therapy and that Petitioner did well with it, reporting a decrease in symptoms. At the time of the May 13, 2019 physical therapy visit, it was noted that Petitioner reported that he had some mild soreness in the knee, that he thought it was part of the healing, and that he was on his feet too much in the house over the weekend. It was noted that Petitioner did well with the progression of exercises on that date without an increase in pain levels, and that the Graston Techniqe for soft tissue mobilization was continued to address the soreness at the medial knee. At the time of the May 17, 2019 physical therapy visit, it was noted that Petitioner reported that he was fine after the last session, that he stepped in a rut the evening before which caused pain 5-6/10 and was still bothering him that morning, and that he reported that he iced it last night and that morning. It was noted that Petitioner tolerated all therapeutic exercises without pain but did not make significant additions, and that he reported reduced pain following the session. It was noted that Petitioner was instructed to ice/elevate and to reduce activity that weekend. (PX7).

The records of Dr. Li reflect that Petitioner was seen for physical therapy on May 22, 2019, at which time it was noted that he reported that his knee was doing a little better and that he had some fatigue from three days of therapy in a row, but otherwise was doing okay. It was noted that Petitioner reported fatigue with some therapeutic exercise but no increase in pain. At the time of the June 4, 2019 visit, it was noted that Petitioner reported that he still had some pain in the patella tendon as well as the medial joint line, that therapy had gone well, and that Game Ready vasopneumatic compression therapy had decreased swelling and narcotic use and had made his therapy a lot easier. The diagnosis was noted to be that of right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the patella. Petitioner was dispensed Mobic, was recommended to continue physical therapy, and was to follow-up in four weeks. At the time of the June 4, 2019 physical therapy visit, it was noted that Petitioner reported that the kinesiotape helped with the anterior pain and that he had some medial knee soreness that date. It was noted that Petitioner completed the exercises with good tolerance without an increase in pain levels, and that the kinesiotape was reapplied since he responded favorably to it at the last session. It was also noted that no new complaints were reported at the end of the session. (PX7).

The records of Dr. Li reflect that Petitioner was seen for physical therapy on June 3, 2019, at which time it was noted that he had increased the weight on the leg press machine without an increase in pain levels, that he continued to experience soreness at the patellar tendon region, and that a trial of kinesiotape was applied to unload the tendon. At the time of the June 12, 2019 physical therapy visit, it was noted that Petitioner reported that his knee was feeling good on that date and that he was not having pain that day. It was noted that Petitioner did well with the progression of exercises without an increase in pain levels, and that no new complaints were reported at the end of the session. At the time of the June 14, 2019 physical therapy visit, it was noted that Petitioner denied swelling and pain with normal walking and standing, and

that he wanted to get back to running. It was noted that Petitioner did well with the progression of exercises without an increase in pain levels, and that a trial of jogging on the treadmill was started on that date. It was also noted that Petitioner had no pain during jogging, and that he would observe how it did over the weekend and would let them know the next week. At the time of the June 5, 2019 physical therapy visit, it was noted that Petitioner reported that he did fine after the last session, that he had no new complaints on that date to report, and that he saw the doctor and was to continue therapy. It was noted that new exercises were initiated with good tolerance, that the Graston Technique for soft tissue mobilization was continued to address tightness in the IT band and hamstring, and that no new complaints were reported at the end of the session. (PX7).

The records of Dr. Li reflect that Petitioner was seen for physical therapy on June 10, 2019, at which time it was noted that he reported that his knee was feeling pretty good, that he had a mild ache in the superior patella, and that he did fine after the last session. It was noted that Petitioner reported mild discomfort with weight bearing flexion but was alleviated with rest, and that overall he tolerated the session well. It was noted that no new complaints were reported at the end of the session. At the time of the June 17, 2019 visit, it was noted that Petitioner reported that he did well with the introduction to jogging on the treadmill, and that he reported being pleased with how it went. It was noted that Petitioner's jogging time was increased without complaints of pain and that he reported some pressure in the knee, but that it resolved with Game Ready vasopneumatic compression therapy. At the time of the June 18, 2019 visit, it was noted that Petitioner reported that he was feeling good that day and that he did well with therapeutic exercises. It was noted that Petitioner did not perform treadmill jogging as he had increased it the day before, and that he wished to focus on strengthening that day to have a recovery day. It was noted that mild pressure was reported in the distal lateral quad with sidestepping but was relieved with rest, and that no complaints were reported at the end of the session. (PX7).

The records of Dr. Li reflect that Petitioner was seen on June 24, 2019 for physical therapy, at which time it was noted that he reported that he was sore that day and pointed to the quad tendon, and that he reported that he was not sure what caused it but had been sore over the weekend. It was noted that Petitioner did well with new and increased therapeutic exercises that day, and that a progress note was planned for Wednesday. At the time of the June 25, 2019 physical therapy visit, it was noted that Petitioner reported mild tightness in the quad tendon but stated that it was improved after yesterday's therapy appointment. It was noted that Petitioner did well that day with therapeutic exercises, but noted continued tightness in the bilateral hips. It was noted that Petitioner had no complaints reported at the end of the session. The Discharge Note dated June 26, 2019 noted that Petitioner demonstrated no significant objective or functional limitation at that time and had returned to full functional mobility. It was noted that Petitioner was advised in a final home exercise program and was given discharge instructions, and that he was to contact them with any further questions or concerns. It was noted that no new complaints were reported at the end of the session, and that Petitioner had met all goals of physical therapy and was discharged. (PX7).

The medical records of Dr. Li dated July 2, 2019 were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that a physical examination revealed no swelling, bruising or redness, and that Petitioner's range of motion was normal in both knees. It was also noted that Petitioner had mild quad atrophy. Petitioner was released to full duty work, was given a prescription for Mobic, and was recommended to call the office if the problem did not resolve. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. It was noted that Petitioner was road patrolling at the time of the injury on November 27, 2018, that he was picking up trash and was walking back to the truck when he fell into a hole in the ground, and that the body parts affected were that of the hip, leg, and knee. (RX2).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. It was noted that Petitioner was working on the roads, that he was picking up trash, that he was walking to the truck after picking up trash and stepped into a hole, and that he twisted his knee. (RX3).

The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

CONCLUSIONS OF LAW

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of November 27, 2018. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA impairment. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he was a highway maintenance worker for Respondent at the time of the accident at issue. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 47 years old on the date of the accident at issue. In light of Petitioner's full duty release with no permanent restrictions by his treating physician, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he returned to work as a highway maintenance worker for Respondent upon the completion of his medical treatment with Dr. Li. As there was no evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected his future earnings capacity, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has continued to experience right knee pain with some swelling since his November 27, 2018 accident. Petitioner testified that if he performs a lot of bending or digging in holes at work, his right knee swells and

flares up for a period of time. Petitioner testified that when his knee flares up, he takes Ibuprofen to help with the swelling and pain. Petitioner further testified that he has continued to experience right knee pain when kneeling, squatting, and going up and down stairs. Petitioner testified that when he works in the cold weather, his right knee hurts. Petitioner also testified that his left hip gets stiff and sore at work on a regular basis. At the time of the July 2, 2019 visit with Dr. Li, it was noted that a physical examination revealed no swelling, bruising or redness, and that Petitioner's range of motion was normal in both knees. It was also noted that Petitioner had mild quad atrophy. Petitioner was released to full duty work, was given a prescription for Mobic, and was recommended to call the office if the problem did not resolve. (PX8). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was somewhat corroborated by his treating records at the conclusion of his treatment. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **20% loss of use of the right leg and 2% loss of use of the left leg** as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC032108
Case Name	ZDON, JASON P v. CITY OF HIGHLAND PARK
Consolidated Cases	12WC033774
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0360
Number of Pages of Decision	13
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	John Scanlon
Respondent Attorney	Adam Rettberg

DATE FILED: 7/16/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON ZDON,

Petitioner,

vs. No: 12 WC 32108

CITY OF HIGHLAND PARK,

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, temporary total disability benefits, maintenance and vocational rehabilitation, and permanent partial disability, 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 permanent partial disability. The Arbitrator ordered an indefinite wage differential award. However, the accident in this case occurred on September 6, 2012. The Commission observes that for accidental injuries that occur on or after September 1, 2011, a wage differential award shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later. 820 ILCS 305/8(d)(1) (West 2012). Accordingly, the Commission modifies the Decision of the Arbitrator to reflect this statutory limitation of the award.

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 November 4, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits, commencing September 18, 2020, of $533.00 per

week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in §8(d)(1) of the Act.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 16,2021

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

o: 7/1/21
BNF/kcb
045

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0360
NOTICE OF ARBITRATOR DECISION

ZDON, JASON
Employee/Petitioner

Case# **12WC033774**

12WC032108

CITY OF HIGHLAND PARK
Employer/Respondent

On 11/4/2020, 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:

0391 HEALY SCANLON
JOHN P SCANLON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ADAM RETTBERG
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

Jason Zdon
Employee/Petitioner

v.

City of Highland Park
Employer/Respondent

Case # **12** WC **33774**

Consolidated cases: **12 WC 32108**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **September 18, 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 6, 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 $**37,759.95**; the average weekly wage was $**726.15**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner maintenance benefits of $ **484.10**/week for **77 4/7** weeks, commencing **March 23, 2019** through **September 18, 2020**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**484.10**/week for **325 5/7** weeks, commencing **December 16, 2013** through **March 22, 2019**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**10,210.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 18, 2020**, of $**533.00**/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Arbitrator Anthony C. Erbacci

October 29, 2020
Date

NOV 4 - 2020

FACTS:

On September 6, 2012, Petitioner was employed by Respondent as a laborer for the water department. As part of his regular job duties, Petitioner was required to snow plow, check and repair water main breaks and remove trees. While working to repair water main breaks, Petitioner would have to lift and carry concrete debris that could weigh in excess of 100 pounds. He would also have to remove manhole covers that weighed between 50 – 100 pounds. His job duties also required him to climb in and out of trenches and work in confined spaces where he would have to kneel and squat. In addition, Petitioner testified that it was fairly common for him to have to use ladders to perform his day to day activities and that he had to carry bags of cement and sand.

On September 6, 2012, Petitioner was working out on the streets of Highland Park, IL when he was struck by a car while he was in a crosswalk. Petitioner stated that the car struck his right leg and the first thing he remembered after the accident was waking up in the hospital.

The medical records and the testimony of the Petitioner show that Petitioner was taken from the scene of the accident to Highland Park Hospital. The Highland Park Hospital emergency room records document that the Petitioner lost consciousness when he hit his head and that he had complaints of right leg weakness and pain from his neck down to his lumbar spine. While at the hospital, Petitioner had an x-ray of is right knee and a CT of his cervical spine, thoracic spine and lumbar spine. The CT's disclosed disc protrusions at C2 – C3, C3 – C4 and C4 –C5, bulging discs at L2 – L3, L3 – L4 and L4 – L5 and a focal disc protrusion at L5 – S1. The emergency room physicians recommended that the Petitioner follow up with his primary care doctor. Petitioner's primary care doctor recommended that he see a neurologist for his head injury and spinal injuries, and an orthopedic surgeon for his knee pain.

The Petitioner was seen by Dr. Roger Chams, an orthopedic surgeon, for treatment of his knee injury. Because Petitioner failed to respond to conservative treatment, Dr. Chams recommended surgery. Respondent initially refused to approve this surgery. Dr. Chams at his deposition testified that more likely than not Petitioner's September 6, 2012 accident caused a knee injury that required surgery. Dr. Chams performed surgery on the Petitioner on June 12, 2013. The operative report notes that the Petitioner sustained a lateral meniscus tear and right knee lateral tilt syndrome of the patella femoral joint along with grade 3 chondromalacia of the patella femoral joint. It was Dr. Chams' further opinion that all of the treatment provided to the Petitioner including injections, therapy and surgery were all reasonable and necessary and required as a result of the work accident.

During this same time frame, Petitioner was also receiving treatment from Dr. Charulatha Nagar, a neurologist, for his spinal and head injuries. Dr. Nagar first saw the Petitioner on September 28, 2012, noting a history of being hit by a car while working on a construction crew. Petitioner complained to Dr. Nagar of problems with his ability to recall information and difficulties with headaches and dizziness.

Dr. Nagar's records note that clear fluid was draining from his left ear. Because of the fluid leak, Dr. Nagar ordered an MRI to determine if there was a dural tear or a tympanic membrane tear. Dr. Nagar noted during her physical exam that Petitioner had nystagmus and likely had an injury to his vestibular system. Dr. Nagar also noted that the Petitioner at that first visit had tandom dystaxia to a significant degree. Dr. Nagar also noted vision deficits based on the Romberg test.

As a result of this exam, Dr. Nagar also ordered a Vorteq motor conduction test to determine if Petitioner's head injury was causing vestibular imbalance. Dr. Nagar's diagnosis at that time was traumatic brain injury and post concussive syndrome. It was Dr. Nagar's opinion that, more likely than not, the leaking from Petitioner's ear was a result of the motor vehicle accident. Dr. Nagar further concluded that based on the Vorteq results, the Petitioner suffered vestibular balance problems as a result of the automobile accident.

At a subsequent visit on October 11, 2012, Dr. Nagar concluded that Petitioner was suffering from lumbar radiculopathy as a result of a protruding disc at L5 – S1. It was Dr. Nagar's opinion that the lumbar injury was, more likely than not, a result of the automobile accident. In addition, Dr. Nagar was of the opinion that Petitioner was having memory issues, balance issues and headaches as a result of the head trauma sustained in the accident. At a subsequent visit on December 3, 2012 Dr. Nagar noted that Petitioner had problems with his balance and increased lumbar radiculopathy.

Dr. Nagar saw the Petitioner again on March 26, 2013 after Petitioner had returned back to work in a modified job position as a computer entry clerk. Dr. Nagar noted that the Petitioner was having migraine headaches and vision problems as a result of the computer entry job. At a July 10, 2013 visit, Dr. Nagar noted that Petitioner was suffering from reduced reflexes in his right knee and right ankle. It was Dr. Nagar's opinion that this loss of reflex function was a result of the compression of the nerve root at L5 – S1.

On August 21, 2013 Dr. Nagar saw the Petitioner to determine if he could return to full job duties. Before releasing him to work, Dr. Nagar recommended that Petitioner undergo a neuropsychological examination and another lumbar MRI. The MRI of the lumbar spine showed a moderate to large far left lateral disc. Dr. Nagar was of the opinion that Petitioner's right sided sciatica was a result of that damaged disc and the spasm and inflammation it would cause. As a result of the MRI, Dr. Nagar was of the opinion that Petitioner had a large disc herniation at L5 – S1 that needed a neurosurgical evaluation. Dr. Nagar's office notes from October 9, 2013 reflect that neurosurgery had been recommended to address Petitioner's lumbar L5 – S1 herniated disc. Respondent declined to approve this surgery.

Dr. Nagar's last visit with Petitioner was on March 22, 2019. At that visit, Dr. Nagar noted the Petitioner's nerve root impingement of the lumbar spine was causing drop foot to Petitioner's right foot. At that time, it was Dr. Nagar's opinion that the Petitioner had plateaued and he would not be getting any better. Dr. Nagar also noted Petitioner had a lifting restriction of no more than 20 pounds. Dr. Nagar also gave the opinion that the Petitioner would not be able to return to work as a laborer due to his lumbar and vestibular problems. It was further Dr. Nagar's opinion that the Petitioner's vestibular imbalance, his headaches, his memory loss, all were a result of the work accident. Dr. Nagar also gave her opinion that, more likely than not, the Petitioner's lumbar radiculopathy and bulging and herniated discs were a result of the automobile accident. Dr. Nagar opined that Petitioner's condition at that time was chronic and likely permanent. Dr. Nagar further opined that these conditions caused disability to the Petitioner and effected his ability to perform his normal functions.

Dr. Nagar referred the Petitioner to Michael DiDomenico, a neuropsychologist, for evaluation of his traumatic brain injury. Dr. DiDomenico performed neuropsychological testing on Petitioner on two different occasions. Dr. DiDomenico produced reports dated September 25, 2013 and July 26, 2019. Dr. DiDomenico concluded in both reports that Petitioner did suffer a traumatic brain injury resulting in

loss of cognition, memory, concentration and processing speed. Dr. DiDomenico gave his opinion that this traumatic brain injury was in fact caused by the automobile accident and that, in his opinion, Petitioner would be unable to carry on any full-time work as a result of his traumatic brain injury. It was his opinion that the traumatic brain injury suffered by Petitioner was a result of the September 6, 2012 work accident.

Dr. DiDomenico gave his opinion that Petitioner's injury was permanent. Dr. DiDomenico also gave his opinion that the Petitioner suffered a "moderate head injury dementia from traumatic brain injury." It was his opinion that the traumatic brain injury resulted in significant cognitive impairment. Dr. DiDomenico concluded that the Petitioner's test results "strongly suggest that Mr. Zdon has significant cognitive impairment especially with slowed mental processing, disturbances of attention, concentration, impaired ability to maintain concepts and impaired memory functions." When asked if these impairments would prevent him from returning to gainful employment Dr. DiDomenico answered yes.

Dr. Ryan Hennessy, an orthopedic surgeon, examined Petitioner at Respondent's request on December 17, 2012. It was Dr. Hennessy's opinion that, as a result of the September 6, 2012 accident, Petitioner suffered a right knee contusion and a lumbar strain. Dr. Hennessy did not assess the Petitioner's head injury or the protruding discs in Petitioner's cervical spine.

On December 18, 2012, the Petitioner was examined by Dr. Russell Glantz at Respondent's request. Dr. Glantz is a neurologist with the Parkview Orthopedic Group. Dr. Glantz opined that the September 6, 2012 work accident had caused a brain injury from which Petitioner's complaints of dizziness stemmed. Neurological examination found no cognitive impairment. Low back pain and right leg weakness may have been due to a nerve stretch injury, but not to any noted disc injury. Dr. Glantz opined that Petitioner had not yet reached a state of maximum medical improvement three months post-injury. He anticipated reaching this state by the six-month post-injury mark. He recommended additional medication and physical therapy for four weeks, to include vestibular therapy. Petitioner could return to desk work if available. From a neurological standpoint, once his dizziness had abated, he would have no further restrictions and be able to return to full-time full-duty work.

Dr. Glantz examined Petitioner again on June 11, 2013. He noted that a knee surgery was to take place the following day but did not further comment on orthopedic questions. Dr. Glantz obtained an updated history from Petitioner, reviewed additional records, and performed a repeat neurological examination. He noted that Petitioner's statement regarding headaches had changed relative to the prior examination; where previously they had been in the right frontal area of the head, now they also radiated to the temporal area and then down across the face to the right side of the jaw. Dr. Glantz noted there was no physiological reason for development of new symptoms so long after an initial injury. He found no evidence of any objective neurological abnormality. He opined that any remaining symptoms were subjective, and not causally related to the September 6, 2012 injury. Dr. Glantz opined that, from a neurological standpoint, Petitioner had reached a state of maximum medical improvement, with no need for further treatment.

Respondent also had Petitioner examined by David E. Hartman, a neuropsychologist. Dr. Hartman authored a report dated April 7, 2015. In that report, Dr. Hartman noted that Dr. Nagar, a neurologist, had diagnosed Petitioner as suffering from post- concussive syndrome. Dr. Hartman also noted that Petitioner's treating neuropsychologist found that Petitioner suffered a brain injury resulting

in decreased cognitive function. Dr. Hartman disagreed with the conclusions of the treating neurologist and treating neuropsychologist. Dr. Hartman opined that the only possible diagnosis for Petitioner was "malingering." In support of his opinion that Petitioner was malingering and had no head injury, Dr. Hartman specifically noted the fact that Petitioner operated a speed boat and went to a health club made a brain injury "highly implausible." The Arbitrator notes, however, that Dr. Nagar recommended that the Petitioner exercise primarily by walking. Dr. Nagar had also approved of Petitioner's use of a boat to fish.

Petitioner's last office visit with Dr. Nagar took place on March 22, 2019. In her testimony, Dr. Nagar agreed that, at that time, the Petitioner had reached a plateau in terms of his recovery. Dr. Nagar opined that the Petitioner would have difficulty lifting anything over 20 pounds and that he was not an appropriate candidate to perform the job duties of a laborer in the water department for the Village of Highland Park. Dr. Nagar agreed that the Petitioner's vestibular imbalance, memory loss and lumbar injury all caused disability to the Petitioner that would affect his normal functions of daily living.

Following the last visit with Dr. Nagar, Petitioner sought out a vocational evaluation. On April 22, 2019, Lisa Byrne performed a vocational assessment of the Petitioner. Her report noted his work activities were to replace water mains, plow snow, remove trees and fill pot holes among other activities. Ms. Byrne noted in her report that the Petitioner had limited education, was a high school graduate who also took classes at the Lake County Community College and John Logan Community College. Ms. Byrne noted the Petitioner didn't do well in his general education classes. She did state that he did better in his automotive classes.

Ms. Byrne noted that Petitioner had been employed in a number of jobs before being employed by Respondent. Most of those jobs were in the auto parts and repair industry. Ms. Byrne testified that she performed a standard battery of tests to evaluate Petitioner's vocational potential and that the test results showed that Petitioner was below average or low average in math, nonverbal reasoning, language skills, finger dexterity and manual speed.

Ms. Byrne noted that Petitioner had a 20 pound lifting restriction which would place him in the light physical demand level of work. Ms. Byrne opined that the Petitioner's opinion, this physical restriction on its own, prevented Petitioner from returning to work at is old job. Specifically, Ms. Byrne opined that the physical injuries on their own, without considering the brain injury, prevented Petitioner from returning to work as a laborer. Ms. Byrne agreed that, more likely than not, Petitioner's knee and back injury qualify him only for light duty, sedentary jobs.

Ms. Byrne opined that based on Petitioner's vocational test results, his educational history, his job history and physical injuries, Petitioner would only qualify for jobs paying wages in the range of between $8.97 to $11.88 per hour. Ms. Byrne recommended that Petitioner look for jobs in the auto parts industry. Ms. Byrne also testified that Petitioner's prior job as a laborer for Respondent currently generates an hourly wage of $26.06 to $34.92 per hour. Ms. Byrne testified that it is her opinion that Petitioner has sustained a wage loss between $14.00 to $26.00 per hour.

Respondent presented no evidence or testimony to contradict Mr. Byrne's assessment. In addition, Respondent offered no evidence to rebut Petitioner's description of his job duties. The Arbitrator notes that Ms. Byrne based her opinion solely on Petitioner's physical injuries to his back

and leg without considering Petitioner's potential brain injury. Those injuries alone, according to Ms. Byrne, caused Petitioner a $14.00 to $26.06 per hour wage loss.

Petitioner testified that he contacted approximately 150 potential employers after his evaluation with Ms. Byrn. Petitioner testified that he followed Ms. Byrne's recommendation and looked for jobs in the auto parts industry, but his job search was unsuccessful. Respondent did not offer the Petitioner any vocational assistance or assistance in his job search. In addition, although Respondent did initially provide Petitioner modified work within his restrictions, Respondent eventually terminated Petitioner on December 16, 2013 without offering another job within his restrictions.

Following his unsuccessful job search, Petitioner applied for and was granted Social Security Disability benefits. Petitioner is currently receiving SSI and SSDI. Petitioner testified that at the present time he continues to have problems with is memory, his low back and radiating pain in his right leg. Petitioner also continues to have loss of range of motion in his right knee. Petitioner testified that prior to his work accident he had no problems with drop foot, no radiating pain from his back, no clicking, popping or tightness in his right knee and no memory problems. This testimony is unrebutted.

CONCLUSIONS:

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:

The Arbitrator finds that the Petitioner's right knee injury, lumbar disc injuries and radiculopathy, cervical disc injuries and traumatic brain injury are related to his September 6, 2012 accident. This finding is supported, in part, by the first complaints made in the emergency room on the day of the accident: in the emergency room chart it was noted that the Petitioner complained of pain from his neck down to his lumbar spine, he had right leg pain and he had lost consciousness. In the first two months following this accident, Petitioner was seen by a neurologist who documented ear drainage, a positive vorteq finding indicating vestibular imbalance, and radiating pain into the lower right extremity.

Respondent presented no evidence to suggest that prior to the date of the accident Petitioner had any difficulties with lumbar radiculopathy, vestibular imbalance or symptoms consistent with post concussive brain injury. The testimony instead establishes that the Petitioner was working full duty as a laborer for the water department. Proof of prior good health and change immediately following an accident and continuing on after that accident may establish that an impaired condition was due to the injury. *Granite City Steel Company v. Industrial Commission*, 97 Ill 2d 402 (1983)

The vorteq finding is of a particular significance as it an objective test measuring vestibular imbalance. At his last office visit with Dr. Nagar, Dr. Nagar noted that Petitioner still had lumbar radiculopathy, difficulty with memory, and difficulty with cognition. In fact, Dr. Nagar testified that during that last office visit his reflexes were abnormal and that Petitioner had drop foot of the right lower extremity. Dr. Nagar specifically agreed at her deposition that the Petitioner's ongoing lumbar neuropathy, more likely than not, was due to a nerve root injury caused by the automobile accident.

As to the Respondent examining medical providers, the Arbitrator notes that Respondent failed to have the Petitioner examined within the past four years. Instead, Respondent relies on an orthopedic surgeon, Dr. Hennessy, who saw Petitioner on only one occasion on December 17, 2012, more than six months prior to Petitioner's knee surgery. The opinions of Dr. Hennessy are not persuasive as they were given prior to the time Petitioner had knee surgery showing a meniscus tear.

As to Dr. Hennessy's findings that Petitioner only suffered a lumbar strain, the Arbitrator notes that this opinion of Dr. Hennessy was based on one examination taking place approximately three months after the accident. Dr. Hennessy did not see the MRI ordered by Dr. Nagar and performed on August 27, 2013. That MRI, according to Dr. Nagar, showed a large left central disc herniation at L5 – S1 and as a result of that finding Dr. Nagar specifically recommended referral to a neurosurgeon. When asked about that lumbar disc herniation and whether it was related to the automobile accident, Dr. Nagar was of the opinion that the disc herniation and the lumbar radiculopathy were a result of the automobile accident at work. The Arbitrator notes that Dr. Nagar saw the Petitioner over ten different times and her most recent visit was on March 22, 2019. The Arbitrator finds the opinions of Dr. Nagar more reliable and persuasive than those of Dr. Hennessy with regards to Petitioner's low back injury.

In addition, the two exams performed by Dr. Russell Glantz, the neurologist, took place on December 18, 2012 and June 11, 2013 – more than seven years ago. Dr. Glantz did agree that Petitioner may have suffered a nerve stretch injury resulting in Petitioner's radiculopathy in the right lower extremity. Dr. Glantz, however, concluded that this radiculopathy had resolved by June 11, 2013. The Arbitrator notes that Dr. Nagar continued to see the Petitioner up to March 22, 2019 and at that particular visit Dr. Nagar noted abnormal reflexes and drop foot in the right lower extremity. The Arbitrator finds Dr. Nagar's opinions are more reliable, credible, and persuasive on the issue of Petitioner's lumbar radiculopathy and spinal injury.

As to Respondent's examining neuropsychologist. Dr. Hartman, the Arbitrator finds that his opinions are less credible than those of Dr. DiDomenico. Dr. Hartman's opinion is that the Petitioner is malingering. In support of this opinion, he cites to the fact that the Petitioner used his boat and went to the gym. The Arbitrator notes that Dr. Nagar approved of both activities. In addition, Dr. Hartman has no opinions regarding the positive finding on the vorteq test supporting the diagnosis of the vestibular imbalance and makes no effort to explain why Petitioner's ear was draining fluid. The Arbitrator finds that the opinions of Dr. Nagar and Dr. DiDomenico are more reliable, credible, and persuasive than those of Dr. Hartman. As a result, the Arbitrator finds that Petitioner's spinal injuries, his knee injury and his brain injury are causally related to the accident.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Petitioner submitted bills from two medical providers: Northwestern Lake Forest Hospital and Northwestern Medicine. The bills from Northwestern Lake Forest Hospital were for the August 27, 2013 MRI of the lumbar spine, the February 7, 2014 vorteq test, the MRI of the brain, and additional tests of balance and hearing. The bills total $9,585.00 and the Arbitrator finds that these bills are reasonable, necessary and related to Petitioner's September 6, 2012 accident. The bill from

Northwestern Medicine in the amount of $625.00 was for the March 22, 2019 visit to Dr. Nagar and the Arbitrator finds that this bill is reasonable, necessary and related to the September 6, 2012 accident. The Arbitrator finds that the bills for Northwestern Lake Forest Hospital and Northwestern Medicine submitted in Petitioner's Exhibit 16 totaling $10,210.00 are reasonable, necessary and related to Petitioner's work accident.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner is owed temporary total disability benefits from the date Respondent terminated Petitioner's position, December 16, 2013, until March 22, 2019. On March 22, 2019, Dr. Nagar found that the Petitioner's condition had plateaued. At that time, Petitioner still had a lifting restriction of 20 pounds and Dr. Nagar was of the opinion that Petitioner was unlikely to return to work as a laborer for the water department. At that time, on his own, Petitioner began his own vocational rehabilitation program through Lisa Byrne. Petitioner attempted to find employment with approximately 150 different employers for job positions within his restrictions. His job search was unsuccessful. Respondent made no offer of alternate modified employment and Respondent failed to perform its own vocational assessment and rehabilitation. The Arbitrator finds that from Dr. Nagar's last office visit of March 22, 2019 to the September 18, 2020 hearing date Petitioner is owed maintenance benefits.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner has shown that he is unable to return to work as a laborer. Based solely on the spinal injury and the knee injury, the Arbitrator finds that Petitioner is no longer employable as a laborer. Petitioner has a 20 pound lifting restriction which would prevent work in that field.

Based on the testimony of Lisa Byrne and Petitioner, the Arbitrator notes that Petitioner has other barriers to employment including his limited educational background and job experience. Ms. Byrne gave her opinion that based on Petitioner's physical injuries and his educational history and his vocational history, Petitioner's job prospects are limited. Ms. Byrne specifically found that the Petitioner's replacement jobs would likely generate, at best, a replacement wage of somewhere between $8.90 per hour and $11.88 per hour. Ms. Byrne gave her opinion that laborers are currently making between $26.06 per hour and $34.92 per hour. This testimony was unrebutted by Respondent. Under Section 8(d)(1), an impaired worker is entitled to a wage differential award when he is partially incapacitated from pursuing his usual line of employment and there is a difference between the average amount which he would have earned in his old job compared to the amount of income he will earn or is able to earn in some suitable employment following the accident. 820 ILCS 305/8(d)(1).

Accordingly, Arbitrator finds that Petitioner has shown that he has lost wages of $20.00 per hour or $800.00 per week and the Arbitrator finds that Petitioner is entitled to a weekly benefit of $533.33.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC033774
Case Name	ZDON, JASON P v. CITY OF HIGHLAND PARK
Consolidated Cases	12WC032108
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0361
Number of Pages of Decision	13
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	John Scanlon
Respondent Attorney	Adam Rettberg

DATE FILED: 7/16/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON ZDON,

Petitioner,

vs. No: 12 WC 033774

CITY OF HIGHLAND PARK,

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, temporary total disability benefits, maintenance and vocational rehabilitation, and permanent partial disability, 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 permanent partial disability. The Arbitrator ordered an indefinite wage differential award. However, the accident in this case occurred on September 6, 2012. The Commission observes that for accidental injuries that occur on or after September 1, 2011, a wage differential award shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later. 820 ILCS 305/8(d)(1) (West 2012). Accordingly, the Commission modifies the Decision of the Arbitrator to reflect this statutory limitation of the award.

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 November 4, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits, commencing September 18, 2020, of $533.00 per

week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in §8(d)(1) of the Act.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 16,2021

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

o: 7/1/21
BNF/kcb
045

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZDON, JASON
Employee/Petitioner

Case# **12WC033774**

12WC032108

CITY OF HIGHLAND PARK
Employer/Respondent

On 11/4/2020, 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:

0391 HEALY SCANLON
JOHN P SCANLON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ADAM RETTBERG
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

Jason Zdon
Employee/Petitioner

v.

City of Highland Park
Employer/Respondent

Case # **12** WC **33774**

Consolidated cases: **12 WC 32108**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **September 18, 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 6, 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 $**37,759.95**; the average weekly wage was $**726.15**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner maintenance benefits of $ **484.10**/week for **77 4/7** weeks, commencing **March 23, 2019** through **September 18, 2020**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**484.10**/week for **325 5/7** weeks, commencing **December 16, 2013** through **March 22, 2019**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**10,210.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 18, 2020**, of $**533.00**/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Arbitrator Anthony C. Erbacci

October 29, 2020
Date

NOV 4 - 2020

FACTS:

On September 6, 2012, Petitioner was employed by Respondent as a laborer for the water department. As part of his regular job duties, Petitioner was required to snow plow, check and repair water main breaks and remove trees. While working to repair water main breaks, Petitioner would have to lift and carry concrete debris that could weigh in excess of 100 pounds. He would also have to remove manhole covers that weighed between 50 – 100 pounds. His job duties also required him to climb in and out of trenches and work in confined spaces where he would have to kneel and squat. In addition, Petitioner testified that it was fairly common for him to have to use ladders to perform his day to day activities and that he had to carry bags of cement and sand.

On September 6, 2012, Petitioner was working out on the streets of Highland Park, IL when he was struck by a car while he was in a crosswalk. Petitioner stated that the car struck his right leg and the first thing he remembered after the accident was waking up in the hospital.

The medical records and the testimony of the Petitioner show that Petitioner was taken from the scene of the accident to Highland Park Hospital. The Highland Park Hospital emergency room records document that the Petitioner lost consciousness when he hit his head and that he had complaints of right leg weakness and pain from his neck down to his lumbar spine. While at the hospital, Petitioner had an x-ray of is right knee and a CT of his cervical spine, thoracic spine and lumbar spine. The CT's disclosed disc protrusions at C2 – C3, C3 – C4 and C4 –C5, bulging discs at L2 – L3, L3 – L4 and L4 – L5 and a focal disc protrusion at L5 – S1. The emergency room physicians recommended that the Petitioner follow up with his primary care doctor. Petitioner's primary care doctor recommended that he see a neurologist for his head injury and spinal injuries, and an orthopedic surgeon for his knee pain.

The Petitioner was seen by Dr. Roger Chams, an orthopedic surgeon, for treatment of his knee injury. Because Petitioner failed to respond to conservative treatment, Dr. Chams recommended surgery. Respondent initially refused to approve this surgery. Dr. Chams at his deposition testified that more likely than not Petitioner's September 6, 2012 accident caused a knee injury that required surgery. Dr. Chams performed surgery on the Petitioner on June 12, 2013. The operative report notes that the Petitioner sustained a lateral meniscus tear and right knee lateral tilt syndrome of the patella femoral joint along with grade 3 chondromalacia of the patella femoral joint. It was Dr. Chams' further opinion that all of the treatment provided to the Petitioner including injections, therapy and surgery were all reasonable and necessary and required as a result of the work accident.

During this same time frame, Petitioner was also receiving treatment from Dr. Charulatha Nagar, a neurologist, for his spinal and head injuries. Dr. Nagar first saw the Petitioner on September 28, 2012, noting a history of being hit by a car while working on a construction crew. Petitioner complained to Dr. Nagar of problems with his ability to recall information and difficulties with headaches and dizziness.

Dr. Nagar's records note that clear fluid was draining from his left ear. Because of the fluid leak, Dr. Nagar ordered an MRI to determine if there was a dural tear or a tympanic membrane tear. Dr. Nagar noted during her physical exam that Petitioner had nystagmus and likely had an injury to his vestibular system. Dr. Nagar also noted that the Petitioner at that first visit had tandom dystaxia to a significant degree. Dr. Nagar also noted vision deficits based on the Romberg test.

As a result of this exam, Dr. Nagar also ordered a Vorteq motor conduction test to determine if Petitioner's head injury was causing vestibular imbalance. Dr. Nagar's diagnosis at that time was traumatic brain injury and post concussive syndrome. It was Dr. Nagar's opinion that, more likely than not, the leaking from Petitioner's ear was a result of the motor vehicle accident. Dr. Nagar further concluded that based on the Vorteq results, the Petitioner suffered vestibular balance problems as a result of the automobile accident.

At a subsequent visit on October 11, 2012, Dr. Nagar concluded that Petitioner was suffering from lumbar radiculopathy as a result of a protruding disc at L5 – S1. It was Dr. Nagar's opinion that the lumbar injury was, more likely than not, a result of the automobile accident. In addition, Dr. Nagar was of the opinion that Petitioner was having memory issues, balance issues and headaches as a result of the head trauma sustained in the accident. At a subsequent visit on December 3, 2012 Dr. Nagar noted that Petitioner had problems with his balance and increased lumbar radiculopathy.

Dr. Nagar saw the Petitioner again on March 26, 2013 after Petitioner had returned back to work in a modified job position as a computer entry clerk. Dr. Nagar noted that the Petitioner was having migraine headaches and vision problems as a result of the computer entry job. At a July 10, 2013 visit, Dr. Nagar noted that Petitioner was suffering from reduced reflexes in his right knee and right ankle. It was Dr. Nagar's opinion that this loss of reflex function was a result of the compression of the nerve root at L5 – S1.

On August 21, 2013 Dr. Nagar saw the Petitioner to determine if he could return to full job duties. Before releasing him to work, Dr. Nagar recommended that Petitioner undergo a neuropsychological examination and another lumbar MRI. The MRI of the lumbar spine showed a moderate to large far left lateral disc. Dr. Nagar was of the opinion that Petitioner's right sided sciatica was a result of that damaged disc and the spasm and inflammation it would cause. As a result of the MRI, Dr. Nagar was of the opinion that Petitioner had a large disc herniation at L5 – S1 that needed a neurosurgical evaluation. Dr. Nagar's office notes from October 9, 2013 reflect that neurosurgery had been recommended to address Petitioner's lumbar L5 – S1 herniated disc. Respondent declined to approve this surgery.

Dr. Nagar's last visit with Petitioner was on March 22, 2019. At that visit, Dr. Nagar noted the Petitioner's nerve root impingement of the lumbar spine was causing drop foot to Petitioner's right foot. At that time, it was Dr. Nagar's opinion that the Petitioner had plateaued and he would not be getting any better. Dr. Nagar also noted Petitioner had a lifting restriction of no more than 20 pounds. Dr. Nagar also gave the opinion that the Petitioner would not be able to return to work as a laborer due to his lumbar and vestibular problems. It was further Dr. Nagar's opinion that the Petitioner's vestibular imbalance, his headaches, his memory loss, all were a result of the work accident. Dr. Nagar also gave her opinion that, more likely than not, the Petitioner's lumbar radiculopathy and bulging and herniated discs were a result of the automobile accident. Dr. Nagar opined that Petitioner's condition at that time was chronic and likely permanent. Dr. Nagar further opined that these conditions caused disability to the Petitioner and effected his ability to perform his normal functions.

Dr. Nagar referred the Petitioner to Michael DiDomenico, a neuropsychologist, for evaluation of his traumatic brain injury. Dr. DiDomenico performed neuropsychological testing on Petitioner on two different occasions. Dr. DiDomenico produced reports dated September 25, 2013 and July 26, 2019. Dr. DiDomenico concluded in both reports that Petitioner did suffer a traumatic brain injury resulting in

loss of cognition, memory, concentration and processing speed. Dr. DiDomenico gave his opinion that this traumatic brain injury was in fact caused by the automobile accident and that, in his opinion, Petitioner would be unable to carry on any full-time work as a result of his traumatic brain injury. It was his opinion that the traumatic brain injury suffered by Petitioner was a result of the September 6, 2012 work accident.

Dr. DiDomenico gave his opinion that Petitioner's injury was permanent. Dr. DiDomenico also gave his opinion that the Petitioner suffered a "moderate head injury dementia from traumatic brain injury." It was his opinion that the traumatic brain injury resulted in significant cognitive impairment. Dr. DiDomenico concluded that the Petitioner's test results "strongly suggest that Mr. Zdon has significant cognitive impairment especially with slowed mental processing, disturbances of attention, concentration, impaired ability to maintain concepts and impaired memory functions." When asked if these impairments would prevent him from returning to gainful employment Dr. DiDomenico answered yes.

Dr. Ryan Hennessy, an orthopedic surgeon, examined Petitioner at Respondent's request on December 17, 2012. It was Dr. Hennessy's opinion that, as a result of the September 6, 2012 accident, Petitioner suffered a right knee contusion and a lumbar strain. Dr. Hennessy did not assess the Petitioner's head injury or the protruding discs in Petitioner's cervical spine.

On December 18, 2012, the Petitioner was examined by Dr. Russell Glantz at Respondent's request. Dr. Glantz is a neurologist with the Parkview Orthopedic Group. Dr. Glantz opined that the September 6, 2012 work accident had caused a brain injury from which Petitioner's complaints of dizziness stemmed. Neurological examination found no cognitive impairment. Low back pain and right leg weakness may have been due to a nerve stretch injury, but not to any noted disc injury. Dr. Glantz opined that Petitioner had not yet reached a state of maximum medical improvement three months post-injury. He anticipated reaching this state by the six-month post-injury mark. He recommended additional medication and physical therapy for four weeks, to include vestibular therapy. Petitioner could return to desk work if available. From a neurological standpoint, once his dizziness had abated, he would have no further restrictions and be able to return to full-time full-duty work.

Dr. Glantz examined Petitioner again on June 11, 2013. He noted that a knee surgery was to take place the following day but did not further comment on orthopedic questions. Dr. Glantz obtained an updated history from Petitioner, reviewed additional records, and performed a repeat neurological examination. He noted that Petitioner's statement regarding headaches had changed relative to the prior examination; where previously they had been in the right frontal area of the head, now they also radiated to the temporal area and then down across the face to the right side of the jaw. Dr. Glantz noted there was no physiological reason for development of new symptoms so long after an initial injury. He found no evidence of any objective neurological abnormality. He opined that any remaining symptoms were subjective, and not causally related to the September 6, 2012 injury. Dr. Glantz opined that, from a neurological standpoint, Petitioner had reached a state of maximum medical improvement, with no need for further treatment.

Respondent also had Petitioner examined by David E. Hartman, a neuropsychologist. Dr. Hartman authored a report dated April 7, 2015. In that report, Dr. Hartman noted that Dr. Nagar, a neurologist, had diagnosed Petitioner as suffering from post- concussive syndrome. Dr. Hartman also noted that Petitioner's treating neuropsychologist found that Petitioner suffered a brain injury resulting

in decreased cognitive function. Dr. Hartman disagreed with the conclusions of the treating neurologist and treating neuropsychologist. Dr. Hartman opined that the only possible diagnosis for Petitioner was "malingering." In support of his opinion that Petitioner was malingering and had no head injury, Dr. Hartman specifically noted the fact that Petitioner operated a speed boat and went to a health club made a brain injury "highly implausible." The Arbitrator notes, however, that Dr. Nagar recommended that the Petitioner exercise primarily by walking. Dr. Nagar had also approved of Petitioner's use of a boat to fish.

Petitioner's last office visit with Dr. Nagar took place on March 22, 2019. In her testimony, Dr. Nagar agreed that, at that time, the Petitioner had reached a plateau in terms of his recovery. Dr. Nagar opined that the Petitioner would have difficulty lifting anything over 20 pounds and that he was not an appropriate candidate to perform the job duties of a laborer in the water department for the Village of Highland Park. Dr. Nagar agreed that the Petitioner's vestibular imbalance, memory loss and lumbar injury all caused disability to the Petitioner that would affect his normal functions of daily living.

Following the last visit with Dr. Nagar, Petitioner sought out a vocational evaluation. On April 22, 2019, Lisa Byrne performed a vocational assessment of the Petitioner. Her report noted his work activities were to replace water mains, plow snow, remove trees and fill pot holes among other activities. Ms. Byrne noted in her report that the Petitioner had limited education, was a high school graduate who also took classes at the Lake County Community College and John Logan Community College. Ms. Byrne noted the Petitioner didn't do well in his general education classes. She did state that he did better in his automotive classes.

Ms. Byrne noted that Petitioner had been employed in a number of jobs before being employed by Respondent. Most of those jobs were in the auto parts and repair industry. Ms. Byrne testified that she performed a standard battery of tests to evaluate Petitioner's vocational potential and that the test results showed that Petitioner was below average or low average in math, nonverbal reasoning, language skills, finger dexterity and manual speed.

Ms. Byrne noted that Petitioner had a 20 pound lifting restriction which would place him in the light physical demand level of work. Ms. Byrne opined that the Petitioner's opinion, this physical restriction on its own, prevented Petitioner from returning to work at is old job. Specifically, Ms. Byrne opined that the physical injuries on their own, without considering the brain injury, prevented Petitioner from returning to work as a laborer. Ms. Byrne agreed that, more likely than not, Petitioner's knee and back injury qualify him only for light duty, sedentary jobs.

Ms. Byrne opined that based on Petitioner's vocational test results, his educational history, his job history and physical injuries, Petitioner would only qualify for jobs paying wages in the range of between $8.97 to $11.88 per hour. Ms. Byrne recommended that Petitioner look for jobs in the auto parts industry. Ms. Byrne also testified that Petitioner's prior job as a laborer for Respondent currently generates an hourly wage of $26.06 to $34.92 per hour. Ms. Byrne testified that it is her opinion that Petitioner has sustained a wage loss between $14.00 to $26.00 per hour.

Respondent presented no evidence or testimony to contradict Mr. Byrne's assessment. In addition, Respondent offered no evidence to rebut Petitioner's description of his job duties. The Arbitrator notes that Ms. Byrne based her opinion solely on Petitioner's physical injuries to his back

and leg without considering Petitioner's potential brain injury. Those injuries alone, according to Ms. Byrne, caused Petitioner a $14.00 to $26.06 per hour wage loss.

Petitioner testified that he contacted approximately 150 potential employers after his evaluation with Ms. Byrn. Petitioner testified that he followed Ms. Byrne's recommendation and looked for jobs in the auto parts industry, but his job search was unsuccessful. Respondent did not offer the Petitioner any vocational assistance or assistance in his job search. In addition, although Respondent did initially provide Petitioner modified work within his restrictions, Respondent eventually terminated Petitioner on December 16, 2013 without offering another job within his restrictions.

Following his unsuccessful job search, Petitioner applied for and was granted Social Security Disability benefits. Petitioner is currently receiving SSI and SSDI. Petitioner testified that at the present time he continues to have problems with is memory, his low back and radiating pain in his right leg. Petitioner also continues to have loss of range of motion in his right knee. Petitioner testified that prior to his work accident he had no problems with drop foot, no radiating pain from his back, no clicking, popping or tightness in his right knee and no memory problems. This testimony is unrebutted.

CONCLUSIONS:

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:

The Arbitrator finds that the Petitioner's right knee injury, lumbar disc injuries and radiculopathy, cervical disc injuries and traumatic brain injury are related to his September 6, 2012 accident. This finding is supported, in part, by the first complaints made in the emergency room on the day of the accident: in the emergency room chart it was noted that the Petitioner complained of pain from his neck down to his lumbar spine, he had right leg pain and he had lost consciousness. In the first two months following this accident, Petitioner was seen by a neurologist who documented ear drainage, a positive vorteq finding indicating vestibular imbalance, and radiating pain into the lower right extremity.

Respondent presented no evidence to suggest that prior to the date of the accident Petitioner had any difficulties with lumbar radiculopathy, vestibular imbalance or symptoms consistent with post concussive brain injury. The testimony instead establishes that the Petitioner was working full duty as a laborer for the water department. Proof of prior good health and change immediately following an accident and continuing on after that accident may establish that an impaired condition was due to the injury. *Granite City Steel Company v. Industrial Commission*, 97 Ill 2d 402 (1983)

The vorteq finding is of a particular significance as it an objective test measuring vestibular imbalance. At his last office visit with Dr. Nagar, Dr. Nagar noted that Petitioner still had lumbar radiculopathy, difficulty with memory, and difficulty with cognition. In fact, Dr. Nagar testified that during that last office visit his reflexes were abnormal and that Petitioner had drop foot of the right lower extremity. Dr. Nagar specifically agreed at her deposition that the Petitioner's ongoing lumbar neuropathy, more likely than not, was due to a nerve root injury caused by the automobile accident.

As to the Respondent examining medical providers, the Arbitrator notes that Respondent failed to have the Petitioner examined within the past four years. Instead, Respondent relies on an orthopedic surgeon, Dr. Hennessy, who saw Petitioner on only one occasion on December 17, 2012, more than six months prior to Petitioner's knee surgery. The opinions of Dr. Hennessy are not persuasive as they were given prior to the time Petitioner had knee surgery showing a meniscus tear.

As to Dr. Hennessy's findings that Petitioner only suffered a lumbar strain, the Arbitrator notes that this opinion of Dr. Hennessy was based on one examination taking place approximately three months after the accident. Dr. Hennessy did not see the MRI ordered by Dr. Nagar and performed on August 27, 2013. That MRI, according to Dr. Nagar, showed a large left central disc herniation at L5 – S1 and as a result of that finding Dr. Nagar specifically recommended referral to a neurosurgeon. When asked about that lumbar disc herniation and whether it was related to the automobile accident, Dr. Nagar was of the opinion that the disc herniation and the lumbar radiculopathy were a result of the automobile accident at work. The Arbitrator notes that Dr. Nagar saw the Petitioner over ten different times and her most recent visit was on March 22, 2019. The Arbitrator finds the opinions of Dr. Nagar more reliable and persuasive than those of Dr. Hennessy with regards to Petitioner's low back injury.

In addition, the two exams performed by Dr. Russell Glantz, the neurologist, took place on December 18, 2012 and June 11, 2013 – more than seven years ago. Dr. Glantz did agree that Petitioner may have suffered a nerve stretch injury resulting in Petitioner's radiculopathy in the right lower extremity. Dr. Glantz, however, concluded that this radiculopathy had resolved by June 11, 2013. The Arbitrator notes that Dr. Nagar continued to see the Petitioner up to March 22, 2019 and at that particular visit Dr. Nagar noted abnormal reflexes and drop foot in the right lower extremity. The Arbitrator finds Dr. Nagar's opinions are more reliable, credible, and persuasive on the issue of Petitioner's lumbar radiculopathy and spinal injury.

As to Respondent's examining neuropsychologist. Dr. Hartman, the Arbitrator finds that his opinions are less credible than those of Dr. DiDomenico. Dr. Hartman's opinion is that the Petitioner is malingering. In support of this opinion, he cites to the fact that the Petitioner used his boat and went to the gym. The Arbitrator notes that Dr. Nagar approved of both activities. In addition, Dr. Hartman has no opinions regarding the positive finding on the vorteq test supporting the diagnosis of the vestibular imbalance and makes no effort to explain why Petitioner's ear was draining fluid. The Arbitrator finds that the opinions of Dr. Nagar and Dr. DiDomenico are more reliable, credible, and persuasive than those of Dr. Hartman. As a result, the Arbitrator finds that Petitioner's spinal injuries, his knee injury and his brain injury are causally related to the accident.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Petitioner submitted bills from two medical providers: Northwestern Lake Forest Hospital and Northwestern Medicine. The bills from Northwestern Lake Forest Hospital were for the August 27, 2013 MRI of the lumbar spine, the February 7, 2014 vorteq test, the MRI of the brain, and additional tests of balance and hearing. The bills total $9,585.00 and the Arbitrator finds that these bills are reasonable, necessary and related to Petitioner's September 6, 2012 accident. The bill from

Northwestern Medicine in the amount of $625.00 was for the March 22, 2019 visit to Dr. Nagar and the Arbitrator finds that this bill is reasonable, necessary and related to the September 6, 2012 accident. The Arbitrator finds that the bills for Northwestern Lake Forest Hospital and Northwestern Medicine submitted in Petitioner's Exhibit 16 totaling $10,210.00 are reasonable, necessary and related to Petitioner's work accident.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner is owed temporary total disability benefits from the date Respondent terminated Petitioner's position, December 16, 2013, until March 22, 2019. On March 22, 2019, Dr. Nagar found that the Petitioner's condition had plateaued. At that time, Petitioner still had a lifting restriction of 20 pounds and Dr. Nagar was of the opinion that Petitioner was unlikely to return to work as a laborer for the water department. At that time, on his own, Petitioner began his own vocational rehabilitation program through Lisa Byrne. Petitioner attempted to find employment with approximately 150 different employers for job positions within his restrictions. His job search was unsuccessful. Respondent made no offer of alternate modified employment and Respondent failed to perform its own vocational assessment and rehabilitation. The Arbitrator finds that from Dr. Nagar's last office visit of March 22, 2019 to the September 18, 2020 hearing date Petitioner is owed maintenance benefits.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner has shown that he is unable to return to work as a laborer. Based solely on the spinal injury and the knee injury, the Arbitrator finds that Petitioner is no longer employable as a laborer. Petitioner has a 20 pound lifting restriction which would prevent work in that field.

Based on the testimony of Lisa Byrne and Petitioner, the Arbitrator notes that Petitioner has other barriers to employment including his limited educational background and job experience. Ms. Byrne gave her opinion that based on Petitioner's physical injuries and his educational history and his vocational history, Petitioner's job prospects are limited. Ms. Byrne specifically found that the Petitioner's replacement jobs would likely generate, at best, a replacement wage of somewhere between $8.90 per hour and $11.88 per hour. Ms. Byrne gave her opinion that laborers are currently making between $26.06 per hour and $34.92 per hour. This testimony was unrebutted by Respondent. Under Section 8(d)(1), an impaired worker is entitled to a wage differential award when he is partially incapacitated from pursuing his usual line of employment and there is a difference between the average amount which he would have earned in his old job compared to the amount of income he will earn or is able to earn in some suitable employment following the accident. 820 ILCS 305/8(d)(1).

Accordingly, Arbitrator finds that Petitioner has shown that he has lost wages of $20.00 per hour or $800.00 per week and the Arbitrator finds that Petitioner is entitled to a weekly benefit of $533.33.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC002454
Case Name	BRANDONISIO,PAT v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0362
Number of Pages of Decision	31
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	William Martay
Respondent Attorney	Lucy Huang

DATE FILED: 7/16/2021

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0362

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

PAT BRANDONISIO

Petitioner,

vs. NO: 17 WC 02454

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission agrees with the Arbitrator's Decision in its entirety with the exception of two sentences on page 23. Therefore, the Commission strikes the second and third sentences in the first full paragraph on page 23, beginning with the words, "The Arbitrator notes" and ending with the words, "vocational rehabilitation." All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on September 11, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is only entitled to maintenance benefits from January 20, 2018, to March 29, 2019. Respondent has paid Petitioner $58,351.30 for maintenance benefits from January 20, 2018, to March 29, 2019. Petitioner is not entitled to maintenance benefits from March 30, 2019, to June 1, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 100 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 20% of the man 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.

Based upon the named Respondent herein, no bond is set by the Commission. *820 ILCS 305/19(f)(2)*. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court. *820 ILCS 305/19(f)(1).*

July 16, 2021

KAD/bsd
O051821
42

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0362

BRANDONISIO, PAT
Employee/Petitioner

Case# **17WC002454**

CITY OF CHICAGO
Employer/Respondent

On 9/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% 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:

1759 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO ASST CORP COUN
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

Pat Brandonisio
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17** WC **02454**

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 June 11, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On December 28, 2016, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,406.58**; the average weekly wage was $**1,411.66**.

On the date of accident, Petitioner was **62** 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 $**52,032.15** for TTD, $ **0**for TPD, $ **58,351.30** for maintenance, and $**3,875.90** for other benefits, for a total credit of $**114,259.35**.

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

ORDER

Petitioner is only entitled to maintenance benefits from January 20, 2018 to March 29, 2019. Respondent has paid Petitioner $58,351.30 for maintenance benefits from January 20, 2018 to March 29, 2019. Petitioner is not entitled to maintenance benefits from March 30, 2019 to June 1, 2019.

Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 100 weeks because the injuries sustained caused 20% loss of the man as a whole, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

09-10-19
Date

SEP 11 2019

Pat Brandonisio v. City of Chicago
17 WC 02454

STATEMENT OF FACTS

It is stipulated to by the parties that on December 28, 2016 Pat Brandonisio ("Petitioner") sustained an injury to his "stomach, groin or left hip" while in the course and scope of his employment with the City of Chicago ("Respondent") (T. 10). His job title was Motor Truck Driver for the Department of Fleet and Facility Management.

Petitioner testified he began working for the respondent in 1993, which means he has worked for this employer for approximately 25 years (T. 34) He is vested in his pension and eligible for retirement. According to the September 23, 2018 Vocational Report, Petitioner inquired what he would need to do if he decided he wanted to retire (RX #1).

The parties stipulated that he was earning $1,411.66 a week at the time of his injury.

On the date of the incident, December 28, 2016, Petitioner stated that felt an acute left stomach, groin or left hip pain after he was lifting garbage cans at work. (T. 10) Petitioner initially sought medical treatment at U.S. Healthworks, (Dr. Saeed) and was diagnosed with a strain of the adductor muscle of the left thigh. (PX #4). Dr. Saeed prescribed an MRI of the pelvis on January 6, 2017, which showed subtle bilateral superior labral tearing, more extensive on the right than the left with mild osteoarthritis and no evidence of bone contusion or acute fracture (PX #4). Petitioner was placed off work for one week was scheduled to return to Dr. Saeed on January 14, 2017. It is unclear if Petitioner returned to him on that date as those records were not put into evidence.

As an aside, the Arbitrator notes that Petitioner also treated at Mercy Works, but those records were not submitted into evidence either.

Additionally, no accident report was entered into evidence, however the injury on duty report states that he injured his "lumbar and/or sacral" area. (PX #4) Further, it stated the accident occurred while pulling a garbage cart from inside the shop. (PX #4) Petitioner's testimony at trial was that he pulled a can outside of the shop. (T. 10)

The Arbitrator notes the "mechanism of injury" details because the Petitioner's diagnoses was never firmly established by any of this doctors.

In any event, the Petitioner decided to treat with Midwest Orthopedics at Rush, where he was treated by a number of physicians whom had difficulty diagnosing his condition. (PX #4) His initial physician was Dr. Forsythe, who examined the Petitioner on January 10, 2017 and reviewed the MRI results. His assessment was "hip pain, possible labral tear with mild arthritis." Since his pain was mostly related to the hip, Petitioner was referred to Dr. Shane Nho for further management. (PX #4)

Dr. Nho examined the Petitioner on January 24, 2017, who wrote, "it is actually felt to left testicular pain, which radiates proximally." It's aggravated by sitting. It is not associated with mechanical symptoms. Further, he wrote that "the cause of the Petitioner's pain was unclear," (PX #4) His assessment was "pubalgia, adductor tendinitis and possible sports hernia," The Arbitrator notes that "publagia" is pain arising from the pubic symphysis and "mechanical pain" refers to any type of pain caused by placing abnormal stress on muscles. Dr. Nho referred the Petitioner to a general surgeon, Dr. Luu, to make sure the hernia repair he had back in 2010 was still intact. It was.

Petitioner began physical therapy at Athletico on January 26, 2017. It appears from the record that Petitioner underwent one physical therapy session.

On January 27, 2017, the Petitioner was examined by Dr. Minh Luu, a general surgeon, who ruled out a sports hernia simply diagnosed groin pain. Petitioner was prescribed Viagra and referred to the pain clinic with Dr. Matthew Jaycox. The Arbitrator notes the record of Dr. Luu's visit is incomplete. (PX #4) However, it reveals Petitioner was previously being prescribed levothyroxine for hypothyroidism. (Id.)

Subsequently, Dr. Nho kept the Petitioner off work until approval was granted for the hip injection, which was prescribed to see if the pain was intraarticular or not; reasoning that if there was no pain relief after the injection, then the pain was not generating from that site. (PX #4) After the injections on March 2, 2017, there was no pain relief nor a change in symptoms. Petitioner was referred to Dr. Levine to consider alternative diagnoses. For instance, Petitioner noticed some curvature in his penis since the work accident and would like to determine whether his could be related to the work injury. (PX #4)

Petitioner was referred to Dr. Levine at Rush because the Petitioner stated that the he noticed a curvature of his penis after the work injury. (PX #4) This appointment occurred on

March 14, 2017, but Dr. Levine's records were not put into evidence. However, it appears he was diagnosed with Peyronie's disease. (RX #3)

On April 17, 2017, the Petitioner was examined by Dr. Ramesh Singa on behalf of Dr. Matthew Jaycox. Petitioner complained of stabbing pain that begins in the scrotum and goes to the left groin. It is worsened by sitting for long periods of time. Dr. Levine thought he might have pudental nerve entrapment syndrome. The primary diagnosis was orchiodynia (testicular pain) and pudental neuralgia. The Arbitrator notes that pudental nerve runs through your genitals, anus and perineum. The perineum is between your anus and genitals. Pudental neuralgia causes pain, especially when you sit. Dr. Jaycox prescribed Lyrica, a nerve pain medication often used to treat fibromyalgia. A hypogastric block was prescribed and the Petitioner to Dr. Shelia Dugan, a pelvic floor specialist. Dr. Singha wrote that the condition was related to work injury (RX #4)

On April 21, 2017, Petitioner attended a section 12 examination at the request of the Respondent. (RX #3) Dr. Mutchnik's IME diagnosed groin pain of the left hip and Peyronie's disease. The doctor noted that Petitioner's Peyronie's disease is not work related and should not affect his ability to return to work (RX #3). The Arbitrator notes that the Mayo Clinic medical definition of Peyronie's disease is the development of fiberous scar tissue inside the penis that causes curved, painful erections. The cause isn't well understood but generally results from repeated injury to the penis.

On April 24, 2017, Petitioner attended an IME with Dr. Michael Stover. (RX #2) Physical examination of the left hip showed "good strength" and reduced range of motion. Neurologically, Petitioner was fully intact. Dr. Stover diagnosed Petitioner with left groin pain. The doctor opined Petitioner appeared to have some degeneration of the hip and some mild cartilage loss and bilateral labral tears, but these were not the cause of Petitioner's pain. Instead, he thought there might be some nerve entrapment near the perineum. Petitioner did not not need further treatment for his hips. The doctor further opined, "With regards to his labral tears,..these are degenerative and I think that these are <u>not</u> a source of his disability. Therefore, he would have no restrictions with regards to these in his return to work. I do not believe that

he will need any further treatment. He is at maximum medical improvement with regard to his hips." (RX #2)

On May 19, 2017, Dr. Matthew Jaycox performed a hypogastric plexus block (c-arm) for treatment and diagnosis. The Arbitrator notes such procedures are designed to help relieve pelvic pain from the testicles. The hypogastric plexus us a bundle of nerves near the bottom of the spinal cord.

The injections didn't help alleviate Petitioner's pain. Petitioner first sought medical attention Dr. Sheila Dugan who recommended expert physical therapy on September 13, 2017 and kept the Petitioner off work. Subsequently, the doctor released Petitioner back to work with the permanent restriction of sitting 30 minutes maximum while using a TENS unit, including travel to and from work. (PX #4) Petitioner noted that it takes 45 minutes to drive each way to physical therapy.

On September 25, 2017, Dr. Dugan attempted to exam the Petitioner, but her assessment was limited secondary to severe pain and poor pain tolerance to any position besides standing. Her primary diagnoses was myalgia. The Mayo Clinic definition of myalgia is muscle pain. Physical therapy began that day at Arc in Westmont, Illinois. It consisted of massage, myofascial release and electric stimulation with external electrodes placed on the left side of the pudental nerve. (PX #4)

On October 16, 2017, the Arc physical therapist wrote that if the Petitioner sits on his right butt cheek, the pain isn't so bad. (RX #4) On exam, Petitioner's bilateral hip active and passive range of motion was within normal limits. His neurological exam was intact. Petitioner was prescribed Lyrica, Viagra and a TENs unit at home. (RX #4) The primary diagnosis was muscle pain and he was unable to return to work. (Id.)

On October 27, 2017, Petitioner stated that he stands and walks without a problem, but sitting was difficult. By November 1, his sitting tolerance in the car was improving. Petitioner began using the electrical stimulation device in the car while driving with approval from the physical therapist. Petitioner reported no pain when standing and walking. (RX #4)

On December 22, 2017, Dr. Dugan wrote that the Petitioner was at maximum medical improvement. He had permanent restrictions in that he could only sit for 30 minutes maximum while using a TENs unit, including travel to and from work. (RX #4)

Unable to return to his usual and customary position with Respondent, Petitioner was placed into a vocational rehabilitation program to aid him in finding gainful employment within his restrictions. Respondent hired Vocamotive for this purpose.

During his Initial Evaluation at Vocamotive on March 7, 2018 with Lisa Hema, a certified rehabilitation counselor, it was noted that Petitioner had a high school diploma, and his previous occupations were Driver, Barback, and Craps Dealer. Ms. Helma noted that Petitioner has permanent restrictions that he was only able to sit for 30 minutes maximum while using a TENS unit, including travel to and from work for his groin injury. Petitioner has no other physical restrictions. Petitioner claimed not to have a computer at home. Currently, he had a CDL A driver's license and a limousine driver's license certification (RX #1).

Ms. Helma opined that Petitioner might have some transferable skills and he expressed an interest in returning to work in a driving occupation. Petitioner reported that he believed he could drive short distances. It was noted that he reported that if a position was available at Midway Airport driving trucks to the Machinist, he would like to try it. Ms. Helma opined that Petitioner remains employable, and Petitioner should be able to locate employment in any position congruent with his previous experiences and physical capabilities. Ms. Helma stated that positions would be available to Petitioner are: Hostler, Front Desk Clerk, Cashier, Security Guard, along with other occupations. Ms. Helma further opined that if Petitioner is able to obtain employment has a Hostler, then his wage-earning potential would be between $18 and $24 per hour. She further opined that if Petitioner is unable to find work in a driving position, his most probable wage earning potential is between minimum wage and $12 per hour. Further, Ms. Helma stated that Petitioner is a viable rehabilitation candidate and that these services should be provided to him. Ms. Helma completed an Initial Evaluation Report and a Rehabilitation Plan on May 13, 2018 (RX #1). In the March 13, 2018 Rehabilitation Plan, it was noted that Petitioner would begin participation in self-directed job search and supervised job search. He would make reasonable effort to conduct a professional level job search with completion of 40-60 employer contacts weekly, with Vocamotive support (RX #11 - Rehabilitation Plan -p.4)

On April 9, 2018, Mr. Brandonisio phoned his vocation rehabilitation counselor stating that he did not "feel well" and that he'd be coming to his appointment in a surgical mask. (RX

#1) Later on April 11, he told his counselor that he had never used a computer before. He stated that he did not have an e-mail account. (Id.)

Petitioner underwent vocational testing in order to assess his overall aptitudes and interests on May 11, 2018. It was noted Petitioner "demonstrated having average aptitudes with regard to reading and comprehension and his scores were in line with his level of education. He demonstrated average verbal reasoning abilities and above average non-verbal reasoning abilities and above average non-verbal reasoning abilities. He also showed a high level of accuracy on clerical-based testing and average ability to follow oral directions." (p.6-7) Several jobs were identified based on the results of test such as: Hotel Clerk, Security Guard, General Laborer, Material Handler, Machine Operator, Hostler, and Cashier. (RX #1 - 05/17/18 Vocational Testing Report)

On April 19, 2018, Dr. Shelia Dugan authored a medical questionnaire stating that Petitioner's permanent restrictions were due to muscle pain, pelvic pain and urinary frequency. (PX #4)

The June 18, 2018 Vocational Report showed Petitioner reported he wanted to work at Midway Airport. He reported that as long as he was "walking around" he would be able to complete the job (RX # 1) He reported he did not like computers. He reported he believed the unemployment problem would never be resolved due to technology (RX #1). Petitioner reported he would not use emailing when he began his job search, stating "That's how people get in trouble." (RX #1) Petitioner reported that he believes that there are City jobs at Midway airport that he could perform, and Petitioner was advised to search job postings with the City so that he can apply (RX #1)

During his vocational rehabilitation appointments, Petitioner would often stop working and report that his head hurt, he had frequent headaches. "he reported his head would hurt when using both hands for typing." (RX #1) Later, he reported getting headaches, stomach aches and feeling dizzy when working on the computer. (RX #1)

The July 24, 2018 Vocational Report showed Petitioner reported he was going to contact someone from the City of Chicago regarding job leads he was interested in including Watchman,

Laborer, and Sanitarium positions (RX #1) He reported that he believed there were several positions at the City of Chicago available to him. He reported that he believed he could work in some driving occupations at Midway such as a Watchman or a Light Laborer. He reported that he was going to following up with his union again. A job lead for a Watchman with City of Chicago was identified. Petitioner was assisted with completing the application and cover letter for the position. (RX #1 -07/24/18 Vocational Report p.5).

A job lead for an Airport Shuttle Driver-Midway RAC with First Transit was identified. Petitioner reported he wanted to apply for the position. He reported he believed he could do the job. Petitioner reported he believed the position would allow him to alternate between driving and walking. He reported he would prefer a position such as this as opposed to an indoor job (RX #1 -07/24/18 Vocational Report p.6). It was noted Petitioner mentioned his desire to go back to work with the City of Chicago on multiple occasions throughout the appointment. He inquired what he would have to do to go back to his previous job. He was advised to speak with his attorney and doctor regarding the matter (RX #1 -07/24/18 Vocational Report p.6). It was noted Petitioner had required assistance with all aspects of the job search. (RX #1 -07/24/18 Vocational Report p.23).

The August 21, 2018 Vocational Report showed that Petitioner failed to follow up with prospective employers, although he had reported doing so. (RX #1 -08/21/18 Vocational Report p.3) The City of Chicago also advised him that he had not completed job logs in "quite some time." (Id. @ p.3) He reported 14 contacts for the week of July 30 through August 3, 2018. He reported 12 online applications and 2 online assessments. It was noted he did not document his job search. He reported no field calls or interviews (p.6). It was noted that he spoke several minutes about how did not trust the internet. Petitioner also stated, "He did not understand why he could not be a Watchman or someone who drove trucks in and out of the airport." (Id. p.7). Petitioner's application for Crew Member with Wendy was reviewed. It was noted he did not use proper grammar for his address on the application. He indicated he was only available early mornings Sunday through Saturday. He did not include his work experience. He did not input his phone number using the correct format (Id. p.11). Petitioner's application for a sandwich artist with Subway showed he did not use proper grammar for his address. Petitioner indicated he was

only available from 7 am. to 3pm. Sunday through Saturday. He indicated he did not obtain his high school diploma. He did not use proper grammar for the address of his employer. He did not include a cohesive statement for his job responsibilities (Id. p.11). It was noted Petitioner did not complete job search on August 13 or 14, 2018 (RX #1 -08/21/18 Vocational Report p.16).

On August 26, 2018, Dr. Dugan wrote additional restrictions in that Petitioner could only stand or walk for 30 minutes at a time. In another section on the same date, no such restrictions were listed. Petitioner was also given 20-pound lifting restrictions. (RX #4) Her final diagnosis was muscle pain, pelvic pain in male and urinary frequency. (Id.) No functional capacity examination was prescribed. No medications were prescribed. However, at the last listed doctor's appointment, Petitioner was taking Norco, Levothyroxine, (hypothyrodism),Pregabalin (nerve pain, fibropmyalgia) and Viagra (erectile dysfunction). At trial, Petitioner denied taking any medication other than over-the-counter, Advil. (T. 25)

The September 23, 2018 Vocational Report showed Petitioner indicated his desire rate of pay was entered as $15 per hour. He was advised he needed to input "Open" or "Negotiable" unless he was required to input an actual dollar amount (Id. p.2). Petitioner reported, "He did not know how he was supposed to live off less than $12.00 per hour." (Id. p.2) He inquired what he would need to do if he decided he wanted to retire (Id. p.3). Petitioner's application for a cashier position with Menards was reviewed. For the questions, "How long do you plan on working on Menards," Petitioner wrote, "1 year." Petitioner was informed that this was not an acceptable response (RX #1 09/23/18 Vocational Progress Report p.4). He reported that he struggled with the computer and that he needed frequent assistance with applications (Id. p.5). He was advised to be mindful of what he was entering and to be careful of typos and grammatical errors. He was reminded that he needed to have open availability (Id. p.6). Petitioner reported he spoke with his attorney and was advised if he received a job with a company outside of the City of Chicago he would no longer be paying into his pension, he would no longer receive benefits, and the pay differential was only 2/3rd of his salary. He reported he would be unable to accept a job which was $10 per hour because he could not live off $21 per hour when he was previously making $36 per hour (RX #1 -09/23/18 Vocational Progress Report p.10).

It was noted Petitioner had indicated his desired rate of pay as $20 per hour in his job applications. Petitioner was advised he needed to indicate what was on his rehabilitation plan. Petitioner became upset and stated, "How am I supposed to live off that?" He reported he could not live off $20 per hour. Petitioner reported, "He would not accept a job if he was offered less than $20 per hour." (Id. p.11) The application for Diverse Facility Solutions was reviewed and it showed Petitioner did not have the information for his education input accurately and he included only one reference when three were indicated (Id. p.13). It was noted Petitioner had been given written and oral directions on a repetitive basis; however, he continued to reach out and request for more assistance (RX #1 -09/23/18 Vocational Progress Report p.21).

The November 2, 2018 Vocational Report showed Petitioner reported that he would not follow through on potential opportunities that did not pay between $32 and $36 per hour. It was discussed with him at length about how there were few, if any, job opportunities with those wages within 30 minutes of his home which also met his physical restrictions, background and skillset (Id. p.14). He was advised of potential job openings, which were targeted for visits this day within the Ford City Mall. He reported he would not visit these companies because they did not pay the wages he was seeking. He reported, "He was only placing phone calls and completing applications in order to stay busy, not to actually find employment." (RX #1 - 11/02/18 Progress Report p.14) Petitioner did not meet the weekly job search contact expectations. Petitioner reported he did not want to put his name or Social Security Number on online applications. It was noted prospective employers would not move forward with Petitioner if pertinent information was not contained in his applications. Petitioner would not be able to successfully complete all online applications if required items were not filled in (Id. p.17). Petitioner reported that he would not follow through on potential job opportunities, which did not pay between $32 and $36 per hour. He was made aware of the limitations this would present and the unlikelihood of finding jobs within this range given his restrictions and background (RX #1 - 11/02/18 Progress Report p.17).

The December 3, 2018 Vocational Report showed Vocamotive had continued to assist Petitioner with applications; however, the majority of employers require Social Security Numbers on the applications. Petitioner had refused to supply this and therefore the applications

could not be completed on his behalf. (Id. p.11) It was noted Petitioner had concerns about this information being shared with employers; however, without providing the basic information needed for employment, he could not obtain interviews. (Id. p.11) It is further noted that despite being given assistance with the computer, Petitioner continued to struggle with the most basic tasks. It was unknown as to why he struggled with these tasks (RX #1 12/03/18 Vocational Report p.12).

The January 12, 2019 Vocational Report showed it was noted that Petitioner continued to report problems with computer; therefore, Vocamotive completed applications on his behalf. Petitioner had agreed to supply last four digits of his Social Security Numbers so that applications could be completed on his behalf. It was noted that this had been a hinderance in the past (RX #1 -01/12/19 Vocational Report p.10).

The February 17, 2019 Vocational Report showed it was noted that Petitioner never scheduled the interview with Skills for Chicagoland's Future regarding Food Service positions with McDonald's, SSP (Midway Airport), and Levy Restaurants (United Center). When asked about this, he reported he did not recollect his February 9, 2019 phone call regarding this or remember the email. It was noted that the email had disappeared from his account. It was noted that Petitioner had not followed protocol when speaking to employers regarding his disability and immediately disclosed that he has a disability. Petitioner continued to report that he has trouble remembering how email worked. Petitioner has not consistently followed the directions of the Job Search Team when given orally or when sent via his itinerary. Petitioner had made few field visits during this reporting period, despite being assigned to do so (RX #1 -02/17/19 Vocational Report p.12-13).

Due to Petitioner's ongoing complaints and resistance with job placement efforts, Vocamotive recommended vocational rehabilitation to be terminated. Ms. Helma sent out a letter dated April 2, 2019 to Respondent outlining why vocational services should be terminated. Ms. Helma stated that Petitioner had been participating in vocational rehabilitation activities for approximately 1 year, and additional services were not recommended at this time as they would not assist with yielding a placement and would continue to be costly. Ms. Helman opined that Petitioner had raised several barriers which impacted his placement potential. These included his

refusal to provide a Social Security Number, his concern regarding positions being outside of his 30-minute driving restriction, his concern for earning less than he was making in his previous position, and his desire to only return to the City of Chicago (PX #1 -04/02/19 Vocamotive Letter p.1-5).

At the hearing, Petitioner testified that he continues to experience groin pain, and he cannot drive for more than 30 minutes. Petitioner reported that he complied with Vocamotive's instructions, and he was cooperative throughout the job search process. On cross-examination, Petitioner reported that he applies from 25 to 30 jobs per week (T. 35). Petitioner reported that he has no problems driving to potential job sites that are less than 30 minutes (T. 39). Petitioner reported that he acknowledges that he does not want to apply for jobs that pay less then $20 per hour (T. 40). Petitioner also acknowledged that several online applications were not completed because he did not want to provide his Social Security Number information (T. 40-41). Petitioner also acknowledged that by doing that it would affect his opportunities to obtain a job. Petitioner stated the he did not apply for all the jobs on the City's career website and he it not sure if he has a profile on the City's career website (T. 44). Petitioner stated that he applied for the Watchman position with the City of Chicago Water Department and Fleet and Facility Management Department ("2FM"). Petitioner acknowledged that he was contacted for a Watchman position with the Water Department. Petitioner acknowledged that he completed a reasonable accommodation with 2FM; however, he did not inform the Water Department about this reasonable accommodation request. Petitioner also acknowledged although he indicated on the Willingness and Ability Questionnaire form that he is unable to remain attentive while monitoring video cameras, he does not have any concentration issues.

Ms. Jackie Toledo, Director of Administration of the City of Chicago Department of Water, also testified at the hearing. Ms Toledo testified the physical requirements of the Watchman position requires standing/walking for less than 1 hour per day, no significant lifting, and minimal driving. Ms. Toledo further explained, "Driving, it's minimal. It depends if you're part of the roving crew, you do drive to our different locations; if you're not part of the roving crew, it would probably less then 30 minutes." (T. 76) Ms. Toledo stated Petitioner was contacted for a Watchman opportunity. Ms. Toledo stated that a letter was sent out to Petitioner about the job

opportunity and informed him to provide medical documentation if for some reason he felt that he would not be able to perform the Watchman job duties. Ms. Toledo stated Petitioner was no longer being considered for the Watchman position because of his answers on the Watchman Willingness Questionnaire. Ms. Toledo stated that if Petitioner had answered that he is willing to try performing all the required tasks as a Watchman, he would be sent for fingerprinting and completing additional paperwork in order to be hired as a Watchman. Ms. Toledo also testified that she is not aware that Petitioner had provided any reasonable accommodation request to the Water Department.

CONCLUSIONS OF LAW

An injury is compensable under the Illinois Workers' Compensation Act only if it arises out of and in the course of employment. *Panagos v. Industrial Commission, 177 Ill.App.3d 12, 524 N.E.2d 1018 (1988)* The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026 (1987)* The burden is also upon the employee to prove that his injuries are causally related to the employment. *New Guard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524 (1974)* Critical to the determination of the aforementioned is the petitioner's credibility. When determining the issues at hand, the Arbitrator must carefully weigh all of the evidence presented.

When determining the issues at hand the Arbitrator must carefully weigh all of the evidence presented. This includes the credibility and testimony of the petitioner.

This Arbitrator finds the petitioner did not make a good faith effort to obtain another job during vocational rehabilitation. His testimony was riddled with statements that directly contradict one another as well the accounts that he, personally, gave to his vocational counselor. It must be noted Petitioner contradicts the statements of his vocational counselor and the vocational progress reports from Vocamotive (RX #1). This Arbitrator observed that the petitioner possessed a demeanor that lacked candor throughout his testimony. The aforementioned cannot be ignored when weighting the evidence submitted against the petitioner's testimony.

The petitioner's testimony was inconsistent, exaggerated, and self-serving. His testimony does not stand up when compared to the contemporaneous vocational records created immediately as events unfolded and occurred. It was clear that not only was Petitioner not truthful in his testimony but that he did not remember events. Benefits have been denied in instances when the petitioner's credibility was suspect and the contemporaneous histories conflicted with and/or failed to corroborate the petitioner's testimony.

Petitioner's lack of credibility must be taken into account when issuing his award in this matter. Furthermore, this Arbitrator adopts the Vocamotive reports as true and correct over Petitioner's testimony.

In regards to (F), "Is the Petitioner's current condition of ill-being related to the injury?", the Arbitrator finds:

To the trier of fact, it is unclear what medical condition(s) the Petitioner suffers from at the present or how it was caused by the work occurrence. Ostensibly, the Petitioner suffers from scrotal pain. More specifically, "muscle pain, pelvic pain and urinary frequency" as stated by Dr. Dugan. However, the only credible diagnoses out of the three is muscle pain or "myalgia." Drs. Forsythe, Nho and Jaycox all struggled to find a working diagnosis for Petitioner's medical condition and they were Petitioner's treating doctors. The record establishes that there was no true hip injury and the urinary frequency diagnosis was later omitted from Dr. Dugan's disability statement to Respondent. (PX #3) The Arbitrator notes some key medical information was not admitted into evidence. For instance, the Mercyworks records would have been helpful to corroborate the Petitioner's history of the accident, mechanism of injury and initial subjective complaints. The medical note of Dr. Levine (curved penis) was absent and the record from Dr. Luu (possible sports hernia) is not in the record either. Apparently, Petitioner suffers from sort of testicular or scrotal pain that was alleged caused by lifting a heavy can or barrel. But even that history is inconsistent, because the Petitioner admitted the object he was moving was on wheels. (T. 71) He never told his doctors about this fact. He led them to believe that he was lifting a heavy barrel, while the report of occupational injury states he injured his back while pulling a cart. (PX #4) Under oath, he stated, "it could have weighed a couple hundred pounds" and "I just kind of pulled it." (T.72) Additionally, he told the Arbitrator that the accident occurred after

9:00 am, (T. 67) but the records states 7:30 am., which was at the beginning of the Petitioner's shift. (RX #4) The Petitioner stated he had three surgeries after the accident (T. 68), but they were injections, not surgeries. Each one of them had a diagnostic component to it was well. The hip and prudential neuralgia diagnosis were discarded as a result of his non-response to the injections. Petitioner stated that he could not describe the surgical procedures because he underwent general anesthesia, but that is not really true, Petitioner never underwent general anesthesia. (PX #4) (T. 68) Nevertheless, Arbitrator finds that Petitioner has proven by the preponderance of the credible evidence that Petitioner's current condition "myalgia" or muscle pain is the only medical condition causally related to his work accident of December 28, 2016.

In regards to (K), "Is the Petitioner entitled to temporary total disability benefits from March 30, 2019 to June 11, 2019?" the Arbitrator finds:

An employee's entitlement to maintenance begins when his medical condition has stabilized, he has reached maximum medical improvement and the period of vocational rehabilitation has begun. It is a benefit that is separate from TTD, even though it is paid at the same rate. Maintenance falls under section 8(a) of the Act in conjunction with vocational rehabilitation. To be entitled to maintenance the petitioner must make a good faith effort in his job search and vocational rehabilitation program.

Petitioner failed to participate in a diligent and good faith job search. Therefore, his claim for maintenance benefits must be denied.

Multiple examples of non-compliance and sabotage on the petitioner's part were detailed earlier in this brief, and further supported in Respondent's exhibit number 1, the vocational reports.

Petitioner reported several concerns with regard to usage of the computer including reporting headaches, stomach aches, and dizziness while utilizing the computer, the reported ability to only type with his right hand, the ability to only look at the screen from the side and fear of the computer. It was noted that Petitioner reported struggling with the materials, and regularly failed concept exams. He would call in frequently throughout the day and require one-

on-one assistance with the programs. It is unknown why Petitioner struggled with the computer. Petitioner was vocationally tested and it was reported that "he demonstrated having average aptitudes with regard to reading and comprehension and his scores were in line with his level of education. He demonstrated average verbal reasoning abilities and above average non-verbal reasoning abilities. He also showed a high level of accuracy on clerical-based testing and average ability to follow oral directions". Petitioner was provided with assistance beyond what would typically be seen in a classroom environment and beyond what is provided to the majority of Vocamotive clients (some have educational levels below Petitioner) (RX #1 04/02/19 Vocamotive Letter p.1-5).

Due to his low exam scores, Petitioner's rehabilitation plan was changed to reflect that he would be completing the Fast Track computer program designed to teach users how to write basic letters using a computer. This change in plan was to provide him with a more basic introduction to computer use. It was noted that due to his difficulties with the computer training, Petitioner was transitioned into fulltime job search activities. It was noted that it took Petitioner 13 days to obtain information for his references. It was noted that while participating in job search activities, Petitioner continued to have difficulties with the computer related aspects of the process. This caused his contact numbers to be significantly lower than what was expected from the typical Vocamotive client (RX #1 -04/02/19 Vocamotive Letter p.1-5).

Petitioner disputes that he was non-compliant. He takes no personal responsibility for his behavior over a lengthy rehabilitation period. Petitioner agreed that he was paid maintenance by Respondent in order to compensate him for his time during his job search as if he was working full time. However, he did not perform a diligent job search. The petitioner was clearly not motivated to find gainful employment. This is clear not only in his actions but in his interest in retirement. His motivation is to hang on and collect benefits until he is at a point where he feels it is to his benefit to retire and collect his pension. Instead all that he did was waste time and energy while stonewalling his vocational rehabilitation program. Petitioner inquired what he would need to do if he decided he wanted to retire (RX #1 - 09/23/18 Progress Report p.3). Petitioner indicated that he was planning to work for only 1 -year for the cashier position with

Menards, and he was informed that this was not an acceptable response (RX #1 -09/23/18 Progress Report p.4).

Petitioner reported he would not visit several companies because they did not pay the wages he was seeking. Petitioner also reported, "He was only placing phone calls and completing applications in order to stay busy, not to actually find employment." (RX #1 -11/02/18 Progress Report p.14). Petitioner reported that he would not follow through on potential job opportunities, which did not pay between $32 and $36 per hour. He was made aware of the limitations this would present and the unlikelihood of finding jobs within this range given his restrictions and background (Rx.#1 -11/02/18 Progress Report p.17).

When there is a lack of "good-faith" cooperation with vocational rehabilitation efforts, the termination of benefits is justified. *Hayden v Industrial Commission, 214 Ill. App.3d 749, 575 NE2d 99, 158 Ill.Dec 305(1st Dist. 1991)* It is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort". *Archer Daniels Midland Co. v Industrial Commission, 138 Ill2d 107, 561, NE2d 623, 149 Ill.Dec 253 (1990)* Petitioner failed to prove that he diligently participated in a bona fide search for employment. He is obligated to make "good-faith effort to cooperate in his rehabilitation effort. The evidence presented overwhelmingly establishes that he did not.

As such, Petitioner is not entitled to maintenance for the period from March 30, 2019 to June 11, 2019.

In regards to (L), "What is the nature and extent of Petitioner's injury?", the Arbitrator finds:

The Petitioner Is Not Permanently Totally Disabled

In this matter, Petitioner alleges that he is permanently and totally disabled from returning to work.

An employee is totally and permanently disabled when he is "unable to make some contribution to the work force sufficient to justify the payment of wages. *Gates Division, Harris-Intertype Corp v Industrial Commission 78 Ill.2d 264, 399 N.E.2d 1308 (1980)* The petitioner may also establish that there is no reasonably stable labor market available. *Valley*

Mould & Iron v Industrial Commission 69 Ill.2d 273, 371 N.E.2d 610 (1977) It is not enough to show that there is an inability to perform strenuous work. If the petitioner is able to perform employment without endangering his health or life he is not entitled to an award of permanent total disability. *A.M.T.C of Illinois, Inc. v Industrial Commission, 77 Ill.2d 481, 387 N.E.2d 804, 34 Ill.Dec 132 (1979)* Furthermore, the Commission has held that when the petitioner lacks the intent to return to work… the employee is not entitled to benefits and was not permanently and totally disabled. *Schoon v. Industrial Commission, 259 Ill.App.3d 587, 630 N.E.2D 1341, 197 Ill. Dec 217 (3d Dist. 1994).*

Petitioner relies on his unsuccessful job search to support his claim for permanent and total benefits. This invites scrutiny to his claim and job search. The examples of how the petitioner failed to comply with his vocational rehabilitation are replete. His job search was undiligent. He intentionally circumvented his ability to secure gainful employment, repeatedly.

The record reflects Petitioner initially expressed that he would not use email as part of the job search process. Petitioner was vocal about not wanting to return to work for employers outside of the City of Chicago. Petitioner turned down several job leads due to the distance. This was evident throughout the job search process, even when employers were within his 30 minute driving capability. Petitioner expressed concerns with regard to providing his social security number on applications and numerous applications could not be completed as a result. It was noted that eventually Petitioner did provide the last 4 digits of his social security number and while this did provide him with greater access to the application, numerous applications still could not be completed. Without providing a full number, Petitioner could not apply for positions through staffing agencies (RX #1 -04/02/19 Vocamotive Letter p.1-5).

When his independent applications were reviewed, it was noted that Petitioner was limiting his availability to work from 7:00 a.m. until 3:00 p.m. He was previously counseled on the importance of having open availability. While working on an application for Menard's, Petitioner reported that he only planned on working for 1 more year as he planned on retiring from the City of Chicago. He was advised this response would not help him gain employment. Petitioner would frequently report that he was waiting for retirement, but that he would not retire

early. He would frequently ask how alternative employment would affect this retirement and he would be directed to his attorney for this matter (RX #1 -04/02/19 Vocamotive Letter p.1-5).

It was noted that Petitioner reported that he would not work for anything less than his previous wages of $36.00 hourly. Despite frequent counseling on this issue and a review of the various factors which impacted his earning potential, he maintained this position. It would be unlikely that Petitioner would obtain a new role with starting wages of $36.00 per hour. He would hurt his chances of gaining employment if he were to report this during an interview. Petitioner's online applications were completed by Vocamotive staff while Petitioner was expected to call and visit companies in-person. This was done in order to alleviate the ongoing issues Petitioner had with using a computer. (RX #1 -04/02/19 Vocamotive Letter p.1-5).

Even though Petitioner was expected to increase his in-person field visits, he failed to do this consistently, even when companies specifically asked him to come in person. Examples included no follow up with the request of a Manager at 7-Eleven or attending open interviews at Thornton's. He was also assigned to visit New Relax Inn on October 16, 2018 because they had a "Now Hiring" sign outside their business, however; failed to do so. Petitioner was scheduled to meet with a Vocamotive staff member to visit employers at Ford City Mall, however; refused as the positions did not pay $36.00 hourly. Ford City Mall was visited on his behalf, and six of the stores were hiring for positions within Petitioner's physical capacities. However, 5 of the 6 applications required a social security number and Petitioner refused to provide this information. Did he think the earnings from his new job would be tax free? Petitioner was assigned to call AutoZone to inquire about job openings. He reported that after speaking to the employer, he was asked to come to a job fair, however; he declined the lead as it was too far for him to drive. It was noted that Google maps showed the position to be 9 miles from his home and approximately a 26 minute drive. It was noted that instead of visiting companies near his home, Petitioner would contact employers outside of his driving restriction to ask if they had closer locations. He would then contact Vocamotive to advise that there was no position closer to his home. Petitioner was asked to contact Billy Jo's Drive Thru as there was a "Now Hiring" sign. He reported that he had contacted the company and had been advised that they were not hiring, but a follow-up phone call from Vocamotive revealed that interested candidates should come in to

apply at any time. Petitioner reported calling Long Horn Steakhouse and being advised to apply in person. However, he reported this was too far for him to drive. When searched in Google maps, it showed it to be 9.2 miles, or about 25 minutes away from his home. (RX #1 -04/02/19 Vocamotive Letter p.1-5).

On February 8, 2018, Petitioner's email was viewed, and it was learned he was invited for an interview with Skills for Chicagoland's Future regarding Food Service positions with McDonald's, SSP (Midway Airport), and Levy Restaurants (United Center). Despite being instructed to schedule the interview, Petitioner never did so. When Vocamotive staff attempted to salvage the interview opportunity, the original email had disappeared from his email account. When asked about this, he reported he had no recollection of the interview opportunity, no recollection of his February 8 phone call with staff about scheduling the interview, and no ideas as to how it may have disappeared. Prior to interviewing for a Cashier position with Continental Nissan, Petitioner received extensive coaching. It was noted that he struggled with answering basic interviewing questions such as what the best aspect of his previous job. (RX #1 -04/02/19 Vocamotive Letter p.1-5)

Petitioner's continued unemployment is not surprising given his less than stellar job search, his overall lack of motivation and lack of a good faith attempt to find employment. It would not matter how long the petitioner conducted his job search, because Petitioner was merely going through the motions and had no intent to find work. There is nothing in the record that speaks of diligence.

Petitioner did as little as possible during this time to secure employment. The reason he has not found employment is his own behavior and not because he is permanently and totally disabled from returning to work. Petitioner has not established that he cannot work or that there is no labor market available to him.

He has established that he has no intent to work, however. The petitioner has not met his burden of proof on this issue and is not permanently and totally disabled.

The Petitioner Is Not Entitled To A Wage Differential Award

The Supreme Court has held that, it is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort". *Archer Daniels Midland Co. v Industrial Commission, 138 Ill2d 107, 561, NE2d 623, 149 Ill.Dec 253 (1990)* That has expanded more recently under *Marzullo,* which found that the petitioner is not entitled to a wage differential, that it is not merely a processes of an award "premised upon a simple arithmetical calculation, but instead the petitioner must establish that he cooperated in his rehabilitation process and reached the highest level of available employment". The *Marzullo* court stressed that the petitioner must not only establish an entitlement to the wage differential but a bona fide effort to return to suitable employment. *Kenneth Marzullo v City of Chicago, 15 WC 24679; 18 IWCC 379*

It is clear that Petitioner made no effort, let alone a good-faith effort, to find any suitable employment. Through his own behavior the petitioner undermined his vocational rehabilitation program and limited his employment prospects. It was noted that he wanted to inform the employer that he was on Worker's Compensation and was being "forced" into this process. Petitioner had several objections to interviewing with Quest Food Management Services as he felt that it was too far from his home and being frustrated with the manager as he had previously stated that he had attempted to call Petitioner and someone had "picked up and hung up". Petitioner reported he did not pick up and hang up, and he was bothered at the unprofessionalism of Mr. Torres to make such a statement (RX #1 -04/02/19 Vocamotive Letter p.1-5).

Petitioner reported calling Food For Less and being advised that they were hiring for people to bring the carts in from the parking lot. He obtained no other information regarding this role. He reported he did not want to push carts so he would not apply for the role. Petitioner was advised to call the company in order to get information about the physical requirements of the job. He showed some hesitancy at first, asking in a sarcastic manner if a Vocamotive staff member could drive to the nearest grocery store and try pushing carts in front of him, so he could show that it was too physical of a job for him (RX #1 -04/02/19 Vocamotive Letter p.1-5).

Petitioner had been participating in vocational rehabilitation activities for approximately 1 year. Additional vocational services were not recommended. Ms. Helma opined that Petitioner had raised several barriers which impacted his placement potential. These included his refusal to provide a Social Security Number, his concern regarding positions being outside of his 30

minute driving restriction, his concern for earning less than he was making in his previous position, and his desire to only return to the City of Chicago (PX #1 -04/02/19 Vocamotive Letter p.1-5).

Petitioner repeatedly indicated that he was only interested in working for the City, and he received assistance from Vocamotive to apply for the Watchman position. However, when he was contacted for the Watchman position, he responded that he would not be able to perform the position due to his permanent restrictions. Petitioner did not inform the Water Department of his permanent restrictions nor did he provide the department with his request for reasonable accommodation. Petitioner also indicated on the Watchman Willingness Questionnaire that he would not be able to perform the Watchman position because he is unable to stay attentive to monitor the video cameras, which is not part of his permanent restrictions. Based on Petitioner's action, it is clear that he was not interested in going back to work. He should have at least tried to do the job before rejecting it.

The evidence overwhelmingly showed that Petitioner did everything in his power to thwart his vocational rehabilitation program and any effort Respondent made to return him to work. His behavior demonstrated a clear and convincing lack of good faith. His job search efforts were completely absent and indicated that he had no intention of returning to gainful employment. The only reason the petitioner is not employed is because he put forth no effort. Without this effort on Petitioner's part, Respondent is prejudiced in any attempt to determine the wage differential, leaving it to pure speculation. There is no way to know how high Petitioner's earnings may have gone had he put forth a diligent job search.

Petitioner had many opportunities to find gainful employment, which would have allowed him to establish an impairment of earnings. He chose to sabotage the vocational process, instead. He did not establish what, if any, his reduced earning capacity would be. This case is similar to *Aaron Conway v City of Chicago 15 IWCC 810*. In that matter the petitioner also failed to conduct a good faith effort with respect to his job search. The Commission found that *Conway* failed to establish that he had an impairment of earnings and denied his request for a wage differential.

Petitioner failed to meet his burden of proof in his attempt to prove that he is entitled to a wage differential. While he demonstrated that he is unable to return to his usual and customary employment, he failed to establish an impairment of earnings. His request for benefits under section 8(d)1 of the Act must be denied.

The Petitioner Is Entitled To An Award of Permanency

Neither party entered an impairment rating into evidence. (i) This does not preclude an award for permanent partial disability. (ii) It is unclear if Petitioner was truly unable to return to his usual and customary position. At one time the vocational rehabilitation process, Petitioner stated he willing to return to his old job. Yet he also stated he wanted to retire. Some weight is given to this factor. (iii) The petitioner was 62 years old on the date of injury, and he is 64 years old at the time of the hearing. The Arbitrator places some weight on this. (iv) The petitioner has not returned to work. The Arbitrator gives this little weight because of his poor vocational rehabilitation effort. (v) The evidence of disability is corroborated by the treating medical records.

In noting (v), the Arbitrator has considered the onerous restrictions by Dr. Dugan, but also notes that Petitioner did not suffer a catastrophic orthopedic injury. Likewise, he did not undergo any significant surgical procedural that involved hardware like rods, screws, cages and wires. No organs were perforated or damaged. Currently, Petitioner is not undergoing any medical treatment nor is he on any prescription pain or nerve medication. He takes Advil when needed. While it is true he currently utilizes an electrical stimulation device to distract him from pain, this is not a pain blocker as when one is prescribed an intravenous pump after a failed back surgery. Dr. Dugan's statement of permanent restrictions is odd as it increased in severity as time passed. It took no account of Petitioner's improvements in physical therapy, nor that Petitioner's pain complaints diminished significantly when sitting on his right side. There is no explanation to why she added the lifting restrictions (20 lbs.) or the standing restrictions later in April of 2018. (PX #4) Coincidentally, it occurred when it was clear Petitioner was having trouble complying with vocational rehabilitation. Neither additional restrictions correlate with Petitioner's complaints or conditions and only serve to cast doubt on her original recommendations. She only saw the patient on four occasions. (PX #4) It is unclear if she

reviewed all treatment records and she was under the impression Petitioner had lifted a heavy barrel. (PX #4)

As a result of the aforementioned, he is entitled to have and to receive from the Respondent 100 weeks at a weekly rate of $775.18 because he is entitled to 20% MAW. The Arbitrator notes the award is less than the pre-trial settlement recommendation, but at the pre-trial, it was intimated that the Petitioner suffered a low back injury after a lifting incident, with two failed surgeries and no return to work. At trial, it was discovered that this case is does not involve the lumbar spine, there were no open surgical procedures with general anesthesia and Petitioner did not comply with vocational rehabilitation.

Finally, the Arbitrator notes that there are no reported workers' compensation cases where the Petitioner was awarded permanent and total disability benefits or wage differential benefits involving the diagnosis of myalgia.

Respondent is entitled to a credit of $3,875.90 representative of a PPD advance.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031346
Case Name	GRASSANO,CIRO A v. CHICAGO BEVERAGE SYSTEMS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0363
Number of Pages of Decision	24
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Hayley Graham
Respondent Attorney	Linda Robert

DATE FILED: 7/19/2021

/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: Accident	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CIRO A. GRASSANO,

Petitioner,

vs. NO: 18 WC 31346

CHICAGO BEVERAGE SYSTEMS,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

Petitioner has been a beer delivery driver for Respondent since August 2018. In this position, Petitioner delivered 5,000 or more cases of beer each week to grocery stores, restaurants, and liquor stores. Each case of beer weighed approximately 40 pounds. Petitioner also delivered ten to 15 kegs per week with a full barrel keg weighing 180 pounds and a half barrel keg weighing 90 pounds.

Except for five times a year when Petitioner had helpers, his route was a one-man job and he was the only person unloading his truck during the deliveries. At the grocery store stops, Petitioner had to open his truck's back door and lower the steel liftgate, which laid tilted and never flush with the ground. Petitioner would then pull pallets of beer backwards off the truck using an electric jack and transport them into the store. Once inside the store, Petitioner had to switch to a manual jack to cart the pallet to the floor, build displays, and fill coolers and shelves with the beer.

Petitioner estimated that a pallet of bottles contained 50 cases of beer and weighed 2,000 pounds. If Petitioner was instead delivering cans, there would be roughly 117 cases per pallet

weighing 40 pounds each. Although it varied, Petitioner approximated that he unloaded six or seven pallets per store. When unloading the pallet, Petitioner usually lifted six cases at a time to form a stack and then pushed the stack on a dolly approximately 100 feet from the receiving room to where the product needed to go. Petitioner also had to lift single cases of beer one at a time onto the shelves.

When Petitioner instead made deliveries to liquor stores or restaurants, he had to stack the cases on the floor outside the building, push the stack into the building using a two-wheel cart, and put the cases away in a location chosen by the vender. This constituted an everyday job duty.

While making a delivery on September 26, 2018, Petitioner felt immediate back pain while stepping off his truck's liftgate in the alley behind For More Liquors. When Petitioner stepped down with his right leg, the liftgate was three inches off the ground and laid cockeyed. At the time, Petitioner had the electric jack and a pallet full of beer in his hand. Despite the pain, Petitioner was able to finish his shift on September 26, 2018.

Petitioner testified that in the month or so leading up to this incident, he was sore all the time from his job. He attributed this prior back pain to the physical work, lifting, and heavy job duties he performed for Respondent. Nevertheless, Petitioner testified that there was a change in the intensity of his pain on September 26, 2018 after he stepped down three inches from the liftgate.

Prior to September 26, 2018, Petitioner underwent acupuncture and chiropractic treatment for his low back pain. Additionally, on September 1, 2018, Petitioner treated at Northwest Community Healthcare for right hip and buttock pain that began two weeks prior. Petitioner denied any known injury but reported that he was in and out of his delivery truck all day. He was prescribed Norco and a Medrol Dosepak for his pain. Lumbar X-rays were also obtained at this visit and showed mild degenerative changes. Shortly thereafter, on September 25, 2018, Petitioner received chiropractic treatment at Nemcek Chiropractic Center for his low back pain. On the patient intake form, Petitioner noted that his condition began one month prior but did not specify that it was job-related.

After the September 26, 2018 incident, Petitioner presented to Dr. Christian Skjong of Illinois Bone and Joint Institute on September 27, 2018. Petitioner told Dr. Skjong that he was constantly loading and unloading his beer truck and jumping up and down off the truck bed. Petitioner also reported that over the last several weeks, he had increasing low back and buttock pain with occasional shooting pain down his right leg. Dr. Skjong believed that Petitioner's pain was consistent with lumbar pathology or radicular-type symptoms. He ordered a lumbar MRI, which was subsequently obtained on September 29, 2018. The MRI revealed severe right-sided arthropathy and a right extraforaminal disc protrusion likely impinging on the L4 nerve root and correlating with a right L4 radiculopathy.

On September 30, 2018, Petitioner was diagnosed with acute right-sided low back pain with sciatica after presenting to Northwest Community Hospital with complaints of right leg pain and spasms for more than one month. The following day, Petitioner returned to Northwest Community Hospital and again indicated that the approximate onset of his right thigh and low back pain was one month prior. Petitioner denied any specific preceding event or injury but stated

that he worked unloading heavy crates. Dr. Shruti Shah diagnosed Petitioner with right-sided sciatica and offered to admit him to the hospital for pain control; however, Petitioner declined since he had an orthopedic appointment later that day.

On the same day, October 1, 2018, Petitioner presented to Illinois Bone and Joint Institute and reported that his low back pain had been going on for the past couple months but had gradually intensified over the last three weeks. The patient intake form signed by Petitioner further stated that there was no fall or injury, but instead, Petitioner's symptoms were of three weeks' gradual duration. Nurse Practitioner Kimberley St. John diagnosed Petitioner with an L4-L5 extruded disc to the right and instructed him to go straight to Dr. Yuriy Bukhalo's office for an epidural injection.

When Petitioner reported to Dr. Bukhalo of Northwest Suburban Pain Center that same day, he again denied any specific event or injury, and instead, indicated that his pain began three weeks ago and progressively worsened. Dr. Bukhalo also noted that Petitioner's radiating right low back pain had begun one month prior. After reviewing Petitioner's MRI, Dr. Bukhalo's assessment included lumbar radiculopathy, intervertebral disc displacement, spondylosis, and low back pain. Dr. Bukhalo then administered lumbar epidural steroid injections at L4-L5. However, after the procedure, Petitioner experienced such increased pain that Dr. Bukhalo sent him back to the emergency room.

Petitioner immediately returned to Northwest Community Hospital and underwent another lumbar MRI, which revealed a L4-L5 disc bulge with facet degenerative change and resultant central canal and right foraminal stenosis, a L5-S1 disc protrusion abutting the origin of the right S1 nerve root, and a L3-L4 disc bulge with facet degenerative change and central canal stenosis. Dr. Rebecca Caton diagnosed Petitioner with back pain and radiculopathy, gave him Dilaudid for pain control, and admitted him to the hospital for further treatment. Dr. Caton noted that Petitioner had the intractable back pain with radiation to his right lower extremity for one month. She indicated that Petitioner delivered beer for a living but could not recall any specific direct trauma.

After being admitted, Dr. Matthew Strauch, an internal medicine hospitalist, also reported that Petitioner had low back pain radiating down his right lower extremity for the past several weeks. Dr. Strauch diagnosed Petitioner with acute right-sided low back pain with sciatica and kept him on medication for pain control. The following day, October 2, 2018, Petitioner consulted with Dr. E. Quinn Regan at the hospital. Dr. Regan noted that Petitioner's symptoms had begun two weeks prior. Given his severe pain, Dr. Regan did not think that facet arthritis was causing Petitioner's problem and instead believed it was from his far lateral disc herniation. Upon Dr. Regan's recommendation, Petitioner thereafter underwent a right-sided L4-L5 far lateral discectomy on October 3, 2018. He was then discharged from the hospital on October 4, 2018.

Shortly thereafter, on October 9, 2018, Petitioner participated in a recorded telephone call with Respondent's adjuster in which Petitioner described his accident as occurring on September 26, 2018 while making a delivery at For More Liquors. Petitioner explained that he had stepped off his truck's liftgate that was three inches off the ground and immediately felt right hip pain.

When Petitioner returned to Illinois Bone and Joint Institute on October 10, 2018, Dr. Regan also described Petitioner's injury as work-related and occurring on September 26, 2018.

He stated that Petitioner was a beer truck driver who "stepped down off it" and felt back pain. At the hearing, Petitioner conceded that this treatment note was the first record to reference any work accident occurring on September 26, 2018. He further testified that when Dr. Regan reported that he had "stepped down off it," he was referring to the liftgate. Although Dr. Regan reported that Petitioner's pain was 90% better post-surgery, he kept Petitioner off work until further notice.

On October 20, 2018, Petitioner returned to Northwest Community Hospital for a wound re-evaluation due to increased swelling at the surgical site. A lumbar CT revealed fluid collection in the posterior paraspinal subcutaneous tissues and right lateral recess as well as foraminal stenosis at L4-L5. Dr. Caton diagnosed Petitioner with a postoperative complication and elevated serum calcium. On October 22, 2018, Dr. Regan also observed superficial swelling on the posterior aspect of the wound consistent with a seroma. He found that it did not look suggestive of any deep infectious process. Dr. Regan aspirated the wound and placed Petitioner on antibiotics.

On October 26, 2018, Dr. Regan found that Petitioner's leg pain had markedly improved and started him on a course of physical therapy. Dr. Regan again noted on November 16, 2018 that Petitioner's pain and function was much better. At that time, a work status note was provided releasing Petitioner to full duty work with no restrictions as of November 26, 2018. Dr. Regan then released Petitioner from his care on December 10, 2018 after Petitioner had displayed a normal gait, a good affect, and a nicely healed wound on physical examination.

At Respondent's request, Petitioner thereafter presented for a §12 examination with Dr. Wellington Hsu on February 25, 2019. Petitioner told Dr. Hsu that he felt low back and right hip pain when stepping off his truck's tailgate on September 26, 2018. However, Petitioner also reported experiencing daily low back pain leading up to this injury and having to lift up to 100 pounds on a regular basis as a beer delivery driver. Dr. Hsu did not believe that Petitioner's lumbar condition was due to any work-related injury. He stated that there was not enough evidence to find that the low back condition was related to an acute accident on September 26, 2018, because the treatment records showed that Petitioner's back pain occurred before that date and Petitioner was unsure as to exactly when his pain started. Additionally, Dr. Hsu did not believe that the mechanism of injury of stepping off a three-inch liftgate was specific to Petitioner's job duties.

Dr. Hsu testified consistently with his §12 report when deposed on January 29, 2020. Dr. Hsu testified that Petitioner had preexisting lumbar spondylosis and a L4-L5 disc herniation, but the September 26, 2018 accident was not the cause of the herniation. Dr. Hsu testified that the liftgate Petitioner stepped down from was a couple inches off the ground and lower than a standard stair. He further noted that there was not a significant amount of force involved in stepping down from a three-inch height. As such, Dr. Hsu testified that he would not expect stepping from such a low height to cause a herniation. Dr. Hsu further testified that he did not inquire as to how Petitioner's deliveries occurred nor ask Petitioner about his lifting activities or the specifics of his day-to-day job duties. Nevertheless, he conceded that it was possible that heavy lifting or lifting as a beer delivery driver could cause a herniated disc.

The parties also deposed Dr. Regan, Petitioner's orthopedic surgeon, on December 4, 2019. Dr. Regan opined that it was more likely than not that Petitioner's lumbar herniated disc was related to his on-the-job lifting activities. He testified that since Petitioner had a physically

demanding job and no history of any other similar physical activities, the herniated disc was more likely than not a result of delivering beer. Dr. Regan further indicated that stepping off his truck's liftgate may have caused or exacerbated the herniated disc.

However, Dr. Regan indicated that he was not sure what Petitioner had stepped down off of or from what height. He testified that when he reported that Petitioner had "stepped down off it" in his October 10, 2018 note, he meant that Petitioner had stepped off a step, whether it was two or three feet high. Dr. Regan further testified that he did not know whether Petitioner's truck used a hydraulic liftgate, as Petitioner never spoke to him about using a liftgate at work. Nevertheless, Dr. Regan testified that stepping down three inches could cause a herniated disc, although uncommon, or exacerbate symptoms from a herniated disc. However, Dr. Regan also testified that it was difficult for him to comment as to if Petitioner stepping down on a three-inch step had a high probability of causing a severe aggravation to a previously herniated disc. He testified that he could testify as to a height of three feet, but he had no clue as to three inches.

At the time of the hearing, Petitioner was still working full duty as a beer delivery driver for Respondent and was able to complete his job duties without any noted difficulties. Nevertheless, Petitioner testified that his low back remained sore daily. For this, Petitioner took two Aleve every morning.

II. Conclusions of Law

Following a careful review of the entire record, the Commission finds that Petitioner proved he sustained a repetitive trauma injury from his daily heavy lifting as a beer delivery driver but failed to prove that he also sustained a separate acute accident from stepping down off his truck's liftgate on September 26, 2018.

Petitioner provided detailed and unrebutted testimony as to his repetitive work duties, which involved the unloading and moving of thousands of cases of beer each week. Petitioner's job required repetitive daily heavy lifting as well as the use of force while pulling and pushing pallets with an electric jack, manual jack, and dolly. Petitioner's testimony, as well as the early treatment records, indicate that Petitioner suffered from some low back pain prior to stepping down off his truck's liftgate on September 26, 2018. Petitioner attributed this prior back pain to the lifting and heavy job duties he performed for Respondent.

Petitioner also alleged that his low back pain occurred as the result of the specific event of stepping down from his truck's liftgate when it was three inches off the ground. However, his early treatment records fail to mention any such accident occurring on September 26, 2018. The first reference in the treatment records of any acute work accident occurring on September 26, 2018 was not until Petitioner's visit with Dr. Regan on October 10, 2018.

When Petitioner initially presented to Dr. Skjong on September 27, 2018, he reported that he was constantly loading and unloading his beer truck. Petitioner also told Dr. Skjong that he had experienced increasing pain over the last several weeks. He made no mention of stepping down off his truck's liftgate or of any acute event occurring on September 26, 2018 at this visit.

When Petitioner then presented to Northwest Community Hospital on September 30, 2018, he again made no mention of stepping down from the liftgate and instead complained of having right leg pain and spasms for more than one month. When he returned to the hospital the following day, Petitioner again reported that the approximate onset of his pain was one month prior. He denied any specific preceding event or injury, but he noted that he worked unloading heavy crates.

On the same day, October 1, 2018, Petitioner presented to Illinois Bone and Joint Institute and stated that his low back pain had been going on for the past couple months yet had gradually intensified over the last three weeks. Petitioner again reported that he had no fall or injury. Petitioner's intake form at this visit also indicated that there was no fall or injury, and instead, the symptoms were of three-weeks' gradual duration. Petitioner also denied any specific event or injury to Dr. Bukhalo on October 1, 2018 and described his pain as beginning three weeks prior and progressively worsening. Likewise, when Petitioner presented to Northwest Community Hospital on October 1, 2018, it was noted that he delivered beer for a living but could not recall any specific direct trauma.

These early treatment records document a gradual repetitive trauma injury but fail to mention any specific acute incident occurring on September 26, 2018 from stepping off the liftgate. The first documented instance of Petitioner telling a medical provider that he was injured by stepping off his truck at work was not until October 10, 2018, which occurred after he underwent lumbar surgery. Petitioner failed to mention that a specific event occurred on September 26, 2018 and even outright denied any work event or injury to his early treating doctors. For this reason, the Commission finds that Petitioner failed to prove that a specific acute accident occurred on September 26, 2018 from stepping off his truck's liftgate.

Additionally, the Commission is not persuaded by Dr. Regan's causal opinion concerning the alleged acute event on September 26, 2018, because Dr. Regan did not know the height that Petitioner stepped down from or whether Petitioner's work truck used a liftgate. Moreover, Dr. Regan conceded that it was difficult for him to comment on whether stepping down from a three-inch step had a high probability of causing a severe aggravation to a previously herniated disc.

Nevertheless, Dr. Regan exhibited significant knowledge of the daily lifting activities required at Petitioner's job. Dr. Regan opined that it was more likely than not that Petitioner's lumbar herniated disc was related to his on-the-job lifting activities from delivering beer. He testified that Petitioner had a physically demanding job and no history of any other similar physical activities that would have caused a herniation.

On the other hand, Dr. Hsu did not know specifics related to Petitioner's job duties, including how much a case of beer weighed or how many cases Petitioner delivered per week. He did not ask Petitioner about his lifting activities. Given that Dr. Regan had more knowledge of Petitioner's repetitive lifting and heavy job duties, the Commission finds that Dr. Regan offered the more persuasive opinion as it related to Petitioner's repetitive trauma claim. Moreover, even with Dr. Hsu's lack of knowledge concerning Petitioner's specific job duties, he nevertheless conceded that it was possible to suffer a herniated disc from lifting objects as a beer delivery driver.

In consideration of the above, the Commission finds that Petitioner failed to prove that he sustained a specific acute accident from stepping down three inches off his truck's liftgate on

September 26, 2018. Nevertheless, the Commission affirms the Arbitrator's finding that Petitioner's lumbar condition was caused or exacerbated by his repetitive job duties that required daily heavy lifting. The Commission thus modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed August 5, 2020, is modified as stated herein. In all other aspects, the Commission affirms and adopts the Corrected Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISION that Petitioner failed to prove that he sustained a specific acute accident that arose out of and in the course of his employment on September 26, 2018. Nevertheless, the Commission affirms the Arbitrator's finding that Petitioner's lumbar and right lower extremity conditions were causally related to his repetitive work duties, which included daily heavy lifting.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $961.54 per week for 8 weeks, commencing October 1, 2018 through November 26, 2018, as provided in §8(b) of the Illinois Workers' Compensation Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for reasonable and necessary medical services in the amount of $51,318.28 as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $813.87 per week for 100 weeks, as the injuries sustained caused a 20% loss of use of the person as a whole, pursuant to §8(d)2 of the Act.

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

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

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

June 19, 2021

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

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

DLS/met
O- 5/18/21
46

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

GRASSANO, CIRO A Case# **18WC031346**
Employee/Petitioner

CHICAGO BEVERAGE SYSTEMS
Employer/Respondent

On 8/5/2020, 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:

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY K GRAHAM
161 N CLARK ST SUITE 2100
CHICAGO, IL 60601

2461 NYHAN BEMBRICK KINZIE & LOWRY
BRIAN A RUDD
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
CORRECTED ARBITRATION DECISION

Ciro A. Grassano
Employee/Petitioner

v.

Chicago Beverage Systems
Employer/Respondent

Case # **18** WC **031346**

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 **Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **6/15/20**. 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 **9/26/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**75,000.00**; the average weekly wage was $**1,442.31**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

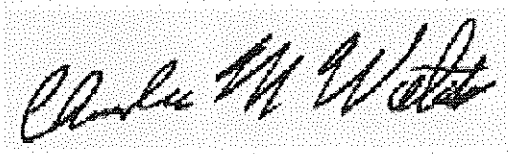
Respondent shall pay Petitioner temporary total disability benefits of $**961.54**/week for **8** weeks, commencing **10/1/18** through **11/26/18**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of outlined in Petitioner's Exhibit 8 in the amount of $**51,318.28**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**813.87**/week for **100** weeks, because the injuries sustained caused the **20%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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



Signature of Arbitrator

July 15, 2020
Date

AUG 5 - 2020

FINDINGS OF FACT

Petitioner, Ciro A. Grassano, has been employed with Respondent, Chicago Beverage Systems, since August of 2018, as a beer delivery driver. He has worked as a beer delivery driver since February of 2017 in the same capacity as it was for the company that was bought out by Respondent.

Petitioner testified that he delivers 5,000 cases of beer each week and drives a semi-tractor trailer on a single-man route. He further testified that he only has a helper on the route approximately five times per year. Petitioner testified that a case of beer weighs approximately 40 pounds, and he delivers 5,000 cases of beer in a normal week. Petitioner testified that he also delivers kegs of beer, both full and half barrels, weighing 90 to 180 pounds. He delivers 10 to 15 kegs each week. Petitioner testified that when he is delivering beer on his route to various grocery stores and liquor stores, he is the only individual unloading the truck.

Petitioner testified that he touches each case of beer three times to make a delivery – once to get it off of the truck and onto a pallet jack, another loading it onto a dolly or pallet to maneuver around the store and finally to place it onto a shelf or display. Petitioner testified that he unloads six to seven pallets, containing 50 cases of beer at each store. He testified each pallet is unloaded one-by-one.

Petitioner testified that when arrives at the store, he opens the door to the trailer, unfolds the lift gate that lays about three inches off the floor and unloads the pallets using an electric jack. He testified that he must push and pull the pallet jack, using great force, to unload the truck and take it into the store for distribution. Petitioner testified that he must push and pull the pallets various lengths, including the entire length of large stores, such as Wal-Mart or Jewel. Petitioner testified that once in the receiving area of the stores, he loads the cases onto a dolly, stacked with six cases, and wheels the dolly to the display areas. From there, he testified he unloads each case onto a shelf or display. Petitioner testified he unloads each case, weighing approximately 40 pounds, onto the display one at a time.

Petitioner testified he was working on September 26, 2018 and started his shift at 3:45 a.m. Petitioner testified he delivered to two Wal-Mart stores and a Jewel. He testified that he then went to Four or More Liquors to make a delivery. Petitioner testified that as he was stepping off the lift gate that he had folded down off of the back of the truck he felt a sharp severe pain in his right hip, leg and back. Petitioner testified he had been pulling a full pallet using an electric jack and stepped down about three inches onto the ground with his right foot. Petitioner testified that the ground below the lift gate, where he stepped, "laid cockeyed" and was not even ground. Petitioner testified he called his supervisor and told him he was in pain and finished he rest of his shift in pain. Petitioner testified that he had smaller liquor stores and restaurants to deliver to the rest of his shift and delivered approximately 150 cases of beer. Petitioner testified the pain progressed and he sought medical treatment the following day.

Petitioner testified that he had back pain leading up to September 26, 2018, for which he underwent chiropractic care, acupuncture and went to a walk-in clinic. Petitioner testified that he had never missed work due to back pain and was able to perform his job duties prior to

September 26, 2018. Petitioner testified that he attributed his pain to the heavy lifting and physical work he does on the job.

Petitioner's Exhibit 2 are the records from Nemcek Chiropractic Center in Arlington Heights Illinois. Here, Petitioner continued treatment for his lower back complaints prior to the alleged accident of September 26, 2018. A confidential patient information form was completed by Petitioner and he admitted on cross-examination that his signature was present along with the date of September 25, 2018 – the date prior to the alleged accident. On this form, Petitioner specifically stated that the condition began one month prior. The form specifically asked whether the condition was job-related, auto related, home injury, fall, or other. Petitioner failed to answer this question. On page 7 of 11, a daily patient record is included in this shows a diagram showing stabbing and cutting pain beginning in the lumbar area and extending down Petitioners right lower extremity. This is consistent with Petitioner's symptoms as described to Dr. Regan.

On September 27, 2018, Petitioner presented to Northwest Community HealthCare with complaints of right buttock and right hip pain for two weeks with no radiation down his leg. He noted pain levels at a 10 out of 10. He underwent x-rays of his lumbar spine and right hip that were negative. He was prescribed Medrol dose pack and Norco. Upon examination, he had full range of motion in his right hip and lumbar spine and straight leg raises were negative. (PX#1)

On September 27, 2018, Petitioner presented to Illinois Bone & Joint Institute where he was seen by Dr. Christian Skjong. (PX#4) Petitioner complained of back, buttock and right leg pain. The history indicates, "He states that he drives a beer truck and is constantly loading and loading the truck and jumping up and down off the truck bed. He has noted over the last several weeks increasing pain in his low back and buttock and occasionally some shooting pains down the back of his leg." (PX#4) This note does not reference the liftgate Petitioner testified that he stepped down from and hurt his back. The history indicates Petitioner reported that he had undergone chiropractic work, acupuncture and massage, as well as taken Medrol Dosepak and Vicodin without relief. Physical examination revealed a positive straight leg raise. Dr. Skjong recommended an MRI of his lumbar spine and referred him to a spine specialist.

On September 29, 2018, Petitioner underwent an MRI of his lumbar spine at Illinois Bone & Joint Institute MRI of Glenview. (PX#5) The MRI revealed severe right-sided facet arthropathy and a right extra foraminal disc protrusion likely impinging on the L4 nerve root that correlates with right L4 radiculopathy.

On October 1, 2018, Petitioner returned to the Illinois Bone & Joint Institute in Arlington Heights and saw Dr. Brian Donahue. (PX#3) Petitioner reported extreme severe pain in his lower back going down into his right thigh that he described as sharp, throbbing, an achy pain that is sever and constant. The history indicates Petitioner reported it has been going on for a few months but over the last three weeks had gradually intensified greatly and became debilitating. The physical examination revealed that Petitioner was in severe distress due to discomfort of his right upper leg and was in a wheelchair. He was unable to bear any weight on his right leg due to discomfort in his right lumbar spine and down the right thigh. Dr. Donahue

diagnosed L4-5 extruded disc due to the right. Dr. Donahue recommended he go immediately for an epidural steroid injection and should follow-up with Dr. Regan.

On September 30, 2018, Petitioner presented to the emergency department at Northwest Community Hospital with complaints of right sided low back, buttocks and leg pain and spasms. (PX#6)

On October 1, 2018, at 3:00am, Petitioner again presented to the emergency department at Northwest Community Hospital complaining of worsening right thigh pain. The history indicates that Petitioner reported that the pain had been going on for about a month and denied any specific injury or trauma, but stated that he works unloading heavy crates for a living. Petitioner was to follow-up with an orthopedic that day.

Treatment continued that day with Illinois Bone and Joint Institute. A medical history form is included in Petitioner's Exhibit 3, page 24. This document was presented to Petitioner at trial and he denied that it was his handwriting throughout the form; however, Petitioner admitted that it was his signature on the third and final page with the date of October 1, 2018. On page 1 of the form, there is a box asking for additional information with instructions that read "if your visits related to an injury, circle the appropriate response in the box below. If it is not related to an injury, skip this box." The box was not completed. The questions within the box ask whether the injury was due to our accident, work injury, sports injury, fall, or other and go on to ask additional questions about the injury and whether there is any legal action or litigation. The form asked for the date of onset of injury and the answer is "unknown." Furthermore, the form notes that there was no fall or injury and that the pain began three weeks gradually. (PX 3 at 24)

The October 1, 2018, Illinois Bone and Joint progress note provided the following summation:

> Patient is a pleasant 49-year-old male who is here today with extreme severe pain in his lower back going down his right thigh. He states that the pain as a sharp throbbing achy pain that is severe and constant increase with any type of walking standing or sitting positions. He believes that it is been going on for the past couple of months however the last 3 weeks it is gradually intensified greatly and become debilitating. He has no fall or injury that he is aware of. He has never had any problems with his back in the past. He was seen in the urgent care center on Sept 4 and given a Medrol dose pack, no pain relief. He took the rx Norco after the steroid course and had no pain relief either. He went to the IBJI immediate care center on 9/27/2018. They did x-rays and ordered an MRI. He had the MRI on Saturday. He then went to the emergency room this morning at 3:00 due to the pain and inability to sleep. He was given Dilaudid and had pain relief for 4 hours. That seems to be the only medication that has helped him. Over the past couple days he has been prescribed 60 mg prednisone tabs, ibuprofen, Norco, diazepam, Flexeril, among other medications. He has not gotten any pain relief from any of these. (PX 3 at 28)

On October 1, 2018, Petitioner presented to Dr. Yuriy Bukhalo of Northwest Suburban Pain Center. (PX#5) Petitioner complained of right sided lower back and right hip pain with radiation to his anterior thigh and right groin. Petitioner also reported numbness, paresthesias and weakness of the right anterior thigh. The history indicates that Petitioner indicated it started three weeks ago and has progressively worsened. Petitioner rated his pain at a 10 out of 10 and described it as sharp and constant. The examination revealed positive straight leg raises. Dr. Bukhalo performed a lumbar epidural steroid injection. (PX#5)

Later that day, Petitioner returned to the emergency department at Northwest Community Hospital with severe back pain with radiation into his right lower extremity. He gave a history that he carries and delivers beer for a living, but could not recall any specific direct trauma. Petitioner noted significantly worse pain following the epidural steroid injection. The records indicate that Petitioner was moaning in pain in the emergency department. Petitioner was admitted to the emergency department. (PX#6) An MRI of the lumbar spine was ordered. He underwent the MRI which revealed L4-5 disc bulge eccentric to the right with severe right and mild to moderate left facet degenerative changes with mild central canal and mild to moderate right foraminal stenosis; L5-S1 mild right paracentral disc protrusion that abuts the origin of the right SI nerve root; as well as L3-4 minimal disc bulge and mild to moderate facet degenerative change with mild central canal stenosis. (PX#6)

On October 2, 2018, Petitioner was still admitted in the hospital and was seen by Dr. E. Quinn Regan, of Illinois Bone & Joint Institute. (PX#6). During examination, Petitioner was unable to lift his right leg off of the bed. Dr. Regan reviewed the MRI of the lumbar spine.

Dr. Regan reviewed the prior MRI and diagnosed a far lateral herniated disc at L4-5 on the right and recommended that Petitioner undergo emergency surgery. Dr. Regan performed a right sided L4-5 metric far lateral discectomy on October 3, 2018. (PX#6). Dr. Regan's post-operative diagnosis was right-sided L4-5 far lateral herniated disc and multiple large fragments. Petitioner was discharged from the hospital on October 4, 2018. At the time, his leg pain was much better.

On October 10, 2018, Petitioner presented to Dr. Regan for a post-op follow visit. (PX#3) Dr. Regan noted he did well after his lateral discectomy at the L4-5 level with the disc herniation and noted "it is work related." Dr. Regan noted Petitioner is a beer truck driver, that Petitioner filed a report with work, and Petitioner stepped down "off it" and had pain and dysfunction in his back but was able to work that day and a couple days later and then the pain became severe so that he could not function. Dr. Regan noted the severe pain he had prior to the surgery was 90 percent better. Dr. Regan noted the date of injury at work was September 26, 2018. Dr. Regan restricted him from working.

On October 20, 2018, Petitioner presented to the emergency department at Northwest Community Hospital with increased pain and swelling at his surgical site. He was discharged and was to follow-up with Dr. Regan. (PX#6)

On October 22, 2018, Petitioner returned to Dr. Regan and reported that his severe leg pain was better. Dr. Regan performed a physical examination and saw swelling at the wound it

was consistent with seroma. Dr. Regan did an aspiration of the wound. Dr. Regan prescribed antibiotics. (PX#3)

On October 26, 2018, Petitioner returned to Dr. Regan for a wound check. Dr. Regan noted that he was moving in the right direction and recommended a course of physical therapy. Dr. Regan continued to restrict him from working. (PX#3)

On November 16, 2018, Petitioner returned to Dr. Regan and reported that his pain was much better. Dr. Regan noted they would re-evaluate him in four weeks' time and consider returning him back to work. Dr. Regan noted he was contemplating changing jobs to go to an easier job. Dr. Regan noted he could return to work with no restrictions as of November 26, 2018. (PX#3)

On December 10, 2018, Petitioner returned to Dr. Regan and noted he was back to work. Dr. Regan discharged him on a return as needed basis. (PX#3)

Petitioner testified that he returned to his regular job as a beer delivery driver in his full capacity on November 26, 2018. He had a visit with Dr. Regan on December 20, 2018 and was discharged from care. He testified that he had one final follow up.

Petitioner testified that he has unpaid medical bills, but most of the bills were paid for through his group health insurance, which is through his wife's employer. Petitioner testified that he is no longer seeking medical treatment and has not missed work since returning to full duty. Petitioner further testified that he continues to have soreness and takes two Aleve every morning.

Dr. E. Quinn Regan

Dr. Regan testified that he is a board-certified orthopedic surgeon that he specializes in spine surgery. (T#6-7) Dr. Regan testified that he treated Petitioner who had suffered a herniated right-sided disc at L4-5. He further testified that he performed discectomy on Petitioner who had significant relief of the severe pain he had. (T#10)

Dr. Regan testified that his understanding of Petitioner 's job was that he was a beer truck driver who moved about four thousand cases of beer a week, five to 15 kegs of beer per week and that he was working up until about three to four weeks before the operation in a high-level, physically demanding job. Dr. Regan further testified "it was more likely than not that the herniated disc was related to on-the-job lifting activities. (T#11) Dr. Regan further testified that Petitioner also reported an incident that exacerbated his pain, which was that he stepped down off of a lift of a truck on September 26, 2018. Dr. Regan further testified that the incident described by Petitioner of stepping backwards off the lift that was about 3 inches off the ground could have caused or exacerbated the herniated disc.

Dr. Regan testified that Petitioner's treatment was reasonable and necessary to help relieve him of the symptoms from his work-related injury. (T#16-#17)

Dr. Wellington Hsu

Petitioner underwent a Section 12 examination with Dr. Wellington Hsu at the request of Respondent on February 25, 2019. Petitioner testified that he told Dr. Hsu he worked as a beer delivery driver, but that Dr. Hsu did not ask how long he had done that job or the specific details of what the job entails. Petitioner further testified he told Dr. Hsu he had to lift to 100 pounds on a regular basis. He further testified he gave Dr. Hsu a history of how he injured himself on September 26, 2018. Petitioner also testified that he told Dr. Hsu he previously treated for lower back pain with Aleve, chiropractic care and acupuncture, but that his symptoms worsened on the date of injury. Petitioner testified he told Dr. Hsu that surgery had improved his symptoms and that he had returned to work within three months.

Dr. Wellington K. Hsu testified that he is an orthopedic spine surgeon with Northwestern Medical Group. He testified that he examined Petitioner on February 25, 2019, and prepared a report following the examination. He testified that he reviewed medical records, photographs of a liftgate, and Application for Adjustment of Claim in preparation of the report.

Dr. Hsu testified that Petitioner told him he injured his lower back when he was stepping off of his truck from a tailgate that was about 3 inches off the ground, and when he his right foot on the pavement, he experienced low back and right-sided hip pain. (T#14) Dr. Hsu testified that after reviewing the records, interviewing Petitioner and performing and examination, he opined that Petitioner suffered an L4-5 right-sided disc herniation and underwent a far lateral discectomy.

Dr. Hsu opined that Petitoner's alleged work accident on September 26, 2018, was not the cause of the lumbar disc herniation. Dr. Hsu testified that the basis of his opinion was that the mechanism of action described was not specific for his line of work because he was merely stepping off a three-inch liftgate. Dr. Hsu further testified that his opinion was also based on the fact there were some inconsistencies in the records to suggest that all of his pain in his low back was not from the alleged date of injury. Dr. Hsu further testified that the treatment Petitioner had received was reasonable and necessary, but not causally related to the alleged accident. Dr. Hsu further opined that Petitioner needed no restrictions.

Dr. Hsu testified that in general he understood the day to day job duties of a delivery truck driver. Dr. Hsu testified that Petitioner told him he frequently lifts 100 pounds and that his pain had developed over several weeks prior to the date of accident of September 26, 2018. Dr. Hsu testified that he was not aware of how much a case of beer was, nor did he inquire from Petitioner how many cases of beer did he deliver in a week. Dr. Hsu testified that he did not ask Petitioner about how the deliveries occur or the specifics of lifting cases of beer.

Dr. Hsu testified that if Petitioner is lifting an average of a 39-pound case of beer just twice a day, that would have no effect on his lumbar health. Dr. Hsu stated that evidence-based literature has shown time and again that repetitive job duties, including, lifting, bending, twisting have no effect on the health of one's lumbar spine. (T#20) However, Dr. Hsu testified that it is possible to herniate a disc with lifting objects like cases of beer. Dr. Hsu later testified that

lifting 4,000 cases of beer per week could certainly cause a herniated disc but indicated Petitioner did not describe lifting as the mechanism of injury.

Dr. Hsu testified that he did not ask Petitioner any questions about the lifting activities of his job despite Petitioner noting that he had pain leading up to the date of injury. Dr. Hsu first testified that he understood the mechanics of delivering the beer and then later stated he really did not know what he does. (T#23) Dr. Hsu testified that it was possible that stepping off the liftgate exacerbated Petitioner's disc herniation but that it was unlikely.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission,* 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board*, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission*, 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was credible. His demeanor at trial was serious and forthright. Petitioner answered questions easily and in a manner that was sincere. The medical records are mostly consistent with Petitioner's testimony. Where there is a discrepancy, the Arbitrator finds that Petitioner had difficulty during the initial days after the date of accident zeroing in on the cause of his painful low back. Upon some thought, Petitioner traced his change in pain symptoms to the specific act of awkwardly stepping off a lift gate a few inches above uneven ground. The credibility of the physicians who testified via evidence deposition are discussed below.

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

Petitioner alleges that on September 26, 2018, he sustained a compensable work injury that was the result of the repetitive heavy nature of the work he does as a beer delivery driver. Petitioner performs very heavy lifting on a daily basis that caused his symptoms of lower back and right lower extremity pain that became exacerbated on September 26, 2018 when he stepped down off of his truck while pulling a pallet of beer.

There is no dispute that Petitioner suffered a herniated L4-5 disc that required surgery. The compensability of this claim comes down to the credibility of Petitioner's testimony and the that of the treating physicians and examiner as to whether the lifting could have caused the herniation and the step from the lift gate could have caused or exacerbated it.

The Arbitrator finds the testimony of Petitioner's treating surgeon, Dr. Regan, more credible on this issue than the testimony of Dr. Wellington Hsu. On cross examination of Dr. Hsu, it was apparent that he was not diligent in his inquiry of the Petitioner regarding the heavy lifting he does in his job. Dr. Hsu was not probative of this issue despite conceding that delivering and lifting 4,000 cases of beer each week could cause a disc herniation. Dr. Regan's testimony regarding causation is found to be more credible as he was familiar with the specifics of the lifting Petitioner does in coming to his opinion that the herniation was more likely than not caused by the heavy lifting. Dr. Regan also opined that the act of stepping off the lift gate could have caused or exacerbated the herniation.

Petitioner testified that he delivers approximately 5,000 cases of beer, each weighing an average of 40 pounds plus kegs weighing up to 180, pounds each week. Petitioner testified in great detail the process of pushing and pulling pallets stacked with 50 cases of beer at a time, and dollies stacked with 60 cases of beer at a time. Petitioner testified he lifts each cases of beer three times to complete his deliveries. The Arbitrator finds Petitioner's testimony about the heavy lifting his job requires credible.

Illinois courts have long held that an employee can be accidentally injured, within the bounds of the Workers' Compensation Act, as the result of repetitive, work-related trauma absent a final, identifiable injury. *Peoria County Belwood Nursing Home v. Industrial Com'n of Ill.*, 115 Ill.2d 524 (1987); see also *Durand v. Industrial Com'n*, 224 Ill.2d 53 (2006).

In this case, Petitioner suffered repetitive, work-related trauma that caused his herniated disc. In repetitive-trauma cases, the date of accident is when the injury manifests itself. *Peoria County Belwood Nursing Home v. Industrial Com'n of Ill.*, 115 Ill.2d at 531. "The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee." *Durand v. Inustrial Com'n*, 224 Ill.2d at 72 (citing *General Electric Co. v. Industrial Comm'n*, 190 Ill.App.3d 847, 857, 137 Ill.Dec. 874, 546 N.E.2d 987 (1989)). An employee's medical treatment, the severity of his injury and how it specifically affects his performance at work are all relevant in objectively determining when a reasonable person would have recognized the injury and its relation to work. *Id.* In this case, the injury manifest itself on September 26, 2018 when Petitioner stepped from the lift gate and his pain progressed to being so unbearable he ended up in the emergency room several times and undergoing urgent surgery within the next few days.

Petitioner's duties of heavy lifting cases of beer to deliver 5,000 cases of beer to various grocery stores, liquor stores and restaurants each week were repetitive in nature. In *Peoria County Belwood Nursing Home v. Industrial Com'n of Ill.*, the claimant worked for the respondent for 12 years, specifically in the laundry room for the last six. 115 Ill.2d 524 at 527. She was required to carry bags of laundry weighing 25 to 50 pounds and then sort and load the laundry into washing machines. *Id.* at 528. The claimant loaded the machines six times a day. *Id.* The Illinois Supreme Court found her daily responsibilities repetitive. *Id.*

At the very least, Petitioner's daily heavy lifting exacerbated the severity of his herniated disc. Under Illinois law, the fact that a work-related accident may have accelerated or aggravated a pre-existing condition does not mean the employee cannot recover benefits, as long as the work-related accident was a factor in contributing to the disability. *Kishwaukee Community Hospital v. Industrial Comm'n*, 356 Ill.App.3d 915, 922 (2nd Dist. 2005) (citing *Gust K. Newberg Construction v. Industrial Comm'n*, 230 Ill.App.3d 96, 111 (1992)). So long as some act or phase of employment was a causative factor, which does not have to be the sole or only principle cause, of the injury, he is entitled to benefits. *Concrete Structures of the Midwest v. Industrial Comm'n*, 315 Ill.App.3d 596, 598 (1st Dist. 2000). Thus, Petitioner is still entitled to benefits under the Act as he has established that the heavy lifting he did daily at work was a causative factor in his herniated disc. Accordingly, the Arbitrator finds that Petitioner suffered a compensable injury that arose out of and in the course of his employment with Respondent.

IN RELATION TO (F) WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder* v. Ill. *Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

There is no dispute among any of the medical providers or Section 12 examiner, whose records or testimony are in evidence, as to Petitioner's diagnosis of a herniated disc at L4-5. Petitioner testified to symptoms in his lower back, right hip, buttock and thigh from that herniated disc, and there is no evidence to suggest any other source of those symptoms. The Arbitrator finds Petitioner's testimony credible.

Having found above that the herniated is the result of a combination of work-related repetitive trauma and the act of stepping off of the lift gate on September 26, 2020, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to that work-related injury.

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

The Arbitrator incorporates and adopts the findings contained within Section (F) of this decision. The Arbitrator determines bills submitted into evidence as Petitioner's Exhibit 8, were reasonable and necessary to cure or relieve the Petitioner of the effects of his injury. The medical records, which reflect improvement in Petitioner's symptoms with the treatment, as well as Petitioner's testimony that the treatment and surgery helped relieve him of his symptoms support this finding. Therefore, the Arbitrator awards these bills, which were admitted into evidence as Petitioner's Exhibit 8, pursuant to the Illinois Workers' Compensation Commission fee schedule under section 8.2 of the Act. Accordingly, Petitioner is awarded and Respondent is directed to pay $51,318.28, representing the outstanding balance of $5,942.71 for services rendered at Northwest Community Hospital and the $45,375.57 in benefits paid by Petitioner's group health insurance carrier, Blue Cross Blue Shield.

IN RELATION TO (K) WHETHER PETITIONER IS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified and the records reflect he was restricted from working from October 1, 2018 through November 26, 2018. Having found a compensable accident did occur and Petitioner's condition of ill-being is related to said injury, the Arbitrator finds that Petitioner was off work and entitled to temporary total disability benefits during this period. Accordingly, the Arbitrator awards and directs Respondent to pay eight weeks of temporary total disability benefits at a rate of $961.54 per week as provided in Section 8(b) of the Act.

IN RELATION TO (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency and weights the five factors enumerated within to determine the nature and extent of the injury as follows:

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 beer delivery 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 continues to have daily soreness that he attributes to his work as a beer delivery driver. Because of the continued heavy nature of Petitioner's work, the Arbitrator therefore gives *greater* 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 Petitioner has nearly 20 years of work life expectancy and continues to work in the same physically demanding job performing heavy lifting on a daily basis, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner was able to return to his prior employment with Respondent. Because there is no evidence of decreased future earning capacity, the Arbitrator therefore *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 all treating physicians and the Section 12 examiner found his diagnosis and treatment reasonable and necessary to cure or relieve Petitioner from his symptoms. Because of the MRIs, operative findings and treatment notes, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC021124
Case Name	CISLO,WILLIAM v. ILLINOIS SCHOOL BUS CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0364
Number of Pages of Decision	20
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Richard Gordon
Respondent Attorney	Robert Cozzi

DATE FILED: 7/19/2021

/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

William Cislo,
Petitioner,

vs. NO: 15 WC 21124

Illinois School Bus Co.,
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, reasonable and necessary medical, prospective medical and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,900.00. 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.

July 19, 2021

o:5/18/21
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 21IWCC0364
NOTICE OF ARBITRATOR DECISION

CISLO, WILLIAM Case# **15WC021124**
Employee/Petitioner

ILLINOIS SCHOOL BUS CO
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:

5272 GORDON LAW OFFICES LTD
RICHARD R GORDON
111 W WASHINGTON ST SUITE 1240
CHICAGO, IL 60602

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
77 W WASHINGTON ST SUITE 1601
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 Cislo
Employee/Petitioner

v.

Illinois School Bus Co.
Employer/Respondent

Case # **15** WC **21124**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **February 19, 2019 and April 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/26/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**16,237.00**; the average weekly wage was $**312.25**.

On the date of accident, Petitioner was **74** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**7,553.84** for TTD, $**0** for TPD, $**0** for maintenance, and $ - 0 -for other benefits, for a total credit of $ **7,553.84**.

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

ORDER

THE PETITIONER'S REQUEST FOR PAYMENT OF TEMPORARY TOTAL DISABILITY BENEFITS IS DENIED.

THE PETITIONER'S REQUEST FOR PAYMENT OF MEDICAL BILLS IS DENIED AND A FINDING OF OVERPAYMENT OF MEDICAL BILLS IS ENTERED.

RESPONDENT SHALL PAY TO THE PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $253.,00/WEEK FOR 10.75 WEEKS BECAUSE THE INJURIES SUSTAINED CAUSED THE 5% LOSS OF USE OF THE RIGHT LEG PURSUANT TO SECTION 8(E) OF THE ACT.

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

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

Signature of Arbitrator

03/30/2020
Date

APR 30 2020

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on February 19, 2019 and April 17, 2019 in Chicago, Illinois.

The parties went to hearing with the following issues in dispute: whether William Cislo's (hereinafter "Petitioner") condition of ill-being is casually related to his injury, whether Illinois School Bus Company, Inc. (hereinafter "Respondent") is liable for unpaid medical bills (P.X 2, 3,4 bills post 11/10/15), whether Petitioner is entitled to TTD for the period of April 28, 2015 through August 5, 2016, and the nature and extent of Petitioner's injury. (Arb. X1) More specifically, the issue here is whether the three knee surgeries undergone by Petitioner subsequent to his 2/26/15 work accident are causally connected to the accident such that Respondent is responsible to pay benefits under the Act.

The parties stipulated that on February 26, 2015, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act (hereinafter "Act"), that their relationship was one of employee and employer, that the accident arose out of and in the course of Petitioner's employment with Respondent, and that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. The parties stipulated that Petitioner's average weekly wage was $312.25 pursuant to Section 10 of the Act, was 74 years of age, married and had 0 dependent children at the time of the accident. (Arb.X1)

The submitted records have been examined and the decision rendered by Arbitrator Kay.

SUMMARY OF FACTS AND EVIDENCE

On February 19, 2019, Petitioner appeared and testified in support of his claim. Petitioner's wife additionally testified at trial. Evidence depositions of Petitioner's treating physicians, Dr. Scott Price and Dr. Steven Wardell, as well as Respondent's IME physician, Dr. Kevin Walsh, were also submitted along with relevant medical records.

Petitioner testified that he was employed by the respondent as a school bus driver. (Tr. 13) He had undergone surgery on his right knee approximately twenty years earlier for a meniscal tear and eventually a knee replacement. (Tr. 15) He also has undergone a total knee replacement surgery on his left knee around the same time. (Tr. 16) In the period between the accident and 1998, his right knee was "no problem." He did not experience stiffness and swelling but could experience pain with weather changes. (Tr. 16 – 17) While the petitioner originally testified that he never saw the doctor between 1998 and February of 2015, he later stated that he saw Dr. Boscardin at Parkview Orthopedics in May of 2014. (Tr. 18)

On February 26, 2015, he was walking to his school bus and he fell on ice whereby injuring his right knee. (Tr. 20) He noticed pain on his kneecap but got up and drove his route. (Tr. 22) While climbing onto the bus that day, he noticed a pain that he had not noticed before. (Tr. 23) Before February 26, 2015, he had not had any trouble climbing the stairs to the bus. (Tr. 23) Before the accident at work in February of 2015, he had not had any problems with his right knee sitting or standing for long periods of time or driving the bus or braking. (Tr. 23 – 24)

In the several weeks following his fall at work, he noticed that his knee was bothersome and affected his ability to climb stairs and ability to walk and stand. He eventually sought medical treatment but he does not know the name of the facility that he first received treatment. (Tr. 28) X-rays were taken and he was instructed to see an orthopedic physician. (Tr. 28)

The records of Palos Heights Medical Center reflect that the petitioner was seen at that facility on April 8, 2015 complaining of right knee pain. The physical examination revealed mild tenderness; no effusion; good stability; full range of motion; no patella tenderness; and decreased quad strength. X-rays revealed that his prior total knee replacement prosthesis was in good position. He reported that since the fall he was working without any problems. He was released to return to his normal job duties. He was also instructed to see his orthopedic surgeon because he had undergone a total knee replacement. (Resp. Ex. 4)

Petitioner then went to his orthopedic surgeon who had performed the total knee replacement, Dr. Boscardin of Parkview Orthopedics, on April 16, 2015. (Tr. 29) He reported that he was having difficulty with driving, walking and climbing stairs, none of which he had experienced prior to the fall of February 26, 2015. (Tr. 30) Dr. Boscardin referred him to Dr. Price, also with Parkview Orthopedics, the same group as Dr. Boscardin. (Tr. 30 – 31)

The records of Parkview Orthopedics (Pet. Ex. 1) reflect that the petitioner was seen by Dr. Boscardin on April 16, 2015. He complained of right knee pain as a result of a fall at work in mid-February. X-rays revealed a total knee to be in excellent position with no loosening. The physical examination revealed no effusion; tenderness over the patella tendon; and difficulty with extension. He ordered a bone scan to rule out a patellar fracture and prescribed medication. (Pet. Ex. 1) A triple phase bone scan was performed on April 21, 2015 which revealed bilateral knee replacements with probable degenerative changes in both knees. (Pet. Ex. 1) The petitioner then returned to Dr. Boscardin on April 28, 2015. Dr. Boscardin believed that the petitioner needed to have the patella resurfaced and the worn out plastic tibial prosthesis changed. Although Dr. Boscardin spoke to Dr. Price about taking over his care, the note fails to mention that Dr. Price had discussed with the petitioner resurfacing the patella and changing the plastic prosthesis nine months prior to the work injury. (Pet. Ex. 1)

Petitioner then saw Dr. Price who recommended that he have surgery on the right knee. The note of Dr. Price from May 5, 2015 reflects that before he fell, he was not having any difficulty climbing into the bus, walking, stairs or prolonged walking or standing. The triple phase bone scan showed only degenerative changes with no fracture or any evidence of loosening of the total knee replacement components. The physical examination revealed a slight valgus alignment; minimal effusion; decreased quad tone; moderate pain upon patellar compression; no joint tenderness; no anterior or posterior laxity; range of motion from 0 to 115. He had a discussion regarding surgical treatment options and the petitioner indicated he wished to proceed with surgery. There was no mention in Dr. Price's note of May 5, 2015 that Dr. Price had a discussion with the petitioner nine months prior to the accident regarding the same surgery. (Pet. Ex. 1)

The surgery was performed on June 4, 2015. The operative report of Dr. Price reflects that he performed the right patella prosthesis implant and revision of the right knee replacement by replacing the polyethylene insert for the right tibia. (Pet. Ex. 1) Following surgery, he underwent physical therapy and he was taken off of work. (Tr. 33) Shortly thereafter, the petitioner noticed that his kneecap "flopped over" while in therapy. (Tr. 34 – 35) He still had the same pain in his right knee after the surgery of June 2015 that he had experienced before. (Tr. 36) Dr. Price told him he should have a second knee operation. (Tr. 38) Following the examination with his employer's physician, the petitioner was advised that the respondent would not pay for the second surgery, so it was paid for by Medicare. According to the petitioner, the employer's physician only moved the knee back and forth. He asked the doctor why his kneecap was flopping over and he indicated he would have to review the records. The examination lasted approximately five minutes. (Tr. 40 – 42)

The second surgery was performed by Dr. Wardell, also of Parkview Orthopedics, on January 5, 2016. It consisted of a revision of the total knee arthroplasty tibial insert; revision of the right knee patellar component

of the total knee arthroplasty; realignment of the extensor mechanism of the total knee arthroplasty; debridement and synovectomy with removal of cement foreign body; and excision of the scar. (Pet. Ex. 1) Following the second surgery, he attended more physical therapy sessions. He was still having problems with the knee. His kneecap was still flopping over even after the second surgery. (Tr. 50) In addition, he could not perform his activities of daily living. (Tr. 50) He was instructed to undergo a third surgery. (Tr. 54) The procedure was performed in May of 2016. According to Dr. Wardell's operative report, the procedure consisted of a repeat revision of the right total knee arthroplasty with realignment of the extensor mechanism, scar revision, open lateral retinacular release secondary to recurrent patellofemoral instability. (Pet. Ex. 1) The third surgery helped, and he was eventually told to return to full duty work by Dr. Wardell. (Tr. 57 – 58) He returned back to work for the respondent in August of 2016. His knee was much better, and he had more confidence performing his daily activities. (Tr. 59) All the medical bills from November 15, through August of 2016 were paid for by Medicare. (Tr. 60)

On cross-examination, the petitioner was asked about his first visit ever with Dr. Price which occurred nine months before his fall at work. He could only vaguely remember that visit. He claimed that he told Dr. Price that only his left knee was catching and locking and that he had no problems with the right knee. (Tr. 61 – 62) He did tell Dr. Price, however, that he was having swelling in both of his knees depending on the weather conditions. (Tr. 67) He also told him he was having difficulty climbing stairs. (Tr. 67) He did not tell Dr. Price nine months before the accident that both of his knees were giving way. (Tr. 67) He did not discuss with Dr. Price nine months before the accident any type of surgery on his right knee. (Tr. 72) He cannot remember whether he discussed with Dr. Price the risks of leaving his right knee unstable nine months before the accident. (Tr. 73) He did not have any problems with his right knee at the time of the visit of May 30, 2014. (Tr. 73)

The progress note for Petitioner's visit with Dr. Price of May 30, 2014, nine months prior to the accident, reflects that he presented "for evaluation of both knees." The note further reflects that the petitioner complained of "discomfort in both knees." The right knee showed range of motion of 0 – 110; satisfactory quad tone; central patellar tracking; and Grade II+ posterior laxity. The Patient Encounter Form reflects that he complained of "bilateral knee pain" with lock/catch, swelling, stairs and giving way. Dr. Price took x-rays of both knees. There was significant degeneration in the right patella with bone-on-bone contacted noted in the patellofemoral compartment. There was evidence of slight posterior subluxation of the tibia on the femur on the right knee suggestive of posterior crucial ligament laxity. He diagnosed "status post-bilateral knee replacements now with evidence of degenerative arthritis." Dr. Price discussed a "total knee revision on the right to address the laxity with patellofemoral replacement." When the petitioner declined the revision surgery, Dr. Price warned him of the risks associated with leaving the right knee unstable. (Resp. Ex. 1)

Following his fall at work, he continued working that day. (Tr. 77) In fact, he continued working his regular job as a bus driver up until the time he first went for medical attention. (Tr. 80) In order to drive a school bus, he was required to use his right leg to operate the pedals.

He did not seek medical attention until April 8, 2015, forty-one days after his injury. (Tr. 81 – 82) He cannot remember if his knee was swollen or if he had difficulty moving his leg. The records of Palos Heights Medical Center reflect that on April 8, 2015, no swelling was present, and Petitioner exhibited a full range of motion. (Resp. Ex. 4) The note further reflects that the petitioner told the physician that he was having no difficulty performing his job duties. (Resp. Ex. 4)

He did not notice his kneecap flopping around or his foot going out sideways until Dr. Price performed his surgery of June 5, 2015. (Tr. 92) When he last saw Dr. Wardell in August of 2017, he advised him that he was back working. He told him that he was very happy with the outcome of the surgeries. Dr. Wardell may

have invited him to return back to see him if he had any additional problems but the petitioner has not since returned. (Tr. 96)

Theresa Cislo testified that she was the wife of the petitioner. (Tr. 99) She went to the examination with Dr. Walsh. All he did was move his legs back and forth. The examination took approximately 5 – 6 minutes. Prior to the injury at work, the petitioner was not having any problems with his right knee. After he fell at work, he slowed down. (Tr. 102) On cross-examination, she does not know how much time Dr. Walsh spent reviewing the medical records pertaining to her husband's condition. (Tr. 108) She does not recall that her husband saw Dr. Price nine months before the accident at work. She does not know if Dr. Price discussed with her husband having a total knee revision on his right knee before the accident at work.

Dr. Scott Price testified that he is a board-certified orthopedic surgeon who has worked at Parkview Orthopedics since 1986. (Pet. Ex. 6, pg. 5) He first saw the petitioner on May 30, 2014 to evaluate him for bilateral knee pain. Since Dr. Boscardin, his prior orthopedic surgeon, was no longer doing surgery, Dr. Boscardin wanted Dr. Price to see if there were any procedures that would be beneficial to the petitioner. (Pet. Ex. 6, pg. 7) The patient had undergone a right knee replacement in 1998 and a left knee replacement in 2000. (Pet. Ex. 6, pg. 8) The petitioner was having problems with both of his legs in May of 2014. He examined his right knee and found posterior laxity of Grade II+. The type of knee replacement that the petitioner had undergone was one in which the posterior ligament was retained. The problem with doing so was it put more stress on the kneecap which can increase the wear and tear on the patella over time. (Pet. Ex. 6, pg. 9) He discussed various treatments at that visit including a revision of the patella component. (Pet. Ex. 6, pg. 11) The petitioner elected to "watch things." (Pet. Ex. 6, pg. 11)

Dr. Price next saw the petitioner on May 5, 2016 but the petitioner had several visits with Dr. Boscardin in the interim. (Pet. Ex. 6, pg. 12) He talked to the petitioner of doing revisions to the knee replacements. As had been discussed in the previous year, he would take all the right knee implants out and put in a posterior stabilizing one or building up the plastic insert to create stability and making the knee a little tighter. (Pet. Ex. 6, pg. 17) The petitioner opted to proceed with the second procedure which was performed on June 4, 2015. Dr. Price felt that the accident at work aggravated the underlying degenerative process of the patella. (Pet. Ex. 6, pg. 16)

When he saw the petitioner after the surgery, he had a hard time walking and was complaining of pain in the back of the knee. (Pet. Ex. 6, pg. 20) Despite physical therapy, the knee was still weak. (Pet. Ex. 6, pg. 22) The petitioner developed a posterior lateral laxity problem after Dr. Price's surgery but it was not recognized by either Dr. Price or the physical therapist right away. (Pet. Ex. 6, pg. 27) He really cannot say whether the posterior lateral instability was present subsequent to the work accident or prior to his first surgery. (Pet Ex. 6, pg. 28)

On November 10, 2015, Dr. Price recommended that he see his partner, Dr. Wardell. (Pet. Ex. 6, pg. 35) Dr. Wardell recommended another surgical procedure. In reviewing Dr. Wardell's operative report, the procedure consisted of a revision of the tibial insert and a revision of the patellar component. (Pet. Ex. 6, pg. 37) Dr. Price believed that the petitioner's ongoing symptoms were related to his fall at work. (Pet. Ex. 6, pg. 38)

On cross-examination, the he stated that the techniques that were used in 1998 when the petitioner had his knee replacement are different than they are today. Knee replacements that were performed in 1998 would last 15 – 20 years. (Pet. Ex. 6, pg. 42) When the petitioner first started treating in the year before the accident and the year of the accident, he would be in the middle of that range when knee replacements would become worn out and would have to be addressed. (Pet. Ex. 6, pg. 42) The tibial insert bears the brunt of the weight in the knee replacement and so it takes major wear and tear. (Pet. Ex. 6, pg. 43) That was one of the reasons he replaced the tibial insert in the surgery in June of 2015. Since he was in there to do a patellar replacement, it

would have been foolish not to replace the tibial insert because it would give him more years with a new implant. The purpose of the surgery was to repair the worn-out patella but the new tibial insert gives it more support. (Pet. Ex. 6, pg. 44) He was shown a report that he had written on November 24, 2015 (Pet. Ex. 6, Deposition Ex. 12) in which he stated, "It is my opinion that replacement of the polyethylene insert was not related to his injury or the resulting problems with the posterior lateral laxity of patellar instability. I replaced the polyethylene purely on the basis that the fact that the patient had a previous knee replacement almost two decades previous and felt that replacement polyethylene would prolong the life of the current knee replacement." At his deposition, Dr. Price disavowed that opinion and claimed that it is, in fact, related to the work injury. He did so not realizing that his office had refunded to the worker's compensation carrier the charges for that insert after he issued the report of November 24, 2015. (Pet. Ex. 6, pg. 47)

With respect to the posterior stabilization post, they were available in 1998 but Dr. Boscardin did not put one in. The posterior stabilization post was designed to prevent posterior cruciate ligament laxity of the knee. (Pet. Ex. 6, pg. 49) This posterior laxity causes increased stress on the patella and causes the patella to wear out. (Pet. Ex. 6, pg. 50) When this wear and tear occurs, it causes arthritis of the patella. End-stage arthritis is when bone-on-bone occurs. (Pet. Ex. 6, pg. 50) The fact that the petitioner was obese often exacerbates the deficient posterior cruciate ligament in addition to the lack of a stabilization post. Patients can develop posterior laxity in the absence of trauma. Posterior laxity can develop posterior rotational laxity in the absence of trauma. (Pet. Ex. 6, pg. 51 – 52) Dr. Boscardin did not replace the patella on this patient although that technique was available in 1999. (Pet. Ex. 6, pg. 53) Such patients with the non-replaced patella develop dysfunction in the patellofemoral joint. (Pet. Ex. 6, pg. 53)

With respect to the visit of May 30, 2014, nine months before the accident at work, the petitioner complained of swelling in both of his knees. (Pet. Ex. 6, pg. 54) He did not sustain an injury that brought about those problems. (Pet. Ex. 6, pg. 54) He noted swelling of the right knee and a Grade II+ posterior laxity of his PCL. He took x-rays and he noted that the patella had not been replaced. The x-rays showed significant degeneration in the patella to the point where there was "bone-on-bone" changes in the patellofemoral compartment. (Pet. Ex. 6, pg. 56) He attributed the significant degeneration to the fact that he had not had his patella replaced when he had the knee replacement surgery. (Pet. Ex. 6, pg. 57) In addition, there was radiographic evidence of posterior laxity. X-rays showed posterior subluxation of the tibia on the femur. This means that there were not only clinical findings of posterior subluxation but also clear radiographic evidence nine months prior to the work injury. (Pet. Ex. 6, pg. 58) The instability and the bone-on-bone condition in the patella were major concerns for Dr. Price because he understood the problems that they would cause. (Pet. Ex. 6, pg. 62) That is why he discussed, nine months before the work injury, that the petitioner undergo the surgical procedure as a treatment option. He discussed no other treatment option at the time of that visit of May 30, 2014. (Pet. Ex. 6, pg. 65) In fact, Dr. Price explained to the patient the risks associated with leaving the knee unstable which included worsening over time. (Pet. Ex. 6, pg. 66) Dr. Price is not claiming that the trauma that the patient sustained in the work injury was so significant it required him to perform the surgery of June 4, 2015. (Pet. Ex. 6, pg. 71) He has no way of knowing whether it was a significant aggravation or a temporary aggravation. (Pet. Ex. 6, pg. 76)

He does not know when the petitioner first sought medical treatment following the fall at work. He would like to know why the petitioner did not seek treatment for forty-one days. He never reviewed the record of the doctor who first examined the petitioner after the work injury, forty-one days later, but it might be helpful. (Pet. Ex. 6, pg. 77) If there is a significant aggravation, he would expect to see evidence of swelling and discoloration afterwards. (Pet. Ex. 6, pg. 79) It would be speculation to say that he had more stress on the patella as a result of the work injury. (Pet. Ex. 6, pg. 80) He did not wish to examine the report of the initial medical treatment. (Pet. Ex. 6, pg. 81) Dr. Price never told Dr. Boscardin that he recommended surgery to the

right knee on May 30, 2015. (Pet. Ex. 6, pg. 84) He thinks that might have been something important for Dr. Boscardin to know. (Pet. Ex. 6, pg. 84)

When Dr. Boscardin first saw the petitioner, there was no swelling, bruising or discoloration, scraping or other signs of physical trauma to the knee. The triple phase bone scan that Dr. Boscardin ordered did not show any signs of trauma; on the contrary, the findings were consistent with the degenerative process. (Pet. Ex. 6, pg. 85 – 86) In fact, the triple phase bone scan reflected the same identical findings on the left knee as it did on the right. (Pet. Ex. 6, pg. 86 – 87)

When he performed the surgery, he did not observe the posterior lateral instability problem. After the May 5, 2015 evaluation, he prepared a note for the employer but made no mention whatsoever of the visit he had eleven months earlier in which he recommended surgery to the right knee. (Pet. Ex., 6, pg. 89) When he examined him on May 5, 2015, he did not observe any physical sign of trauma to the knee. (Pet. Ex. 6, pg. 90) The range of motion was nearly identical to the range of motion at the May 30, 2014 visit. In fact, the range of motion following the accident was better than it was nine months before the accident at work. (Pet. Ex. 6, pg. 90) The x-rays that he took on May 5, 2015 showed no evidence of trauma. (Pet. Ex. 6, pg. 92) In fact, it may have been a HIPAA violation to reference events that occurred prior to the accident at work. (Pet. Ex. 6, pg. 94) At the visit of May 5, 2015, he recommended the exact same surgery he said he recommended in May of 2014, nine months prior to the accident. (Pet. Ex. 6, pg. 95) There were other non-surgical options available on May 30, 2015 but he did not mention any of those in his note of that date. (Pet. Ex. 6, pg. 99)

Dr. Kevin Walsh testified that he is a board-certified orthopedic surgeon whose surgically treats patients with knee problems. (Resp. Ex. 6, pg. 4 – 6) He performs several hundred knee arthroscopies per year and performs approximately 140 knee replacements per year. He has been performing that same number of surgeries for the past twenty years. (Resp. Ex. 6, pg. 6)

Speaking in general terms, a total knee replacement was developed to eliminate arthritic pain by resurfacing the end bones of the knee. New surfaces are put into place which can be made of plastic. Instead of bone striking bone, you have plastic striking plastic and it eliminates pain allowing the patient to function better. (Resp. Ex. 6, pg. 6) Total knee replacements performed in 1998 could last up to twenty years. At that time, some surgeons put in stabilizing posts which sacrificed the posterior cruciate ligaments; others did not. It was a matter of philosophy of the surgeon. (Resp. Ex. 6, pg. 7) At that time, some doctors were resurfacing the underside of the patella and some did not. Dr. Walsh always uses posterior stabilizing posts and resurfaces the patella. The reason he does so is that the patella has nerve endings which will eventually rub against the femur and be painful to the patient. The reason why he always uses a posterior stabilizing post is because eventually a patient will end up tearing his posterior cruciate ligament and the knee will become unstable. The best way for that not to happen it is better to put in the posterior stabilized knee from the start. (Resp. Ex. 6, pg. 9)

Dr. Walsh performed an examination of the petitioner on October 22, 2015. The examination consisted of a history, review of radiographs, review of medical records, physical examination and issuance of a report with opinion. (Resp. Ex. 6, pg. 10) By way of history, the petitioner told him that he has had both right and left knee replacements in 1999. In February of 2015, he slipped and fell onto his right knee. He continued working for approximately a month and a half before he sought medical attention. He then underwent surgery on June 5, 2015 which did not help him.

With respect to the medical records, he reviewed the records of Parkview Orthopedics, Dr. Boscardin and Dr. Price. Dr. Price recommended a patellofemoral replacement and a possible polyethene exchange which meant taking out the old insert and replacing it with a new one into the tibia. (Resp. Ex. 6, pg. 16) A resurfacing of the knee cap would consist of putting a plastic button underneath the patella cementing it into place so that

bone would no longer be striking plastic or metal. (Resp. Ex. 6, pg. 16) Dr. Price's examination of May 5, 2015 revealed minimal effusion, decreased quad tone, patella tracking centrally, moderate pain on patella compression, no joint tenderness and Grade II+ locking, no posterior laxity. The patient agreed to undergo the proposed surgery which took place on June 4, 2015. (Resp. Ex. 6, pg. 17) The petitioner reported problems following this surgery which included weakness and discomfort in his leg going out to the side. His kneecap was also becoming unstable popping in and out of the joint. (Resp. Ex. 6, pg. 19) On October 13, 2015, Dr. Price recommended a second surgery which included a revision to a posterior stabilized knee. Dr. Walsh then performed his examination nine days later. (Resp. Ex. 6, pg. 20)

Dr. Walsh's examination revealed an obvious posterior laxity meaning that when he lifted his leg up, the leg sagged posteriorly and also hyper-extends when the knee was flexed. At 90 degrees, the patient was able to sublux his kneecap in and out of place. The patient was able to walk unassisted with a brace. His quad tone was 4+ out of 5. (Resp. Ex. 6, pg. 21) Dr. Walsh diagnosed a posterior laxity of the knee that was causing lateral subluxation of the patella. These conditions were not related to the fall at work. At the time that the petitioner fell, he sustained only a knee contusion as a result of the fall. He basis this on the fact that there was no tear of the PCL based on the records of treatment. (Resp. Ex. 6, pg. 22) Moreover, the petitioner did not seek any medical attention for a month and a half after he fell which also indicates that it was fairly minor injury. Furthermore, neither Dr. Boscardin or Dr. Price noted any swelling, marks or other sign of trauma at the time of their examination. It was reasonable for the petitioner to see Dr. Boscardin and also to see Dr. Price. (Resp. Ex. 6, pg. 23) The decision to proceed with the resurfacing of the patella was also reasonable but it was not causally related to the work injury. One does not replace a patella as a result of a simple fall but rather does so as a result of the degenerative condition and significant osteoarthritis. (Resp. Ex. 6, pg. 24 – 25) The decision to put in a different tibial insert was not related to the work injury either. With respect to the second surgery, the decision to insert a stabilizing post was not related to the work injury either because there was no tear of the PCL. The petitioner was capable of returning to work after his knee contusion which was the only condition that was related to the work accident. (Resp. Ex. 6, pg. 26 – 27)

As of the time of Dr. Walsh's evaluation, the petitioner had not reached maximum medical improvement. This is because of his ligamentous instability including an unstable knee. Although the surgery was reasonable, it was not related to the work injury. (Resp. Ex. 6, pg. 26 – 27)

After he issued his initial report, which was dated October 21, 2015, he was sent additional materials including the note from Dr. Price for the visit of May 30, 2014, nine months before the accident at work. That note revealed that the petitioner had problems with both of his knees. This was contrary to what the petitioner had told Dr. Walsh at the time of his examination. (Resp. Ex. 6, pg. 29) More importantly, the visit of May 30, 2014 shows the pre-existing condition of posterior ligamentous laxity and Dr. Price proposed surgery to correct it. The examination nine months before the work accident reflected x-ray evidence of posterior subluxation and bone-on-bone degeneration. There was no cartilage left on the back side of the kneecap in 2014. This is indicative of end-stage osteoarthritis and the condition cannot get any worse than bone-on-bone. (Resp. Ex. 6, pg. 31) The note further reflects that Dr. Price warned him of the risks of walking around on an unstable knee. (Resp. Ex. 6, pg. 32) The surgery that was proposed was a revision to address the laxity and also perform a patella placement. The procedure Dr. Price recommended after the work injury had been proposed nine months prior to the work accident. (Resp. Ex. 6, pg. 33) He was a candidate for revision surgery and patella replacement prior to the work accident and all of the care he received after the work accident addressed the problem that he had prior to the work accident. When he fell on his knee and had a contusion, it had nothing to do with the degenerative changes in the kneecap and the instability that he had prior to the work event. (Resp. Ex. 6, pg. 34) The work event did not cause the condition for which the petitioner underwent surgery nor did that aggravate or accelerate the condition. (Resp. Ex. 6, pg. 35)

With respect to Dr. Price's contention that the posterior lateral laxity may have been a finding that was caused by the work injury, neither Dr. Boscardin nor Dr. Price noted posterior lateral laxity when they evaluated him after the accident and before the first surgery. It was not noticed until months after he had undergone the surgery by Dr. Price when the kneecap began to sublux. This condition was not related to the accident but rather was a condition that developed after Dr. Price's surgery. (Resp. Ex. 6, pgs. 35 - 38)

On cross-examination, Dr. Walsh stated that his opinions remain the same in both reports: the need for surgery was not related to the work accident. (Resp. Ex. 6, pg. 39)

A traumatic event to an arthritic surface can cause further degeneration of the knee. In this instance, that was not the case. That is because the petitioner was already bone-on-bone and really cannot get worse than that. (Resp. Ex. 6, pg. 42) The first time the posterior lateral instability was in the records was in August of 2015, two months after his first surgery. (Resp. Ex. 6, pg. 44) A fall onto his right knee could not create stress on the PCL. It was already strained and lax in 2014 before the work accident when Dr. Price told him to consider a revision surgery. The posterior cruciate ligament was deficient, and he needed a posterior stabilized knee in 2014.

In the past year, he probably performed 100 independent medical examinations but he does not know how many depositions he has given. (Resp. Ex. 6, pg. 54) Less than 10% of his income is generated from medical legal consulting. (Resp. Ex. 6, pg. 55) He has been hired by claimants to give his opinion on behalf of injured workers but the majority is on behalf of respondents.

Dr. Steven Wardell testified that he is a board-certified orthopedic surgeon who specializes in hip and knee surgeries. (Pet. Ex. 5, pg. 5) He treated the petitioner for the first time on November 15, 2015. Dr. Price asked him to evaluate the patient following a procedure he performed in June of 2015 consisting of a patella resurfacing and exchange of the tibial insert. (Pet. Ex. 5, pg. 10) The petitioner still had significant complaints and one would not expect to hear such complaints following the procedure that the petitioner underwent in June of 2015. (Pet. Ex. 5, pg. 11) When he examined him, Petitioner demonstrated the subluxation and instability in his kneecap. Dr. Wardell diagnosed a painful right total knee arthroplasty with patellofemoral instability. (Pet. Ex. 5, pg. 12)

Dr. Wardell performed surgery on January 5, 2016 which consisted of a revision of his total knee arthroplasty tibial insert and a patella component; extensor mechanism realignment and open lateral retinacular release; debridement and complete synovectomy and excision of scar tissue. (Pet. Ex. 5, pg. 18) Based on the petitioner's representation to him that he had a fully functional knee that was without pain or instability prior to his work injury in February of 2015, he felt that the treatment was related. (Pet. Ex. 5, pg. 19) The retinacular was probably stretched out subsequent to the surgery of Dr. Price. (Pet. Ex. 5, pg. 21) This condition was not present prior to Dr. Price's surgical intervention in June of 2015. (Pet. Ex. 5, pg. 22)
With respect to the 10 – 15 degrees rotation of the tibial component, that was present since his original operation for a total knee replacement in 1998. It did not occur in his injury in 2015. (Pet. Ex. 5, pg. 23)
Even after undergoing the second surgery, the petitioner continued to feel unstable and his kneecap was coming in and out of position. (Pet. Ex. 5, pg. 28) He recommended another surgery which was performed on May 3, 2016 which consisted of a revision of his right total knee arthroplasty with the femoral and tibial components were exchanged with new implants. He again realigned the extensor mechanism and performed a lateral release to allow the patella to track normally. His scar was revised as well. (Pet. Ex. 5, pg. 31 – 32) He believes that these conditions were causally related to the work injury of February, 2015. When asked whether he agreed with Dr. Walsh's opinion that the petitioner sustained only a bone contusion as a result of the fall, he indicated he would not be the ideal person to be answering this question because he was not the original treater. Dr. Price would be the most likely individual to answer that question.

On cross-examination, he admitted that he did not review any of the records from Dr. Price prior to the work injury. Moreover, the petitioner did not tell him about any of the problems he was experiencing prior to February 26, 2015 with his right knee. (Pet. Ex. 6, pg. 39) If he was having problems prior to this date, that could change his opinion on causation. He simply accepted what the petitioner told him as true. (Pet. Ex. 5, pg. 40) The petitioner did not tell him that he had seen Dr. Price for a problem with his right knee prior to the work injury. The patient did not tell him that he discussed having a revision to his right knee replacement with Dr. Price nine months prior to the work injury. (Pet. Ex. 5, pg. 41) He would have liked to know that before he expressed his opinion on causation. (Pet. Ex. 5, pg. 41) He was not aware that the patient was exhibiting laxity in the posterior cruciate ligament nine months prior to the accident. He did not review any of the radiographs that had been performed nine months prior to the accident. (Pet. Ex. 5, pg. 41 – 42) Although he met with counsel for the petitioner prior to the deposition, he was not shown any of these records.

He then reviewed that note and it reflected that the patient was complaining of bilateral knee pain which contradicts what the patient told him. (Pet. Ex. 5, pg. 44) Dr. Price noted Grade II+ posterior laxity and the x-rays taken on that date confirmed posterior subluxation of the tibia on the femur suggestive of posterior cruciate ligament laxity. (Pet. Ex. 5, pg. 45) These problems can be caused by polyethylene wear and Dr. Price had noted at the time of his surgery that the prior polyethylene implant was worn out. (Pet. Ex. 5, pg. 46) Dr. Price then discussed a total knee revision for the right knee to address the laxity with a patellofemoral replacement. (Pet. Ex. 5, pg. 47) The two problems that Dr. Price said he wanted to address by the total knee revision nine months prior to the accident was the osteoarthritis of the patella and the laxity in the posterior cruciate ligament. (Pet. Ex. 5, pg. 50) Although degenerative changes can be asymptomatic, the petitioner had bone-on-bone contact which means that it is severe arthritis. It is bone-on-metal that was rubbing against one another. (Pet. Ex. 5, pgs. 51 – 52) Dr. Price discussed the risks of leaving a knee unstable with the petitioner in May of 2014. One of those risks was that an unstable knee could cause a fall. (Pet. Ex. 5, pg. 54)

Dr. Wardell does not know when the petitioner first sought medical treatment following the fall at work in February of 2015 nor does he know what type of findings were present at his first visit after the accident. He is basing his opinion on what the patient told him and the initial visit with Dr. Boscardin. (Pet. Ex. 5, pg. 59) When Dr. Boscardin examined him, there was no fluid within the knee. (Pet. Ex. 5, pg. 60) Although Dr. Boscardin noted tenderness of the patella, that finding could be caused by the bone-on-metal contact that had been previously documented. (Pet. Ex. 5, pg. 66) He would have expected the petitioner to have sought medical treatment within a couple of days or a couple of weeks. He was surprised to learn that the petitioner did not seek any medical attention until six weeks later. (Pet. Ex. 5, pgs. 67 – 68) It would have been difficult for him to operate a school bus using his right leg if he had sustained a significant injury to it. (Pet. Ex. 5, pg. 68)

He was shown the medical records of when the petitioner first sought medical treatment on April 8, 2015. There was tenderness but no effusion. There was no problem with but and some decreased quad tone. None of these findings can be attributed to the work injury. (Pet. Ex. 5, pgs. 69 – 71) The petitioner told Dr. Wardell that he was asymptomatic before the injury. He had not been provided with evidence that the petitioner was seeking out care with Dr. Price on May 30, 2014. The petitioner was at the mid-point of the life expectancy for a knee replacement that had been done in 1998.

The last office visit was on April 12, 2017. The petitioner told him he was working full duty and was tolerating his job activities. The physical examination revealed only mild crepitation. Stability was excellent and there was no effusion. The patella was tracking normally. The petitioner reported he was happy with the results. He was invited to return if he had any additional problems but the petitioner has not since returned. (Pet. Ex. 5, pg. 76)

CONCLUSIONS OF LAW

With respect to issue (F) whether the Petitioner's condition of ill-being is causally related to the accident of February 26, 2015, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The issue of causation is the central issue in this case. The petitioner contends that his fall of February 26, 2015 at work caused the need for him to undergo surgery on June 4, 2015 and two other surgeries that were subsequently performed by Dr. Wardell on January 5, 2016 and May 3, 2016. The respondent, on the other hand, contends that the petitioner sustained only a knee contusion as a result of his injury of February 26, 2015. The Arbitrator concludes that the weight of the evidence supports the conclusion that the petitioner sustained only a knee contusion as a result of the work injury and that the three surgeries that were performed on the petitioner's right knee were not causally related to the work injury. The Arbitrator bases this conclusion on the following factors.

With respect to the work injury, the petitioner fell but did not seek medical attention until forty-one days later. He continued working his normal job duties in this forty-one-day period. Although the petitioner contends that he experienced significant problems during this period, prior to seeking medical attention, the medical records of Palos Medical Center (Resp. Ex. 4) refute this contention. When he first sought medical attention following his injury of April 8, 2015, the note for that visit reflects that the petitioner reported that he was "able to work without any problems." (Resp. Ex. 4)

In addition, the medical records following the fall at work do not show any findings consistent with physical trauma of the knee. When the petitioner first went for medical treatment forty-one days after the work injury, there were no cuts, bruising, scraping, discoloration or swelling consistent with a recent trauma. On the contrary, the physician noted no effusion and full range of motion. Likewise, when Dr. Boscardin examined the petitioner on April 16, 2015 and April 28, 2015, no signs or evidence of physical trauma were noted in those examinations. Moreover, Dr. Boscardin ordered a triple phase bone scan which revealed only degenerative changes and no evidence of fracture or other trauma to the knee. The same finding was made for the uninjured left knee as were present on the right.

Even Dr. Wardell, Dr. Price's partner, was "surprised" to learn that the petitioner did not seek any medical attention until six weeks later. He would have expected the petitioner to have sought medical attention in a couple of weeks or a couple of days. He was asked to review the note of April 8, 2015 when the petitioner first sought medical treatment. He agreed that there were no findings at all that could be attributed to the petitioner's work injury.

Based on the above, the Arbitrator finds that the objective medical evidence following the fall at work demonstrates no significant trauma to the knee which could have caused, aggravated or accelerated the petitioner's right knee condition resulting in the need for three subsequent surgeries.

The second factor that the Arbitrator relies upon is that the surgery that Dr. Price performed on June 4, 2015 was the exact same surgery that Dr. Price had proposed to the petitioner on May 30, 2014, nine months before the accident. Although the petitioner claimed at various times in his testimony that he was having no problems at all with his right knee prior to the work accident, the undisputed medical evidence indicates otherwise. The petitioner was seen by Dr. Price on May 30, 2014, nine months before the work injury complaining of bilateral knee pain that resulted in catching, locking, swelling, difficulty with stairs and giving way. (Resp. Ex. 1) The x-rays revealed that the petitioner's posterior cruciate ligament was lax and that the undersurface of the right patella had degenerated to the point of "bone-on-bone" contact with the femur. Dr.

Price's note reflects that he proposed performing a revision surgery of the total knee replacement. Dr. Price even warned the petitioner of the risks associated with walking around with an unstable knee. It should be noted that Drs. Walsh, Price and Wardell all agree that the posterior ligament laxity and patella degeneration occurred because Dr. Boscardin elected not to insert a stabilizing post or replace the undersurface of the patella when he performed the total knee replacement in 1998. Although no doctors criticized Dr. Boscardin's decision in that regard, they agreed that not doing so eventually led to laxity in the posterior cruciate ligament and degeneration of the underside of the patella.

The procedure that was performed by Dr. Price on June 4, 2015 which the petitioner contends was caused by the accident, is the exact same procedure that Dr. Price had proposed nine months prior to the work injury. He resurfaced the underside of the patella and replaced the worn-out tibial insert. All doctors agree that the life span of the tibial insert is 15 – 20 years and that at the time of the replacement of the tibial insert, it was 18 years old and worn out. Dr. Price admitted in his report of November 24, 2015 that the replacement of the polyethylene insert was not related to his injury but rather due to the fact that it was almost two decades old. All doctors agreed that the x-rays taken nine months before the injury showed bone-on-bone degeneration of the patella which is "end stage arthritis." It is implausible that the fall at work made any change to his "end stage arthritis". All doctors agreed that the x-rays after the accident revealed no findings consistent with trauma. In the two ensuing surgeries preformed by Dr. Wardell, these same problems were addressed including the insertion of a posterior stabilizing post, the lack of which had caused posterior laxity and the bone-on-bone contact on the underside surface of the patella. Therefore, the evidence demonstrates to the Arbitrator that all of the problems for which the petitioner had undergone the three surgeries were for problems identified nine months prior to the work injury and that surgery was proposed to fix these problems nine months before the work injury.

Lastly, the Arbitrator accepts and adopts the opinions of Dr. Kevin Walsh that the petitioner sustained only a knee contusion as a result of the work injury and that the three subsequent surgeries were unrelated to the work injury. The Arbitrator further finds the testimony of Dr. Walsh more consistent and persuasive. Dr. Walsh's opinions were based on a complete review of all of the medical records. Neither Drs. Price nor Wardell had reviewed all of the medical records before rendering their opinions. Additionally, although Drs. Price and Wardell stated at various times in their testimony that the need for the surgeries may have been related, they made other statements to the contrary. For instance, Dr. Price stated that he was not claiming that the trauma that the petitioner sustained in the work injury was so significant that it required him to perform his surgery of June 4, 2015. In fact, he conceded that he would have no way of knowing whether it was a significant aggravation or if it was merely a temporary aggravation. (Pet. Ex. 6, pgs. 70 – 76) He admitted it would be speculative to say the fall at work put more stress on the patella. (Pet. Ex. 6, pg. 80) Further, he conceded that the surgery he performed was the exact same surgery he recommended nine months prior to the accident. Dr. Price issued a report on November 24, 2015 unambiguously stating that putting in a new plastic insert at the time of the surgery was not related to the work injury; yet, in his deposition, he refused to admit that such was the case. Moreover, Dr. Price could not say whether the posterior lateral instability, which is the condition for which he attributed the need for the surgery, was present after the work injury but before his surgery. (Pet. Ex. 6, pg. 95) Dr. Wardell admitted he had never seen Dr. Price's report from nine months before the accident nor had he seen the note for the first visit after the fall. When Dr. Wardell was asked whether he agreed or disagreed with Dr. Walsh's opinion that the petitioner sustained only a knee contusion as a result of the fall, he conceded he would not be the ideal person to answer that question because he was not the original treater. Dr. Wardell when shown the record for the first medical visit after the fall admitted that there were no findings he could attribute to the fall. If he had aggravated the knee in the fall, he would have expected him to go for treatment in a couple of days or weeks. (Pet. Ex. 5, pgs. 67 - 68) Additionally, Dr. Wardell admitted that he based his opinion on causation on the fact that the petitioner told him that he was asymptomatic before the injury. He had not been aware that the petitioner discussed having a revision of the total right knee replacement

performed nine months before the accident. He had not reviewed the May 30, 2014 report of Dr. Price before rendering his opinions. To summarize, the Arbitrator adopts and relies upon the opinion of Dr. Walsh.

The Arbitrator finds that the petitioner sustained a knee contusion as a result of the work injury of February 26, 2015. The Arbitrator further finds that the surgeries performed on June 4, 2015, January 5, 2016 and May 3, 2016 are not causally related to the work injury.

With respect to issue (J) whether the medical services that were provided to Petitioner reasonable and necessary?, Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", and Was there an overpayment by the respondent of medical bills?, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The petitioner offered into evidence several medical bills from Parkview Orthopedics reflecting a balance of $14.16 (Pet. Ex. 2) Palos Health showing a balance of zero (Pet. Ex. 3) and ATI Physical Therapy (Pet. Ex. 4) also showing a zero balance. (Pet. Ex. 4) The petitioner testified that all medical bills subsequent to the independent medical examination of Dr. Walsh were paid for by Medicare. Based on the Arbitrator's finding with respect to Issue (F) (Causal Connection), the petitioner's request for the respondent to pay these medical bills is denied.

Dr. Walsh testified that the treatment up to the surgery of June 4, 2015 was reasonable, necessary and causally related to the petitioner's knee contusion but not thereafter. The bills from Parkview Orthopedics (Pet. Ex. 2), Palos Health (Pet. Ex. 3), and ATI Physical Therapy (Pet. Ex. 4), and the payment ledger of Gallagher Bassett, the third-party administrator for the respondent (Resp. Ex. 2), reflect payments for unrelated treatment to Parkview Orthopedics, SC totaling $2,820.07 (after Parkview refunded the charge for the plastic tibial insert on December 28, 2014); Palos Health in the amount of $27,872.20; and total payments to ATI Physical Therapy of $12,304.62. These payments represent overpayments to medical care providers as they relate to the charges that were not causally related to the work injury.

With respect to issue (K) whether Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. Dr. Walsh testified that the petitioner did not require to be taken off of work as a result of the knee contusion he sustained. Dr. Walsh further noted that the petitioner worked forty-one days following the work accident performing his normal job duties before he sought medical attention. Based on the Arbitrator's finding with respect to Issue (F) (Causal Connection), the petitioner's claim for temporary total disability benefits is denied.

With respect to issue (L), what is the Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The petitioner sustained a knee contusion as a result of his work injury that required several doctor's visits. For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the Section §8.1b of the Illinois Workers' Compensation Act. Here, the accident occurred on February 26, 2015 making section §8.1b applicable.

With regard to subsection (i) of §8.1b(b), an AMA Impairment Rating was not provided by either party. Therefore, the Arbitrator gives this factor no weight.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner returned to his position pre-injury as a bus driver for the Respondent. Therefore, the Arbitrator gives this factor little weight.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 74 years of age at the time of the accident. Petitioner may have a more difficult time recuperating from his injury than a younger employee. Therefore, the Arbitrator gives this factor more weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was able to return to work to his regular job on a full duty basis. Therefore, the Arbitrator gives this factor little weight.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, Dr. Kevin Walsh opined that Petitioner sustained a knee contusion as a result of the work injury and that the three subsequent surgeries were unrelated to the work injury. Dr. Walsh's opinions were based on a complete review of all of the medical records. According to the testimony, neither Drs. Price nor Wardell had reviewed all of the medical records before rendering their opinions. Additionally, although Drs. Price and Wardell stated at various times in their testimony that the need for the surgeries may have been related, they made other statements to the contrary.

In addition, when Petitioner and his wife were asked during their testimony's about Petitioner's alleged injury, previous medical conditions and various medical appointments and occurrences they were both unable to answer many of the questions.

Based on the above, the record taken as a whole and testimony, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use to the right leg.

Signature of Arbitrator

3/30/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC004515
Case Name	SLOAN, SUSAN v. JAROSCH BAKERY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0365
Number of Pages of Decision	30
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Michael Nicholson
Respondent Attorney	Jeremy Mazza

DATE FILED: 7/19/2021

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify *Accident, Causal Connection, Notice, Medical, TTD, PPD (Cervical)*	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUSAN SLOAN,

Petitioner,

vs. NO: 17 WC 004515

JAROSCH BAKERY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of jurisdiction, the employer-employee relationship, accident (whether the accident occurred, arose out of employment, and was in the course of employment), notice, medical expenses (causal connection, the reasonableness and necessity of medical treatment and prospective medical care), temporary disability benefits, permanent disability benefits, and penalties and attorneys' fees, and being advised of the facts and law, modifies and corrects the Decision of the Arbitrator as set forth below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. MANIFESTATION DATE

The manifestation date (the date of an accidental injury in a repetitive-trauma compensation case) "means 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." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026 (1987). It is well-settled that the date of manifestation of a repetitive trauma injury is subject to a "flexible standard," to "ensure a fair result for both the faithful employee and the employer's insurance carrier." *Durand v Industrial Commission*, 224 Ill. 2d 53, 69-71, 862

N.E.2d 918 (2006); *see also Three 'D' Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261 (1989). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Three 'D' Discount Store*, 198 Ill. App. 3d at 47. In deciding the manifestation date of a repetitive-trauma injury, courts consider various factors, including the dates on which: (1) the claimant first sought medical attention for the condition, (2) the claimant was first informed by a physician that the condition is work-related, (3) the claimant was first unable to work as a result of the condition, (4) the symptoms became more acute at work, and (5) the claimant first noticed the symptoms of the condition. *See Durand v Industrial Commission*, 224 Ill. 2d 53, 68-71, 862 N.E.2d 918 (2006) (citing *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026, 1029, 106 Ill. Dec. 235 (1987); *Three "D" Discount Store*, 198 Ill. App. 3d at 47-48, 556 N.E.2d at 266-65; and *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 611-12, 531 N.E.2d 174, 176-77, 126 Ill. Dec. 41 (1988)). The Commission does not believe that the January 26, 2016 date meets any of the above criteria.

The Commission finds that although the Petitioner alleges a manifestation date of January 26, 2016, the evidence better supports a manifestation date of November 29, 2016. The record shows that on November 29, 2016, Petitioner first complained of tingling in her hands and arms to Dr. Smriti Wagle at Advocate Medical Group. The progress note from that date indicates Petitioner had tingling in her arms for the past ten months, which had worsened in the last three months, in addition to numbness. The note also indicates that Petitioner worked in a bakery and "does a lot with her hands… lots of lifting..." Dr. Wagle diagnosed Petitioner with probable carpal tunnel syndrome present for one year; prescribed physical therapy, NSAIDS, and a muscle relaxer; and recommended wrist splints and an EMG/NCV study. Pet.'s Ex. 3. Additionally, Petitioner testified that she began to experience symptoms in both of her hands around August 2016. Petitioner testified: "I had told Ken and Kathy [Jarosch] that I couldn't feel my arms, and the back of my head felt like it was being tipped forward; but I kept working." Petitioner also testified that it was around this time that she began to seek medical treatment for her symptoms. T.14-15. Petitioner's testimony is corroborated by the medical records. There are no medical records dated January 26, 2016 and there was no testimony as to the significance of this date. Accordingly, the Commission finds that November 29, 2016 is a more objectively appropriate manifestation date of Petitioner's bilateral carpal tunnel syndrome.

Based on the above, the Commission corrects the date listed under the "Findings" section of the Decision of the Arbitrator ("Decision") from January 11, 2019 to November 29, 2016.

II. ACCIDENT/CAUSAL CONNECTION

The Arbitrator found that Petitioner's bilateral carpal tunnel syndrome was causally related to Petitioner's repetitive work activities as a bakery worker. The Arbitrator found as follows:

> Petitioner testified regarding the repetitive nature of her work duties at the bakery, which included gripping and grasping pans and trays, along with various stocking activities. This description of her job duties was verified by testimony from Kenneth [Kenneth] and Katherine [Katherine] Jarosch [Respondent's witnesses]. Based upon the testimony at trial and the medical histories found in the exhibits,

> the Arbitrator finds that Petitioner sustained a compensable work injury to the bilateral wrists within the course and scope of her employment duties with the Respondent.

The Commission agrees with the Arbitrator's above findings and conclusions with respect to Petitioner's bilateral carpal tunnel syndrome condition. Further, the Commission finds that Petitioner's testimony overall was credible, persuasive, and supported by the medical records.

With respect to Petitioner's cervical spine condition, the Arbitrator found that Petitioner's cervical pathology was unrelated to her work at Respondent's Bakery. The Arbitrator relied on the opinion of Respondent's Section 12 medical examiner, Dr. Edward Goldberg, who opined that Petitioner's cervical pathology and the surgical intervention that followed, were not associated with Petitioner's work activities. The Commission sees the evidence differently and finds that Petitioner proved by the preponderance of the evidence that her cervical spine condition is also causally related to her repetitive work activities as a bakery worker.

The Commission finds that Petitioner's cervical spine pathology and carpal tunnel syndrome are connected. The Commission relies on Dr. Eric Belin's treatment note which indicates that Petitioner suffered a "double crush" injury from the outset; however, this condition was not diagnosed until July 12, 2017. Pet.'s Ex. 2. Additionally, the Commission relies on treating spine surgeon Dr. Chris Bergin's October 3, 2017 treatment note, which states "[it] is my opinion that the patient's symptoms are related to the disc herniation at C5-6 and that the symptoms are resolved of the work injury from September and October of last year were due to the repetitive nature of her job." Pet.'s Ex. 4.

The Commission further finds Petitioner credibly testified that after undergoing carpal tunnel release surgeries to both hands, she only experienced partial relief from her symptoms. Petitioner testified that she continued to have pain in her neck that radiated down, and she continued to feel as though her head was "being tipped forward." T. 20-21. Additionally, the medical records show that after the bilateral carpal tunnel releases, Petitioner reported persistent stiffness, pain and cramping in her hands, neck, and shoulder. Pet.'s Ex. 2, 3. However, Petitioner testified that after undergoing an anterior cervical discectomy with decompression and total disc arthroplasty at C5-C6 on December 21, 2017, she experienced significant symptom relief the very next day. Petitioner testified that she had immediate relief from most of her symptoms and she no longer felt as though her head was "being pushed forward." T.24. The medical records show that Petitioner had a good surgical result and she reported 90% improvement of her symptoms at physical therapy on April 12, 2018. Pet.'s Ex. 4 at 27. Dr. Goldberg, Respondent's section 12 examining physician, opined that Petitioner's cervical spine condition was not causally related to her work activities without providing a credible basis for his opinions. However, Dr. Goldberg acknowledged that the cervical disc replacement surgery was appropriate, although he maintained that it was not related to Petitioner's work activities. The Commission finds Dr. Goldberg's opinions to be unpersuasive.

Based on Petitioner's credible testimony and the medical records which support Petitioner's testimony, the Commission finds that Dr Belin's diagnosis of a double crush injury to Petitioner's cervical spine at C5-6 and the upper extremities was accurate.

III. NOTICE

The Arbitrator found that Petitioner proved notice as to her bilateral carpal tunnel syndrome condition but did not prove notice as to her cervical spine condition. In finding notice as to the bilateral carpal tunnel syndrome, the Arbitrator reasoned:

> Kenneth and Katherine Jarosch both testified that they were aware of Petitioner's physical ailments, including "ice cold hands," numbness, difficulty sleeping, and pain, but stated that Petitioner had never attributed any of her ailments to her work activities…Petitioner has essentially claimed a repetitive trauma injury and so notice was sufficient when Petitioner complained of specific physical ailments to Respondent.

The Commission finds that in the same way Petitioner proved she provided sufficient and timely notice of her bilateral carpal tunnel syndrome condition to Respondent, she also proved she provided sufficient and timely notice of her cervical spine condition to Respondent.

Section 6(c) of the Illinois Workers' Compensation Act provides that "[n]otice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident." 820 ILCS 305/6(c) (West 2008). "Notice of the accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing." *Id.* "No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that it is unduly prejudiced in such proceedings by such defect or inaccuracy." *Id.* In a repetitive trauma case, the date from which notice must be given is the date when the injury manifests itself. *White v. Workers' Compensation Comm'n*, 374 Ill. App. 3d 907, 910, 873 N.E.2d 388 (2007). The legislature has mandated a liberal construction on the issue of notice. *S & H Floor Covering, Inc.,* v. *Workers' Compensation Comm'n*, 373 Ill. App. 3d 259, 265, 870 N.E.2d 821 (2007); *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96, 631 N.E.2d 724 (1994).

Petitioner's unrebutted testimony was that she began to experience symptoms in both of her hands and her neck in the fall of 2016. Petitioner specifically testified: "I had told Ken and Kathy [Jarosch] that I couldn't feel my arms, and the back of my head felt like it was being tipped forward; but I kept working." T.14-15. Katherine Jarosch testified that she first became aware that Petitioner was pursuing a workers' compensation claim at the end of January 2017 when Petitioner's husband called to ask for paperwork. T.47. However, Katherine Jarosch later acknowledged that at some point before January 2017, she spoke to Petitioner about Petitioner's physical complaints. Katherine Jarosch testified that Petitioner reported having "ice cold hands, numbness, difficulty sleeping, pain," but stated that Petitioner did not specifically attribute these symptoms to her work activities. T. 46-48. The Commission finds that both Petitioner's testimony and Katherine Jarosch's testimony establish that Petitioner provided timely and sufficient notice of her specific symptoms even if Petitioner did not specifically state that her work activities were connected to her symptoms as making this type of connection is not required to provide sufficient notice. The Commission finds Respondent received sufficient and timely notice of Petitioner's workers' compensation claim before January 2017 and Respondent has not demonstrated it was

unduly prejudiced in any way.

IV. Medical Expenses and Temporary Total Disability

Based on the Commission's finding that Petitioner's cervical condition is causally related to her work for Respondent, Petitioner is entitled to medical expenses for treatment to her cervical spine, including the cervical spine surgery on December 21, 2017.

Further, the Commission finds that Petitioner is entitled to additional temporary total disability ("TTD") benefits during the time period that she treated for her cervical spine condition based on Petitioner's unrebutted testimony that she treated with Dr. Bergin and underwent physical therapy at least until the date of the FCE. The Arbitrator awarded TTD benefits from March 2, 2017 through May 7, 2018, the date when Respondent terminated TTD benefits pursuant to Dr. Goldberg's opinions. The Commission finds that Petitioner is also entitled to temporary total disability ("TTD") benefits from March 8, 2018, through November 20, 2018, the date of the valid Functional Capacity Evaluation ("FCE") which placed Petitioner at a light to medium physical demand level. Although Petitioner testified that after the FCE, she followed up with Dr. Bergin who recommended that she return to work per the FCE, this note is not included in the record and there are no other treatment notes after the FCE in the record. Accordingly, the Commission finds that Petitioner is entitled to additional TTD benefits from March 8, 2018, through November 20, 2018.

V. Permanent Partial Disability

Our conclusion that Petitioner's cervical spine condition is also causally related to her work activities necessarily implicates an analysis of Petitioner's permanent disability. The Commission analyzes the §8.1b factors as follows.

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 was a bakery worker and performed both customer service work and "store stocker" work. Petitioner's unrebutted testimony was that she performed more store stocker work as time went on, which included lifting and carrying heavy trays, stocking the store, and retrieving items from coolers. Following her work-related injuries to her bilateral hands and cervical spine, Petitioner has not returned to work and per a valid FCE, she is only able to work at a light to medium physical demand level. Specifically, Petitioner is unable to lift 30 pounds occasionally from floor to waist, 25 pounds occasionally from waist to crown, and 15 pounds occasionally from platform to overhead. Further, Petitioner is unable to perform occasional 15-pound "shelf lowering with waiter's carry and tray placement to 24-inch table," and unable to perform occasional 15-pound management of trays for lifting and overhead carrying.

Of note, Katherine Jarosch testified that she believed the FCE accurately stated the type of work Petitioner had to perform but the weights in the FCE were inaccurate. Katherine Jarosch testified that nobody on the sales staff was required to lift more than 50 pounds. Kenneth Jarosch testified that nobody on the sales staff or the front-of-the-house was required to lift more than 50 pounds. However, Kenneth Jarosch testified that Petitioner would have to lift between 10 and 30 pounds. Both Kenneth and Katherine Jarosch testified the frequency with which Petitioner had to lift was hard to quantify and varied. The Commission finds that the testimony of Kenneth and Katherine Jarosch establishes that Petitioner is unable to return to her previous job as a bakery worker based on the FCE, which indicated that Petitioner is unable to lift between 15 and 30 pounds occasionally. The Commission gives this factor significant weight and finds that it weighs heavily in favor of increased permanent disability.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was approximately 53 years old as of the manifestation date. The Commission finds this factor weighs in favor of slightly increased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

Neither party presented any expert vocational evidence or testimony in this case. The Commission gives this factor no weight.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

The treatment records show Petitioner underwent bilateral carpal tunnel releases, and at C5-C6, an anterior cervical discectomy with decompression of bilateral nerve roots, and a total disc arthroplasty with hardware implantation. Petitioner had a good result, but Petitioner has permanent restrictions at a light to medium physical demand level pursuant to a valid FCE. Additionally, Petitioner credibly testified that she continues to have a little "pressure on the right side" and some problems with her forearms. T. 24. The Commission gives this factor significant weight and finds that it weighs in favor of increased permanent disability.

The Commission finds that Petitioner has suffered a loss of 25% of the person-as-a-whole under section 8(d)2 of the Act.

All else is affirmed.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment to Petitioner's cervical spine and bilateral carpal tunnel syndrome.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $246.01 per week for a period of 89 and 6/7 weeks, representing March 2, 2017 through November 20, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $221.41 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to the cervical spine caused 25% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $221.41 per week for a period of 28.5 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused 15% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $221.41 per week for a period of 28.5 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused 15% loss of use of the right hand.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, to or on behalf of Petitioner on account of said accidental injury, including a credit of $15,147.19 for temporary total disability payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to penalties pursuant to §§19(l) and 19(k) or attorneys' fees pursuant to §16 based on Respondent's reliance on Dr. Goldberg's opinions which was not unreasonable, vexatious, or in bad faith.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,200.00. 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.

July 19, 2021

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

DJB/cak

O: 5/18/21

/s/ *Stephen Mathis*
Stephen Mathis

43

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0365
NOTICE OF ARBITRATOR DECISION

SLOAN, SUSAN
Employee/Petitioner

Case# **17WC004515**

JAROSCH BAKERY
Employer/Respondent

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

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

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

3098 MICHAEL NICHOLSON
7111 W HIGGINS AVE
CHICAGO, IL 60656

2389 GILDEA COGHLAN & REGAN LTD
JEREMY MAZZA
901 W BURLINGTON AVE #500
WESTERN SPRINGS, IL 60558

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

Susan Sloan
Employee/Petitioner

v.

Jarosch Bakery
Employer/Respondent

Case # **17** WC **4515**

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **January 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 11, 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 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 $**19,189.04**; the average weekly wage was $**369.02**.

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 $**15,147.19** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**15,147.19**.

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

ORDER

Because Petitioner failed to prove an accident to the cervical spine, failed to provide appropriate notice to the Respondent, and failed to prove any causal connection between the cervical spine and her work duties with the Respondent, benefits are denied with respect to the cervical spine.

Respondent shall pay Petitioner temporary total disability benefits of $246.01 per week for 61 4/7 weeks, commencing March 2, 2017 through May 7, 2018, as provided in Section 8(b) of the Act. Respondent is entitled to a credit for any amounts paid during this period.

Respondent shall pay reasonable and necessary unpaid medical services pertaining to Petitioner's bilateral wrist/carpal tunnel conditions, as provided in Sections 8(a) and 8.2, pursuant to the Illinois Fee Schedule. Respondent shall be given a credit for any medical charges paid. Medical benefits are denied with respect to the cervical spine.

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 §8.1(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a salesperson/stocker at the time of the accident and that she is able to return to work in some capacity, per the FCE and the testimony of her supervisors. The Arbitrator notes that the FCE suggested that Petitioner may require some restriction when working. However, according to the testimony of Kathy and Kenneth Jarosch, the therapists who completed Petitioner's FCE did not have an accurate depiction of Petitioner's work duties. Because of the FCE results and the testimony of representatives of the Respondent, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. Because there is no indication that Petitioner's age will limit her ability to return to work with the Respondent, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the testimony of Kathy and Kenneth Jarosch, who testified that the Respondent could provide Petitioner work within the outlines of the FCE. As there is no indication that the injuries will impact Petitioner's future earnings capacity, 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 the medical exhibits failed to show that Petitioner has sought treatment for her carpal tunnel condition since June 2017. Though the records make reference to the possibility of locating other employment to minimize Petitioner's exposure to repetitive activities involving her hands, the Arbitrator notes that the FCE did not place any restriction upon Petitioner's ability to complete activities with her hands/wrists. Because of this evidence, the Arbitrator therefore gives greater weight to this factor.

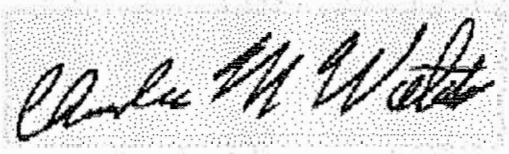
Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right hand, and 15% loss of use of the left hand, pursuant to §8(e) 9. The Arbitrator notes that as this injury occurred after June 28, 2011, and involved carpal tunnel syndrome due to repetitive trauma, the hand will be valued at 190 weeks.

As the Petitioner failed to prove that she sustained a compensable injury to her cervical spine, failed to provide appropriate notice to the Respondent, and failed to prove causal connection between the cervical condition and her work duties, Petitioner is not entitled to benefits for the cervical spine pursuant to §8(e).

The Petitioner is not entitled to penalties or fees pursuant to Sections 19 or 16 as the Arbitrator finds that the facts and evidence present a real case or controversy, and Respondent's denial of benefits was not vexatious or unreasonable.

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

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



Signature of Arbitrator

October 11, 2019
Date

OCT 16 2019

Susan Sloan v. Jarosch Bakery
17 WC 4515

STATEMENT OF FACTS

Petitioner Susan Sloan, a 53-year old married female, testified that she began working for the Respondent in April 2015. She was hired for front-of-the-house, which included customer service activities, and filling customer orders. Later she became involved in store stocking activities, and testified that these activities required stooping, bending, and lifting trays. (Tr. 8-9). Petitioner stated that her duties required her to lift trays "on average between 10 and 30 pounds, sometimes 40 pounds," and that she "could even get heavier ones." Pans containing layered/tiered cakes or brownies could weight "around 35, 40 pounds" and "sometimes heavier." Petitioner estimated that she could lift and carry 30-40 pans per day, sometimes more on busier days. (Tr. 13-14). She did admit that she never measured or weighed the trays she lifted at the bakery. (Tr. 37).

Petitioner stated that her symptoms in August 2016 included a feeling that that her arms were "completely ice cold" and "numb." She also stated that the back of her head "felt like it was being tipped forward." (Tr. 15). Petitioner noted that her work periods and duties were more intense, with longer work days, around the time when "the Cubs were winning the World Series" in the fall of 2016. (Tr. 9). When asked to further illustrate her symptoms, Petitioner testified that her head felt "pushed forward," and resulted in constant pain down the shoulder to her forearms, and all the way to the wrists. She also reported feelings of associated numbness. (Tr. 22).

The earliest medical records offered included a report from an MRI of the brain on November 21, 2016. On the same date, Petitioner's primary care provider, Dr. Berman, wrote a note indicating that Petitioner was experiencing significant carpal tunnel symptoms. Dr. Berman's note also stated that Petitioner's treating neurologist, Dr. Wagle, had recommended therapy and EMG testing, and referenced the possibility for a future lumbar MRI. (Pet. Ex. 1).

On November 29, 2016, Petitioner presented to Dr. Wagle, her treating neurologist. Her complaints on that date included bilateral numbness and tingling of the arms and legs. Recommendations included EMG testing and commencement of physical therapy. She could also consider wrist splints for both hands. Additional recommendations included possible decrease in work hours, muscle relaxant, and Motrin as needed. Dr. Wagle noted that Petitioner might be a candidate for diagnostic testing of her spinal column. (Pet. Ex. 3).

Petitioner underwent EMG testing at Lutheran General Hospital on December 30, 2016. She reported a constant sense of coldness and numbness in both hands, extending up the arms. Petitioner also noted neck pain on the left side. The study revealed evidence of severe bilateral median neuropathies at the wrists, suggestive of carpal tunnel syndrome. There was no evidence of right or left ulnar neuropathy, and no evidence or right or left cervical radiculopathy. (Pet. Ex. 2).

She followed up with Dr. Wagle on January 9, 2017 with EMG results revealing severe bilateral carpal tunnel syndrome. Petitioner was scheduled to begin therapy that week. She had undergone an MRI of the brain to evaluate migraine symptoms. If she failed to improve with therapy, she might be a candidate for operative intervention for her hands. She was also directed to undergo an MRI of the lumbar spine to evaluate foot drop issues. (Pet. Ex. 3).

Petitioner commenced physical therapy on January 13, 2017. Complaints on that date included left-sided low back pain, increased pain in the neck and upper part of the shoulders. She also noted a history of bilateral carpal tunnel syndrome. (Id).

On January 14, 2017, Petitioner underwent an MRI of the lumbar spine which revealed degenerative facet changes at L4-5 with no central spinal or foraminal stenosis. (Id).

Petitioner presented to Dr. Williams of Illinois Bone and Joint on January 25, 2017. She reported a longstanding history of bilateral digital numbness and tingling which had been going on for about a year. Her past medical history was notable for diabetes mellitus and thyroid disease. Dr. Williams' upper extremity exam suggested bilateral positive Tinel's and Durkan's testing, with a negative Phalen's test. Petitioner's EMG findings were consistent with bilateral carpal tunnel syndrome. Dr. Williams recommended she proceed with operative intervention. (Pet. Ex. 2).

Petitioner's medical records, from Dr. Williams and Dr. Berman, make reference to a history of diabetes. When asked about this condition, Petitioner denied being diagnosed with diabetes. (Tr. 35).

A work status note from Dr. Williams, dated January 30, 2017, stated that Petitioner could return to work with no lifting greater than five (5) pounds, no forceful, repetitive actions or fine movements with the wrists, and full-time bracing. (Id).

A Physical Therapy Reevaluation Note from February 23, 2017 included reference to overall improvement in Petitioner's low back pain. She continued to have neck and shoulder pain, with difficulty turning her head. Petitioner wanted to continue therapy to work on strengthening and pain reduction. (Pet. Ex. 3).

Petitioner saw Dr. Berman for a pre-operative visit on February 27, 2017. She was scheduled to undergo carpal tunnel release with Dr. Williams. Petitioner stated that she had lost sensation in the finger tips. She also reported significant pressure on the neck. (Pet. Ex. 1).

On March 2, 2017, Petitioner underwent right carpal tunnel release. Post-operative diagnosis was right carpal tunnel syndrome. (Pet. Ex. 2).

Petitioner followed up with Dr. Wagle on March 9, 2017. She had undergone right-sided carpal tunnel surgery the previous week. Petitioner continued to receive therapy for neck and shoulder pain. She had tried Flexeril for tight neck muscles, but this made her agitated and edgy. Dr. Wagle provided a different muscle relaxant and advised Petitioner to continue with therapy. (Pet. Ex. 3).

Petitioner followed up with Dr. Williams on March 15, 2017 reporting improvements in numbness of the index and long fingers of the right hand. She continued to have left-sided symptoms and was scheduled to proceed with left-sided release. Petitioner could begin therapy activities for the upper extremities. (Pet. Ex. 2).

Dr. Berman authored a letter, dated March 27, 2017, in which he related his opinion that Petitioner's carpal tunnel symptoms came from the work she completed at the bakery. She was currently completing PT for the wrist, shoulders, and neck. (Pet. Ex. 1).

Dr. Williams authored a narrative report on March 27, 2017. He received a work description completed by the Petitioner outlining her duties. Dr. Williams noted that Petitioner had two (2) risk factors, referencing her diabetes and thyroid disease, and stated that Petitioner's work activities were not the sole etiology of her symptoms. However, he did believe that the work duties were likely a "significant contributing factor" to the severity of her symptoms and need for surgery. (Pet. Ex. 2).

On March 30, 2017, Petitioner underwent left carpal tunnel release. Post-operative diagnosis was left carpal tunnel syndrome. (Id).

A Physical Therapy Reevaluation Note from April 3, 2017 stated that Petitioner reported continued neck and shoulder pain. Petitioner also noted ongoing right-sided thumb pain and numbness in her fingers. She was advised to continue therapy two (2) times per week for four (4) weeks. (Id).

Petitioner followed up with Dr. Berman on April 17, 2017 reporting neck and head pain. She reported doing "a lot of lifting over her head" and felt her symptoms were not getting better with therapy. Petitioner was planning to see a Dr. Clay about these issues. She was directed to continue with therapy and heating pad. Dr. Berman advised Petitioner to remain off work. (Pet. Ex. 1).

On April 24, 2017, Petitioner saw Dr. Clay of Illinois Bone and Joint. Her complaints on that date included neck pain and bilateral upper extremity pain. She reported that her symptoms began in October 2016 in association with her work-related activities. The symptoms included constant, aching axial cervical pain radiating into the lateral aspects of both arms, exacerbated with activity. She was currently completing therapy activities twice per week. Exam revealed restricted motion of the cervical spine. X-rays showed mild disc space height loss at C5-6, and mild facet arthrosis at C3-4 and C4-5. Impression was cervical spondylosis with radiculopathy and cervicalgia. Dr. Clay recommended continued therapy and gabapentin. She might be a candidate for MRI and ESIs in the future. (Pet. Ex. 2).

A Physical Therapy Reevaluation Note from May 12, 2017 indicated overall improvement in bilateral wrist pain with PT. She did continue to have some stiffness and cramping in the hands. Petitioner also reported stiffness and pressure through her neck and shoulders. (Pet. Ex. 3).

Petitioner followed up with Dr. Williams on May 17, 2017. Her neuritis symptoms had improved, but she continued to have symptoms to her back and neck. She had not received relief with gabapentin prescribed by Dr. Clay. Petitioner had responded well to the carpal tunnel surgeries. She was advised to complete her therapy and remain off work. (Pet. Ex. 2).

Petitioner returned to Dr. Clay on May 24, 2017 reporting persistent symptoms. He recommended ongoing therapy and medications. She could consider an ESI, pending an MRI of the cervical spine. (Id).

The MRI of the cervical spine took place on May 26, 2017 and revealed left-sided disc protrusion into the left foramen at C5-6 and mild changes of spondylosis. At C5-6 there was moderate left foraminal stenosis. (Id).

On June 2, 2017, Petitioner underwent an interlaminar cervical ESI at C6-7. Diagnosis was cervical radiculopathy. Dr. Clay ordered Petitioner to remain off work. (Id).

Petitioner returned to Dr. Williams on June 14, 2017 noting improvement in neuritis symptoms on the left. She continued to have pain, more proximal near the forearm and elbow area. On the right side, she had some residual numbness to the tips of the long and ring fingers. Dr. Williams diagnosed her with bilateral forearm myofascial pain. She could continue with her present therapy regimen and hold on any strengthening. Petitioner was advised to remain off work. (Id).

A note from Dr. Clay, dated June 16, 2017, stated that Petitioner should remain off work pending a surgical evaluation for the cervical spine. (Id).

Petitioner saw Dr. Belin of Illinois Bone and Joint on June 19, 2017. Her complaints on that date included neck pain and bilateral upper extremity pain, left greater than right. Injections had not provided relief of her symptoms. MRI of the cervical spine showed left-sided C5-6 disc herniation with stenosis. Dr. Belin stated that Petitioner may have a double crush-type phenomenon causing her symptoms, particularly those in the left upper extremity. She might be a candidate for posterior foraminotomy at C5-6 to alleviate pressure on her nerve root. Dr. Belin recommended Petitioner see Dr. Bovis for confirmation of this plan. (Pet. Ex. 4).

On July 12, 2017, Dr. Belin of Illinois Bone and Joint authored a prescription stating that Petitioner's symptoms may be caused by a "double crush-type phenomenon." She had failed nonoperative treatment with Dr. Clay and was a candidate for posterior foraminotomy to alleviate pressure on the nerve root at C5-6. (Pet. Ex. 2).

Dr. Williams issued a disability slip on July 26, 2017 advising Petitioner to remain off work due to ongoing neuritis symptoms. (Id).

Petitioner followed up with Dr. Belin on August 23, 2017. She continued to have pain radiating down her extremity. Her most recent electrodiagnostic studies did not show any cervical involvement. Dr. Belin recommended updated EMG studies to evaluate for the double crush phenomenon. (Pet. Ex. 4).

On August 30, 2017, Petitioner underwent an updated EMG. In the report, Dr. Rechitsky stated that an MRI of the cervical spine showed left paracentral C5-6 disc protrusion with foraminal extension creating left foraminal stenosis. Petitioner reported undergoing two (2) ESIs with minimal improvement. She continued to attend therapy. EMG testing revealed improvement in bilateral medial neuropathy following the CTS surgery. Clinically, the Petitioner reported complete resolution of numbness and paresthesias in the hands following surgery. The testing also showed chronic C6 radiculopathy on the left. Dr. Rechitsky stated that the Petitioner exhibited a "multitude of symptoms" that were "difficult to explain from the standpoint of cervical radiculopathy, degenerative disc disease." (Pet. Ex. 2).

Petitioner returned to Dr. Belin on September 11, 2017. Her EMG revealed chronic C6 radiculopathy. The note indicated Petitioner could be a candidate for posterior foraminotomy at C5-6. (Id).

On November 3, 2017, Petitioner was seen by Dr. Bergin of the Spine Center in Park Ridge. Her complaints included neck pain radiating into both upper extremities. The pain went from the posterior neck to the trapezius muscles into the scapulae down the arms to the hands. She stated that her symptoms related to repetitive lifting at work, beginning in September 2016. Dr. Bergin stated that Petitioner's symptoms were related to the disc herniation at C5-6, and the result of her repetitive work injury. He offered her the option between cervical fusion and disc replacement. (Pet. Ex. 4).

On December 21, 2017, Petitioner underwent anterior cervical discectomy at C5-6 with decompression of the bilateral nerve roots and spinal cord, and total disc arthroplasty at C5-6. Post-operative diagnosis was herniated disc and stenosis at C5-6. (Id).

Petitioner testified that the cervical surgery relieved her symptoms. She did not feel her "head being pushed forward anymore." Petitioner still felt a little bit of pressure on the right side, and "a little bit" of problem in her forearms. (Tr. 24).

Petitioner followed up with Dr. Bergin on January 5, 2018. She stated that her feelings of numbness and cramping were gone, and Petitioner was very happy with the results. Dr. Bergin provided a referral to begin physical therapy and advised Petitioner to remain off work. (Id).

Petitioner began post-operative therapy on January 22, 2018. She stated that she was feeling much better following the cervical surgery. Petitioner returned to Dr. Bergin on March 20, 2018 reporting that she no longer had pain in the neck and arms. She denied any numbness, radicular pain, and tingling. Dr. Bergin recommended she pursue an FCE. She was directed to continue with therapy and remain off work. (Id).

She followed up with Dr. Bergin on May 1, 2018 and denied any numbness, radicular pain, or tingling. Petitioner continued to participate in therapy which had helped her neck and shoulder symptoms. She did continue to have some forearm and elbow pain and discomfort and referenced possible further follow up with Dr. Williams. Petitioner was advised to follow up in four (4) weeks and remain off work in the interim. (Id).

Petitioner attended an IME with Dr. Edward Goldberg of Rush Orthopedics on May 4, 2018. She reported developing posterior neck pain into the dorsum of her shoulders in the fall of 2016. Petitioner denied any specific injury, but attributed her symptoms to repetitive heavy lifting. She stated that her work duties required 9-10 hours per day, and lifting of 25-50 pounds. Her neck pain had improved following the disc replacement procedure. She did have some soreness in the radial portions of her forearms and muscles. Dr. Goldberg referenced reviewing a job description which indicated that Petitioner had to occasionally lift up to 25 pounds. In the report, Dr. Goldberg identified the relevant records he reviewed as part of his examination. He opined that Petitioner's left-sided disc herniation at C5-6 was not related to any repetitive injury or any one specific injury at work. Her symptoms subjectively started increasing in September 2016 and October 2016 without any mention of specific trauma. Dr. Goldberg felt that an FCE would be appropriate to gauge her ability to work. However, he noted that any restrictions regarding the cervical spine would not be due to any work accident. In the interim, Petitioner was capable of returning to work with a 20-pound lifting restriction. This restriction was not due to any work accident. The cervical disc replacement procedure was appropriate for her cervical issues, but it was not due to any work accident. (Resp. Ex. 2).

Dr. Bergin issued an off work slip on June 22, 2018. (Id).

Dr. Williams authored a narrative report dated July 25, 2018. He stated that he felt it would be inadvisable for Petitioner to return to a "similar role" at work given the forceful repetitive activities with her hand and upper extremity. He felt this would likely lead to deterioration in her condition and increase her pain. (Pet. Ex. 2).

The last treating medical note included in the exhibits offered by Petitioner was an off work slip from Dr. Bergin, dated October 26, 2018. (Pet. Ex. 4).

On November 20, 2018, Petitioner underwent a functional capacity evaluation. She advised the therapist that her "initial onset of pain" took place in October 2016 and included bilateral upper extremity and neck pain "with no distinct trauma." Petitioner reported that her work duties required her to pull and lift trays, and engage in overhead work, lifting "40 to 85 pounds." She also stated that she needed to be able to lift and carry 20-50 pounds on a frequent basis. The report states that Petitioner gave a maximum effort and consistent performance throughout the FCE. She maximized weight carrying at 35 pounds. The FCE report included a job outlining the "required weight," pursuant to Petitioner's reported job duties. (Resp. Ex. 3).

Petitioner confirmed that she received temporary total disability benefits while recovering for her carpal tunnel conditions. These benefits continued until May 8, 2018. (Tr. 25-26).

Petitioner also testified that she stopped treatment in November 2018. She had remained off work through the functional capacity evaluation. Petitioner stated that Dr. Bergin reviewed the FCE and advised Petitioner to follow the instructions of the FCE to go back to work. (Tr. 27-28). With respect to her current condition, Petitioner felt she was not as strong. Her forearms were not back to normal, and she had occasional cramping in her thumbs. Petitioner stated that she was able to complete light duties around the house, and sometimes used Aleve during the day. (Tr. 30).

Respondent offered testimony from Kathy and Kenneth Jarosch, the owners of the bakery. Kathy Jarosch testified that she had worked at the bakery for 30 years. She identified the 4 major departments in the bakery - cleanup crew, production, cake department, and customer service. (Tr. 45). Mrs. Jarosch testified that Petitioner had been hired to work in customer service. Her duties included waiting on customers, answering phones, taking orders, stocking/replenishing the store, assembling cookies, cutting strawberries, folding boxes, replenishing supplies, and other multi-tasking activities. Mrs. Jarosch stated that she agreed with Petitioner's description of her job duties. (Tr. 46).

However, after reviewing the FCE report, Mrs. Jarosch stated that she felt the description of the job duties in the FCE was inaccurate with the weights the sales staff was required to lift. She stated that no one on the sales staff was required to lift more than 50 pounds. In addition, she did not agree that Petitioner was required to lift between 40 and 70 pounds occasionally, as described in the FCE. Mrs. Jarosch confirmed that the bakery had undertaken efforts to weigh different items that were required to be carried by the staff. (Tr. 50-52).

Mrs. Jarosch testified that she was aware that Petitioner experienced symptoms of "ice cold hands," numbness, difficulty sleeping, and pain. Petitioner never attributed any of these ailments to her work activities. Petitioner also never advised Mrs. Jarosch that she was unable to complete any work duties because of physical ailments. Mrs. Jarosch first learned that Petitioner was pursuing a workers' compensation claim at the end of January 2017, prior to undergoing carpal tunnel surgery. Her first notice of Petitioner's intentions regarding workers' compensation came when Mrs. Jarosch received a phone call from Petitioner's husband seeking paperwork to be filled out. (Tr. 47-48).

Upon receipt of a light duty note from Petitioner's doctor, Mrs. Jarosch testified that she had discussions with Petitioner in January 2017 about the possibility of working within those restrictions. She stated that the bakery was planning to hire a new college student, and that Petitioner could assist in training the new hire. (Tr. 49-50). In addition, Mrs. Jarosch stated that she had engaged in discussions with Petitioner about coming back to work within the limitations set forth by the FCE. Mrs. Jarosch believed that the Respondent could provide some form of work within the restrictions laid out in the FCE. (Tr. 50-51).

Mr. Kenneth Jarosch testified that he had worked in the bakery since he was 10 years old, and operated the bakery in an ownership fashion for 30-plus years. (Tr. 54). He concurred with Mrs. Jarosch's testimony regarding the departments in the bakery, and stated that the sales staff have the least weight to carry on a routine basis. (Tr. 55).

Mr. Jarosch became aware of Petitioner's workers' compensation claim right after Mrs. Jarosch completed the telephone conference with Petitioner's husband in late January 2017. Petitioner did not make any complaints to Mr. Jarosch that her work duties were "hurting" her. (Tr. 55-56). Mr. Jarosch also recalled that he and his wife had offered Petitioner the ability to train an individual in January 2017 which would provide "meaningful work" and something that the bakery needed. (Tr. 55-56).

After reviewing the FCE report, Mr. Jarosch stated that he disagreed with many of the weights and frequencies of activity detailed therein. He noted that he had undertaken to weigh a number of items in the bakery. By completing this weighing activity, Mr. Jarosch confirmed that no one on the sales staff was required to lift anything greater than 50 pounds. There were members of the clean up crew, and the bakery department that were required to lift that much weight. In discussing the FCE report in more detail, Mr. Jarosch voiced his disagreement that Petitioner was required to lift up to 40 pounds. He also disagreed with some of the characterization of the repetitive nature of the work activities, and noted that the job duties at the bakery were interspersed with times of idleness while waiting for customers. (Tr. 57, 61-62).

Arbitrator's Exhibit 1 indicates that Petitioner argues that she is entitled to penalties and attorney's fees pursuant to Sections 19(k) and (l) and Section 16. Petitioner did not offer a Penalty Petition as evidence or as an exhibit. Respondent admitted a Response to Petitioner's request for penalties, noting that the facts and evidence of the case presented a real case or controversy. (Resp. Ex. 1).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board,* 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

C. In support of the Arbitrator's Decision as to whether an accident occurred that arose out of and in the course of Petitioner's employment with the Respondent, the Arbitrator finds and concludes as follows:

A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course, of the employment. 820 ILCS 305/2. Both elements must be present in

order, to justify compensation. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill. 2d 478 (1989).

The phrase "in-the course of" refers to the time, place, and circumstances under which an incident occurred. *Orsini v. Industrial Commission*, 117 Ill. 2d 38 (1987). The words "arising out of" refer to the origin or cause of the incident and presuppose a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Commission,* 129 Ill. 2d 52 (1989).

"Preponderance of the evidence is evidence which is of greater weight, or more convincing than the evidence offered in opposition of it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Houck v. Nationwide Rail Service*, 11 IWCC 249, citing, *Jones v. J. Rubin*, 02 IIC 142; [Note, the compensability holding in *Houck* was overturned at the Circuit Court on other grounds] *Parro v. Industrial Commission*, 630 N.E.2d 860 (1st Dist. 1993); *Central Rug & Carpet v. Industrial Commission,* 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried his burden, is the credibility of declarant. See, *Houck*, supra. Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission,* 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission,* 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

To determine whether a claimant has met him requisite burden of proof by a "preponderance of credible evidence" it is necessary for the Arbitrator to look for consistency and corroboration between a witness's testimony and conduct and other documentary evidence to determine the truth of the matter. Where that other evidence tends to impeach or undermine a claimant's testimony, there may be sufficient cause to find that a claimant has failed to meet his requisite burden.

After considering the entirety of the evidence, including Petitioner's testimony and the medical treatment records, the Arbitrator finds Petitioner had credibility issues. Specifically, the Arbitrator finds that Petitioner exaggerated the weight she lifted and the frequency with which she lifted. The Arbitrator also notes that Petitioner denied she was diabetic when medical records stated otherwise. Petitioner's description of her pain and injury appeared exaggerated at trial. That said, Petitioner's testimony was consistent enough with the medical records on important matters that she is believable enough to help prove part of her allegations.

The Arbitrator finds the testimony of Mr. and Mrs. Jarosch to be very credible based upon their demeanor at trial and thorough explanations of their responses to questions.

The Arbitrator notes that the Petitioner has, throughout the course of her treating medical, denied any specific accident or injury. As a result, her claims are made on the basis of repetitive trauma. In reviewing the relevant medical evidence and testimony, the Arbitrator chooses to evaluate the bilateral wrist and upper extremity issues separately from the cervical spinal issues.

Petitioner claims that her upper extremity carpal tunnel issues manifested themselves beginning in January 2016. This is consistent with her initial presentation to Dr. Williams on January 25, 2017. Petitioner testified regarding the repetitive nature of her work duties at the bakery, which included gripping and grasping pans and trays, along with various stocking activities. This description of her job duties was verified by testimony from Mr. and Mrs. Jarosch. Based upon the testimony at trial and the medical histories found in the exhibits, the Arbitrator finds that Petitioner sustained a compensable work injury to the bilateral wrists within the course and scope of her employment duties with the Respondent.

With respect to the cervical spine, the medical records indicate that Petitioner experienced neck pain or symptoms in line with the manifestation date referenced in the pleadings. Petitioner never reported any work injury to the owners of the bakery until more than 1 year after the alleged manifestation date. It is true that Petitioner's testimony exaggerates the weight she was required to lift and manipulate as part of her work duties. It is also true that Dr. Goldberg's section 12 report finds the cervical injuries to Petitioner to be unrelated. Against this evidence, the records of her treating physicians opine that Petitioner's work activities caused her cervical spine injury.

The arbitrator finds Respondent's evidence on causation of Petitioner's cervical injury to be more persuasive than that offered by Petitioner. The arbitrator finds the testimony of Mr. and Mrs. Jarosch credible in general and specifically credible as to the amount of weight Petitioner repetitively lifted as part of her work duties. This testimony means that Petitioner must show that repetitively lifting up to 25 pound trays could cause a structural injury to the cervical spine. Dr. Goldberg's concludes that the cervical spine injury is not related to Petitioner's work activities because (1) there was no reported single trauma event and (2) Petitioner's cervical condition is not related to any repetitive injury. (RX 2). Although Dr. Goldberg admits that all of Petitioner's treatment for her cervical injury – including a disc replacement surgery – was appropriate, this does not invalidate his opinion on whether the injury was a result of a work accident. (RX 2)

One of Petitioner's treating physicians, Dr. Bergin, opined on November 3, 2017 that Petitioner's cervical injury was causally related to the repetitive trauma Petitioner experienced at work without explanation. This opinion was also premised upon Petitioner lifting much heavier weight at work. Dr. Bergin also dates the accident to the cervical spine as October 2016. (PX 4). There is no further explanation for Dr. Bergin's opinions.

Based upon this evidence, the Arbitrator finds that Petitioner did not sustain a compensable work injury to the cervical spine within the course and scope of her employment duties.

D. In support of the Arbitrator's Decision as to the date of the accident, the Arbitrator finds and concludes as follows:

In her pleadings, Petitioner claims a manifestation date of January 26, 2016. With respect to her carpal tunnel complaints, Petitioner advised Dr. Williams (on January 25, 2017) that she had a "longstanding" history of wrist and hand complaints for "about a year." Petitioner's testimony at trial was not necessarily consistent with this manifestation date, as Petitioner associated the onset, or at least the worsening of her symptoms, to the fall of 2016, coinciding with the Chicago Cubs' World Series win. However, the Arbitrator does find sufficient evidence to confirm the January 26, 2016 date of accident for the carpal tunnel complaints.

With respect to the cervical complaints, the evidence supports onset of symptoms on or about January 26, 2016. The medical exhibits do not include any treatment prior to November 2016. In her visit with Dr. Clay (on April 24, 2017), Petitioner suggested that her axial neck pain and radiating symptoms began in October 2016. Dr. Bergin's records (from October 3, 2017) reference an onset of symptoms in September 2016. This timeframe (fall 2016) was also identified by the Petitioner during her testimony.

The Arbitrator finds that the evidence supports January 26, 2016 as the date of any injury to the cervical spine.

E. In support of the Arbitrator's Decision as to whether timely notice was provided to the Respondent, the Arbitrator finds and concludes as follows:

According to testimony from both Kathy and Kenneth Jarosch, Petitioner did not provide notice of her intent to pursue a workers' compensation claim until January 2017, prior to her initial carpal tunnel surgery. Mr. and Mrs. Jarosch both testified that they were aware of Petitioner's physical ailments, including "ice cold hands," numbness, difficulty sleeping, and pain, but stated that Petitioner had never attributed any of her ailments to her work activities. Kathy Jarosch testified that her first notice of a workers' compensation claim came upon receipt of a phone call from Petitioner's husband, seeking paperwork to be filled out.

Petitioner has essentially claimed a repetitive trauma injury and so notice was sufficient when Petitioner complained of specific physical ailments to Respondent.

F. In support of the Arbitrator's Decision as to whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds and concludes as follows:

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n,* 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the

primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

With respect to the bilateral carpal tunnel condition, the Arbitrator finds persuasive the opinions of Drs. Berman and Williams, who both authored reports dated March 27, 2017 stating that Petitioner's work activities were a contributing factor to her carpal tunnel symptoms. Petitioner testified that her job duties at the bakery included repetitive and frequent manipulation of her hands and wrists, including activities that could be characterized as fine grasping/gripping. Kathy and Ken Jarosch both confirmed that Petitioner's duties as part of the sales staff required her to complete repetitive activities with her hands and wrists.

Based upon this evidence, the Arbitrator finds that Petitioner's bilateral carpal tunnel conditions, and all associated treatment, including the bilateral carpal tunnel releases, are causally related to her repetitive work activities with the Respondent.

With respect to the cervical spine, the Arbitrator finds there is sufficient evidence to support a causal connection between her neck symptoms and her work duties with the Respondent. In so finding, the Arbitrator considered the opinion of Respondent's Section 12 physician, Dr. Edward Goldberg as set forth in his May 4, 2018 report. (RX 2). Dr. Goldberg opined that Petitioner's left-sided disc herniation at C5-6 was not related to any repetitive injury, or any specific injury at work. The Arbitrator notes that the Petitioner exaggerated the amount of weight she was required to lift, carry, and manipulate as part of her work duties. This is seen in the testimony of the Petitioner and Mrs. and Mr. Jarosch, and in the summary FCE findings. Mr. Jarosch testified that he had weighed a number of the items utilized in the bakery, and thus had the most accurate understanding of the weights Petitioner manipulated.

Dr. Goldberg's IME report emphasizes this point - Petitioner advised Dr. Goldberg that her work duties required her to lift up to 50 pounds. Mr. Jarosch confirmed that this was not accurate, as only members of the cleanup crew or the baking/production department were required to lift and handle weights of that amount. Dr. Goldberg stated that he reviewed a job description that indicated Petitioner was required to occasionally lift up to 25 pounds. As seen in Mr. Jarosch's testimony, this is a more accurate depiction of Petitioner's job requirements.

Based upon this information, Dr. Goldberg had the clearest understanding of Petitioner's job duties at the bakery, and thus was in the best position to determine whether her job duties could have caused her neck symptoms, and the need for treatment to the cervical spine, including the fusion surgery in December 2017. The Arbitrator finds Dr. Goldberg's opinion the most credible

in determining that Petitioner's cervical condition was not causally related to her work with the Respondent.

The Arbitrator notes that Petitioner consistently characterized her cervical condition as a "double crush" phenomenon. Petitioner did not present any medical evidence explaining or supporting this characterization. Dr. Belin referenced the phenomenon on June 19, 2017 but did not explain the significance of this term. He did recommend that Petitioner undergo EMG studies to evaluate this phenomenon.

In the EMG report (from August 30, 2017), Dr. Rechitsky stated that there was evidence for chronic C6 radiculopathy on the left. He did not make any reference to "double crush" phenomenon in the report. Dr. Rechitsky did state that Petitioner exhibited a "multitude of symptoms" that were "difficult to explain." The Arbitrator notes that Dr. Bergin, Petitioner's spinal surgeon, did not make any reference to this "double crush" phenomenon.

Based upon this evidence, the Arbitrator again finds Dr. Goldberg's opinions more persuasive on the issue of causal connection between the cervical condition and her work activities with the Respondent.

G. In support of the Arbitrator's Decision as to Petitioner's earnings, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner did not present any evidence regarding her earnings with the Respondent. As a result, the Arbitrator adopts the wage figures referenced by the Respondent in the stipulation sheet, and finds that Petitioner's average weekly wage is $369.02.

J. In support of the Arbitrator's Decision as to Respondent's liability for reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

As the Arbitrator finds that Petitioner sustained compensable repetitive trauma to the bilateral wrists causally related to her work activities with the Respondent, the Arbitrator awards all reasonable and necessary medical services relating to the bilateral carpal tunnel condition.

K. In support of the Arbitrator's Decision as to whether Petitioner is entitled to any TTD benefits, the Arbitrator finds and concludes as follows:

According to the medical evidence, Petitioner did not receive any work restrictions from a medical professional until January 30, 2017. On that date, Dr. Williams provided Petitioner with a work note stating that she could return to work with no lifting greater than five (5) pounds, no forceful, repetitive actions or fine movements with the wrists, and full-time bracing. (Pet. Ex. 2). Following receipt of the restrictions, Kathy Jarosch testified that she spoke with the Petitioner about the possibility of returning to work on a light duty basis. Kenneth Jarosch confirmed that Petitioner was presented with an opportunity to return to the bakery to assist in training a new

employee. Per Kathy Jarosch's testimony, Petitioner chose to remain off work at that time. The Arbitrator notes that Petitioner did not dispute that she was offered a light duty opportunity.

Based upon this information, the Arbitrator finds that the Petitioner is not entitled to TTD benefits from January 30, 2017 through March 1, 2017.

According to the stipulation sheet, Petitioner received TTD benefits from March 2, 2017 (the date of her initial carpal tunnel procedure) through May 7, 2018. The Arbitrator notes that the medical exhibits do not include any reference to an off work/disability slip pertaining to the carpal tunnel condition after July 26, 2017. In fact, the last chart note from Dr. Williams in the Petitioner's exhibits is from June 14, 2017. It is not clear to the Arbitrator whether Petitioner followed up with that provider for the wrist conditions after that date. Dr. Williams did author a narrative report (dated July 25, 2018) suggesting that Petitioner should avoid returning to a "similar role" at work given the activities required of her. However, the Arbitrator notes that the FCE report did not place any limitations upon Petitioner's ability to complete repetitive activities with the hands and upper extremities. The Respondent continued to pay Petitioner TTD benefits in good faith until receipt of the IME report of Dr. Goldberg, providing support for denial of the cervical condition, and also providing light duty work restrictions. The Arbitrator finds that the Respondent appropriately terminated TTD on May 8, 2018 given the opinions of Dr. Goldberg, and the lack of evidence supporting ongoing treatment for the carpal tunnel conditions.

The Arbitrator also notes that the Petitioner failed to present sufficient evidence to support a finding of disability through the date of the hearing on January 11, 2019. The last medical chart note from Dr. Bergin in the exhibits is dated May 1, 2018. Subsequent disability slips from that provider (on June 22, 2018 and October 26, 2018) did not include corresponding chart notes from Dr. Bergin. Additionally, although Petitioner testified that Dr. Bergin had reviewed Petitioner's FCE and released her within the restrictions included therein, Petitioner failed to present any evidence confirming any follow up visit with Dr. Bergin, or further assessment of her ability to work.

With respect to the findings of the FCE, the Arbitrator notes that both Kathy and Ken Jarosch reviewed the FCE report and disagreed with the information Petitioner provided to the therapist about the lifting and carrying required of members of the sales staff. Kathy Jarosch also testified that the Respondent would be able to locate work in the bakery within the recommendations made in the FCE, and also stated that she had been in contact with the Petitioner about returning to work. The Arbitrator notes that the Respondent took these proactive steps in an effort to attempt a return to work, even though the Petitioner had yet to provide evidence of notes from a treating physician confirming any work limitations or restrictions.

Based upon these facts, and the relevant medical evidence provided, the Arbitrator finds that Petitioner is not entitled to any additional TTD benefits.

L. In support of the Arbitrator's Decision as to the nature and extent of Petitioner's injuries, the Arbitrator finds and concludes as follows:

The Arbitrator notes that the parties identified that the nature and extent of Petitioner's injuries are in dispute. Based upon the medical evidence presented, Petitioner underwent bilateral carpal tunnel releases with Dr. Williams. There is no indication in the medical exhibits that Petitioner has returned to this provider for further treatment to the bilateral wrists since June 2017.

In examining issues of permanency for injuries occurring after September 1, 2011, the Arbitrator must evaluate various factors, pursuant to subsection (i) of §8.1b(b) of the Workers' Compensation Act.

The Arbitrator notes that the parties did not submit any permanent partial disability impairment report into evidence. As a result, the Arbitrator will not give any weight to the factor identified in subsection (i) of §8.1b(b).

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a salesperson/stocker at the time of the alleged accident. Evidence included in the record, including the FCE report, and testimony from Petitioner, indicates that Petitioner has received a release to return to work with limitations. Testimony from the Respondent suggests that Petitioner could return to work in some capacity at the bakery, and also confirms that the parties have been in contact about returning to work within the FCE results. The Arbitrator also notes the discrepancies between the weights required to be handled in the FCE, based upon the testimony from Mr. and Mrs. Jarosch, and finds that the therapists conducting the FCE did not have a complete and accurate depiction of Petitioner's work duties. The Arbitrator does give greater weight to this factor, given the evidence suggesting that Petitioner can return to work with the Respondent in some capacity.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. Because there is no indication that Petitioner's age will limit her ability to return to gainful employment, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the testimony of Kathy and Kenneth Jarosch, who testified that the Respondent could provide Petitioner work within the outlines of the FCE. As there is no indication that the injuries will impact Petitioner's future earnings capacity, 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 the medical exhibits failed to show that Petitioner has sought treatment for her carpal tunnel condition since June 2017. Though the records make reference to the possibility of locating other employment to minimize Petitioner's exposure to repetitive activities involving her hands, the Arbitrator notes that the FCE did not place any restriction upon Petitioner's ability to complete activities with her hands/wrists. Because of this evidence, 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 15% loss of use of the right hand, and 15% loss of use of the left hand, pursuant to §8(e) 9. The Arbitrator notes that as this injury occurred

after June 28, 2011, and involved carpal tunnel syndrome due to repetitive trauma, the hand will be valued at 190 weeks.

As the Arbitrator found that Petitioner failed to prove that she sustained a repetitive trauma injury to her cervical spine that was causally related to her work duties with the Respondent, she is not entitled to permanency for that body part.

M. In support of the Arbitrator's Decision as to whether penalties or fees should be imposed upon the Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Respondent reasonably relied upon the expert opinion of the Section 12 physician, Dr. Edward Goldberg, an orthopedic spinal surgeon, in denying benefits for the cervical condition. Given the presence of a real case and controversy with respect to that body part, the Arbitrator finds that Respondent's denial of benefits is not unreasonable or vexatious, and denies Petitioner's Petition for Penalties and Fees.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC034345
Case Name	ELLIS, DAVID v. R & R GENERAL CONTRACTORS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0366
Number of Pages of Decision	27
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Martin Haxel
Respondent Attorney	Jessica Bell

DATE FILED: 7/19/2021

/s/ Deborah Baker, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID ELLIS,

Petitioner,

vs. NO: 15 WC 034345

R & R GENERAL CONTRACTORS,

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 whether an accident arose out of and in the course of employment, causal connection, entitlement to and the necessity of past medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator with respect to the issues of accident and causal connection.

FINDINGS OF FACT

Testimony of David Ellis

David Ellis ("Petitioner") testified that he was employed by R & R General Contractors ("Respondent") for approximately thirteen years. On February 19, 2015, Petitioner was working as a foreman, supervising worker Larry Sinkhorn (hereinafter referred to as "Sinkhorn"). T. 14. Petitioner was working in "the Annex" which was part of the "East Plant" at the Archer-Daniels-Midland ("ADM"") facility in Decatur, Illinois. T. 16. Petitioner testified that on February 19, 2015, as he returned from break, he grabbed the doorknob of a door with a window that was frosted from the cold weather. As he held the doorknob, someone came through the door and it hit him in the right shoulder. T. 17. Petitioner testified that the corner of the door hit the front portion of his right shoulder and he was holding tools in his left hand when the door struck him. T. 17-19. Petitioner testified that the door stuck a lot and "frosted up" in the winter. T. 17. Petitioner notified his supervisor, John Medler, of the incident. T. 19.

Petitioner testified that he did not seek medical attention on the day of the accident. T. 20. After he went home, Petitioner applied ice and took aspirin and hydrocodone, which he had been prescribed for an unrelated ankle injury. Later that evening Petitioner received a phone call from Respondent's "part owner" Rick Betterton ("Betterton"). T. 21. Betterton asked Petitioner if Petitioner's pain was age-related and recommended that Petitioner continue using ice and aspirin and "watch the swelling." T. 21.

Petitioner testified he returned to work but was not able to do much with his right arm. Petitioner stated, "I couldn't hardly lift it or, you know, do anything." T. 21. Petitioner testified that Sinkhorn did most of the heavier tasks like pushing drills or screwing on drywall. Petitioner held drywall up at waist level. T. 22. Petitioner continued to work until he underwent surgery, but he only did work below the waist. T. 22.

Petitioner testified that he first sought treatment for his right shoulder after he called Betterton and told him he needed to seek medical attention for his shoulder. T. 23. Petitioner testified that he and Betterton "had some words" but later, Betterton called him back and told him he had an appointment at "Corporate." T. 24.

Petitioner testified that when he returned to work after treating at corporate health on March 4, 2015, his arm felt the same. T. 26. Petitioner told Betterton that he had problems sleeping due to pain and Petitioner intended to take days off as a result. T. 28. Petitioner testified that he had a telephone conversation with Betterton and Betterton advised him that Respondent had two recordable injuries, that Respondent could not afford to have another one, and that he asked Petitioner to state that he was injured away from work. Petitioner testified Betterton assured him that he would "take care of it," referring to the medical bills. T. 33. Petitioner claimed that he had a previous work-related ankle injury at the ADM Plant in 2012. Petitioner stated Betterton asked him not to report that previous work injury also. T. 33-35.

Petitioner testified that on April 16, 2015, he sought treatment from his family physician, Dr. Cynthia Marschner. Petitioner testified he told Dr. Marschner that he injured his right shoulder when he ran into a two-by-four because he was getting ready to build a small walkway around the pool deck at his home. However, on April 16, 2015, he had not started building the pool deck yet. T. 38-39. Petitioner testified that he lied to Dr. Marschner about how he had injured his right shoulder because he "was told to" and he wanted to keep his job. T. 39.

Petitioner testified that on August 21, 2015, he had a conversation with Betterton in Betterton's office after a safety meeting at work. T. 43-44. On that day, Petitioner presented the first bill from DMH Corporate Health to Betterton. T. 44. Petitioner testified that Betterton "didn't believe it," and told him that he was not going to pay the bill. T. 45. Petitioner told Betterton "well then, it's going to be workman's comp." T.45. Petitioner testified that Betterton turned his chair around and faced the wall, but then said he would "get Mike on it right away." T. 45. Petitioner never returned to work for Respondent after that meeting. T. 46.

Petitioner testified that he underwent surgery to his right shoulder in August 2015. T. 43-46. Petitioner testified that following his surgery he was not re-employed by Respondent and he was receiving Social Security Disability benefits as of the date of the hearing. T. 57-58. Petitioner

last sought treatment for his right shoulder on June 6, 2016. T. 57. Petitioner acknowledged that at first, he did not tell Dr. Marschner and Dr. Brustein the truth about how his right shoulder injury occurred. Petitioner testified that he did not hurt his right shoulder at any time other than when the door hit him on February 19, 2015. T. 63.

On cross examination, Petitioner testified that before he left work on February 19, 2015, he completed a "Daily Safety Record," on which he printed and signed his name below a heading called, "CONFIRMATION OF NON-INJURY WORKDAY." Resp.'s Ex. 7, T. 86. Petitioner testified that he bought supplies to build a pool deck at his home about two months after April 16, 2015. T. 74. Petitioner acknowledged that he lied to Dr. Marschner about building a deck in mid-March or April 2015. T. 74. Petitioner introduced into evidence a receipt from Menard's (a building supply store) dated June 18, 2015, which Petitioner intended to show when he bought the materials to build the deck around his pool. Pet.'s Ex. 10.

On redirect examination, Petitioner testified that he signed the Daily Safety Record on February 19, 2015, because he knew that he was supposed to "[k]eep [his] mouth shut" and because employees were not to report injuries to ADM. T. 88.

Testimony of Richard Betterton

Richard ("Rick") Betterton (hereinafter referred to as "Betterton") testified as a witness for Respondent. Betterton stated that he is the Vice President and Owner of Respondent, R & R General Construction, general contractors. T. 124. Betterton explained the history of the company's MOD factor (Resp.'s Ex. 4). He testified that the "MOD" factor was a rating that was provided by the NCCI, a national insurance rating organization. T. 124-125. The NCCI evaluates the size of the company, the number of hours of work, the type of work to determine an expected loss amount. A MOD factor below one indicates that a company performed better than the national average with respect to the expected loss amount. A MOD factor above one indicates that a company performed worse than the national average and exceeded the expected loss amount. Respondent never had a MOD factor above one between 2012 and 2018, and Respondent's MOD factor in 2015 was 0.62. T. 125. Betterton testified that even if this case were a workers' compensation injury, it would be insignificant to the company's MOD. T. 126.

Betterton testified that he had never instructed a "supervisor or safety person" to misrepresent a work-related injury. T. 130. Betterton testified that Respondent takes the injury reporting process seriously. T. 130-131. Betterton testified that he did not recall having a phone conversation with Petitioner on February 19, 2015, but "[he] may have." T. 132. Betterton testified he would never advise Petitioner to "make this a personal health insurance claim," and explained: *"We knew that the incident occurred at work and I am not going to tell somebody to make a false claim."* (Emphasis added). T. 132-133.

On cross examination, when asked, "And you are aware of the fact that a door struck Mr. Ellis' shoulder while working for you on the ADM premises on February 19, 2015?" Betterton answered, *"Yes, I am aware of that."* (Emphasis added). T.135.

Testimony of John Medler

John Medler (hereinafter referred to as "Medler") testified as a witness for Respondent. Medler was Respondent's General Superintendent. Medler testified that he prepared the incident report for the February 19, 2015 incident and submitted the report to ADM. Medler testified that after February 19. 2015, Petitioner continued to work for Respondent and performed his regular job assignments as directed. T. 138. Medler had the opportunity to observe Petitioner working between February 19, 2015 and the last day of his employment on August 2015 and Petitioner never appeared as though he was unable to perform any job assignments. T.138-139. On cross examination, Medler testified that on average, Medler observed Petitioner for about 30 to 60 minutes each workday. T. 141.

Non-Medical Record Documents

A form titled "ADM Non-Injury Investigation" indicates that an incident took place on February 19, 2015, at 10:30 AM at the "East Plant" in Decatur, Illinois. The form states that "Jon Medler" was the Investigation Team Leader and "Dave Elis" was the "Other Team Member." Under the "Incident Description," it states: "Employee went to enter door and reached for the handle and a contractor existed [sic] the door and the door came in contact with our employee's right shoulder." Under a section titled "Root Causes," it states: "Window of the door was frosted over." At the bottom of the form, it is blank where a manager's and regional manager's names should be. There are no dates on the form and the boxes to indicate that a manager or regional manager reviewed and approved the form are blank. Pet.'s Ex. 1.

A form titled "Confirmation of Non-Injury Workday" shows the printed name and signature of "Dave Ellis." Resp.'s Ex. 7.

A group exhibit of records from Dr. Michael E. Clark contains billing information regarding Petitioner's 2012 injury, which Petitioner testified was work-related. T. 33-35. A Consociate Claim Administration Explanation of Services ("EOS") form dated January 23, 2013 indicates that there was a bill for $250.50 for treatment in 2012 and it was paid via a check from R & R General Contractors. A copy of the check is attached to the EOS and it is made payable to Dr. Clark and signed by Richard Betterton. Additionally, there is a handwritten note on the EOS which states, "Returned check 3-19-13." The following page is a letter from Consociate, Employee Benefit Administration Division, advising Dr. Clark that they were seeking a refund of the payment of $250.50 because it was brought to Consociate's attention that the amount should have been paid by workers' compensation. Pet.'s Ex. 9.

Medical Records

On March 4, 2015, Petitioner treated at Decatur Memorial Hospital ("DMH") Corporate Health Services. Petitioner reported that a door hit his right shoulder about two weeks before and he continued to have pain. Petitioner complained of pain with motion, limited range of motion, and increased pain at night. Petitioner indicated that he felt the pain was getting worse and his pain was accompanied by swelling. On examination of the right shoulder, Petitioner had limited range of motion. X-rays of the right shoulder were negative. Petitioner was diagnosed with a right

shoulder strain and was released to regular duty work. However, under a heading called "Aftercare Instructions," it states: "Limit use of rt shoulder, avoid lifting anything greater than 10 lbs. Use heat for 20 minutes every 2 hours. Use ice for 20 minutes every 2 hours. Take Ibuprofen (Motrin) as needed for pain and swelling. Return in 1 week for further evaluation." (Pet.'s Ex. 2.)

On April 10, 2015, Petitioner returned to DMH Corporate Health Services. Petitioner reported hitting his right shoulder on a door at work about four or five weeks before and indicated that his shoulder remained painful. It was noted that Petitioner had 80 percent improvement but still had pain with certain movements and at the end of the workday. Petitioner was diagnosed with a right shoulder strain and advised to continue using the shoulder as tolerated and continue home exercises, ice, heat, and Ibuprofen at least two times per day. Petitioner was advised further to follow up in two weeks if abduction did not improve and at that time, he would be referred for physical therapy and treatment.

On April 16, 2015, Petitioner sought treatment with his family physician, Dr. Cynthia Marschner and her assistant at Decatur Memorial Hospital. Petitioner reported right shoulder pain from an injury that occurred about one month before. The treatment note states: "He is right hand dominant and it sounds like he has been putting on a deck. Regarding the initial injury he states he ran into the end of a 2 x 4. It was a direct blow to the anterior aspect of the shoulder." Petitioner reported that his pain had improved somewhat since he treated at "corporate health" but he still had episodes of weakness and a generalized ache in his shoulder. Petitioner reported that there were some overhead movements that were difficult due to pain and sometimes he had to hold his arm up to paint. Dr. Marschner diagnosed Petitioner with right shoulder joint pain, recommended physical therapy, and recommended that Petitioner continue taking NSAIDs. Dr. Marschner indicated that she would order an MRI if Petitioner's symptoms did not improve with physical therapy. Pet.'s Ex. 3. Petitioner went to therapy approximately five to ten times before Dr. Marschner ordered an MRI. T. 40.

On May 15, 2015, Petitioner underwent a right shoulder MRI which showed a full thickness rotator cuff tear with tendon retraction and superior subluxation of the humeral head. The MRI also showed complete subluxation of the biceps tendon with apparent split thickness tear. Pet.'s Ex. 3.

On May 25, 2015, Petitioner sought treatment with Dr. Marshall Brustein at Dr. Marschner's recommendation. Petitioner completed a medical history on which he indicated that he hit his shoulder with a two-by-four. In response to a question asking whether he was treating for a work-related problem, Petitioner circled "no." Petitioner printed and signed his name at the bottom of the page. Pet.'s Ex. 4, Resp.'s Ex. 1 at 120.

On June 3, 2015, Petitioner returned to Dr. Brustein with right shoulder pain. Petitioner described decreased motion and weakness that started three months before and stated that he walked into a two-by-four. Dr. Brustein opined that the MRI showed a full thickness rotator cuff tear with retraction, labral tear, bicep tendon subluxation, and severe AC arthritis. Dr. Brustein diagnosed Petitioner with an acute rotator cuff tear and discussed treatment options with Petitioner. Dr. Brustein noted that Petitioner had tried a few therapy sessions already which had made his shoulder worse. Petitioner and his wife preferred to proceed with surgery. Pet.'s Ex. 4.

On June 23, 2015, Petitioner followed up with Dr. Marschner for pre-operative clearance for a right shoulder surgery with Dr. Brustein. Dr. Marschner noted that "this occurred when Petitioner was building a deck approximately mid-March/early April." Petitioner was cleared for surgery. Pet.'s Ex. 3, Resp.'s Ex. 1, 2.

On August 24, 2015, Petitioner underwent a right shoulder arthroscopy with debridement and open rotator cuff repair of a "massive tear." Resp.'s Ex. 1 at 60.

On September 4, 2015, Petitioner presented for a post-op evaluation and Dr. Brustein noted Petitioner appeared to be making adequate progress. Dr. Brustein recommended he continue wearing the sling and undergoing therapy for passive range of motion. Dr. Brustein recommended Petitioner return in two weeks and issued light duty work restrictions of no lifting, pushing, pulling, or carrying with the right upper extremity. Pet.'s Ex. 4, Resp.'s Ex. 1 at 34.

Petitioner followed up with Dr. Brustein on September 18, 2015; October 5, 2015; and November 2, 2015. During these visits, Dr. Brustein continued Petitioner's light duty restrictions and recommended Petitioner continue physical therapy. From November 30, 2015 to June 6, 2016, Dr. Brustein's records document that Petitioner was injured when a two-by-four hit him in the right shoulder. While Petitioner recovered from surgery and underwent physical therapy, Dr. Brustein released Petitioner to work with various light duty restrictions for the right upper extremity. The medical records indicate that Petitioner had a slow recovery and underwent extensive physical therapy as well as some injections to the right shoulder. Pet.'s Ex. 4.

On June 6, 2016, Petitioner presented to Dr. Brustein for the last time and reported that he continued to have problems with his right shoulder. Petitioner also reported he did not go to therapy because insurance had denied it, but he continued to do his home exercises. The treatment note indicates that Petitioner was a construction worker his entire life and he did not feel he would be able to perform his regular duties due to his shoulder dysfunction and some problems with his lower extremities. Dr. Brustein released Petitioner with permanent restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 10 pounds and no overhead work. Dr. Brustein advised Petitioner to follow up PRN. Pet.'s Ex. 4.

In July 2017, Petitioner sought treatment with Dr. Marschner for left shoulder complaints. Petitioner reported that he previously underwent a right shoulder surgery in 2015 and at that time, he used his left arm more than his right arm. Petitioner believed that this had contributed to the development of left shoulder pain. In November 2017, Dr. Marschner diagnosed Petitioner with chronic pain in multiple areas, including the ankle, low back, and both shoulders. Pet.'s Ex. 3.

CONCLUSIONS OF LAW

I. Accident

Under the Illinois Workers' Compensation Act ("Act"), in order for a claimant to be entitled to workers' compensation benefits, the injury must "aris[e] out of" and occur "in the course of" the claimant's employment. 820 ILCS 305/1(d) (West 2014). Therefore, in order to obtain compensation under the Act, a claimant bears the burden of proving by a preponderance of the

evidence two elements: (1) that the injury occurred in the course of claimant's employment; and (2) that the injury arose out of claimant's employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

"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. An injury arises out of his or her employment if the origin of the injury "is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Saunders v. Industrial Comm'n*, 189 Ill.2d 623, 627 (2000). A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling the employee's duties. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). In order to prove that an accident "arises out of" employment, it must be shown that the employee was engaged in a risk that was distinctly associated with an employee's employment when at the time of the occurrence, the employee was performing: (1) acts he or she was instructed to perform by the employer; (2) acts that he or she had a common-law or statutory duty to perform; or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. *Caterpillar Tractor*, 129 Ill. 2d at 58; *see also McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848, ¶¶ 36-40.

In this case, Petitioner proved by the preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent on February 19, 2015. Betterton, one of Respondent's witnesses, testified that he knew "*the incident occurred at work*" and he was aware that a door struck Petitioner's shoulder while he was working for Respondent at ADM on February 19, 2015. Betterton's testimony is corroborated by the "ADM 'Non-Injury' Investigation[1]," which documents that on February 19, 2015, Petitioner was hit in the right shoulder by a door while working for Respondent due to the window of the door being frosted. The initial treatment records from DMH Corporate Health Services further corroborate Betterton's testimony as they document Petitioner sustained an injury when he was hit in the right shoulder by a door while working for Respondent. Based on the evidence in the record, there is no dispute that Petitioner sustained a compensable work accident on February 19, 2015. Accordingly, the Commission reverses the Arbitrator's finding that Petitioner failed to prove he sustained a compensable work accident.

II. Causal Connection

The Commission finds that Petitioner sustained a right shoulder strain as a result of the February 19, 2015 work accident and Petitioner's right shoulder condition of ill-being was causally related to the work accident until April 15, 2015. The Commission finds that Petitioner did not prove his right shoulder rotator cuff tear and subsequent right shoulder arthroscopy are causally related to the February 19, 2015 work accident.

The Commission first notes that the evidence in this case is highly conflicting and casts doubt on the credibility of Petitioner and Respondent's witnesses. Petitioner testified that on

[1] The Commission notes that the title of the "ADM 'Non-Injury' Investigation" form (Pet.'s Ex. 1) has no impact on its weight as evidence of whether Petitioner was injured at work on February 19, 2015 based on the information on the form and the totality of the evidence.

February 19, 2015, he reported sustaining a work accident to Medler. Petitioner testified that he did not seek medical attention that day, however, when he went home, he applied ice to his right shoulder and took aspirin and hydrocodone for the pain. Petitioner testified that Betterton called him that evening and told him to continue using ice and "watch the swelling." Betterton testified that he did not recall having a telephone conversation with Petitioner on February 19, 2015, but "[he] may have."

Petitioner testified that he returned to work and performed his job as best he could with the help of Sinkhorn, the worker whom Petitioner supervised, and by modifying the way that he performed his job duties. Medler testified that he observed Petitioner between February 19, 2015 and August 2015 and Petitioner never appeared as though he was unable to perform any job assignments.

Petitioner testified that at some point, he informed Betterton he needed medical treatment and Betterton eventually made an appointment for him at DMH Corporate Health Services. Petitioner treated at DMH Corporate Health Services on March 4, 2015 and on April 10, 2015 and both times, he was diagnosed with a right shoulder strain and released with instructions to limit the use of his right shoulder, apply ice and heat, and take Ibuprofen.

Petitioner testified that Betterton asked him not to report his right shoulder injury as a work injury but promised to pay for his medical treatment. Petitioner testified that Betterton had asked him not to report a work injury previously in 2012 when Petitioner injured his ankle at work. Betterton testified he had never instructed a "supervisor or a safety person" to misrepresent a work-related injury. A Consociate Claim Administration Explanation of Services ("EOS") form dated January 23, 2013 reflects charges for treatment in 2012 in the total amount of $250.50 and there is a copy of a check attached to the EOS which is made payable to Dr. Clark and signed by Richard Betterton. There is also a letter from Consociate, Employee Benefit Administration Division, advising Dr. Clark that they were seeking a refund of the payment of $250.50 because it was brought to Consociate's attention that the amount should have been paid by workers' compensation.

On April 16, 2015, Petitioner sought treatment from his family physician, Dr. Marschner. Petitioner testified and the medical records show that he told Dr. Marschner he injured his right shoulder when he ran into a two-by-four while building a deck for his pool. After April 16, 2015, all references to the right shoulder injury in the medical records indicate that the injury occurred when Petitioner walked into a two-by-four and/or when building a deck. Petitioner admitted that he did not report the February 19, 2015 accident as a work injury to Dr. Marschner and Dr. Brustein, however, he testified that he did not do so because he was told not to and because he wanted to keep his job.

Based on the totality of the evidence, the Commission finds Petitioner proved he sustained a right shoulder strain, as diagnosed at DMH Corporate Health Services, as a result of the February 19, 2015 work accident. The Commission finds further that Petitioner's right shoulder strain resolved as of April 15, 2015 based on the fact that Petitioner began attributing his right shoulder injury to a non-work related injury (walking into or being hit by a two-by-four) on April 16, 2015. Additionally, the Commission finds that there is insufficient medical evidence as to whether the

February 19, 2015 accident caused Petitioner's right rotator cuff tear and there is no medical opinion or explanation of how the mechanism of injury of being hit with a door caused the rotator cuff tear as both Dr. Marschner and Dr. Brustein believed Petitioner sustained his right shoulder injury when he was hit in the right shoulder with a two-by-four. Accordingly, the Commission finds Petitioner did not prove that his rotator cuff tear and subsequent need for surgery is related to the February 19, 2015 work accident.

III. Medical Expenses

Consistent with our conclusion as to causal connection, the Commission finds Petitioner's right shoulder medical treatment between February 19, 2015 and April 15, 2015 was reasonable, necessary, and causally related to the work accident. Petitioner's request for the payment of medical expenses incurred after April 15, 2015 is denied.

IV. Permanent Disability

Our conclusion that Petitioner's right shoulder strain is causally related to the February 19, 2015 work accident necessarily implicates an analysis of Petitioner's permanent disability. The Commission analyzes the §8.1b factors as follows.

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 for Respondent as a foreman. Petitioner has a high school level education and vocational training in building and construction. Petitioner has worked in construction since he was eight years old. T. 61. This factor weighs in favor of slightly increased permanency.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was 58 years old on the date of his accidental injury. The Commission finds this factor weighs in favor of slightly increased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

Neither party presented any expert vocational testimony in this case. The Commission gives this factor no weight.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

The DMH Corporate Health Services records show Petitioner suffered a right shoulder strain and as of April 10, 2015, he had improved by 80 percent but still had some pain with certain

movements and at the end of the workday. Petitioner testified that he continued to have pain in his right shoulder between February 19, 2015 and April 10, 2015. This factor weighs in favor of increased permanency.

The Commission finds that Petitioner has suffered a 2.5 percent loss of use of the person-as-a-whole under section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2020, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that as a result of the February 19, 2015 work accident, Petitioner sustained a right shoulder strain that resolved on April 15, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses as provided in §8(a), subject to §8.2 of the Act, for treatment of Petitioner's right shoulder condition from February 19, 2015 through April 15, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $593.69 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injury sustained caused 2.5% loss of use of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury including a credit of $13,130.00 for non-occupational indemnity benefits, 1,625.00 for out of pocket medical expenses paid to Petitioner, and $23,672.82 in medical expenses paid through Respondent's group medical plan for which credit may be allowed under Section 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 100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 19,2021

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

DJB/cak

O: 5/18/21

/s/ *Stephen Mathis*
Stephen Mathis

43

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELLIS, DAVID Case# **15WC034345**
Employee/Petitioner

R&R GENERAL CONTRACTORS
Employer/Respondent

On 1/13/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5757 HAXEL LAW
MARTIN J HAXEL
310 E ADAMS
SPRINGFIELD, IL 62701

0771 FEATHERSTUN GAUMER STOCKS ET A
EDWARD F FLYNN
101 S STATE ST SUITE 240
DECATUR, IL 62523

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

David Ellis
Employee/Petitioner

v.

R&R General Contractors
Employer/Respondent

Case # **15** WC **34345**

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Springfield**, on **November 21, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 19, 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 alleged accident ***was*** given to Respondent.

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$50,828.16**; the average weekly wage was **$989.49**.

On the date of accident, Petitioner was **58** years of age, ***married,*** with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$13,130.00** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$13,130.00.**

Respondent is entitled to a credit for medical bills paid in the amount of **$23,672.82** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$13,130.00** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$13,130.00.**

Respondent is entitled to a credit for medical bills paid in the amount of **$23,672.82** through its group medical plan for which credit may be allowed under 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.

Melinda M. Pope Gallivan

Signature of Arbitrator

1/9/2020

Date

JAN 13 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Ellis
Employee/Petitioner

Case # **15** WC **34345**

v.

Consolidated cases: N/A

R & R General Contractors
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent R & R General Contractors for approximately 13 years. He testified that on February 19, 2015, he was a foreman who supervised Larry Sinkhorn. He further testified that on that date, he was working in the annex which was part of the East Plant at the Archer-Daniels-Midland (hereinafter "ADM") facility in Decatur. He testified that he was returning from a break when he grabbed ahold of a door knob and that somebody was coming through the door at the same time, at which time the door struck him in front part of his right shoulder. He testified that he reported the incident to his supervisor, John Medler. He further testified that he finished his shift and did not seek medical treatment that day.

Petitioner testified that prior to his second medical appointment at DMH Corporate Health he had a telephone conversation with Rick Betterton and that Mr. Betterton advised him that Respondent had two recordable injuries, that they could not afford to have another one, and that he asked Petitioner to state that he was injured away from work. Petitioner testified that Mr. Betterton, part owner of R & R, would take care of paying the medical bills. Petitioner claimed that he previously had a sprained ankle that occurred at work at the ADM Plant and that he was asked by Mr. Betterton to not report this injury either. Petitioner claimed that this work-related injury in 2012 was treated as a non-work-related injury.

On cross examination regarding the prior ankle injury, Petitioner agreed that it was his position that he was asking the Arbitrator to believe that Respondent was paying for the medical bills to avoid a worker's compensation claim. In support of this contention, Petitioner submitted Petitioner's Exhibit 9, which contained various medical records from Dr. Clark who treated him for his prior ankle injury. On cross examination, Petitioner acknowledged that page 3 of Petitioner's Exhibit 9 consisted of a Consociate Claim Administration form summarizing the services of Dr. Clark totaling an amount due of $250.50, with a copy of a check from R & R General Contractors made payable to Dr. Clark and a handwritten notation at the top stating "returned check 3/19/13". Petitioner also acknowledged that the following page was a letter from Consociate, Employee Benefit Administration Division, advising Dr. Clark that they were seeking a refund of the payment of $250.50 because it had been brought to Consociate's attention that this amount should have been paid by worker's comp.

Petitioner testified that he was treated by his primary care physician on April 16, 2015. He testified that he advised his physician that he injured his shoulder when he ran into a 2x4, and further testified that when he told her this it was a lie and that he lied in order to keep his job. Petitioner further testified that he

was subsequently treated by Dr. Brustein who performed surgery on August 24, 2015 to repair a torn rotator cuff. Petitioner claimed that he continued work until the surgery, but that he only did work below the waist.

Petitioner testified that on August 21, 2015 after a safety meeting, he had a conversation with Mr. Betterton and that he presented the first bill from DMH Corporate Health to him. Petitioner testified that Mr. Betterton advised him that he was not going to pay the bill.

Petitioner testified that he continued to work up until the day before surgery. As to the history provided to Dr. Marschner about running into a 2x4, Petitioner introduced Petitioner's Exhibit 10, a receipt from Menards (a building supply store) dated June 18, 2015. Petitioner testified that this receipt was for materials to build a deck around his pool. He testified that the deck around his pool was primarily constructed by his son, Matt Ellis. At the time of arbitration, Matt Ellis testified that he built the deck. On cross examination, however, Matt Ellis admitted that he had no formal construction training and almost no construction experience.

Petitioner testified that following his surgery he had not been re-employed by R & R and that he was now receiving Social Security Disability benefits.

On cross examination, after Petitioner had acknowledged that his 2012 ankle injury had become a worker's compensation claim, he was asked about Petitioner's Exhibit 1. Petitioner acknowledged that Petitioner's Exhibit 1 was titled "ADM Non-Injury Investigation". Petitioner agreed and acknowledged that this incident report described the incident of the door striking his shoulder on February 19, 2015. He testified that he did not know that the incident report as indicated at the bottom of the exhibit was e-mailed to the Regional Safety Manager and the Regional Manager.

On cross examination, Petitioner was shown a part of the Decatur Memorial Hospital records. Petitioner acknowledged that he filled out the document on May 15, 2015 and that the document was in his handwriting. The document in Petitioner's handwriting stated that Petitioner ran into a 2x4 2-3 months ago. Petitioner admitted that he signed this document immediately below the attestation clause, swearing that its contents were true and accurate.

On cross examination, Petitioner was shown the Medical History document dated May 25, 2015 which was a part of Dr. Brustein's records. Petitioner agreed that the medical history provided to Dr. Brustein on page 2 stated that a brief explanation of the pain, injury, and how it happened was that Petitioner hit his shoulder with a 2x4. Petitioner stated that that was consistent with the story that he provided to Dr. Marshner and the MRI staff at Decatur Memorial Hospital in regard to working on his deck. Petitioner further testified that in this form when asked whether this a work-related problem, he circled "no." Petitioner further acknowledged that at the bottom of the page, he printed and signed his name.

On cross examination, Petitioner acknowledged that on February 19, 2015 at the end of the work day he signed a document stating that he had confirmed that his day had been a non-injury work day. On redirect, Petitioner testified that he signed the daily safety record on February 19, 2015 because he knew that he was supposed to and that they were not supposed to say anything to ADM.

Respondent called Richard Betterton as a witness at the time of arbitration. Mr. Betterton testified that he is the President and owner of R & R General Contractors. Mr. Betterton explained Respondent's Exhibit 4, the history of the company's MOD factor. He testified that the MOD factor was a rating that was provided by the National Insurance Rating Organization. He testified that the NCCI would evaluate the size of the company, the number of hours of work, the type of work, and the expected loss amount. He testified that if your MOD factor was below 1, you had performed better than the national average. He testified that if your claims exceeded the expected norm, you had a MOD factor above 1. He testified that

Respondent's MOD factor for 2012 was .75; that for 2013 it was .73; that for 2014 it was .65; that for 2015 it was .62; that for 2016 it was .58; that for 2017 it was .57; and that for 2018 it was .59.

Mr. Betterton further testified regarding the claims recording procedures when his company was working on the grounds of ADM. He testified that claim reports were prepared immediately upon notice to a foreman or higher-level person and then forwarded to ADM. He testified that ADM was actively involved in the safety and claims on their grounds in order to provide a safe work environment and to be prepared for third party lawsuits.

As to the significance of Petitioner's claim, Mr. Betterton explained that if it were a worker's compensation injury it would be insignificant regarding the company's MOD. Mr. Betterton testified that if his company was found to be fraudulent in their injury reports or their workers' compensation claims then it would be detrimental to his relationship with ADM, and that it could result in his company being eliminated from the ADM grounds. He testified that ADM constituted approximately 70% of his company's business.

Mr. Betterton further testified regarding Respondent's health insurance plan. He testified that the health insurance plan was a self-funded group, meaning that claims were processed by a third-party administrator and they funded the claim payments up to a certain dollar value. He testified that if this case were found to be a compensable worker's compensation case, his company would be repaid all the group health insurance payments which amounted to over $27,000.00, and that that would be a net effect of an increase of $27,000.00 in net income to Mr. Betterton as the owner of the company. He further testified that he would never have advised Petitioner to cover up a worker's compensation claim and to place it on his personal health insurance coverage.

Respondent also called John Medler as a witness at the time of arbitration. Mr. Medler testified that he was the General Superintendent for Respondent. Mr. Medler testified that he prepared the incident report involving the February 19, 2015 incident and submitted the report to ADM. Mr. Medler testified that subsequent to February 19, 2015, Petitioner continued to work for Respondent and performed his regular job assignments as directed. He testified that he had the opportunity to observe Petitioner working between February 19th and the last day of his employment in 2015, and that Petitioner never appeared as though he was unable to perform any job assignments. He further testified that Petitioner was never assigned light job tasks or job tasks that would not require the normal physical effort of an employee within his supervision, and that Petitioner never approached him or requested special accommodations in regard to job assignments. He further testified that Petitioner never complained that he was unable to perform any job tasks and that the person Petitioner supervised, Larry Sinkhorn, was still employed by R & R. and that Mr. Sinkhorn never complained about working with Petitioner, that Petitioner was not carrying his weight, or that Petitioner was not performing adequately as the result of an injured shoulder.

The ADM Non-Injury Investigation Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report reflects that the incident date was that of February 19, 2015, that the investigation team leader was John Medler, and that Petitioner went to enter a door and reached for the handle, that a contractor exited the door, and that the door came in contact with Petitioner's right shoulder. The "root cause" was noted to be that the window of the door was frosted over. (PX1).

The medical records of DMH Corporate Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on March 4, 2015, at which time it was noted that he had his right shoulder hit by a door around two weeks ago, that it remained painful, that he had pain with motion, that he had limited range of motion, and that it hurt worse at night. The injury date was noted to be that of March 4, 2015. The diagnosis was noted to be that of right shoulder strain. It was noted that Petitioner's shoulder x-rays were negative. Petitioner was instructed to use moist heat to reduce pain and improve mobility, to use ice for approximately 20 minutes every two hours as needed to

reduce pain and swelling, and to keep the arm elevated and limit use of the right shoulder. Petitioner was also recommended to take Ibuprofen over-the-counter as needed for pain. It was noted that Petitioner's recommended work status was regular duty. At the time of the April 10, 2015 visit, it was noted that it had been five weeks since the onset of pain, that Petitioner stated that it seemed to be worst at night, that he had noticed that it was made worse by moving it and at the end of a work day, and that it was improved with rest. The diagnosis was noted to be that of right shoulder strain. It was noted that Petitioner stated that his range of motion had improved greatly and that he felt 80% improved, but still had some pain with certain movement and at the end of a work day. Petitioner was recommended to continue his home exercise program, and to use ice, heat, and Ibuprofen at least two times a day. Petitioner was recommended to return in two weeks for further evaluation. It was noted that Petitioner's recommended work status was regular duty. (PX2).

The medical records of Dr. Cynthia Marschner were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on January 5, 2015, at which time it was noted that he was seen for a med check. It was noted that Petitioner had chronic foot pain of the left foot, that he had been evaluated by the podiatrist and was to undergo surgery, and that he was hoping he could wait until October so that he could be off for the winter months as it was his understanding that he would need to be off for eight months and he reported that he could not afford that at this time. It was noted that Petitioner took between 2-4 Norco daily and between 2-6 over-the-counter Tylenol daily. It was noted that Petitioner had normal full range of motion of all joints in the extremities on physical examination. The assessment was noted to be that of hypertension and low HDL, among other issues. (PX3).

The records of Dr. Marschner reflect that Petitioner was seen on April 16, 2015, at which time it was noted that he came with continuing concerns for right shoulder pain. It was noted that Petitioner injured it a little over a month ago, that he was actually seen at Corporate Health in early March, that the physician's assistant saw that an x-ray was done but did not have access to the note, and that he was told there was no break and should initiate conservative therapy. It was noted that Petitioner took Hydrocodone for a previous ankle problem, that he had been taking Advil and Aleve sporadically, that he was right-hand dominant, and that it sounded like he had been putting on a deck. It was noted that regarding the initial injury Petitioner stated that he ran into the end of a 2x4, that it was a direct blow to the anterior aspect of the shoulder, and that he stated that the pain had improved since he was seen at Corporate Health but he was still concerned that he still had episodes of weakness and still had generalized ache in the shoulder. It was noted that Petitioner stated that there were certain overhead movements that were difficult due to pain and that sometimes he had to hold his arm up to paint. The assessment was noted to be that of pain in the right shoulder joint. It was noted that the x-ray was reviewed, that there was no fracture or dislocation, that reassurance was given that as he had improved greatly over the past month that this should continue to slowly improve, and that he had crepitus on exam and diffuse mild tenderness with palpation of the joint line but otherwise no muscle weakness was noted and he had full range of motion. Petitioner was recommended to undergo physical therapy for range of motion of the right shoulder and muscle strengthening. It was noted that they could consider an MRI if Petitioner saw no improvement with physical therapy. (PX3).

Included within the records of Dr. Marschner was an interpretive report for an MRI of the right shoulder dated May 15, 2015, which noted that the films were interpreted as revealing (1) no acute fracture identified; degenerative changes are seen at the acromioclavicular joint with mild impingement; (2) full thickness rotator cuff tear with tendon retraction; there is superior subluxation of the humeral head and small joint effusion; (3) complete subluxation of the biceps tendon with apparent split thickness tear; a portion of the split thickness tear demonstrates enlargement of the tendon with significant increased intrinsic signal most consistent with additional partial tear and tendinopathy; (4) abnormal signal and irregularity of the superior labrum near the biceps insertion with suspected associated labral tear. (PX3).

The records of Dr. Marschner reflect that Petitioner was seen on June 23, 2015, at which time it was noted that he was seen for pre-operative clearance for right shoulder surgery with Dr. Brustein. It was noted that this occurred when Petitioner was building a deck approximately mid-March/early April. Petitioner was cleared for surgery. At the time of the September 28, 2016 visit, Petitioner was seen for complaints of right lower back pain for two weeks and left ear pain. It was noted that Petitioner's low back pain had started about two weeks ago when he was painting, that it had gotten up to a 9-10/10 and was sharp at times, though it had caused some numbness to the outer edge of his thigh and sometimes felt like muscle cramping. It was also noted that Petitioner had had some problems with left ear drainage for the past two or three months after he had started working on an older home and had been having some fullness in his ear, though he denied any ear pain he could not hear very well out of his left ear. The assessment was noted to be that of sciatica and lumbar radiculopathy, among other issues. Petitioner was recommended to undergo lumbar x-rays and an ear wash was done. (PX3).

The records of Dr. Marschner reflect that Petitioner was seen on July 25, 2017, at which time it was noted that he was seen for a complaint of left shoulder pain. It was noted that Petitioner had a history of torn rotator cuff of the right shoulder repaired in 2015 by Dr. Brustein, that he still had limited range of motion and therefore used his left arm more, and that he thought this was what had contributed to his increased pain of the left shoulder. It was noted that Petitioner described it as aching and a soreness with inactivity that worsened the more he used it, that there was some impingement when he abducted the arm, and that he noted that trying to pour the coffee in the morning could be painful. It was noted that Petitioner had chronic ankle pain for which he underwent surgery in the past, that he was on disability because of this, and that he used up to 10 over-the-counter Naproxen daily for pain relief with the shoulder. The assessment was noted to be that of (1) chronic shoulder pain; (2) chronic ankle pain; (3) left shoulder pain; (4) history of long-term use of high-risk medication. Petitioner was recommended to undergo x-rays of the left shoulder and was given various prescriptions. (PX3).

The records of Dr. Marschner reflect that Petitioner was seen on August 7, 2017, at which time it was noted that he was there for a left shoulder cortisone injection. It was noted that Petitioner was now off Naproxen that he was using heavily and that he was on Celebrex. It was noted that Petitioner's medication was helping but that he still had pain and limited range of motion, especially with abduction. It was noted that Petitioner had a history of right rotator cuff repair. The assessment was noted to be that of left shoulder pain. Petitioner was given a left intraarticular shoulder injection. At the time of the November 7, 2017 visit, Petitioner was seen for follow-up of hypertension, hyperlipidemia, and impaired fasting glucose. It was noted that Petitioner had chronic pain of multiple areas including his ankle, low back, and both shoulders. It was noted that Petitioner had had surgery to the ankle and the right shoulder, and that they tried a cortisone shot to the left shoulder in August but he reported that it was not helpful. It was noted that Petitioner still had a squeezing-type of pain of the lateral and posterior left elbow that radiated into the back of the left arm and left inner elbow, and that he had some subjective weakness with a curl of the left bicep. It was noted that Petitioner was off the chronic NSAIDs and that his stomach pain had resolved, and that he used one Hydrocodone daily when needed and a muscle relaxer occasionally when needed for his back. The assessment was noted to be that of chronic ankle pain, chronic shoulder pain, and low back pain, among other issues. Petitioner was recommended to undergo various lab work. It was noted that they would continue present management for pain. It was further noted that a discussion was had regarding the next steps regarding the left shoulder, which was that of consideration of physical therapy versus MRI versus referral to Dr. Brustein who performed surgery to Petitioner's right shoulder. (PX3).

The records of Dr. Marschner reflect that Petitioner was seen on May 7, 2018, at which time it was noted that he was seen for a med check. The assessment was noted to be that of hypertension and elevated blood sugar, among other issues. At the time of the May 24, 2018 visit, Petitioner was seen for a re-check of his blood pressure. The assessment was noted to be that of hypertension. (PX3).

The medical records of Dr. Brustein were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner completed a Medical History on May 25, 2015, on which he indicated that he hit his shoulder with a 2x4. At the time of the June 3, 2015 visit, it was noted that Petitioner presented with right shoulder pain. It was noted that Petitioner's pain was located on the right shoulder, that prior treatments included therapy and an MRI, that it was described as decreased motion, sharp and weakness, that it started three months ago, and that he stated that he walked into a 2x4. It was noted that the MRI showed a full thickness rotator cuff tear with retraction, labral tear, bicep tendon subluxation, and severe AC arthritis. It was noted that it appeared that Petitioner was suffering from an acute rotator cuff tear and that treatment options were discussed. It was noted that Petitioner had tried a few therapy sessions and stated that it made his shoulder worse. It was noted that Petitioner and his wife preferred to proceed with surgery. (PX4).

The records of Dr. Brustein reflect that a History and Physical was prepared on August 24, 2015, which noted that Petitioner presented with complaints of persistent right shoulder pain with rotator cuff tear. It was noted that Petitioner complained of decreased motion, sharp pain with motion, and weakness, that the symptoms started four months ago, and that he stated that he injured his right shoulder when he walked into a 2x4. At the time of the September 4, 2015 visit, it was noted that Petitioner presented for post-op evaluation. It was noted that Petitioner stated that he was doing ok. It was noted that Petitioner appeared to be making adequate progress. Petitioner was recommended to continue the sling and therapy for passive range of motion. Petitioner was recommended no use of the right upper extremity. Petitioner was recommended to return in two weeks. Petitioner was also issued a work slip dated September 4, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 0 pounds. At the time of the September 18, 2015 visit, Petitioner stated that his shoulder was sore on that date. It was noted that Petitioner's pain and motion was coming along nicely, and that he was recommended to continue with therapy and his sling. Petitioner was issued a work slip dated September 18, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 0 pounds. Petitioner was recommended to return in two weeks. (PX4).

The records of Dr. Brustein reflect that Petitioner was seen on October 5, 2015, at which time it was noted that he was six weeks post right shoulder arthroscopy, debridement of labral tear, and massive rotator cuff repair. It was noted that Petitioner may gradually wean from his sling, that he was recommended to continue with therapy and begin active range of motion, and that he was to return in four weeks to check his pain and motion. Petitioner was issued a work slip dated October 5, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 0 pounds. At the time of the November 2, 2015 visit, it was noted that Petitioner stated that his shoulder was feeling better. It was noted that Petitioner may progress to strengthening in therapy, that his work restrictions may be increased to 5-10 pounds with no overhead with the right upper extremity, and that he was to return in four weeks. Petitioner was issued a work slip dated November 2, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 10 pounds and no overhead work. At the time of the November 30, 2015 visit, it was noted that Petitioner stated that his shoulder felt weak, that it slightly limited activities, and that the mechanism of injury was that he hit his shoulder on a 2x4. Petitioner was recommended to continue with therapy to work on strengthening and was issued work restrictions. Petitioner was also recommended to return in four weeks. Petitioner was issued a work slip dated November 30, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 10-20 pounds and limited overhead work. (PX4).

The records of Dr. Brustein reflect that a MetLife Disability Form was completed on December 3, 2015, which noted that Petitioner's disability was due to an injury/accident of February 16, 2015, that he was at work at the ADM annex, that the window on the door was frosted, that he was starting to open the

door and someone was coming out, and that the door hit his shoulder. At the time of the December 28, 2015 visit, it was noted that Petitioner's pain was located on the right shoulder, that it was described as weakness, and that the symptoms started 18 weeks ago. It was noted that the mechanism of injury was that of Petitioner hitting the shoulder with a 2x4. It was noted that Petitioner continued to have weakness, that he was recommended to continue with therapy to work on strengthening, and that he was issued work restrictions. Petitioner was recommended to return in four weeks. Petitioner was issued a work slip dated December 28, 2015, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 20-30 pounds and limited overhead work. At the time of the January 25, 2016 visit, it was noted that Petitioner was seen to evaluate pain and motion, that it was located on the right shoulder, that he had had surgery five months ago, and that the complaints slightly limited activities, such as overhead work. It was noted that the mechanism of injury was that of Petitioner hitting the shoulder on a 2x4. Petitioner was recommended to continue with more strengthening in therapy and was to return in four weeks. Petitioner was issued a work slip dated January 25, 2016, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 30-40 pounds and limited overhead work. (PX4).

The records of Dr. Brustein reflect that Petitioner was seen on February 22, 2016, at which time it was noted that he was there to evaluate pain and motion. It was noted that Petitioner stated that his shoulder was sore due to increased weight in therapy and that his therapist would like to continue working on strengthening. It was noted that Petitioner's symptoms started 11 months ago and that the mechanism of injury was that of hitting the shoulder on a 2x4. It was noted that Petitioner had good range of motion but complained of weakness, and that he was recommended to continue with therapy to work on strengthening. Petitioner was issued work restrictions and was recommended to return in four weeks. Petitioner was issued a work slip dated February 22, 2016, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 30-40 pounds and limited overhead work. At the time of the March 21, 2016 visit, Petitioner stated that his shoulder still hurt, that the symptoms started one year ago, and that the mechanism of injury included hitting the shoulder with a 2x4. It was noted that Petitioner appeared to be making slow progress with this issue, that his motion was improving but he continued to have some weakness and pain, and that he was recommended an injection to help with his ongoing pain. Petitioner was to continue therapy to help with weakness and was to return in 4-6 weeks. Petitioner was issued a work slip dated March 21, 2016, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 50 pounds and limited overhead work. (PX4).

The records of Dr. Brustein reflect that Petitioner was seen on April 25, 2016, at which time it was noted that he stated that his shoulder was about the same and that the injection did not seem to help much. It was noted that Petitioner had a cortisone injection on March 21, 2016 and surgery eight months ago. It was noted that the mechanism of injury was that of hitting the shoulder with a 2x4. It was noted that a discussion was had that the primary problem did not appear to be pain but rather that of dysfunction. It was noted that Dr. Brustein recommended trying several different options to a reverse total shoulder, waiting or not returning to heavy overhead work, or signing up for disability for the shoulder. It was noted that Petitioner had perfect motion and no real pain but was just weak. It was noted that Petitioner was recommended six more weeks of therapy and was to return in six weeks. Petitioner was issued a work slip dated April 25, 2016, which noted that he was given light duty restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 20 pounds and no overhead work. At the time of the June 6, 2016 visit, it was noted that Petitioner stated that his shoulder was no better, that he did not go to therapy because insurance denied it, and that the mechanism of injury included hitting the shoulder on a 2x4. It was noted that Petitioner had been a construction worker his entire lifetime and did not feel he would be able to perform his regular duties due to his shoulder dysfunction, and that he stated that he also had problems with his lower extremities as well. It was noted that Petitioner was currently awaiting a decision from Social Security Disability. It was noted that Petitioner had finished with formal therapy due

to insurance issues but had continued with his home exercise program. It was noted that a discussion was had regarding proceeding with permanent restrictions to include no lift, push, or pull greater than 10 pounds with no overhead work. Petitioner was issued a work slip dated June 6, 2016, which noted that he was given permanent restrictions for the right upper extremity of no lifting, pushing, pulling, or carrying more than 10 pounds and no overhead work. (PX4).

The Physical Therapy records of Decatur Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent physical therapy on August 31, 2015, at which time it was noted that he stated that he was doing okay from the evaluation and that his pain rating was 5/10. It was noted that Petitioner had decreased guarding as the session went on, but that he was still very guarded and had increased pain on descent of motion. At the time of the September 8, 2015 visit, it was noted that Petitioner reported that he was still waking up at night due to the shoulder and that his pain level was 3-4/10. It was noted that Petitioner had moderate guarding during descending of the shoulder and that he needed constant verbal commands to help him relax. At the time of the September 9, 2015 visit, it was noted that Petitioner stated that his shoulder really only bothered him at night and that otherwise it had been feeling pretty good. It was noted that Petitioner was doing well at that time with range of motion, although he continued to have muscle guarding especially at his end range. It was also noted that Petitioner felt that he was meeting his goals appropriately at that time and was maintaining capsular flexibility and integrity while protecting his repair. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that at the September 11, 2015 visit, it was noted that Petitioner stated that he was doing well, that he reported no new complaints or problems from the last treatment, and that he stated he sometimes had trouble sleeping due to increased discomfort and pain mostly at night. It was noted that Petitioner rated his pain 2/10 on that date. At the time of the September 14, 2015 visit, it was noted that Petitioner stated that he was doing fine, that he stated that most of his pain now was with stretching when his arm came down, and that his pain was 1/10 on that date. It was noted that Petitioner tolerated the session well and was less guarded with all motions, and that he had increased range of motion in flexion. At the time of the September 16, 2015 visit, it was noted that Petitioner stated that he was doing fine, that he stated that he was ready to do more, and that he was to go to the doctor on Friday. At the time of the September 18, 2015 visit, it was noted that Petitioner stated that his pain ranged from 2-6/10 best/worse, respectively, and that he stated that he was really sore after the last session. It was noted that Petitioner had a lot less guarding from his initial visit to that date, but that he still anticipated pain with movement and needed a reminder to relax. It was noted that Petitioner had popping in the right shoulder on descent of motion but that it went away when he did not guard on the return. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that at the September 22, 2015 visit, it was noted that Petitioner reported no problems, that he wondered how long he still needed to wear the sling, and that he reported sleeping in bed and still waking up a few times because of pain in the night. It was noted that Petitioner did very well on that date with guarding. At the time of the September 24, 2015 visit, it was noted that Petitioner stated that he was still getting woken up with pain that he rated 5/10, that stated most of the time it was just an ache in his shoulder, and that he rated his pain most of the time 2/10. At the time of the September 29, 2015 visit, it was noted that Petitioner was reinforced that he was not to be trying to move his shoulder actively. It was noted that Petitioner had significant muscle guarding during flexion and passive range of motion. At the time of the October 6, 2015 visit, it was noted that Petitioner had seen the doctor the other day and was told that he did not have to wear his sling and that he could start raising his arm. It was also noted that Petitioner continued to lack significant strength to complete all exercises correctly. At the time of the October 8, 2015 visit, it was noted that Petitioner stated that he was doing good with changing his activity with therapy and that he stated that his shoulder was sore but did not have much pain. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that at the October 12, 2015 visit, it was noted that Petitioner reported minimal pain of 1/10 on that date and that he stated he had been doing a home exercise program. At the time of the October 15, 2015 visit, it was noted that Petitioner stated that he had irritation on the back of his shoulder describing it as pain "underneath the shoulder blade" and that he stated that he still had irritation/pain in front of his shoulder with movement. It was also noted that Petitioner rated his pain 2-3/10 and noted that it was sporadic. At the time of the October 19, 2015 visit, it was noted that Petitioner stated that his pain in his right arm was about the same. At the time of the October 26, 2015 visit, it was noted that Petitioner rated the pain in his left upper extremity pretty much all the time and that he stated it was more of an ache. At the time of the October 28, 2015 visit, it was noted that Petitioner reported that he was now able to lay on his right side at night and was sleeping all night, and that worker's comp told him that he could return to work once he could lift 25#. It was noted that range of motion of Petitioner's right shoulder was improving but remained very weak, that his pain complaints were decreased, and that he was sleeping better. At the time of the November 4, 2015 visit, it was noted that Petitioner stated that his right shoulder was getting better and that he stated that he had noticed improvement with activities of daily living over the past few weeks. It was also noted that Petitioner stated that his pain was 0/10 and that his chief complaint was soreness along the biceps tendon and down into the biceps with abduction at 90 degrees. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that Petitioner was seen on November 9, 2015, at which time it was noted that he came to therapy with a note for light duty at work. At the time of the November 11, 2015 visit, it was noted that Petitioner stated that his shoulder felt pretty good but ached at night and that it bothered him. It was also noted that Petitioner was doing well with exercises and was able to raise his arm overhead without much difficulty, but that he had significant weakness in the right shoulder that required additional skilled physical therapy before he would be able to return to work. At the time of the November 16, 2015 visit, it was noted that Petitioner stated that he was doing some painting last week and thath e felt good while doing it. At the time of the November 18, 2015 visit, it was noted that Petitioner stated that his shoulder had been feeling pretty good and that he just had trouble keeping it overhead for any period of time. At the time of the November 23, 2015 visit, it was noted that Petitioner reported no pain on that date but that his muscles felt tired. At the time of the November 27, 2015 visit, it was noted that Petitioner reported 0/10 pain before treatment and that he reported still having issues. It was also noted that Petitioner reported that reaching above head was still difficult. At the time of the November 30, 2015 visit, it was noted that Petitioner was feeling about the same and that his doctor had cleared him for 20# lifting but no above head lifting at work. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that Petitioner was seen on December 9, 2015, at which time it was noted that he stated that his shoulder felt pretty good but was just "so weak." It was also noted that Petitioner had been trying to use it more at home, but just could not lift anything with any weight on it. At the time of the December 14, 2015 visit, it was noted that Petitioner stated that he was doing all the exercises at home that he could and that he felt it was getting better, but still felt pretty weak. At the time of the December 18, 2015 visit, it was noted that Petitioner stated that he was doing ok with his right arm and did not have any pain, and that he stated that he had been doing a lot of home improvements including laying hardwood floor and sanding overhead. It was also noted that Petitioner complained of soreness on the side of his trunk. At the time of the December 21, 2015 visit, it was noted that Petitioner was feeling "good" on that date and that he was able to do more overhead activity. At the time of the December 23, 2015 visit, it was noted that Petitioner reported that the pain was not bad, that he stated he was using the arm more but did not have endurance, and that he could lift his drill but was unable to hold it to screw in a screw. At the time of the January 6, 2016 visit, it was noted that Petitioner stated that he was doing ok and that he was able to lift his drill without the battery, but that as soon as he put the battery in his pain increased and he was unable to lift. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that Petitioner was seen on January 13, 2016, at which time it was noted that he stated that he was doing good on that date and that he denied any pain in the right shoulder. At the time of the January 18, 2016 visit, it was noted that Petitioner stated that his shoulder was definitely getting stronger, but that he was having a hard time with drywall tape movements. At the time of the January 22, 2016 visit, it was noted that Petitioner was doing good, that his pain was 0/10, and that he felt mostly his issue was with weakness and getting shaky when he had his arm above his head. At the time of the January 27, 2016 visit, it was noted that Petitioner stated that he was still working at trying to get his arm over his head, that he had trouble when he lifted it over his head when it was out to the side, and that he denied any pain on that date. At the time of the February 4, 2016 visit, it was noted that Petitioner stated that he was doing fine, that he had no complaints after the last session, and that he stated that he did not have any pain and was still trying to get more work at home with his exercises to get overhead. At the time of the February 11, 2016 visit, it was noted that Petitioner reported no problems from the last few sessions and that he stated that he did not have much pain, but just fatigued quickly. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that Petitioner was seen on February 16, 2016, at which time it was noted that he reported no new pain in his shoulder and that he stated that he was to go back to the doctor on Monday the 22nd. At the time of the February 19, 2016 visit, it was noted that Petitioner reported no increase in pain in his shoulder since the last session. It was also noted that Petitioner continued to require skilled physical therapy to address limitations, which were primarily strength-related. At the time of the February 25, 2016 visit, it was noted that Petitioner stated that he went to see the doctor and stated that he was doing ok and was to keep doing therapy. It was also noted that Petitioner stated that he was not really having any pain in his right upper extremity. At the time of the February 29, 2016 visit, it was noted that Petitioner stated that he was doing good with his pain and that he had no increased pain with exercises, but increased pain with manual testing on that date. At the time of the March 10, 2016 visit, it was noted that Petitioner stated that he was doing ok on that date without increased pain after the last session. At the time of the March 14, 2016 visit, it was noted that Petitioner reported that he felt about the same. It was also noted that Petitioner continued to progress in therapy and gain on his strength, and that he continued to have fatigue issues with strength with activities overhead. At the time of the March 17, 2017 visit, it was noted that Petitioner reported that his shoulder was feeling very good that morning and was having no pain so far. At the time of the March 22, 2016 visit, it was noted that Petitioner stated that his shoulder was doing pretty well but that he was still having trouble with overhead-type work. (PX5).

The Physical Therapy records of Decatur Memorial Hospital reflect that Petitioner was seen on March 28, 2016, at which time it was noted that he reported no new pain in the shoulder and that he stated the toughest exercises were the over the head things that he did. It was also noted that Petitioner was performing simulated job tasks to help strengthen him to return to his activities of daily living. At the time of the March 30, 2016 visit, it was noted that Petitioner reported no new shoulder pain and said his only discomfort came with shoulder abduction with weight. At the time of the April 7, 2016 visit, it was noted that Petitioner reported no pain on that date and that he stated that his shoulder felt about the same. At the time of the April 11, 2016 visit, it was noted that Petitioner arrived stating that he tried to use a hammer over the weekend and that it was too heavy for him to use. It was also noted that Petitioner also stated that his insurance sent him a large bill and would like for them to send something to them, that he was informed that they still had him listed as work comp, and that he stated he had not been work comp since October when he got denied. At the time of the May 4, 2016 visit, it was noted that Petitioner stated that he had no complaints after the last session. (PX5).

The Physical Therapy from DMH Sports Enhancement Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent an Initial Evaluation on August 28, 2015, at which time it was noted that he was having a very hard time relaxing

with passive range of motion, that he was very guarded with any motion, and that he had greater relaxation with abduction than flexion. At the time of the September 2, 2015 visit, it was noted that Petitioner stated that he constantly had pain but that it was not as bad as it had been, and that he rated his pain 1-2/10. At the time of the October 2, 2015 visit, it was noted that Petitioner reported that he continued to wear his sling and stated that pain still woke him up at night at least once a night. At the time of the November 2, 2015 visit, it was noted that Petitioner stated that he was doing ok, that he got new orders from his doctor but forgot them at home, that he stated that he could do more stuff but could not remember what the order said, and that he rated his shoulder pain 0/10 on that date. At the time of the December 2, 2015 visit, it was noted that Petitioner stated that he was feeling "about the same today." At the time of the December 30, 2015 visit, it was noted that Petitioner returned from the doctor with orders to continue, that he stated that he still had overhead restrictions on work duties, and that he reported that his arm was a little tired because he already used it a lot that morning. (PX6).

The Physical Therapy from DMH Sports Enhancement Center reflect that Petitioner was seen on January 4, 2016, at which time it was noted that he stated that he had had no problems since the last rehab session, and that he came in with a letter that required notes be sent to the insurance company. At the time of the February 1, 2016 visit, it was noted that Petitioner stated that he was sore from starting to lift 5# and that he stated that he felt the pain in the front of the arm. At the time of the February 8, 2016 visit, it was noted that Petitioner reported that he had no significant pain from the last few sessions, and that he still reported difficulty with overhead activities and tiring easily. At the time of the March 3, 2016 visit, it was noted that Petitioner stated that he was doing ok and that now that he was doing more strengthening for his right shoulder, he was sore but did not have increased pain. At the time of the April 4, 2016 visit, it was noted that Petitioner stated that he was doing fine, and that he also stated that he was really sore after his last session because he felt like there was weight added to some of the exercises. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Group Health Insurance records were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The medical records of Dr. Clark were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Menards's Receipt dated June 18, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Zurich Insurance Letter dated January 25, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The Timeline was entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

The medical records of Dr. Brustein were entered into evidence at the time of arbitration as Respondent's Exhibit 1. While primarily duplicative of records as contained in Petitioner's Exhibits 4, 5, and 6, the records further reflect that Petitioner underwent surgery by Dr. Brustein on August 24, 2015, which was that of (1) right shoulder diagnostic arthroscopy with intraarticular synovectomy; (2) arthroscopic debridement labral tear; (3) open rotator cuff repair, massive tear for a pre- and post-operative diagnosis of right shoulder with rotator cuff tear. (RX1; PX4; PX5; PX6).

The medical records of Dr. Varma were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were duplicative of those as contained in Petitioner's Exhibit 3. (RX2; PX3).

The medical records of Decatur Memorial Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen for physical therapy on May 5, 2015, at which time it was noted that he presented with impaired range of motion, joint mobility, muscle performance, pain, and activity tolerance associated with soft tissue dysfunction. It was noted that Petitioner had positive signs of an AC joint strain/separation and possible rotator cuff involvement. The Physical Therapy Evaluation dated May 5, 2015 noted that Petitioner was building a deck and hit his shoulder on a board, striking it. The records reflect that Petitioner underwent x-rays of the right shoulder

on March 4, 2015, which were interpreted as revealing nothing acute in the right shoulder. The physical therapy records were duplicative of those as contained in Petitioner's Exhibits 5 and 6. (RX3; PX5; PX6).

The R&R Insurance Claims Summary and Mod Factor Reports were entered into evidence at the time of arbitration as Respondent's Exhibit 4. Petitioner's Attendance Report was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The R&R Employee Manual was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

Petitioner's February 19, 2015 Daily Safety Record was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Confirmation of Non-Injury Workday included Petitioner's name on line #3. (RX7).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on February 19, 2015.

It is undisputed that Petitioner on February 19, 2015 was struck in the shoulder by a door, as evidenced by the ADM Non-Injury Investigation Report which was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. (PX1). The report reflects that the incident date was that of February 19, 2015, that the investigation team leader was John Medler, and that Petitioner went to enter a door and reached for the handle, that a contractor exited the door, and that the door came in contact with Petitioner's right shoulder. The "root cause" was noted to be that the window of the door was frosted over. (PX1).

It is further undisputed that Petitioner completed his work day on February 19, 2015 and executed a daily work sheet stating that he had worked injury-free on February 19, 2015, as evidenced by Petitioner's February 19, 2015 Daily Safety Record which was entered into evidence at the time of arbitration as Respondent's Exhibit 7. (RX7). The Confirmation of Non-Injury Workday included Petitioner's name on line #3. (RX7). It is also apparent from Respondent's Exhibit 5 and Petitioner's own testimony that in a seven-day work week he typically worked four 10-hour days followed by three days off, and that he regularly maintained this schedule from February 29, 2015 until his date of surgery in August 2015. (RX5).

Furthermore, the Arbitrator notes that the medical evidence in this case reveals that Petitioner did not seek medical assistance for nearly two weeks after the alleged accident when he was examined at DMH Corporate Health on March 4, 2015 and again on April 10, 2015. The Arbitrator notes that in each instance, Petitioner was released to return to work without restrictions. (PX2). Thereafter, Petitioner was examined by the physician's assistant of his primary care physician approximately one month after alleged incident, at which time it was noted that Petitioner stated that he ran into the end of a 2x4, that it was a direct blow to the anterior aspect of the shoulder, and that he stated that the pain had improved since he was seen at Corporate Health but he was still concerned that he still had episodes of weakness and still had generalized ache in the shoulder. (PX3).

The only medical record entered into evidence that reflected an incident arising upon the ADM grounds was that of a MetLife Disability Form as contained in Dr. Brustein's records, which was completed on December 3, 2015 and noted that Petitioner's disability was due to an injury/accident of February 16, 2015, that he was at work at the ADM annex, that the window on the door was frosted, that he was starting to open the door and someone was coming out, and that the door hit his shoulder. (PX4). However, it should be noted that the portion which claimed the injury occurred at work not only contained a different accident date but also was filled out by Petitioner (*i.e.*, employee). It is also important to note that in visits

with Dr. Brustein the history that consistently appeared in Dr. Brustein's records was that Petitioner hit his shoulder on a 2x4 and, in fact, nowhere in these records did Dr. Brustein have a report, history, or reference of a work-related incident. (PX4). In fact, Dr. Brustein's records repeatedly indicated that the mechanism of injury was that of Petitioner striking his shoulder on a 2x4. (PX4).

At the time of arbitration, Petitioner's theory was that his employer directed him to lie about the history of his injury and that injuries were not reported to ADM, the site at which Petitioner's claimed injury allegedly occurred. Respondent's witness John Medler, however, established that an accident report was prepared and submitted to ADM. Furthermore, Richard Betterton established that the group health insurance plan was self-funded and that if this claim were to be found to be a compensable workers' compensation claim, he stood to benefit by a nearly $27,000.00 net income gain when workers' compensation paid back the health insurance payments made on the claim.

Having considered and reviewed the entirety of the evidence in this matter, the Arbitrator finds that that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on February 19, 2015. All benefits are denied. The remaining issues of causation, medical bills, temporary total disability, and the nature and extent of the injuries are moot, and the Arbitrator makes no conclusions as to those issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031030
Case Name	MCCARTHY,TIMOTHY v. NCP CORP
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0367
Number of Pages of Decision	15
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Russell Haugen
Respondent Attorney	Martin Spiegel

DATE FILED: 7/20/2021

/s/ Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY MCCARTHY,

Petitioner,

vs. NO: 18 WC 31030

NCR CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical, and temporary total disability (TTD) 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. 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 August 11, 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 $55,400.00. 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 the Circuit Court.

July 20, 2021

CAH/pm
O: 7/15/21
052

Christopher A. Harris
Christopher A. Harris

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0367
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

McCARTHY, TIMOTHY
Employee/Petitioner

Case# **18WC031030**

NCR CORP
Employer/Respondent

On 8/11/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% 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:

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

1872 SPIEGEL & CAHILL PC
MARTIN SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)8/A

Timothy McCarthy
Employee/Petitioner

v.

NCR Corp.
Employer/Respondent

Case # **18** WC **31030**

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 venued in New Lenox was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **July 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/28/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**46,623.20**; the average weekly wage was $**896.60**.

On the date of accident, Petitioner was **57** 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 $**10,161.41** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,161.41**.

Respondent is entitled to a credit of $**3,109.19** under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $597.73 per week for 100-4/7 weeks, commencing August 10, 2018 through July 13, 2020 as provided in Section 8(a) of the Act.
- Respondent shall be given a credit of $10,161.41 for temporary total disability benefits paid under Section 8(a) of the Act.
- Respondent shall authorize and pay of the treatment recommended by Dr. Darwish.
- Respondent shall pay reasonable, necessary and causally related medical services incurred in the care and treatment of Petitioner's lumbar spine, right lower extremity, and right foot pursuant to Sections 8 and 8.2 of the Act.
- Respondent shall be given a credit of $3,109.19 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Carolyn M. Doherty

Signature of Arbitrator

8/6/20
Date

ICArbDec19(b)

AUG 11 2020

FINDINGS OF FACT

At trial, Petitioner testified that he sustained accidental injuries arising out of and in the course of his employment for Respondent on 6/28/18. On that date, Petitioner worked for Respondent as a technician and his duties required him to repair computer registers for "big box" companies. While performing these duties, Petitioner drove his own work truck, a Dodge Ram 1500. Petitioner testified that as of the date of accident, he had worked 5 years for Respondent. Petitioner testified that prior to 6/28/18, he had no back, right leg or right foot pain or treatment and that he never missed time from work for any of these conditions.

Petitioner testified that on 6/28/18, he was at work parked in a Walmart parking lot in anticipation of going inside the store to make a repair. Petitioner was asked what if anything unusual happened at that time and he answered, "I went to get out of my truck and like I normally do at the Walmart in Lockport. …It was like 2:00 o'clock in the afternoon I pulled up. Do my normal thing on my cell phone and I was going to get out of my truck and I don't know what happened. I opened up the door. I went to spin around and step down and I was on the ground. I was standing on the ground in an instant." T. 7-8. Petitioner further testified "I landed standing up from all the way from. …from the seat of the truck." Petitioner testified that he measured the distance from the seat of the truck to the ground to be 3 feet. Petitioner testified that upon landing, he felt immediate pain in his right leg and right buttock. T. 8.

Petitioner testified that he walked to the other side of the truck opened the sliding door of the truck and sat down for 45 minutes. He then went into Walmart and completed the job. Petitioner further testified that he called off work on June 29, 2018 and July 2, 2018. Petitioner further testified that he did go into work on July 3, 2018. Petitioner testified that despite continued pain, he went to work on July 3 so that he could get paid for the holiday on July 4. Petitioner testified that he felt he had a foot bruise and treated it at home over the prior weekend with ice and heat. T. 11. Petitioner testified that on July 3, "At the end of my shift I was in New Lenox this time at Walmart. And I stepped out really hard of my truck and my right leg just started massively hurting again, more than it was. … Stepping out of my truck too hard." T. 10.

Petitioner testified that when he was off on the July 4th holiday and that he went to the emergency room on July 5, 2018 at St. Joseph's Hospital. He testified that he reported the 6/28/18 work injury to medical personnel. He didn't have any explanation as to why the records were void of the history of a specific accident on 6/28/18. The history in the 7/5/18 ER records state "57 year old male presenting with concerns for right hip pain. Within this past week developed right leg pain. Worse in his hip. Worse with movement. Able to walk but painful. … states that he gets in and out of a truck frequently throughout the day for deliveries. May have knocked it on the door but no other reported injuries. No similar history." PX 1. Right hip x-rays were ordered with indication of "right hip pain, history of trauma." The hip x-rays were positive for mild osteoarthritis. PX 1. Petitioner was given Norco for pain and told to follow up with his primary care doctor. PX 1.

Petitioner further testified that he emailed his supervisor after his visit to the emergency room on July 5, 2018. PX 11. Petitioner testified that he emailed his supervisor which included his off-work note. In his email, Petitioner wrote, "So this started on Thursday last week getting out of my truck I slipped and landed on my leg a little hard and hurt it. I done it a couple of times over the last year or so. Thought the pain would go away after a couple of days. But then on Tuesday late afternoon same leg start [sic] hurt getting out of my truck. Doc said x-ray looked fine maybe just bruise hip. Rest it couple day [sic]. Should be good by Monday." PX 11. This email was sent to Petitioner's supervisor, Gary Chardovoyne, on July 5, 2018 at 2:32 p.m. PX 11.

Petitioner next sought treatment at Presence Medical Group with a Thomas Joseph Mark, PA, on July 25, 2018. The history given on that date indicates, "W/C – Patient was getting out of his work truck and slipped, injured

right leg, went to PSJMC ER 7/5/18." His primary complaint on 7/25/18 was acute right ankle pain along with right hip pain. PX 2. Right ankle x-rays were normal. The progress notes of PA Mark indicate " Pt presents with R ankle pain since falling out of truck on 6/29 and 7/2; pet went to ER on 7/5 due to R hip pain at the time, x-ray showed arthritis, otherwise normal; now R hip is feeling a little better, mostly having pain in R ankle + pain with weight bearing, no numbness/tingling..." PX 2. Petitioner was released and told to follow up in 2 weeks. The records also indicate that PA Mark ordered a possible MRI for follow up. Petitioner called the next day on 7/26/18 indicating that he could not wait 2 weeks due to his pain level and he requested an MRI earlier. PX 2, p. 11. Petitioner was given pain medication. On August 10, 2018, PA Mark took Petitioner off work for 10 days until he could an orthopedic physician for his complaints of continued right ankle pain. PX 2, p. 32, PX 3. The records of Presence and PA Mark do not mention complaints of low back pain. At trial, Petitioner testified that he had low back pain and that he complained of it to PA Mark but does not know why those complaints are not reflected in the records.

Petitioner saw Dr. Ho at Hinsdale Orthopedic on 8/15/18. PX 5. Petitioner complained of right ankle and foot pain after he slipped out of a truck on 6/28/18. Petitioner reported pain at 7 out of 10 along with some "stiffness in his great toe. ... he reports that the pain occasionally shoots up to his hip." PX 5. The impression was "right leg pain DOI 6/28/18." Petitioner was ordered an MRI of the right tibia and pain medication. Petitioner was kept off work. At the follow up on 8/23/18, Petitioner continued to complaint of pain in the right leg which radiated to his right hip on occasion. The right tibia MRI showed soft tissue edema and Petitioner was told to attend PT with a focus on Achilles stretching. He was kept off work and told to follow up in 6 weeks. The diagnosis was right leg inflammation and right Achilles equines contracture. PX 5.

On 10/4/18, Petitioner returned to Dr. Ho complaining of continued and unimproved right leg pain radiating to his right knee and hip. Conservative measures did not help. Petitioner no longer reported right ankle pain. Dr. Ho ordered an MRI and EMG of the lumbar spine "to evaluate for possible lumbar compression as a cause of his radiating leg pain." PX 5. Petitioner was kept off work.

On 3/13/19, Petitioner was seen at Illinois Orthopedic Institute. At that time, Petitioner reported right hip pain which he described as constant, achy, numbness, and sharp. He further reported that he slipped out of his work truck and landed on his feet and has been in pain since that occurred. Petitioner's diagnosis was right hip pain with lumbar radiculopathy. Petitioner further reported that in June 2018 he fell out of his truck injuring his right hip and his right ankle. He further reported that he took a couple days off of work, felt that he was okay and upon returning to work he jumped out of his truck and felt a sharp shock of pain from his right great toe all the way up his leg into his low back. On examination, Petitioner had a positive straight leg raise to the right but a negative straight leg raise on the left. After being denied pain medication, Petitioner was discharged from Illinois Orthopedic Institute due to his obscene actions and vulgar language. PX 7. He did not receive any treatment at Illinois Orthopedic.

Petitioner underwent the prescribed lumbar MRI on 4/1/19. PX 6. The indication was for lower back pain and right leg pain. Dr. Ho read the MRI to demonstrate moderate right-sided foraminal stenosis at L5. Mild foraminal stenosis of the left L4 nerve root. Mild spinal stenosis of the lumbar spine. An MRI of the right knee was ordered and an EMG of the bilateral lower extremities to "confirm that his pathology is stemming from his spine." PX 6. On 4/19/19, Dr. Bardfield of Hinsdale Ortho performed an EMG which revealed evidence of right L5 radiculopathy. The right knee MRI of 5/2/19 showed mild to moderate degeneration. On 5/9/19, Dr. Ho reviewed the results with Petitioner and diagnosed right L5 radiculopathy, right knee chondromalacia and

right Achilles equines contracture. The plan was to refer Petitioner to Dr. Darwish for further treatment of the lumbar radiculopathy. PX 6.

On 5/28/19, Petitioner saw Dr. Darwish who indicated that the injury occurred on 7/27/18 and that Petitioner worked as a "Field Tech." The history indicates that Petitioner's chief complaint was lumbar pain. He noted that "patient works as a computer technician and reports that he was at work on June 28, 2018, when he slipped out of his truck falling approximately 3 feet. Patient was taken to the emergency room and evaluated for low back and ankle pain. Tim reports that since the injury the main focus of treatment has been on his ankle and LE." On 5/28/19, Petitioner complained of low back pain radiating into bilateral lower extremities and feet with numbness and tingling right worse than left. Exam revealed bilateral tenderness or the left and right paraspinal. Dr. Darwish reviewed the April 2019 lumbar MRI and diagnosed Petitioner with L5-S1 bilateral foraminal narrowing, right worse than left, caused by degenerative changes along with a small acute superimposed right paracentral disc protrusion. PX 6. He recommended physical therapy, home exercise, and a referral to pain management with Dr. Patel for right L5-S1 epidural steroid injection. PX 8. He was to follow up in 6 weeks. PX 6.

On 7/16/19, Petitioner again complained of increased back pain after the ESI performed on 6/20/19. He did indicate that the injection helped his right lower extremity pain for 7 days. Seated straight right leg raise was positive. Dr. Darwish indicates "MRI of the lumbar spine was completed this was reviewed and reveals L5-S1 diffuse disc bulge with a superimposed right lateral disc protrusion causing severe right and moderate left foraminal narrowing." He diagnosed a herniated lumbar disc, lumbar radiculopathy, right, and lumbar pain. Due to the failure of conservative care, Dr. Darwish recommended a L5-S1 transforaminal lumbar interbody fusion with posterior instrumentation. Dr. Darwish continued the fusion recommendation on 8/13/19. Petitioner testified that he would like to undergo the recommended surgery.

Dr. Darwish's evidence deposition was taken on 2/18/20. PX 10. He opined that Petitioner's accident of falling out of his truck in June 2018 "caused exacerbation of a previously asymptomatic condition of lumbar degenerative changes as well as right sided paracentral disc protrusion at L5-S1 causing the low back pain and lower extremity radiculoapthy. According to my records, the patient did not have any complaints of low back pain or lumbar radicular symptoms or radiculopathy prior to that date." PX 10, p. 14. Dr. Darwish reviewed video of the Petitioner performing what he considered activities of daily living in October and November 2018. Petitioner's abilities depicted in the video did not change his opinion regarding Petitioner's diagnosis or need for treatment. PX 10, p. 16-17.

On cross-exam, Dr. Darwish testified that the history given to Presence on July 5, 2018 which does not mention falling out of a truck is not relevant to his diagnosis as his diagnosis is based on the history given to him by Petitioner. He found Petitioner to be honest in his history and symptom description. PX 10. P. 40-48. He further opined that the ankle pain Petitioner complained of immediately after the accident "could be caused by the lumbar pathology seen on MRI as well as that noted in the EMG study." PX 10, p. 54,55. He explained that Petitioner's lumbar foraminal stenosis at L5-S1 effects the L5 nerve root which is the nerve root that supplies the right lower extremity from the buttocks to the lateral thigh to the ankle and leg. PX 10. P, 55. He concluded that Petitioner's ankle pain and right hip pain could be caused by the lumbar pathology/radiculopathy. P. 55,56, 64. Dr. Darwish specifically testified that it is not abnormal for a patient who had an incident that causes lower extremity symptoms to be initially treated for ankle or hip pain which in retrospect are interpreted as radicular symptoms. PX 10, p. 64. He opines that this occurred in Petitioner's case. His opinion on causal connection between Petitioner falling out of a truck and his radicular complaints would not change based on discrepancies on the date of accident or the type of truck involved. P. 66. He again opined that Petitioner had a traumatic injury that caused aggravation or exacerbation of a previously asymptomatic condition of lumbar degenerative changes as well as acute disc herniation. P. 66.

Petitioner attended a Section 12 exam with Dr. Weber at Respondent's request in June 2019. RX 1. At her evidence deposition, Dr. Weber testified that based on her physical examination of Petitioner, I concluded... his examination was out of proportion to a diagnosis of what he was reporting to me, a disk herniation at L5-S1. He had nondermatomal loss of sensation that did not correspond to a specific nerve root. He didn't have any neural tensions. He had degenerative changes, which I would expect at somebody his age. And I thought that he had gross over-expression of severe pain that didn't correlate with the disk issue." RX 1, p. 24. Dr. Weber determined that Petitioner's entire physical exam of all body parts including the low back, right hip, knee and right ankle and left elbow, was completely normal and that all of his complaints were subjective and unsupported by physical exam. She opined that Petitioner did not need any treatment for these conditions. P. 27-28.

Dr. Weber reviewed the April 2019 lumbar MRI and concluded that the MRI findings did not correlate with Petitioner's subjective complaints. P. 34. With regard to the April 2019 EMG, Dr. Weber testified, "So even though he's calling this a right L5 radiculopathy, his examination does not correlate with that." P. 35. In her opinion, Petitioner did not need any injections or the recommended surgery for his lumbar complaints. P. 36-37. Dr. Weber also reviewed videos of Petitioner and testified that in her opinion, Petitioner did not demonstrate any limitations and that he was moving normally in October and November 2018. She testified that the video depiction of Petitioner's abilities in 2018 did not match his reported limitations in June 2019. P. 40. She testified, "the videos just re-enforce the fact that the information that he provided to me did not appear to be truthful." RX 1, p. 40. Dr. Weber opined that based on Petitioner's medical records, his exam and the video, Petitioner was not in need of any treatment for any body part and that he could return to full unrestricted work as of June 10, 2019. RX 1, p. 61. She further opined that "shortly thereafter his alleged injury, that he had no recall of any direct trauma, it was my opinion that his complaints were unrelated to the events of June 28, 2018. P, 62.

Respondent submitted video evidence. RX 2. The Arbitrator viewed the video depicting Petitioner in October 2018. Petitioner is seen walking, bending, pushing a grocery cart and getting in and out of his car. He is seen hanging a Halloween decorative spider on his house reaching up with his right arm and standing on his toes. He is seen pushing a woman in a wheeled chair from the store to the car. The Arbitrator notes his slight wobble when walking but otherwise does not note any pain behavior by Petitioner during these activities. On the video dated November 2018, Petitioner is again seen pushing grocery carts and walking in and out of stores. He is also seen doing yard work and is seen freely kneeling, bending, twisting, and lifting small weeds and a yard waste bag. The activities performed while doing the yard work in November 2018 are inconsistent with Petitioner's reported level of pain with activities given to Dr. Darwish 7 months later in late May 2019 and at trial 20 months later. When asked at trial whether the activities depicted on the video caused him pain at the time he testified that the activities depicted did not elicit pain and that the video was taken "at the beginning." He agreed that he was the individual on the video.

Petitioner testified that he has not worked in any capacity since August 10, 2018. Her further testified that other than the federal stimulus check, he has not received any income since August 10, 2018. He further testified that he has not sustained any new traumas or accidents since June 28, 2018.

Petitioner testified that he continues to have pain in his back and right buttock when he tries to lift more than ten pounds. He further testified that the only thing he can do is go to the grocery store and cook dinner. Petitioner further testified that he wants to proceed with the surgery that Dr. Darwish is recommending.

On cross examination, Petitioner testified that he signed the Application of Adjustment of Claims on or around October 16, 2018 and that his back is not listed as an injured body part despite his ongoing back pain at the

time. He further testified that medical records from 7/5/18 were not accurate. He further testified that he never told his doctor on 7/25/18 that he got hurt on 6/29 and 7/2. Petitioner further testified that he has difficulty walking more than a block and that his trips to the grocery store only require him to walk the equivalent of one block.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In support of the Arbitrator's decision relating to ("C"), did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent, the Arbitrator finds the following facts:

The Arbitrator notes Petitioner's testimony that on June 28, 2018, he was at work parked in a Walmart parking lot getting ready to perform services on behalf of Respondent when he slipped and fell out of his work truck. The Arbitrator notes that Petitioner's testimony was lacking in specific description of his fall. However, from Petitioner's testimony at trial, the Arbitrator concludes that while alighting from the truck seat measured to be 3 feet from the ground, Petitioner stumbled before landing on his feet. Petitioner testified that he immediately felt pain in his right buttock and right foot. Petitioner was able to complete his shift that day but was unable to work on June 29th and July 2nd. Petitioner returned to work on July 3 but testified that he had increased pain while again alighting from his truck.

Petitioner sought treatment at Presence St. Joseph on July 5, 2018. Petitioner testified that he provided a history of the June 28, 2018 work accident even though it was not included in the medical records. The Arbitrator notes that Petitioner was not the most accurate or detailed historian. Nonetheless, the records are consistent with the fact that Petitioner developed right hip and leg pain within the past week. Furthermore, the history in the records from Presence Medical Group and Hinsdale Orthopaedics are consistent with him stumbling out of his truck and complaining of symptoms in his right hip and right lower extremity. In addition, on July 5, 2018, Petitioner sent an email to his supervisor, Gary Chardavoyne. In the email, Petitioner specifically states that "this started on Thursday last week getting out of my truck I slipped and landed on my leg a little hard and hurt it." (PX 11).

Accordingly, based on a preponderance of the credible evidence including Petitioner's testimony, the medical records indicating the development of pain shortly before the visits and on the email sent to his supervisor, the Arbitrator finds that an accident occurred on June 28, 2018 that arose out of and in the course of Petitioner's employment by Respondent.

In support of the Arbitrator's decision relating to ("F"), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

Having considered Petitioner's credible testimony as well as all the medical evidence submitted by both parties at trial, and based upon the chain of events supported by the record, the Arbitrator concludes that Petitioner's current condition of ill being with respect to his low back is causally related to his June 28, 2018 work injury. In so finding, the Arbitrator also notes that the complaints of right leg, right knee, right ankle and right hip pain are symptoms of the lumbar condition which the Arbitrator finds causally related to the accident.

In finding, causal connection, the Arbitrator notes that prior to the June 28, 2018 accident, Petitioner had worked for Respondent for five years. Petitioner testified that he never had any complaints of pain to his right foot, right leg, or his back prior to June 28, 2018. Immediately following the accident, Petitioner experienced pain in his right buttock, right leg and right ankle. Petitioner was unable to report to work on June 29th and July 2nd. When he returned to work on July 3rd, the pain continued and was increased by stepping out of the truck. The email was sent to the supervisor on July 5.

Although the etiology of the pain was later determined to be the lower back, Petitioner continuously and consistently reported pain in his right hip, right leg and right foot to all of his providers. As the records indicate, Petitioner was initially treated for right foot and ankle pain. However, Dr. Ho eventually realized that Petitioner's pain in his right leg and right foot might be radicular in nature. (PX 6). Dr. Ho recommended a lumbar spine MRI which revealed a disc protrusion. Petitioner underwent an EMG with confirmed radiculopathy. Petitioner underwent an epidural steroid injection which provided some temporary relief which is indicative of lumbar radiculopathy. (PX 10).

Dr. Darwish opined that Petitioner's current condition of ill-being was causally related to the June 28, 2018 work accident. Dr. Darwish opined that Petitioner's complaints of right hip/leg pain and right foot pain were radicular in nature. Dr. Darwish reviewed the MRI films of Petitioner and credibly opined that the work accident caused an exacerbation of the pre-existing degenerative condition in Petitioner's lumbar spine. PX 10.

The Arbitrator adopts the opinions of Dr. Darwish in finding causation, as the doctor provided a credible explanation of the cause and source of Petitioner's condition and symptoms. The Arbitrator places greater weight on the opinion of Dr. Darwish rather than on Dr. Weber's opinion that Petitioner sustained no injury whatsoever and that his pain complaints were completely without objective basis. The Arbitrator further notes that Dr. Weber did not review the actual films of Petitioner's April 2019 lumbar MRI and that Dr. Weber only examined Petitioner on one occasion.

Petitioner testified that at no time subsequent to the June 28, 2018 accident did he sustain any new traumas or accidents to his back or right lower extremity. The medical evidence has established that Petitioner has continued to treat, initially for his right foot and right lower extremity and then for his back since July 5, 2018. The Arbitrator is not dissuaded in finding causal connection based on the activities depicted in the videos of Petitioner taken in October and November 2018. The Arbitrator notes that Petitioner is seen moving freely in October and November 2018. However, Petitioner admitted at trial that he was not in pain performing the depicted activities and explained that those activities were "in the beginning." The Arbitrator notes that the video activity was captured well prior to his ultimate diagnosis of lumbar radiculopathy based on his pain complaints at the time he saw Dr. Darwish in late May/June 2019 and on the April 2019 MRI and EMG testing. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being in his lumbar spine is causally related to the injury.

In support of the Arbitrator's decision relating to ("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, the Arbitrator finds the following facts:

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary, and causally related medical expenses, including the out of pocket expenses, incurred in the care and treatment of Petitioner's back, right leg, and right foot complaints and injuries pursuant to Sections 8 and 8.2 of the Act. (PX 9). Respondent shall be given a credit for all medical benefits that have been previously paid by Respondent and Petitioner's group insurance.

Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's decision relating to ("K"), is Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

Based on the Arbitrator's findings on the issue of accident and causal connection, the Arbitrator further finds that Respondent shall authorize and pay for the treatment that is being recommended by Dr. Darwish including the L5-S1 transforaminal lumbar interbody fusion with posterior instrumentation pursuant to Sections 8 and 8.2 of the Act.

In support of the Arbitrator's decision relating to ("L"), what temporary benefits are in dispute, temporary total disability benefits, the Arbitrator finds the following facts:

Petitioner was taken off work by PA. Mark on August 10, 2018. He was subsequently kept off work while treating with Dr. Ho. Thereafter, he was referred to Dr. Darwish who testified that Petitioner was unable to return to work until he proceeded with the recommended surgery.

Based on the Arbitrator's findings on the issue of accident and causal connection, the Arbitrator further finds that Respondent is responsible for temporary total disability benefits from August 10, 2018 through July 13, 2020. Respondent is entitled to a credit for the benefits previously paid to Petitioner in the amount of $10,161.41. ARB EX 1.

In support of the Arbitrator's decision relating to ("O"), choice of physicians, the Arbitrator finds the following facts:

Petitioner initially sought emergency care with Presence St. Joseph Medical Center on an emergency basis and was referred for follow up care. Petitioner then sought treatment with Mr. Thomas Mark, PA at Presence Medical Group. Petitioner testified that Mr. Thomas Mark referred him to Dr. Ho. The records are consistent with that testimony. (PX 2, 3, 5, 6). Petitioner testified that Dr. Ho referred him to Dr. Darwish. The medical records are consistent with that testimony (PX 5, 6). Petitioner testified that Dr. Darwish referred him to Dr. Patel for pain management and conservative treatment. The medical records are consistent with that testimony. (PX 5, 6, 8). Petitioner testified that he sought treatment at Illinois Orthopedic Institute for a second opinion but was immediately discharged from that facility without receiving treatment.

Based on the above, the Arbitrator finds that Petitioner clearly did not exceed his choice of physicians within the allowed choices under the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC004094
Case Name	BROWN, BRIAN v. WESLEY COMPANIES, INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0368
Number of Pages of Decision	19
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Kevin Elder
Respondent Attorney	R. Mark Cosimini

DATE FILED: 7/19/2021

/s/ Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN BROWN,

Petitioner,

vs. NO: 19 WC 04094

WESLEY COMPANIES, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, page 9 paragraph 1, 2nd sentence, to replace "Dr. Arnold" with "Dr. Alpert."

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, page 9, paragraph 4, the last sentence should read, "The Arbitrator notes that the medical records of Dr. Arnold of June 24, 2018 and July 8, 2018 were not consistent with that opinion as they reflect Petitioner continuing to complain of pain in his back and numbness in his left leg." (Pet. Ex. #2)

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 14, 2020 is, otherwise, 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 $40,000.00. 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.

July 19, 2021

o-7/13/21
KAD/jsf

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

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

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

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

21IWCC0368

BROWN, BRIAN
Employee/Petitioner

Case# **19WC004094**

WESLEY COMPANIES INC
Employer/Respondent

On 12/14/2020, 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 0.09% 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:

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242 N KNOXVILLE AVE
PEORIA, IL 61614

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BRIAN BROWN
Employee/Petitioner

v.

WESLEY COMPANIES, INC.
Employer/Respondent

Case # **19** WC **4094**

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 **Urbana**, 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. ☒ 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, **April 13, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,480.00**; the average weekly wage was $**990.00**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** dependent child.

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

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

Respondent is entitled to a credit of $all amounts paid by its group health insurer under Section 8(j) of the Act.

ORDER

Petitioner's current condition of ill being, low back sprain and the aggravation of his lumbar spinal stenosis, is causally related to the accident of April 13, 2018.

Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibits 4 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from April 16, 2018 to October 16, 2020 which are causally related to the accident of April 13, 2018. Respondent shall pay these bills in accordance with the Medical Fee Schedule. The Arbitrator finds that Respondent is to be given credit for all amounts paid by its group health insurer pursuant to Section (j)(1) of the Act.

Petitioner is entitled to the surgery recommended by Dr. Arnold, laminectomies at L2-3 and L3-4 as well as removal of portions of ligament and facets joints, as necessary to decompress nerve roots. Respondent is to pay for said treatment 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

December 8, 2020
Date

ICArbDec19(b)

DEC 14 2020

Brian Brown vs. Wesley Companies, Inc. 18 WC 4094

EVIDENCE AT ARBITRATION

Petitioner testified that he was 53 years of age and that he had been hired by Respondent on July 1, 2013. He said Respondent was a construction and restoration company which did insurance work, performing water mitigation from floods and fire restoration after fires. They also did general construction and remodeling work, primarily on residential property.

Petitioner said his job title at the time of the accident was lead carpenter. His job physically required him to perform construction tasks such as hanging drywall, carrying materials, framing up room additions, and lifting and carrying OSB panels. He said he had been performing construction work as a carpenter for 22 years. He said that during that time he had occasional back pain but had never seen a surgeon in regard to his back or had an MRI of his back.

Petitioner said that in the past he had experienced neck problem and had undergone two neck surgeries, one being a fusion. He had been treated by Dr. Harms at Carle Spine & Brain for one of the surgeries. He said the current claim had nothing to do with his neck.

Petitioner testified that on April 13, 2018 he was unloading a 4 X 8 sheet of three-quarter inch OSB which weighed about 85 pounds. He carried it about 20 feet, and as he was sliding it onto a rack, he felt pain as if someone had hit him in the back with a sledgehammer. He said he had a tremendous amount of pain in his back, left hip and left leg. This occurred at the end of work on a Friday, all the other carpenters were gone, so he finished cleaning up some paint equipment and his truck and went home. He said when he woke up the next morning he was in an extreme amount of pain and his left leg was numb and felt extremely weak, causing him to have trouble walking up and down stairs.

On the following Monday he told his supervisor, Scott Harvey, of his accident. They did not fill out an accident report at that time, but he did so later with Alicia Kessel, the office manager.

Petitioner said he went to see his chiropractor, Dr. Melby, that afternoon, gave him the history of the accident, was started on a series of adjustments and was restricted from lifting more than 10 pounds. He said he missed some time from work his first week but otherwise had not lost any work as a result of the accident.

He said he wanted to see Dr. Harms, who had treated his neck in the past, but he was not available, so he saw Dr. Victoria Johnson at Carle Spine Institute on Tuesday. He said she ordered an MRI and did not give him any restrictions, which he did not agree with. He only saw her on that one occasion. He said he then saw Dr. Harms who thought he had a herniated disk but should wait nine to twelve weeks to see if the symptoms would improve or go away.

Petitioner said he continued treating with Dr. Selby for adjustments through April 1, 2019. He said some of the chiropractic bills were paid by his group health insurance, while the rest was paid out of pocket. An MRI was eventually performed, and he then saw Dr. Harms who recommended surgery for spinal stenosis. Since Dr. Harms is no longer performing surgery, he referred Petitioner to Dr. Arnold for surgery.

Petitioner said he saw Dr. Arnold in June of 2019, but since he did not have his MRI with him, he had to see him a second time a few weeks later. He said Dr. Arnold also recommended surgery, an L2 through L4 laminectomy and decompression. Petitioner said he had not yet had that surgery as he had been trying to get workers' compensation to cover the claim, as he would be off work for three months and that was something he could not afford. That was why he was litigating the case, to obtain an award for prospective back surgery.

Petitioner said Dr. Selby had been his chiropractor since 2010, when he saw the chiropractor a lot as he had weakness and atrophy in his left arm, receiving treatment for his neck. He said he eventually had to have surgery on his neck. He said that on one occasion in April of 2011 he did complain to Dr. Selby of low back pain which was the result of his overdoing it at work. At that visit Dr. Selby did adjust his low back, though he was principally concentrating on the neck.

Petitioner testified that on the day before this April 12, 2018 accident he was not having any left leg problems and was not under any activity restrictions.

As of the day of arbitration, Petitioner testified he had persistent tingling in his knee, atrophy from nerve injury in his left quadricep that became apparent three months after his injury, something he had not experienced before in his lower extremities. He said he continued to have low back pain as well as continuing numbness and periodic tingling.

Petitioner said he had not reinjured his low back of left leg since April 13, 2018.

Petitioner said he had changed jobs in June of 2018 as Respondent was sold to another company, Men old Construction & Restoration, and they shifted his job title and responsibilities from lead carpenter to construction superintendent, which was more management and less ands-on work. Petitioner was still working for Menold Construction as of the date of arbitration. He said that as a construction superintendent he did not have to do the heavy lifting carpenters did, that he had employees who worked under him, that he scheduled the work to be done on various projects. He had therefore been able to modify his activity at work so it was not irritating his back.

Petitioner said that while he had previously had workers' compensation work injuries, he had never had to hire an attorney before. He said he had never had a personal injury claim from a car accident or slip and fall.

On cross-examination Petitioner said his previous workers' compensation claims were just settled with the insurance company. Those injuries involved a hand injury in 1993 or 1994 which required ligament surgery

and skin graft surgery, an injury where he tore a ligament for which surgery was recommended but he chose to live with the partial tear of the ligament. He said in 2010 he had an accident while working for his brother at CBE Construction, he had stepped off the end of a plank and fell three feet, his knee bent sideways and he had a torn ACL for which he received surgery, along with neck surgery for degenerative disk disease and spinal stenosis.

Petitioner said the chiropractic treatment he received in 2010 and 2011 involved adjustments to his neck, midback and low back, the chiropractor would just treat everything. The treatment he received after the April 13, 2018 was to the mid back and the low back, Petitioner said he would not let the chiropractor treat his neck after he had neck surgery. He said that following his April 13, 2018 accident his symptoms would sometimes be better and sometimes be worse. He said that since the April 13, 2018 accident he had undergone two DOT exams which cleared him to work without restrictions. He said he monitors himself and if he overdoes it his symptoms flare up and cause pain and increased numbness and tingling in his left leg. But he agreed that as far as his company was concerned, he had no restrictions.

Petitioner said that while his symptoms were activity related, that when he did something physical it would hurt and then get better, he said there was also constant low back pain, numbness and tingling as well as the atrophy of his left leg which was always there. He said he could not do any heavy lifting.

He said he was hired in 2013 and the company did not change between the date of his hire and the date of this accident.

Petitioner said that Dr. Harms did not tell him he needed immediate surgery, but that he would probably want it within the next five years or so, and it would probably be sooner than later.

MEDICAL EVIDENCE

The records of Petitioner's chiropractor, Dr. Melby, were introduced into evidence by Petitioner. They include records dating from September 27, 2010 through April 1, 2019. Chiropractic records for 23 treatments from September 27, 2010 through April 7, 2011 were almost exclusively in regard to neck complaints for cervical segmental dysfunction and degeneration of cervical disk. The only occasion where low back complaints were voiced was on April 7, 2011 when Petitioner told Dr. Melby of intermittent aching in his low back. (Pet. Edh. #3)

Following that April 7, 2011 visit Petitioner did not see Dr. Melby again or receive chiropractic treatment from him until three days after this accident, April 16, 2018. His complaints on that day were low back pain, leg problems, sore/weak muscles, numbness and tingling sensation, and examination findings of muscle spasms in his left quadricep and a positive straight leg raising test on the left. Dr. Melby's diagnoses on

that day were segmental and somatic dysfunction of the lumbar region, lumbar region spondylosis with radiculopathy, and low back pain. Dr. Melby provided chiropractic treatment to Petitioner for back, left hip, left thigh and left knee pain complaints on 36 occasions through April 1, 2019. (Pet. Exh. #3)

On October 6, 2020 Dr. Melby wrote a To Whom It May Concern letter and in it stated that his diagnosis was, "low back pain as the result of a work injury." (Pet. Exh. #3)

Petitioner saw Dr. Johnson on April 17, 2018 with complaints of low back pain and left leg pain radiating to the knee. He also advised her that his left leg felt weak. His physical examination showed the left illiopsoas and quadricep muscles had diminished strength at 4/5 and his patella reflex on the left was also diminished. Dr. Johnson ordered an MRI of the lumbar spine and noted her belief that Petitioner had lumbar spondylosis with radiculopathy, suspecting a preexisting back problem exacerbated by his work-related injury. (Pet. Exh. #2)

Dr. Harms saw Petitioner on April 30, 2018. He noted that following two neck surgeries performed on Petitioner by him in the past Petitioner had done well with only occasional aches and pains in his back and some leg symptoms until two weeks earlier when while unloading his truck he had left leg pain that became terrible a couple of days later. He diagnosed premature degenerative disc disease and facet arthritis with a possible herniated disc at l3/4 on the left being the most likely pain generator. (Pet. Exh. #2)

Petitioner received a preplacement physical and Department of Transportation physical from Dr. James DeSalvo on July 5, 2018. He found Petitioner to have a normal physical examination of his extremities as well as a normal neurologic examination. No mention of low back pain is noted in the examination record, but Petitioner did answer "yes" to neck or back problems on the DOT driver health history form. Petitioner also noted that he had a possible herniated disk in his low back on that form. (Resp. Exh. #3)

An MRI of the lumbar spine was performed on September 21, 2018. It showed mild central canal stenosis T12 through L2 and L4 through S1, mild to moderate central canal stenosis at L2/3, moderate central canal stenosis at L3, an L4/5 right paracentral disc protrusion, and an L5/S1 broad based central disc protrusion. (Pet. Exh. #2)

Dr. Harms saw Petitioner again on October 3, 2018. He noted Petitioner continued to have tingling and numbness in his leg and that his left quadriceps was atrophying. He noted the MRI had shown narrowing of the spinal canal and said that Petitioner had to be tough to have put up with it, and it certainly explained Petitioner's leg symptoms. He noted Petitioner's treatment options, which included living with it, temporary treatment measures, and surgery to increase the room for the nerves, to help the leg pain and to keep the weakness and numbness from getting worse. He noted that 80% of patients who had surgery were happy with the results. Dr. Harms was of the opinion that Petitioner would want the surgery within five years, and he felt it might be sooner than that. (Pet. Exh. #2)

Petitioner saw Dr. Paul Arnold, a neurosurgeon, on June 24, 2018. Petitioner was complaining of pain in his back, numbness and weakness in the left leg, and atrophy in the left leg. Dr. Arnold postponed his evaluation at that time as Petitioner did not have a copy of his MRI with him. He was seen on July 8, 2018. Petitioner had the same complaints at that time, Dr. Arnold found him to have full strength in his legs, and his review of the MRI was that it showed multilevel stenosis. He offered surgery to Petitioner and noted that they would wait until they heard from workers' compensation before scheduling surgery. (Pet. Exh. #2)

On August 12, 2019 Dr. Arnold wrote a letter to Petitioner's attorney stating that the goal of the surgery was to decompress the spinal canal to try to relieve pressure on the nerve roots, allowing the nerves to recover. He further stated, "I think there is some causal relationship to the injury and his pain. However, some of this is certainly due to an underlying preexisting condition because the stenosis appears to be there for a long period of time. " (Pet. Exh. #2)

Petitioner again saw Dr. Delsavio for a Department of Transportation physical on June 18, 2020. During his physical examination on that date Dr. Delsavio observed atrophy of the left quadriceps, and although he found Petitioner to have good strength in his legs, he did note a slight decrease in the leg reflexes, especially on the left side. Petitioner again noted neck and back problems on his DOT health history form. Petitioner was again approved for a DOT medical examiner certificate. (Resp. Exh. #6)

TESTIMONY OF DR. PAUL ARNOLD

Dr. Arnold was called as a witness by Petitioner and testified via deposition. Dr. Arnold's testimony in regard to examination findings was consistent with the summary above. In addition he testified, in responding to hypothetical questions, that the accident did not cause Petitioner's stenosis, but "it may have contributed some." He said that the accident aggravating the asymptomatic stenotic condition in the spine causing it to become symptomatic and leading to the need for surgery was "a possible scenario." He said that aggravation was more likely than not if Petitioner was asymptomatic before the accident. He noted that Petitioner's making one low back complaint to a chiropractor seven years prior to the accident would not cause him to change those opinions. (Pet. Exh. #1 p.16-18)

On cross-examination Dr. Arnold testified that the history in Dr. Harms' records of Petitioner having "occasional aches and pains in his back and some leg symptoms" up to the time of this accident did not necessarily mean he was symptomatic, and without seeing a physician about that it was hard to speculate. He agreed that there was no reason to think the degenerative changes were modified or changed as a result of the accident. He did think that the accident could have injured the L3/4 and L4/5 areas, and potentially the disc. He

said it was hard to know how much of the pain overlay was due to this injury, but "certainly a little of it could be." Pet. Exh. #1 p.16-18, 20,21,24,28,29)

TESTIMONY OF DR. JOSHUA ALPERT

Dr. Alpert was called as a witness by Respondent and testified via deposition. Dr. Arnold testified that he is an orthopedic surgeon whose medical practice focused on knees, shoulders and elbows. He said he does not perform spinal surgery, though he did some spine surgery during his residency, which ended in 2007. (Resp. Exh. #7 p. 4,18,22)

At Respondent's request Dr. Alpert performed a Section 12 examination on Petitioner on December 4, 2018. The history he received from Petitioner included having had low back pain in the past with "gave out on him" six times in his life, the last time being two years before his examination. Petitioner denied ever previously having leg pain or of having a "more recent" episode of back pain. His history included left leg pain and weakness, as well as numbness and tingling to his foot. Petitioner told him that his pain was worse than it had ever been in the past. Petitioner was working full duty when he saw him. (Resp. Exh. #7 p. 6-8)

Dr. Alpert said his physical examination of Petitioner showed his range of motion was normal, and he had a negative straight leg raising test. He did observe some mild left-sided quadricep atrophy, though he felt the leg had normal strength. He reviewed the MRI of September 21, 2018 which he said showed degenerative disk disease, arthritis, and central spinal cord stenosis from L1 through L4. He said that he was not able to identify any traumatic pathology on the MRI. His diagnosis was low back pain with degenerative arthritic changes in the back and facet hypertrophy. He felt petitioner suffered a back strain at work on April 13, 2018. (Resp. Exh. #7 p. 8-12)

Dr. Alpert said that soft tissue sprains or strains generally take six to twelve weeks to improve. He said one office note of Dr. Melby shows that on June 4, 2018, during that 12 week period, Petitioner noted 1/10 leg pain and there was no mention of back pain, which was consistent with his opinion that Petitioner reached maximum medical improvement on June 4, 2018. (Resp. Exh. #7 p. 12,13) The Arbitrator notes that the medical records of Dr. Arnold of June 24, 2019 and July 8, 2018 were not consistent with the reflect Petitioner continuing to complain of pain in his back and numbness in his left leg. (Pet. Exh. #2)

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner's rendition of the facts at arbitration, and to every medical provider, as well as to Respondent's Section 12 examining physician, was consistent. While doctors may have recorded slight

differences in how or where he was carrying the material he was unloading from his truck, they all noted that he was injured while moving material and twisted his back. Petitioner's testimony did not appear at any time to be exaggerated, either in regard to how the accident occurred or his medical condition following the accident. The Arbitrator finds Petitioner's testimony to be credible.

Dr. Arnold's testimony was not totally consistent with is previously recorded opinions, and that could be due to his admitted lack of memory of Petitioner's history of accident given to him on June 24, 2018, though after reviewing his office notes he found Petitioner to be a reliable historian. He said he did not have an independent recollection of the Petitioner, noting that if he walked into the deposition room, he probably would not recognize him. (Pet. Exh. #1 p.7,8,19) While the Arbitrator believes Dr. Arnold was truthful in his answers at the deposition he gives limited weight to the pinions given on the date of the deposition as he could not remember Petitioner in the least, and instead gives greater weight to the opinions noted in the contemporaneous office notes while he was treating Petitioner.

Dr. Alpert's also appeared to be giving honest opinions during his testimony. Those opinions are those of an arm and leg joint orthopedist, not of an orthopedist or neurosurgeon who includes spinal surgery in his practice. Dr. Alpert noted that he last performed spinal surgery during the last year of his residency, which ended in 2007. Dr. Alpert also saw Petitioner eight months after the accident while the other physicians treated Petitioner in the days, weeks and months immediately following the accident. Dr. Alpert's opinions are therefore given lesser weight than those of Dr. Harms and Dr. Arnold.

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being is causally related to the accident of April 13, 2018, the Arbitrator makes the following findings:

The accident of April 13, 2018 is undisputed. Petitioner described the accident, his unloading an 85-pound 4 X 8 sheet of OSB and, while placing it on a rack experiencing a tremendous amount of pain in his back, left hip and left leg. His description of the accident was not contradicted by any testimony or exhibits. The medical providers are in agreement that Petitioner had a preexisting degenerative condition resulting in mild to moderate lumbar spinal stenosis which could cause the type of symptoms Petitioner is complaining of subsequent to this accident.

Petitioner's saw Dr. Melby, a chiropractor who had treated him in the past principally for cervical complaints. He took a low back complaint on one out of 23 visits in 2011. Dr. Melby did not see Petitioner for any type of complaint from April 7, 2011 until three days after this accident, April 16, 2018, just over seven years after his last visit. After treating Petitioner on 36 occasions following this accident Dr. Melby

wrote a To Whom It May Concern letter and in it stated that his diagnosis was, "low back pain as the result of a work injury." (Pet. Exh. #3)

Petitioner next saw Dr. Johnson on April 17, 2018 with complaints of low back pain and left leg pain radiating to the knee as well as left leg weakness. Dr. Johnson believed that Petitioner had lumbar spondylosis with radiculopathy, suspecting a preexisting back problem exacerbated by his work-related injury. (Pet. Exh. #2)

Petitioner then saw Dr. Harms, who had treated him in 2011 for neck problems, having performed two cervical surgeries at that time. After seeing Petitioner on April 30, 2018 he noted that following Petitioner's two neck surgeries in 2011 Petitioner had done well with only occasional aches and pains in his back and some leg symptoms until two weeks earlier, when this accident occurred, when while unloading his truck he had left leg pain that became terrible a couple of days later. He diagnosed premature degenerative disc disease and facet arthritis with a possible herniated disc at l3/4 on the left being the most likely pain generator. (Pet. Exh. #2)

Dr. Harms saw Petitioner again on October 3, 2018, noting Petitioner continued to have tingling and numbness in his leg and that his left quadriceps was atrophying. He noted the MRI had shown narrowing of the spinal canal and said that Petitioner had to be tough to have put up with it, and it certainly explained Petitioner's leg symptoms. (Pet. Exh. #2)

Dr. Arnold examined Petitioner on July 8, 2018 finding him to have full strength in his legs, and his review of the MRI was that it showed multilevel stenosis. He offered surgery to Petitioner and noted that they would wait until they heard from workers' compensation before scheduling surgery. (Pet. Exh. #2)

On August 12, 2019 Dr. Arnold wrote a letter to Petitioner's attorney stating that the goal of the surgery was to decompress the spinal canal to try to relieve pressure on the nerve roots, allowing the nerves to recover. He further stated, "I think there is some causal relationship to the injury and his pain. However, some of this is certainly due to an underlying preexisting condition because the stenosis appears to be there for a long period of time." (Pet. Exh. #2)

Dr. Arnold testified via deposition. and, in responding to hypothetical questions, stated that the accident did not cause Petitioner's stenosis, but "it may have contributed some." He said that the accident aggravating the asymptomatic stenotic condition in the spine causing it to become symptomatic and leading to the need for surgery was "a possible scenario." He said that aggravation was more likely than not if Petitioner was asymptomatic before the accident. He noted that Petitioner's making one low back complaint to a chiropractor seven years prior to the accident would not cause him to change those opinions. (Pet. Exh. #1 p.16-18)

On cross-examination Dr. Arnold testified that the history in Dr. Harms' records of Petitioner having "occasional aches and pains in his back and some leg symptoms" up to the time of this accident did not necessarily mean he was symptomatic, and without seeing a physician about that it was hard to speculate. He

agreed that there was no reason to think the degenerative changes were modified or changed as a result of the accident. He did think that the accident could have injured the L3/4 and L4/5 areas, and potentially the disc. He said it was hard to know how much of the pain overlay was due to this injury, but "certainly a little of it could be." Pet. Exh. #1 p.16-18, 20,21,24,28,29)

Dr. Alpert examined Petitioner at the request of the Respondent. He said his physical examination of Petitioner showed Petitioner's range of motion was normal, and he had a negative straight leg raising test. He did observe some mild left-sided quadricep atrophy, though he felt the leg had normal strength. He reviewed the MRI of September 21, 2018 which he said showed degenerative disk disease, arthritis, and central spinal cord stenosis from L1 through L4. He said that he was not able to identify any traumatic pathology on the MRI. His diagnosis was low back pain with degenerative arthritic changes in the back and facet hypertrophy. He felt petitioner suffered a back strain at work on April 13, 2018. (Resp. Exh. #7 p. 8-12)

Dr. Alpert said that soft tissue sprains or strains generally take six to twelve weeks to improve. He said one office note of Dr. Melby shows that on June 4, 2018, during that 12 week period, Petitioner noted 1/10 leg pain and there was no mention of back pain, which was consistent with his opinion that Petitioner reached maximum medical improvement on June 4, 2018. (Resp. Exh.#7 p. 12,13) The Arbitrator notes that the medical records of Dr. Arnold of June 24, 2019 and July 8, 2018 showed Petitioner continued to complain of pain in his back and numbness in his left leg. (Pet. Exh. #2)

The Arbitrator finds:

A work injury does not need to be the sole, exclusive or only cause of the medical condition complained of, an injury is compensable if the work accident aggravated, accelerated, exacerbated or contributed to the current condition of ill-being.

Dr. Melby stated he felt Petitioner's condition was the result of his work injury. Dr. Johnson noted that she felt Petitioner had lumbar spondylosis with radiculopathy, suspecting a preexisting condition exacerbated by his work related injury. Dr. Harms records, where he said Petitioner had done well after his 2007 cervical surgeries with only occasional aches and pains in his back and some leg symptoms until two weeks earlier, when this accident occurred, when while unloading his truck he had left leg pain that became terrible a couple of days later, and a later office note where Dr. Harms noted objective evidence of injury, atrophy of the left quadriceps muscle, in the area where Petitioner had been complaining of pain and sensory changes. Dr. Harms said the MRI showed spinal stenosis, which certainly explained Petitioner's leg complaints. Dr. Arnold, an orthopedist who performs spinal surgery, who on August 12, 2018 noted in his office records, "I think there is some causal relationship to the injury and his pain. However, some of this is certainly due to an underlying preexisting condition because the stenosis appears to be there for a long period of time," and he further stated

that the accident did not cause Petitioner's stenosis, but "it may have contributed some," saying in his deposition that the accident aggravating the asymptomatic stenotic condition in the spine causing it to become symptomatic and leading to the need for surgery was "a possible scenario," and that aggravation was more likely than not if Petitioner was asymptomatic before the accident, and that Petitioner's making one low back complaint to a chiropractor seven years prior to the accident would not cause him to change those opinions. There is no medical record introduced into evidence which reflects Petitioner seeking medical treatment for low back or left leg complaints in the seven years prior to this accident. No testimony was introduced indicating petitioner had ever voiced low back of left leg complaints in that seven year period. The Arbitrator gives little weight to the opinions of Dr. Alpert, an orthopedist who does not perform spinal surgery and had not done so since his last year of residency. With the exception of Dr. Alpert all other physicians felt this accident had caused an asymptomatic preexisting condition to become symptomatic, exacerbated, or aggravated that preexisting condition. Further, had there been no opinions of medical providers indicating a causal connection the Arbitrator finds that causal connection is also proved under a chain-of-events theory, based upon Petitioner's having had no low back or left leg complaints to medical providers or treatment or treatment to those areas in the seven years prior to this accident, a sudden traumatic injury to the low back traceable to a definite time, place and cause and immediate complaints and of an injury following the accident. Those complaints have continued through the date of arbitration.

Petitioner's aggravation of his preexisting spinal stenosis is causally related to the accident of April 13, 2018.

In support of the Arbitrator's decision relating to whether the medical services that were provided to Petitioner were reasonable and necessary as a result of the Accident of April 13, 2018, the Arbitrator makes the following findings:

The findings of fact in regard to causal connection, above, are incorporated herein.

All medical bills introduced into evidence in Petitioner Exhibit #4 are for testing and treatment in regard to Petitioner's low back injury subsequent to April 13, 2018 as evidenced by the medical records introduced into evidence. Some of these bills were apparently paid by Respondent's group health insurer.

The Arbitrator finds that the medical bills contained in Petitioner's Exhibit #4 were reasonable and were necessitated as a result of the accident of April 13, 2018. Respondent shall pay these bills in accordance with the Medical Fee Schedule. The Arbitrator finds that Respondent is to be given credit for all amounts paid by its group health insurer pursuant to Section (j)(1) of the Act.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to any prospective medical treatment, the Arbitrator makes the following findings:

The findings of fact in regard to causal connection, above, are incorporated herein.

Dr. Harms noted that based on his complaints and findings Petitioner's treatment options included surgery to increase the room for the nerves, to help the leg pain and to keep the weakness and numbness from getting worse. He noted that 80% of patients who had surgery were happy with the results. Dr. Harms was of the opinion that Petitioner would want the surgery within five years, and he felt it might be sooner than that.

Dr. Arnold, after examining Petitioner on July 8, 2018 offered surgery to Petitioner but noted that they would wait until they heard from workers' compensation before scheduling surgery. That surgical authorization was never received.

Petitioner testified that his low back and left leg complaints continued, and he wanted to have the surgery recommended by Dr. Arnold.

The Arbitrator finds that Petitioner is entitled to the surgery recommended by Dr. Arnold, laminectomies at L2-3 and L3-4 as well as removal of portions of ligament and facets joints, to decompress nerve roots. This finding is based upon the testimony of Petitioner and Dr. Arnold as well as the medical records of Dr. Harms and Dr. Arnold.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC013692
Case Name	MARKIEWICZ, CRAIG v. MCHUGH CONSTRUCTION
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	21IWCC0369
Number of Pages of Decision	43
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	John Popelka
Respondent Attorney	Shawn Biery

DATE FILED: 7/21/2021

/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

CRAIG MARKIEWICZ,

Petitioner,

vs. NO: 12 WC 13692

McHUGH CONSTRUCTION,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court. The Commission, in its Decision dated August 15, 2018, modified the Arbitrator's Decision and reduced temporary total disability (TTD) benefits to only cover December 19, 2011 through January 17, 2013 and vacated the award of maintenance benefits. The Commission vacated the Arbitrator's award of 40% loss of use of the left leg and 25% loss of the person as a whole, and instead awarded 40% loss of the person as a whole which, as a matter of law, was the proper award for the Arbitrator's finding that Petitioner was partially incapacitated from pursuing the duties of his usual and customary line of employment pursuant to Section 8(d)2 of the Act. The Commission vacated the award of $2,000.00 for payment to Thomas Grzesik, Petitioner's vocational rehabilitation counselor. The remainder of the Arbitrator's Decision was otherwise affirmed, including the Arbitrator's denial of penalties and attorney's fees under Sections 16, 19(k), and 19(l) of the Act.

The Circuit Court of Cook County confirmed the Commission's Decision in its Order dated November 7, 2019.

Petitioner appealed to the Appellate Court. In its Order and Opinion, dated October 23, 2020, the Appellate Court reversed those portions of the Circuit Court's judgment that confirmed the Commission's Decision reducing TTD benefits, vacating maintenance benefits, and vacating the Arbitrator's order that Respondent pay the $2,000.00 bill for services rendered by Mr. Grzesik. The Appellate Court vacated the Circuit Court's judgment that confirmed the Commission's denial of an award of penalties and attorney's fees. The Appellate Court affirmed the Circuit Court's

judgment in all other respects. The Appellate Court remanded the matter to the Commission with directions to:

1) Award TTD benefits from December 19, 2011 through January 31, 2013;
2) Award maintenance benefits from February 1, 2013 through June 30, 2015;
3) Order Respondent to pay $2,000.00 to Thomas Grzesik; and,
4) Conduct a hearing, consistent with the Appellate Court's opinion, to determine whether penalties under Sections 19(k) and 19(l) and attorney's fees under Section 16 of the Act should be imposed upon Respondent.

The parties, through their respective counsel, requested that in lieu of hearing, the Commission consider their original Briefs and arguments presented during the Commission's initial review of the claim.

The Commission hereby incorporates by reference the findings of fact contained in the Arbitrator's Decision to the extent it does not conflict with the Appellate Court's Order and Opinion dated October 23, 2020. The Commission further incorporates by reference the Appellate Court's Order and Opinion which delineates the relevant facts and analysis, and is attached hereto and made a part hereof.

In compliance with the Appellate Court's Order, the Commission awards the TTD and maintenance benefits as mandated, and orders Respondent to pay $2,000.00 to Mr. Grzesik. The Commission has further considered the entire record, and being advised of the facts and law, and in accordance with the remand Order, as discussed below, the Commission finds that penalties under Sections 19(k) and 19(l) and attorney's fees under Section 16 of the Act should be imposed upon Respondent. Accordingly, the Commission reverses the Arbitrator's Decision with respect to penalties and attorney's fees.

Penalties and Attorney's Fees

The Appellate Court noted that the Arbitrator denied an award of penalties and attorney's fees in part because the Arbitrator found that Respondent had a reasonable basis to deny TTD and maintenance benefits as a legitimate dispute existed between the parties as to whether Petitioner rejected a modified job offer. The Arbitrator also found that Petitioner failed to show what efforts he made to secure the truck necessary to complete the SPE – a physical test to determine whether Petitioner could perform the job duties of a truck driver safely. The SPE was in turn necessary to obtain a CDL; Petitioner instead quit the CDL MEGA Driving School program.

With respect to the alleged legitimate dispute between the parties as to whether Petitioner rejected a modified job offer, the Appellate Court reviewed the timeline of events concerning Petitioner's physical capabilities and restrictions after the work accident. (Appellate Court Order and Opinion, pgs. 26-27). Based upon the evidence in the record, the Appellate Court determined that the finding that a "legitimate dispute" existed on the issue of whether Petitioner rejected an offer of employment with duties within the restrictions imposed by his treating physician, Dr. Stephen Gryzlo, was against the manifest weight of the evidence.

The Appellate Court found that Respondent may have reasonably believed that it had offered Petitioner work within his restrictions when it issued its initial job offer on October 5, 2012; that initial offer stated that Petitioner would only be assigned tasks consistent with Dr. Gryzlo's work restrictions and if Petitioner felt that his tasks were outside his work restrictions, then Petitioner was not to attempt or perform such tasks. (RX1). The Appellate Court noted that by October 5, 2012, Dr. Gryzlo had released Petitioner to work at a medium demand level restricted only to not lifting in excess of 50 pounds. (Appellate Court Order and Opinion, pgs. 27-28).

However, the Appellate Court stated that once Respondent received a copy of the FCE report, Dr. Gryzlo's January 17, 2013 progress note, and the report by its Section 12 examiner, Dr. Ram Aribindi, following his April 17, 2013 evaluation, Respondent was on notice that Petitioner could not perform the duties outlined in its modified job description. (Appellate Court Order and Opinion, pg. 28). Respondent had provided Petitioner with a description of the modified job offer on January 7, 2013. (PX5, Deposition Exhibit 4; PX11). The Appellate Court further did not find Respondent's vocational expert, Lawrence Kahan, credible noting that Mr. Kahan did not review Dr. Gryzlo's January 17, 2013 progress note and did not review the description for the modified job offer to Petitioner. The Appellate Court concluded, "There is no competent evidence in the record supporting the conclusion that a 'legitimate dispute' existed on the issue of whether the claimant rejected an offer of employment with duties within the restrictions imposed by Dr. Gryzlo." (Appellate Court Order and Opinion, pg. 28).

Notwithstanding, the Appellate Court remanded the matter to the Commission to address the issue of whether Respondent could have reasonably believed, based upon Dr. Aribindi's opinions, that Petitioner was not entitled to maintenance benefits, and whether penalties and attorney's fees could be denied on that basis. Dr. Aribindi had opined that Petitioner's restrictions were due to pain resulting from underlying chronic degenerative arthritic changes and not the December 16, 2011 work injury. (RX7, pgs. 15-17).

Section 19(k) of the Act provides:

> 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)*.

Section 19(l) states:

> 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)*.

According to Section 16,

> Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. *820 ILCS 305/16*.

Our Supreme Court, in *McMahan v. Indus. Comm'n*, clarified:

> The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment 'without good and just cause.' If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.
>
> In contrast to section 19(l), section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory. (Citation omitted). The statute is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.' Section 16, which uses identical language, was intended to apply in the same circumstances. 183 Ill. 2d 499, 515 (1998).

Here, Respondent relied in part on its Section 12 examiner, Dr. Aribindi, to deny compensation. In *Avon Products v. Indus. Comm'n*, our Supreme Court explained that "[w]hen the employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties are not ordinarily imposed. (Citation omitted). As long as the insurer 'had a

legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable.'" 82 Ill. 2d 297, 302 (1980). The employer bears the burden of proving the objective reasonableness of its belief. "The test for penalties is whether the employer's conduct and reliance on medical opinion to contest liability is reasonable under the circumstances presented." *Connell v. Indus. Comm'n*, 170 Ill. App. 3d 49, 56 (1988).

Respondent disputed the issue of causal connection at arbitration and during its Review before the Commission. A review of the medical evidence and testimony demonstrate that both Drs. Gryzlo and Aribindi agreed that Petitioner had pre-existing degenerative findings in his left knee. (PX5, pgs. 23-24; RX7, pgs. 15-16; 24). Petitioner's testimony that he had neither injured nor received treatment for his left knee nor had difficulty performing his job for Respondent prior to December 16, 2011 was unrebutted. (T.23). Dr. Aribindi agreed that Petitioner's work injury on December 16, 2011 was a causative factor in the onset of his left knee pain. (RX7, pg. 19). The testimony of both physicians supported causal connection for Petitioner's left knee condition by way of the chain of events in this claim. (PX5, pgs. 8-9; 23-25; RX7, pgs. 19; 21-22; 25-26). Dr. Gryzlo also testified at his deposition on June 20, 2013 that he believed the work accident accelerated or aggravated Petitioner's underlying condition in the knee. (PX5, pg. 25). Dr. Aribindi conceded at his deposition on June 21, 2013 that a traumatic injury could aggravate underlying arthritic changes in the knee. (RX7, pg. 23).

Even with Petitioner's pre-existing arthritis, the Commission finds no indication in the record until after the December 16, 2011 work accident that Petitioner required permanent restrictions; Dr. Aribindi acknowledged this. (RX7, pgs. 27-28). By 2013, both Dr. Gryzlo and Dr. Aribindi agreed that Petitioner was at maximum medical improvement (MMI). Although Dr. Aribindi did not offer an opinion with respect to the modified job offer, he agreed that Petitioner could not return to his regular duties as an ironworker. Dr. Aribindi agreed that work at a medium physical demand level was appropriate for Petitioner. (RX7, pgs. 17; 26-27).

Respondent's reliance on Dr. Aribindi's opinion that Petitioner's need for restrictions was related solely to arthritic pain and not the December 16, 2011 accident is not only unsupported by the record, but contradicted by Dr. Aribindi's overall deposition testimony. Respondent acknowledged as such in its Brief. The evidence supports that the December 16, 2011 was *a* cause in Petitioner's current condition of ill-being to the left knee and subsequent need for restrictions. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). Here, the Commission must underscore *Avon Products v. Indus. Comm'n*, which again provides that "[w]hen the employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties are not ordinarily imposed." 82 Ill. 2d 297, 302 (1980). Our Supreme Court stated that this rule was necessary to "protect the employer's right to appeal an award which he reasonably believes to be contrary to the manifest weight of the evidence; the right to a legitimate appeal would be substantially burdened were penalties to be imposed on all employers who appeal and lose." *O'Neal Bros. Constr. Co. v. Indus. Comm'n*, 93 Ill. 2d 30, 41 (1982). In this case, however, the Commission finds Respondent's reliance on Dr. Aribindi's opinions to deny payment of maintenance benefits unreasonable. The Commission finds no real controversy existed on the issue of causal connection following Dr. Aribindi's Section 12 examination on April 17, 2013. The Commission further finds no evidence of conflicting medical opinions based on Dr. Aribindi's overall testimony which ultimately coincided with Dr. Gryzlo's opinions on causation. The

Commission cannot assert that a reasonable person would conclude that Respondent had a legitimate doubt of its liability once it obtained Dr. Aribindi's opinions regarding causation and Petitioner's restrictions – especially when it was aware of the causal opinion already given by Respondent's first Section 12 examiner, Dr. Mark Levin.

Taking the foregoing into context with the overall record, the Commission finds compelling the consistent history of unreasonable and vexatious behavior in this claim. In other words, "[t]he employer's conduct was not the result of simple inadvertence or neglect. More was involved than a lack of good and just cause." *McMahan v. Indus. Comm'n*, 183 Ill. 2d 499, 515 (1998). The record demonstrates that the issue of accident was undisputed, and the lack of prior injuries, treatment, or work restrictions was unrebutted. Not only did Dr. Aribindi concede that Petitioner sustained a work-related injury to his left knee on December 16, 2011 and that a traumatic event could aggravate underlying arthritis, but so did Dr. Levin. (RX7, pg. 21; 23). Respondent sent Petitioner for a Section 12 examination on February 20, 2012 with Dr. Levin. (T.28; PX3). Dr. Levin recommended either an FCE to determine Petitioner's ability to work and perhaps some work conditioning, or proceed with a diagnostic arthroscopy "to determine if there is any true objective pathology giving him his marked subjective pain." (T.28; PX3). Respondent's carrier authorized the diagnostic arthroscopy which Petitioner underwent on June 22, 2012. As to causal connection, Dr. Levin's opinion was simply that Petitioner had no pain prior to December 16, 2011, and then had pain after his twisting injury. Dr. Levin authored an addendum report on March 1, 2012, wherein he clarified that the need for the diagnostic arthroscopy was because of Petitioner's continued subjective pain. He also stated that Petitioner reported that he was unable to do his job because of subjective pain, thus leading to the FCE recommendation. (PX3).

Petitioner completed the FCE on October 22, 2012, which validly indicated that Petitioner could function at the medium physical demand level. Petitioner's work as an ironworker for Respondent was classified in the very heavy physical demand level. (PX4; PX7; RX2). Respondent's own Exhibit Number 8, Deposition Exhibit Number 5, was a letter from Petitioner's union "stating that an ironworker has to be 100 percent capable of performing their job responsibilities." (T.34; RX8, Deposition Exhibit 5).

The Commission also notes the extensive correspondence between the parties with respect to the October 5, 2012 job offer and Petitioner's counsel's multiple requests (at least five) for a detailed job description of the alleged job offer. (PX10; RX8, Deposition Exhibits 1-2). Once received however, the job description did not mirror the requirements of work within the medium physical demand level – despite Respondent's protestations to the contrary. (PX5, Deposition Exhibit 4; PX11; RX8, Deposition Exhibit 4).

Thereafter, Petitioner enrolled in driving school on September 3, 2013 so he could obtain his CDL. (T.46; PX8). Petitioner testified that Respondent had made him an offer that if he enrolled in driving school, they would start paying him disability benefits. (T.46). Respondent commenced payment of maintenance benefits on September 5, 2013. (T.46; RX4). Respondent also paid the $1,650.00 tuition for Petitioner to attend the driving school. (PX8). As part of the CDL training, Petitioner was required to undergo a physical; he went to Concentra for his physical on September 17, 2013. (T.50). Dr. Simon, of Concentra did not clear Petitioner to drive at that time, but instead ordered an SPE. (T.50-51). Petitioner stated that an SPE "is when you're actually physically tested

to see if you can perform the job duties of a truck driver safely." (T.51). Petitioner could not perform the SPE without an actual tractor, trailer, or semi-trailer, and Respondent did not supply Petitioner with the required vehicle despite Petitioner's requests. (T.52-54; PX9, Deposition Exhibit 6). As a result, Petitioner was unable to complete the physical, which required the SPE, and Petitioner was unable to finish the CDL course. (T.54). Petitioner's maintenance benefits were terminated on June 3, 2014. (T.54). Petitioner testified that if he had taken the SPE, the next step would have been to complete the actual road test; for that test, the driving school would supply the vehicle. (T.55).

The Commission notes much confusion throughout the record regarding the CDL course, the need for the SPE, and who was responsible for obtaining the necessary truck. Correspondence between the parties indicated both agreement and disagreement on this issue. Respondent's counsel requested status of the CDL training on November 12, 2013. Petitioner's counsel requested authorization for Petitioner to return to Dr. Gryzlo to complete certain forms for the SPE on November 14, 2013. Petitioner's counsel again requested authorization for the SPE in June 2014 and August 2015. Petitioner's counsel then requested a truck as well as maintenance benefits in September 2014. (RX8, Deposition Exhibit 4). Respondent's Exhibit 9 are Respondent's responses to Petitioner's penalty petitions. In its response dated October 15, 2013, Respondent stated that penalties were not indicated because Petitioner refused to participate in training for a CDL license. (RX9).

The Arbitrator noted in her Decision that Petitioner did not receive a written explanation for why benefits owed from October 5, 2012 through September 4, 2013 were not paid. (T.46-47; Arbitrator's Decision, pg. 8). This violated Section 9110.70(b) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission which states:

> When an employer begins payment of temporary total compensation and later terminates or suspends further payment before an employee in fact has returned to work, the employer shall provide the employee with a written explanation of the basis for the termination or suspension of further payment no later than the date of the last payment of temporary total compensation.

Petitioner also testified that he did not undergo a vocational assessment before starting the CDL Mega Driving School Program and did not receive anything in writing from a vocational counselor stating that truck driving was suitable employment for Petitioner. (T.47; Arbitrator's Decision, pg. 8). Respondent eventually obtained a vocational report from Lawrence Kahan in July 2015. However, Petitioner testified that he never met with Mr. Kahan and was never asked to meet with him. (T.57-58; RX8, pg. 82). Mr. Kahan testified that he was hired by Respondent "to analyze Mr. Grzesik's report and also to complete a Labor Market Survey to the best of my ability based on the information provided." (RX8, pg. 82). He did not perform a vocational assessment and did not perform a transferable skills analysis. (RX8, pg. 82; 85). Mr. Kahan completed his report, titled Vocational Assessment Report, on July 12, 2015. (RX8, Deposition Exhibit 2). The report stated that Petitioner could work as a truck driver because it was within the medium physical demand level; however, Petitioner would have to obtain the necessary CDL licensure and pass the required physical. (RX8, Deposition Exhibit 2).

In light of the foregoing chronology of the record as it relates to the behavior between the parties, the Commission finds that the reasons for the delay in payment of benefits were unreasonable, frivolous, confounding, and vexatious. The Commission has further considered Respondent's various explanations for the delay or cessation of benefits as noted in the record. The Commission acknowledges that the Act and our Rules provide specific provisions with respect to one's duty of cooperation, albeit as it relates to employees, *e.g.*, Section 1(a)4: duty to cooperate in proceedings involving loaning/borrowing employers; Section 19(d): duty to cooperate to promote recovery or rehabilitation. The Commission also acknowledges that discovery rules do not apply in workers' compensation cases. Additionally, our case law generally instructs that,

> It is impractical to set a definite time limitation for payment. As was said in the earlier *Board of Education* case: '* * * where all legal proceedings have been exhausted and a considerable time has been permitted to elapse thereafter during which the award is not paid, it is incumbent upon the one liable to pay the same to excuse the delay.' *Bd. of Educ. v. Indus. Comm'n*, 39 Ill. 2d 167, 171 (1968) (emphasis in original); see also *Bd. of Educ. v. Indus. Comm'n*, 351 Ill. 128, 132 (1932).

Some examples for when the delay in payment may be excused include *Avon Products v. Indus. Comm'n*, 82 Ill. 2d 297 (1980) (no penalties and fees because reasonable grounds for challenging liability existed); *Chicago v. Indus. Comm'n*, 63 Ill. 2d 99 (1976) (no unreasonable or vexatious delay evidenced by discussions between counsel on the issue of credit for a prior award); *Sanchez v. Indus. Comm'n*, 53 Ill. 2d 514 (1973) (seven-week delay by the employer in tendering payment of the award was neither unreasonable or vexatious as there was evidence of negotiations between counsel in an effort to arrive at a lump-sum settlement).

Here, there was no justifiable excuse for the delay in payment of benefits to Petitioner. There was little room for doubt with respect to Respondent's liability for temporary payments to Petitioner given the chain of events in this claim, the medical testimony, the valid FCE, the fact that there was no legitimate dispute that Petitioner could not return to work as an ironworker or as to whether he had rejected the modified job offer. Based on the evidence in its entirety, the Commission finds that Petitioner is entitled to an award of penalties and attorney's fees.

The Commission calculates penalties and attorney's fees as follows:

1) TTD benefits: $1,140.00 x 58.57 (58 4/7) weeks = $66,769.80 [12/19/2011-1/31/2013]
2) Maintenance benefits: $1,140.00 x 125.71 (125 5/7) weeks = $143,309.40 [2/1/2013-6/30/2015]
3) Payment to Mr. Grzesik, Petitioner's vocational counselor: $2,000.00

Total award: $212,079.20
Less credit to Respondent: -$93,000.00
TOTAL: $119,079.20

4) Section 19(k) penalties: $119,079.20 / 2 = $59,539.60
5) Section 16 attorney's fees: $119,079.20 x 20% = $23,815.84
6) Section 19(l) penalties: $10,000.00

The Commission finds that this calculation not only comports with the Appellate Court's mandate in the case at bar with respect to the TTD and maintenance period, but it further aligns with our Appellate Court's instructions in *Moore v. Indus. Comm'n*, 188 Ill. App. 3d 31, 36 (1989). The Court in *Moore* determined that the phrase "amount payable," as referred to in Section 19(k) of the Act, means that the penalty is to be 50% of the entire amount of the type of benefit originally awarded and not only on the amount remaining unpaid at the time the penalty is awarded. "This interpretation best implements the legislative intent to expedite payment to the injured worker and to penalize the employer for the unreasonable withholding of benefits duly owed to a claimant." *Id;* see also *Roodhouse Envelope Co. v. Indus. Comm'n*, 276 Ill. App. 3d 576, 580-81 (1995).

The Commission further finds that the "amount payable at the time of such award" also should reflect credits for stipulated payments as referenced in the Arbitrator's Decision. The issue of credits was decided by the Appellate Court in *Roodhouse Envelope Co. v. Indus. Comm'n*, 276 Ill. App. 3d 576, 580-84 (1995); see also *Scott v. Indus. Comm'n*, 184. Ill. 2d 202, 220 (1998) (employer payments made prior to a finding of unreasonable or vexatious delay are excluded from calculating section 19(k) additional compensation and section 16 attorney fees).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed September 12, 2017, 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 $1,140.00 per week for a period of 58 4/7 weeks, from December 19, 2011 through January 31, 2013, 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 receive a credit of $93,000.00 for TTD benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $1,140.00 per week for a period of 125 5/7 weeks, from February 1, 2013 through June 30, 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 $695.78 per week for a period of 200 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 40% loss of the person as a whole. The Arbitrator's award of 40% loss of use of the left leg and 25% loss of the person as a whole is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the $2,000.00 bill for services rendered by vocational rehabilitation counselor Thomas Grzesik.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties pursuant to Section 19(k) of the Act equal to 50% of the amount payable at the time of such award, or $59,539.60.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner attorney's fees pursuant to Section 16 of the Act, and as detailed in this Decision, in the amount of $23,815.84.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties pursuant to Section 19(l) of the Act in the amount of $10,000.00.

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

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

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

July 21, 2021

CAH/pm

D: 6/17/2021
052

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

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

/s/ *Marc Parker*
Marc Parker

CLERK'S OFFICE
APPELLATE COURT FIRST DISTRICT
STATE OF ILLINOIS
160 NORTH LASALLE STREET, RM S1400
CHICAGO, ILLINOIS 60601

December 14, 2020

Honorable Iris Y. Martinez
Richard J. Daley Center
Room 1001
Chicago, IL 60602

RE: CRAIG MARKIEWICZ v. IWCC
General No.: 1-19-2428WC
County: Cook County
Trial Court No: 18L50550

Dear Honorable Martinez:

Attached is the Mandate of the Appellate Court in the above entitled cause.

We are sending the attorneys of record a copy of this letter to inform them that the mandate of the Appellate Court has been filed with you.

Thomas D. Palella
Clerk of the Appellate Court

c: John M. Popelka
Keefe, Campbell, Biery & Associates

12WC13692

No. 1-19-2428WC

2020 IL App (1st) 192428WC-U

Workers' Compensation
Commission Division
Order Filed: October 23, 2020

No. 1-19-2428WC

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

CRAIG MARKIEWICZ, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.*, (McHugh Construction, Appellee).	)	Appeal from the Circuit Court of Cook County Nos. 18 L 050550 Honorable Daniel P. Duffy, Judge, Presiding.

JUSTICE HOFFMAN delivered the judgment of the court.
Presiding Justice Holdridge and Justices Hudson, Cavanagh, and Barberis concurred in the judgment.

ORDER

¶ 1 *Held:* We: 1) reversed that portion of the circuit court's judgment that confirmed the portions of the Commission's decision vacating the maintenance benefits awarded to the claimant, reducing the claimant's TTD benefits from 59 3/7 weeks of benefits to 56 4/7 weeks of benefits, and vacating the order upon McHugh to pay Grzesik

> $2,000; 2) vacated that portion of the circuit court's judgment that confirmed the Commission's denial of penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act; 3) affirmed the circuit court's judgment in all other respects; 4) reversed those portions of the Commission's decision vacating the maintenance benefits awarded to the claimant, reducing the claimant's TTD benefits from 59 3/7 weeks of benefits to 56 4/7 weeks of benefits, and vacating the order upon McHugh to pay Grzesik $2,000; 5) vacated that portion of the Commission's decision denying the claimant penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act; and 6) remanded this cause to the Commission with directions to: a) award the claimant 59 3/7 weeks TTD benefits for the period of December 19, 2011, through January 31, 2013; b) award the claimant 125 4/7 weeks of maintenance benefits for the period from February 1, 2013, through June 30, 2015; c) order McHugh to pay $2,000 to Thomas Grzesik; and d) conduct a hearing, consistent with the opinions expressed herein, to determine whether the claimant is entitled to penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act.

¶ 2 The claimant, Craig Markiewicz, appeals from an order of the circuit court, confirming a decision of the Illinois Workers' Compensation Commission (Commission) which modified the decision of an arbitrator that awarded him certain benefits under the the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2010)) for injuries to his left knee which he sustained on December 16, 2011, while wording for McHugh Construction Company (McHugh). For the reasons which follow, we: affirm the circuit court's order in part; reverse the circuit court's order in part; vacate the circuit court's order in part; reverse the Commission's decision in part; vacate the Commission's decision in part; and remand this matter to the Commission with directions.

¶ 3 The following recitation of the facts relevant to a disposition of this appeal is taken from the evidence adduced at the arbitration hearing held on January 19, 2016.

¶ 4 The claimant was a journeyman ironworker who had been employed by McHugh off and on for approximately 10 years. On December 16, 2011, the claimant was working for McHugh as a rodbuster on a reconstruction project on lower Wacker Drive in Chicago. His duties included installing rebar, wire mesh, and post tension cables. As he was walking to his work position on a

freshly installed slab covered completely with concrete, the claimant stepped onto an unmarked area for a manhole cover, causing him to step into a hole and twist his left knee. The claimant testified that he experienced immediate pain but, nevertheless, finished working that day. The accident took place on a Friday.

¶ 5 On the following Monday, December 19, 2011, the claimant reported to work and told his supervisor that his knee was not better and that he needed medical care. McHugh sent the claimant to the Northwestern Corporate Health facility where he was seen by Dr. Milton. The claimant was given crutches and a knee immobilizer, released to light duty work, and told to undergo an MRI. The claimant testified that Dr. Milton referred him to Dr. Stephen Gryzlo.

¶ 6 The claimant had the recommended MRI at Advantage MRI on December 23, 2011. Rather than see Dr. Gryzlo, the claimant had a follow-up appointment with Dr. Eugene Lopez on December 27, 2011. On that date, Dr. Lopez diagnosed the claimant as suffering from a meniscal tear. He prescribed physical therapy and authorized the claimant to remain off of work.

¶ 7 The claimant began physical therapy at ATI on December 29, 2011. On January 13, 2012, the claimant returned to see Dr. Lopez, who reviewed the MRI of the claimant's left knee, administered a steroid injection, and authorized the claimant to remain off of work. According to the claimant, he received no relief from the injection.

¶ 8 The claimant next saw Dr. Lopez on February 9, 2012. Dr. Lopez administered the first of a series of five Supartz injections into the claimant's left knee. The claimant testified that his symptoms did not improve with the injections, the last of which was administered on April 11, 2012.

¶ 9 At the request of McHugh, the claimant was evaluated by Dr. Mark Levin on February 20,

2012. According to the claimant, Dr. Lavin recommended that he undergo an exploratory arthroscopy of his left knee. He testified that Dr. Levin stated that his condition was causally related to his accident and he required surgery. The claimant stated that Dr. Lopez was not in agreement with Dr. Levin's recommendation for surgery.

¶ 10 The claimant continued in physical therapy until April 27, 2012. Desirous of a second opinion, the claimant presented to Dr. Gryzlo on May 3, 2012. The claimant testified that Dr. Gryzlo examined him, took x-rays, recommended a repeat MRI followed by surgery, and authorized him to remain off of work. Dr. Gryzlo testified that he recommended surgery as all conservative treatment had failed.

¶ 11 On June 22, 2012, Dr. Gryzlo operated on the claimant's left knee at Northwestern Memorial Hospital. The operation consisted of a partial medial meniscectomy, debridement of the patella femoral chondromalacia, and debridement of an ACL ganglion cyst. Dr. Gryzlo testified that he removed the meniscus because it could not be repaired. He opined that the meniscal tear in the claimant's left knee was caused by his work accident and that both the surgery and the claimant's post-operative care are causally related to that accident.

¶ 12 The claimant continued to treat with Dr. Gryzlo post-operatively. He also underwent physical therapy at ATI from July 3, 2012, through August 28, 2012, followed by work hardening beginning on September 4, 2012. On September 27, 2012, Dr. Gryzlo released the claimant to return to work at a medium demand physical level, with no lifting over 50 pounds, and he recommended that the claimant undergo vocational retraining.

¶ 13 According to the claimant, McHugh ceased paying TTD benefits on October 4, 2012.

¶ 14 The claimant testified that, on October 5, 2012, he received an offer from McHugh of light

duty work. The offer came in the form of an attachment to an e-mail to his attorney. In relevant part, the written job offer states:

> "After reviewing information provided to us dated September 27, 2012 by examining doctor, Dr. Gryzlo, this will confirm we are offering the following medically modified work assignment.
>
> Your most recent work restrictions provided to us indicate that Dr. Gryzlo states that you are able to lift up to 50 pounds, within a medium level work duty. This assignment is within medically modified abilities described as safe for you to perform by the examining doctor. The duration of these modifications and this work offer will follow future changes to medical modifications.
>
> You will only be assigned to tasks consistent with this Dr. Gryzlo's work restriction recommendations. If you feel you have been given tasks to perform in excess of the medical modifications, this will confirm you are not to attempt or perform such tasks but call or see the undersigned at your earliest opportunity.
>
> ***
>
> Job Title: Ironworker
> Description of physical requirements for this medically modified position:
> Within the restrictions described above."

On October 12, 2012, claimant's attorney forwarded a letter to McHugh's workers' compensation insurance carrier in which he advised the carrier that the claimant was attending work hardening five days each week from 7:30 a.m. until 12:30 p.m. and that McHugh's offer of employment overlaps those hours. The letter goes on to state that the claimant will not return to work until he is in receipt of a job description of the work he will be doing and that, in the absence of a detailed job description, the claimant would be unable to respond to the job offer.

¶ 15 On October 22, 2012, the claimant had a functional capacity evaluation (FCE) at ATI. The report of that evaluation placed the claimant at a medium physical demand level with no standing more than four hours per day for a one-hour duration only, no walking more than four to five hours, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. The claimant testified that he gave full effort during the evaluation.

¶ 16 On January 7, 2013, McHugh's attorney forwarded a modified job description to the claimant's counsel. The document states that the job title was "IRONWORKER – (rodbuster)," with a general job description of: rigs, unloads, carries, drays, and ties reinforcing steel for concrete placement; directs operators and operates forklifts, man lifts and scissors lifts; and generally perform duties as required to satisfy the overall purpose of the job. The physical requirements set forth in the document included ability to: lift up to 50 pounds; bend over as much as four to six hours in an eight hour work day to move rebar, place rebar, and tie rebar in place with tie wire; install rebar for three to four hours in an eight hour work day; and building rebar cages.

¶ 17 The claimant testified that he took the job description to Dr. Gryzlo on January 17, 2013. According to the claimant, Dr. Gryzlo reviewed the job description and stated that he was unable to perform the modified duties. In a progress note dated that same day, Dr. Gryzlo wrote that the claimant was eight months post left knee surgery, had not progressed, and will not progress. Dr. Gryzlo found the claimant to be at maximum medical improvement (MMI) and that he will always fall into the medium physical demand level. In the progress note, Dr Gryzlo went on to state:

> "A report on a modified job description for an iron worker was given to me, which suggests climbing ladders, scaffold, carrying heavy items and climbing up a wall in rebar, to place rebar. The modified duties make it somewhat possible for an injured worker to

> get back, but his medium level duty, with pain when he bends and kneels and squats and works on beam and uneven surfaces, would be, again, jeopardized with this modified iron worker position. I therefore don't think that he can do the modified job description as described by me and brought to my viewing. I think that he can find vocational retraining, but returning to an iron worker, even on a modified level, would not be possible with his restrictions with regards to his left knee."

On January 24, 2013, a copy of Dr. Gryzlo's note was sent by the claimant's attorney to McHugh's counsel via facsimile. In that transmission, the claimant's attorney demanded that vocational rehabilitation be provided and that the claimant be brought current on maintenance benefits. The claimant testified that he rejected McHugh's modified job offer. He admitted, however, that he never attempted to perform the duties of the job that he was offered.

¶ 18 According to the claimant, he began a self-directed job search on February 1, 2013. At the arbitration hearing, the claimant identified his job logs, representing his job search efforts through the date of the arbitration hearing. The claimant stated that he had not received any offers of employment as a result of his job search.

¶ 19 On April 17, 2013, the claimant was examined by Dr. Ram Aribindi at the request of McHugh. Dr. Aribindi diagnosed the claimant as suffering from left knee anterior pain attributable to underlying degenerative arthritic changes. Dr. Aribindi testified that the claimant was restricted from climbing ladders, kneeling or squatting, and that the claimant fell into the medium physical demand level as outlined in his FCE. In the report of his examination, Dr. Aribindi opined that the claimant's restrictions were due to a longstanding arthritic condition, which predated his work accident. He did admit that the claimant's work accident was a causative factor in the onset of left

knee pain, and that the work accident could have aggravated the claimant's underlying arthritic condition. Dr. Aribindi testified that the claimant had reached MMI, that he could not perform his regular job duties, and that the claimant would not be able to squat or go up and down stairs. He attributed the claimant's physical limitations to "his underlying arthritis." According to Dr. Aribindi, all of the claimant's medical care was reasonable and necessary.

¶ 20 On June 20, 2013, the claimant next saw Dr. Gryzlo for a post-operative follow-up visit. Dr. Gryzlo testified that the claimant's medium physical demand work level restriction is permanent, and he again opined that the claimant could not return to work as an iron worker but could work at a medium physical demand level or less. He stated that he could not release the claimant to return to ironwork based upon what the claimant could only do occasionally.

¶ 21 On September 5, 2013, the claimant enrolled at the CDL Mega Driving School (MEGA) in an effort to obtain a Class A truck driving license. The claimant testified that he was offered the training by McHugh and that McHugh paid the fees for a commercial driving license (CDL) permit. According to the claimant, he did not undergo a vocational assessment before starting the CDL program, nor did he receive any opinion from a vocational counselor stating that truck driving was suitable employment for him. The program consisted of 40 hours of classroom instruction and behind the wheel training. The claimant was also required to have a physical examination to determine his ability to drive. On September 17, 2013, the claimant underwent a physical examination by Dr. Simon who did not clear him to drive but, instead, ordered that he undergo an SPE before he was cleared to drive. According to the claimant, the SPE is a test to determine if he could physically drive a truck safely. The test required him to climb into the cab of a truck, climb up into the engine compartment, climb on the truck to connect air lines, crawl under the truck to

check the brakes, squat to check tire pressure, and climb onto a trailer to secure a load with straps. He stated that successful completion of the SPE was necessary to complete the qualification for a DOT physical. The SPE test required the use of a semi-trailer Class A truck, which MEGA did not provide. Through his attorney, the claimant requested both authorization for the SPE test and that McHugh provide a truck to complete the test. Those requests were made on six occasions, but McHugh never authorized the test, nor did it provide the required truck. The claimant testified that, because he was unable to take the SPE test, he did not complete the CDL course. He stated that McHugh paid maintenance benefits beginning on September 5, 2013, the day that he began the CDL course, but terminated maintenance on June 3, 2014, when he failed to complete the course.

¶ 22 At the request of his attorney, the claimant underwent a vocational assessment conducted by Thomas Grzesik, a certified rehabilitation counselor. Grzesik interviewed the claimant on October 30, 2014. In his report of that assessment dated January 19, 2015, Grzesik enumerated the documents that he reviewed and set forth the claimant's biographical data, which included the fact that, in 1994, the claimant earned a B.S. degree in Health Science – Occupational Safety from Illinois State University. He also set forth other information relating to the claimant's medical treatment, his current activities, social activities, hobbies, work history, and physical capabilities. The report sets forth the vocational tests that Grzesik administered and the claimant's results. In that report, Grzesik opined as follows: the claimant is unable to perform the duties of a journeyman ironworker; his B.S. degree in Health Science "has very little to no efficacy with respect to employment;" commercial truck driving is not suitable employment for the claimant; the claimant's self-directed job search was diligent but unsuccessful; the claimant meets the criteria for vocational rehabilitation; and that, based upon his vocational profile, the claimant is currently

limited to entry level unskilled or semi-skilled occupations. Grzesik then listed 15 examples of entry level unskilled or semi-skilled occupations; he testified that the claimant considered some of those jobs. When deposed, Grzesik testified that the claimant met the need for vocational rehabilitation and again opined that the claimant performed a diligent, but unsuccessful, job search. He admitted, however, that, when the claimant began his job search, he was looking at the high end, "not so much looking for a job but contacting employers that were advertising jobs that were outside his area." He stated that the claimant eventually pared back his search to positions "that were more specific to what he could do now without having to go through perhaps more screening to see if maybe he could be used, but openings that were there that he could perform now." According to Grzesik, the claimant "was diligent, he went and he looked." He testified that, if the claimant had professional assistance with his job search, "it's more likely than not he would become employed." Grzesik did not believe that the claimant was at a full medium physical demand level due to his restriction. He again stated his opinions that: the claimant is not able to return to work as an ironworker; he is not able to work as a commercial truck driver; the claimant meets the criteria for vocational rehabilitation; and the claimant's self-directed job search was diligent but unsuccessful.

¶ 23 Lawrence Kahan, a vocational rehabilitation counselor, testified that, at the request of McHugh, he prepared a report relating to the claimant dated July 13, 2015. In that report, Kahan wrote that the claimant "was offered a medically appropriate modified duty position within his physical demand capacity by McHugh Construction." According to Kahan, a truck driving position is within the claimant's medium physical demand level. The report states that the claimant is "capable of working in this capacity based on an assessment of his vocational profile and physical

capacity to perform the work". Kahan noted, however, that the claimant would be required to obtain the necessary CDL license and pass the required physical. He noted that there are 464,700 projected job openings for truck drivers for the period of 2012 through 2022, and listed 10 company contacts. When deposed, Kahan admitted that he did not evaluate the claimant face to face. He testified that he performed a labor market survey for a Class A truck driving job and that the survey was based entirely on CDL Class A truck driving jobs. According to Kahan, if the claimant failed to pass a SPE test, he would not qualify for the jobs listed in the labor market survey. Kahn stated that a truck driving job would require the claimant to: load and unload the truck; squat to inspect the tires and check tire pressure; inspect the lights, brakes, gas, oil and water; change spark plugs; and put chains on the tires. Kahan admitted that he did not perform a transferred skills analysis or a vocational assessment. Kahan also admitted that he did not review the claimant's job logs and had no opinion as to whether the claimant's job search efforts were diligent. He was uncertain as to which of Dr. Gryzlo's records he reviewed, but he denied ever seeing Dr. Gryzlo's January 17, 2013, progress note that states the claimant could not perform the job offered by McHugh. Kahan admitted that he never reviewed the job description for the position offered to the claimant by McHugh. Nevertheless, he opined that the claimant could perform the modified job offered by McHugh. Kahan testified that he did not review Dr. Aribindi's deposition testimony. After viewing the ironworker work rules, Kahan acknowledged that ironworker contract rules require members to be capable of performing 100% of their job duties and that no light duty is available in ironwork. Kahan conceded that, under the ironworker contract rules, the job offered to the claimant would not be appropriate for, or available to, him.

¶ 24 At the arbitration hearing, the claimant testified that prior to his work accident of December

16, 2011, he had never before injured his left knee, received medical care for the knee, missed work due to his left knee, or had any difficulty performing his job as an ironworker as the result of his left knee. As to his current physical symptoms, the claimant stated that he experiences constant pain in his left knee, more so when he climbs stairs and when sitting in a chair. He stated that his daily activities are limited because his left knee gets sore and stiff and that his knee is stiff when bent. The claimant testified that he had no medical appointments scheduled, although he did plan to see his doctor in the future. When questioned about several videos that depicted him working out at a gym and getting in and out of his pick-up truck, the claimant stated that he works out at a gym regularly, three to four times each week, using elliptical machines and weight lifting exercises he learned in physical therapy and work conditioning. He stated that his ongoing physical conditioning was directed by his doctor. As for the video depicting him getting in and out of his pick-up truck, the claimant explained that the truck is equipped with running boards which aid him in getting in and out of the vehicle. The claimant also testified that his union prohibits light-duty work for a journeyman ironworker, but he did not know whether McHugh was authorized to offer him work in a non-union capacity.

¶ 25 Following the arbitration hearing held on January 19, 2016, pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2014)), the arbitrator issued a written decision on September 12, 2017, finding that the claimant sustained an injury to his left knee on December 16, 2011, that arose out of and in the course of his employment with McHugh. The arbitrator awarded the claimant: 59 3/7 weeks of temporary total disability (TTD) benefits for the period of December 19, 2011, through January 31, 2013; 125 4/7 weeks of maintenance benefits for the period from February 1, 2013, through June 30, 2015; 86 weeks of permanent partial disability (PPD) benefits

for a 40% loss of use of the left leg; and 125 weeks of PPD benefits for a 25% loss of trade due to permanent restrictions. McHugh was ordered to pay $2,000 to the claimant's vocational expert, Thomas Grzesik, and was given a credit of $93,000 for TTD benefits paid. The arbitrator found that the claimant was not totally and permanently disabled. In addition, the arbitrator denied the claimant's request for penalties pursuant to sections 19(k) and 19(*l*) of the Act (820 ILCS 305/19(k), 19(*l*) (West 2016)) and attorney fees pursuant to section 16 of the Act (820 ILCS 305/19(16) (West 2014)). In the request for hearing form, McHugh did not dispute either accident or notice.

¶ 26 Both the claimant and McHugh filed petitions for review of the arbitrator's decision before the Commission. On August 15, 2018, the Commission issued a unanimous decision in which it modified the arbitrator's decision. Finding that McHugh offered to accommodate the claimant and provide work within his physical demand level and that the claimant made no attempt to work in the accommodated position, the Commission: awarded the claimant 56 4/7 weeks of TTD benefits for the period of December 19, 2011, through January 17, 2013; vacated the arbitrator's award of maintenance benefits; and vacated the order requiring McHugh to pay $2,000 to the claimant's vocational expert, Thomas Grzesik. The Commission also vacated the award of 86 weeks PPD benefits for a 40% loss of use of the left leg and the award of 125 weeks of PPD benefits for a 25% loss of trade due to permanent restrictions, and instead awarded the claimant 200 weeks of PPD benefits for a 40% loss of the person as a whole. In all other respects, the Commission affirmed and adopted the decision of the arbitrator, including, but not limited to, the $93,000 credit granted to McHugh for TTD benefits paid and the denial of the claimant's request for penalties pursuant to sections 19(k) and 19(*l*) of the Act and attorney fees pursuant to section 16 of the Act. The

Commission did not remand the matter back to the arbitrator.

¶ 27 The claimant sought a judicial review of the Commission's decision in the circuit court of Cook County. On November 7, 2019, the circuit court confirmed the Commission's decision, and this appeal followed.

¶ 28 Again, we find it necessary to admonish a litigant for failure to comply with the requirements for briefs filed with this court. Illinois Supreme Court Rule 341(h)(7) (eff. Nov. 1, 2017) requires that the argument section of a brief contain citations to the pages in the record relied upon in support of factual contentions. The requirements set forth in Rule 341(h)(7) are applicable to appellees briefs. S. Ct. R. 341(i) (eff. May 25, 2018). In the 17-page argument section of the brief filed by McHugh, there are only 3 citations to the record and 2 citations to the arbitrator's decision supporting factual assertions. The result is that this court was required to search a 3000+ page record to determine the veracity of the factual statements made by McHugh that do not appear in the claimant's brief, which does contain record page citations. Supreme Court rules "are not suggestions;" rather, they are rules which have the force of law, and the presumption is that they will be followed as written. *Bright v. Dicke*, 166 Ill. 2d 204, 210 (1995). This court has the discretion to strike a brief for failure to comply with the rules of the supreme court. *Holzrichter v. Yorath*, 2013 IL App (1st) 110287, ¶ 77. We elect not to do so in this case and will address the issues raised on the merits.

¶ 29 We also wish to comment that, contrary to McHugh's assertion, our function is not to determine if the circuit court's decision is against the manifest weight of the evidence; rather, we review the Commission's decision to determine whether that decision is against the manifest weight of the evidence and, based on that review, either affirm or reverse the circuit court's

judgment. *Dodaro v. Illinois Workers' Compensation Comm'n*, 403 Ill. App. 3d 538, 543 (2010).

¶ 30 Before addressing the claims of error raised by the claimant in this appeal, we address the appropriate standard of review. The claimant argues that we should review the Commission's decision *de novo*. According to the claimant, the facts in this case are "essentially undisputed and the Commission's decision was based upon a misapplication of the law to those undisputed facts." McHugh argues that the appropriate standard of review is the manifest weight standard. It contends that numerous disputed issues of fact were resolved by the Commission that should be reviewed pursuant to a manifest-weight standard of review. We agree with McHugh; the appropriate standard of review in this case is manifest weight with the exception of the issues relating to the denial of penalties pursuant to section 19(k) of the Act and attorney fees pursuant to section 16 of the Act, to which we apply the abuse of discretion standard. See *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 516 (1998)).

¶ 31 Even in cases where the facts are undisputed, this court must apply the manifest-weight standard of review if more than one reasonable inference might be drawn from the facts. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 549 (1991). It is only in those cases where the undisputed facts are susceptible to a single inference that we conduct a *de novo* review. *Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279 (2011). When, as in this case, the issues presented are addressed to the Commission's factual determinations, we apply a manifest-weight standard of review. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44 (1987). Under that standard, we will not disturb the Commission's factual determinations unless an opposite conclusion is clearly apparent. *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 291 (1992). Whether this court might have reached the same

conclusion is not the test of whether the Commission's determination of a question of fact is supported by the manifest weight of the evidence. Rather, the appropriate test is whether there is sufficient evidence in the record to support the Commission's determination. *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450 (1982).

¶ 32 Turning now to the substantive issues raised in this appeal, we first address the claimant's argument that the Commission erred in failing to award him permanent total disability (PTD) benefits under the odd-lot theory. He asserts that the evidence of record established that he performed a diligent, but unsuccessful, job search, and McHugh failed to meet its burden of proving both that he is employable in a stable labor market and that such a market exists. McHugh argues that the claimant failed to prove that he conducted a diligent job search and that the evidence established that the claimant is employable in a stable labor market.

¶ 33 A claimant is entitled to PTD benefits pursuant to section 8(f) of the Act (820 ILCS 305/8(f) (West 2014)) if, as the result of his work injury, he can make no contribution to the work force sufficient to earn a wage. *Lenhart v. Illinois Workers' Compensation Comm'n*, 2015 IL App (3d) 130743WC, ¶ 32. Entitlement to PTD benefits does not require that a claimant be completely physically incapacitated. *Id.* When, as in this case, the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden rests with the claimant to establish that he will not be regularly employed in a well-known branch of the labor market. However, once the employee has initially established that he falls in what has been termed the "odd-lot" category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market), the burden shifts to the employer to prove that the claimant is

employable in a stable labor market and that such a market exists. *Valley Mold & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981); *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). A claimant can satisfy his burden of proving that he falls within the odd-lot category by showing either that he has made diligent but unsuccessful attempts to find work or that, because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel*, 372 Ill. App. 3d at 544. A claimant is not entitled to PTD benefits if he is capable of obtaining gainful employment without seriously injuring his health. *Lenhart,* 2015 IL App (3d) 130743WC, ¶ 32.

¶ 34 The claimant asserts that "[t]he Commission never considered [him] *** for permanent total disability because it held that he refused [McHugh's] *** 'modified job' offer to his detriment." The Commission's decision reflects that, other than observing that the arbitrator found that the claimant was not permanently and totally disabled under an odd-lot theory, the Commission never addressed the claimant's request for an award of PTD benefits. Rather, the determination of the issue is contained within a portion of the arbitrator's decision that the Commission affirmed and adopted. The arbitrator's decision reflects that the claimant's failure to accept McHugh's job offer never entered into the analysis of his entitlement to PTD benefits. The arbitrator found that the claimant had not conducted a diligent job search and was capable of gainful employment. In her decision, the arbitrator noted that, although Grzesik opined that the claimant's job search was diligent, he admitted that, when the claimant began his job search, he was looking at the high end, "not so much looking for a job but contacting employers that were advertising jobs that were outside his area." According to Grzesik, if the claimant had professional assistance with his job search, "it's more likely than not he would become employed." The

arbitrator also noted that the claimant has a B.S. degree from Illinois State University, he is articulate and organized, and he does not suffer from a language barrier. She concluded that all of the evidence supports the fact that the claimant is capable of working at a medium physical demand level. Based upon these facts, and not the claimant's refusal to accept McHugh's job offer, the arbitrator determined that the claimant did not fall into the odd-lot category for PTD. The Commission affirmed and adopted that finding. We also note that, in his report, Grzesik found that, based upon the claimant's vocational profile, he is limited to entry level or unskilled jobs. Grzesik then listed 15 examples of such jobs.

¶ 35 Whether a claimant is permanently and totally disabled is a question of fact to be resolved by the Commission, and its determination will not be disturbed on review unless it is against the manifest weight of the evidence. *Lenhart*, 2015 IL App (3d) 130743WC, ¶ 31. Based upon the record before us, we are unable to conclude that an opposite conclusion from the Commission's finding that the Claimant did not fall into the odd-lot category is readily apparent. Consequently, the Commission's determination that the claimant is not entitled to PTD benefits is not against the manifest weight of the evidence.

¶ 36 Next, the claimant argues that the Commission erred in refusing to award him maintenance benefits. He asserts both that his vocational expert, Grzesik, and McHugh's vocational expert, Kahan, opined that his self-directed job search satisfied the criteria for vocational rehabilitation, and that the search entitled him to maintenance benefits. McHugh argues that, due to his refusal to accept its job offer, the claimant was not entitled to maintenance benefits.

¶ 37 Section 8(a) of the Act (820 ILCS 305/8(a) (West 2014)) authorizes awards for vocational rehabilitation. The section provides that the employer shall pay for "vocational rehabilitation of

the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a) (West 2014); *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1075 (2004). If the claimant is not engaged in some type of physical rehabilitation program, formal job training or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Industrial Comm'n*, 358 Ill. App. 3d 1002, 1019 (2005). Whether a claimant is entitled to maintenance benefits is a question of fact to be resolved by the Commission, and its determination of the issue will not be disturbed on review unless it is against the manifest weight of the evidence. *W.B. Olson, Inc. v. Illinois Worker's Compensation Comm'n*, 2012 IL App (1st) 113129WC, ¶¶ 31, 39.

¶ 38 The arbitrator awarded the claimant 125 4/7 weeks of maintenance benefits for the period from February 1, 2013, through June 30, 2015, the period during which he was conducting a self-directed job search. She found that the claimant proved his entitlement to maintenance benefits and that McHugh's modified job offer "was not suitable or appropriate." The Commission disagreed and vacated the award of maintenance benefits, finding that the claimant refused McHugh's offer of accommodated work. The Commission noted that McHugh's job offer states that "you [the claimant] will only be assigned tasks consistent with Dr. Gryzlo's work restrictions. If you feel you have been given tasks to perform in excess of the medical modifications, this will confirm you are not to attempt or perform such tasks." The Commission's decision states that it "not only gives weight to *** [McHugh's] offer of employment" it found that the claimant "was, at a minimum, obligated to prove that *** [McHugh's] offer of employment was not genuine."

¶ 39 The claimant argues that McHugh's job offer of October 5, 2012, and the modified job description received by his attorney on January 7, 2013, exceeded his physical restrictions. He asserts that he was not obliged to accept a job that he could not safely perform and that exceeded

his physical restrictions. The claimant takes issue with the Commission's determination that McHugh's job offer comported with his physical restrictions, merely because the offer states that "you will only be assigned tasks consistent with Dr. Gryzlo's work restrictions." He also takes issue with the Commission's assertion that "he ran to Dr. Grzylo and obtained a letter that indicated that *** [he] was unable to perform the tasks as outlined [in McHugh's job offer] *** in an obvious effort to avoid a return to accommodated work."

¶ 40 Benefits may be denied to a claimant who refuses to work within his physical restrictions. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132, 147 (2010); *City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (1996). Whether a claimant has refused work within his physical restrictions is a question of fact to be resolved by the Commission, and its determination will not be disturbed on review unless it is against the manifest weight of the evidence. *Otto Baum Company, Inc. v. Illinois Worker's Compensation Comm'n*, 2011 IL App (4th) 100959WC, ¶ 13. However, we will not hesitate to overturn a factual determination made by the Commission when the clearly evident, plain, and indisputable weight of the evidence compels an opposite conclusion. *Dye v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110907WC, ¶ 10.

¶ 41 McHugh's job offer of October 5, 2012, states, in relevant parts, that: the claimant was offered the position of "Ironworker;" "[t]he assignment is within medically modified abilities described as safe for you to perform by the examining doctor;" "[t]he duration of these modifications and this work offer will follow future changes to medical modifications;" "[y]ou will only be assigned tasks consistent with Dr. Gryzlo's work restrictions; " and "[i]f you feel that you have been given tasks to perform in excess of the medical modifications, you are not to attempt

or perform such tasks." Nowhere in the document does it describe the tasks that the claimant was expected to perform, prompting the claimant's attorney to advise McHugh's workers' compensation insurance carrier by e-mail, on October 10, 2012, that the claimant "will not return to work until we have a detailed job description of what he will be doing." In that same e-mail, the claimant's attorney stated that the claimant "is more than willing to return to work within his restrictions, but is entitled to confirm, through his physician, that the work available is within his restrictions and it is safe for him to return to work." The modified job description that the claimant's counsel received on January 7, 2013, has a job title of "IRONWORKER – (Rodbuster)" with a general job description of a general job of: rigs, unloads, carries, drays, and ties reinforcing steel for concrete placement; directs operators and operates forklifts, man lifts and scissors lifts; and generally perform duties as required to satisfy the overall purpose of the job. The document also includes "Physical Requirements," which include: "[g]ood arm, hand, leg, foot coordination for climbing ladders and scaffolding and walking carrying materials plus climbing up wall rebar to place rebar;" "[m]ust be able to bend over to move rebar, place rebar on centers and tie in-place with tie wire;" and "[m]ust be able to bend over as much as 4-6 hours out of an 8 hour work day." The document also states that the job includes installing rebar "in walls in place" during which a safety belt is secured to the in-place rebar and the worker then lays back on the safety belt with his feet and legs supported on the lower rebar like the rungs of a ladder and that three to four hours out of an eight hour work day could be spent on this type of work.

¶ 42 It is undisputed that the claimant can only work at a medium physical demand level as determined by the claimant's FCE, Dr. Gryzlo, Dr. Aribindi, and Grzesik. According to Grzesik's report, ironwork is "HEAVY in physical demand." He opined that the claimant is unable to

perform the duties of a journeyman ironworker. Dr. Aribindi, McHugh's examining physician, testified that the claimant is restricted from climbing ladders, going up and down stairs, kneeling, or squatting. Dr. Aribindi did not render an opinion as to whether the claimant was physically capable of performing the tasks outlined in McHugh's modified job description. According to Dr. Gryzlo's progress note of January 17, 2013, he was given a copy of the modified job description, which he found "suggests climbing ladders, scaffold, carrying heavy items and climbing up a wall in rebar to place rebar." The note states that the pain the claimant experiences when bending, kneeling, and squatting would be "jeopardized with this modified iron worker position." The note also states that Dr. Gryzlo did not think that the claimant "can do the modified job description." Dr. Gryzlo concluded by stating that the claimant returning to work as an ironworker, "even on a modified level, would not be possible with his restrictions with regards to his knee." The only evidence in the record that even remotely supports the conclusion that the claimant was capable of performing the tasks outlined in McHugh's modified job description is the report and testimony of Kahan, McHugh's vocational expert. Kahan opined that McHugh "offered [the claimant] a medically appropriate modified duty position within his physical demand capacity." The record reflects, however, that: Kahan never met the claimant; he denied ever seeing Dr. Gryzlo's progress note of January 17, 2020; he admitted that he never reviewed the job description for the position that McHugh offered to the claimant; and he admitted that he did not review Dr. Aribindi's deposition testimony. Kahan even conceded that, under the ironworker contract rules, the job offered to the claimant would not be appropriate for, or available to him.

¶ 43 Simply put, there is no competent evidence in the record before us that could even support an inference that the claimant was offered a position within his physical capabilities. The fact that

McHugh's offer of October 5, 2012, states that the claimant would only be assigned tasks consistent with Dr. Gryzlo's work restrictions and that, if he felt that he had been given tasks to perform in excess of the medical modifications, he was not to attempt or perform such tasks, does not change our conclusion in this regard. The general work duties and physical requirements described in McHugh's modified job description exceeded the claimant's physical capabilities and restrictions against climbing ladders and scaffolding, going up and down stairs, kneeling, squatting, carrying heavy items, and climbing up a wall in rebar to place rebar; and McHugh has pointed to nothing within the duties described that fell within the claimant's physical capabilities and restrictions. We conclude, therefore, that the Commission's determination that McHugh offered to accommodate the claimant and provide him with work falling within his physical capabilities and restrictions is against the manifest weight of the evidence.

¶ 44 A claimant's refusal to accept an offer of work that does not fall within his physical capabilities and restrictions is not a basis for denying benefits. It was the Commission's determination that the claimant had refused a job offer within his physical capabilities and restrictions that was its sole articulated rational for vacating the arbitrator's award of 125 4/7 weeks of maintenance benefits for the period from February 1, 2013, through June 30, 2015. Having found that the Commission's determination that McHugh offered to accommodate the claimant and provide him with work falling within his physical capabilities and restrictions is against the manifest weight of the evidence, it follows that we also find that the Commission's refusal to award the claimant maintenance benefits on that basis is against the manifest weight of the evidence.

¶ 45 For the same reason that it vacated the arbitrator's award of maintenance benefits to the claimant, the Commission also reduced the claimant's TTD benefits from the 59 3/7 weeks of

benefits awarded by the arbitrator to 56 4/7 weeks of benefits and vacated the arbitrator's order that McHugh pay $2,000 to Grzesik. Having found that the Commission's reason for denying the claimant maintenance benefits is against the manifest weight of the evidence, we also find that the Commission's reduction of the claimant's TTD benefits and its vacation of the arbitrator's order that McHugh pay $2,000 to Grzesik is against the manifest weight of the evidence.

¶ 46 Other than its contention that the claimant refused its job offer, McHugh has made no other argument in support of the Commission's denial of maintenance benefits, its reduction of the claimant's TTD benefits, or its vacation of the arbitrator's order that McHugh pay $2,000 to Grzesik. Failure to raise an argument in a litigant's brief results in a forfeiture of the issue for purposes of appeal. Ill. S. Ct. Rule 341(h)(7), (8) (eff. May 25, 2018).

¶ 47 Next, the claimant argues that the Commission erred in failing to award penalties pursuant to sections 19(k) and 19(*l*) of the Act and attorney fees pursuant to section 16 of the Act. He argues that McHugh acted unreasonably in failing to pay benefits based upon his refusal of its modified job offer, which the claimant describes as a "sham." He also argues that McHugh acted unreasonably in refusing to supply him with a truck to use while taking the SPE test, which resulted in his inability to complete the truck driving course at MEGA, and in relying upon Dr. Aribindi's opinion that his physical restrictions were the result of a pre-existing arthritic condition. McHugh argues that it acted in reasonable reliance upon both the claimant refusal of its job offer and Dr. Aribindi's opinion that the claimant's physical restrictions were the result of a pre-existing arthritic condition and not his work accident.

¶ 48 Again, the Commission did not directly address the issue of penalties and attorney fees other than to state that they were denied. It is the arbitrator's decision that sets forth the rational

behind the denial of the claimant' request for an award of penalties and attorney fees. Other than the modifications in the arbitrator's decision relating to TTD benefits, maintenance, PPD benefits, and Grzesik's bill, the Commission affirmed and adopted the arbitrator's decision. In denying an award of penalties and attorney fees, the arbitrator found that McHugh had a reasonable basis to deny TTD and maintenance benefits. According to the arbitrator, there existed a "legitimate dispute" as to whether the claimant rejected McHugh's offer of employment with duties within the restrictions imposed by Dr. Gryzlo. She also found that the claimant failed to show what efforts he made to secure the truck necessary for him to complete the SPE test necessary to obtain a CDL, and instead, he quit the MEGA program.

¶ 49 Section 19(k) penalties and section 16 attorney fees are intended to address situations where there is not only a delay in the payment of benefits, but the delay is deliberate or the result of bad faith or improper purpose. *McMahan*, 183 Ill. 2d at 514-15. Penalties and attorney fees are not warranted in circumstances where the employer could have reasonably believed that the claimant was not entitled to benefits. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 302 (1980); *Mobil Oil Corp. v. Industrial Comm'n*, 309 Ill. App. 3d 616, 626 (2000). However, the standard is one of objective reasonableness. *General Refractories v. Industrial Comm'n*, 255 Ill. App. 3d 925, 931 (1994). The question of whether an employer acted reasonably under the circumstances is one of fact to be resolved by the Commission. *Roodhouse Envelope Co. v. Industrial Comm'n*, 276 Ill. App. 3d 576, 579 (1995).

¶ 50 A review of the Commission's decision to deny penalties under section 19(k) of the Act and/or attorney fees under section 16 involves a two-part analysis. First, we must determine whether the Commission's factual finding in support of the denial are contrary to the manifest

weight of the evidence. Second, we must determine whether it would be an abuse of discretion to deny section 19(k) penalties and/or attorney fees under section 16. *McMahan*, 183 Ill. 2d at 516; *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 25.

¶ 51 The additional compensation authorized by section 19(*l*) is in the nature of a late fee. *McMahan*, 183 Ill. 2d at 515; *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 20. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment without good and just cause. *McMahan*, 183 Ill. 2d at 515. If the payment is late for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory. *Id.* Whether the employer had an adequate justification for the delay is a question of fact to be resolved by the Commission, and its determination will not be disturbed on appeal unless it is against the manifest weight of the evidence. *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 20.

¶ 52 As noted earlier, the basis for denying an award of penalties and attorney fees was the finding that a "legitimate dispute" existed on the issue of whether the claimant rejected an offer of employment with duties within the restrictions imposed by Dr. Gryzlo. In order to determine whether that factual finding is supported by the manifest weight of the evidence, it is necessary to examine the evolution of information concerning the claimant's physical capabilities and restrictions. On September 27, 2012, Dr. Gryzlo released the claimant to work at a medium demand level with the only restriction being no lifting in excess of 50 pounds. On October 5, 2012, McHugh conveyed its offer of employment which, as noted earlier, stated that the claimant would only be assigned tasks consistent with Dr. Gryzlo's work restrictions, and that, if he felt that he was given tasks to perform in excess of the medical modifications, he was not to attempt or perform such

tasks. That offer also states that McHugh had reviewed Dr. Gryzlo's September 27, 2012 "information." On October 22, 2012, the claimant had an FCE that determined he was capable of performing medium demand level work with no standing for more than four hours per day, no walking more than four to five hours per day, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. On January 7, 2013, McHugh's modified job description was received by the claimant's attorney, and the claimant took that document to Dr. Gryzlo on January 17, 2013. Dr. Gryzlo issued his progress note on that same day, concluding that the claimant could not "do the modified job description." A copy of that progress note was sent to McHugh's counsel on January 24, 2013. On April 17, 2013, McHugh had the claimant examined by Dr. Aribindi who issued a report in which he opined that the claimant's restrictions were due to an arthritic condition which predated his work accident. According to Dr. Aribindi's report, the pain that the claimant suffers is the result of underlying chronic degenerative-arthritic changes that are not the result of his work injury. Dr. Aribindi found that, although the claimant is not able to perform his regular duties at the very high physical demand level, he is capable of working at a medium demand level. He advised that the claimant should refrain from climbing ladders, kneeling, or squatting activities, and opined that the claimant was in need of no further medical or surgical intervention for the injury he suffered on December 16, 2011. Neither in his report, nor in his subsequent deposition, did Dr. Aribindi render an opinion as to the claimant's ability to perform the duties outlined in McHugh's modified job description.

¶ 53 Based upon the evidence in the record, we believe that the finding that a "legitimate dispute" existed on the issue of whether the claimant rejected an offer of employment with duties within the restrictions imposed by Dr. Gryzlo is against the manifest weight of the evidence.

McHugh may well have reasonably believed when it issued its initial job offer on October 5, 2012, which stated that the claimant would only be assigned tasks consistent with Dr. Gryzlo's restrictions, that it had in fact offered work within the claimant's physical capabilities because as of that date Dr. Gryzlo had released the claimant to work at a medium demand level restricted only to not lifting in excess of 50 pounds. However, once it was in possession of a copy of the report of claimant's October 27, 2012 FCE, a copy of Dr. Gryzlo's progress note of January 17, 2013, and Dr. Aribindi's report of his April 17, 2013 examination, McHugh was on notice that the claimant could not perform the duties outlined in its modified job description. According to the FCE report, the claimant was restricted from standing for more than four hours per day and walking more than four to five hours per day. The report states that he is allowed only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. Dr. Gryzlo's progress note states that the claimant could not climb ladders or scaffolds, carry heavy items, or climb up a wall in rebar. Dr. Aribindi advised that the claimant should refrain from climbing ladders, kneeling, or squatting. There is no evidence in the record that the claimant was physically capable of performing the duties outlined in the modified job description until Kahan issued his report on July 12, 2015, stating that McHugh had offered the claimant "a medically appropriate modified duty position within his physical demand capacity." However, the credibility of Kahan' s opinion in that regard must be measured against his deposition testimony in which he denied ever seeing Dr. Gryzlo's January 17, 2013 progress note and admitted that he had not reviewed McHugh's modified job description for the position offered to the claimant. There is no competent evidence in the record supporting the conclusion that a "legitimate dispute" existed on the issue of whether the claimant rejected an offer of employment with duties within the restrictions imposed by Dr. Gryzlo.

¶ 54 Although the basis stated in the arbitrator's decision for denying an award of penalties and attorney fees that the Commission adopted finds no support in the record, McHugh argues that, in failing to pay maintenance benefits, it also relied upon the opinion of Dr. Aribindi that the left-knee pain which the claimant suffers is the result of underlying chronic degenerative-arthritic changes and not the result of his work injury. Neither the arbitrator nor the Commission ever addressed the issue of whether McHugh could have reasonably believed, based upon Dr. Aribindi's opinion, that the claimant was not entitled to maintenance benefits. Penalties and attorney fees are not warranted in circumstances where an employer reasonably relied on a medical opinion as the basis for failing to pay benefits. *Avon Products, Inc.*, 82 Ill. 2d at 302; *Mobil Oil Corp*, 309 Ill. App. 3d at 626. The question of whether McHugh acted in reasonable reliance upon Dr. Aribindi's opinion in failing to pay the claimant maintenance benefits is one of fact to be resolved by the Commission. *Roodhouse Envelope Co.*, 276 Ill. App. 3d at 579. As the reasonableness of McHugh's reliance on Dr. Aribindi's opinion underlies the question of whether the claimant should be awarded penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16, we deem it appropriate to vacate the Commission's denial of penalties and attorney fees and remand the matter to the Commission to decide the issue.

¶ 55 Based upon the foregoing analysis, we: 1) reverse that portion of the circuit court's judgment that confirmed the portions of the Commission's decision vacating the maintenance benefits awarded to the claimant, reducing the claimant's TTD benefits from 59 3/7 weeks of benefits to 56 4/7 weeks of benefits, and vacating the order upon McHugh to pay Grzesik $2,000; 2) vacate that portion of the circuit court's judgment that confirmed the Commission's denial of penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act;

3) affirm the circuit court's judgment in all other respects; 4) reverse those portions of the Commission's decision vacating the maintenance benefits awarded to the claimant, reducing the claimant's TTD benefits from 59 3/7 weeks of benefits to 56 4/7 weeks of benefits, and vacating the order upon McHugh to pay Grzesik $2,000; 5) vacate that portion of the Commission's decision denying the claimant penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act; and 6) remand this cause to the Commission with directions to: a) award the claimant 59 3/7 weeks TTD benefits for the period of December 19, 2011, through January 31, 2013; b) award the claimant 125 4/7 weeks of maintenance benefits for the period from February 1, 2013, through June 30, 2015; c) order McHugh to pay $2,000 to Thomas Grzesik; and d) conduct a hearing, consistent with the opinions expressed herein, to determine whether the claimant is entitled to penalties under sections 19(k) and 19(*l*) of the Act and attorney fees under section 16 of the Act.

¶ 56 Circuit court judgment affirmed in part, vacated in part and reversed in part.

Commission decision reversed in part and vacated in part.

Cause remanded to the Commission with directions.

CLERK'S OFFICE
APPELLATE COURT FIRST DISTRICT
STATE OF ILLINOIS
160 NORTH LASALLE STREET, RM S1400
CHICAGO, ILLINOIS 60601

STATE OF ILLINOIS, FIRST DISTRICT APPELLATE COURT MANDATE

Panel: Honorable Donald C. Hudson
Honorable William Ernest Holdridge
Honorable John B. Barberis, Jr.
Honorable Peter C. Cavanagh
Honorable Thomas E. Hoffman

BE IT REMEMBERED, that on 23rd day of October, 2020 the final judgment of said Appellate Court was entered of record as follows:

CRAIG MARKIEWICZ,
Plaintiff-Appellant,
v.
ILLINOIS WORKERS' COMPENSATION COMMISSION and MCHUGH CONSTRUCTION,
Defendants-Appellees.

General No: 1-19-2428WC
County/Agency: Cook County
Trial Court/Agency Case No.: 18L50550

Circuit court judgment affirmed in part, vacated in part and reversed in part.

Commission decision reversed in part and vacated in part.

Cause remanded to the Commission w/directions.

In accordance with Supreme Court Rule 368, this Mandate is issued. As Clerk of the Appellate Court and keeper of the records, files and Seal thereof, I certify that the foregoing is a true statement of the final Order of said Appellate Court in the above cause of record in my office. Pursuant to Supreme Court Rule 369, the clerk of the circuit court shall file the Mandate promptly.

APPELLATE COURT OF ILLINOIS FIRST DISTRICT
JULY 1, 1877
SEAL

IN WITNESS WHEREOF, I hereunto set my hand and affix the Seal of the Illinois Appellate Court this 14th day of December, 2020.

Thomas D. Palella

Clerk of the Appellate Court

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC010348
Case Name	ANGLIN, VICTORIA v. MENARDS, INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0370
Number of Pages of Decision	23
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Patrick Hanlon
Respondent Attorney	Christopher Crawford

DATE FILED: 7/22/2021

/s/ Thomas Tyrrell, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Victoria Anglin,

Petitioner,

vs. NO: 17 WC 10348

Menards,

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, medical expenses and prospective medical treatment, affirms the Decision of the Arbitrator, with changes as stated herein, said decision being 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 corrects a clerical error in the Arbitrator's decision to show that Petitioner was temporarily totally disabled from 2/24/17 through 2/10/20 and from 2/14/20 through 2/19/20, for a period of 155-3/7 weeks (not 155 weeks).

Further, the Commission corrects the reference to a date of accident of 2/19/20 at p.19, 2nd sentence, to show that the injury was actually sustained on 2/23/17.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 3/20/20, is hereby affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $183.81 per week for a period of 155-3/7 weeks, from 2/24/17 through 2/10/20 and from 2/14/20 through 2/19/20, 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 reasonable and necessary medical expenses related to her right foot/ankle and CRPS from 2/23/17 through 2/19/20, under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall authorize and pay for reasonable and necessary medical services related to the spinal cord stimulator trial recommended by Dr. Spizzirri and Dr. Benyamin, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons of 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 $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.

July 22, 2021

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

TJT: pmo
o 6/8/21
51

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

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

21IWCC0370

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

ANGLIN, VICTORIA
Employee/Petitioner

Case# **17WC010348**

MENARDS INC
Employer/Respondent

On 3/20/2020, 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 0.30% 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:

0874 FREDERICK & HAGLE
PATRICK J HANLON
129 W MAIN ST
URBANA, IL 61801

0358 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER S CRAWFORD
227 NE JEFFERSON ST
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

VICTORIA ANGLIN,
Employee/Petitioner

v.

MENARDS, INC.,
Employer/Respondent

Case # **17** WC **10348**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Urbana**, on **2/19/20**. 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. ☒ 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, **2/23/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**9,558.12**; the average weekly wage was $**183.81**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of $**19,265.65** for TTD from 2/24/17-12/15/19, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**19,265.65**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $183.81/week for 155 weeks, commencing 2/24/17 through 2/10/20, and 2/14/20 through 2/19/20, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/24/17 through 2/10/20, and 2/14/20 through 2/19/20, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $19,265.65 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services related to petitioner's right foot/ankle and CRPS from 2/23/17 through 2/19/20, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all for medical benefits related to the treatment of petitioner's right foot/ankle and CRPS from 2/23/17 through 2/19/20, that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services related to the spinal cord stimulator trial recommended by Dr. Spizzirri and Dr. Benyamin, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

3/15/20
Date

ICArbDec19(b)

MAR 20 2020

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 33 year old cashier, sustained an accidental injury to her right foot, that arose out of and in the course of her employment by respondent on 2/23/17.

On 2/23/17 petitioner was checking out a customer who had a 4 foot 2x4 piece of wood on top of his cart. As the customer was emptying his cart he struck the 2x4 and the end of the 2x4 fell on the top of petitioner's right foot. She testified that she experienced immediate pain in her right foot. Petitioner reported the injury right away. She was offered to be taken to the emergency room, but declined. She denied any injury to her right foot prior to this injury.

Petitioner first sought treatment at the emergency room at Carle on 2/24/17. She reported that she injured her right foot/ankle and left knee the day before. There was no break in the skin. An examination of the right ankle revealed decreased range of motion and swelling. There was no ecchymosis, deformity, or laceration. She had a normal pulse. She had lateral malleolus tenderness, without any medial malleolus, AITFL, CF ligament, posterior TFL, no head of 5th metatarsal, and no proximal tenderness. Her Achilles tendon was normal. An x-ray of the right ankle was negative for an acute fracture, but soft tissue swelling was noted on the lateral aspect of the malleolus. Petitioner was prescribed Tylenol-Codeine #3, and a walking boot. She was authorized off duty that day and released to work the following day. She refused to full out a Workman's Comp.

On 2/26/17 petitioner presented to Presence Covenant Medical Center emergency room for worsening right foot pain. She gave a consistent history of the injury. She reported that she was having difficulty getting the boot back on due to swelling. She had no other complaints. A history of bipolar disorder and PTSD was noted. An examination revealed tenderness along the lateral malleolus and dorsal lateral right foot, and swelling of the right foot. An x-ray of the right foot showed no acute fracture. Petitioner was given a prescription for Norco, and referred to a podiatrist.

On 3/19/17 petitioner presented to Presence Covenant Medical Center emergency room for right ankle pain. She reported a consistent history of the injury. She reported that she ran out of Norco and was icing the area. Petitioner underwent a repeat right ankle x-ray that was normal. An intact ankle mortise was noted. There was no acute fracture or dislocation. An examination revealed tenderness in the right ankle, no tenderness to the right foot, and no edema or swelling of the right ankle. Petitioner was assessed with an ankle sprain. Petitioner was instructed to remain in the walking boot and follow-up with Dr. Muthana Sartawi in orthopedics. Petitioner was prescribed Norco.

On 3/28/17 petitioner presented to Dr. Sarah Spizzirri, a podiatrist. She complained of severe right foot and ankle pain. She reported that she could barely walk on it. She reported that the quality of her pain was "burning". She reported numbness and a pop in her right ankle when she takes off her boot to take a shower. She rated her pain at a 7/10, and a 9/10 when walking. She reported that the swelling on the top of her right foot had improved. Petitioner had difficulty actively dorsiflexing her right ankle. No significant allodynia was noted with light touch of the foot or proximal lower leg. Her vascular, neurologic, and dermatologic examinations were normal. Prior x-rays were reviewed. Dr. Spizzirri's assessment was right ankle pain, contusion of the right ankle, and spontaneous rupture of the extensor tendon of the right ankle. Petitioner was given scripts for Norco and Naproxen. An MRI of the right foot was ordered. Dr. Spizzirri recommended immobilization and strict nonweightbearing. A cast was applied and petitioner was given crutches.

On 4/18/17 petitioner returned to Dr. Spizzirri complaining of ongoing pain. Dr. Spizzirri noted that petitioner had been walking on the nonweightbearing cast, based on the significant breakdown of the cast plantarly, and due to the fact that the cast was very dirty. Petitioner reported that the Norco was not taking care of her pain. She wanted something stronger. (The arbitrator notes that the final page of this office record was omitted.)

On 5/12/17 petitioner returned to Dr. Spizzirri complaining of severe, intermittent right foot pain, worse with activity, and relieved with rest. She rated her pain at a 10/10. Dr. Spizzirri noted that petitioner had been walking on the nonweightbearing cast, based on the significant breakdown of the cast plantarly, and due to the fact that the cast was very dirty. Petitioner stated that she was walking on the cast without crutches. She reported more numbness. She stated that if she lets her foot hang her pain and numbness ease up. Dr. Spizzirri saw no signs of CRPS. Her assessment remained unchanged. An MRI of the right ankle performed that day revealed mild to moderate tendinosis, and probable partial tear of the extensor digitorum longus tendon at the level of the talonavicular joint.

On 5/26/17 petitioner returned to Dr. Spizzirri still complaining of right foot and ankle pain, localized to the dorsal aspect of the right ankle and foot. Her pain was unchanged. Her cast was again dirty. She stated that she tried to remain mostly nonweightbearing, but did walk on the cast. Dr. Spizzirri examined petitioner and assessed right ankle tendinosis, neuritis of the right foot, contusion of the right ankle, subsequent encounter, and right ankle pain. Petitioner was placed in a new cast and again told to keep it clean, dry, intact, and non-weightbearing. She was also prescribed Neurontin. Dr. Spizzirri was concerned about the possibility of CRPS given the petitioner's worsening allodynia. An EMG was ordered. She was also given another script for Norco as needed for pain.

On 6/6/17 petitioner underwent a cast change due to pain. On 6/7/17 she was put in a CAM boot for the EMG. It was noted that her cast was split along the lateral aspect upon arrival.

On 6/12/17 petitioner presented to Pain Management and was seen by Nurse Practitioner, Patricia Finegan. She reported that her pain was getting worse and going up her leg. She complained of pain, swelling and burning in the anterior right ankle and foot. She complained of muscles contracting in the proximal lower leg. She reported changes in her toenails, that were thicker and not like they used to be. She also reported shiny swelling and redness in the right lower extremity. Following an examination, petitioner was assessed with CRPS I of the right lower limb, pain in the right ankle and joints of the right foot, neuritis of the right foot, and allodynia. Her dosage of Gabapentin was increased. She was also prescribed Ibuprofen. Dr. King reviewed the exam and examined petitioner. A 3 phase bone scan and sympathetic nerve blocks twice a week for at least a month or more was recommended. Therapy for aggressive range of motion was ordered. Norco was discontinued.

X-rays of the right ankle performed 6/16/17 showed valgus angulation in the forefoot. No acute osseous abnormality was noted.

On 7/5/17 petitioner underwent a sympathetic paravertebral nerve block performed by Dr. King. On 7/10/17 petitioner underwent an NM Bone Scan 3 Phase. The impression was normal.

On 7/5/17 petitioner underwent an initial physical therapy evaluation for her CRPS symptoms. The treatment plan was 3 times a week for 4 weeks.

On 7/10/17 petitioner underwent a 2nd sympathetic paravertebral nerve block performed by Dr. King.

On 8/2/17 petitioner was excused from work on 6/12/17, 7/5/17 and 7/10/17 by Christie Clinic Spine Department.

On 8/4/17 petitioner received a letter from Christie Clinic Spine Department informing her that she missed her 2nd appointment scheduled that day with Dr. King, and missed a scheduled appointment with him on 8/3/17. She was informed that missing appointments may result in termination of her care.

On 8/9/17 Kristen Erickson, Nurse Practitioner, drafted a letter to "To Whom It May Concern". It stated "Victoria had been diagnosed with H. Pylori and will be receiving antibiotic treatment for 14 days. She will have a repeat test 1 month after finishing treatment to make sure infection is cleared."

On 8/16/17 petitioner followed-up with Dr. Spizzirri. She reported ongoing right foot and ankle pain that had worsened. She reported that the first injection provided some tingling in her right leg, and

the 2nd injection provided no improvement in the right foot pain. She noted that she was still in physical therapy. She stated that she was noticing her right foot turning in more of an inverted position. She noted that then pain is always there, but worse with walking. Dr. Spizzirri noted that petitioner had remained nonweightbearing in her cam boot with her crutches. She also noted that petitioner had difficulty with light touch to the right lower extremity, and difficulty getting the right lower extremity wet due to pain. Following an examination and x-rays of the right foot that showed the ankle mortise in a rectus position, with an inverted position of the rear foot, Dr. Spizzirri assessed CRPS I of the right lower limb. Right ankle tendonitis, neuritis of the right foot and acute right ankle pain. Petitioner was prescribed Norco. Dr. Spizzirri noted that petitioner was not consistent with follow-up with Dr. King, but that petitioner told her that she was having side effects from the medications prescribed. Dr. Spizzirri discussed further treatment that included physical therapy, further immobilization and bracing, and further investigation and treatment for CRPS. A new cast was applied since petitioner stated that she felt improved in the cast. Dr. Spirrizzi emphasized the importance of strict nonweightbearing. She informed petitioner how important it was for her to follow-up on a consistent basis with her and a pain management specialist. She told petitioner that if she does not aggressively treat her symptoms there would be a potential of long-term pain and deformity secondary to the CRPS. Petitioner was told to follow-up in 2 weeks.

On 8/17/17 petitioner was discharged from physical therapy because she was found to be noncompliant. The discharge summary noted that petitioner's right foot was more ashen than the left, and that her nailbeds ere being affected by CRPS and the right 5th toe had an increased dead skin appearance.

On 8/31/17 petitioner reported to Dr. Spizzirri that her pain was improved in the cast. Dr. Spizzirri noted that she still had symptoms of CRPS. She also referred petitioner to Millennium Pain Center once approved by workers' comp. Petitioner was once again placed in a cam boot and told to use crutches. She was instructed to do passive range of motion exercises on the right ankle. Petitioner was continued off work. She was told to follow-up in two weeks, but did not follow-up as directed.

On 9/29/17 petitioner presented to Millennium Pain Center and was examined by Dr. Ramsin Benyamin, for continued complaints of her right foot pain. She gave a consistent history of the injury. She complained of a temperature change (coldness) on the right foot, and a difference in the way the nails grow on the right foot. He noted that her right foot was inverted and extremely sensitive to touch. She stated that she could not sleep due to the pain. He also noted that petitioner was having a brace made that would help her inverted foot heal. Petitioner reported that she was unable to undergo the last block due to a stomach infection. She stated that she could not bear weight on her foot, and takes Norco. She stated

that the Gabapentin made her ill. Petitioner described her pain as continuous, aching, throbbing, shooting, stabbing, and burning in the right foot. She also reported associated numbness, weakness, burning, discoloration and nail changes, and exacerbation with any activity. An examination revealed cutaneous hypersensitivity, contracture, temperature change (cool), continuing pain disproportionate to any inciting event, sensory hyperesthesia, allodynia, skin color changes, temperature asymmetry, decreased range of motion, trophic changes, and that petitioner met the Budapest clinical diagnosis criteria for CRPS. Dr. Benyamin's impressions were CRPS I of the right lower extremity, right ankle tendonitis, neuritis of right foot pain, and acute right ankle pain. Because petitioner was very tearful, could not sleep, and was always in pain, Dr. Benyamin recommended that petitioner see a pain psychologist. He was of the opinion that the brace would help the structural issue with her foot. He was also of the opinion that petitioner was in the contracture phase of CRPS. He wanted to review the records of Dr. King to see if the injections were done correctly since petitioner complained of complete numbness after the procedure, which is not a typical reaction. He recommended a Butrans patch instead of Norco for her nerve pain. He also started her on Cymbaltis for her nerve pain and depression. Lastly, he discussed a trial of a spinal cord stimulator as an option for her CRPS.

Petitioner next returned to Dr. Spirrizzi about 5 weeks later on 10/5/17. She stated that her pain had improved slightly. She stated that she had been treating at Millennium Pain Center and they were considering a spinal cord stimulator. She also stated that they gave her Butran patches, and she was getting a custom brace for her right foot the next week. An examination revealed diffuse pain with palpation along the right lower leg, right ankle and right foot. She continued to have difficulty moving her right foot, and her right ankle and was in a varus position that was reducible with range of motion manually. However, the petitioner had pain with movement. Dr. Spizzirri recommended continued range of motion exercises.

On 11/7/17 petitioner reported to Dr. Spizzirri that her pain was unchanged. She stated that she had not heard back from Millennium Pain Center since her last visit. Her allodynia in her right leg was unchanged. Her skin temperature, color and tugor of the right foot and leg were normal. The positioning of the foot and ankle was improved since she was wearing her AFO. Dr. Spizzirri was of the opinion that petitioner's right foot and ankle pain continued to be consistent with CRPS. She again stressed the importance continued follow-up for her CRPS. She was going to work with Millennium Pain Center for further treatment options for petitioner's CRPS. She continued petitioner in her use of the AFO.

On 12/19/17 petitioner followed up with Spizzirri and reported her condition was unchanged. She stated that she was working with her lawyer and Millennium Pain Center for further treatment for CRPS.

She was wearing her AFO and using a cane for ambulation. Dr. Spizzirri noted continued allodynia along the dorsal aspect of the right foot, ankle, and lower leg extending just proximal to the knee. Her skin was of normal color, tugor, and temperature. She still had difficulty moving her right ankle and foot. Dr. Spizzirri noted that petitioner continued to have contracture deformity of the right foot that was manually reducible with pain. She told petitioner to continued to wear her AFO and await approval for further treatment for her CRPS. Dr. Spizzirri approved short term use of narcotics.

On 1/17/18 petitioner underwent a Section 12 examination performed by Dr. Richard Noren, at the request of the respondent. Petitioner reported pain in her right foot extending to her knee. Dr. Noren reviewed a letter from Coventry IMEs and petitioner's medical records. An examination revealed that petitioner was wearing a brace and boot on her right foot and needed a cane to ambulate. Severe allodynia from the right knee to the foot with light touch palpation, as well as decreased pinprick sensation in the same area. However, she had no complaints of allodynia when Dr. Noren was doing measurement testing of the right foot using a tape measure. Petitioner reported decreased cool and wet distribution of the allodynia. Petitioner had no right ankle movement. Ankle and knee reflexes were absent. Dr. Noren noted that petitioner had bilateral nail fungal infections. Lateral edema over her lateral ankle and malleolar region was noted. She had decreased motion of the right foot and ankle. With temperature testing with an infrared probe petitioner described a burning and tingling sensation from the red light on the probe. The temperatures of the dorsal surface of her left foot was 71.4 degrees, and was 70.8 degrees on the right. Temperature of the plantar surface on the left was 63.8 degrees, and 64.8 degrees on the right. Photos were taken. Petitioner's score on the Pain Disability Questionnaire was 139/150. Dr. Noren was of the opinion that the petitioner met only one criteria of the Budapest Criteria, the ankylosing of the ankle. He noted no measurable edema, visible color changes, or temperature changes. He also noted that her complaints of allodynia resolved with distraction and additional testing. She had no hyperalgesia. Dr. Noren was of the opinion that the medical documentation supported a causal relationship between the accident and subsequent pain complaints, with no documentation that supported the Budapest Criteria. Dr. Noren was of the opinion that petitioner's medical status and reported impairment appeared to be without physiologic basis. He noted that petitioner appeared to be developing increasing inversion and ankylosing of her right foot and ankle. He was of the opinion that she could work a sedentary job.

On 2/2/18 petitioner next returned to Dr. Spirrizzi. She stated that she had a burning pain and sometimes numbness in her right foot. Her right ankle was in a contracted equinovarus position with contracture. She also still had allodynia to the right lower extremity with decreased sensation and hyper

sensitivity. Her ankle was resting in an equinox varus position. She had no strength on eversion of the right ankle. Dr. Spirrizzi again assessed CRPS and a contracture of the right lower extremity. She recommended that petitioner get treatment with the Spine and Pain Clinic for a spinal cord stimulator, and gave her pain meds until she could be seen. She continued petitioner off work. On 2/20/18 petitioner returned requesting a medication refill. An examination revealed that the right foot was slightly cooler than the left foot and there was increased pigmentation in the right extremity compared to the left. Motion was again painful, but her right foot and ankle could be brought back to neutral with pain. She stated that it is medically necessary that petitioner be treated by a pain specialist for her CRPS. She was of the opinion that a spinal cord stimulator would be beneficial. She continued petitioner in her AFO. She prescribed more Norco.

On 2/6/18 petitioner was examined by Dr. Andrew Kluesner. He noted that petitioner's ankle was in an equinovarus position and that she had positive allodynia of the right lower extremity. He was of the opinion that petitioner definitely had findings consistent with CRPS and definitely has a contracted right lower extremity. He recommended treatment with a spine and pain clinic for a spinal stimulator.

On 2/7/18 Dr. Noren drafted an Addendum Report. He opined that petitioner's past treatment, including medical services, diagnostic studies done to date were medically necessary as related to her injury. He opined that petitioner had reached maximum medical improvement, and was not in need of any additional interventional pain management.

On 2/20/18 Dr. Spizzirri noted edema, allodynia in the dorsal aspect of the foot, ankle, and lower leg, slightly cooler right foot than the left, and increased pigmentation in the right extremity as compared to the left. Dr. Spirrizzi noted that these findings were consistent with CRPS and petitioner would benefit from a spinal cord stimulator and continued use of the AFO.

On 3/6/18 petitioner returned to Spizzirri. She reported a lot of pain in the last couple of days. She stated that recently she had difficulty tolerating touch to the right foot, as well as slight limp ambulation to put on her brace. Her examination remained unchanged. Dr. Spizzirri started petitioner on a knee scooter. She noted that petitioner could not get treatment at the pain clinic because workers' comp would not approve. Dr. Spizzirri told petitioner that she had nothing else to offer petitioner. She noted that due to her pain in her right foot she was unable to bear any weight on her right foot. Additional Norco was prescribed.

On 3/27/18 petitioner returned to Dr. Spirrizzi with similar symptoms of pain, numbness, and burning that radiates from the top of her right foot to the level of her knee. She stated that she could not

walk without severe pain, and had pain at rest. She stated that she wanted the spinal cord stimulator. Her examination was unchanged. Dr. Spizzirri recommended continued use of the brace.

On 4/11/18 the evidence deposition of Dr. Spizzirri, a podiatrist, was taken on behalf of petitioner. Dr. Spizzirri opined that petitioner had CRPS that was caused by the injury she sustained to her right foot and ankle in February 2017. She stated that as far as she knew petitioner was compliant with her use of the AFO and motion exercises. Dr. Spirrizzi was of the opinion that the nerve issues related to the CRPS was what was causing petitioner's foot to be in the contracted position. She testified that a cooler sensation in one foot compared to the other is a symptom of CRPS.

On cross examination, Dr. Spizzirri admitted that she did not mention anywhere in her records that petitioner was disabled from working, but believed she did provide her with a note restricting her from working. She noted that petitioner's guarding on examination was a subjective complaint, and she was unable to objectively assess her range of motion and strength in the right foot and ankle. With regards to her feeling that the petitioner's right foot was slightly cooler in February 2018, Dr. Spizzirri noted that this was the first time she had seen this since she began seeing her, but this was not an issue because with CRPS a lot of changes seem to worsen as times goes on so you can see changes of symptoms in a worsening manner. Dr. Spizzirri testified that she was not aware of the Budapest criteria when diagnosing CRPS. Dr. Spizzirri testified that a person can put their ankle in a varus position voluntarily. She noted that petitioner had two stages where she was in a walking boot. The first one was when she first had the injury, and the 2nd one was when she transitioned into the AFO. Dr. Spizzirri admitted that there were several episodes where she noted petitioner's nonweightbearing cast was dirty and worn on the underside, that indicated that petitioner was not compliant with being nonweightbearing, and was actually walking on the cast. She was of the opinion that this was improper use of the cast. She stated that Gabapentin is not always effective for the treatment of neuritis, and that is why they moved to nerve medications, which petitioner had no relief from. She stated that petitioner should have at least had some temporary relief.

On redirect examination, Dr. Spizzirri testified that neuritis is not the same as CRPS. She testified that neuritis is more of a specific nerve irritation and CRPS is more of a global type of condition for a part of the body. She testified that petitioner was compliant since she was in the AFO brace. She testified that she authorized petitioner off work from 5/3/17-12/1/17.

On 4/17/18 petitioner told Dr. Spizzirri that she was wearing her brace and using her crutches, but they were rubbing on her armpits. She stated that she could not use the cane because she could not put

all her weight on her right foot. Her examination remained unchanged. Dr. Spizzirri was of the opinion that petitioner's symptoms were consistent with CRPS.

On 5/3/18 the evidence deposition of Dr. Noren, board certified in anesthesia and pain management, was taken on behalf of respondent. He was of the opinion that there is an increased incidence of CRPS type symptoms in women with a history of abuse, which petitioner told Dr. Noren she had experienced. Dr. Noren was of the opinion that there was no objective reason why her right ankle would not move. Dr. Noren was of the opinion that a temperature difference of at least 2 degrees is the temperature basis for CRPS. Dr. Noren was of the opinion that petitioner's reaction to the red infrared light was a psychogenic response. Dr. Noren was of the opinion petitioner did not meet the Budapest Criteria. He noted that although she subjectively had allodynia, with distraction on at least three other tests it resolved. He also noted she had no objective findings of color changes, hair changes, or nail changes. He noted that her use of Nair is not consistent with the history portion of somebody who has allodynia. Dr. Noren opined that petitioner does not suffer from CRPS. He also noted that petitioner's bone scan was normal, and she had no relief from the sympathetic nerve blocks, which you would expect with CRPS. He noted trophic changes in all nails, and with CRPS it is usually just one or two nails.

On cross examination, Dr. Noren was of the opinion that with CRPS the symptoms are always present with varying degrees of intensity being present from day to day. He was of the opinion that CRPS can cause ankylosing of a joint. He was of the opinion that the cause of the ankylosing of her joint could be caused by her foot in a boot all the time.

On redirect examination, Dr. Noren was of the opinion that he would refer to an orthopedist for further addressing petitioner's ankylosing of the right ankle. He did not think she needed the boot as part of her treatment, and that is what could have led to her ankylosing of her right foot. He did not believe the edema he noted was the type of edema noted in CRPS. Dr. Noren suggested that petitioner may have been magnifying the degree of her pain. Dr. Noren opined that petitioner's current impairment and pain did not appear to be related to a piece of wood causing a soft tissue contusion to the top of her foot.

On 7/2/18 petitioner followed-up with Dr. Spizzirri and reported that her condition was unchanged. Dr. Spizzirri noted that they were still waiting for approval of the spinal cord stimulator by workers' comp. Her examination remained unchanged. Dr. Spizzirri warned petitioner of prolonged use of pain medication. Dr. Spizzirri was of the opinion that it was essential that petitioner have the spinal cord stimulator in order to help her progress with decreased pain and hopefully improved function. She recommended continued use of her AFO as well as range of motion as much as possible.

On 7/27/18 petitioner reported increased pain in her back and hands to Dr. Spizzirri. She noted improvement in the swelling when wearing the brace but no improvement in her pain. Her examination remained unchanged. Dr. Spizzirri's recommendations remained unchanged.

On 8/16/18 the evidence deposition of Dr. Ramsin Benyamin, a pain physician who specializes in interventional pain management, was taken on behalf of the petitioner. He was of the opinion that her symptomatology summary was described as neuropathic type pain. He testified that he noted a color change in the right foot, and a difference in the toenails on each foot. He was of the opinion that the growth of nails is usually affected by sympathetic dysfunction. He used his hand to measure the temperature changes in the feet, and the right was colder. He testified that he used the Budapest Criteria to diagnosis CRPS in petitioner, which includes three symptoms and two signs. He stated that most important of this is the extreme pain disproportionate to the injury. He then went through the sensorimotor, sudomotor, and all the signs and symptoms. He was of the opinion that the only thing she did not have was sudomotor edema. He opined that she met enough of the criteria to qualify for the diagnosis of CRPS. He opined that something as simple as a 2x4 falling on a foot can cause CRPS, and he saw this injury as the cause of her CRPS symptoms. Since petitioner had failed sympathetic blocks, medications, and physical therapy, Dr. Benyamin recommended a spinal cord stimulator trial. He also wanted her moved off the Norco to Buprenorphine, and prescribed Cymbalta. He opined that this treatment was appropriate and reasonable for CRPS. He was of the opinion that with CRPS the sooner you bring the patient to functional status and restore the function the more successful you will be.

On cross examination Dr. Benyamin stated that you cannot objectively measure a person's pain, but, was of the opinion that there are other objective measures within the Budapest Criteria that can be measured and petitioner had them, as it relates to temperature and color changes. He testified that CPRS patients' conditions change, they may have coldness sometimes, and then not a few hours later. He stated that one time a person can respond to sympathetic blocks and another time they don't. Lastly, he testified that CRPS is as gray as it can get in medicine, and that is why the Budapest Criteria was established.

On 9/21/18 she reported to Dr. Spizzirri recent difficulty getting her right AFO on due to pain. Her examination was unchanged. Again, Dr. Spirrizzi was of the opinion that petitioner had significant pain in her right lower leg secondary to CRPS, and her best treatment would be a spinal cord stimulator. On 11/19/18 she returned to Dr. Spirrizzi and everything was the same. On 12/26/18 petitioner reported to Dr. Spizzirri that she continued to have pain and numbness in her right leg and could not wear her AFO due to pain. She stated that she was mainly non-weightbearing. On 1/30/19 she told Dr. Spizzirri that

she was occasionally able to wear her AFO but when she does she gets a rash from it and it does create increasing pain. She stated that she rotated in and out of it every few days. She stated that she was still waiting for approval of the spinal cord stimulator.

On 9/18/18 petitioner underwent a Section 12 examination performed by Dr. George Holmes, Jr., at the request of the respondent, for her right foot injury. Dr. Holmes performed a record review and examination. On examination she had tenderness circumferentially from the tip of the toes up into the knee. She also had complaints of some swelling, and permanent burning in the foot. She noted that she was taking Norco and Gabapentin. She also stated that she normally wears an AFO but now had it off since it had been rubbing on her foot, and causing some skin lesions. Her right calf and ankle were each 1 cm smaller than on the left. Her right foot was 1 cm larger than her left. Dr. Holmes examination was limited secondary to petitioner's diffuse pain with light touch. He noted normal skin color, tugor, tone and temperature of the right foot. Dr. Holmes diagnosed CRPS. He noted no swelling or atrophy. With respect to her prognosis Dr. Holmes deferred to that of a Pain Management specialist, neurologist, or anesthesiologist. He was of the opinion petitioner did not need any orthopedic care. He was of the opinion that she was not capable of working full duty at that point. Dr. Holmes was of the opinion that petitioner's current condition of ill-being as it relates to her CRPS is causally related to the injury while working for respondent. He offered the option of the petitioner undergoing anesthesia for her CRPS to see if the foot relaxes.

Petitioner last followed-up with Dr. Spizzirri on 4/4/19. She reported that her pain had slightly worsened since her last visit. She continued to complain of pain in her right foot and lower leg to her knee. She stated that she had difficulty wearing her APO secondary to pain. Her physical examination remained unchanged. Dr. Spizzirri was of the opinion that it was essential that the petitioner be treated by pain management, and that every day she was not seen her chances of recovery decrease. Dr. Spizzirri stressed her concerns about petitioner's need to see a pain management specialist. She told petitioner to use her AFO as much as possible and do range of motion exercises. She discussed with petitioner a transition to decrease and eventually stop the narcotics.

On 6/21/19 Dr. Holmes drafted an addendum after receiving a letter from respondent's attorney, Christopher Crawford. Dr. Holmes was of the opinion that his examination of petitioner did not produce any objective criteria that would suggest that petitioner had CRPS. He indicated that by definition she should have had some atrophy, swelling, or some other objective parameters that would distinguish the left from the right lower extremity. He was of the opinion that it would be incongruent that petitioner would hold the position of the right foot in the position it was without some adjacent atrophy. Therefore,

based on his examination and radiographic results, Dr. Holmes concluded that petitioner did not have CRPS. He was of the opinion that if the petitioner's foot involuntarily corrects under anesthesia, this would be proof positive that it is not an organic problem. Dr. Holmes also changed his opinion and stated that he would not defer to a pain management specialist to determine if petitioner does or does not have CRPS. Dr. Holmes reviewed letters from Dr. Noren and agreed with the doctor's findings.

On 12/12/18 Dr. Noren drafted a 2nd addendum report after reviewing Dr. Holmes report. He stated that it remained his opinion that petitioner does not have CRPS. He noted that during her exam on 2 occasions with him and Dr. Holmes, petitioner had no measurable swelling or temperature changes. He noted that Dr. Holmes noted decreased circumference at her calf and ankle. He again noted that her subjective complaints of allodynia resolved during his exam. Dr. Noren also noted that petitioner's x-rays did not show intervening osteoporosis or osteopenia, which are objective findings of CRPS. He also noted that she had a bone scan that had no findings of CRPS. With respect to Dr. Holmes request for an evaluation under anesthesia, Dr. Noren was of the opinion that this would be best performed by an orthopedic foot and ankle specialist. He opined that petitioner does not have CRPS.

On 12/16/19 the evidence deposition of Dr. Holmes, Jr., an orthopedic surgeon, was taken on behalf of respondent. Dr. Holmes was of the opinion that given petitioner's history that she had not been able to function normally on her right foot, one would have anticipated significant atrophy or swelling, and there was none. He found the lack of atrophy and osteopenia inconsistent with her diagnosis of CRPS. Dr. Holmes was of the opinion that she had no orthopedic condition related to the injury. He stated that he found no objective evidence of CRPS on examination. Based on the totality of the records he reviewed Dr. Holmes was of the opinion that petitioner did not sustain an injury. He was of the opinion that she does not suffer from CPRS. Then he testified that if he had made a diagnosis of CRPS it was based on subjective complaints.

On cross examination, Dr. Holmes indicated that he was vaguely familiar with the Budapest Criteria, and does not cite them when making a determination as to CRPS. He testified that he did not have Dr. Noren's reports at the time he examined petitioner. Dr. Holmes admitted that his addendum was based only on Dr. Noren's reports and not any further treatment records regarding petitioner. Dr. Holmes testified that petitioner had no objective findings to support a finding of CRPS. Dr. Holmes agreed that some of the objective findings of CRPS can wax and wane, but the majority cannot, such as an x-ray, bone scan, or atrophy. Dr. Holmes testified that he does not treat patients with CRPS. He works with and refers them to pain management, neurology or anesthesia. Dr. Holmes recommended that petitioner

be examined under anesthesia to see if there is a psychosomatic component to her holding her foot adducted in a position that would be beyond that of CRPS.

On 2/14/20 petitioner presented to the emergency room at Gibson Area Hospital & Health Services for right foot pain. She was authorized off work from 2/14/20-2/17/20. She was examined and instructed to follow-up with her PCP for referral of a spinal cord stimulator to relieve her pain. She was told she could resume normal activity as tolerated.

Petitioner offered into evidence a Job Log for jobs she stated that she applied for from 1/23/20 through 2/10/20. All applications were online through Indeed.com. She indicated that she called, emailed, and went in person to follow-up. 38 entries were identified. The logs look to have been completed by different people based on the handwriting. On the top of one log she indicated that she was hired at State Street Grille on 2/11/20, but only worked until 2/12/20. She testified that she was an AM breakfast server thar would bring out drinks and did refills at the table, but after two days of walking around her feet were swollen like a cantaloupe. She testified that she was able to use her cane if needed. She stated that this swelling was greater than normal.

One page of the Job Log was for the period 9/2/19-12/29/19 and included 10 entries. This form was completed by another individual and included positions such as maintenance worker, field inspector, and driver. Most applications were processed through Indeed. Petitioner testified that she got confirmation back from Indeed on each application, but did not offer them into evidence.

Petitioner testified that she currently experiences burning, swelling, numbness, and stiffness in her right foot/ankle/leg. She testified that she has used a cane to ambulate since 2018. She stated that her right ankle was inverted and would not go flat. She also testified that she cannot actively move it at all. She stated that her ankle has been inverted since 2017. She denied that she was ever diagnosed with fungus with respect to her toe nails. She stated that she felt the top of her right foot was swollen.

Petitioner denied that she was discharged from physical therapy due to noncompliance. She testified that the therapy was not working and her doctor told her to stop. She also testified that she stopped nerve blocks because of an infection. She testified that she requested a doctor change from Dr. King because his treatment was not right and they did not treat her right. She stated that they were mean and disrespectful. She testified that she was not given medication for numbness, and they just stuck something in her back. She believes that is where the infection came from. Petitioner testified that she did look up the symptoms of CRPS online because she wanted to know if she would die from it. She testified that she is still not sure of what the symptoms of CPRS are.

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

In support of petitioner's current condition of ill-being being causally related to the injury on 2/23/17, the petitioner offers the opinions of petitioner's treating physician Dr. Spizzirri, Dr. Kluesner, and Dr. Benyamin who all opined that petitioner has CRPS. Dr. Spizzirri and Dr. Benyamin further opined that petitioner's diagnosis of CRPS is causally related to the injury she sustained on 2/23/17 while working for respondent. In the alternative, respondent relies on the Section 12 opinions of Dr. Noren and Dr. Holmes in finding that petitioner's current condition of ill-being, as it relates to her CRPS, is not causally related to the injury petitioner sustained while working for respondent on 2/23/17.

It is unrebutted that petitioner had no treatment to her right foot/ankle prior to the injury on 2/23/17, and was never diagnosed with CRPS prior to the injury on 2/23/17. It is also unrebutted that patients with a diagnosis of CRPS have symptoms that wax and wean, and are not always consistent at each and every doctor visit. Given the nature of CRPS, and the fact that the symptomatology can wax and wean, the arbitrator gives greater weight to the treater, Dr. Spirrizzi, who treated petitioner on a regular basis and noted most, if not all, characteristics of CRPS in petitioner during the time she treated her. The arbitrator notes that Dr. Spirrizzi confirmed the diagnosis of CRPS in petitioner on 6/21/17, and that this diagnosis was confirmed by both Dr. Kluesner and Dr. Benyamin, upon their examinations of petitioner. The arbitrator also finds it significant that petitioner's CRPS complaints remained consistent throughout her treatment from the summer of 2017 through the present. Although the arbitrator notes that petitioner was not always compliant with her treatment, the fact remains that her symptomatology was consistent and her compliance with her treatment became more consistent after she was removed from non-weightbearing cast.

The arbitrator finds it significant that Dr. Spirrizzi, Dr. Kluesner, and Dr. Benyamin noted the temperature change in petitioner's right foot, allodynia of the right foot, change in the growth of her toe nails on the right foot, and the inversion of her right foot and ankle.

Respondent had petitioner examined by Dr. Holmes. The arbitrator finds it significant that when petitioner was initially examined by Dr. Holmes on 9/18/18 he performed a record review and examination. On examination he noted tenderness circumferentially from the tip of the toes up into the knee. He also noted complaints of some swelling, and permanent burning in the foot. An examination revealed that petitioner's right calf and ankle were each 1 cm smaller than on the left, and her right foot was 1 cm larger than her left. Dr. Holmes examination was limited secondary to petitioner's diffuse pain with light touch. He noted normal skin color, tugor, tone and temperature of the right foot, but diagnosed

CRPS. Dr. Holmes was also of the opinion that petitioner's current condition of ill-being as it relates to her CRPS is causally related to the injury while working for respondent.

It was not until after this examination, and after respondent's attorney sent a letter to Dr. Holmes, that on 6/21/19 Dr. Holmes drafted an addendum report. Despite never having examined petitioner again, Dr. Holmes concluded that petitioner did not have CRPS. Dr. Holmes also changed his opinion and stated that he would not defer to a pain management specialist to determine if petitioner does or does not have CRPS. Dr. Holmes also noted that he had reviewed letters from Dr. Noren and agreed with the doctor's findings.

Based on Dr. Holmes complete reversal of his opinion, based on a letter from respondent's attorney, and no further examination of petitioner, the arbitrator gives no weight to Dr. Holmes opinions rendered on 6/21/19. The arbitrator gives more weight to Dr. Holmes' opinions most contemporaneous to his examination of petitioner.

The only other opinion respondent offered was that of Dr. Noren. Like, Dr. Holmes, Dr. Noren examined petitioner pursuant to Section 12 of the Act. Dr. Noren was of the opinion that petitioner did not have CRPS because he only noted one of the Budapest Criteria when he examined her on that one occasion. However, what Dr. Noren does not acknowledge is that the other Budapest Criteria were noted by Dr. Spizzirri, Dr. Benyamin, Dr. Kluesner, and the therapist at ATI, on various prior examinations.

Although Dr. Noren opined that petitioner does not have CRPS because he only noted one of the Budapest Criteria in petitioner when he examined her, the arbitrator finds it very significant that Dr. Noren was of the opinion that the medical documentation supported a causal relationship between the injury petitioner sustained on 2/23/17 and her subsequent pain complaints. Given this opinion by Dr. Noren, as well as the opinions of Dr. Spizzirri, Dr. Kluesner, Dr. Benyamin, and the therapist at ATI noting the other Budapest Criteria, and the fact that the criteria for CRPS can wax and wane, the arbitrator finds the credible medical evidence supports a finding that petitioner's current condition of ill-being as it relates to her right foot/ankle and her CRPS, is causally related to the injury she sustained on 2/23/17 while working for respondent.

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?

Having found the petitioner's current condition of ill-being as it relates to her right foot/ankle and her diagnosis of CRPS, is causally related to the injury she sustained while working for respondent on 2/23/17, the arbitrator finds all treatment for petitioner's right foot/ankle and CRPS from 2/23/17 through

2/19/20 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 2/19/20.

Respondent shall pay reasonable and necessary medical services related to petitioner's right foot/ankle and CRPS from 2/23/17 through 2/19/20, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all for medical benefits related to the treatment of petitioner's right foot/ankle and CRPS from 2/23/17 through 2/19/20, that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner's current condition of ill-being as it relates to her right foot/ankle and her diagnosis of CRPS, is causally related to the injury she sustained while working for respondent on 2/23/17, the arbitrator finds the spinal cord stimulator trial recommended by Dr. Spirrizzi, Dr. Kluesner, and Dr. Benyamin is reasonable and necessary to cure or relieve petitioner from the effects of the injury that arose out of and in the course of her employment by respondent on 2/23/17. Respondent shall pay reasonable and necessary medical services related to the spinal cord stimulator trial, as provided in Sections 8(a) and 8.2 of the Act.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she was temporarily totally disabled from 2/24/17 through 2/10/20 and 2/14/20 to 2/19/20, a total of 155 weeks. Respondent claims petitioner was temporarily totally disabled from 2/24/17 through 12/15/19, and that it has already paid petitioner these benefits in the amount of $19,265.65. Therefore, the period the arbitrator finds in dispute is 12/16/19 through 2/9/20 and 2/15/20 through 2/19/20.

Respondent terminated temporary total disability benefits on 12/16/19 based on the opinions of Dr. Holmes in his addendum report. Given that the arbitrator finds the opinions of Dr. Holmes in his addendum report less than persuasive, the arbitrator gives no weight to his opinion regarding petitioner's ability to work.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner was temporarily totally disabled from 2/24/17 through 2/10/20, and 2/14/20 through 2/19/20, a period of 155 weeks, at $183.81 per week. The arbitrator finds the respondent is entitled to a credit of $19,265.65 for temporary total disability benefits already paid for these periods.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC003322
Case Name	OLSON, ERIC THOR v. STATE OF ILLINOIS DEPARTMENT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0371
Number of Pages of Decision	17
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Gregory Booth
Respondent Attorney	Thomas Owen

DATE FILED: 7/23/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0371

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Thor Olson,

Petitioner,

vs. NO: 17 WC 3322

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 issues of causation, temporary total disability, maintenance, benefit rate, and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator, as set forth below, and otherwise affirms and adopts, said decision being attached hereto and made a part hereof.

The Commission modifies the decision of the Arbitrator to find that Petitioner's average weekly wage was equal to $1,152.32 (not $1,199.52). This is premised on base pay of $55,680.00 per year plus mandatory overtime wages (at straight time pay) of $4,240.53 (159 hours x $26.67 straight time rate), for total wages of $59,920.53. This equates to an average weekly wage of $1,152.32 ($59,920.53 ÷ 52 weeks).

The Commission also modifies the decision of the Arbitrator to find that Petitioner was entitled to temporary total disability benefits from 2/19/16 (the date of the ORA Orthopedics office note wherein he was taken off work) through 10/5/16 (the day before he was released to return to sedentary work on 10/6/17) and from 3/1/17 (the date he was taken off work by Dr. Hussain) through 3/12/17 (the day before his return to work on 3/13/17), for a period of 34-3/7 weeks at a rate of $768.21 (2/3[$1,152.32]) per week.

In addition, the Commission modifies the decision of the Arbitrator to find that Petitioner was entitled to maintenance benefits from 9/22/17 (when Respondent began paying maintenance

benefits) through 1/14/19 (when he apparently began working for R&R Recovery), and from 5/8/19 (given that copies of checks issued by R&R Recovery to Petitioner extend through 5/7/19 [RX24]) through 9/22/19 (the date prior to the hearing at arbitration), for a period of 88-2/7 weeks at a rate of $768.21 (2/3[$1,152.32]) per week.

Furthermore, the Commission modifies the Arbitrator's decision to find that Petitioner was entitled to a §8(d)1 award in the amount of $528.21 (2/3[$1,152.32 - $360.00 {$9.00/hour x 40 hours/week}], or 2/3[$792.32])= $792.32 x 2/3rd, the wage differential would be paid out at $ $528.21 per week commencing 9/23/19.

Finally, the Commission clarifies the Arbitrator's decision to find that Respondent is entitled to a total credit of $88,417.70, based on TTD paid in the amount of $22,436.21 and maintenance paid in the amount of $65,981.49.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 12/6/19 is affirmed and adopted as modified herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $768.21 per week for a period of 34-3/7 weeks, from 2/19/16 through 10/5/16 and from 3/1/17 through 3/12/17, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $768.21 per week for a period of 88-2/7 weeks, from 9/22/17 through 1/14/19 and from 5/8/19 through 9/22/19, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on 9/23/19, Respondent pay to the Petitioner the sum of $528.21 per week until such time the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later, as provided in Sec. 8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitates him from pursuing the duties of his usual and customary line of employment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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.

July 23, 2021

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

TJT: pmo
o 6/8/21
51

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

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

OLSON, ERIC THOR Case# **17WC003322**
Employee/Petitioner

ILL DEPT OF TRANSPORTATION-DIST 3
Employer/Respondent

On 12/6/2019, 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 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0787 MEYERS & FLOWERS LLC
GREGORY H BOOTH
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

6202 ASSISTANT ATTORNEY GENERAL
COURTNEY L SCHOCH
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

DEC - 6 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ERIC THOR OLSON
Employee/Petitioner

v.

ILL. DEPT. OF TRANSPORTATION- DIST.3
Employer/Respondent

Case # **17** WC **03322**

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Ottawa, Illinois**, on **September 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 any credit?
O. ☒ Other **Wage Differential under 8(d)(1)**

FINDINGS

On **November 4, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**62,375.09**; the average weekly wage was $**1,199.52**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**22,436.21** for TTD, $**0** for TPD, $**65,981.49** for maintenance, and $**0** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $799.68/week for 32-6/7 weeks, commencing 02/29/2016 through 10/05/2016 and 03/03/2017 through 03/13/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $799.68/week for 103-6/7 weeks, commencing 09/22/2017 through 09/23/2019, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing September 23, 2019, of $738.13/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

12/4/19
Date

DEC 6 - 2019

Attachment to Arbitrator Decision
(17 WC 3322)

FINDINGS OF FACT

Petitioner, Eric Thor Olson, testified that he began working for Respondent, Illinois Department of Transportation, District 3, in December of 2014. He worked as a Highway Maintainer. Petitioner testified that on November 4, 2015, he was 49 years old, single, with no dependent children.

Petitioner testified that he graduated from high school in 1984, and then joined the Marines shortly thereafter. He worked for NATO security and as a Marine Sniper in the Gulf War and served until about 1992. Then he joined the United States Army as a Special Forces Medical Operator and Green Beret from 1992 to 2000. Petitioner was the CEO of some businesses in Afghanistan. He later worked as a medical officer in Iraq, and Director of Security for the Kabul airport in Afghanistan. Petitioner testified that upon returning to Illinois, he applied for and began working as a Highway Maintainer for the Illinois Department of Transportation in December 2014.

Petitioner testified that he started out with a base pay of $55,680.00. This is further supported by Respondent's Wage Statement which showed Petitioner's total earnings prior to the accident (RX #21). Petitioner testified that this was 80% of his salary and that the State had contracted with him for 5% step raises each year until he reached 100% of his base pay.

Petitioner also testified that Highway Maintainer's had to work mandatory overtime. He testified that if they did not work the overtime, they could be terminated. Petitioner testified that in 2015, he made $62,375.09 in wages from the Illinois Department of Transportation. Petitioner submitted copies of his tax returns and W-2 forms as proof of his wages from the State of Illinois (PX# 9). Petitioner testified that the amount of wages paid to him in excess of his $55,680.00 base pay was for overtime wages. The overtime for this same period totaled $6,695.00.

It is undisputed that Petitioner sustained an accident on November 4, 2015 which arose out of and in the course of his employment. He testified that on November 4, 2015, he was working for Respondent and stepped down into a ditch and his left knee twisted. This accident was witnessed by Mitchell McCoy, Wayne Hulstander, and Richard Fisher, who all filled out accident reports detailing how Petitioner injured his left knee (PX#7, p.3-5).

Petitioner testified that he continued to work over the following days but that his knee continued to bother him. Petitioner then followed up with his primary physician, Dr. Pratt on November 20, 2015 (PX #1 p.6-10). An MRI was performed at Perry Memorial Hospital on November 25, 2015, and the report showed abnormal signal throughout the ACL and the medial meniscus, among other problems (PX#2 p8). Petitioner was then referred by Dr. Pratt to ORA Orthopedics.

Following some unrelated heart conditions, Petitioner was able to be examined by Dr. Lindaman at ORA on January 8, 2016. Dr. Lindaman diagnosed exacerbation of degenerative joint disease and possible medial meniscus tear of the left knee. (PX#4 p65). After review of the MRI, Dr. Lindaman diagnosed a medial meniscus tear and partial ACL tear and Petitioner was placed off work. Petitioner also began to complain of some back pain and left leg pain (PX#4 p.57 and 61). Petitioner was then referred to an orthopedic surgeon, Dr. Suleman Hussain, at ORA Orthopedics.

Petitioner was examined by Dr. Hussain on April 11, 2016. He reported that he began experiencing some neuropathy in his leg and that he continues to have many falls as a result of his left knee injury. He complained that his left leg was locking, catching, had instability, and also had tingling, swelling, weakness, stiffness, and pain (PX#4 p. 49-50). Dr. Hussain's assessment was that Petitioner had arthritis, an ACL injury, medial and

lateral meniscal pathology, and peroneal nerve palsy. He also recommended a brace, EMG nerve testing, and physical therapy. (Id).

Petitioner began physical therapy at Advanced Rehab and Sports Medicine in May 2016 (PX#5). On May 18, 2016, an EMG was performed of the left lower extremity. Dr. Hussain diagnosed him with peroneal nerve palsy and he was referred to Dr. Timothy Millea for consideration of peroneal nerve exploration/neurolysis (PX# 4 p47).

Petitioner submitted to a Section 12 examination by Dr. Shane Nho on July 11, 2016 (RX #23). It was Dr. Nho's opinions that Mr. Olson sustained an accident on November 4, 2015, that Mr. Olson injured his ACL, meniscus, and peroneal nerve in his left knee, and that the accident caused those injuries. He believed that the objective findings demonstrated laxity of the ACL and MCL, as well as weakness in the distribution of the peroneal nerve and a positive Tinel sign over the peroneal nerve. His diagnosis was left deep peroneal nerve palsy as well as left knee ACL injury, chondromalacia and possible posterolateral comer injury with meniscus tear (RX#23 p4). When asked if there was a causal relationship between the patient's current objective findings and the reported accident, he answered "Yes." Additionally, Dr. Nho recommended left knee surgery and also a neurolysis of the peroneal nerve. Dr. Nho stated, "I think he has good intention and legitimate work injury however nerve injuries sometimes are unpredictable in terms of their response to treatment and it may result in permanent nerve damage as a result of his work accident." (RX#23 p5).

On August 25, 2016, Dr. Millea examined Petitioner. He also noted that Petitioner has a history of a work injury where he twisted his left knee and subsequently was found to have an injury to the ACL and meniscus. His knee has continued to give way and he has worsening weakness of left ankle dorsiflexion. The EMG study was consistent with left deep peroneal nerve involvement. He stated that there was an option for surgical decompression of the nerve. However, given the length of time since his injury and the duration of weakness, Dr. Millea advised him that he had no more than guarded optimism regarding recovery of the nerve function (PX#4 p44). Petitioner decided to proceed with knee surgery first and then consider a nerve decompression later.

On October 5, 2016, Petitioner followed up with Dr. Hussain. Arthroscopic surgery was recommended by Dr. Hussain, and Petitioner was released to sedentary work only. (PX#4 p.40-41). However, Dr. Hussain was concerned about proceeding with surgery until Petitioner had evaluation and clearance from the cardiologist.

After a wait for cariology clearance, arthroscopic surgery was ultimately performed by Dr. Hussain on March 9, 2017. (PX#4 p31-34). The procedures consisted of left knee arthroscopy with partial medial meniscectomy, chondroplasty of the medial tibial plateau, and then debridement of synovitis and partial injury to the anterior crucial ligament (Id). Petitioner was off work from March 3, 3017 through March 13, 2017. He was released to light duty on March 10, 2017, which was then accommodated by the employer on March 14, 2017. (PX# 4 p.28). Petitioner was provided with a medial unloader brace and ordered to undergo additional physical therapy (PX#4 p.27).

Petitioner followed up with Dr. Hussain on March 24, 2017 (PX# 4 p.26). He reported his swelling decreased and he was doing well. Stitches were removed and he continued to be placed at sedentary light duty work. On April 26, 2017, Petitioner stated that sitting in his vehicle or in a chair with his knee bent caused a lot of pain and felt as if his leg was asleep when he stood up. The doctor stated that he was continuing to have peroneal nerve symptoms post-surgery (PX#4 p.22-23).

Another EMG of the left lower extremity was performed on May 23, 2017. A follow up visit on June 22, 2017 was set so that Dr. Millea could review the results of the EMG (PX#4 p13). He noted findings suggestive of entrapment neuropathy of the left common peroneal nerve at the level of the fibular head. Petitioner then

followed up with Dr. Hussain on July 26, 2017. He informed him that he did not want to proceed with surgical intervention of the peroneal nerve. Dr. Hussain ordered an FCE at that time.

An FCE was performed at Athletico on August 23, 2017. Mr. Olson had a valid FCE which demonstrated the physical capabilities and tolerances to function at the Medium physical demand level (PX# 6).

On August 25, 2017, Petitioner followed up with Dr. Pratt (PX#1 p.79-82). Petitioner stated that he was told he could not do his current job. Dr. Pratt stated that it was his "suspicion that Petitioner had developed complex regional pain syndrome of the left leg related to his injury." (PX#1 p.80). He agreed with the continuation of Gabapentin.

Petitioner's final follow-up with Dr. Hussain took place on September 8, 2017 (PX#4 p.5-7). Petitioner stated that his knee feels very good structurally, but that the nerve pain is bothersome. Dr. Hussain reviewed the FCE and provided him with permanent left knee restrictions. These restrictions include floor to waist lift of 20 pounds and carry of 25 pounds, pushing of 28.5 pounds, pulling of 25 pounds, occasional squatting and avoid sustained squatting, occasional kneeling, avoid crawling, climbing ladders, and walking on uneven ground. He was further restricted to occasional sitting, standing, and walking. (Id).

Following his permanent restrictions, Petitioner testified that his employer informed him that they could no longer accommodate his restrictions. On September 22, 2017, Petitioner began receiving maintenance benefits (RX#20). On January 19, 2018, Petitioner was interviewed for a transferable skills analysis and labor market survey through Creative Case Management (RX#2).

Petitioner testified that he provided information regarding his education history, military history, work history, hobbies, and permanent restrictions. Mr. Olson then began to participate in Vocational Guided searches with Samantha Hoevel-Kujawa. He testified that he fully participated in what was required of him and that this occurred over the course of a few months from November 2018 through June 2019.

Petitioner testified that despite the case manager's efforts, she was unable to get him set up with any interviews or find him any jobs. However, he did find two jobs of his own. Each of those jobs were full time and would pay him $9.00 per hour.

The first job offer that Petitioner received was from Rick Constantine at R&R Recovery. Petitioner testified that he was going to begin this job in January 2019. Petitioner testified that he went on a ride along for the job, but that he was unable to begin working for Mr. Constantine because Mr. Constantine was in an auto accident and off work for an indefinite amount of time (RX#7). Petitioner explained that he was unable to begin working for Mr. Constantine, however, he did lease him a truck to use since Mr. Constantine's truck had over 300,000 miles on it. He testified that Mr. Constantine paid him for the use of his car. However, Petitioner never received any wages from Mr. Constantine or R&R Recovery.

Petitioner stated that when this job fell through, vocational services were reinstated, and he continued to cooperate and participate in job searches. In his meeting with Ms. Hoevel-Kujawa on June 11, 2019, Petitioner informed her that he was offered a position at Tumbelson Automotive as a Car Porter/Associate. This was also a full-time position and he was to start on June 22, 2019 (RX#17).

Petitioner testified that he was acquaintances with Michael Tumbelson, the owner, and had known him for 40 years. He testified that on Saturday, June 22, he did a favor for Mr. Tumbelson and drove a party bus for a wedding. He did not get paid for this day and this was outside of what his job duties would be for Tumbelson when he was to begin working. Petitioner testified that on Sunday, his left leg gave out at home and he hurt his

back. He was unable to go to work on June 24, 2019. He testified that he never had any employment documents in place with Tumbelson and he never received any wages from Tumbelson.

A subpoena response from Tumbelson Auto Group was admitted into evidence (PX#8). A letter from Michael Tumbelson states that Mr. Olson has not been employed by Tumbelson, although he still plans to do so in the future. He affirmed that there are no employment records or documents relating to Petitioner. He also stated that because Petitioner never worked for him, there are no paychecks or pay records of any kind. He also confirmed that his proposed rate of pay was $9.00 an hour (PX#8).

Petitioner testified that Ms. Hoevel-Kujawa never followed up with him. She never contacted him to see how the job was going with Tumbelson. She also never re-opened her file as she had done previously to continue vocational rehabilitation services. Petitioner testified that the last maintenance check he received paid him through June 30, 2019.

The Arbitrator notes that Respondent attempted to cross-examine Petitioner with a Facebook post from Michael Tumbelson. The documents were objected to by Petitioner's counsel as containing hearsay statements and lacking proper foundation. Respondent did not admit these documents into evidence and any reference thereto is improper.

Testimony of Samantha Hoevel-Kujawa

Petitioner called Samantha Hoevel-Kujawa, an employee of Creative Case Management and the vocational case manager assigned to Eric Thor Olson. She testified that she is certified as a rehabilitation counselor and obtained certifications in 2009, 2014 and 2019. (RX# 1). She testified that 100 percent of her work is dedicated to workers' compensation placement for individuals. She has performed labor market surveys and created vocational reports in the past. She was assigned to Mr. Olson by her employer, who was hired through the State of Illinois by Tristar to help Mr. Olson find employment.

Ms. Hoevel-Kujawa testified that she had reviewed medical records of Mr. Olson. She was aware that Mr. Olson had permanent physical restrictions and that the State of Illinois was unable to place Mr. Olson at his pre-injury position as a Highway Maintainer. She believed that Mr. Olson could work in some capacity and that a Labor Market Survey was completed by Creative Case Management (RX #2). She testified that through the initial interview, Creative Case Management was able to obtain information about Mr. Olson, including his educational history, military history, age, residential location, permanent restrictions, and other health issues including PTSD and heart disease.

Ms. Hoevel-Kujawa testified that one of the goals of a vocational rehabilitation counselor is to assist the individual in finding employment which would pay them as much as they can earn. She testified that Mr. Olson was 53 years old and had a high school education. He had extensive military history but limited work history. She testified that Petitioner lived in Sheffield, Illinois, an area of Berea County with a population of 900 people. She testified that this reduced population was due to agricultural nature and the job market was reduced because of this (RX#2) She testified that Petitioner had a length of time away from active employment which was an impediment to his job search. Additionally, she testified that other impediments were his advanced age, difficulty focusing, residing in a rural area, and his permanent physical restrictions.

Ms. Hoevel-Kujawa was asked about various employment opportunities that were used to determine the range of salaries that Mr. Olson could earn in his new employment. She testified that the range of wages was from $8.25 per hour, or minimum wage, up to $48,000 per year, or $23.00 per hour. However, she agreed that the Salary.com data shows an average salary in the Petitioner's geographic area of $10.10 per hour and $15.87 per hour. (RX#2).

On examination, Ms. Hoevel-Kujawa admitted that many of the jobs suggested in the reports as available for Mr. Olson were actually not suitable for him. She testified that the job which would pay Mr. Olson the most money, an emergency communication telecommunicator, was not suitable for an individual such as Mr. Olson because he has PTSD, trouble focusing, prior heart attacks and coronary disease, and permanent restrictions of no sitting or standing for long periods of time. She also testified that many of the other jobs were not suitable for his restrictions such as a zoo train operator, USPS mail carrier, and a bus operator.

Ms. Hoevel-Kujawa testified that she helped Petitioner create a resume and perform a guided job search. She testified that she did not find any employment opportunities or obtain any job offers for Mr. Olson. However, he found two job opportunities on his own. She noted in her December 12, 2018 report that Petitioner had a job opportunity with a local repossession company. It was a full time position and would pay the Petitioner $9.00 an hour. (RX#6). She testified that $9.00 an hour was within her range and an appropriate pay rate for Mr. Olson. Ms. Hoevel-Kujawa testified that she encouraged Mr. Olson to take the position. She did not tell him that it was inappropriate or that she was going to continue to look for other jobs for Petitioner that paid him more money. Instead, she testified that she marked her file as resolved, but that she would keep it open for 30 days to make sure the Petitioner was properly placed in this position.

Ms. Hoevel-Kujawa testified that she contacted the owner of the company, Rick Constantine, to confirm the offer of the position. He confirmed the job offer and the rate of pay for $9.00 per hour. However, he was involved in an accident and injured himself which prevented him from training Mr. Olson. Her report notes that he wanted to train Mr. Olson personally and therefore, could not hire him at that time (RX#7). She testified when she learned of this, that she reopened her file and reinstated the job search and vocational counseling for Mr. Olson.

Ms. Hoevel-Kujawa testified that after meeting with Mr. Olson every few weeks, she would create a report within a few days. In her report of June 14, 2019, she noted that Mr. Olson informed her of a new job offer with Tumbelson Auto Group and that Mr. Olson would begin his work on June 22, 2019 (RX# 17). She testified that Mr. Olson was also going to make $9.00 an hour with this position. She again testified that this was an appropriate wage for someone in Mr. Olson's condition. Ms. Hoevel-Kujawa testified that her final report of July 17, 2019 was created two and a half weeks after a telephonic meeting with Mr. Olson on July 1, 2019 (RX# 18). She testified that she did not contact the employer to confirm he had started the position as she had done in the past. She testified that if she had, it would have been in her report. She also testified that she did not have any further communications with Petitioner, and that if she did, it would have been noted in her report. She also acknowledged that her final report did not state that she was going to keep her file open for 30 days to ensure Petitioner's job placement. Instead, she testified that she closed her file.

Testimony of William Cox

Respondent called William Cox as a witness. He testified that he is the Human Resources Manager for Illinois Department of Transportation. He testified that he had a conversation with Rick Constantine of R&R Repossession on May 10, 2019. The majority of the testimony of Mr. Cox was objected to as hearsay and not admitted into evidence. He testified that after a conversation with Mr. Constantine, he reached out to the State of Illinois concerning the workers' compensation benefits of Mr. Olson.

On cross-examination, Mr. Cox admitted that after May 10, 2019 he had no knowledge as to the workers' compensation benefits of Mr. Olson. Lastly, he testified that he had no opinions about the Petitioner's accident, injuries, or permanent restrictions.

Testimony of Joseph O'Sullivan

Joseph O'Sullivan was called as a witness by the Respondent. He testified that he was an investigator for the State of Illinois. He testified that on June 28, 2019 he spoke to Rick Constantine of R&R Repossession. He testified that he obtained copies of pay checks issued to Mr. Olson from January 2019 to May 2019 (RX 24). He testified that Mr. Constantine represented to him that Mr. Olson was his employee and working for him during that time.

On cross-examination, Mr. O'Sullivan admitted that all of the copies of checks he received contained a blank memo line. He testified that none of them stated that they were for employment or wages for work performed by Mr. Olson. He testified that he did not receive any employment documents from Mr. Constantine. He was unable to produce any employment contract, tax documents, health insurance forms, or any other documentation to show that Mr. Olson was an employee of R&R Recovery. In fact, Mr. O'Sullivan testified that it was his understanding that Mr. Olson was a 1099 independent contractor.

Mr. O'Sullivan also testified that there was no evidence as to the number of hours Mr. Olson was working each week for R&R Recovery. Interestingly, some of these weekly checks were for $60, $70 or $80. He testified that he did not investigate Mr. Constantine for underpaying Mr. Olson and violating minimum wage laws in the State of Illinois.

Mr. O'Sullivan further testified that he was unaware that Mr. Constantine was leasing a vehicle from Mr. Olson and paying him for the vehicle use. Lastly, he was asked on cross-examination if he was aware that prior to his meeting with Mr. Constantine, that Mr. Olson had filed a report of theft to the Bureau County Sherriff's Department against Mr. Constantine. Mr. O'Sullivan testified that he was aware of the report filed by Mr. Olson against Mr. Constantine prior to his meeting with Mr. Constantine and any allegations made by Mr. Constantine.

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

The Arbitrator finds that Petitioner presented sufficient, credible evidence that his current condition is causally related to the work injury.

The parties stipulate that Petitioner sustained a work related accident on November 4, 2015 which arose out of his employment with Respondent. Petitioner was stepping down in to a ditch and his left knee twisted. Petitioner testified that there were three witnesses to the accident, Mitchell McCoy, Wayne Hulstander, and Richard Fisher, who all filled out accident reports detailing how Petitioner injured his left knee (PX#7, p.3-5). Additionally, a report was filled out by Petitioner's supervisor Brandon Chandler (PX #7 p.6).

Petitioner testified that he continued to work over the following days but that his knee continued to bother him. Petitioner then followed up with his primary physician, Dr. Pratt on November 20, 2015 (PX #1 p.6-10). An MRI was ordered, and the report showed abnormal signal throughout the ACL and the medial meniscus, among other problems (PX#2 p8). Petitioner was then referred to ORA Orthopedics. Following some unrelated heart conditions, Petitioner was able to be examined by Dr. Lindaman at ORA on January 8, 2016. Dr. Lindaman diagnoses exacerbation of degenerative joint disease and possible medial meniscus tear of the left knee. (PX#4 p65). After review of the MRI, Dr. Lindaman diagnosed a medial meniscus tear and partial ACL tear and Petitioner was placed off of work. (PX#4 p.57 and 61). Petitioner was then referred to Dr. Suleman Hussain at ORA Orthopedics.

Petitioner was examined by Dr. Hussain on April 11, 2016. He reported that he began experiencing some neuropathy in his leg and that he continues to have many falls as a result of this. (PX#4 p. 49-50). His assessment that Petitioner has arthritis, an ACL injury, medial and lateral meniscal pathology, and peroneal nerve palsy. He also recommended a brace, EMG nerve testing, and physical therapy. (Id). After a long wait for cariology clearance, arthroscopic surgery was ultimately performed by Dr. Hussain on March 9, 2017. (PX#4 p31-34). The procedures consisted of left knee arthroscopy with partial medial meniscectomy, chondroplasty of the medial tibial plateau, and then debridement of synovitis and partial injury to the anterior crucial ligament (Id).

The Section 12 report of Dr. Nho from July 11, 2016 was admitted as evidence (RX #23). It was Dr. Nho's opinions that Mr. Olson sustained an accident on November 4, 2015, that Mr. Olson injured his ACL, meniscus, and peroneal nerve in his left knee, and that the accident caused those injuries. He believed that the objective findings demonstrated laxity of the ACL and MCL, as well as weakness in the distribution of the peroneal nerve and a positive Tinel sign over the peroneal nerve. His diagnosis was left deep peroneal nerve palsy as well as left knee ACL injury, chondromalacia and possible posterolateral comer injury with meniscus tear (RX#23 p4). When asked if there was a causal relationship between the patient's current objective findings and the reported accident, he answered "Yes." He noted that Mr. Olson did not demonstrate any evidence of symptom magnification. Additionally, Dr. Nho recommended left knee surgery and also a neurolysis of the peroneal nerve. Dr. Nho stated, "I think he has good intention and legitimate work injury however nerve injuries sometimes are unpredictable in terms of their response to treatment and it may result in permanent nerve damage as a result of his work accident." (RX#23 p5).

Petitioner testified that he had previously hurt his left knee and had arthroscopic surgery in 2011. However, he recovered from that injury and did not have any physical restrictions on his left knee following surgery in 2011. Petitioner testified that when he began working for the State of Illinois, he did not have any work restrictions on his left knee. He was able to fully perform the job duties of a Highway Maintainer and prior to the accident he was working full duty without restrictions. Following the work accident on November 4, 2015, Mr. Olson felt pain in his left knee. The accident was witnessed by 3 co-workers and a supervisor (PX# 7). He sought timely medical care and was diagnosed with meniscus tears, ACL tear, and peroneal nerve palsy. The medical records and Petitioner's testimony are consistent with a twisting injury when stepping down into a hole on November 4, 2015. Based on this chain of events, Petitioner has sufficiently proven that his left knee injury was causally related to his work accident on November 4, 2015.

The Arbitrator notes that Respondent attempted to call Petitioner's credibility into question throughout the trial. However, the Arbitrator found Respondent's witnesses' testimony to be based largely on hearsay and lack any significant value. Additionally, the Arbitrator finds the testimony of Mr. O'Sullivan to be unpersuasive as he was unaware of Petitioner's vehicle lease agreement with Rick Constantine, and fully aware of the police report Petitioner filled out against Mr. Constantine. This itself creates significant bias and issues of credibility as to Mr. Constantine. The Arbitrator finds that the testimony of Petitioner, his medical records, and the opinions of the Section12 examiner to be credible, reliable, and consistent.

Petitioner further testified that he continues to have pain and swelling in his left knee. He continues to have weakness in his left knee and his leg gives out and he falls a lot. The Arbitrator finds it credible that Petitioner's left leg injury would cause his ongoing symptoms and need for permanent restrictions. Respondent did not present any evidence or medical opinions that Petitioner's current condition of ill-being was unrelated to the work injury.

Based upon the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition is causally related to the work injury.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

Petitioner testified that he began working as a Highway Maintainer for the State of Illinois in December of 2014. He states that he started out with a base pay of $55,680.00. This is further supported by the wage records which showed Petitioner's total earnings prior to the accident (RX #21). Petitioner testified that this was 80% of his salary and that the State had contracted with him for 5% step raises each year until he reached 100% of his base pay. Petitioner testified that as of December of 2018, he would have been at 100% of his base pay, which would have been $69,600.00.

Petitioner also testified that Highway Maintainer's had to work mandatory overtime. He testified that if one did not work the overtime, they could be terminated. Petitioner testified that in 2015, he made $62,375.09 in wages from the Illinois Department of Transportation. Petitioner submitted copies of his tax returns and W-2 forms as proof of his wages from the State of Illinois (PX#9). Petitioner testified that the amount of wages paid to him in excess of his $55,680.00 base pay was for overtime wages. The overtime for 2015 totaled $6,695.00.

The Arbitrator notes that Respondent called the Human Resources Manager, William Cruz, as a witness in their case. However, Respondent did not ask Mr. Cruz any questions about Petitioner's wages. Respondent did not present any evidence contrary to the testimony of Petitioner as to the wages he made at the time of the accident or as to the wages he would currently be making if he was still employed as a Highway Maintainer.

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence his average weekly wage. As such, the Arbitrator finds that Petitioner earned an average weekly wage of $1,199.52 on November 4, 2015. Additionally, the Arbitrator finds that if Petitioner was still employed as a Highway Maintainer, he would be capable of earning a base pay of $69,600.00 and mandatory overtime wages of $6,695.00, totaling $76,295.09 per year. This provides an average weekly wage of $1,467.21 if Petitioner was able to continuing working as a Highway Maintainer as of the date of this hearing.

WITH RESPECT TO ISSUE (K), WHAT TEMPORARY AND TOTAL DISABILITY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS:

To be entitled to TTD benefits a claimant must prove not only that he did not work but that he was unable to work. *Freeman United Coal Min. Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 175, 741 N.E.2d 1144, 1148 (2000). Petitioner testified that he was placed off work by his medical providers and unable to work from February 29, 2016 through October 5, 2016. Additionally, he was off work from March 3, 2017 through March 13, 2017. After that, the State of Illinois provided him with a light duty job and accommodated his restrictions. (RX #20). Petitioner was placed at MMI and provided with permanent restrictions from Dr. Hussain on September 8, 2017 (PX#4 p.5-7). Respondent was unable to accommodate Petitioner's permanent restrictions and maintenance benefits were issued from September 22, 2017 through June 30, 2019 (RX#20).

Petitioner claims he is entitled to temporary disability benefits for 32-6/7 weeks, covering a period from February 29, 2016 through October 5, 2016 and March 3, 2017 through March 13, 2017 (Arb.Ex.#1). Additionally, Petitioner claims he was entitled to Maintenance benefits for 103-6/7 weeks from September 22, 2017 through the date of hearing on September 23, 2019. Petitioner claims he was paid at a TTD and maintenance rate of $713.84 instead of the appropriate rate of $799.68, resulting in an underpayment of TTD and maintenance benefits.

Based upon the above, the Arbitrator finds that Petitioner presented sufficient, credible evidence that he earned $1,199.52 per week prior to the accident. As such, the Arbitrator finds that the Petitioner's average weekly wage was $1,199.52 per week, and his TTD and Maintenance rate is $799.68.

The Arbitrator finds that Petitioner has shown that he was entitled to 32-6/7 weeks of TTD at a rate of $799.68, totaling $26,275.20. The Respondent has a credit of $22,436.21 in TTD paid. As such, Respondent owes the Petitioner $3,838.99 in TTD benefits. Additionally, the Arbitrator finds that Petitioner has shown that he was entitled to 103-6/7 weeks of Maintenance benefits at a rate of $799.68, totaling $83,052.48. Respondent has a credit of $65,981.49 in Maintenance paid. As such, Respondent owes the Petitioner $17,070.99 in maintenance benefits.

WITH RESPECT TO ISSUE (L) and (O), WHAT IS THE NATURE AND EXTENT OF THE INJURY, and WAGE DIFFERENTIAL, THE ARBITRATOR FINDS:

The findings and conclusions of the Arbitrator relating to the issue of causal relation are adopted and incorporated herein.

Petitioner seeks a wage differential award under Section 8(d)(1) of the Act. In order to be entitled to a wage differential, Petitioner must prove that the disability has caused (1) a partial incapacity that prevents him from pursuing his usual and customary line of employment and (2) impairment of earnings. Albrect v. Industrial Commission, 217 Ill.App.3d 756, 648 N.E.2d, 925, 208 Ill.Dec.1(1st Dist. 1995).

As a result of the accident of November 4, 2015, Petitioner sustained injuries which resulted in a left knee meniscus tear, ACL tear, and peroneal nerve damage. Petitioner required and underwent extensive physical therapy, testing, rest, medications, and ultimately arthroscopic surgery to repair his knee. The peroneal nerve damage was not repaired and remains a permanent deficit for which Petitioner continues to take Gabapentin. Petitioner also underwent an FCE evaluation on August 23, 2017, which showed Petitioner capable of performing at the Medium physical demand level.

Petitioner gave credible testimony that he continues to suffer from pain and swelling in his left knee. Petitioner testified that he has difficulty with his leg giving out and he falls often. Petitioner has difficulty with walking and standing for long periods of time and has been restricted from doing so. On September 8, 2017, Petitioner's treating surgeon, Dr. Hussain, placed him at MMI and provided him with permanent restrictions (PX#4 p. 5-7). These restrictions include floor to waist lift of 20 pounds and carry of 25 pounds, pushing of 28.5 pounds, pulling of 25 pounds, occasional squatting and avoid sustained squatting, occasional kneeling, avoid crawling, climbing ladders, and walking on uneven ground. He was further restricted to occasional sitting, standing, and walking. (Id). It is uncontroverted that with the restrictions Petitioner has he could not meet the physical demands of his former job with Respondent.

The vocational rehabilitation counselor, Samantha Hoevel-Kujawa testified that she helped Petitioner create a resume and perform job searches. She testified that Mr. Olson was 53 years old and had a high school education. He had extensive military history but limited work history. She testified that Petitioner lived in Sheffield, Illinois, an area of Berea County with a population of 900 people. She testified that this reduced population was due to agricultural nature and the job market was reduced because of this (RX#2) She testified that Petitioner had a length of time away from active employment which was an impediment to his job search. Additionally, she testified that other impediments were his advanced age, difficulty focusing, residing in a rural area, and his permanent physical restrictions.

Petitioner presented credible evidence of his job searches through vocational rehabilitation and two different job opportunities he obtained with an offer of $9.00 per hour. Unfortunately, Petitioner was unable to work at either

of those positions. Ms. Hoevel-Kujawa testified that she agreed that $9.00 an hour was an appropriate rate of pay for someone in Petitioner's situation. She testified that she encouraged Petitioner to take the two job offers he received at $9.00 an hour and that she did not continue his job search or try to find him a higher paying job. The Arbitrator notes that $9.00 an hour is within the expected pay range determined for Mr. Olson in the Labor Market Survey (RX # 2). As such, the Arbitrator finds that Petitioner has proven that his current rate of pay is $9.00 per hour.

Section 8(d)(1) provides that "If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall . . . receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later."

Additionally, a proper calculation of the award is based on the amount that claimant would have been earning at the time of hearing in the job which he had at the time of the accident rather than the amount the claimant earned in that job at the time of the accident. General Electric Co. v. Industrial Commission, 144 Ill.App.3d 1003, 495 N.E2d 68, 99 Ill.Dec 3 (4th Dist. 1986). Parties have the ability to present relevant evidence regarding the claimant's earning capacity at arbitration hearing, including factors such as wage increases, overtime, and increased hours of work; however, a wage differential award must be calculated as of the date of the arbitration hearing. United Airlines, Inc. v. IWCC, et al., 2013 IL APP (1st) 121136WC, 991 N.E.2d 458, 372 Ill.Dec 151 (1st Dist. 2013).

Based upon the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved that he sustained a partial incapacity that prevented him from pursuing his usual and customary line of employment. At the time of the accident, the Arbitrator finds that Petitioner earned $62,375.09 per year while working for Respondent. The Arbitrator finds that Petitioner has proven that he would be capable of earning $76,295.09 per year if he was currently in full performance of his duties as a Highway Maintainer by the Illinois Department of Transportation. This is the equivalent of $36.68 per hour, or $1,467.20 per week. Additionally, Petitioner has proven that with his current restrictions and physical limitations, he is able to work at a job earning an average of $9.00 per hour. This testimony was uncontroverted by Respondent.

The Arbitrator finds that commencing September 23, 2019, Petitioner is entitled to a wage differential in the amount of $738.13 [$1,467.20-$360.00 x 2/3] per week under Section 8(d)(1) of the Act. Respondent to pay outstanding maintenance benefits through September 23, 2019.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC036904
Case Name	MANZO, ERNESTO v. CONTINENTAL SALES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0372
Number of Pages of Decision	30
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Daniel Klosowski
Respondent Attorney	Thomas Mallers

DATE FILED: 7/23/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0372

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

Ernesto Manzo,

Petitioner,

vs. NO: 11 WC 36904

Continental Sales,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/8/19, denying compensation in claim 11 WC 36904, is affirmed and adopted.

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.

July 23, 2021

TJT: pmo
o 6/22/21
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

21IWCC0372

MANZO, ERNESTO
Employee/Petitioner

Case# **11WC036904**
11WC038145

CONTINENTAL SALES
Employer/Respondent

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

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

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

2553 McHARGUE & JONES LLC
DANIEL R KLOSOWSKI
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
MICAELA CASSIDY
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

ERNESTO MANZO
Employee/Petitioner

v.

CONTINENTAL SALES
Employer/Respondent

Case # **11** WC **36904**

Consolidated cases: **11 WC 38145**

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 **August 17, 2018 & August 27, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 10, 2010 & September 9, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On these dates, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$20,736.04**; the average weekly wage was **$398.77**.

On the date of accident, Petitioner was **34 & 36** years of age, ***married*** with **6** dependent children.

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

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

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

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that he sustained an accident on either May 10, 2010 or September 9, 2011, which arose out of and in the course of his employment, therefore no benefits will be awarded pursuant to 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

March 7, 2019
Date

MAR 8 - 2019

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

Ernesto Manzo, Petitioner,	)		
	)	Number:	11 WC 36904
vs.	)		11 WC 38145
Continental Sales, Respondent.	)		

MEMORANDUM OF DECISION OF ARBITRATOR

The matter was heard by an Arbitrator designated by the Commission in the City of Chicago, County of Cook and State of Illinois.

The Arbitrator renders findings on the following disputed issues:

(B) Whether an accident occurred;
(C) Whether Petitioner gave Respondent notice of the alleged accident:
(F) Whether Petitioner's current condition of ill-being causally related to the injury;
(J) Were the medical services provided to Petitioner reasonable and necessary; has Respondent paid all appropriate charges for all reasonable and necessary medical services;
(K) Whether Petitioner is entitled to temporary total disability; and
(L) The nature and extent of the injury;

STATEMENT OF FACTS

May 10, 2010 (11 WC 36904)

The Petitioner was hired by the Respondent on November 14, 2003. (TA75). On May 10, 2010 he worked for them as a stocker. He was 36 years old. His job involved moving salvaged food, shrink wrapped on pallets in the stocking room, into empty banana boxes for transport to the sales floor. (TA79). The Petitioner would first remove the items from each pallet in the stock room, organize the food by type and place into empty banana boxes for transport to the sales floor. He would place the filled boxes onto a hand cart or pallet and move them to the sales floor using the cart or a pallet jack. (TA155). Once on the sales floor, the Petitioner would empty the banana boxes to stock the shelves with food. (TA155). He estimated that he would move up to fourteen carts/pallet jacks of boxes to the sales floor per work day. (TA9-12, TA80-81).

On May 10, 2010 the Petitioner presented to work and felt perfectly well. (TA15). He testified that he was stocking a pallet of food that had four layers, with another pallet in between two of the layers. He finished the top layers and moved the middle pallet to the ground behind him, to begin working on the lower layers. He explained that the middle pallet was placed on the ground, as the Respondent had a safety rule against standing the pallets. (TA15-16). As he lifted one of the last boxes of food, he stepped backward, his foot stepped on the edge of the pallet behind him, and he fell to the ground in a seated position. His buttocks were on the floor, and his back hit the edge of the pallet. (TA17). He testified that the pallet did not break. (TA88).

He claimed that, ten to thirty minutes later, he saw Araceli Magana coming from the Cashier's Office. He testified that he told her he fell on a pallet. She suggested he talk to to Mr. Ramon (Ray) Hernandez. (T19-20, TA89). Petitioner admitted that Ms. Magana was not his supervisor. (TA89). Mr. Hernandez testified that Ms. Magana was a bookkeeper in May 2010 and confirmed that she was not the Petitioner's supervisor. (TA156-157). The Petitioner testified he spoke to Mr. Hernandez ten to fifteen minutes later and told him he fell on a pallet onto his back, and had a scratch, but was okay. (TA90). Mr. Hernandez did not recall the Petitioner speaking to him about this incident. (TA156). The Petitioner claimed that Mr. Hernandez sent him home that day, and that he didn't return to work for three to four days afterward. (T19-22). Mr. Hernandez testified that he never sent the Petitioner home due to a back injury, nor did he advise the Petitioner on May 10, 2010 that he would take three to four days off work. (TA171-172).

The Respondent's records show that for the time period between April 29, 2010 and May 12, 2010, the Petitioner worked 71.58 hours. For the time period between May 13, 2010 and May 26, 2010, the Petitioner worked 79.62 hours and 5.38 hours overtime. For the time period between May 27, 2010 and June 9, 2010, the Petitioner worked 80 regular hours and 11.78 hours overtime. (RX17).

The Petitioner stated that between May 10, 2010 and September 9, 2011, he would miss work, and show up late, and leave without telling anybody. (TA90). He claimed that he could miss work without doctor's notes to justify lost time, because he said that his boss, Mr. Hernandez knew of the accident. He claimed he was never written up for being late or leaving early. He claimed that he was never disciplined for this behavior. (TA22-23, 91-92, 146). He admitted that he sought no treatment for his back between May 10, 2010 and September 9, 2011. (TA22-23).

Mr. Hernandez testified that the Petitioner was not permitted to come and go from work as he pleased. (TA170-171). He was not permitted to come in late or leave early whenever he wanted. (TA171). Had the Petitioner behaved in this regard, he would have received verbal warning and then a written write-up. (TA171). Mr. Hernandez believed that the Petitioner's personnel file contained write-ups. (TA171).

Mr. Hernandez testified that he had worked for the Respondent for the past thirty-five or thirty-six years. (TA150). In May 2010, he was the Merchandising Manager, the direct supervisor over the crew. (TA150-152). In this job, he was the Petitioner's direct supervisor. (TA153-154). He testified that he would see the Petitioner six to eight times per day, and would travel to different locations in Respondent's facility, including the stocking room. (TA154).

Ms. Hernandez testified that on February 28, 2011, the Respondent hired her to manage human resources at Continental Sales and Salvage. (TA174). She testified to schooling in business management, and prior work in human resources for a prior employer. (TA174). The Petitioner acknowledged knowing when Ms. Hernandez was hired. (TA97). Ms. Hernandez stated that there is a separate office for Human Resources. When she was first hired, she had the office to herself. (TA175). She was responsible for overseeing and managing workers' compensation files and completing paperwork for the reporting of work injuries. (TA175-176). She stated that, when she was hired, the Respondent already used an incident report form. (TA177).

Mr. Hernandez stated that once Ms. Hernandez was hired, they began to use incident reports to document accidents, and supervisors would bring the reports to Human Resources. (TA162-163). Mr. Hernandez testified that the employee is present at the time an incident report is prepared. (TA165).

Ms. Hernandez stated that she would see the Petitioner on the sales floor, or if the Petitioner needed anything from Human Resources he would come to her office. (TA177-178). She confirmed that she speaks Spanish fluently, and would communicate with the Petitioner in Spanish. (TA178).

The Petitioner testified that he asked for more help in his department from Mr. Hernandez and Ms. Hernandez. (TA85). However, Ms. Hernandez testified that between her hire and September 9, 2011, the Petitioner never turned in doctors' notes, or requested lighter work. (TA178-179). When asked whether he had asked for a raise, prior to September 9, 2011, he answered "I believe I did. I'm not sure". (TA84). He later guessed that he asked for a raise in May 2011. (TA87). He testified that he did not think he was given a raise when he asked but admitted that raises were only considered once per year, near an employee's anniversary date. (TA85, 87).

The Petitioner testified that after he told Mr. Hernandez about his back injury involving the pallet on May 10, 2010, he never discussed his back with him until after September 9, 2011. (TA96, 147). Mr. Hernandez testified that he did not witness the Petitioner injure his back in May 2010, nor did he recall the Petitioner telling him about back pain between May 2010 and September 2011. (TA159-160). He also testified that he never told Ms. Hernandez about his fall into the pallet in May 2010, at any time between her hire in February 2011 and September 9, 2011. (TA97, 146). Ms. Hernandez confirmed that between her hire and September 8, 2011, the

Petitioner never told her that he injured his back after tripping on a pallet and falling backward while at work. (TA178). She stated that the Petitioner never turned in doctors notes or requested lighter work during this period of time. (TA178-179). There is no incident report in the Petitioner's personnel file regarding an incident on May 10, 2010. (TA200).

Ms. Hernandez testified that, when looking through the Petitioner's personnel files, she noted several counseling forms in his file. (TA202). The Respondent's records include numerous write ups for the Petitioner prior to May 10, 2010 for tardiness or missed work. In February 2010, he was written up for excessive tardiness in January 2010 – he was tardy on six days and missed three days of work. He was offered a schedule adjustment but declined. On March 8, 2010, a half hour before his shift was to begin, he called Mr. Hernandez's cell phone to report he would miss work due to a family emergency. On March 23, 2010, he called seven minutes before his shift was to start, to report he would be two hours late for work due to an emergency. He was given a verbal warning after failing to call or show for work on March 25, 2010, documented in a Counseling Report signed by Mr. Hernandez and the Petitioner. (RX17).

After May 10, 2010, the Petitioner continued to have difficulty with tardiness. For example, on April 9, 2010, fifteen minutes before his shift was to begin, he called to report he would be late due to childcare issues. On May 3, 2010, the Petitioner called, nineteen minutes after his shift started, to advise that he would be absent due to the need to find papers for his lawyer. On June 10, 2010, the Petitioner called at the beginning of his shift to advise he would be twenty minutes late due to oversleeping. On July 5, 2010, the Petitioner called, ten minutes before his shift was to begin to advise he would be late due to oversleeping. Between March 24, 2011 and March 29, 2011, the Petitioner was late every day, and took longer lunch breaks than allowed. It was noted on his Timecard Report for that week that Mr. Hernandez spoke with him about this issue and warned of a next step. Then, between April 14, 2011 and April 20, 2011, the Petitioner was tardy each day, and on one occasion took a longer lunch break than allowed. Then, between April 21, 2011 and April 27, 2011, the Petitioner was tardy each day, and on two days took a longer lunch break than allowed. On May 4, 2011, the Petitioner was written up for gross misconduct. He was asked to complete a task by his manager and refused. He left the premises rather than following his supervisor's direction. The Petitioner refused to sign the counseling report. Between May 12, 2011 and May 25, 2011, the Petitioner was late on nine out of ten work days, took a longer than allowed lunch period on one occasion, and left before his shift was over on one occasion. There is no documentation that any of the Petitioner's missed work was due to low back pain. (RX17).

September 9, 2011 (11 WC 38145)

The Petitioner testified at Arbitration that when he arrived at work on September 9, 2011, he didn't notice anything about his low back. Later while stacking cases of 24-ounce juices, he felt a pinch in his low back. He was working alone in the food and promo department, stocking. (TA83). He testified that he told David Solano about his back symptoms, and David instructed

him to see Human Resources. (TA25-27). He testified that he did not fall on a pallet or break a pallet with his back on September 9, 2011. (TA92-93).

The Petitioner presented to Human Resources and spoke with Danelia Hernandez. Ms. Hernandez testified that the Petitioner presented to her, mid-morning, on September 9, 2011. (TA179, 213). The Petitioner admitted that both Ms. Hernandez and Mr. Hernandez speak Spanish, and that he was able to communicate with them in Spanish. (TA95).

Petitioner advised Ms. Hernandez that a year ago, he had an accident "here". (TA27, 84, 93-94). He said that Ms. Hernandez asked when it had happened, and he didn't know the date. He denied telling her that a pallet broke at the time of the incident and denied telling her he was standing on top of the pallet at the time of that incident. (TA93-94). The Petitioner testified that he told Ms. Hernandez what he was doing when his back started pinching. (TA27-30, TA96). She asked him if he wanted to see a doctor. He said yes and was seen at Concentra Medical Center. (TA31-32, 184). Ms. Hernandez denied that the Petitioner reported a second incident occurring on September 9, 2011. (TA198).

Ms. Hernandez testified that the Petitioner did not go directly from work to Concentra. She explained that when an employee is sent to the clinic, the clinic notes show what time they arrived at the clinic, and what time they left. She sent the Petitioner to the clinic by at 10:00 a.m. but he didn't arrive for about one and one-half hours. (TA184-186; 216). It should have taken him fifteen minutes to drive from Continental Sales to Concentra. (TA184-186). Ms. Hernandez testified that she spoke with the Petitioner in person regarding his delay in presenting at Concentra. (TA186). The Petitioner claimed that he traveled home to pick up his wife to interpret for him at Concentra. (TA187). Ms. Hernandez testified that she had advised him, before he left Continental Sales, that there was a Spanish-speaking person at Concentra for his assistance. (TA187). She testified that she would let know any employee who didn't speak English know that Concentra provided Spanish-speaking individuals, to make them feel comfortable. (TA217).

Conversely, at Arbitration, the Petitioner claimed that the employees at Concentra did not speak Spanish, and he could not speak English. (TA99). When questioned about whether he went home to get his wife to interpret for him at Concentra on September 9, 2011, he admitted that he retrieved her to interpret at Concentra on either September 9th, or September 13th. (TA99). He then stated that his wife had driven him to work on September 9th. (TA100). Finally, he admitted that there were Spanish speaking interpreters at Concentra, but alleged that they were not attending to him, because he did not know what the human resource person talked to them about. (TA100).

Ms. Hernandez identified the report that she prepared on September 9, 2011 regarding the Petitioner's claimed accident in May 2010. (TA188-192; RX1; RX17). She confirmed that this was the first notice received regarding the claimed accident in May 2010. (TA189-190). The

report indicates the alleged accident happened over one year ago. (TA192; RX1). The description provided was that "employee states he was standing on top of a pallet, the pallet broke, causing him to fall and land on his behind." (TA193). He alleged an injury to his low back. (TA193-194). The Petitioner did not report a second incident on September 9, 2011 involving his low back. (TA198).

Ms. Hernandez referred to her notes while testifying. (TA181-182). She testified that her notes were created in a Word document, and she added to them as the events or conversations occurred. (TA182). She kept notes because the Petitioner was claiming an injury that had occurred so long ago. (TA183-184).

Medical Histories and Treatment

The medical records at Concentra indicate that the Petitioner's low back accident happened on May 2, 2011. (RX4). The Petitioner stated that the Concentra records are wrong as to the date of accident. (TA98). He claimed that if the records were different at Concentra, it was because there was no one to help him fill out the forms in Spanish. (TA101).

The Concentra records indicate the Petitioner reported on May 2, 2011 he fell on top of a pallet, and the pallet broke, causing injury to his back. (RX4). Concentra doctors diagnosed a lumbar sprain, prescribed medication and told to apply a gel ice pack, and released him to return to regular duty work. (TA32; RX4). He returned to Concentra on September 12, 2011 and reported no improvement in low back pain. He reported no radicular pain, and the straight leg raise test was negative bilaterally. He underwent an X-ray, which was negative for dislocation or fracture. He was diagnosed with a lumbar sprain. He was released to return to work with a 15-pound lifting restriction and pushing-pulling not to exceed 25-pounds. He was referred for physical therapy. On September 13, 2011 he presented to Concentra for physical therapy. His advised the therapists that one year prior, he stepped off the edge of a pallet, and fell backwards onto his buttocks. He alleged pain since that time. Dr. Garces also saw him that day, and noted he was working within restrictions and was discharged from care and released to regular duty work. (TA33-34, 102; RX4).

On September 14, 2011, the Petitioner returned to work for Respondent. He testified he only worked for two hours. (TA102). The employment records from Respondent indicate that the Petitioner worked a full day on September 14th. (RX17). When asked whether he called the Respondent on September 15, 2011 to say that he was not coming back to work, the Petitioner testified, "It's a lie. They are lying." (TA103, RX17).

On September 15, 2011, the Petitioner presented to Mercy Medical Center at 43rd and Pulaski for his low back. (TA103; RX5). He reported low back pain for one week. (TA107). There is no mention in the records that the back pain was related to a work injury. (RX5). At Arbitration, the Petitioner claimed he provided Mercy with a history of a September 9, 2011 work injury and might have told them about a May 10, 2010 work injury. (TA105, 107). On direct he testified

that he was sent for an MRI, but later stated it could have been an X-ray. (TA34-35, 108). The X-ray showed Grade I anterolisthesis of L4 on L5 with bilateral spondylolysis of the neural arch of L5, with osteopenia out of proportion for a patient with a stated age of 36. (RX5). He was recommended to undergo a qualitative bone mineral assessment, DEXA scanning and, if disc protrusion or spinal canal stenosis was clinically suspected, consider an MRI. (RX5).

The Petitioner called off work on September 16, 2011. He advised that he would either see a doctor that he had seen in the past or would see a doctor that he had seen on television. He claimed that the doctor from television would pick him up at his house. He said that for the time-being, he would not be coming in to work. (RX17).

The Petitioner presented to Continental Sales on September 17, 2011 to speak with Ms. Hernandez and Mr. Hernandez. He claimed his doctor told him to get an attorney. He refused to speak with them about his doctor's visit. He began to leave the human resources office and was agitated. Both Ms. Hernandez and Mr. Hernandez urged him to calm down. He stated that he no longer wanted to work as a stocker and wanted a different position. (RX17).

The Petitioner returned to Mercy Medical on September 21, 2011 to discuss the X-ray results. (TA108; RX5). He received a note from Mercy Medical limiting lifting to 20 pounds due to chronic back pain. (TA108, RX5).

The Petitioner hired Mr. Christopher J. Johnson, of the law firm of Katz, Friedman, Eagle, Eisenstein, to represent him for his work injury. He testified that Mr. Johnson was his first attorney. (TA110). The Application for Adjustment of Claim (11 WC 36904), which was signed by the Petitioner on September 22, 2011, and filed at the Commission on September 29, 2011 (11 WC 36904), alleges a work injury on May 10, 2010. (TA110). The Petitioner testified that he met with Mr. Johnson once or twice. He provided Mr. Johnson with the information to file the workers' compensation claim. (TA109-110). He testified later that the Application filed by Mr. Johnson was incorrect as to the date. (TA114). He explained that he lied about the date because human resources told him he could put whatever date on there. He said human resources lied. He said he lied. (TA114). He admitted that Ms. Hernandez did not create or file the Applications for Adjustment of claim. He alleged that he used May 10, 2010 as an accident date because Ms. Hernandez allegedly told him it didn't matter. (TA114).

The Petitioner also hired The Law Offices of James Ellis Gumbiner & Associates to represent him. They prepared an Application for Adjustment of Claim, filed on October 4, 2011 (11 WC 38145). The second Application alleged an accident on September 9, 2011 wherein the Petitioner fell on top of a pallet at work. The Petitioner's signature was not dated. The Petitioner originally testified that Mr. Johnson was the first lawyer he hired, but later claimed that Mr. Gumbiner was his first lawyer. (TA111). When he was shown the Application for Adjustment of Claim (11 WC 38145), he admitted he signed it, but stated that the accident

description was wrong. (TA112-113). He characterized that accident description as "a lie". (TA114).

At some point, Mr. Johnson withdrew from case 11 WC 36904, and Mr. Gumbiner handled both Applications. (TA113). In 2013, the Petitioner fired Mr. Gumbiner's law firm, and hired Mr. Serkland at Corti & Aleksy to represent him in both claim 11 WC 36904 and 11 WC 38145. (TA113). In 2014, the Petitioner fired Corti & Aleksy, and hired the current law firm, McHargue Law Office. (TA113).

The Petitioner admitted that attorney James Ellis Gumbiner referred him to New Life Medical Center. (TA115, 139). His first visit was on September 29, 2011. He testified that he told the doctors at New Life that he had injured his low back at work in May 10, 2010 (TA116). The records from New Life indicate that Petitioner reported the May 10, 2010 injury to Araceli Magana on May 2, 2011, and again on September 9, 2011. (PX3). At arbitration he testified that the New Life records regarding the dates were "a lie". (TA116; PX3). He testified that he told New Life that his pain began, or became more profound, on September 9, 2011. (TA35, 116; PX3). The doctors at New Life placed him in therapy for one and one-half to two years. (TA36; PX3).

The Petitioner testified that on October 4, 2011 New Life authorized him off all work until October 25, 2011. (TA41; PX3). He testified that his last date of work for the Respondent was either September 22, 2011 or September 23, 2011. (TA41-44). He received therapy at New Life. (TA41, 47). The Petitioner testified that New Life sent him to Instant Care to treat with Dr. Patel. (TA45, 116). The Petitioner underwent a lumbar MRI on October 28, 2011. The doctors at Instant Care referred him for a course of three injections to his low back. (TA46). He testified that the injections were 90% ineffective. (TA47; PX3).

Dr. Mehta referred the Petitioner to Dr. Kern Singh for a neurosurgical consult. (TA48). On January 9, 2012, the Petitioner told Dr. Singh that on May 20, 2010 he was unloading a pallet and tripped backward, (TA117). He stated that by this time, pain was in his low back and left leg. (TA48). Dr. Singh sent him for another MRI and then recommended surgery, a minimally invasive L4-5 laminectomy, transforaminal lumbar interbody fusion. (TA49-50; PX6). Dr. Singh stated that the need for this treatment was causally related to the alleged incident on May 20, 2010. (PX6). He returned to Dr. Singh on April 30, 2012, and Dr. Singh continued to recommend surgery at the visit on June 18, 2012. (TA 50-51; PX3; PX6).

The Petitioner continued physical therapy at New Life, and to see doctors at Instant Care until January 2013. He testified that the therapy made his low back pain worse. The records from New Life and Instant Care indicate no improvement with their treatment and therapies, and Petitioner testified that their treatment made him worse. (TA53-154, 137-139; PX3; PX6). When he ceased treatment at New Life, he still had the same back pain and pain in his leg. He testified it would come and go. (TA54).

In 2012, the chiropractic treatment at New Life was analyzed by Triune Health Group for Utilization Review. On November 2, 2012, New Life's chiropractic treatment was certified between the dates of September 29, 2011 and October 25, 2011 only. All chiropractic treatment after 10-25-11 was non-certified and deemed not reasonable. New Life chiropractor, Terence Patrick, D.C. appealed. On appeal the non-certification was upheld by David F. Cox, D.C., who certified ten visits only.

In addition, the pain management and injections by Instant Care were analyzed by Triune for Utilization Review. Only the injection from November 8, 2011, and the follow up visit with Dr. Mehta on November 15, 2011 were certified. As there was no evidence of functional improvement or decreased medication use following the initial injection, further injections were deemed not medically necessary. Further treatment by Instant Care was not certified. The Triune Health Group Utilization Review reports regarding non-certification of treatment by Instant Care and New Life were forwarded to the medical provider and to the Petitioner. (RX3).

The doctors at Instant Care referred the Petitioner next to Dr. Michel Malek. The Petitioner admitted it was possible he told Dr. Malek that his work injury occurred on May 20, 2010. (TA118: RX6). The records from Dr. Malek indicate Petitioner reported that on May 20, 2010 he stepped backward while stocking a pallet and hit his legs on the edge of the pallet, falling and landing in a twisted position on his left side. Then, on September 9, 2010, he reported re-injury while stocking cans of lemon tea in a repetitive manner. (RX6). The Petitioner testified that he was not able to communicate with Dr. Malek, as Dr. Malek did not speak Spanish. (TA118). Dr. Malek ordered another MRI, which was completed on June 1, 2012. (TA52). The Petitioner returned to Dr. Malek on June 26, 2012, Dr. Malek recommended surgery. (TA52).

At the request of the Respondent, the Petitioner was examined by Dr. Alexander Ghanayem on August 6, 2012. The Petitioner advised only of a back injury at work in May 2010 which involved him falling backwards, striking his back on a pallet. (RX2). The Petitioner testified that he also told Dr. Ghanayem about the lifting incident on September 9, 2011. (TA119-120). However, Dr. Ghanayem reports that the Petitioner denied other injuries to his low back. (RX2). Dr. Ghanayem had X-rays performed as part of his analysis, and reviewed imaging of the Petitioner's MRI scans from October 2011 and June 2012. He opined that the imaging disclosed congenital sacralization of L5-S1. He stated that the Petitioner did not have a true herniation at L4-5, but rather the ridge of the disc was associated with the slip at L4-5. He stated that the imaging disclosed a long-standing problem. Due to the congenital sacralization he was at greater risk of developing this problem. Dr. Ghanayem noted no evidence of medical treatment between May 2010 and September 2011. He reported that the Petitioner made no report to him of any injury in September 2011. Dr. Ghanayem concluded that there was no injury of substance in May 2010, and he did not relate the need for treatment to any work injury in May 2010. (RX2). Dr. Ghanayem indicated that treatment was reasonable for his non-work low back condition and that he should limit lifting to 15-20 pounds and refrain from repetitive bending or stooping. He

stated that the restrictions were not related to any work injury, but rather to the nature of spondylolisthesis. (RX2).

On cross-examination, the Petitioner was questioned about treatment by Dr. Saleh Rifai, and admitted that Dr. Rifai treated his low back, and referred him for an MRI and for physical therapy at Little Company of Mary Hospital. (TA121-122; RX7; RX8). The Petitioner admitted that in May of 2013, Dr. Rifai issued a return to work note, beginning part-time, and graduating to full time, due to spinal stenosis. (TA122; RX7). On August 16, 2013, the Petitioner was discharged from physical therapy due to lack of progress. (RX8).

The Petitioner returned to Dr. Ghanayem on December 19, 2013 at the request of the Respondent. (TA55-56, 123; RX2). Dr. Ghanayem noted that the Petitioner switched the date of his injury from May 2010 to September 2011 and claimed to have been fine prior to September 2011. Dr. Ghanayem opined that in the past, he did not believe the Petitioner's low back condition was causally related to his alleged work injuries, and his opinion remained unchanged. (RX2). Dr. Ghanayem opined that it was medically reasonable for the Petitioner to undergo lumbar fusion, but that the need to it was unrelated to the injuries he claimed occurred. (RX2). At Arbitration, the Petitioner thought that he provided Dr. Ghanayem with both dates of alleged injury (TA123).

The Petitioner admitted on cross-examination that he also treated at Healthy Family Medical with Dr. Masood Syed. Dr. Syed treated him for his low back. (TA123; RX9). The records from Healthy Family indicate that the Petitioner presented on March 1, 2014 with back pain of three-year duration. He reported having fallen on his back three years prior, with low back and left leg pain since that time. (RX9). Dr. Syed referred him to an orthopedic surgeon. (RX9).

On March 25, 2014, the Petitioner presented to the University of Illinois Medical Center and was seen by Dr. El Shami. He reported low back and left leg pain with no relief from at least four injections and physical therapy. (PX8, PX9). He also reported a recent fall with 4th metacarpal fracture. Dr. El Shami referred him for imaging of his lumbar spine, and EMG, and for consultation by an orthopedic hand surgeon. The MRI disclosed anterolisthesis of L4 on L5 due to past defect with degeneration of the disc and bilateral foraminal narrowing at L4-5. The EMG was consistent with mild, subacute L5 radiculopathy. On May 7, 2014, Dr. El Shami discussed injections, back braces and a TENS unit, but the Petitioner was very frustrated with the amount of his pain so Dr. El Shami referred him to a surgeon. (TA56-57; PX8; PX9).

On May 27, 2014, the Petitioner requested Dr. Syed prescribe pain medication for back pain that he claimed was worse. He told Dr. Syed that he was supposed to have low back surgery but was not ready for it. (RX9).

On June 17, 2014, the Petitioner was examined by Dr. Kyle Macgillis of the University of Illinois. The Petitioner reported undergoing multiple epidural steroid injections and medications since working in a stock yard stacking pallets and falling backwards. Dr. Macgillis noted X-rays

and MRIs showed Grade I spondylolisthesis at L4-5 with a defect in the pars interarticularis. He was referred for a CT scan of his lumbar spine, which was performed on June 23, 2014. It showed no change since the last radiographs on March 25, 2014. The impression was of degenerative disc disease at L4-5 with generalized disc herniation and neuroforaminal narrowing. It was negative for acute fracture. (PX8, PX9).

The Petitioner was scheduled for surgery by Dr. Krzysztof Siemionow on July 25, 2014. His history to Dr. Siemionow was of an injury to his low back three years previous, which stacking large objects in an elevated position, falling, and landing on his back. Dr. Siemionow performed posterior spinal fusion at L4-5, posterior spinal instrumentation at L4-5. (PX8, PX9). After surgery, the Petitioner underwent physical therapy. He testified that after surgery, he felt worse as to his left low back and left leg pain. (TA57-59; PX8; PX9).

On July 30, 2014, the Petitioner presented to Dr. Syed with complaints of pain upon weight bearing. Dr. Syed advised him about wound care and the medications prescribed by his orthopedic surgeon. On August 29, 2013, the Petitioner returned to Dr. Syed requesting pain medication and Dr. Syed asked him to bring an empty bottle of pain medication for identification. (RX9). On September 16, 2014, the Petitioner presented to University of Illinois for an X-Ray and medication refills. The X-rays showed satisfactory appearance of the fusion. (PX8, PX9). On October 6, 2014 the Petitioner requested refill of pain medications from Dr Syed, claiming that the surgery did not help, and he continued to have severe pain in his low back and left leg. Dr. Syed refilled his medication again on October 24, 2014 and November 24, 2014. (RX9). He returned to University of Illinois on December 2, 2014 and reported much improvement and no complaints with therapy. He received refills on his pain medication and underwent an X-ray. (PX8, PX9).

On December 29, 2014, the Petitioner presented to Dr. Syed for refills on pain medication. He reported back pain getting worse with radiation to both thighs, constant with or without movement. Dr. Syed re-prescribed Norco and added Soma. (TA125; RX9). The Petitioner returned to Dr. Syed on January 14, 2015 and February 6, 2015 due to complaints and refills on pain medication.

On February 12, 2015, the Petitioner filled a prescription for Hydrocodone/Acetaminophen 10/325, #45. (RX10). On February 24, 2015 and March 2, 2015, he followed up with Dr. Syed for refills on pain medication. (RX9).

On March 3, 2015, the Petitioner saw Dr. Danil Rybalko at University of Illinois due to a four week increase in low back pain. He reported taking Norco 10, 2-3 times per day. Dr. Rybalko recommended repeat X-rays and a CT scan, and refilled Petitioner's prescription for Norco. X-rays at University of Illinois were unchanged as to prior. There was no motion in the area of L4-L5 on flexion extension views. (PX8, PX9). The Petitioner returned to University of Illinois on March 17, 2015 and saw Dr. Iacobelli. It was noted that his CT scan indicated stable fusion.

The Petitioner advised Dr. Iacobelli that he was applying for Social Security Disability. Dr. Iacobelli provided a new prescription for Norco. (PX8, PX9).

On May 4, 2015, the Petitioner presented to Mercy Hospital and Medical Center emergency room with head and neck pain. He was diagnosed with a migraine headache. He claimed to have been told that his head and neck pain was caused by his back pain. He underwent an out-patient mental health assessment. He admitted to drinking alcohol, 1-2 beers at a time, use of marijuana and cigarette smoking, 4-5 cigarettes per day. (RX12). He reported a history of physical abuse as a child in Mexico, and a work injury in May 2010, when he slipped and fell on a pallet. He reported having begun working at age eight and immigrating to the United States when he was nineteen. (RX12).

On May 18, 2015, the Petitioner was seen by Dr. Slavin at University of Illinois. To Dr. Slavin, the Petitioner denied drug or alcohol use. He admitted to 2-3 cigarettes per day. Dr. Slavin recommended a spinal cord stimulator following evaluation by a psychologist. (TA60; RX13).

On June 9, 2015, the Petitioner was examined by Dr. Neil Pliskin, Ph.D., ABPP-CN of The University of Illinois. He reported to Dr. Pliskin that he had worked as a stock person in a factory. He backed into a stack of wooden pallets while lifting a heavy object and was injured. He went to a doctor and had a twenty-five-pound lifting restriction and one session of physical therapy. He eventually returned to work full duty but told his boss that he was in pain. He claimed the boss did not believe him. He claimed that his co-workers teased him. He reported re-injuring himself in September 2011. Dr. Pliskin's examination and testing were conducted in Spanish. Dr. Pliskin found no cognitive or emotional contraindications for spinal cord stimulator. (TA127; RX13).

On July 6, 2015, the Petitioner returned to Dr. Slavin and complained of more weakness and discomfort, so Dr. Slavin referred him for more physical therapy. His pain medications were refilled. He was to return after therapy to re-consider implementation of a spinal cord stimulator. He participated in physical therapy at University of Illinois. On September 1, 2015 Dr. Siemionow stated that the Petitioner was capable of lifting up to twenty pounds, or light duty work. On September 17, 2015, Dr. Slavin advised the Petitioner to contact him when he was ready for surgery related to the spinal cord stimulator. (PX8, PX9). On October 16, 2015, the Petitioner advised Dr. Slavin that he was capable of climbing two flights of stairs or walking four blocks but continued to have pain. He admitted to marijuana use and smoking ½ pack of cigarettes per day. (TA127; PX8; PX9).

On October 21, 2015, the Petitioner presented to Dr. Guzman at Galilee Medical Center complaining of back pain and requesting medication refill. Dr. Guzman referred him for repeat X-rays. On October 24, 2015, the Petitioner underwent X-rays at Preferred Open MRI. The impression was of pedicle screws and rods fusing L4-5 and disc space narrowing and retrolisthesis of L5 with respect to L4 by 8 mm. There was no evidence of hardware failure or

loosening. (RX10; PX10). At his follow up appointment on November 3, 2015, Dr. Guzman recommended pain management, but also refilled pain medication. (TA125, 126).

On November 5, 2015, the Petitioner began treatment at Esperanza Health Center for mental health issues. (RX11). He received counseling and psychotherapy.

On December 1, 2015, the Petitioner failed to show up for scheduled spinal cord stimulator by Dr. Slavin. (PX8, PX9). On the same date, he presented to Dr. Guzman for refills of pain medication. Dr. Guzman recommended that he return in two months, and recommended pain management for further narcotic prescriptions. (TA128, 129; PX10).

On January 4, 2016, the Petitioner returned to Dr. Slavin to discuss, for the fourth time, implementation of a spinal cord stimulator. He reported his pain was getting worse, and traveling into the heel on his right foot, making it difficult to walk. Dr. Slavin prescribed Tramadol. (PX8; PX9). On January 19, 2016, the Petitioner saw Dr. Siemionow, complained of continued pain, and that he had not undergone spinal cord stimulator implementation. Dr. Siemionow refilled Norco and Tramadol.

On February 10, 2016, the Petitioner returned to Dr. Guzman, who recommended pain management. (RX10). On March 15, 2016, he returned to Dr. Siemionow who noted CT scan showed solid fusion. The Petitioner told him that he did not have a primary care doctor to prescribe him pain medication. The Petitioner offered that Norco 10 reduces his pain. Dr. Siemionow prescribed Norco 10 until he was able to get a consult with Dr. Iacobelli at the Pain Clinic. (PX8; PX9).

On April 8, 2016, the Petitioner returned to Dr. Guzman for medication refills. Dr. Guzman provided Vicodin 10, #14 with no refills. On April 12, 2016, the Petitioner presented to Dr. Iacobelli in Pain Management at University of Illinois. He reported that Norco helped him the most, and that he took 3-4 Norco per day. He admitted to trying physical therapy ordered by Dr. Slavin only three times, discontinuing due to pain. (PX8; PX9). He advised Dr. Iacobelli that he had not taken Norco in one month. (TA130, 131)

On May 3, 2016, the Petitioner presented to Esperanza Health Center due to panic attacks and fear of going outdoors or to public places. On August 1, 2016, he returned to Esperanza for pain medication and received refill of Vicodin. Between August 3, 2016 and September 6, 2016, the Petitioner was seen by various practitioners at Esperanza for counseling and refills of Vicodin. He reported marital and legal troubles. (RX11).

At Arbitration, PhotoFax investigator, Joseph Pierce testified to surveillance performed in September 2016 at the request of Auto Owners Insurance. (TA219-230). He testified to the chain of custody of the September 2016 surveillance videotape at PhotoFax. He testified that the video contains footage of the Petitioner, when in view. (TA226-227). The surveillance video obtained in September 2016 was two hours, forty minutes and four seconds. (TA226; RX14).

On September 7, 2016, the Petitioner was observed on surveillance video driving to a local high school to drop off a teenaged male. Later, he walked around his neighborhood while smoking a cigarette and talking on a cellphone and returned to his residence accompanied by a female and children. He used no assistive device to walk and appeared to have no difficulty. (RX14).

On September 8, 2016, the Petitioner was observed on surveillance video driving a vehicle to a nearby gas station, entering and emerging with a bag of unidentified items, and returning to his residence. Later he walked through his neighborhood. He used no assistive device to walk and appeared to have no difficulty. (RX14).

On September 9, 2016, the Petitioner was seen at Esperanza Health Center by Dr. Adriana Guerrero for counseling. He was encouraged to follow up with contacts provided in the prior session, especially since he admitted he hadn't returned their phone calls or made effort to follow up. (RX11).

On September 10, 2016, the Petitioner was observed on surveillance video throughout the day. The Petitioner confirmed his address on 64th Street in Chicago. (TA143). He testified at Arbitration that he drivers a red 1996 Chevy Tahoe, and a black 2009 Explorer. (TA140). He departed from his home, accompanied by two unidentified individuals and travelled by vehicle first to McDonalds, and then to "4 Less", where Petitioner purchased a variety of meats and other food items. From there, the group travelled by vehicle to Homeland Gas Station, and then to Marquette Park where they attended outdoor soccer matches for many hours. The Petitioner was observed to walk on grass and paved surfaces, stand under a tent for hours, grill meat in a standing position, grill meat on a smaller grill while seated on the ground, arise from a seated, cross-legged position on the ground without assistance, crouch at the grill to turn meat while holding a plate in one hand, serve attendees grilled food, drink several beers, intermittently sit in a chair, smoke cigarettes, use a cell phone while standing and walking, clean the grill and disassemble the grill while seated on the ground, cross legged, and load up his vehicle with items at the end of the day. The Petitioner did not use an assistive device to walk or stand, and appeared to laugh, and socialize with others. Over six hours, approximately one hour and forty minutes of surveillance video was obtained. (RX14).

On September 11, 2016, the Petitioner was observed on surveillance video, in the morning, entering his vehicle and driving to downtown Chicago. Contact was lost, and investigators returned to Petitioner's residence to find the Petitioner's vehicle parked outside. A bit later, the Petitioner exited his home and went to his vehicle to retrieve an unknown item, and then walked out of view. He did not ambulate with an assistive device or exhibit obvious signs of pain. (RX14).

On September 12, 2016, the Petitioner returned to Esperanza Health Center. He reported his mood was worse; he had increased anxiety and panic symptoms. He reported a better weekend

than usual as he had taken his children to the park. (RX11). His counselors assisted him in completing a Social Security Administration form. (RX11).

On September 20, 2016, the Petitioner returned to Dr. Siemionow. He complained that he could not sit or stand as both caused shooting pain in his legs and tingling in his feet. He claimed to be considering the stimulator implant by Dr. Slavin. He admitted to smoking cigarettes, which the doctor noted made him non-compliant. A CT scan was performed and exhibited a well-fused back with components in place and no fracture or dislocation. (PX8; PX9). The Petitioner testified that he failed to receive much relief from the surgery performed by Dr. Siemionow. (TA139).

On October 4, 2016, the Petitioner returned to Dr. Chico at Esperanza Health Center to refill his Vicodin. Dr. Chico expressed concern over his use of prescriptions. Dr. Chico referred him back to Dr. Slavin. The Petitioner saw Dr. Slavin on October 17, 2016. He complained that he was unable to perform any activity or stand for any period of time without severe pain, making him feel crippled to the point where he almost falls down. (PX8; PX9). Dr. Slavin referred him for another MRI. The MRI, performed on October 21, 2016, it disclosed stable post op changes after L4-5 posterior spinal fusion with stable, mild anterolisthesis due to bilateral L4 neural arch spondylolysis with no evidence of neural compromise. (PX8; PX9).

The records from Esperanza Health document that the Petitioner presented on a monthly basis to obtain refills of medication, including Vicodin. Each time, he was provided with a one-month supply of Vicodin (10 milligrams, #60). (RX11).

On December 12, 2016, the Petitioner returned to University of Illinois and saw Dr. Hrubes. He reported a recent fall out of bed due to leg weakness. Dr. Hrubes stated that there was no need for him to follow up in their clinic as Petitioner was not interested in interventional injections, or the spinal cord stimulator, or physical therapy. He was advised to follow up with his primary care physician. He was given one last prescription for Norco 10/325 and was advised he would receive no further prescriptions. On December 13, 2016, Dr. Iacobelli noted that Petitioner was fully healed from a surgical standpoint. (PX8; PX9).

On December 20, 2016, the Petitioner returned to Esperanza Health. They recommended he wean off narcotics. On February 13, 2017, the Petitioner reported he was recently arrested for driving without a driver's license or car insurance. (RX11).

On February 26, 2017, the Petitioner submitted to a toxicology screen on referral from Esperanza. On March 11, 2017 he saw Dr. Solari at Esperanza and inquired about medical Cannabis. Dr. Solari noted the Petitioner's prior receipt of a DUI after being caught by the police with Cannabis in his car and pending two-year probation factoring in to the recommendation for medical Cannabis. (RX11).

On March 22, 2017, the Petitioner saw Dr. Chico to discuss the drug screen from February 26, 2017. The Petitioner tested positive for cannabinoids, cocaine and opioids. The Petitioner denied use of cocaine but endorsed use of marijuana. It was noted he would be retested in a week, and if positive for marijuana and cocaine, they would terminate care. (TA132-135; RX11).

On March 29, 2017, the Petitioner returned to Dr. Chico and requested an increase in opioids. He was given another drug screen the following day. On April 3, 2017 Dr. Chico noted the drug screen was positive for cannabinoids, benzodiazepine and opiates. Another drug screen was administered on April 6, 2017 and was later found to be positive for cannabinoids and opiates. A drug screen administered on May 17, 2017 was also positive for cannabinoids and opiates. (TA 144; RX11). The Petitioner testified that he took narcotic pain medication as directed. (TA145).

At Arbitration, investigator Joseph Dizeo of PhotoFax testified to surveillance video of the Petitioner in April and May 2018. (TA231-238). He received the assignment to conduct surveillance on the Petitioner from Joseph Pierce. (TA233). He testified to the chain of custody of the surveillance video. (TA234). He shot surveillance video on April 29, 2018, May 5, 2018 and May 12, 2018. (RX15, RX16). The total running time of the video is two hours, twelve minutes and eleven seconds. (RX15, RX16). At Arbitration, Mr. Dizeo identified the Petitioner as the subject seen in the videos from April and May 2018. (TA238).

On April 29, 2018, The Petitioner was observed on surveillance video at 8:30 a.m., arriving at his residence driving his vehicle. He exited, carrying plastic bags containing unknown items into his residence. He used no assistive device to walk. At 1:31 p.m. that day, he departed with two unidentified females and an unidentified male and drove to Prestige Liquors. He was observed entering and exiting Prestige several times, without the use of assistive device, the first trip he carried a plastic bag containing unknown items and two cases of beer. On a second trip into Prestige, he returned with a bag of ice. The next group traveled to Bogan High School, arrived at 1:57 p.m., and walked to the soccer fields. The Petitioner testified that he has a daughter that plays soccer at Bogan High School (TA140). The Petitioner walked from his car to a soccer field without use of assistive device. The Petitioner walked and stood, without assistive device or apparent difficulty, for nearly three hours. He was observed to bend at the waist, squat, sit on the ground and arise without assistance, and sit in a chair and arise without assistance. He drank multiple beers while at the soccer match. He smoked multiple cigarettes throughout the soccer match. (RX15).

More specifically, between 2:16 p.m. and 2:19 p.m., he smoked a hand-rolled cigarette, which was passed around by the Petitioner, amongst a group of men. At 2:22 p.m., the Petitioner lit a traditional cigarette. At 2:51 p.m., the Petitioner kneeled, and then sat on the ground while doing something with his hands. He was able to rise from the ground without assistance or difficulty. From 2:54 to 2:56 p.m., he appeared to seal a hand rolled cigarette with his lips. He looked around the area, scanning the crowd. From 2:57 p.m. to 3:04 p.m., the Petitioner walked and stood, talking with two other men, while passing the hand rolled cigarette between them. During

his three hours at the soccer match, the Petitioner was seen to socialize, stand, bend, sit and walk, to laugh, to drink and to smoke without difficulty or evidence of pain. (RX15).

On May 5, 2018, the Petitioner was observed on surveillance video driving his black Explorer from his residence to a Dunkin Donuts with an unidentified female. Between 7:38 a.m. and 7:40 a.m., while the female was not in the vehicle, the Petitioner was captured smoking a brown wrapped cigarette, which he held pinched between his index finger and thumb. He extinguished and saved the end of this cigarette. At 7:41 a.m., after the female returned to the car, the Petitioner lit, and smoked a traditional cigarette wrapped in white paper. (RX15).

The Petitioner testified that the doctors at New Life released him to light duty work as did the doctors at University of Illinois. (TA66). He testified that he has received Social Security Disability benefits since 2017. (TA67). The Petitioner testified that at the time of Arbitration he was a Medicare beneficiary. He is prescribed medication from his pain specialist at the University of Illinois, and treats with doctors at Esperanza, located at 65th and Richmond. (TA62-63). The Petitioner testified that before he received Disability in 2017, he received medical benefits through the State of Illinois. He said the doctors at University of Illinois have both his white card from the State of Illinois, and his blue and white card from Social Security Disability. (TA63-65).

At Arbitration, the Petitioner admitted that he never underwent implementation of the stimulator. (TA60-61). He stated that he participates in pool therapy and receives injections. (TA62).

At Arbitration, on August 17, 2018, the Petitioner testified that he still experienced extreme pain in his back and legs. He stated that his back pain is in the middle and to the left side, and it is down his left leg. (TA68-69). He testified that he no longer plays soccer with his children, or goes dancing, which he would do once or twice per year. (TA69-70). He testified that he takes pain pills in the morning and afternoon and takes other medication for his left leg symptoms three times per day. (TA72).

The Petitioner presented at Arbitration using a cane to ambulate. He testified that he uses the case once awhile when it's hot but does not use it when it is cold. (TA140-141). He testified while seated and asked to stand on at least one occasion. He moaned in pain during the hearing. The Petitioner testified that his back was hurting after recent participation in pool therapy (TA141-142).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of fact in support of the conclusions of Law set forth below. To obtain compensation under the act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980) including that the accidental injury both arose out of and occurred in the course of his employment (Horvath v. Industrial Commission, 96 Ill.2d. 349 (1983))

and that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, I29 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980). The mere existence of testimony does not require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evidence it might be that his story is a fabricated afterthought. U.S. Steel v. Industrial Commission, 44 Ill2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill. App. 3d 284, 574 N.E.2d 1244 (1991). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). The above Statement of Facts contains many examples of Petitioner's testimony being at odds with the medical records and testimony of other witnesses. The Arbitrator finds Petitioner to have substantial credibility issues that prevent the Arbitrator from finding in his favor on any of the disputed issues in this case. Specific findings regarding credibility that lead the Arbitrator to make findings on the disputed issues are explained below.

As to disputed issue "C", did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence, that he sustained an accidental injury that arose out of and in the course of his employment by Respondent, Continental Sales, on either May 10, 2010 or September 9, 2011. In support of this finding, the Arbitrator finds the following facts.

The Petitioner's alleged injury on May 10, 2010 was not witnessed, by his own admission. He did not present any post-occurrence witness to corroborate his testimony. He alleged that he told his supervisor, Mr. Ramon Hernandez, on the date that it occurred, but Mr. Hernandez denies knowledge of this injury on the date that it occurred. The Petitioner sought no treatment for this alleged injury for sixteen months.

The Petitioner's testimony regarding the mechanism of his injury on May 10, 2010 is inconsistent with the Respondent's employment/human resources records and the medical histories. At Arbitration, the Petitioner testified that, while lifting a box of food, he stepped backward, and his foot stepped on the edge of a pallet behind him, causing him to fall to the ground in a seated position. He stated his buttocks were on the floor, and his back hit the edge of the pallet. He denied that the pallet broke. However, the Respondent's records include the First Report of Injury, completed by Human Resources Generalist, Ms. Danelia Hernandez, on September 9, 2011. On that document, Ms. Hernandez noted that the Petitioner reported that sixteen months prior, he was standing on top of the pallet, when the pallet broke, causing him to fall and land on his behind.

The first medical treatment for the May 10, 2010 alleged accident was on September 9, 2011, the date that he reported it to the Respondent. However, to the doctors at Concentra, he reported an accident on May 2, 2011 in which he fell on top of a pallet, and the pallet broke, causing back pain. He testified that the Concentra records contain the wrong date of accident.

The Petitioner explained the incorrect date by claiming that there was no one to help him at Concentra to fill out the forms in Spanish. He also claimed that the employees at Concentra did not speak Spanish, and he did not speak English. However, Ms. Hernandez testified that she told the Petitioner, as she would any Spanish speaking employee, that Concentra employs Spanish speaking personnel to assist Spanish speaking patients. She testified that she is also fluent in Spanish and spoke to the Petitioner on September 9, 2011 in his native tongue. Later that day, Ms. Hernandez learned that the Petitioner did not travel directly from Continental Sales to Concentra, a fifteen-minute drive. Rather, he presented there approximately ninety minutes later. When Ms. Hernandez questioned him about his delay in presenting for treatment, he told her that he had traveled first to his home, to pick up his wife so that she could translate for him at Concentra. When asked about this inconsistency at Arbitration, he admitted that he had traveled

home to pick up his wife to translate and admitted that there were Spanish speaking employees at Concentra.

The Petitioner presented to Mercy Medical Center at 43rd and Pulaski on September 15, 2011, for treatment to his low back. The records fail to document that his back pain was work related.

Within a couple weeks of providing notice to the Respondent of his back injury in May 2010, the Petitioner hired two different law firms to represent him. One filed an Application for an accident on May 10, 2010, and the other filed an Application for an accident on September 9, 2011. The Application for the May 2010 accident simply alleges an injury while working. The Application for the September 9, 2011 accident alleges that the Petitioner fell on a pallet at work. At Arbitration, the Petitioner claimed that the description of the September 9, 2011 accident was a lie.

The Petitioner alleges that he told his supervisor, Mr. Ramon Hernandez about the May 10, 2010 accident on the day that it occurred. Mr. Hernandez denies knowing about the Petitioner's accident on that date. The Petitioner alleges that Mr. Hernandez told him to go home on May 10, 2010, and that he missed several days of work after that. The Respondent's Employee Attendance Tracking forms fail to indicate any absence due to an alleged work injury on May 10, 2010.

The Petitioner admitted that, once he allegedly told Mr. Hernandez about the May 10, 2010 accident, he didn't mention it again until September 9, 2011. However, Petitioner claims that Mr. Hernandez allowed him to come and go as he pleased due to his back problem, and that the Respondent never disciplined him about his late arrival, early departure or missed work. The Respondent's personnel records document several instances in which the Petitioner was late, left early or missed work in 2010 and 2011. These same records indicate Petitioner was spoken to or disciplined on several occasions. In May 2011, the Petitioner was written up for gross misconduct for refusing to follow his supervisor's instructions, and when an alternate job was proposed, the Petitioner instead left to go home. The Respondent's attendance records indicate the Petitioner provided other excuses for his tardiness and lost time – babysitting problems, car problems, legal problems, oversleeping, and childcare issues. There is no documentation that Petitioner's attendance problems were related to his low back condition. Mr. Hernandez testified that he did not learn about the Petitioner's alleged back injury in May 2010 until September 2011.

The Petitioner was sent by his lawyer to New Life for medical treatment. The medical history at New Life indicates Petitioner sustained an accident on May 10, 2010, which he reported to co-worker Araceli Magana on May 2, 2011, and reported again on September 9, 2011. At Arbitration, the Petitioner claimed that the new life dates were "a lie". The records from New Life and Instant Care fail to document a second accident on September 9, 2011.

The Petitioner was sent by New Life to Dr. Kern Singh, who examined him on January 9, 2012. Dr. Singh's records document that on May 20, 2010 the Petitioner was unloading a pallet and tripped backward.

The Petitioner was sent by Instant Care to Dr. Michel Malek, who examined him in 2012. Dr. Malek's records document that on May 20, 2010, the Petitioner stepped backward while stocking a pallet and hit his legs on the edge of the pallet, falling down and landing in a twisted position on his left side. Dr. Malek's report indicates further that the Petitioner was re-injured on September 9, 2010 while stocking cans of lemon tea, twisting and performing repetitive work.

The Petitioner was examined by Dr. Alexander Ghanayem on several occasions. On August 6, 2012, he advised Dr. Ghanayem that his injury occurred in May 2010 when he fell backward and struck his low back on a pallet. The Petitioner returned to Dr. Ghanayem on December 19, 2013. This time, he failed to allege a work injury in May 2010, but rather claimed to have been injured on September 9, 2011.

The Petitioner sought treatment with Dr. Saleh Rifai. Dr. Rifai's records from 2013 fail to contain a history of any work injury but mention only that the Petitioner ceased working one and one-half years prior and wanted to return to work part time.

The Petitioner sought treatment with Dr. Masood Syed at Healthy Family Medical in March 2014. The Petitioner did not provide a detailed history of a work injury, but rather report a fall on his back three years previous.

The Arbitrator finds that the Petitioner lacks credibility. In addition to the above-stated inconsistencies, the Petitioner was seen to behave on surveillance video very differently than he presented while testifying at the Commission. While at the Commission, he ambulated with a cane, and exhibited numerous pain behaviors, including wincing facial expressions and audible moans of pain. On surveillance video in 2016 and 2018, the Petitioner is seen to ambulate without a cane over multiple days of surveillance, stand for hours at a time without difficulty, squat, kneel and sit on the ground without difficulty rising, and is able to carry items in his hands. In addition, the Petitioner appears to engage in behavior which would contradict instructions of his doctors. For example, the Petitioner is seen to consume numerous alcoholic beverages while watching his children play soccer in 2016 and 2018. The Petitioner is seen to smoke numerous cigarettes on surveillance video in 2016 and 2018, which his surgeon stated would make him non-compliant with surgical guidelines. In 2017, the doctors at Esperanza administered drug screens to the Petitioner, one of which was positive for cannabinoids, opiates and cocaine. Subsequent drug screens were positive for cannabinoids, opiates and on one occasion, also benzodiazepines. During two separate days of surveillance in 2018, the Petitioner is seen also to smoke non-traditional cigarettes while at a soccer match, and while preparing to drive his vehicle with a passenger.

The Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment on either May 10, 2010 or September 9, 2011. As such, the Arbitrator declines to award any benefits under the Illinois Workers' Compensation Act.

As to disputed issue "E", was timely notice of the accident given to Respondent, the Arbitrator finds the following facts:

Because of the Arbitrator's finding that the Petitioner failed to prove an accident occurred on May 10, 2010 or September 9, 2011, the issue of notice is moot. However, the Petitioner's failure to provide timely notice also supports the Arbitrator's finding that the Petitioner failed to prove accident.

The Arbitrator finds that the Petitioner failed to provide timely notice to the Respondent of his alleged accident on May 10, 2010. The Arbitrator adopts the testimony of Mr. Ramon Hernandez over that of the Petitioner. Mr. Hernandez denies that the Petitioner came to him on May 10, 2010 to report the alleged injury. Even the Petitioner admits that he didn't discuss this alleged injury with Mr. Hernandez between May 11, 2010 and September 9, 2011. The Petitioner admits further that he never reported his alleged injury in May 2010 to Human Resources Generalist, Ms. Danelia Hernandez between the date she was hired in February 2011, and the date that he provided notice, September 9, 2011. There is no medical documentation, or personnel/human resources documentation of lost time due to a back injury.

As to the Application alleging an accident on September 9, 2011, a discrete accident is alleged thereon, but the Petitioner testified that it the accident alleged on that Application was "a lie". When the Petitioner notified the Respondent on September 9, 2011, he reported only a discrete trauma from May 2010. He did not provide testimony or proof of any new accident on September 9, 2011 or allege any facts to prove an alleged repetitive trauma injury to the low back caused by his employment. When he provided notice on September 9, 2011, it was of an accident that allegedly occurred sixteen months earlier. The Arbitrator finds that the Respondent was prejudiced by the Petitioner's failure to provide timely notice of the May 10, 2010 alleged accident, or any notice of an accident on September 9, 2011.

As to disputed issue "F", is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following facts.

The Arbitrator adopts the causation opinion of Dr. Alexander Ghanayem to find that the Petitioner failed to prove that his low back condition and need for surgery were causally related to his employment. Dr. Ghanayem noted that at his first evaluation in 2012, the Petitioner reported an accident in May 2010 for which he failed seek treatment for over sixteen months. At his second evaluation in 2013, the Petitioner instead alleged an accident on September 9, 2011. The delay in treatment and the switching of accident dates called into question whether there was any trauma to the Petitioner's spine caused by his employment. Dr. Ghanayem reviewed original

imaging of the Petitioner's spine and opined that his spinal condition was related to congenital sacralization, which placed him at greater risk of developing spondylolisthesis. He opined that the Petitioner did not have a true herniation at L4-5, but that the ridge of the disc was associated with the slip at L4-5. Dr. Ghanayem stated in August 2012, that the petitioner's spinal condition was of long-standing duration. He stated that the Petitioner's condition was unrelated to any work injury, but rather to the nature of spondylolisthesis.

The Petitioner offered no causal relationship opinion.

As to disputed issue "J", were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

The Arbitrator declines to award any medical expenses due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "J", is the Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

The Arbitrator declines to award any prospective medical care due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "K", what temporary benefits are in dispute, the Arbitrator finds the following facts:

The Arbitrator declines to award any temporary total disability benefits due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "L", what is the nature and extent of the injury, the Arbitrator finds the following facts:

The Arbitrator declines to award any permanent partial disability benefits due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC038145
Case Name	MANZO, ERNESTO v. CONTINENTAL SALES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0373
Number of Pages of Decision	31
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Daniel Klosowski
Respondent Attorney	Thomas Mallers

DATE FILED: 7/23/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0373

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

Ernesto Manzo,

Petitioner,

vs. NO: 11 WC 38145

Continental Sales,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the decision of the Arbitrator to find that Petitioner provided proper and adequate notice with respect to claim 11 WC 38145. Specifically, the Commission finds that the acknowledged receipt of an Application for Adjustment of Claim alleging a date of accident of 9/9/11 within 45 days of said accident is sufficient to find that Petitioner provided proper and adequate notice with respect to said claim. The Commission also finds no evidence that Respondent was in any way prejudiced by any alleged defect in notice with respect to said claim. Therefore, the Commission modifies the Arbitrator's decision to find that Petitioner provided proper and adequate notice with respect to claim 11 WC 38145.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/8/19, denying compensation in claim 11 WC 38145, is affirmed and adopted as modified herein.

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

July 23, 2021

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

TJT: pmo
o 6/22/21
51

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MANZO, ERNESTO
Employee/Petitioner

Case# **11WC036904**
11WC038145

CONTINENTAL SALES
Employer/Respondent

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

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

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

2553 McHARGUE & JONES LLC
DANIEL R KLOSOWSKI
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
MICAELA CASSIDY
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

ERNESTO MANZO
Employee/Petitioner

v.

CONTINENTAL SALES
Employer/Respondent

Case # **11** WC **36904**

Consolidated cases: **11 WC 38145**

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 **August 17, 2018 & August 27, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 10, 2010 & September 9, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On these dates, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$20,736.04**; the average weekly wage was **$398.77**.

On the date of accident, Petitioner was **34 & 36** years of age, ***married*** with **6** dependent children.

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

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

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

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that he sustained an accident on either May 10, 2010 or September 9, 2011, which arose out of and in the course of his employment, therefore no benefits will be awarded pursuant to 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

March 7, 2019
Date

MAR 8 - 2019

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

Ernesto Manzo, Petitioner,	)		
	)	Number:	11 WC 36904
vs.	)		11 WC 38145
Continental Sales, Respondent.	)		

MEMORANDUM OF DECISION OF ARBITRATOR

The matter was heard by an Arbitrator designated by the Commission in the City of Chicago, County of Cook and State of Illinois.

The Arbitrator renders findings on the following disputed issues:

(B) Whether an accident occurred;
(C) Whether Petitioner gave Respondent notice of the alleged accident:
(F) Whether Petitioner's current condition of ill-being causally related to the injury;
(J) Were the medical services provided to Petitioner reasonable and necessary; has Respondent paid all appropriate charges for all reasonable and necessary medical services;
(K) Whether Petitioner is entitled to temporary total disability; and
(L) The nature and extent of the injury;

STATEMENT OF FACTS

May 10, 2010 (11 WC 36904)

The Petitioner was hired by the Respondent on November 14, 2003. (TA75). On May 10, 2010 he worked for them as a stocker. He was 36 years old. His job involved moving salvaged food, shrink wrapped on pallets in the stocking room, into empty banana boxes for transport to the sales floor. (TA79). The Petitioner would first remove the items from each pallet in the stock room, organize the food by type and place into empty banana boxes for transport to the sales floor. He would place the filled boxes onto a hand cart or pallet and move them to the sales floor using the cart or a pallet jack. (TA155). Once on the sales floor, the Petitioner would empty the banana boxes to stock the shelves with food. (TA155). He estimated that he would move up to fourteen carts/pallet jacks of boxes to the sales floor per work day. (TA9-12, TA80-81).

On May 10, 2010 the Petitioner presented to work and felt perfectly well. (TA15). He testified that he was stocking a pallet of food that had four layers, with another pallet in between two of the layers. He finished the top layers and moved the middle pallet to the ground behind him, to begin working on the lower layers. He explained that the middle pallet was placed on the ground, as the Respondent had a safety rule against standing the pallets. (TA15-16). As he lifted one of the last boxes of food, he stepped backward, his foot stepped on the edge of the pallet behind him, and he fell to the ground in a seated position. His buttocks were on the floor, and his back hit the edge of the pallet. (TA17). He testified that the pallet did not break. (TA88).

He claimed that, ten to thirty minutes later, he saw Araceli Magana coming from the Cashier's Office. He testified that he told her he fell on a pallet. She suggested he talk to to Mr. Ramon (Ray) Hernandez. (T19-20, TA89). Petitioner admitted that Ms. Magana was not his supervisor. (TA89). Mr. Hernandez testified that Ms. Magana was a bookkeeper in May 2010 and confirmed that she was not the Petitioner's supervisor. (TA156-157). The Petitioner testified he spoke to Mr. Hernandez ten to fifteen minutes later and told him he fell on a pallet onto his back, and had a scratch, but was okay. (TA90). Mr. Hernandez did not recall the Petitioner speaking to him about this incident. (TA156). The Petitioner claimed that Mr. Hernandez sent him home that day, and that he didn't return to work for three to four days afterward. (T19-22). Mr. Hernandez testified that he never sent the Petitioner home due to a back injury, nor did he advise the Petitioner on May 10, 2010 that he would take three to four days off work. (TA171-172).

The Respondent's records show that for the time period between April 29, 2010 and May 12, 2010, the Petitioner worked 71.58 hours. For the time period between May 13, 2010 and May 26, 2010, the Petitioner worked 79.62 hours and 5.38 hours overtime. For the time period between May 27, 2010 and June 9, 2010, the Petitioner worked 80 regular hours and 11.78 hours overtime. (RX17).

The Petitioner stated that between May 10, 2010 and September 9, 2011, he would miss work, and show up late, and leave without telling anybody. (TA90). He claimed that he could miss work without doctor's notes to justify lost time, because he said that his boss, Mr. Hernandez knew of the accident. He claimed he was never written up for being late or leaving early. He claimed that he was never disciplined for this behavior. (TA22-23, 91-92, 146). He admitted that he sought no treatment for his back between May 10, 2010 and September 9, 2011. (TA22-23).

Mr. Hernandez testified that the Petitioner was not permitted to come and go from work as he pleased. (TA170-171). He was not permitted to come in late or leave early whenever he wanted. (TA171). Had the Petitioner behaved in this regard, he would have received verbal warning and then a written write-up. (TA171). Mr. Hernandez believed that the Petitioner's personnel file contained write-ups. (TA171).

Mr. Hernandez testified that he had worked for the Respondent for the past thirty-five or thirty-six years. (TA150). In May 2010, he was the Merchandising Manager, the direct supervisor over the crew. (TA150-152). In this job, he was the Petitioner's direct supervisor. (TA153-154). He testified that he would see the Petitioner six to eight times per day, and would travel to different locations in Respondent's facility, including the stocking room. (TA154).

Ms. Hernandez testified that on February 28, 2011, the Respondent hired her to manage human resources at Continental Sales and Salvage. (TA174). She testified to schooling in business management, and prior work in human resources for a prior employer. (TA174). The Petitioner acknowledged knowing when Ms. Hernandez was hired. (TA97). Ms. Hernandez stated that there is a separate office for Human Resources. When she was first hired, she had the office to herself. (TA175). She was responsible for overseeing and managing workers' compensation files and completing paperwork for the reporting of work injuries. (TA175-176). She stated that, when she was hired, the Respondent already used an incident report form. (TA177).

Mr. Hernandez stated that once Ms. Hernandez was hired, they began to use incident reports to document accidents, and supervisors would bring the reports to Human Resources. (TA162-163). Mr. Hernandez testified that the employee is present at the time an incident report is prepared. (TA165).

Ms. Hernandez stated that she would see the Petitioner on the sales floor, or if the Petitioner needed anything from Human Resources he would come to her office. (TA177-178). She confirmed that she speaks Spanish fluently, and would communicate with the Petitioner in Spanish. (TA178).

The Petitioner testified that he asked for more help in his department from Mr. Hernandez and Ms. Hernandez. (TA85). However, Ms. Hernandez testified that between her hire and September 9, 2011, the Petitioner never turned in doctors' notes, or requested lighter work. (TA178-179). When asked whether he had asked for a raise, prior to September 9, 2011, he answered "I believe I did. I'm not sure". (TA84). He later guessed that he asked for a raise in May 2011. (TA87). He testified that he did not think he was given a raise when he asked but admitted that raises were only considered once per year, near an employee's anniversary date. (TA85, 87).

The Petitioner testified that after he told Mr. Hernandez about his back injury involving the pallet on May 10, 2010, he never discussed his back with him until after September 9, 2011. (TA96, 147). Mr. Hernandez testified that he did not witness the Petitioner injure his back in May 2010, nor did he recall the Petitioner telling him about back pain between May 2010 and September 2011. (TA159-160). He also testified that he never told Ms. Hernandez about his fall into the pallet in May 2010, at any time between her hire in February 2011 and September 9, 2011. (TA97, 146). Ms. Hernandez confirmed that between her hire and September 8, 2011, the

Petitioner never told her that he injured his back after tripping on a pallet and falling backward while at work. (TA178). She stated that the Petitioner never turned in doctors notes or requested lighter work during this period of time. (TA178-179). There is no incident report in the Petitioner's personnel file regarding an incident on May 10, 2010. (TA200).

Ms. Hernandez testified that, when looking through the Petitioner's personnel files, she noted several counseling forms in his file. (TA202). The Respondent's records include numerous write ups for the Petitioner prior to May 10, 2010 for tardiness or missed work. In February 2010, he was written up for excessive tardiness in January 2010 – he was tardy on six days and missed three days of work. He was offered a schedule adjustment but declined. On March 8, 2010, a half hour before his shift was to begin, he called Mr. Hernandez's cell phone to report he would miss work due to a family emergency. On March 23, 2010, he called seven minutes before his shift was to start, to report he would be two hours late for work due to an emergency. He was given a verbal warning after failing to call or show for work on March 25, 2010, documented in a Counseling Report signed by Mr. Hernandez and the Petitioner. (RX17).

After May 10, 2010, the Petitioner continued to have difficulty with tardiness. For example, on April 9, 2010, fifteen minutes before his shift was to begin, he called to report he would be late due to childcare issues. On May 3, 2010, the Petitioner called, nineteen minutes after his shift started, to advise that he would be absent due to the need to find papers for his lawyer. On June 10, 2010, the Petitioner called at the beginning of his shift to advise he would be twenty minutes late due to oversleeping. On July 5, 2010, the Petitioner called, ten minutes before his shift was to begin to advise he would be late due to oversleeping. Between March 24, 2011 and March 29, 2011, the Petitioner was late every day, and took longer lunch breaks than allowed. It was noted on his Timecard Report for that week that Mr. Hernandez spoke with him about this issue and warned of a next step. Then, between April 14, 2011 and April 20, 2011, the Petitioner was tardy each day, and on one occasion took a longer lunch break than allowed. Then, between April 21, 2011 and April 27, 2011, the Petitioner was tardy each day, and on two days took a longer lunch break than allowed. On May 4, 2011, the Petitioner was written up for gross misconduct. He was asked to complete a task by his manager and refused. He left the premises rather than following his supervisor's direction. The Petitioner refused to sign the counseling report. Between May 12, 2011 and May 25, 2011, the Petitioner was late on nine out of ten work days, took a longer than allowed lunch period on one occasion, and left before his shift was over on one occasion. There is no documentation that any of the Petitioner's missed work was due to low back pain. (RX17).

September 9, 2011 (11 WC 38145)

The Petitioner testified at Arbitration that when he arrived at work on September 9, 2011, he didn't notice anything about his low back. Later while stacking cases of 24-ounce juices, he felt a pinch in his low back. He was working alone in the food and promo department, stocking. (TA83). He testified that he told David Solano about his back symptoms, and David instructed

him to see Human Resources. (TA25-27). He testified that he did not fall on a pallet or break a pallet with his back on September 9, 2011. (TA92-93).

The Petitioner presented to Human Resources and spoke with Danelia Hernandez. Ms. Hernandez testified that the Petitioner presented to her, mid-morning, on September 9, 2011. (TA179, 213). The Petitioner admitted that both Ms. Hernandez and Mr. Hernandez speak Spanish, and that he was able to communicate with them in Spanish. (TA95).

Petitioner advised Ms. Hernandez that a year ago, he had an accident "here". (TA27, 84, 93-94). He said that Ms. Hernandez asked when it had happened, and he didn't know the date. He denied telling her that a pallet broke at the time of the incident and denied telling her he was standing on top of the pallet at the time of that incident. (TA93-94). The Petitioner testified that he told Ms. Hernandez what he was doing when his back started pinching. (TA27-30, TA96). She asked him if he wanted to see a doctor. He said yes and was seen at Concentra Medical Center. (TA31-32, 184). Ms. Hernandez denied that the Petitioner reported a second incident occurring on September 9, 2011. (TA198).

Ms. Hernandez testified that the Petitioner did not go directly from work to Concentra. She explained that when an employee is sent to the clinic, the clinic notes show what time they arrived at the clinic, and what time they left. She sent the Petitioner to the clinic by at 10:00 a.m. but he didn't arrive for about one and one-half hours. (TA184-186; 216). It should have taken him fifteen minutes to drive from Continental Sales to Concentra. (TA184-186). Ms. Hernandez testified that she spoke with the Petitioner in person regarding his delay in presenting at Concentra. (TA186). The Petitioner claimed that he traveled home to pick up his wife to interpret for him at Concentra. (TA187). Ms. Hernandez testified that she had advised him, before he left Continental Sales, that there was a Spanish-speaking person at Concentra for his assistance. (TA187). She testified that she would let know any employee who didn't speak English know that Concentra provided Spanish-speaking individuals, to make them feel comfortable. (TA217).

Conversely, at Arbitration, the Petitioner claimed that the employees at Concentra did not speak Spanish, and he could not speak English. (TA99). When questioned about whether he went home to get his wife to interpret for him at Concentra on September 9, 2011, he admitted that he retrieved her to interpret at Concentra on either September 9th, or September 13th. (TA99). He then stated that his wife had driven him to work on September 9th. (TA100). Finally, he admitted that there were Spanish speaking interpreters at Concentra, but alleged that they were not attending to him, because he did not know what the human resource person talked to them about. (TA100).

Ms. Hernandez identified the report that she prepared on September 9, 2011 regarding the Petitioner's claimed accident in May 2010. (TA188-192; RX1; RX17). She confirmed that this was the first notice received regarding the claimed accident in May 2010. (TA189-190). The

report indicates the alleged accident happened over one year ago. (TA192; RX1). The description provided was that "employee states he was standing on top of a pallet, the pallet broke, causing him to fall and land on his behind." (TA193). He alleged an injury to his low back. (TA193-194). The Petitioner did not report a second incident on September 9, 2011 involving his low back. (TA198).

Ms. Hernandez referred to her notes while testifying. (TA181-182). She testified that her notes were created in a Word document, and she added to them as the events or conversations occurred. (TA182). She kept notes because the Petitioner was claiming an injury that had occurred so long ago. (TA183-184).

Medical Histories and Treatment

The medical records at Concentra indicate that the Petitioner's low back accident happened on May 2, 2011. (RX4). The Petitioner stated that the Concentra records are wrong as to the date of accident. (TA98). He claimed that if the records were different at Concentra, it was because there was no one to help him fill out the forms in Spanish. (TA101).

The Concentra records indicate the Petitioner reported on May 2, 2011 he fell on top of a pallet, and the pallet broke, causing injury to his back. (RX4). Concentra doctors diagnosed a lumbar sprain, prescribed medication and told to apply a gel ice pack, and released him to return to regular duty work. (TA32; RX4). He returned to Concentra on September 12, 2011 and reported no improvement in low back pain. He reported no radicular pain, and the straight leg raise test was negative bilaterally. He underwent an X-ray, which was negative for dislocation or fracture. He was diagnosed with a lumbar sprain. He was released to return to work with a 15-pound lifting restriction and pushing-pulling not to exceed 25-pounds. He was referred for physical therapy. On September 13, 2011 he presented to Concentra for physical therapy. His advised the therapists that one year prior, he stepped off the edge of a pallet, and fell backwards onto his buttocks. He alleged pain since that time. Dr. Garces also saw him that day, and noted he was working within restrictions and was discharged from care and released to regular duty work. (TA33-34, 102; RX4).

On September 14, 2011, the Petitioner returned to work for Respondent. He testified he only worked for two hours. (TA102). The employment records from Respondent indicate that the Petitioner worked a full day on September 14th. (RX17). When asked whether he called the Respondent on September 15, 2011 to say that he was not coming back to work, the Petitioner testified, "It's a lie. They are lying." (TA103, RX17).

On September 15, 2011, the Petitioner presented to Mercy Medical Center at 43rd and Pulaski for his low back. (TA103; RX5). He reported low back pain for one week. (TA107). There is no mention in the records that the back pain was related to a work injury. (RX5). At Arbitration, the Petitioner claimed he provided Mercy with a history of a September 9, 2011 work injury and might have told them about a May 10, 2010 work injury. (TA105, 107). On direct he testified

that he was sent for an MRI, but later stated it could have been an X-ray. (TA34-35, 108). The X-ray showed Grade I anterolisthesis of L4 on L5 with bilateral spondylolysis of the neural arch of L5, with osteopenia out of proportion for a patient with a stated age of 36. (RX5). He was recommended to undergo a qualitative bone mineral assessment, DEXA scanning and, if disc protrusion or spinal canal stenosis was clinically suspected, consider an MRI. (RX5).

The Petitioner called off work on September 16, 2011. He advised that he would either see a doctor that he had seen in the past or would see a doctor that he had seen on television. He claimed that the doctor from television would pick him up at his house. He said that for the time-being, he would not be coming in to work. (RX17).

The Petitioner presented to Continental Sales on September 17, 2011 to speak with Ms. Hernandez and Mr. Hernandez. He claimed his doctor told him to get an attorney. He refused to speak with them about his doctor's visit. He began to leave the human resources office and was agitated. Both Ms. Hernandez and Mr. Hernandez urged him to calm down. He stated that he no longer wanted to work as a stocker and wanted a different position. (RX17).

The Petitioner returned to Mercy Medical on September 21, 2011 to discuss the X-ray results. (TA108; RX5). He received a note from Mercy Medical limiting lifting to 20 pounds due to chronic back pain. (TA108, RX5).

The Petitioner hired Mr. Christopher J. Johnson, of the law firm of Katz, Friedman, Eagle, Eisenstein, to represent him for his work injury. He testified that Mr. Johnson was his first attorney. (TA110). The Application for Adjustment of Claim (11 WC 36904), which was signed by the Petitioner on September 22, 2011, and filed at the Commission on September 29, 2011 (11 WC 36904), alleges a work injury on May 10, 2010. (TA110). The Petitioner testified that he met with Mr. Johnson once or twice. He provided Mr. Johnson with the information to file the workers' compensation claim. (TA109-110). He testified later that the Application filed by Mr. Johnson was incorrect as to the date. (TA114). He explained that he lied about the date because human resources told him he could put whatever date on there. He said human resources lied. He said he lied. (TA114). He admitted that Ms. Hernandez did not create or file the Applications for Adjustment of claim. He alleged that he used May 10, 2010 as an accident date because Ms. Hernandez allegedly told him it didn't matter. (TA114).

The Petitioner also hired The Law Offices of James Ellis Gumbiner & Associates to represent him. They prepared an Application for Adjustment of Claim, filed on October 4, 2011 (11 WC 38145). The second Application alleged an accident on September 9, 2011 wherein the Petitioner fell on top of a pallet at work. The Petitioner's signature was not dated. The Petitioner originally testified that Mr. Johnson was the first lawyer he hired, but later claimed that Mr. Gumbiner was his first lawyer. (TA111). When he was shown the Application for Adjustment of Claim (11 WC 38145), he admitted he signed it, but stated that the accident

description was wrong. (TA112-113). He characterized that accident description as "a lie". (TA114).

At some point, Mr. Johnson withdrew from case 11 WC 36904, and Mr. Gumbiner handled both Applications. (TA113). In 2013, the Petitioner fired Mr. Gumbiner's law firm, and hired Mr. Serkland at Corti & Aleksy to represent him in both claim 11 WC 36904 and 11 WC 38145. (TA113). In 2014, the Petitioner fired Corti & Aleksy, and hired the current law firm, McHargue Law Office. (TA113).

The Petitioner admitted that attorney James Ellis Gumbiner referred him to New Life Medical Center. (TA115, 139). His first visit was on September 29, 2011. He testified that he told the doctors at New Life that he had injured his low back at work in May 10, 2010 (TA116). The records from New Life indicate that Petitioner reported the May 10, 2010 injury to Araceli Magana on May 2, 2011, and again on September 9, 2011. (PX3). At arbitration he testified that the New Life records regarding the dates were "a lie". (TA116; PX3). He testified that he told New Life that his pain began, or became more profound, on September 9, 2011. (TA35, 116; PX3). The doctors at New Life placed him in therapy for one and one-half to two years. (TA36; PX3).

The Petitioner testified that on October 4, 2011 New Life authorized him off all work until October 25, 2011. (TA41; PX3). He testified that his last date of work for the Respondent was either September 22, 2011 or September 23, 2011. (TA41-44). He received therapy at New Life. (TA41, 47). The Petitioner testified that New Life sent him to Instant Care to treat with Dr. Patel. (TA45, 116). The Petitioner underwent a lumbar MRI on October 28, 2011. The doctors at Instant Care referred him for a course of three injections to his low back. (TA46). He testified that the injections were 90% ineffective. (TA47; PX3).

Dr. Mehta referred the Petitioner to Dr. Kern Singh for a neurosurgical consult. (TA48). On January 9, 2012, the Petitioner told Dr. Singh that on May 20, 2010 he was unloading a pallet and tripped backward, (TA117). He stated that by this time, pain was in his low back and left leg. (TA48). Dr. Singh sent him for another MRI and then recommended surgery, a minimally invasive L4-5 laminectomy, transforaminal lumbar interbody fusion. (TA49-50; PX6). Dr. Singh stated that the need for this treatment was causally related to the alleged incident on May 20, 2010. (PX6). He returned to Dr. Singh on April 30, 2012, and Dr. Singh continued to recommend surgery at the visit on June 18, 2012. (TA 50-51; PX3; PX6).

The Petitioner continued physical therapy at New Life, and to see doctors at Instant Care until January 2013. He testified that the therapy made his low back pain worse. The records from New Life and Instant Care indicate no improvement with their treatment and therapies, and Petitioner testified that their treatment made him worse. (TA53-154, 137-139; PX3; PX6). When he ceased treatment at New Life, he still had the same back pain and pain in his leg. He testified it would come and go. (TA54).

In 2012, the chiropractic treatment at New Life was analyzed by Triune Health Group for Utilization Review. On November 2, 2012, New Life's chiropractic treatment was certified between the dates of September 29, 2011 and October 25, 2011 only. All chiropractic treatment after 10-25-11 was non-certified and deemed not reasonable. New Life chiropractor, Terence Patrick, D.C. appealed. On appeal the non-certification was upheld by David F. Cox, D.C., who certified ten visits only.

In addition, the pain management and injections by Instant Care were analyzed by Triune for Utilization Review. Only the injection from November 8, 2011, and the follow up visit with Dr. Mehta on November 15, 2011 were certified. As there was no evidence of functional improvement or decreased medication use following the initial injection, further injections were deemed not medically necessary. Further treatment by Instant Care was not certified. The Triune Health Group Utilization Review reports regarding non-certification of treatment by Instant Care and New Life were forwarded to the medical provider and to the Petitioner. (RX3).

The doctors at Instant Care referred the Petitioner next to Dr. Michel Malek. The Petitioner admitted it was possible he told Dr. Malek that his work injury occurred on May 20, 2010. (TA118: RX6). The records from Dr. Malek indicate Petitioner reported that on May 20, 2010 he stepped backward while stocking a pallet and hit his legs on the edge of the pallet, falling and landing in a twisted position on his left side. Then, on September 9, 2010, he reported re-injury while stocking cans of lemon tea in a repetitive manner. (RX6). The Petitioner testified that he was not able to communicate with Dr. Malek, as Dr. Malek did not speak Spanish. (TA118). Dr. Malek ordered another MRI, which was completed on June 1, 2012. (TA52). The Petitioner returned to Dr. Malek on June 26, 2012, Dr. Malek recommended surgery. (TA52).

At the request of the Respondent, the Petitioner was examined by Dr. Alexander Ghanayem on August 6, 2012. The Petitioner advised only of a back injury at work in May 2010 which involved him falling backwards, striking his back on a pallet. (RX2). The Petitioner testified that he also told Dr. Ghanayem about the lifting incident on September 9, 2011. (TA119-120). However, Dr. Ghanayem reports that the Petitioner denied other injuries to his low back. (RX2). Dr. Ghanayem had X-rays performed as part of his analysis, and reviewed imaging of the Petitioner's MRI scans from October 2011 and June 2012. He opined that the imaging disclosed congenital sacralization of L5-S1. He stated that the Petitioner did not have a true herniation at L4-5, but rather the ridge of the disc was associated with the slip at L4-5. He stated that the imaging disclosed a long-standing problem. Due to the congenital sacralization he was at greater risk of developing this problem. Dr. Ghanayem noted no evidence of medical treatment between May 2010 and September 2011. He reported that the Petitioner made no report to him of any injury in September 2011. Dr. Ghanayem concluded that there was no injury of substance in May 2010, and he did not relate the need for treatment to any work injury in May 2010. (RX2). Dr. Ghanayem indicated that treatment was reasonable for his non-work low back condition and that he should limit lifting to 15-20 pounds and refrain from repetitive bending or stooping. He

stated that the restrictions were not related to any work injury, but rather to the nature of spondylolisthesis. (RX2).

On cross-examination, the Petitioner was questioned about treatment by Dr. Saleh Rifai, and admitted that Dr. Rifai treated his low back, and referred him for an MRI and for physical therapy at Little Company of Mary Hospital. (TA121-122; RX7; RX8). The Petitioner admitted that in May of 2013, Dr. Rifai issued a return to work note, beginning part-time, and graduating to full time, due to spinal stenosis. (TA122; RX7). On August 16, 2013, the Petitioner was discharged from physical therapy due to lack of progress. (RX8).

The Petitioner returned to Dr. Ghanayem on December 19, 2013 at the request of the Respondent. (TA55-56, 123; RX2). Dr. Ghanayem noted that the Petitioner switched the date of his injury from May 2010 to September 2011 and claimed to have been fine prior to September 2011. Dr. Ghanayem opined that in the past, he did not believe the Petitioner's low back condition was causally related to his alleged work injuries, and his opinion remained unchanged. (RX2). Dr. Ghanayem opined that it was medically reasonable for the Petitioner to undergo lumbar fusion, but that the need to it was unrelated to the injuries he claimed occurred. (RX2). At Arbitration, the Petitioner thought that he provided Dr. Ghanayem with both dates of alleged injury (TA123).

The Petitioner admitted on cross-examination that he also treated at Healthy Family Medical with Dr. Masood Syed. Dr. Syed treated him for his low back. (TA123; RX9). The records from Healthy Family indicate that the Petitioner presented on March 1, 2014 with back pain of three-year duration. He reported having fallen on his back three years prior, with low back and left leg pain since that time. (RX9). Dr. Syed referred him to an orthopedic surgeon. (RX9).

On March 25, 2014, the Petitioner presented to the University of Illinois Medical Center and was seen by Dr. El Shami. He reported low back and left leg pain with no relief from at least four injections and physical therapy. (PX8, PX9). He also reported a recent fall with 4th metacarpal fracture. Dr. El Shami referred him for imaging of his lumbar spine, and EMG, and for consultation by an orthopedic hand surgeon. The MRI disclosed anterolisthesis of L4 on L5 due to past defect with degeneration of the disc and bilateral foraminal narrowing at L4-5. The EMG was consistent with mild, subacute L5 radiculopathy. On May 7, 2014, Dr. El Shami discussed injections, back braces and a TENS unit, but the Petitioner was very frustrated with the amount of his pain so Dr. El Shami referred him to a surgeon. (TA56-57; PX8; PX9).

On May 27, 2014, the Petitioner requested Dr. Syed prescribe pain medication for back pain that he claimed was worse. He told Dr. Syed that he was supposed to have low back surgery but was not ready for it. (RX9).

On June 17, 2014, the Petitioner was examined by Dr. Kyle Macgillis of the University of Illinois. The Petitioner reported undergoing multiple epidural steroid injections and medications since working in a stock yard stacking pallets and falling backwards. Dr. Macgillis noted X-rays

and MRIs showed Grade I spondylolisthesis at L4-5 with a defect in the pars interarticularis. He was referred for a CT scan of his lumbar spine, which was performed on June 23, 2014. It showed no change since the last radiographs on March 25, 2014. The impression was of degenerative disc disease at L4-5 with generalized disc herniation and neuroforaminal narrowing. It was negative for acute fracture. (PX8, PX9).

The Petitioner was scheduled for surgery by Dr. Krzysztof Siemionow on July 25, 2014. His history to Dr. Siemionow was of an injury to his low back three years previous, which stacking large objects in an elevated position, falling, and landing on his back. Dr. Siemionow performed posterior spinal fusion at L4-5, posterior spinal instrumentation at L4-5. (PX8, PX9). After surgery, the Petitioner underwent physical therapy. He testified that after surgery, he felt worse as to his left low back and left leg pain. (TA57-59; PX8; PX9).

On July 30, 2014, the Petitioner presented to Dr. Syed with complaints of pain upon weight bearing. Dr. Syed advised him about wound care and the medications prescribed by his orthopedic surgeon. On August 29, 2013, the Petitioner returned to Dr. Syed requesting pain medication and Dr. Syed asked him to bring an empty bottle of pain medication for identification. (RX9). On September 16, 2014, the Petitioner presented to University of Illinois for an X-Ray and medication refills. The X-rays showed satisfactory appearance of the fusion. (PX8, PX9). On October 6, 2014 the Petitioner requested refill of pain medications from Dr Syed, claiming that the surgery did not help, and he continued to have severe pain in his low back and left leg. Dr. Syed refilled his medication again on October 24, 2014 and November 24, 2014. (RX9). He returned to University of Illinois on December 2, 2014 and reported much improvement and no complaints with therapy. He received refills on his pain medication and underwent an X-ray. (PX8, PX9).

On December 29, 2014, the Petitioner presented to Dr. Syed for refills on pain medication. He reported back pain getting worse with radiation to both thighs, constant with or without movement. Dr. Syed re-prescribed Norco and added Soma. (TA125; RX9). The Petitioner returned to Dr. Syed on January 14, 2015 and February 6, 2015 due to complaints and refills on pain medication.

On February 12, 2015, the Petitioner filled a prescription for Hydrocodone/Acetaminophen 10/325, #45. (RX10). On February 24, 2015 and March 2, 2015, he followed up with Dr. Syed for refills on pain medication. (RX9).

On March 3, 2015, the Petitioner saw Dr. Danil Rybalko at University of Illinois due to a four week increase in low back pain. He reported taking Norco 10, 2-3 times per day. Dr. Rybalko recommended repeat X-rays and a CT scan, and refilled Petitioner's prescription for Norco. X-rays at University of Illinois were unchanged as to prior. There was no motion in the area of L4-L5 on flexion extension views. (PX8, PX9). The Petitioner returned to University of Illinois on March 17, 2015 and saw Dr. Iacobelli. It was noted that his CT scan indicated stable fusion.

The Petitioner advised Dr. Iacobelli that he was applying for Social Security Disability. Dr. Iacobelli provided a new prescription for Norco. (PX8, PX9).

On May 4, 2015, the Petitioner presented to Mercy Hospital and Medical Center emergency room with head and neck pain. He was diagnosed with a migraine headache. He claimed to have been told that his head and neck pain was caused by his back pain. He underwent an out-patient mental health assessment. He admitted to drinking alcohol, 1-2 beers at a time, use of marijuana and cigarette smoking, 4-5 cigarettes per day. (RX12). He reported a history of physical abuse as a child in Mexico, and a work injury in May 2010, when he slipped and fell on a pallet. He reported having begun working at age eight and immigrating to the United States when he was nineteen. (RX12).

On May 18, 2015, the Petitioner was seen by Dr. Slavin at University of Illinois. To Dr. Slavin, the Petitioner denied drug or alcohol use. He admitted to 2-3 cigarettes per day. Dr. Slavin recommended a spinal cord stimulator following evaluation by a psychologist. (TA60; RX13).

On June 9, 2015, the Petitioner was examined by Dr. Neil Pliskin, Ph.D., ABPP-CN of The University of Illinois. He reported to Dr. Pliskin that he had worked as a stock person in a factory. He backed into a stack of wooden pallets while lifting a heavy object and was injured. He went to a doctor and had a twenty-five-pound lifting restriction and one session of physical therapy. He eventually returned to work full duty but told his boss that he was in pain. He claimed the boss did not believe him. He claimed that his co-workers teased him. He reported re-injuring himself in September 2011. Dr. Pliskin's examination and testing were conducted in Spanish. Dr. Pliskin found no cognitive or emotional contraindications for spinal cord stimulator. (TA127; RX13).

On July 6, 2015, the Petitioner returned to Dr. Slavin and complained of more weakness and discomfort, so Dr. Slavin referred him for more physical therapy. His pain medications were refilled. He was to return after therapy to re-consider implementation of a spinal cord stimulator. He participated in physical therapy at University of Illinois. On September 1, 2015 Dr. Siemionow stated that the Petitioner was capable of lifting up to twenty pounds, or light duty work. On September 17, 2015, Dr. Slavin advised the Petitioner to contact him when he was ready for surgery related to the spinal cord stimulator. (PX8, PX9). On October 16, 2015, the Petitioner advised Dr. Slavin that he was capable of climbing two flights of stairs or walking four blocks but continued to have pain. He admitted to marijuana use and smoking ½ pack of cigarettes per day. (TA127; PX8; PX9).

On October 21, 2015, the Petitioner presented to Dr. Guzman at Galilee Medical Center complaining of back pain and requesting medication refill. Dr. Guzman referred him for repeat X-rays. On October 24, 2015, the Petitioner underwent X-rays at Preferred Open MRI. The impression was of pedicle screws and rods fusing L4-5 and disc space narrowing and retrolisthesis of L5 with respect to L4 by 8 mm. There was no evidence of hardware failure or

loosening. (RX10; PX10). At his follow up appointment on November 3, 2015, Dr. Guzman recommended pain management, but also refilled pain medication. (TA125, 126).

On November 5, 2015, the Petitioner began treatment at Esperanza Health Center for mental health issues. (RX11). He received counseling and psychotherapy.

On December 1, 2015, the Petitioner failed to show up for scheduled spinal cord stimulator by Dr. Slavin. (PX8, PX9). On the same date, he presented to Dr. Guzman for refills of pain medication. Dr. Guzman recommended that he return in two months, and recommended pain management for further narcotic prescriptions. (TA128, 129; PX10).

On January 4, 2016, the Petitioner returned to Dr. Slavin to discuss, for the fourth time, implementation of a spinal cord stimulator. He reported his pain was getting worse, and traveling into the heel on his right foot, making it difficult to walk. Dr. Slavin prescribed Tramadol. (PX8; PX9). On January 19, 2016, the Petitioner saw Dr. Siemionow, complained of continued pain, and that he had not undergone spinal cord stimulator implementation. Dr. Siemionow refilled Norco and Tramadol.

On February 10, 2016, the Petitioner returned to Dr. Guzman, who recommended pain management. (RX10). On March 15, 2016, he returned to Dr. Siemionow who noted CT scan showed solid fusion. The Petitioner told him that he did not have a primary care doctor to prescribe him pain medication. The Petitioner offered that Norco 10 reduces his pain. Dr. Siemionow prescribed Norco 10 until he was able to get a consult with Dr. Iacobelli at the Pain Clinic. (PX8; PX9).

On April 8, 2016, the Petitioner returned to Dr. Guzman for medication refills. Dr. Guzman provided Vicodin 10, #14 with no refills. On April 12, 2016, the Petitioner presented to Dr. Iacobelli in Pain Management at University of Illinois. He reported that Norco helped him the most, and that he took 3-4 Norco per day. He admitted to trying physical therapy ordered by Dr. Slavin only three times, discontinuing due to pain. (PX8; PX9). He advised Dr. Iacobelli that he had not taken Norco in one month. (TA130, 131)

On May 3, 2016, the Petitioner presented to Esperanza Health Center due to panic attacks and fear of going outdoors or to public places. On August 1, 2016, he returned to Esperanza for pain medication and received refill of Vicodin. Between August 3, 2016 and September 6, 2016, the Petitioner was seen by various practitioners at Esperanza for counseling and refills of Vicodin. He reported marital and legal troubles. (RX11).

At Arbitration, PhotoFax investigator, Joseph Pierce testified to surveillance performed in September 2016 at the request of Auto Owners Insurance. (TA219-230). He testified to the chain of custody of the September 2016 surveillance videotape at PhotoFax. He testified that the video contains footage of the Petitioner, when in view. (TA226-227). The surveillance video obtained in September 2016 was two hours, forty minutes and four seconds. (TA226; RX14).

On September 7, 2016, the Petitioner was observed on surveillance video driving to a local high school to drop off a teenaged male. Later, he walked around his neighborhood while smoking a cigarette and talking on a cellphone and returned to his residence accompanied by a female and children. He used no assistive device to walk and appeared to have no difficulty. (RX14).

On September 8, 2016, the Petitioner was observed on surveillance video driving a vehicle to a nearby gas station, entering and emerging with a bag of unidentified items, and returning to his residence. Later he walked through his neighborhood. He used no assistive device to walk and appeared to have no difficulty. (RX14).

On September 9, 2016, the Petitioner was seen at Esperanza Health Center by Dr. Adriana Guerrero for counseling. He was encouraged to follow up with contacts provided in the prior session, especially since he admitted he hadn't returned their phone calls or made effort to follow up. (RX11).

On September 10, 2016, the Petitioner was observed on surveillance video throughout the day. The Petitioner confirmed his address on 64th Street in Chicago. (TA143). He testified at Arbitration that he drivers a red 1996 Chevy Tahoe, and a black 2009 Explorer. (TA140). He departed from his home, accompanied by two unidentified individuals and travelled by vehicle first to McDonalds, and then to "4 Less", where Petitioner purchased a variety of meats and other food items. From there, the group travelled by vehicle to Homeland Gas Station, and then to Marquette Park where they attended outdoor soccer matches for many hours. The Petitioner was observed to walk on grass and paved surfaces, stand under a tent for hours, grill meat in a standing position, grill meat on a smaller grill while seated on the ground, arise from a seated, cross-legged position on the ground without assistance, crouch at the grill to turn meat while holding a plate in one hand, serve attendees grilled food, drink several beers, intermittently sit in a chair, smoke cigarettes, use a cell phone while standing and walking, clean the grill and disassemble the grill while seated on the ground, cross legged, and load up his vehicle with items at the end of the day. The Petitioner did not use an assistive device to walk or stand, and appeared to laugh, and socialize with others. Over six hours, approximately one hour and forty minutes of surveillance video was obtained. (RX14).

On September 11, 2016, the Petitioner was observed on surveillance video, in the morning, entering his vehicle and driving to downtown Chicago. Contact was lost, and investigators returned to Petitioner's residence to find the Petitioner's vehicle parked outside. A bit later, the Petitioner exited his home and went to his vehicle to retrieve an unknown item, and then walked out of view. He did not ambulate with an assistive device or exhibit obvious signs of pain. (RX14).

On September 12, 2016, the Petitioner returned to Esperanza Health Center. He reported his mood was worse; he had increased anxiety and panic symptoms. He reported a better weekend

than usual as he had taken his children to the park. (RX11). His counselors assisted him in completing a Social Security Administration form. (RX11).

On September 20, 2016, the Petitioner returned to Dr. Siemionow. He complained that he could not sit or stand as both caused shooting pain in his legs and tingling in his feet. He claimed to be considering the stimulator implant by Dr. Slavin. He admitted to smoking cigarettes, which the doctor noted made him non-compliant. A CT scan was performed and exhibited a well-fused back with components in place and no fracture or dislocation. (PX8; PX9). The Petitioner testified that he failed to receive much relief from the surgery performed by Dr. Siemionow. (TA139).

On October 4, 2016, the Petitioner returned to Dr. Chico at Esperanza Health Center to refill his Vicodin. Dr. Chico expressed concern over his use of prescriptions. Dr. Chico referred him back to Dr. Slavin. The Petitioner saw Dr. Slavin on October 17, 2016. He complained that he was unable to perform any activity or stand for any period of time without severe pain, making him feel crippled to the point where he almost falls down. (PX8; PX9). Dr. Slavin referred him for another MRI. The MRI, performed on October 21, 2016, it disclosed stable post op changes after L4-5 posterior spinal fusion with stable, mild anterolisthesis due to bilateral L4 neural arch spondylolysis with no evidence of neural compromise. (PX8; PX9).

The records from Esperanza Health document that the Petitioner presented on a monthly basis to obtain refills of medication, including Vicodin. Each time, he was provided with a one-month supply of Vicodin (10 milligrams, #60). (RX11).

On December 12, 2016, the Petitioner returned to University of Illinois and saw Dr. Hrubes. He reported a recent fall out of bed due to leg weakness. Dr. Hrubes stated that there was no need for him to follow up in their clinic as Petitioner was not interested in interventional injections, or the spinal cord stimulator, or physical therapy. He was advised to follow up with his primary care physician. He was given one last prescription for Norco 10/325 and was advised he would receive no further prescriptions. On December 13, 2016, Dr. Iacobelli noted that Petitioner was fully healed from a surgical standpoint. (PX8; PX9).

On December 20, 2016, the Petitioner returned to Esperanza Health. They recommended he wean off narcotics. On February 13, 2017, the Petitioner reported he was recently arrested for driving without a driver's license or car insurance. (RX11).

On February 26, 2017, the Petitioner submitted to a toxicology screen on referral from Esperanza. On March 11, 2017 he saw Dr. Solari at Esperanza and inquired about medical Cannabis. Dr. Solari noted the Petitioner's prior receipt of a DUI after being caught by the police with Cannabis in his car and pending two-year probation factoring in to the recommendation for medical Cannabis. (RX11).

On March 22, 2017, the Petitioner saw Dr. Chico to discuss the drug screen from February 26, 2017. The Petitioner tested positive for cannabinoids, cocaine and opioids. The Petitioner denied use of cocaine but endorsed use of marijuana. It was noted he would be retested in a week, and if positive for marijuana and cocaine, they would terminate care. (TA132-135; RX11).

On March 29, 2017, the Petitioner returned to Dr. Chico and requested an increase in opioids. He was given another drug screen the following day. On April 3, 2017 Dr. Chico noted the drug screen was positive for cannabinoids, benzodiazepine and opiates. Another drug screen was administered on April 6, 2017 and was later found to be positive for cannabinoids and opiates. A drug screen administered on May 17, 2017 was also positive for cannabinoids and opiates. (TA 144; RX11). The Petitioner testified that he took narcotic pain medication as directed. (TA145).

At Arbitration, investigator Joseph Dizeo of PhotoFax testified to surveillance video of the Petitioner in April and May 2018. (TA231-238). He received the assignment to conduct surveillance on the Petitioner from Joseph Pierce. (TA233). He testified to the chain of custody of the surveillance video. (TA234). He shot surveillance video on April 29, 2018, May 5, 2018 and May 12, 2018. (RX15, RX16). The total running time of the video is two hours, twelve minutes and eleven seconds. (RX15, RX16). At Arbitration, Mr. Dizeo identified the Petitioner as the subject seen in the videos from April and May 2018. (TA238).

On April 29, 2018, The Petitioner was observed on surveillance video at 8:30 a.m., arriving at his residence driving his vehicle. He exited, carrying plastic bags containing unknown items into his residence. He used no assistive device to walk. At 1:31 p.m. that day, he departed with two unidentified females and an unidentified male and drove to Prestige Liquors. He was observed entering and exiting Prestige several times, without the use of assistive device, the first trip he carried a plastic bag containing unknown items and two cases of beer. On a second trip into Prestige, he returned with a bag of ice. The next group traveled to Bogan High School, arrived at 1:57 p.m., and walked to the soccer fields. The Petitioner testified that he has a daughter that plays soccer at Bogan High School (TA140). The Petitioner walked from his car to a soccer field without use of assistive device. The Petitioner walked and stood, without assistive device or apparent difficulty, for nearly three hours. He was observed to bend at the waist, squat, sit on the ground and arise without assistance, and sit in a chair and arise without assistance. He drank multiple beers while at the soccer match. He smoked multiple cigarettes throughout the soccer match. (RX15).

More specifically, between 2:16 p.m. and 2:19 p.m., he smoked a hand-rolled cigarette, which was passed around by the Petitioner, amongst a group of men. At 2:22 p.m., the Petitioner lit a traditional cigarette. At 2:51 p.m., the Petitioner kneeled, and then sat on the ground while doing something with his hands. He was able to rise from the ground without assistance or difficulty. From 2:54 to 2:56 p.m., he appeared to seal a hand rolled cigarette with his lips. He looked around the area, scanning the crowd. From 2:57 p.m. to 3:04 p.m., the Petitioner walked and stood, talking with two other men, while passing the hand rolled cigarette between them. During

his three hours at the soccer match, the Petitioner was seen to socialize, stand, bend, sit and walk, to laugh, to drink and to smoke without difficulty or evidence of pain. (RX15).

On May 5, 2018, the Petitioner was observed on surveillance video driving his black Explorer from his residence to a Dunkin Donuts with an unidentified female. Between 7:38 a.m. and 7:40 a.m., while the female was not in the vehicle, the Petitioner was captured smoking a brown wrapped cigarette, which he held pinched between his index finger and thumb. He extinguished and saved the end of this cigarette. At 7:41 a.m., after the female returned to the car, the Petitioner lit, and smoked a traditional cigarette wrapped in white paper. (RX15).

The Petitioner testified that the doctors at New Life released him to light duty work as did the doctors at University of Illinois. (TA66). He testified that he has received Social Security Disability benefits since 2017. (TA67). The Petitioner testified that at the time of Arbitration he was a Medicare beneficiary. He is prescribed medication from his pain specialist at the University of Illinois, and treats with doctors at Esperanza, located at 65th and Richmond. (TA62-63). The Petitioner testified that before he received Disability in 2017, he received medical benefits through the State of Illinois. He said the doctors at University of Illinois have both his white card from the State of Illinois, and his blue and white card from Social Security Disability. (TA63-65).

At Arbitration, the Petitioner admitted that he never underwent implementation of the stimulator. (TA60-61). He stated that he participates in pool therapy and receives injections. (TA62).

At Arbitration, on August 17, 2018, the Petitioner testified that he still experienced extreme pain in his back and legs. He stated that his back pain is in the middle and to the left side, and it is down his left leg. (TA68-69). He testified that he no longer plays soccer with his children, or goes dancing, which he would do once or twice per year. (TA69-70). He testified that he takes pain pills in the morning and afternoon and takes other medication for his left leg symptoms three times per day. (TA72).

The Petitioner presented at Arbitration using a cane to ambulate. He testified that he uses the case once awhile when it's hot but does not use it when it is cold. (TA140-141). He testified while seated and asked to stand on at least one occasion. He moaned in pain during the hearing. The Petitioner testified that his back was hurting after recent participation in pool therapy (TA141-142).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of fact in support of the conclusions of Law set forth below. To obtain compensation under the act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980) including that the accidental injury both arose out of and occurred in the course of his employment (Horvath v. Industrial Commission, 96 Ill.2d. 349 (1983))

and that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, I29 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980). The mere existence of testimony does not require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evidence it might be that his story is a fabricated afterthought. U.S. Steel v. Industrial Commission, 44 Ill2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill. App. 3d 284, 574 N.E.2d 1244 (1991). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). The above Statement of Facts contains many examples of Petitioner's testimony being at odds with the medical records and testimony of other witnesses. The Arbitrator finds Petitioner to have substantial credibility issues that prevent the Arbitrator from finding in his favor on any of the disputed issues in this case. Specific findings regarding credibility that lead the Arbitrator to make findings on the disputed issues are explained below.

As to disputed issue "C", did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence, that he sustained an accidental injury that arose out of and in the course of his employment by Respondent, Continental Sales, on either May 10, 2010 or September 9, 2011. In support of this finding, the Arbitrator finds the following facts.

The Petitioner's alleged injury on May 10, 2010 was not witnessed, by his own admission. He did not present any post-occurrence witness to corroborate his testimony. He alleged that he told his supervisor, Mr. Ramon Hernandez, on the date that it occurred, but Mr. Hernandez denies knowledge of this injury on the date that it occurred. The Petitioner sought no treatment for this alleged injury for sixteen months.

The Petitioner's testimony regarding the mechanism of his injury on May 10, 2010 is inconsistent with the Respondent's employment/human resources records and the medical histories. At Arbitration, the Petitioner testified that, while lifting a box of food, he stepped backward, and his foot stepped on the edge of a pallet behind him, causing him to fall to the ground in a seated position. He stated his buttocks were on the floor, and his back hit the edge of the pallet. He denied that the pallet broke. However, the Respondent's records include the First Report of Injury, completed by Human Resources Generalist, Ms. Danelia Hernandez, on September 9, 2011. On that document, Ms. Hernandez noted that the Petitioner reported that sixteen months prior, he was standing on top of the pallet, when the pallet broke, causing him to fall and land on his behind.

The first medical treatment for the May 10, 2010 alleged accident was on September 9, 2011, the date that he reported it to the Respondent. However, to the doctors at Concentra, he reported an accident on May 2, 2011 in which he fell on top of a pallet, and the pallet broke, causing back pain. He testified that the Concentra records contain the wrong date of accident.

The Petitioner explained the incorrect date by claiming that there was no one to help him at Concentra to fill out the forms in Spanish. He also claimed that the employees at Concentra did not speak Spanish, and he did not speak English. However, Ms. Hernandez testified that she told the Petitioner, as she would any Spanish speaking employee, that Concentra employs Spanish speaking personnel to assist Spanish speaking patients. She testified that she is also fluent in Spanish and spoke to the Petitioner on September 9, 2011 in his native tongue. Later that day, Ms. Hernandez learned that the Petitioner did not travel directly from Continental Sales to Concentra, a fifteen-minute drive. Rather, he presented there approximately ninety minutes later. When Ms. Hernandez questioned him about his delay in presenting for treatment, he told her that he had traveled first to his home, to pick up his wife so that she could translate for him at Concentra. When asked about this inconsistency at Arbitration, he admitted that he had traveled

home to pick up his wife to translate and admitted that there were Spanish speaking employees at Concentra.

The Petitioner presented to Mercy Medical Center at 43rd and Pulaski on September 15, 2011, for treatment to his low back. The records fail to document that his back pain was work related.

Within a couple weeks of providing notice to the Respondent of his back injury in May 2010, the Petitioner hired two different law firms to represent him. One filed an Application for an accident on May 10, 2010, and the other filed an Application for an accident on September 9, 2011. The Application for the May 2010 accident simply alleges an injury while working. The Application for the September 9, 2011 accident alleges that the Petitioner fell on a pallet at work. At Arbitration, the Petitioner claimed that the description of the September 9, 2011 accident was a lie.

The Petitioner alleges that he told his supervisor, Mr. Ramon Hernandez about the May 10, 2010 accident on the day that it occurred. Mr. Hernandez denies knowing about the Petitioner's accident on that date. The Petitioner alleges that Mr. Hernandez told him to go home on May 10, 2010, and that he missed several days of work after that. The Respondent's Employee Attendance Tracking forms fail to indicate any absence due to an alleged work injury on May 10, 2010.

The Petitioner admitted that, once he allegedly told Mr. Hernandez about the May 10, 2010 accident, he didn't mention it again until September 9, 2011. However, Petitioner claims that Mr. Hernandez allowed him to come and go as he pleased due to his back problem, and that the Respondent never disciplined him about his late arrival, early departure or missed work. The Respondent's personnel records document several instances in which the Petitioner was late, left early or missed work in 2010 and 2011. These same records indicate Petitioner was spoken to or disciplined on several occasions. In May 2011, the Petitioner was written up for gross misconduct for refusing to follow his supervisor's instructions, and when an alternate job was proposed, the Petitioner instead left to go home. The Respondent's attendance records indicate the Petitioner provided other excuses for his tardiness and lost time – babysitting problems, car problems, legal problems, oversleeping, and childcare issues. There is no documentation that Petitioner's attendance problems were related to his low back condition. Mr. Hernandez testified that he did not learn about the Petitioner's alleged back injury in May 2010 until September 2011.

The Petitioner was sent by his lawyer to New Life for medical treatment. The medical history at New Life indicates Petitioner sustained an accident on May 10, 2010, which he reported to co-worker Araceli Magana on May 2, 2011, and reported again on September 9, 2011. At Arbitration, the Petitioner claimed that the new life dates were "a lie". The records from New Life and Instant Care fail to document a second accident on September 9, 2011.

The Petitioner was sent by New Life to Dr. Kern Singh, who examined him on January 9, 2012. Dr. Singh's records document that on May 20, 2010 the Petitioner was unloading a pallet and tripped backward.

The Petitioner was sent by Instant Care to Dr. Michel Malek, who examined him in 2012. Dr. Malek's records document that on May 20, 2010, the Petitioner stepped backward while stocking a pallet and hit his legs on the edge of the pallet, falling down and landing in a twisted position on his left side. Dr. Malek's report indicates further that the Petitioner was re-injured on September 9, 2010 while stocking cans of lemon tea, twisting and performing repetitive work.

The Petitioner was examined by Dr. Alexander Ghanayem on several occasions. On August 6, 2012, he advised Dr. Ghanayem that his injury occurred in May 2010 when he fell backward and struck his low back on a pallet. The Petitioner returned to Dr. Ghanayem on December 19, 2013. This time, he failed to allege a work injury in May 2010, but rather claimed to have been injured on September 9, 2011.

The Petitioner sought treatment with Dr. Saleh Rifai. Dr. Rifai's records from 2013 fail to contain a history of any work injury but mention only that the Petitioner ceased working one and one-half years prior and wanted to return to work part time.

The Petitioner sought treatment with Dr. Masood Syed at Healthy Family Medical in March 2014. The Petitioner did not provide a detailed history of a work injury, but rather report a fall on his back three years previous.

The Arbitrator finds that the Petitioner lacks credibility. In addition to the above-stated inconsistencies, the Petitioner was seen to behave on surveillance video very differently than he presented while testifying at the Commission. While at the Commission, he ambulated with a cane, and exhibited numerous pain behaviors, including wincing facial expressions and audible moans of pain. On surveillance video in 2016 and 2018, the Petitioner is seen to ambulate without a cane over multiple days of surveillance, stand for hours at a time without difficulty, squat, kneel and sit on the ground without difficulty rising, and is able to carry items in his hands. In addition, the Petitioner appears to engage in behavior which would contradict instructions of his doctors. For example, the Petitioner is seen to consume numerous alcoholic beverages while watching his children play soccer in 2016 and 2018. The Petitioner is seen to smoke numerous cigarettes on surveillance video in 2016 and 2018, which his surgeon stated would make him non-compliant with surgical guidelines. In 2017, the doctors at Esperanza administered drug screens to the Petitioner, one of which was positive for cannabinoids, opiates and cocaine. Subsequent drug screens were positive for cannabinoids, opiates and on one occasion, also benzodiazepines. During two separate days of surveillance in 2018, the Petitioner is seen also to smoke non-traditional cigarettes while at a soccer match, and while preparing to drive his vehicle with a passenger.

The Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment on either May 10, 2010 or September 9, 2011. As such, the Arbitrator declines to award any benefits under the Illinois Workers' Compensation Act.

As to disputed issue "E", was timely notice of the accident given to Respondent, the Arbitrator finds the following facts:

Because of the Arbitrator's finding that the Petitioner failed to prove an accident occurred on May 10, 2010 or September 9, 2011, the issue of notice is moot. However, the Petitioner's failure to provide timely notice also supports the Arbitrator's finding that the Petitioner failed to prove accident.

The Arbitrator finds that the Petitioner failed to provide timely notice to the Respondent of his alleged accident on May 10, 2010. The Arbitrator adopts the testimony of Mr. Ramon Hernandez over that of the Petitioner. Mr. Hernandez denies that the Petitioner came to him on May 10, 2010 to report the alleged injury. Even the Petitioner admits that he didn't discuss this alleged injury with Mr. Hernandez between May 11, 2010 and September 9, 2011. The Petitioner admits further that he never reported his alleged injury in May 2010 to Human Resources Generalist, Ms. Danelia Hernandez between the date she was hired in February 2011, and the date that he provided notice, September 9, 2011. There is no medical documentation, or personnel/human resources documentation of lost time due to a back injury.

As to the Application alleging an accident on September 9, 2011, a discrete accident is alleged thereon, but the Petitioner testified that it the accident alleged on that Application was "a lie". When the Petitioner notified the Respondent on September 9, 2011, he reported only a discrete trauma from May 2010. He did not provide testimony or proof of any new accident on September 9, 2011 or allege any facts to prove an alleged repetitive trauma injury to the low back caused by his employment. When he provided notice on September 9, 2011, it was of an accident that allegedly occurred sixteen months earlier. The Arbitrator finds that the Respondent was prejudiced by the Petitioner's failure to provide timely notice of the May 10, 2010 alleged accident, or any notice of an accident on September 9, 2011.

As to disputed issue "F", is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following facts.

The Arbitrator adopts the causation opinion of Dr. Alexander Ghanayem to find that the Petitioner failed to prove that his low back condition and need for surgery were causally related to his employment. Dr. Ghanayem noted that at his first evaluation in 2012, the Petitioner reported an accident in May 2010 for which he failed seek treatment for over sixteen months. At his second evaluation in 2013, the Petitioner instead alleged an accident on September 9, 2011. The delay in treatment and the switching of accident dates called into question whether there was any trauma to the Petitioner's spine caused by his employment. Dr. Ghanayem reviewed original

imaging of the Petitioner's spine and opined that his spinal condition was related to congenital sacralization, which placed him at greater risk of developing spondylolisthesis. He opined that the Petitioner did not have a true herniation at L4-5, but that the ridge of the disc was associated with the slip at L4-5. Dr. Ghanayem stated in August 2012, that the petitioner's spinal condition was of long-standing duration. He stated that the Petitioner's condition was unrelated to any work injury, but rather to the nature of spondylolisthesis.

The Petitioner offered no causal relationship opinion.

As to disputed issue "J", were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

The Arbitrator declines to award any medical expenses due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "J", is the Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

The Arbitrator declines to award any prospective medical care due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "K", what temporary benefits are in dispute, the Arbitrator finds the following facts:

The Arbitrator declines to award any temporary total disability benefits due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

As to disputed issue "L", what is the nature and extent of the injury, the Arbitrator finds the following facts:

The Arbitrator declines to award any permanent partial disability benefits due to the finding that the Petitioner failed to prove he sustained an accident on either May 10, 2010 or September 9, 2011.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC002826
Case Name	KASPRZAK,MARGARET v. STATE OF ILLINOIS DEPT OF
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0374
Number of Pages of Decision	19
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	DAVID BARISH
Respondent Attorney	Danielle Curtiss

DATE FILED: 7/26/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0374

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

Margaret Kasprzak.,

Petitioner,

vs. NO: 11 WC 2826

SOI/Dept. of Human Services,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission clarifies the decision of the Arbitrator to find that Petitioner suffered a left hip strain/contusion as a result of the accident on 12/13/10, which has since resolved, but that she failed to prove her current condition of ill-being relative to her left hip, including the need for an arthroplasty, is causally related to said accident. The Commission also strikes the Arbitrator's finding at p.9 of the addendum of his decision wherein he found that "… Petitioner's causal chain is broken by her unrelated hip surgery…"

In addition, the Commission corrects scrivener's errors at p.2 of the addendum [third paragraph], p.3 [first paragraph] and p.9 (in the second and fourth sentences of the first full paragraph], to show Petitioner underwent a left total hip "*arthroplasty*", not "arthroscopy." The Commission also corrects a scrivener's error at p.2 [first paragraph, 2nd sentence] to show a date of January 20, 2011 (not 2013).

Finally, the Commission corrects/clarifies the Arbitrator's award to show that Petitioner was entitled to $447.37 per week for a period of 2.15 weeks for the reason that she suffered the

permanent partial loss of use of 1% of her left leg pursuant to §8(e)12 of the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/9/20 is hereby modified, as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $754.86 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $447.37 per week for a period of 2.15 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused permanent partial loss of use of 1% of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

July 26, 2021

TJT: pmo
o 7/13/21
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

21IWCC0374

KASPRZAK, MARGARET Case# **11WC002826**
Employee/Petitioner

ST OF IL/ILLINOIS DEPT OF HUMAN SERVICES
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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

6096 ASSISTANT ATTORNEY GENERAL
JOHN M CATALANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

APR - 9 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Margaret Kasprzak
Employee/Petitioner

v.

State of Illinois/Illinois Department of Human Services
Employer/Respondent

Case # **11** WC **2826**

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Cook**, on **May 8, 2019 and July 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 13, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,772.27**; the average weekly wage was $**745.62**

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

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

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

Respondent shall be given a credit of $**35,612.64** for TTD, $**0** for TPD, $**0** for maintenance, and $0 for other benefits, for a total credit of $**35,612.64**.

Respondent is entitled to a credit of $**754.86** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $35,612.64 for TTD, $0 for TPD, and $0 for maintenance benefits, for a total credit of $35,612.64.

Respondent shall be given a credit of $754.86 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.

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the accident. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident and for that is awarded 1% of a leg.

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.

Charles M. Watts

April 6, 2020

APR 9 - 2020

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARGARET KASPRZAK,	)	**Case No. 11 WC 2826**
	)	
Petitioner,	)	
	)	Chicago, IL
v.	)	
	)	
STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF HUMAN SERVICES,	)	
	)	
Respondent.	)	

FINDINGS OF FACTAND CONCLUSIONS OF LAW

An Application for Adjustment of Claim was filed by Petitioner, Margaret Kasprzak, seeking relief under the Illinois Workers' Compensation Act from Respondent, Illinois Department of Human Services ("DHS"). Arbitrator Charles Watts held a hearing on May 8, 2019 and proofs were closed on July 11, 2019 in Chicago, Illinois. Petitioner was represented by Katz Friedman and Respondent was represented by the Illinois Attorney General's Office.

FINDING OF FACTS

Petitioner's Testimony

Petitioner currently works for DHS as a caretaker, or personal assistant. As part of her job duties, Petitioner washes her client, helps with exercises, dresses him, moves him to and from his wheelchair, as well as assists him in anyway necessary.

Petitioner stated that prior to the accident her hip was pain free, although she underwent hip surgery when she was five years old. Her hip had been pain free for 20 to 30 years prior to her workplace accident. On December 13, 2010, Petitioner was working as a personal assistant

and preparing to move her client from the bed to the wheelchair when her foot slipped. Petitioner fell to the floor. She had immediate hip pain. Her husband came home from work and took care of her client while she saw a doctor the next day.

After December 13, 2010, Petitioner continued to work and performed her normal job duties. On January 20, 2013, Petitioner's pain had increased to the point of where she could no longer perform her job duties, so she took time off for her injury and was paid TTD.

When Petitioner began working for DHS, she was paid $8.76 an hour. She is currently paid $13.00 an hour. At the time of the accident, Petitioner was paid somewhere between those two amounts. Petitioner testified that DHS set the amount of hours she could work per month. In 2010, she was allowed to work 297 hours each month.

Medical History

On February 4, 2011, nearly two months after her alleged fall, Petitioner began treating with Dr. Wu at Loyola University Medicine. Px 3. Petitioner reported that she had sustained an injury at work on December 13, 2010 when she slipped while turning her patient. *Id.* She told Dr. Wu that she had never had pain in her left hip prior to this injury. *Id.* Dr. Wu found that Petitioner had a history of hip developmental dysplasia and pelvic osteotomy, now with secondary degenerative joint disease. *Id.* An x-ray showed a (1) symmetric appearance of her pelvic bones which was consistent with pelvic osteotomy as a child, (2) an abnormally shaped femoral head, and (3) an incongruous hip joint. *Id.* Dr. Wu noted there were degenerative changes of the joint with joint interval narrowing, subchondral sclerosis, and peripheral osteophyte formation. *Id.* Based on this examination, Dr. Wu recommended a total hip arthroscopy. *Id.*

On March 18, 2011, Petitioner told Dr. Wu that she would like to have a total hip replacement, but needed to establish care for workers' compensation first. *Id.* Dr. Wu referred Petitioner to get an injection. *Id.* On June 30, 2011, Petitioner saw Dr. Wu after receiving an injection, which did not provide any substantial relief. *Id.* On May 2, 2012, Dr. Wu reviewed radiographs of Petitioner's hip that showed severe left hip degenerative joint disease with superior joint space during intercostal sclerosis without acute fracture or dislocation. *Id.* On June 11, 2012, Petitioner underwent a left total hip arthroscopy for degenerative joint disease from hip dysplasia. *Id.*

After surgery, Petitioner started physical therapy at Loyola on July 13, 2012. She attended approximately 14 sessions before being discharged on September 14, 2012. On July 24, 2012, Petitioner followed up with Dr. Wu for the last time and reported that she felt one out of ten pain. An x-ray showed that Petitioner's hip arthroplasty was well positioned. Dr. Wu told Petitioner to continue physical therapy and home exercise. After September 14, 2012, Petitioner did not return for treatment for her left hip.

Dr. Cohen's Independent Medical Examination

On March 20, 2012, Dr. Cohen performed an independent medical examination ("IME") at the behest of Respondent. Rx 1. At the IME, Petitioner denied any hip pain or prior hip problems. *Id.* at 1. When pressed about this issue, Petitioner told Dr. Cohen that she 'had to be strong to take care of a paralyzed man.' *Id.* Dr. Cohen questioned Petitioner about an incision scar around her hip and Petitioner stated that she had hip surgery when she was five years of age. *Id.* at 2.

As part of his examination, Dr. Cohen performed a record review, which uncovered that Petitioner had left hip problems dating back to 2002 and that continued up until one month

before the accident. *Id.* On January 13, 2003, Petitioner's left hip MRI showed asymmetric deformity of the left femoral head and neck as compared to right and slight flattening of the superomedial aspect of the articular surface. *Id.* Her left femoral head was partially uncovered. *Id.* On January 23, 2003, Petitioner was sent for an orthopaedic referral. *Id.* On June 2, 2003, follow-up note indicated that Petitioner had continued hip pain. *Id.* On December 9. 2005, Petitioner again complained of left hip pain to her doctor. *Id.* Her physical therapy diagnosis from June 23, 2010 was left hip pain. *Id.* On November 9, 2010, she complained of moderate to severe pain in both hips, left greater than right. *Id.* at 3. Petitioner was diagnosed with osteoarthritis along with severe pain and decreased range of motion. *Id.* The treating physician ordered an MRI of the left hip at that time. *Id.*

While Petitioner did not submit her primary care physician records into evidence from Dr. Plonski, Dr. Cohen reviewed Dr. Plonski's records. *Id.* Dr. Plonski's note from December 14, 2010 states that Petitioner fell on her left side; however, his assessment remained exactly the same as prior to Petitioner's alleged accident. *Id.* Dr. Plonski told Petitioner to undergo a left hip MRI, which he also had recommended in November 2010. *Id.*

Based on Petitioner's medical history, Dr. Cohen determined that Petitioner's current left hip condition was not related, caused, aggravated, or accelerated by Petitioner's alleged work incident. *Id.* at 4. Dr. Cohen diagnosed Petitioner with severe arthritis, secondary to previous surgery, and congenital dysplasia of the left hip. *Id.* at 5. Because Petitioner maintained that she never had prior hip problems, Dr. Cohen remarked that there was a "credibility issue with the history that [he] obtained from the patient as well as the history obtained by Dr. Wu." *Id.* Instead, Dr. Cohen related Petitioner's current diagnosis to her preexisting left hip condition. *Id.*

Dr. Coe's Independent Medical Examination

On October 20, 2015, Petitioner was examined by Dr. Coe at the request of her attorney. Px5. At that time, Petitioner had already underwent left hip surgery. *Id.* at 4. Dr. Coe did not find that the left hip surgery was related to her alleged workplace incident. *Id.* at 5. Instead, Dr. Coe determined that Petitioner's preexisting left hip deformity and arthritis required the left hip replacement surgery performed by Dr. Wu. *Id.* Dr. Coe opined that Petitioner only suffered a contusion and strain as a result of the work accident. *Id.* at 6.

Nature and Extent

Petitioner testified that she did not recall any prior treatment for her left hip other than her childhood surgery. She did not recall getting an x-ray of her left hip in 2002, undergoing an MRI of her left hip in 2003, going to an orthopaedic specialist in 2005, or doing physical therapy in June 2010. She did not recall if she had seen Dr. Plonski in November 2010 for her left hip or that he ordered an x-ray at that time.

Petitioner testified that she had pain in her left hip when the weather changed.

I. CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

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

to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980).

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was not very credible. The Arbitrator believes that Petitioner was injured only because there are medical records that indicate this to be so. Petitioner testified that she did not have prior complaints of hip pain. The medical records indicate otherwise over and over again. Petitioner simply cannot be believed.

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

The Arbitrator has finds that Petitioner's injury did arise out of and in the course of her employment. Petitioner testified that she was injured while attempting to move her client. This is corroborated by medical records including Dr. Cohen's recount of Petitioner's medical history.

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

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her injury.

"For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." Global Products v. Workers' Comp. Com'n, 392 Ill.App.3d at 411, 331 Ill.Dec. 812, 911 N.E.2d at 1046 (1st Dist. 2009). As long as there is a "but-for" relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable. *Id.*

In this case, Petitioner's fall did not cause her degenerative, pre-existing condition prior to the accident. While Petitioner told Dr. Wu and this Court that she did not have any prior hip pain, the medical records that Dr. Cohen reviewed indicate that her left hip pain did not originate from this fall. The only doctor that causally connected Petitioner's condition to the alleged workplace accident is Dr. Wu, who was not privy to Petitioner's prior treatment history. Even Dr. Wu acknowledged that Petitioner must have had a history of developmental dysplasia and pelvic osteotomy with degenerative joint disease.

Notably, both independent medical examiners agree that Petitioner's left hip condition was not related to her workplace accident. Respondent's examiner, Dr. Cohen, found that Petitioner's

hip condition was not caused, aggravated, or accelerated by Petitioner's workplace incident. Petitioner's examiner, Dr. Coe, agreed and opined that Petitioner's preexisting left hip deformity and arthritis required the left hip replacement surgery, not her fall.

Dr. Coe determined that Petitioner suffered a left hip strain and bruise as a result of her workplace accident; however, neither is supported by the medical records entered into evidence. Dr. Plonski saw Petitioner the day after the accident. He did not diagnosis her with either a bruise or strain, but rather severe pain and decreased range of motion, which was the same diagnosis he had given prior to the accident. Dr. Wu also did not note any left hip contusions or hip strain, merely hip pain. Petitioner did not testify that she sustained a bruise or contusion as a result of her fall but this can be inferred because she fell and went to her physician the next day.

There is no evidence that Petitioner's long-standing pain changed as a result of the alleged workplace accident. Petitioner was seeking treatment for hip pain one month prior to the accident and was referred to undergo a hip MRI. Dr. Plonski's note from December 14, 2010 states that Petitioner still complained of severe pain in her low back and hips. Dr. Plonski's assessment remained exactly the same as prior to Petitioner's alleged accident: left hip pain and chronic gastritis. He also recommended a left hip MRI like he had prior to Petitioner's fall in November 2010. Simply put, Petitioner had left hip pain prior to the accident and she had left hip pain after the accident. There is no medical evidence that this pain was worsened by her alleged fall other than the fact that she sought treatment soon after the fall.

Instead, Petitioner relies on her testimony that she had never had left hip pain prior to her accident. On direct examination, Petitioner stated that she had not felt pain in her left hip for the past 20 to 30 years. This is not true and not supported by the medical records. The medical records that Dr. Cohen reviewed indicate that Petitioner had left hip surgery when she was five

years old. From 2002 until November 2010, Petitioner treated for left hip pain. After undergoing a left hip MRI in 2003, Petitioner was told to follow up with an orthopaedic specialist, which she never did. In November 2010, Petitioner was diagnosed with osteoarthritis and an MRI of the left hip was ordered. When questioned about her medical history on cross examination, Petitioner purposefully could not recall if she had been previously treated for her left hip. The Arbitrator finds that Petitioner was not credible when she testified that she could not recall if she had previously treated for her left hip.

Moreover, Petitioner's causal chain is broken by her unrelated hip surgery. Petitioner's current complaints regarding her left hip cannot be attributed to Petitioner's fall, but rather the arthroscopy that Petitioner underwent and her degenerative condition. As a result of this surgery, Petitioner underwent months of physical therapy and treatment all to the same body part that was allegedly injured in her fall. Any hip pain that Petitioner alleges was caused by her fall cannot be distinguished from her arthroscopy.

Accordingly, the Arbitrator finds that Petitioner's current condition is not causally connected to her alleged workplace accident. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident.

G. What were Petitioner's earnings?

Based on Respondent's Exhibit 3, which shows Petitioner's actual wages for the year prior to the accident, the Arbitrator finds that Petitioner earned $38,772.27 between December 13, 2009 and December 13, 2009, meaning that Petitioner's average weekly wage was $745.62.

K. What temporary benefits are in dispute?

The Arbitrator has already found Petitioner's injury is not causally connected to her current condition. Petitioner suffered a hip strain and contusion whose symptoms were

indistinguishable from prior complaints and did not cause her to miss any time at work. Thus, no benefits are awarded and the Arbitrator makes no finding in regard to temporary benefits for Petitioner's injury. The Arbitrator recognizes that Respondent paid temporary total disability benefits from December 14, 2010 until March 31, 2012 totaling $35,612.64 in good faith and awards a credit for that amount. Rx 2.

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

The Arbitrator has already found Petitioner's injury is not causally connected to her current condition. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident.

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 (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. However, the Arbitrator has considered the doctor's comments as a factor in the evaluation of Petitioner's permanent partial disability as required by §8.1b(b)(i). The doctor noted no AMA rating. Because of no 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 that the record reveals that Petitioner was employed as a Home Health Care worker at the time of the accident and that she was able to return to work in her prior capacity and reported that her hip felt better. The Arbitrator notes this is a physical job but finds that Petitioner fully recovered from her hip strain and contusion and had surgery that made her hip feel and function better. The Arbitrator therefore gives appropriate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no change because Petitioner continues to work at the same job. Substantial weight is given 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 has an artificial hip because of non-work related condition and the surgery has improved both the function of her hip and diminished any pain. The Arbitrator therefore gives no 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 1% loss of use of left leg.

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.

Further, Respondent's Exhibit 2 reflects that Respondent paid $754.86 to Loyola University Medical. Therefore, this Arbitrator finds that Respondent is due a credit of $754.86 in addition to any amount paid through group insurance.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Kasprzak,

Petitioner,

vs. NO: 11 WC 2826

SOI/Dept. of Human Services,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

Pursuant to Section 19(f) of the Act, the Commission finds that a clerical error exists in its Order on Review dated July 26, 2021, in the above captioned.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order on Review dated July 26, 2021 is hereby vacated and recalled pursuant to Section 19(f) for clerical error contained therein.

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

July 30, 2021

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

TJT:yl
51

21IWCC0374

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

Margaret Kasprzak,

Petitioner,

vs. NO: 11 WC 2826

SOI/Dept. of Human Services,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

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

The Commission clarifies the decision of the Arbitrator to find that Petitioner suffered a left hip strain/contusion as a result of the accident on 12/13/10, which has since resolved, but that she failed to prove her current condition of ill-being relative to her left hip, including the need for an arthroplasty, is causally related to said accident. The Commission also strikes the Arbitrator's finding at p.9 of the addendum of his decision wherein he found that "… Petitioner's causal chain is broken by her unrelated hip surgery…"

In addition, the Commission corrects scrivener's errors at p.2 of the addendum [third paragraph], p.3 [first paragraph] and p.9 (in the second and fourth sentences of the first full paragraph], to show Petitioner underwent a left total hip "*arthroplasty*", not "arthroscopy." The Commission also corrects a scrivener's error at p.2 [first paragraph, 2nd sentence] to show a date of January 20, 2011 (not 2013).

Finally, the Commission corrects/clarifies the Arbitrator's award to show that Petitioner was entitled to $447.37 per week for a period of 2.15 weeks for the reason that she suffered the

permanent partial loss of use of 1% of her left leg pursuant to §8(e)12 of the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/9/20 is hereby modified, as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $754.86 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $447.37 per week for a period of 2.15 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused permanent partial loss of use of 1% of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

July 30, 2021

TJT: pmo
o 7/13/21
51

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

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

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

21IWCC0374

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KASPRZAK, MARGARET Case# **11WC002826**

Employee/Petitioner

ST OF IL/ILLINOIS DEPT OF HUMAN SERVICES

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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

6096 ASSISTANT ATTORNEY GENERAL
JOHN M CATALANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

APR -9 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Margaret Kasprzak
Employee/Petitioner

v.

State of Illinois/Illinois Department of Human Services
Employer/Respondent

Case # **11** WC **2826**

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Cook**, on **May 8, 2019 and July 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 13, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,772.27**; the average weekly wage was $**745.62**

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

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

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

Respondent shall be given a credit of $**35,612.64** for TTD, $**0** for TPD, $**0** for maintenance, and $0 for other benefits, for a total credit of $**35,612.64**.

Respondent is entitled to a credit of $**754.86** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $35,612.64 for TTD, $0 for TPD, and $0 for maintenance benefits, for a total credit of $35,612.64.

Respondent shall be given a credit of $754.86 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.

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the accident. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident and for that is awarded 1% of a leg.

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.

Charles M. Watts

April 6, 2020

APR 9 - 2020

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARGARET KASPRZAK,	)	**Case No. 11 WC 2826**
	)	
Petitioner,	)	
	)	Chicago, IL
v.	)	
	)	
STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF HUMAN SERVICES,	)	
	)	
Respondent.	)	

FINDINGS OF FACTAND CONCLUSIONS OF LAW

An Application for Adjustment of Claim was filed by Petitioner, Margaret Kasprzak, seeking relief under the Illinois Workers' Compensation Act from Respondent, Illinois Department of Human Services ("DHS"). Arbitrator Charles Watts held a hearing on May 8, 2019 and proofs were closed on July 11, 2019 in Chicago, Illinois. Petitioner was represented by Katz Friedman and Respondent was represented by the Illinois Attorney General's Office.

FINDING OF FACTS

Petitioner's Testimony

Petitioner currently works for DHS as a caretaker, or personal assistant. As part of her job duties, Petitioner washes her client, helps with exercises, dresses him, moves him to and from his wheelchair, as well as assists him in anyway necessary.

Petitioner stated that prior to the accident her hip was pain free, although she underwent hip surgery when she was five years old. Her hip had been pain free for 20 to 30 years prior to her workplace accident. On December 13, 2010, Petitioner was working as a personal assistant

and preparing to move her client from the bed to the wheelchair when her foot slipped. Petitioner fell to the floor. She had immediate hip pain. Her husband came home from work and took care of her client while she saw a doctor the next day.

After December 13, 2010, Petitioner continued to work and performed her normal job duties. On January 20, 2013, Petitioner's pain had increased to the point of where she could no longer perform her job duties, so she took time off for her injury and was paid TTD.

When Petitioner began working for DHS, she was paid $8.76 an hour. She is currently paid $13.00 an hour. At the time of the accident, Petitioner was paid somewhere between those two amounts. Petitioner testified that DHS set the amount of hours she could work per month. In 2010, she was allowed to work 297 hours each month.

Medical History

On February 4, 2011, nearly two months after her alleged fall, Petitioner began treating with Dr. Wu at Loyola University Medicine. Px 3. Petitioner reported that she had sustained an injury at work on December 13, 2010 when she slipped while turning her patient. *Id.* She told Dr. Wu that she had never had pain in her left hip prior to this injury. *Id.* Dr. Wu found that Petitioner had a history of hip developmental dysplasia and pelvic osteotomy, now with secondary degenerative joint disease. *Id.* An x-ray showed a (1) symmetric appearance of her pelvic bones which was consistent with pelvic osteotomy as a child, (2) an abnormally shaped femoral head, and (3) an incongruous hip joint. *Id.* Dr. Wu noted there were degenerative changes of the joint with joint interval narrowing, subchondral sclerosis, and peripheral osteophyte formation. *Id.* Based on this examination, Dr. Wu recommended a total hip arthroscopy. *Id.*

On March 18, 2011, Petitioner told Dr. Wu that she would like to have a total hip replacement, but needed to establish care for workers' compensation first. *Id.* Dr. Wu referred Petitioner to get an injection. *Id.* On June 30, 2011, Petitioner saw Dr. Wu after receiving an injection, which did not provide any substantial relief. *Id.* On May 2, 2012, Dr. Wu reviewed radiographs of Petitioner's hip that showed severe left hip degenerative joint disease with superior joint space during intercostal sclerosis without acute fracture or dislocation. *Id.* On June 11, 2012, Petitioner underwent a left total hip arthroscopy for degenerative joint disease from hip dysplasia. *Id.*

After surgery, Petitioner started physical therapy at Loyola on July 13, 2012. She attended approximately 14 sessions before being discharged on September 14, 2012. On July 24, 2012, Petitioner followed up with Dr. Wu for the last time and reported that she felt one out of ten pain. An x-ray showed that Petitioner's hip arthroplasty was well positioned. Dr. Wu told Petitioner to continue physical therapy and home exercise. After September 14, 2012, Petitioner did not return for treatment for her left hip.

Dr. Cohen's Independent Medical Examination

On March 20, 2012, Dr. Cohen performed an independent medical examination ("IME") at the behest of Respondent. Rx 1. At the IME, Petitioner denied any hip pain or prior hip problems. *Id.* at 1. When pressed about this issue, Petitioner told Dr. Cohen that she 'had to be strong to take care of a paralyzed man.' *Id.* Dr. Cohen questioned Petitioner about an incision scar around her hip and Petitioner stated that she had hip surgery when she was five years of age. *Id.* at 2.

As part of his examination, Dr. Cohen performed a record review, which uncovered that Petitioner had left hip problems dating back to 2002 and that continued up until one month

before the accident. *Id.* On January 13, 2003, Petitioner's left hip MRI showed asymmetric deformity of the left femoral head and neck as compared to right and slight flattening of the superomedial aspect of the articular surface. *Id.* Her left femoral head was partially uncovered. *Id.* On January 23, 2003, Petitioner was sent for an orthopaedic referral. *Id.* On June 2, 2003, follow-up note indicated that Petitioner had continued hip pain. *Id.* On December 9. 2005, Petitioner again complained of left hip pain to her doctor. *Id.* Her physical therapy diagnosis from June 23, 2010 was left hip pain. *Id.* On November 9, 2010, she complained of moderate to severe pain in both hips, left greater than right. *Id.* at 3. Petitioner was diagnosed with osteoarthritis along with severe pain and decreased range of motion. *Id.* The treating physician ordered an MRI of the left hip at that time. *Id.*

While Petitioner did not submit her primary care physician records into evidence from Dr. Plonski, Dr. Cohen reviewed Dr. Plonski's records. *Id.* Dr. Plonski's note from December 14, 2010 states that Petitioner fell on her left side; however, his assessment remained exactly the same as prior to Petitioner's alleged accident. *Id.* Dr. Plonski told Petitioner to undergo a left hip MRI, which he also had recommended in November 2010. *Id.*

Based on Petitioner's medical history, Dr. Cohen determined that Petitioner's current left hip condition was not related, caused, aggravated, or accelerated by Petitioner's alleged work incident. *Id.* at 4. Dr. Cohen diagnosed Petitioner with severe arthritis, secondary to previous surgery, and congenital dysplasia of the left hip. *Id.* at 5. Because Petitioner maintained that she never had prior hip problems, Dr. Cohen remarked that there was a "credibility issue with the history that [he] obtained from the patient as well as the history obtained by Dr. Wu." *Id.* Instead, Dr. Cohen related Petitioner's current diagnosis to her preexisting left hip condition. *Id.*

Dr. Coe's Independent Medical Examination

On October 20, 2015, Petitioner was examined by Dr. Coe at the request of her attorney. Px5. At that time, Petitioner had already underwent left hip surgery. *Id.* at 4. Dr. Coe did not find that the left hip surgery was related to her alleged workplace incident. *Id.* at 5. Instead, Dr. Coe determined that Petitioner's preexisting left hip deformity and arthritis required the left hip replacement surgery performed by Dr. Wu. *Id.* Dr. Coe opined that Petitioner only suffered a contusion and strain as a result of the work accident. *Id.* at 6.

Nature and Extent

Petitioner testified that she did not recall any prior treatment for her left hip other than her childhood surgery. She did not recall getting an x-ray of her left hip in 2002, undergoing an MRI of her left hip in 2003, going to an orthopaedic specialist in 2005, or doing physical therapy in June 2010. She did not recall if she had seen Dr. Plonski in November 2010 for her left hip or that he ordered an x-ray at that time.

Petitioner testified that she had pain in her left hip when the weather changed.

I. CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

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

to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980).

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was not very credible. The Arbitrator believes that Petitioner was injured only because there are medical records that indicate this to be so. Petitioner testified that she did not have prior complaints of hip pain. The medical records indicate otherwise over and over again. Petitioner simply cannot be believed.

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

The Arbitrator has finds that Petitioner's injury did arise out of and in the course of her employment. Petitioner testified that she was injured while attempting to move her client. This is corroborated by medical records including Dr. Cohen's recount of Petitioner's medical history.

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

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her injury.

"For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." Global Products v. Workers' Comp. Com'n, 392 Ill.App.3d at 411, 331 Ill.Dec. 812, 911 N.E.2d at 1046 (1st Dist. 2009). As long as there is a "but-for" relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable. *Id.*

In this case, Petitioner's fall did not cause her degenerative, pre-existing condition prior to the accident. While Petitioner told Dr. Wu and this Court that she did not have any prior hip pain, the medical records that Dr. Cohen reviewed indicate that her left hip pain did not originate from this fall. The only doctor that causally connected Petitioner's condition to the alleged workplace accident is Dr. Wu, who was not privy to Petitioner's prior treatment history. Even Dr. Wu acknowledged that Petitioner must have had a history of developmental dysplasia and pelvic osteotomy with degenerative joint disease.

Notably, both independent medical examiners agree that Petitioner's left hip condition was not related to her workplace accident. Respondent's examiner, Dr. Cohen, found that Petitioner's

hip condition was not caused, aggravated, or accelerated by Petitioner's workplace incident. Petitioner's examiner, Dr. Coe, agreed and opined that Petitioner's preexisting left hip deformity and arthritis required the left hip replacement surgery, not her fall.

Dr. Coe determined that Petitioner suffered a left hip strain and bruise as a result of her workplace accident; however, neither is supported by the medical records entered into evidence. Dr. Plonski saw Petitioner the day after the accident. He did not diagnosis her with either a bruise or strain, but rather severe pain and decreased range of motion, which was the same diagnosis he had given prior to the accident. Dr. Wu also did not note any left hip contusions or hip strain, merely hip pain. Petitioner did not testify that she sustained a bruise or contusion as a result of her fall but this can be inferred because she fell and went to her physician the next day.

There is no evidence that Petitioner's long-standing pain changed as a result of the alleged workplace accident. Petitioner was seeking treatment for hip pain one month prior to the accident and was referred to undergo a hip MRI. Dr. Plonski's note from December 14, 2010 states that Petitioner still complained of severe pain in her low back and hips. Dr. Plonski's assessment remained exactly the same as prior to Petitioner's alleged accident: left hip pain and chronic gastritis. He also recommended a left hip MRI like he had prior to Petitioner's fall in November 2010. Simply put, Petitioner had left hip pain prior to the accident and she had left hip pain after the accident. There is no medical evidence that this pain was worsened by her alleged fall other than the fact that she sought treatment soon after the fall.

Instead, Petitioner relies on her testimony that she had never had left hip pain prior to her accident. On direct examination, Petitioner stated that she had not felt pain in her left hip for the past 20 to 30 years. This is not true and not supported by the medical records. The medical records that Dr. Cohen reviewed indicate that Petitioner had left hip surgery when she was five

years old. From 2002 until November 2010, Petitioner treated for left hip pain. After undergoing a left hip MRI in 2003, Petitioner was told to follow up with an orthopaedic specialist, which she never did. In November 2010, Petitioner was diagnosed with osteoarthritis and an MRI of the left hip was ordered. When questioned about her medical history on cross examination, Petitioner purposefully could not recall if she had been previously treated for her left hip. The Arbitrator finds that Petitioner was not credible when she testified that she could not recall if she had previously treated for her left hip.

Moreover, Petitioner's causal chain is broken by her unrelated hip surgery. Petitioner's current complaints regarding her left hip cannot be attributed to Petitioner's fall, but rather the arthroscopy that Petitioner underwent and her degenerative condition. As a result of this surgery, Petitioner underwent months of physical therapy and treatment all to the same body part that was allegedly injured in her fall. Any hip pain that Petitioner alleges was caused by her fall cannot be distinguished from her arthroscopy.

Accordingly, the Arbitrator finds that Petitioner's current condition is not causally connected to her alleged workplace accident. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident.

G. What were Petitioner's earnings?

Based on Respondent's Exhibit 3, which shows Petitioner's actual wages for the year prior to the accident, the Arbitrator finds that Petitioner earned $38,772.27 between December 13, 2009 and December 13, 2009, meaning that Petitioner's average weekly wage was $745.62.

K. What temporary benefits are in dispute?

The Arbitrator has already found Petitioner's injury is not causally connected to her current condition. Petitioner suffered a hip strain and contusion whose symptoms were

indistinguishable from prior complaints and did not cause her to miss any time at work. Thus, no benefits are awarded and the Arbitrator makes no finding in regard to temporary benefits for Petitioner's injury. The Arbitrator recognizes that Respondent paid temporary total disability benefits from December 14, 2010 until March 31, 2012 totaling $35,612.64 in good faith and awards a credit for that amount. Rx 2.

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

The Arbitrator has already found Petitioner's injury is not causally connected to her current condition. Petitioner did sustain a hip strain and hip contusion that resolved soon after the accident.

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 (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. However, the Arbitrator has considered the doctor's comments as a factor in the evaluation of Petitioner's permanent partial disability as required by §8.1b(b)(i). The doctor noted no AMA rating. Because of no 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 that the record reveals that Petitioner was employed as a Home Health Care worker at the time of the accident and that she was able to return to work in her prior capacity and reported that her hip felt better. The Arbitrator notes this is a physical job but finds that Petitioner fully recovered from her hip strain and contusion and had surgery that made her hip feel and function better. The Arbitrator therefore gives appropriate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no change because Petitioner continues to work at the same job. Substantial weight is given 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 has an artificial hip because of non-work related condition and the surgery has improved both the function of her hip and diminished any pain. The Arbitrator therefore gives no 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 1% loss of use of left leg.

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.

Further, Respondent's Exhibit 2 reflects that Respondent paid $754.86 to Loyola University Medical. Therefore, this Arbitrator finds that Respondent is due a credit of $754.86 in addition to any amount paid through group insurance.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC038111
Case Name	DYER,ALLAN C v. IL DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0375
Number of Pages of Decision	22
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Frank Gaughan
Respondent Attorney	

DATE FILED: 7/23/2021

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0375

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 increase PPD—Loss of occupation	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALLAN C. DYER,

Petitioner,

vs. NO: 14 WC 38111

STATE OF ILLINOIS,
ILLINOIS DEPARTMENT
OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, permanent partial disability, and other-any and all other issues raised at hearing, 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 the Arbitrator's decision as to accident, causal connection, temporary total disability, medical expenses, and other-any and all other issues raised at hearing. The Commission modifies the Arbitrator's award regarding permanent partial disability from 20% loss of use of Petitioner's person as a whole to 35% loss of use of Petitioner's person as a whole considering loss of trade.

Whether a claimant is permanently and totally disabled is a question of fact to be resolved by the Commission, and its determination will not be disturbed on review unless it is against the manifest weight of the evidence. *Lenhart*, 2015 IL App (3d) 130743WC. The Commission agrees with the Arbitrator that Petitioner failed to prove he was permanently and totally disabled under an odd lot theory. However, after a careful review of the evidence, the Commission modifies the award of permanent partial disability based on the following.

The Commission performs an analysis under Section 8.1(b) as follows:

1) There was no impairment rating performed so this factor is given no weight.
2) Petitioner worked as a laborer for Respondent. Petitioner has been unable to return to his same occupation, and, in fact, Petitioner sustained a loss of trade due to his injuries. This factor is given significant weight.
3) Petitioner was 64 years-old at the time of his injury. Petitioner currently resides in New York. He may have had some working years ahead of him. This factor is given some weight.
4) Petitioner had been unable to return to his former position and has since gone from SSDI to regular social security benefits. Petitioner's earning capacity was affected. Petitioner's injuries resulted in a loss of trade. This factor is given significant weight.
5) Petitioner's injury and disability were corroborated by the medical records. Petitioner had prior congestive heart failure before of the accident of November 3, 2014 incident; however, the shoveling incident aggravated the condition. He does have to live with the residual effects from his work accident. He is less active with his regular exercise routines. It has long been recommended that Petitioner have a permanent pacemaker implanted and Petitioner requires ongoing follow-up visits for his condition. Petitioner was interviewed on April 12, 2018 by Edward Pagella of Health Connection of Illinois, who is a Certified Rehabilitation Counselor and licensed Clinical Professor Counselor. Mr. Pagella noted that Petitioner had a GED and Associates degree in applied Science. Petitioner had previously worked as a commercial truck driver, HVAC repairman, and as a laborer for Respondent. Mr. Pagella opined Petitioner was unable to perform those job duties as they involved heavy labor and he opined Petitioner had no transferable skills. He opined Petitioner was unemployable. The Commission disagrees with the opinions of Mr. Pagella. The Commission considers all the other medical records in evidence, including various treaters at Northwestern, doctors at Hines VA, and VA New York Harbor Health Systems, and Section 12 examiner, Dr. Soble. While all have indicated that Petitioner was unable to return to his former, heavy lifting, exertional manual work duties, Petitioner's permanent restrictions remain at clerical or sedentary type work. The Commission further notes Petitioner has some transferable skills given his employment and educational background. The Commission finds that Petitioner is employable under the permanent restrictions and takes notice that Petitioner did not attempt to seek alternative employment within his restrictions. This factor is given significant weight.

In reviewing the totality of the evidence, the Commission finds that the Arbitrator issued an award for permanency insufficient to consider Petitioner's loss of trade. Petitioner was unable to return to work full duty in his heavy exertional work as a laborer/highway maintainer for Respondent. Petitioner was returned to work with permanent clerical or sedentary job restrictions. Although he does continue to run and lift weights, that is not the same as performing full time heavy exertional type work. Petitioner received short-term disability benefits and applied for and received Social Security Disability benefits which have since been converted to regular Social Security benefits when he turned 66 years old. Given Petitioner is currently 68 years old, some

restrictions related to the accident potentially could prevent him from working. The Commission finds Petitioner sustained a loss of trade due to his permanent work restrictions incurred as a result of the work related accident.

Based on the above, when considering the five factors, the Commission modifies the Arbitrator's Decision, to increase Petitioner's permanent partial disability award from 20% loss of use of his person as a whole, to 35% loss of use of his person as a whole pursuant to Section 8(d)(2) of the Act. Petitioner has essentially lost his trade as he is unable to return to his former job duties as a laborer/highway maintainer and requires ongoing medical attention and potentially a surgical implantation of a pacemaker.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $739.93 per week for a period of 45-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. ($33,508.26 total TTD)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $665.94 per week for a period of 175 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 35% loss of use of Petitioner's person as a whole, based on loss of trade. ($116,539.50 total PPD)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,357.33 for medical expenses under §8(a) of the Act.

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

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

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)*.

July 23, 2021

o-6/22/21
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 21IWCC0375
NOTICE OF ARBITRATOR DECISION

DYER, ALLAN C
Employee/Petitioner

Case# **14WC038111**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 9/3/2019, 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 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOCIATES LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

6202 ASSISTANT ATTORNEY GENERAL
COURTNEY SCHOCH
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

SEP 3 - 2019

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

A. Dyer v. Ill. Dept. of Transportation, 14 WC 038111

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

Allan C. Dyer
Employee/Petitioner
v.
Illinois Department of Transportation
Employer/Respondent

Case # **14** WC **038111**

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 **1/8/2019**. 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 _____

A. Dyer v. Ill. Dept. of Transportation, 14 WC 038111

FINDINGS

On **11/3/2014**, 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, in part,*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$57,715.00**; the average weekly wage was **$1,109.90**.

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

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

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

Respondent shall be given a credit of **$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 to Petitioner reasonable and necessary medical services of $4,357.33, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner temporary total disability benefits of $739.93/week for 45-2/7 weeks, commencing 11/4/2014 through 9/16/2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $665.94/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.

Respondent shall pay Petitioner all compensation benefits that have accrued from 11/3/2014 to 1/8/2019 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

September 3, 2019
Date

SEP 3 - 2019

FINDINGS OF FACT

On November 3, 2014, Petitioner, Allan C. Dyer, was employed by Respondent, the Illinois Department of Transportation (IDOT), as a laborer in its highway maintenance division. He began this job in February of 2013. His job duties involved heavy labor, including the use of sledge hammers, jack hammers and shovels to repair and maintain roadways in Illinois. He worked out of the IDOT garage in Hillside, Illinois. Petitioner's date of birth is June 25, 1950.

On November 3, 2014, Petitioner arrived at work at approximately 7:00 a.m. and was instructed to remove asphalt from some trucks and then to drive the trucks to the IDOT facility in Spring Grove, Illinois. The asphalt had to be removed from the truck bed by hand using a shovel described as a coal scoop. Each shovel full weighed 20 to 25 pounds. Petitioner was working with Mike Carter, his immediate supervisor that day.

After about 15 minutes of shoveling, Petitioner became short of breath and experienced weakness. He tried to continue shoveling the asphalt, but the shortness of breath worsened to the point where Petitioner had trouble standing. He told Mike Carter about the shortness of breath and then went to the day room to rest. The Petitioner testified that he never experienced an event like this before or after. He was feeling weak and had some difficulty breathing before starting work.

Sometime later, Mike Carter came into the day room to ask how Petitioner was feeling and if he could drive a truck to the Spring Grove facility and back. Petitioner, although still short of breath, said he would try. Driving the truck to Spring Grove made Petitioner feel worse and he told Carter he was unable to drive back to Hillside because of the shortness of breath. Carter drove Petitioner back to Hillside, where he clocked out at 1:00 p.m. and went to the Loyola University Medical Center emergency room after reporting the accident to Johnny Jones, another supervisor.

At the Loyola University Hospital emergency department, the Petitioner was examined by Dr. Shiria Poonja, M.D., who wrote:

> "Mr. Dyer is a 64 yo with a h/o HTN and HLD who present to ED with SOB. Pt states that last night he was "feeling off" but could not elaborate further but when he awoke this morning he felt SOB. He went to work and had difficulty shoveling because he was feeling very short of breath. This SOB worsened throughout the day prompting his ED visit. He denies chest pain but does state that he had some chest pressure while at rest in his truck earlier this morning. It did not radiate and was not a/w diaphoresis or nausea and it is resolved currently. Denies any fever or chills. States that for the past week or two he has been unable to exercise due to fatigue and new SOB chest pressure. States he usually runs a few miles without a problem. In the ED, he had a CXR that was c/w pulmonary edema and was given ASA and Lasix. Denies any current chest pain."

(Pet. Ex. No. 1, p. 31)

He was admitted to the hospital.

Dr. Poonja, who admitted Petitioner to the hospital, diagnosed the Petitioner as suffering from Congestive Heart Failure and wrote:

> "64yo with h/o HTN and HLD who presents with SOB and is found to have new onset CHF. New onset acute systolic failure: BNP ~2000 with e/o pulmonary edema on CXR
>
> Patient requires continued hospitalization for management of acute decompensated systolic/ diastolic heart failure."

(Pet. Ex. No. 1, pp. 34, 35)

On November 4, 2014, Petitioner was examined by Dr. Melissa Linton M.D., a resident caradiologist. After taking a history and conducting an examination, Dr. Linton wrote:

> "Mr. Dyer is a 64yo with a h/o HTN and HLD who presented yesterday with SOB x 1 day. At work, he experienced DOE while shoveling which progressively worsened throughout the day yesterday. He has never experienced this before. He reports chest pressure associated with his SOB yesterday. Resolved with rest. It did not radiate and was not a/w diaphoresis or nausea. He has never had chest pain before and has not had any more episodes since this occurred. He is very active and has a strenuous job doing manual labor on the highways that has not induced SOB/CP in the past. He denies any recent changes in his energy level,

> stating he is always tired from work. His abdominal girth has increased which he attributes to increased caloric intake. He has not noted any orthopnea or LE edema. In the ED, he had a CXR that was c/w pulmonary edema and he was given ASA and Lasix 40 mg IV x 1. Denies any current chest pain."

(Pet. Ex. No. 1, p. 27)

She went on to write an assessment of:

> "64 yo with h/o HTN and HLD who presents with SOB and is found to have new onset fluid overload in presence of LBBB on EKG and severely depressed EF.
>
> Acute systolic/diastolic heart failure/cardiomyopathy of unknown etiology:
> - EF newly depressed at 15%"

(Pet. Ex. No. 1, p. 30)

Dr. Lara Bakhos, M.D., the attending cardiologist, concurred with Dr. Linton's diagnosis and assessment and referred to Petitioner's condition as a "new onset, decompensated HF" (heart failure). (Pet. Ex. No. 1, p. 48)

After undergoing a series of tests, including a cardiac catherization and MRI, Petitioner was discharged from Loyola Hospital on November 8, 2014. Upon discharge, Dr. Marika Manolopoulou, M.D., a cardiology resident, wrote:

> "64 yo with h/o HTN and HLD who presented with new onset fluid overload in presence of LBBB (Left Bundle Brand Block) on EKG and severely depressed EF (ejection fraction), found to have non-compaction cardiomyopathy.
>
> LV (left ventricle) non-compaction NICM (Nonischemic cardiomyopathy)
> -EF newly depressed at 15%, 19% on cMR
> -treatment for this condition is optimization of typical heart failure regimen; EP saw pt and suggested AICD (automatic implantable cardioverter defibrillator), pt however declines."

(Pet. Ex. No. 1, pp. 93-94)

Petitioner was told to follow-up with Dr. Bakhos.

After his discharge, Petitioner sought treatment at the Northwestern Memorial Hospital Cardiology Department. He saw Dr. Robert A. Gordon, M.D., on November 24, 2014. Dr. Gordon ordered an echo-cardiogram that again showed that the left ventricle was severely dilated and that the ejection fraction was only 16%. (Pet. Ex. No. 2, p. 7)

After reviewing the test results, taking a history and conducting an exam, Dr. Gordon wrote:

> "Assessment: Mr. Allan Dyer is a 64y/o male with:
> Non-ischemic cardiomyopathy, stage C HFrEF, NYHA FC II-III, who is euvolemic to mildly hypervolemic on exam
> Chronic systolic and diastolic heart failure
> LV non-compaction
> CKD stage II-III?
> HTN"

(Pet. Ex. No. 2, p. 34)

On March 3, 2015, Dr. Gordon, in a letter to Petitioner's attorney wrote:

> "I am writing to you in regards to Mr. Dyer's medical condition. Mr. Dyer has a severe congenital cardiomyopathy called LV non-compaction with a low ejection fraction of about 15-20%. A normal ejection fraction is about 60%. People with LV non-compaction have some propensity to develop arrhythmias and have a higher incidence of cardiac death in addition to developing a dilated cardiomyopathy. Mr. Dyers condition is such that he has developed a dilated cardiomyopathy and certainly the shoveling he was doing may have been more than his heart could handle leading to his increased shortness of breath and subsequent hospitalization. He will require ongoing medical management of his condition with regular follow up and I have advised that he get an internal cardiac defibrillator placed as primary prevention for sudden cardiac death."

(Pet. Ex. No. 2, p. 66)

Dr. Gordon saw Petitioner on April 15, 2015 and, in a note to the Respondent's Central Management Services, stated that Petitioner was still temporarily and totally disabled from work. (Pet. Ex. No. 9)

Dr. Gordon left Northwestern and Petitioner's care was transferred to Dr. Allen Anderson, M.D. Dr. Anderson agreed with Dr. Gordon's diagnosis and course of treatment. On September 16, 2015, Dr. Anderson, in another note to Central Management Services, wrote that Petitioner was still

temporarily totally disabled from his job as a laborer with IDOT. Dr. Anderson thought that Petitioner could only perform clerical or sedentary work, but no manual labor due to his cardiovascular condition and that Petitioner needed to elevate his legs during the day. (Pet. Ex. No. 10)

After September 16, 2015, Petitioner had to transfer his care to Edward Hines VA Hospital because his group medical insurance from Respondent was stopped.

Petitioner started to treat with the doctors at the Hines VA on October 15, 2015. The doctors at the Hines VA also agreed with the diagnosis of left ventricle myocardial non-compaction cardiomyopathy and a dilated cardiomyopathy. (Pet. Ex. No. 3, pp. 3, 49, 52) Doctors at the Hines VA also recommended the implantation of a defibrillator. (Pet. Ex. No. 3, pp. 54, 64)

On February 18, 2016, Respondent sent Petitioner to be examined by Dr. Jeffrey Soble, M.D., pursuant to §12 of the Act. Dr. Soble agreed with the diagnosis made by Petitioner's treating physicians and also recommended the implantation of the defibrillator. He did not believe that Petitioner could return to work operating heavy commercial equipment or perform manual labor requiring heavy lifting and/or strenuous exertion. Where Dr. Soble disagreed with the treating doctors is that he stated there is no direct connection between shoveling asphalt or the associated asphalt fumes at the time he became symptomatic and the development of the patient's dilated cardiomyopathy. (Resp. Ex. No. 2, p. 6)

On May 20, 2016, Dr. Latanich indicated that although it would be against medical advice, the Petitioner could drive if he has not had black outs or if he had recently had the defibrillator implanted. Dr. Latanich also suggested that Petitioner seek advice from an attorney. (Pet. Ex. No. 3, p. 80)

In October 2016, Petitioner moved to New York to be closer to family. He transferred his medical care to the VA New York Harbor Health System. The records there indicate that Petitioner's cardiac condition is relatively unchanged and that the doctors are recommending the implantation of

the cardiac defibrillator. (Pet. Ex. No. 4) Petitioner testified that he is considering a defibrillator ans a test was scheduled for January 15, 2019.

The records from the VA New York and Petitioner's own testimony confirm that Petitioner performs regular exercise such as walking, short jogs and lifting light weights. No doctor has told him not to perform the exercises. Petitioner did testify that he will still feel shortness of breath or a heaviness in his chest after performing this exercise for a short time or distance. Petitioner never had shortness of breath like he experienced on November 3, 2014, when he could barely stand. He did not experience it before November 3, 2014 and he has not experienced it after November 3, 2014.

On April 12, 2018, Edward Pagella of Health Connection of Illinois, a Certified Rehabilitation Counselor and Licensed Clinical Professional Counselor, interviewed Petitioner. Mr. Dyer has a GED and an Associates degree in Applied Sciences in HVAC. Mr. Dyer worked as a commercial truck driver, an HVAC repair man and a laborer for IDOT. He is unable to perform these jobs, as they involve heavy labor and he has no readily transferrable skills. Pagella is of the opinion that based on Petitioner's vocational profile to include his age (68), education, work history and physical limitations, he is disabled and there is no suitable or viable occupation for him. Petitioner is unemployable and totally disabled. (Pet. Ex. No. 8)

Petitioner testified that he received some short-term disability from the State but no TTD. After the short-term disability ran out, he applied for and received Social Security Disability benefits, which converted to regular Social Security benefits when he turned 66.

Petitioner's last day of work was November 3, 2014. He has not had any employment since that date. Apparently, Petitioner made no effort to obtain employment within the restrictions placed upon him by Drs. Gordon and Anderson. Respondent apparently never offered Petitioner work within these restrictions and provided no vocational assistance.

The Arbitrator redacted Petitioner's Social Security Number from the following Exhibits, in compliance with Supreme Court Rule 138: Petitioner's Exhibits 9 and 10; Respondent's Exhibits 1, 3 and 4.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all 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 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill.2d 214 (1969).

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

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent.on November 3, 2014.

Our Supreme Court in Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 797 N.E.2d 665, 278 Ill.Dec. 70 Ill. (2003), wrote:

> "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 Comm'n, 201 Ill.2d 187, 266 Ill.Dec. 836, 775 N.E.2d 908 (2002) (citations omitted). "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). (citations omitted). . . It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also "arise out of" the employment. Parro v. Industrial Comm'n, 167 Ill.2d 385, 393, 212 Ill.Dec. 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.Dec. 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 accidental injury. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). 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. 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." Caterpiller Tractor Co. v. Industrial Comm'n, 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665."

In the present case, Petitioner was employed as a highway maintenance worker and on the morning of November 3, 2014, he was instructed to shovel asphalt, an extremely repetitive heavy job requiring extreme exertion. While doing so, Petitioner started to experience severe shortness of breath and heaviness in his chest, consistent with acute and symptomatic CHF. There is a clear nexus between Petitioner's work activities and the cardiac symptoms that he developed at that time, sufficient to support a finding of accident. See: Swartz v. Illinois Industrial Commission, 359 Ill.App.3d 1083 (2005)

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

The Arbitrator finds that Petitioner's current condition of ill-being is, in part, causally related to the injury. .

Again, in Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, (2003) our Supreme Court explained:

> "It has 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. (Citations omitted).
>
> It is axiomatic that employers take their employees as they find them. Baggett, 201 Ill.2d at 199, 266 Ill.Dec. 836, 775 N.E.2d 908. "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 and in the course of employment." General Electric Co. v. Industrial Comm'n, 89 Ill.2d 432, 434, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. . . (citations omitted). (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 of ill-being. Rock Road Construction Co. v. Industrial Comm'n, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967)."

Here, Petitioner was performing heavy exertional work of shoveling asphalt when he had the "new" episode of heart failure and the "new onset of acute systolic failure" as documented by the treating doctors at Loyola University Medical Center. Therefore, while Petitioner may have had non-compaction cardiomyopathy before November 3, 2014, the work of shoveling asphalt caused the new acute systolic failure.

Although Petitioner is more susceptible to develop arrhythmias and a higher incidence to cardiac death in addition to developing dilated cardiomyopathy, it was this accident that accelerated the need for medical treatment. Clearly, he was experiencing symptoms of CHF for weeks before the accident of November 3, 2014. The activities of daily living did not cause this acute episode, rather Petitioner's occupational exertion caused this acute episode. Petitioner was able to perform normal daily activities and moderate exercise without severe shortness of breath both prior to and subsequent to the accident of November 3, 2014.

The Arbitrator finds that the opinions of Dr. Robert Gordon, M.D. of Northwestern and the opinions of the treating doctors at Loyola, where Petitioner's condition is called new or acute, are more persuasive than the opinion of Dr. Jeffrey Soble, M.D., Respondent's §12 examiner. Indeed, Dr. Soble's tepid no causal opinion (no direct connection between the shoveling and fumes at the time the patient became symptomatic and the development of his cardiomyopathy condition) lines up with the other medical opinions. Petitioner had several cardiac risk factors: Male; Above age 60; Ejection fraction of around 15%; Hypertension; Hyperlipidemia; Family history (Mother); Remote smoking history (age 18 to 20); Cardiomyopathy and Lower branch bundle blockage, which combined could have led to sudden cardiac death prior to the event at work. He could very well have died in his sleep and he was likely symptomatic weeks before the shoveling incident, per the histories given at Loyola. He has not again experienced the dramatic shortness of breath, feeling of weakness and chest pressure symptoms that occurred on November 3, 2014, such that an argument could be made that there is minimal permanent disability associated with the events of November 3, 2014. On the other hand, if Petitioner continued working to the point of collapse, the resulting damage would clearly be causally related to the work event. In this case, the work activities accelerated the CHF condition, which was related to the congenital cardiomyopathy condition.

Therefore, the Arbitrator finds that the Petitioner's current condition of ill-being is, in part, causally related to the accident of November 3, 2014.

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

The Arbitrator finds that the medical services rendered to Petitioner were reasonable and necessary. The Arbitrator further finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

The Arbitrator finds that the following medical charges for reasonable and necessary treatment have not been paid by Respondent:

1. **Northwestern Medicine - $389.09 (Pet. Ex. No. 5);**
2. **Northwestern Memorial Hospital - $325.62 (Pet. Ex. No. 6); and**
3. **Elite Administration & Insurance Group (ERISA lien from Teamsters 727) - $3,642.62 (Pet. Ex. No. 7).**

Total - $4,357.33

The Arbitrator awards $4,357.33 in medical bills to be paid by Respondent directly to Petitioner pursuant to the Act.

K. What temporary total disability benefits are in dispute?

The Arbitrator finds that the Petitioner has been off work from the day of the accident through the date of hearing. He made no effort to find employment within the restrictions set forth by Dr. Anderson on September 16, 2015. Pagella's opinions do not convince the Arbitrator that Petitioner was totally unable to work. Therefore, the Arbitrator awards temporary total disability benefits from November 4, 2014 through September 16, 2015, a time period of 45-2/7 weeks, at the rate of $739.93 per week.

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

The Arbitrator does not find that Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act as a result of the injuries sustained. Petitioner's current restrictions are due to the CM and HF conditions and would be in effect regardless of whether Petitioner experienced the symptoms that he had on the date of the accident. Petitioner's current restrictions and symptomology do not render him permanently and totally disabled.

The Arbitrator is compelled to consider the 5 factors set forth in §8.1b(b) of the Act in determining an award of PPD.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a laborer for IDOT in the highway maintenance division at the time of the accident and that he is not able to return to work in his prior capacity. The Arbitrator notes that the job with IDOT was very heavy and exertional. Petitioner's treating doctors and Respondent's Section 12 examining doctor have all stated that Petitioner is unable to go back to that job. He has permanent restrictions of a clerical or sedentary job, but he continues to run and lift weights. This factor is given substantial weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 64 years old at the time of the accident. Because he is now 68, the Arbitrator gives some weight to this factor, as some restrictions related to the accident could prevent him from working.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has not returned to work (there apparently was no attempt), but it can be

assumed that his earning capacity has been limited by his now symptomatic CM condition. The Arbitrator therefore gives moderate weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating and medical records that Arbitrator notes all of the doctors have stated that Petitioner either cannot work or have given him severe restrictions. Because of this, 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 the injuries sustained caused Petitioner to suffer the 20% loss of use of the person as a whole, in accordance with §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC005917
Case Name	NICHOLSON, KEVIN v. REPUBLIC SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0376
Number of Pages of Decision	16
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Gregory Keltner

DATE FILED: 7/26/2021

/s/Deborah Baker, 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

KEVIN NICHOLSON,

Petitioner,

vs. NO: 20 WC 05917

REPUBLIC SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of whether Petitioner sustained an accidental injury arising out of and occurring in the course of his employment on January 7, 2020, entitlement to incurred medical expenses, entitlement to Temporary Total Disability benefits, and whether continuing treatment with Dr. Bradley is reasonable, necessary, and causally related to the work accident, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 29, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $582.40 per week for a period of 23 2/7 weeks, representing March 5, 2020 through August 14, 2020, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses detailed in Petitioner's Exhibit 1, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Responent shall provide and pay for treatment recommended by Dr.Bradley as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 26, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 7/13/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0376
NOTICE OF 19(b) ARBITRATOR DECISION

NICHOLSON, KEVIN Case# **20WC005917**

Employee/Petitioner

REPUBLIC SERVICES

Employer/Respondent

On 10/29/2020, 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:

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

2999 LITCHFIELD CAVO LLP
GREG KELTNER
222 S CENTRAL AVE SUITE 110
ST LOUIS, MO 63105

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)

KEVIN NICHOLSON
Employee/Petitioner

v.

REPUBLIC SERVICES
Employer/Respondent

Case # 20 WC 05917

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 Cantrell**, Arbitrator of the Commission, in the city of **Herrin,** on **August 14, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,427.20**; the average weekly wage was **$873.60**.

On the date of accident, Petitioner was **47** 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 **$13,118.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,118.60**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 1, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Matthew Bradley.

Respondent shall pay Petitioner temporary total disability benefits of **$582.40**/week from the date he was taken off work by Dr. Bradley, March 5, 2020, through the date of arbitration, August 14, 2020, representing **23-2/7** weeks, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $13,118.60 in TTD benefits paid.

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

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

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

Signature of Arbitrator

10/23/20
Date

ICArbDec19(b)

OCT 29 2020

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KEVIN NICHOLSON,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 20-WC-5917
	)	
REPUBLIC SERVICES,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Herrin on August 14, 2020, pursuant to Sections19(b) of the Act. The issues in dispute are accident, causal connection, medical expenses, temporary total disability benefits, and prospective medical care. All other issues have been stipulated.

TESTIMONY

Petitioner was 48 years old, single, with no dependent children at the time of arbitration. Petitioner testified he was hired by Respondent in January 2018 as a trash truck driver. He operates an automatic truck that lifts and empties trash containers. Petitioner testified that on January 7, 2020 he was servicing an apartment complex and had to leave his truck to access a trash bin enclosure. He had to drag trash totes to the curb where his truck could dump them. One of the totes did not have wheels and was full of ice and debris. As he drug the trash tote around a corner he stepped on a dry, rotten branch causing him to slip and do the splits. He felt pain in his knee and down the side of his leg, but he continued working his shift because he believed his symptoms would improve. Petitioner reported back to the depot at the end of his shift and filled out a form indicating he did not have an accident. He testified he believed the form was asking whether or not he was involved in a motor vehicle accident. He stated he iced his knee and took Naproxen when he got home.

Over the next few weeks, Petitioner noticed his knee pain was getting intense but he tried to work through it. During the last week and a half prior to notifying his employer, he described it was more difficult to walk and he was trying to finish the work week. On 2/6/20, Petitioner notified his supervisor, Jarvis Clark, about the accident. Petitioner was ordered to report to SIH Workcare where x-rays were performed. A knot was noted in the back of knee and he reported

his knee was buckling. Petitioner was examined by Dr. Bradley on 2/17/20 and an MRI was ordered. Petitioner ultimately had left knee surgery.

Petitioner testified he was released to light duty work and Respondent will not currently accommodate his restrictions and he remains off work. Petitioner testified that his next appointment with Dr. Bradley is on 10/1/20 at which time he expects to be released to full duty work. He testified that the surgery and subsequent physical therapy helped his symptoms. Petitioner denied having any prior left knee injuries, surgeries, arthroscopic portals, or scars, and testified his medical records that mention a prior left knee surgery are incorrect.

He acknowledged that he was reminded in occasional safety meetings since his date of hire that he needed to report accidents promptly; however, he testified he had never had that problem. Petitioner testified that his knee pain after the accident was 6 or 7 on a pain scale of 1 to 10. His knee pain was constant from the date of injury through the date he reported his accident. His knee pain gradually increased and was a level 10 and was buckling when he reported the accident.

Petitioner testified he had difficulty walking between the date of his injury and the date he reported his accident. He testified that after his route he had to stand for a few minutes before he could walk. He began limping a couple of days before reporting his accident because his home conservative treatment was not helping anymore.

Petitioner testified that at the end of each route he reported to the dispatcher, Pam Graham, who would ask Petitioner a series of questions. Petitioner stated Mrs. Graham would ask, "Any accidents, anything change today?" He denied being asked if he had any injuries on 1/7/20. Mrs. Graham would record Petitioner's responses on a form. Petitioner was shown the form dated 1/7/20 and testified that the boxes were checked by Mrs. Graham and he simply signed the report to clock out. He testified he did not believe the form was the proper way to report a work injury, which was done by calling the supervisor or Pam Graham during the work shift the injury occurred. Petitioner testified that Jarvis Clark was his supervisor during his entire employment.

Petitioner testified he worked light duty from the date he reported to Workcare until 3/5/20. He testified he worked full duty the day after receiving his restrictions and was told by another supervisor that was filling for Mr. Clark to stay off his leg and in the truck during his route. Petitioner testified he ran his regular route between the date of his injury and the date he reported his accident and had to traverse uneven terrain during that time.

Respondent called Pamela Graham as a witness. Mrs. Graham has worked for Respondent for 16 years and has held the position of dispatcher for over two years. She testified she spoke to Petitioner on a daily basis when he returned to the depot at the end of his shifts. Mrs. Graham testified that employees would report to her at a dispatch window to return cell phones, truck keys, clipboards, route sheets, vehicle condition reports, and to complete a driver check-out form. The form includes the times the employee clocked in and out, how many customers were not serviced, accidents, injuries, hazards, among other things.

Mrs. Graham testified that all of the responses on Petitioner's clock-out form dated 1/7/20 is in her handwriting, with the exception of Supervisor Clark's clock-in time and Petitioner's signature. Mrs. Graham testified she asks all employees if they had any accidents, injuries, or hazards to report for the day and she records their responses. The employee then clocks out and returns to sign the form. She testified employees are allowed to review the form before signing. She testified if Petitioner would have reported an injury to her she would have instructed him to see the operations supervisor. She further stated she had no reason to disbelieve that Petitioner was injured. Lastly, she testified that when Petitioner reported the injury, he reported it to Jarvis Clark. That she did not know anything about the protocol with regard to reporting accidents since it was not her job.

Respondent called Petitioner's supervisor, Jarvis Clark, to testify. Mr. Clark was employed with Respondent for approximately ten years through April 2020. He testified he was the operations supervisor in January 2020 and held that position for three years. He testified Petitioner called him on 2/6/20 while he was on his route and advised him he was injured in the beginning of January. Mr. Clark testified he observed Petitioner between the time of the accident and the date he reported it and did not notice anything unusual about his gait. He testified the employees perform stretches and exercises every morning and it is his job to observe the employees for any injuries before the start of their shifts.

On cross-examination, Mr. Clark testified Petitioner was a good employee and he had no reason to doubt that Petitioner injured himself in January, but he did not notice any evidence of injury. He testified Petitioner was given light duty work through 3/5/20 of riding along as a passenger in a truck or cleaning the shop. Mr. Clark testified he did not know why Petitioner was not allowed to return to light duty work after his surgery.

MEDICAL HISTORY

Petitioner reported to SIH Workcare on 2/6/20 with complaints of pain located in his left posterior knee. He describes it as awful, deep, and aching and considered it to be intense. He provided a history of pulling a tote with no wheels back to the truck when he stepped down weird on a stick. His foot rolled and he felt a sharp pain down the side of his knee. Examination showed no abrasions or bruising, pain on motion with limited strength, and objective swelling over the posterior knee. X-rays revealed mild tricompartmental osteoarthritis. The family nurse practitioner noted Petitioner's symptoms were related to his work activities. She recommended restricted activity, no kneeling, no climbing, and no lifting greater than five pounds, with no pushing, pulling, squatting, or stooping. He was instructed to keep his leg elevated, iced, and take Ibuprofen. Respondent accommodated these restrictions.

Petitioner returned to SIH Workcare on 2/11/20 and gave the same consistent history. Examination was unchanged and an MRI was recommended. On 2/17/20, Petitioner was examined by Dr. Matthew Bradley at Midwest Bone and Joint Surgery where he reported that on 1/7/20 he was dragging a tote through a wooded area and stepped on a dry rotten branch causing him to hyperextend his knee. He reported immediate pain in the posterior aspect of his knee and slightly along the medial aspect, but thought he had merely sprained or strained it. He tried walking and working it off but his pain persisted after one month. He denies any other traumas,

falls, or injuries to this knee. He stated that prior to 1/7/20 his left knee was pain-free and he had full, unrestricted range of motion and normal strength. Dr. Bradley's examination was positive for pain to palpation and mild pain appreciated medially and posteriorly on McMurray's testing. Weight-bearing x-rays revealed no acute fractures or dislocation with no significant narrowing of the lateral or medial tibiofemoral joint. A diagnostic ultrasound revealed moderate joint effusion. Dr. Bradley recommended anti-inflammatory medication, a short runner brace, home exercises, and an MRI. Dr. Bradley believed Petitioner's examination findings were consistent with his symptoms and mechanism of injury.

The MRI was performed on 3/3/20 and revealed partial lateral meniscectomy changes without evidence of a recurrent tear, a diffuse ACL sprain injury, and moderate joint effusion along with some degenerative changes. On 3/4/20, Dr. Bradley inquired of Petitioner whether or not he had any injuries to his left knee prior to 1/7/20 and Petitioner denied same. No prior records of any left knee injuries, diagnostic studies, or treatment were offered into evidence. Dr. Bradley believed that Petitioner likely had a left knee posterior lateral horn medial meniscus tear with probable ACL insufficiency. He reviewed the MRI scan, which showed some intact fibers of the ACL, but a significant amount of swelling and a fairly large tear of the posterior aspect of the lateral meniscus. He recommended arthroscopic evaluation of Petitioner's knee and took Petitioner off work.

Petitioner saw Dr. Bradley on 4/23/20 for his preoperative appointment at which time Petitioner continued to have severe left knee pain and instability. Any twisting or turning of his knee caused his knee to give out and made him nearly stumble and fall. Surgery was performed on 4/24/20 that revealed a nearly complete rupture of the ACL off the femoral side and a very large tear of the posterior horn of the medial meniscus. There was also a flap piece of cartilage on the lateral femoral condyle which had an acute appearance, with some sharp edges and surrounding areas of thin cartilage. Dr. Bradley performed a left knee ACL reconstruction using an allograft and a partial meniscectomy. Petitioner recovered well with surgery and postoperative physical therapy. On 8/6/20, Petitioner was released to return to work with restrictions of no squatting, crawling, climbing ladders, twisting, or lifting more than 20 pounds. He was also cleared to ride in a truck.

Petitioner was examined on 5/27/20 by Dr. George Paletta pursuant to Section 12 of the Act. He reviewed Petitioner's medical records and took the same consistent history of injury. He noted Petitioner did not immediately report the injury because he thought things would improve. Dr. Paletta noted Petitioner was still wearing his long leg brace, participating in physical therapy, walking without crutches, and making progress. He noted the examination was consistent with his recent anterior cruciate ligament surgery. X-rays demonstrated postsurgical changes consistent with an ACL reconstruction. He reviewed the preoperative MRI and believed it showed tricompartmental degenerative joint disease, abnormality of the lateral meniscus, consistent with a probable meniscus tear. There was also abnormality of the anterior cruciate ligament suggestive of a tear. He noted no significant edema involving the posterior lateral femoral condyle. However, he noted the MRI was done two months after the original injury. He believed that Petitioner was where one would expect him to be four weeks after an ACL reconstruction and believed that he should continue to comply with Dr. Bradley's post-op recovery and rehabilitative requirements. He stated that he had no reason to doubt Dr. Bradley's

finding at the time of surgery which documented a complete ACL tear and explained that although the MRI did not show evidence of acute ACL injury, it was done eight weeks after the injury. He agreed with the radiologist and Dr. Bradley that the ACL appeared grossly abnormal, but as there were no classic radiographic signs of recent or acute ACL injury, he could not state whether it represented an acute or subacute tear. He also agreed that the lateral meniscus was consistent with a probable meniscal tear. He agreed that Dr. Bradley's surgery was appropriate, that Petitioner continued to need restrictions, and continued to need physical therapy. However, he disagreed that the initial ultrasound and the pre-operative unloader brace were necessary. He acknowledged Petitioner was not given a brace until after surgery, at which time he agreed it would be reasonable. Dr. Paletta did not testify at arbitration.

Dr. Bradley testified by way of evidence deposition on July 28, 2020. He is a board-certified orthopedist. Dr. Bradley reviewed all of Petitioner's medical records, including the report of Dr. Paletta, and testified consistent with his medical records. Dr. Bradley testified as to his intraoperative surgical findings. He believed that both Petitioner's pathology and his history were consistent with the work accident he described in January 2020. Dr. Bradley testified he recommended and performed surgery because meniscal and ACL tears do not have a blood supply, and therefore there is no capacity for them to heal. He believed that Petitioner's recovery was such that between six and nine months after surgery he would return to full, unrestricted duty. He testified he has referred patients to Dr. Paletta, because he performs particular procedures that he does not, and had received referrals from Dr. Paletta for the same reason. He noted that Petitioner's ACL was not completely torn and he did have some fibers left that afforded some stability. As long as Petitioner walked on flat ground he would not have a lot of instability. Instability would be when he would try to twist or turn or walk on uneven ground. Dr. Bradley noted Petitioner described weakness in his knee. He explained that Petitioner did not exhibit the typical bone bruise caused by the thigh and shin bone hitting each other when an ACL tears, which was likely due to the MRI not being performed for weeks after the injury. The mechanism of injury is what gives you the bone bruise and Petitioner had a hyperextension injury that may not have caused the bone bruise. Dr. Bradley testified that Dr. Paletta's Section 12 report was well written and does not really contradict anything he has done or the treatment he has recommended or provided.

On cross-examination, Dr. Bradley testified he was pleased with Petitioner's postoperative progress. He stated that although Petitioner had pain immediately after his injury, he believed Petitioner thought he had simply sprained or tweaked his knee. He disagreed with Dr. Paletta's statement that Petitioner would have likely had difficulty walking immediately after the accident. He indicated he had plenty of patients that walked into his office with a completely torn, unstable knee without difficulty walking, but what they did have difficulty doing was twisting and turning, which caused the knee to become unstable. He testified that Petitioner's history was consistent and he found Petitioner to be very honest, pleasant, and compliant. He affirmed that after Petitioner injured himself he tried to live with the pain, walk it off, and keep working.

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 twisted his knee on debris. Respondent disputes that Petitioner suffered an injury because he did not report his accident until one month later and did not advise the dispatcher of his injury the day of the accident. The Arbitrator finds that the evidence is in favor of a finding that Petitioner suffered a compensable work accident. Petitioner's report of the accident was unrebutted, his testimony regarding the accident was consistent with every history contained in his medical records, Petitioner's delay in reporting his accident was not unreasonable or unexplained, and Petitioner provided credible testimony.

Petitioner testified that when he signed off on the check-out form completed by the dispatcher the day of the accident, he believed the form referred to any motor vehicle accidents. Moreover, Petitioner initially believed his injury was an inconsequential strain that would resolve with time. As his condition progressed he discovered this was not the case. The Arbitrator finds his testimony credible and further notes that all of Respondent's witnesses agreed they had no reason to disbelieve Petitioner's testimony. Although it would seem Respondent was justified in at least inquiring as to the reason for the "delay" in reporting the accident, Respondent cannot impose a greater burden on Petitioner than the one set forth under the Act. The Act only requires that notice be given within 45 days of the injury. 820 ILCS 305/6(c). Respondent agrees that Petitioner gave timely notice as required by the Act, though untimely notice pursuant to company policy. Therefore, it cannot be said that Petitioner "delayed" in reporting his injury when it was timely under the Act. The Commission has previously held that it is not unreasonable for claimants to decline to report injuries immediately after they occur in the hope that they will "simply heal with time." *William Gordon v. State of Illinois DOT Joliet Yard*, 07 I.W.C.C. 1599 (2007). The Arbitrator likewise declines to "penalize an employee who diligently worked through progressive

pain" until it required medical attention. *William Gordon*, citing *Durand v. Industrial Commission,* 224 Ill.2d 53, 862 N.E.2d 918 (2007).

Given the absence of any evidence contrary to Petitioner's testimony of the injury and the records which consistently document the occurrence of same, the Arbitrator finds that Petitioner met his burden of proof and did sustain accidental injuries that arose out of and in the course of his employment with Respondent.

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

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 442 N.E.2d 908 (1982). A chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident is sufficient to satisfy the claimant's burden. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Comp. Comm'n*, 371 Ill. App. 3d 882, 888, 864 N.E.2d 266, 272 (2007). Accidental injury need only be a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 673 (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*, 207 Ill. 2d 193, 797 N.E.2d 665 (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*, 359 Ill. App. 3d 582, 834 N.E.2d 583 (2005). Employers are to take their employees as they find them. *A.C. & S. v. Indus. Comm'n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Indus. Comm'n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982). 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, 37 Ill. 2d 123 (1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

The evidence shows that Petitioner had no problems with his left knee prior to his January 2020 accident. Although Petitioner may have had some underlying processes in his knee as noted by Dr. Paletta, it is clear this incident accelerated the need for same given Petitioner's lack of

complaints prior to the accident. The Arbitrator is therefore not persuaded that Petitioner's condition was not aggravated by his accidental injury based on the clear chain of events. The Arbitrator further notes that intraoperative objective findings were consistent with imaging studies but also showed a somewhat acute appearance of the ACL, as noted by Dr. Bradley in his testimony, as well as an acute cartilage flap. Dr. Bradley testified that not every patient who suffers an ACL injury is unable to walk following the accident, and he further pointed out that the lack of a complete tear of the ACL would have afforded Petitioner some stability until he had to pivot. While Petitioner's initial presentation may have been atypical from the perspective of Respondent's examiner, the Arbitrator finds Dr. Bradley's testimony persuasive and consistent with the evidence. It is hard to believe that Petitioner was capable of working full duty, no restrictions, in a heavy job with the pathology found in his knee, for months or years without a trauma.

Based on the above, the Arbitrator finds that Petitioner met his burden of proof and his current condition of ill-being with respect his left knee is causally related to his employment and work injury of January 7, 2020.

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 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings as to causal connection, the Arbitrator herby awards the medical expenses claimed in Petitioner's group exhibit 1, as well as prospective medical benefits. In support thereof, the Arbitrator notes that Dr. Paletta agreed that the surgery performed by Dr. Bradley was reasonable and necessary given Petitioner's condition. Dr. Paletta further agreed that Petitioner required further care pursuant to Dr. Bradley's treatment plan. The Arbitrator also finds that the ultrasound recommended by Dr. Bradley was a reasonable, conservative diagnostic study to diagnose Petitioner's condition.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 1, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Further, Respondent shall authorize and pay for the treatment recommended by Dr. Matthew Bradley.

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

Respondent disputed liability for benefits based on its dispute of accident and causal connection. Based upon the above findings that Petitioner satisfied his evidentiary burden regarding these issues under the Act, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of $582.40/week from the date he was taken off work by Dr. Bradley, March 5, 2020, through the date of arbitration, August 14, 2020, representing 23-2/7 weeks. Respondent shall be given a credit of $13,118.60 in TTD benefits paid.

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

Linda. J. Cantrell, Arbitrator

10/23/20

DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC004668
Case Name	VALENTIN, JOSE v. WALMART DISTRIBUTION CENTER
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0377
Number of Pages of Decision	19
Decision Issued By	Deborah Baker, Commisioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Dru Dennis

DATE FILED: 7/26/2021

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE VALENTIN,

Petitioner,

vs. NO: 19 WC 04668

WALMART DISTRIBUTION CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission considers the issues of whether Petitioner's right shoulder condition remains causally related to his October 22, 2018 accident, entitlement to incurred medical expenses, and whether the surgery recommended by Dr. Garst is reasonable, necessary, and causally related to the work accident, noting that Respondent only argues in its brief that Petitioner's current right shoulder condition of ill-being is not causally related to the work accident, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $115.94 for medical expenses, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner

harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Responent shall provide and pay for the right shoulder surgery recommended by Dr.Garst as provided in §8(a) of the Act.

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

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

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

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

July 26, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 7/13/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

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

21IWCC0377

VALENTIN, JOSE
Employee/Petitioner

Case# **19WC004668**

WALMART DISTRIBUTION CENTER
Employer/Respondent

On 10/8/2020, 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
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

2593 GANAN & SHAPIRO PC
DRU DENNIS
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

JOSE VALENTIN
Employee/Petitioner

v.

WALMART DISTRIBUTION CENTER
Employer/Respondent

Case # **19** WC **04668**

Consolidated cases: _____

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

DISPUTED ISSUES

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

Valentin v. Walmart Dist. Center, 19 WC 04668

FINDINGS

On the date of accident, **October 22, 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 $**23,546.18**; the average weekly wage was $**588.65**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of his employment with the Respondent on October 22, 2018. The Arbitrator further finds that the Petitioner's right shoulder condition of ill-being is causally related to the October 22, 2018 accident.

Respondent shall pay reasonable and necessary medical services of $115.94, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any and all causally related medical expenses that have been paid by Respondent prior to hearing, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the right shoulder surgery being recommended by Dr. Garst.

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

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

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

Signature of Arbitrator

October 1, 2020
Date

OCT 8 - 2020

STATEMENT OF FACTS

Petitioner began working for Respondent in January 2018. He was working as a case lot order filler on 10/22/18 at one of their distribution center/warehouses. He testified this job involved picking cases of products by hand in bundles and putting them onto a conveyor line. He is on his feet while doing this job and his regular schedule involved working three 12-hour shifts on Saturdays, Sundays and Mondays. He testified he changed into a position with Respondent as an RSR forklift driver in 2019. Petitioner has also worked for XPO Logistics part-time as a forklift driver since 2019, testifying this job involved moving heavy freight pallets weighing at least 700 pounds from trailer to trailer, and noting the job involved no manual lifting given the significant weight of the pallets. He testified that his financial situation led to his obtaining this job, as the Respondent was not offering any overtime hours and he had the situation with his shoulder condition, though he agreed he had been released to full duty by his doctor and was able to perform the job.

Petitioner testified at the beginning of his 6 a.m. shift, following a morning meeting and stretching, he was throwing an approximate 50-pound empty pallet when he felt a slight pinch in his right shoulder. He testified he stretched the shoulder and continued working but again felt the pinch in his shoulder. He testified he reported it to his boss within 10 to 20 minutes after the initial incident. He completed an accident report in the company nurse's office and obtained an ice pack. Petitioner testified that he continued to work in pain and completed his shift, indicating the Respondent advised him he would otherwise receive an "occurrence of attendance", a strike against him. The Arbitrator notes that a report of Dr. Mulhern indicates he is right hand dominant.

The incident occurred on a Monday and Petitioner was not again scheduled to work until the following Saturday (10/27/18). He continued to have a lot of pain but did not seek medical treatment, testifying his boss said he should contact the boss if he had ongoing pain and he would be referred for treatment. After working on Saturday (10/27/18) and Sunday (10/28/18), Petitioner came into work on Monday, 10/29/18, and advised his boss that he was still in pain. He was asked if he needed medical treatment and his boss then took him to Illinois Valley Community Hospital. The 10/29/18 report from Occupational Health notes complaints of acute right shoulder pain at work on 10/22/18 while lifting a 30-pound pallet from ground to shoulder level. He reported pain at a 6/10 level radiating into the right neck and popping and clicking in the right shoulder. He had pain raising his arm above shoulder level. He denied any prior right shoulder injuries. Right shoulder x-ray was normal. Following examination, an MRI was prescribed to rule out rotator cuff pathology. He was advised to return to work with minimum use of the right arm, no overhead reaching and no lifting over 10 pounds. (Px1).

The 11/20/18 right shoulder MRI indicated tendinosis versus partial tear of the distal supraspinatus, possible bursitis and possible anterior glenoid labral tear, along with degenerative AC joint changes that could be contributing to rotator cuff impingement. (Px1; Rx4).

At a 12/11/18 follow-up, Petitioner reported ongoing constant right shoulder pain that was worse with activity. Dr. Mitchell diagnosed right shoulder impingement, injected the right shoulder and prescribed four weeks of physical therapy. On 12/27/18, the report states that the Petitioner indicated his shoulder pain was resolved,

with almost 100% improvement in pain and range of motion, and that he felt able to return to work. PA-C Debra Pyszka released Petitioner to return to work and indicated he would be at maximum medical improvement (MMI) as of 1/17/19. (Px1; Rx4).

Petitioner testified that electrical stimulation in therapy was helpful and he continued to work light duty through the end of 2018. While the medical records indicate he was released back to regular duty, he testified he was advised by his doctors that his shoulder was not improving so he requested a job change and was placed into a new job operating a forklift, which he testified he was continuing to perform at the time of the hearing.

Petitioner testified that his primary care provider on 12/11/18 sent him to Dr. Mitchell, who referred him for physical therapy at PT & Rehab Specialists from 12/18 to 7/19. Interestingly, at an unrelated 1/4/19 visit with Dr. Peterson, the doctor stated in his report that Petitioner indicated: "in his life of bodybuilding, gets stressed before shows." (Px4).

On 2/1/19, Petitioner saw Dr. Peterson, reporting that he was in a lot of right shoulder pain and he requested a prescription for Norco. Noting the problem was a chronic issue, Dr. Peterson prescribed naproxen and, if needed, Flexeril. A 2/19/19 follow-up report of Dr. Peterson states that Petitioner felt a pinch in the right shoulder as he lifted and threw a pallet forward in October. He complained that he was unable to do his normal workouts due to the shoulder. The pain was from shoulder to elbow and was worse with lifting, noting he had to do heavy lifting at work. He was in therapy and noted pain with biceps curls. Dr. Peterson restricted Petitioner to light duty and referred him for therapy and an orthopedic visit at OSF (Px4).

Records of OSF from February and March of 2019 reflect issues with whether the Petitioner's work duties at that time should have been causing him pain, with Respondent indicating Petitioner's job involved sitting in a chair and crossing off numbers on boxes while working less than 8 hours per day, and Dr. Peterson declining to provide a requested work note for Petitioner because he took a muscle relaxer before work. Apparently, the Petitioner had gone home early from work one day due to pain and then took a muscle relaxer before work the next day and showed up 3 hours late, and he was seeking a note from Dr. Peterson to avoid discipline at work. (Px4).

A 3/1/19 OSF phone note indicates the Petitioner "did not agree with plan of care by provider, requesting new referral be submitted to new provider." (Px4). Petitioner testified that his primary care provider ultimately referred him to Dr. Mulhern and Dr. Miller, who referred him to Dr. Garst.

At his 3/1/19 visit with Dr. Mulhern, the doctor recorded the following: "He was performing his normal job duties in October when he felt the onset of pain in his right shoulder. Otherwise there was no specific injury directly to the shoulder but he felt that while lifting some heavier boxes that this caused him to have acute onset of pain." Petitioner reported the injection he received did not provide improvement, and that since his release to full duty his pain and loss of mobility had worsened. The pain was more proximal in the shoulder and into the biceps depending on his activity level. He denied neck or radiating pain down the arm. The doctor opined that x-rays did not show any significant degeneration, and he saw no indication of any full thickness tears in MRI films, though it was made clear that the images were not optimal. Following exam, Dr. Mulhern believed the symptoms were more suggestive of a rotator cuff problem or chronic bursitis than of labral involvement. Given the increase in symptoms with full duty, he recommended Petitioner continue with light duty work. A second injection was performed and further therapy was prescribed. (Px3; Rx5).

An unrelated OSF note from 3/13/19 indicates that Petitioner was a former body builder. (Px4).

Petitioner returned to Dr. Peterson on 4/3/19, and his report indicated a history of developing right shoulder pain in October "while lifting/tossing a pallette [sic] at his job", when he felt a pinch in the superior area of the shoulder. He indicated that his regular work duties required him to lift over 40 pounds. Petitioner reported the injection with Dr. Mulhern helped him a great deal but that he had ongoing pain in the top of the shoulder with pain and popping along the biceps and focused near the anterior elbow. The doctor noted a level of possible adhesive capsulitis. Dr. Peterson noted Petitioner wanted a second opinion because he didn't care for Dr. Mulhern's assessment and plan, but that Petitioner nevertheless agreed with ongoing therapy. While he did not see a basis for surgery at that time, Dr. Peterson recommended referral to a shoulder surgeon if Petitioner did not improve. Light duty was continued. (Px3; Rx5).

Petitioner was examined by Dr. Cohen, an orthopedic surgeon at DuPage Medical Orthopaedics at the request of the Respondent on 4/26/19. Petitioner noted he was a bodybuilder but had never quite made it to where he could compete. He reported a 10/22/18 incident where he was lifting 30 to 40-pound pallets up to shoulder height and felt a pinch in his right shoulder with subsequent ongoing pain. Petitioner was currently not working, indicating that his shoulder felt good during the day but he had pain at night. He believed he was 75% improved from when the condition was at its worst. Dr. Cohen's review of the right shoulder MRI reflected biceps tendinitis, some irregularity of the labrum and AC joint arthritis with no evidence of a cuff tear. Following his review of Petitioner's medical records and examination of the Petitioner, Dr. Cohen opined that Petitioner sustained a sprain/strain of the shoulder and possible biceps tendinitis on 10/22/18. Noting Petitioner's own report of 75% improvement, Dr. Cohen indicated the main ongoing problems were strength and a slight decrease in abduction versus the left extremity (165 versus 175 degrees). Dr. Cohen noted that Dr. Peterson's 12/29/18 release indicated Petitioner had no pain and that it therefore was "unclear why he sought further treatment with Dr. Peterson, and he denies any interim injury to explain the recurrent pain in the shoulder. I am not able to identify any specific other etiology of the pain in the shoulder." Dr. Cohen stated that Petitioner said he could lift 40 pounds without difficulty and issued a 40-pound lifting restriction with the right arm pending additional recommended treatment of two to four weeks of work conditioning (noting Petitioner needed to be able to lift more than 40 pounds). Dr. Cohen opined that the treatment to date had been appropriate with the exception of the "unexplained gap" from 12/29/18 to 2/19/19. (Rx2).

Petitioner next sought treatment with Dr. Miller at OSF on 5/23/19. Petitioner reported significant improvement and that he was advancing in physical therapy. He had ongoing popping in the shoulder which was painless. The doctor advised that Petitioner would be ready to return to full duty in two weeks with ongoing physical therapy. He was to return as needed. (Px3; Rx5).

By May 2019, physical therapy records from Kewanee Physical Therapy and Rehab Specialists indicate Petitioner had significantly improved and was having minimal to no pain with ongoing exercises. On 6/3/19, Petitioner reported improvement since starting formal therapy and that he would be returning to work on 6/8/19 but was concerned he would reaggravate his shoulder with heavy lifting if he was unable to change jobs. The final therapy note in the evidentiary record, dated 6/21/19, states that Petitioner reported increased shoulder soreness after returning to work, but was hopeful he would be changing to a job that would be lighter on his shoulder. (Px2).

On 9/6/19, Petitioner returned to Dr. Miller, reporting that he was able to perform the lighter parts of his regular job but was still having increased right shoulder and elbow symptoms with heavier lifting. The report also states Petitioner had been abstaining from heavy lifting at the gym. The doctor stated: "Patient has a number of mixed physical exam tests which makes his clinical picture a little murky. I think he has distal and proximal biceps tendinitis, but also has a few positive labral signs and has pain with AC joint compression. Rotator cuff strength is good, but the significant pain that he has with resisted testing and overhead range of motion suggest that he

still has continued tendinitis of the rotator cuff." As such, he referred Petitioner to a shoulder specialist to determine if a new MRI was appropriate or if he should continue with conservative treatment. (Px3).

Petitioner saw orthopedic surgeon Dr. Garst on 9/18/19. His review of the x-ray and MRI films indicated some biceps tendinosis, a probable partial tear of the rotator cuff at the supraspinatus, and a possible superior labral (SLAP) tear. He agreed that there were some degenerative AC joint degeneration contributing to the impingement. Given the failure of therapy and injections over 11 months, Dr. Garst believed more definitive treatment, in the form of arthroscopic surgery, was indicated. This would involve acromioplasty, distal clavicle excision, debridement versus repair of the rotator cuff and possible labral repair. He noted that the Petitioner could need a biceps tenotomy but did not want to do it at Petitioner's young age. The doctor indicated Petitioner could work full duty and that "mainly, he is doing a job that does not involve too much lifting. I think that is good for him." (Px3).

Petitioner was again evaluated by Dr. Cohen pursuant to Section 12 of the Act on 10/25/19. Petitioner reported currently working as a forklift operator with no heavy lifting without any issues. He denied having worked out at a gym since the 10/22/18 injury and denied any interim injuries. The doctor reviewed updated medical records and indicated the MRI showed a likely degenerative labral tear. Dr. Cohen stated that his prior diagnosis of a sprain with biceps tendonitis remained the same, and that Petitioner's current main complaints around the AC joint "are different than the last IME." He indicated that current tenderness over the AC joint and positive crossover test were negative findings at the last examination. Dr. Cohen opined that Petitioner's AC joint complaints were not uncommon with people actively involved in weightlifting/bodybuilding. Petitioner indicated he was capable of performing his current job, and restrictions were not recommended, though Dr. Cohen recommended he restrict overhead activity due to the unrelated AC joint complaints. Dr. Cohen believed that Dr. Garst's recommended surgery to the rotator cuff and labrum was not supported by Dr. Cohen's exam findings. He stated: "He does have some minimal impingement symptoms on exam, which may overlap with his AC issues, but his main issue is the AC joint, which is not related to the events of 10/22/18." He noted the unrelated nature of the AC joint and the fact Petitioner had been asymptomatic as of 12/29/18 and returned for treatment about 2 months later with no explanation in determining Petitioner had reached MMI. A cortisone injection was recommended for the unrelated AC joint pain, noting a decompression surgery would be reasonable if this provided temporary relief. Dr. Cohen also provided an AMA rating of 0.6% whole body impairment/1% upper extremity impairment. (Rx3).

Dr. Cohen testified via deposition on 2/19/20, indicating his specialty was in the hand and upper extremity. As to his 4/26/19 examination, Dr. Cohen's review of the 11/20/18 right shoulder MRI films indicated biceps tendinitis, meaning inflammation around the biceps tendon, with no significant fluid in the subacromial space. There was some irregularity of the labrum and some arthritis of the AC joint, but the rotator cuff did not show any evidence of a tear. He noted Petitioner's report of 75% improvement but that he was not working and his pain occurred mainly at night. Dr. Cohen referenced the 12/27/18 report of Dr. Peterson documenting a normal exam, no pain complaints and a release to return to work. On 2/19/19, Dr. Cohen noted Petitioner was diagnosed with acute right shoulder pain, rotator cuff tendinitis, biceps tendinitis and given a recommendation for further evaluation with an orthopedic surgeon. (Rx1).

On 4/26/19, Dr. Cohen noted Petitioner was a pretty muscular guy and apparently had been a bodybuilder. Noted abnormalities on exam included a negative primary impingement sign, minimal secondary impingement sign, bursitis, and rotator cuff issues, along with tenderness over the biceps tendon with mildly positive Speed's and Yergason's testing, which test the biceps tendon. Petitioner had no provocative signs for a labral tear, as he had full rotator cuff strength without pain on testing. Petitioner subjectively believed he was limited to about 40 pounds at that time. Dr. Cohen testified that his exam did not reflect the AC joint or labrum as the source of Petitioner's pain. He noted the MRI was suspicious for degenerative changes in the labrum, which would not be

uncommon for a bodybuilder. Dr. Cohen acknowledged his labral exam does not confirm whether there is or isn't a labral tear, but rather whether a possible labral tear is potentially causing the patient's pain. Therefore, if the provocative signs are negative, this would support a finding that a labral tear, if it exists, is not responsible for the symptoms. Dr. Cohen diagnosed aa right shoulder sprain/strain and possibly biceps tendinitis, resulting from the October, 2018, incident. However, he testified Petitioner's subjective complaints exceeded the objective findings. Specifically, he noted Petitioner's exam was very close to normal, with some biceps tenderness and a minimal sign of impingement, and was less impressive than he would expect given the Petitioner's subjective complaints and limitations. While he opined that Petitioner's treatment program was reasonable and medically necessary for the sprain/strain and biceps tendinitis resulting from the 10/22/18 accident, Dr. Cohen noted the gap in treatment between December, 2018 and February, 2019, following the Petitioner's pain free December release. Dr. Cohen recommended additional work conditioning, but otherwise believed the Petitioner could return to work with a 40-pound restriction. Dr. Cohen testified the Petitioner was optimistic that he would be able to return to his normal activities following work conditioning. (Rx1).

When he re-examined the Petitioner on 10/25/19, Dr. Cohen noted the 5/23/19 report of Dr. Miller indicating Petitioner had significantly improved, had full rotator cuff strength without pain, and experienced painless popping in the right shoulder, and that Dr. Miller diagnosed Petitioner with chronic shoulder pain, impingement, rotator cuff tendinitis, AC arthritis, and biceps tendinitis. Dr. Cohen recommended that Petitioner continued therapy and return to full duty work in two weeks. He acknowledged that Petitioner returned to Dr. Miller on 9/6/19 and was referred to Dr. Garst at the time of his first visit with Petitioner. Dr. Cohen testified Petitioner advised he was working a different job as a forklift operator and did not have to do any heavy lifting or overhead lifting. As he didn't advise Dr. Cohen he was working for a new employer, the doctor assumed Petitioner's new job as a forklift operator was for Respondent. (Rx1).

On exam, Dr. Cohen found reduced range of motion in the right shoulder when compared to the left, a normal liftoff test, negative primary impingement sign, mildly positive secondary impingement sign, and tenderness over the AC joint with a positive crossover test that reproduced his pain. Speed's and Yergason's tests this time were negative, as was testing for biceps tendon tenderness. Dr. Cohen testified that these findings (positive crossover test, AC joint tenderness, resolution of the Speed's and Yergason's tests and biceps tendon tenderness) were all different from his previous exam, and that Petitioner continued to have no provocative signs for a labral tear or instability. Dr. Cohen on 10/25/19 diagnosed AC joint arthritis and resolved biceps tendinitis. While Petitioner's previous exam involved pain that was more focused on the biceps tendon, this pain was resolved at the time of the second examination and the pain was instead now focused at the AC joint. Dr. Cohen noted that AC joint symptoms are usually caused by direct trauma or overhead lifting, and he testified that Petitioner indicated he was not performing any overhead lifting activities as part of his new job duties. Dr. Cohen again noted Petitioner was a weightlifter or bodybuilder prior to the alleged October, 2018, accident, and that AC joint pain is common in bodybuilding or weightlifting due to overhead activities. For these reasons, Dr. Cohen testified that Petitioner's complaints and symptoms at the time of the second examination were not related to the original incident given the change in the location of his pain and no history of any AC joint injuries. Because Dr. Garst was recommending surgery based on diagnoses that Dr. Cohen believed were not part of the records from any previous doctor and unrelated to the October, 2018 injury, including a rotator cuff tear, Dr. Cohen opined that Petitioner had reached MMI as to the work accident, but that a cortisone injection into the AC joint was reasonable for the unrelated AC joint condition. Dr. Cohen further testified that Petitioner did not need any work restrictions related to his current job, as Petitioner was not performing any overhead activities, and the AC joint issue was not related to the work accident. (Rx1).

On cross-examination, Dr. Cohen testified he initially diagnosed Petitioner with a right shoulder strain based on exam findings of soreness around the shoulder and his other exam findings, as well as the mechanism of injury and his subjective complaints. He agreed that a strain can involve muscles, tendons and the soft tissue

structures. As to having findings of impingement while diagnosing a shoulder strain, Dr. Cohen testified that impingement can be secondary to a strain due to inflammation. He testified that the Speed's and Yurgason's tests, as well as the crossover test, are very specific tests, for the biceps in the former and the AC joint with the latter. Therefore, if Petitioner had an injury to the AC joint, whether that be a sprain/strain, or fracture/dislocation, one would expect the crossover test to be positive. In relation to a shoulder impingement diagnosis, Dr. Cohen testified this generally means bursitis, i.e. inflammation of the bursa underneath the acromion. The condition can arise from almost any kind of shoulder injury and the main symptoms would involve "pain kind of in the deltoid distribution, some pain with overhead lifting." Dr. Cohen further testified that a previously asymptomatic, degenerated or narrowed AC joint would not usually contribute to a condition of impingement unless there is significant spurring underneath the AC joint, and he did not believe that was the case with Petitioner per the x-rays. (Rx1).

Dr. Cohen testified that he has performed the surgery Dr. Garst is recommending for Petitioner, and performs many shoulder surgeries. As to whether a diagnosis of impingement syndrome requires surgical intervention, Dr. Cohen testified that rarely, by itself, would you operate based solely on a finding of impingement. However, he agreed that if a patient's symptoms could not be resolved through conservative treatment, and the patient had a significant spur, such as a type III acromion, surgery would be considered. An arthroscopic "cleanup" of the labrum could be performed if that is the problem, and patients who have a partial rotator cuff tear in the 50% range or greater, some percentage of those could require surgical repair if the condition doesn't resolve with conservative treatment. He would rarely operate on a rotator cuff with small fraying. On further questioning, Dr. Cohen admitted that consideration for a patient's subjective pain and failure of conservative care, including physical therapy and injections, are factors for potential future surgery. Furthermore, lifestyle factors, such as a job change and loss of access to hobbies could potentially be additional considerations when determining whether surgery is necessary. (Rx1).

In regard to his examinations, Dr. Cohen indicated that initially he wants the patient to point to where the pain is, and that is followed by drilling down more specifically with various exam testing procedures. As to his statement that the 10/25/19 exam that Petitioner had minimal impingement symptoms which may overlap with AC joint issues, Dr. Cohen testified that Petitioner did not have classic primary impingement findings but rather was more overlapping with pain on the superior shoulder area where the AC joint is. He acknowledged that physicians may perform examinations a little bit differently: "I mean, it's not an exact science." With Petitioner, he testified that there was a variance of findings in his two exams with regard to the AC joint, and this was significant to him and his opinion that this variance broke the causal chain of connection. Dr. Cohen acknowledged that it was not surprising that on 4/3/19 Petitioner reported he was noted by Dr. Mulhern to be much better given he reported significant improvement with the 3/1/19 injection. He also agreed that a positive impingement sign prior to the injection could result in an exam negative for impingement following an injection that improves the condition. However, he testified that crossover test exam findings should not be different since the AC joint is in its own capsule and the steroid would not have reached that area. (Rx1).

Dr. Cohen testified that a cortisone injection should last for roughly 6 weeks, after which a person may have resolved pain or the original pain could return. He agreed that increased activity could be a triggering factor for the pain returning, and that such pain recurrence would probably still relate back to the original injury, but only if it was the same pain and same findings as before, barring any intervening injury. In terms of his opinion that Petitioner's subjective complaints were in excess of the objective findings, Dr. Cohen testified he is not saying that Petitioner is malingering. Petitioner's QuickDASH score of 79 would reflect someone "pretty significantly impaired", and Petitioner's examination did not support this. He acknowledged Petitioner is muscular and that an underestimation his strength loss is therefore possible. Dr. Cohen testified that his understanding is that Petitioner continued to improve with therapy following his April 2019 exam and was released by Dr. Miller to return as needed in May 2019, after which he completed therapy and returned to work shortly thereafter. Dr.

Cohen testified he was not aware of Petitioner complaining in therapy on 6/23/19 that he had increased pain after returning to work, but testified this would not be unusual as a patient often may need a good six weeks to recondition after being off work. When he returned to Dr. Miller after this, the doctor was somewhat concerned about the clinical picture and some inconsistencies on exam which he described as "murky." Counsel advised Dr. Cohen that positive crossover tests were noted by Dr. Miller on 12/11/18 and 4/3/19 and agreed the finding can be indicative of an AC joint problem, but Cohen pointed out he did his crossover exam exactly the same way he always does and had different results in his two exams. Dr. Cohen testified that he recommended an injection into the AC joint as opposed to the sub-acromial space. If it is an inflammatory issue and it resolves permanently, you're done. If he gets significant but temporary relief, the odds of success of a distal clavicle resection would be pretty high. Simply basing such a surgery on a person having AC joint pain is not appropriate as the chance of success improvement would be 50% and maybe less. Dr. Cohen admitted that, while AC joint issues are common in bodybuilders, he had no evidence that Petitioner had any AC joint issues prior to the alleged accident. (Rx1).

On re-direct examination, Dr. Cohen testified that Petitioner he did not know what Petitioner's duties may have been when he returned to work in 2019, but agreed that if he returned to work performing different job duties, including overhead work, that could cause AC joint issues: "Well, yeah, then obviously that's the source of AC joint symptoms." He testified that not only were Petitioner's exam findings different between his first and second exams, but also that Dr. Miller's findings changed between April 2019 and May 2019. Dr. Cohen further testified that based on his examinations, there were no findings, provocative testing, that supported labral instability or a partial thickness rotator cuff tear. He did acknowledge that once surgery is prescribed and performed, you would look at everything in the shoulder at that point. (Rx1).

Petitioner first testified that the shoulder injections he had temporarily helped the pain, for a few weeks or months, then indicated that the initial injection didn't help and actually made him worse, which he explained to the doctor. He indicated that because the injection wasn't supposed to cause pain, they assumed it was improperly performed. The 2nd injection helped for a month or two, but pain was excruciating when it came back. Currently, his right shoulder pain is significant. He has difficulty sleeping and can't lay on his right side because his arm falls asleep. He testified he can't do heavy lifting with the right arm so he uses his left arm much more at work now. However, he testified he is working more hours now due to being behind financially from being off work. He testified he had no prior problems and has had no new injuries to his right shoulder.
The Petitioner agreed that he had been working out with a professional trainer for eight or nine years, including weightlifting, but testified that his workouts haven't involved the right shoulder since his work injury. He testified his therapist advised he shouldn't work out with the shoulder but could do lower body and cardio.

On cross-examination, Petitioner agreed that he was working part-time at an Ace Distribution Center at the time of the 10/22/18 injury, indicating he made the Respondent aware of it and was told he couldn't work there, so he quit the job after a month or two, again only performing forklift work. At XPO Logistics, Petitioner also worked as a forklift driver. He agreed that he indicated in his application that he was able to lift 50 pounds frequently and 70 pounds occasionally, and that the job description indicated this was a requirement of the job, but he testified that all he does at XPO is move pallets trailer to trailer with a forklift despite what the job description says.

Petitioner acknowledged that he still has to manually lift pallets like he did on the alleged accident date in his current job with Respondent as a forklift driver. However, the lifting is not performed as often as it is working as an order filler. Petitioner denied having been a professional bodybuilder and denied that he participated in any bodybuilding shows. He testified that he would lift at the gym two to three days a week, and would do a shoulder press once a week, maybe 40 pounds, noting he didn't lift as much because of his shoulder. He would work the biceps and triceps, curing 25 pounds with each arm.

Petitioner agreed his alleged accident was unwitnessed, noting he generally would work alone in his area as an order filler, particularly in the morning, as more people work together towards the end of his shift. He agreed that he had requested two weeks off work just prior to 10/22/18, indicating he had to go to Florida due to the death of his uncle. He agreed he returned from Florida on 10/21/18, but indicated he did work his shift on 10/21/18, so 10/22/18 was his second day back at work after the noted vacation time. This testimony was somewhat unclear, as Petitioner then testified that his shift would have begun at 6 a.m. on 10/21/18, so 10/22/18 had to be his first day back at work. Petitioner testified he did have issues with attendance working for Respondent, indicating this was due to having custody of his children and having to work on weekends.

Respondent's Spring Valley District environmental health and safety manager, Jason Floyd, testified that he was familiar with the Petitioner as an RSR forklift driver. He testified the job involves driving a stand-up forklift and picking pallets of merchandise, racking them, scanning the pallet, and, when required, removing the pallet to a location where another worker can order fill. It also involved the removal of the empty pallet stacks with the forklift. Order fillers slot the empty pallets, stacked to about 3', after which a forklift driver will pick them up. On a regular day, he estimated that a forklift driver would have to do a very limited amount of lifting, noting such lifting is not really in their job description unless they knock over products or pallets which then might have to be restacked. He acknowledged he would only be notified of such knock downs if there is damage to the products. On cross examination, Mr. Floyd agreed that the Petitioner has a manager he directly reports to between himself and the Petitioner in terms of authority levels

Documentation submitted by the Respondent indicates the Petitioner was hired by XPO Logistics on 6/24/19 as a Dock Worker (Part-Time), earning $16.62 per hour. This documentation indicates that a Dock Worker needs to be able to lift weights up to 50 pounds frequently and up to 70 pounds occasionally. The job involves sorting, handling, loading and unloading of palletized and non-palletized freight using appropriate motorized and manual equipment, including with use of a pallet jack, forklift and by hand. (Rx6).

The Arbitrator notes that the parties stipulated on the record that other than the claimed medical expense from OSF Orthopedics totaling $115.94, the Respondent has paid all outstanding causally related medical expenses pursuant to Sections 8(a) and 8.2 of the Act, and that the Respondent shall have credit for same and shall hold Petitioner harmless with regard to the expenses for which the Respondent is receiving credit.

Respondent's Exhibit 7 purports to be documentation of the medical expenses and TTD paid by Respondent through the hearing date, with TTD ending as of 6/7/19.

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:

Petitioner testified that on 10/22/18 he was involved in a work incident where he lifted an approximate 50-pound empty pallet and felt a pinch in his right shoulder. He tried to continue working but felt an increase in pain. He testified he reported the incident to his supervisor shortly after the initial occurrence, was seen by the company nurse, where he was given ice and completed a statement regarding what occurred. This testimony was not rebutted by Respondent. Petitioner's initial treating medical records contain generally consistent histories. While the exact details may differ slightly, the Arbitrator finds that the discrepancies are not significant given that the contemporaneous medical records support the testimony. The Arbitrator acknowledges the Petitioner's incident occurred the first day after returning from bereavement leave after the death of his

uncle. While this does raise a red flag of sorts, there is no evidence that was introduced which indicates the Petitioner had a shoulder injury or problem prior to the described incident, and coming to such a conclusion would require unjustified speculation on the part of the Arbitrator, as the Petitioner's testimony was that he suffered no accidents or injuries to his shoulder prior to 10/22/18.

The Arbitrator finds that the Petitioner was in the course of his employment when he lifted the pallet. The incident and injury also arose out of the employment based on such lifting of a 50-pound item increasing the risk of a shoulder injury. The Arbitrator finds that the preponderance of the evidence supports the conclusion that the Petitioner sustained accidental injury to the right shoulder which arose out of and in the course of his employment on 10/22/18.

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

The Arbitrator finds that the Petitioner's right shoulder condition is causally related to the 10/22/18 accident.

The Petitioner testified that his shoulder pain began contemporaneously with the noted work accident. After being off work for a few days on his regular schedule, Petitioner returned to work but indicated his pain increased to the point where he asked his supervisor for medical treatment. An MRI indicated tendinosis or a possible partial tear of the supraspinatus tendon, as well as possible evidence of impingement on the rotator cuff and a possible labral tear. On 12/11/18, Dr. Mitchell diagnosed right shoulder impingement and injected the right shoulder. Petitioner underwent therapy and on 12/27/18 he reported almost 100% improvement in pain and he was returned to work, but with instructions to continue therapy pending MMI as of 1/17/19. However, Petitioner saw Dr. Peterson shortly thereafter, on 2/1/19, indicating he had significant right shoulder pain, and after noting the Petitioner's problem was chronic and prescribing medication, on 2/19/19, Dr. Peterson restricted the Petitioner to light duty and referred him to orthopedics.

It should be noted that on 2/19/19, Dr. Peterson also indicated that Petitioner stated both that he had to do heavy lifting at work, as well as that he had pain when performing bicep curls and that he was unable to do his normal workouts.

Petitioner testified that electrical stimulation in therapy was helpful and he continued to work light duty through the end of 2018. While the medical records indicate he was released back to regular duty, he testified he was advised by his doctors that his shoulder was not improving so he requested a job change and was placed into a new job operating a forklift, which he testified he was continuing to perform at the time of the hearing.

When he saw Dr. Mulhern on 3/1/19, Petitioner indicated that the injection did not provide improvement and that his pain and loss of motion had worsened after he returned to full duty. Following his exam and review of the films, Dr. Mulhern believed the Petitioner had more of a rotator cuff problem or chronic bursitis rather than labral involvement. He injected the shoulder again and, given the symptoms had increased with full duty, he recommended light duty work and more therapy. Instead of returning to Dr. Mulhern, Petitioner on 4/3/19 saw Dr. Peterson. While he reported the injection helped a lot, but that he had ongoing pain in the top of the shoulder with pain and popping along the biceps and near the anterior elbow. The doctor believed there was a level of possible adhesive capsulitis and, given that Petitioner indicated he wasn't happy with Dr. Mulhern's assessment and plan and wanted a second opinion, he recommended referral to a shoulder surgeon if Petitioner did not improve and continued light duty restrictions.

At the 4/26/19 Section 12 exam with Dr. Cohen, the doctor noted that Petitioner reported he was 75% improved and diagnosed a sprain/strain of the shoulder and possible biceps tendinitis that was causally related to the

10/22/18 accident. He also questioned why Petitioner had returned to Dr. Peterson following the 12/29/18 release indicating Petitioner had no pain, but noted the Petitioner denied any intervening injury to explain the recurrent pain. On 5/23/19, Petitioner reported significant improvement to Dr. Miller but with ongoing painless popping in the shoulder which was painless, and the doctor recommended ongoing therapy and a return to work in two weeks. Physical therapy records indicate reports of significant improvement in May 2019 with minimal to no pain, but Petitioner reported he was returning to work on 6/8/19, while the last note of 6/21/19 states that Petitioner reported increased shoulder soreness after returning to work, though he was hoping he would be put into a lighter job. It appears that Petitioner then did not return for treatment until seeing Dr. Miller on 9/6/19, but at that time he reported that he was able to perform the lighter parts of his regular job but was still having increased right shoulder and elbow symptoms with heavier lifting. Dr. Miller did state that the Petitioner had "a number of mixed physical exam tests which makes his clinical picture a little murky", but believed that Petitioner had distal and proximal biceps tendinitis, a few positive labral signs, pain with AC joint compression and continued rotator cuff tendinitis given he had significant pain that with resisted testing and overhead range of motion. At that point he referred Petitioner to shoulder surgeon Dr. Garst, who believed x-rays and the original MRI films showed some biceps tendinosis, a probable partial tear of the rotator cuff at the supraspinatus, and a possible superior labral (SLAP) tear. He also agreed that there was some degenerative AC joint degeneration contributing to impingement. Given the failure of more conservative treatments over almost a year, Dr. Garst recommended arthroscopic surgery. While he was recommending surgery, he nevertheless indicated Petitioner could continue to work full duty, which at that time Petitioner indicated did not involve a lot of lifting.

Petitioner was evaluated by Dr. Cohen on 4/26/19 and again on 10/25/19. He testified that at the initial exam the Petitioner reported he had improved significantly and his findings included an MRI showing biceps tendinitis, some irregularity of the labrum and AC joint arthritis with no evidence of a cuff tear, and a diagnosis of a sprain/strain of the shoulder and possible biceps tendinitis on 10/22/18. He testified that the subsequent 10/25/19 exam no longer shows a problem with the biceps on exam and instead reflected an AC joint problem. Since the Petitioner had no AC joint symptoms previously, and had already been released to return to work with virtually no symptoms in June 2019, he opined that the Petitioner's current condition was unrelated to the work accident.

Petitioner credibly testified that he was in a condition of good health with respect to his right shoulder prior to the work accident, and that he had sustained no prior or subsequent injuries involving the right shoulder. Petitioner's shoulder specialist, Dr. Garst, indicated in his records that Petitioner's long-standing right shoulder pain stemmed from an injury at work in October 2018. His diagnosis was a partial rotator cuff tear with impingement as well as AC joint arthritis and a probable labral tear. The Arbitrator finds that these conditions are causally related to the work accident.

The Arbitrator does not find the testimony of Dr. Cohen to be persuasive in terms of causation. While he indicated no findings regarding the AC joint at his initial exam, it is clear that the MRI that took place prior to that exam noted some degeneration in that area. Additionally, Dr. Cohen also relies on the findings that the Petitioner had recovered and been released to full duty prior to the second exam, and that he'd had a gap in treatment of three months in 2019. However, the Arbitrator finds that the May and June 2019 physical therapy records quite clearly point out that the Petitioner had significant improvement in May and early June, but reported an increase in symptoms following his return to work. Additionally, the findings of Dr. Miller and

The Arbitrator fully acknowledges that there are some issues with the Petitioner's veracity in this case, particularly in terms of how extensive his prior bodybuilding was. For example, he indicated to Dr. Cohen that he did not advance in bodybuilding to the point that he was participating in shows, but it makes no sense that Dr. Peterson on 1/4/19 would have noted Petitioner had anxiety with regard to participating in bodybuilding

shows if this had not been reported by the Petitioner. It also is concerning that the Petitioner twice has indicated unhappiness with treatment of his physicians despite what appears to have been improvement with those physicians' treatments. However, this does not change the fact that the Petitioner has had ongoing symptoms in the right shoulder since the work accident, admittedly with periods of improvement during treatment (therapy and injections) and light duty, but with increases in symptoms upon his returns to work. It is difficult for the Arbitrator to base a causation opinion solely on examination findings such as those made by Dr. Cohen at both of his examinations, particularly when the initial MRI reflected tendinosis or a possible partial tear of the supraspinatus tendon, as well as possible evidence of impingement on the rotator cuff and a possible labral tear, and where other doctors who examined Petitioner prior to Dr. Cohen's initial exam had different diagnoses, including positive crossover testing on exam reflecting an AC joint problem. It is clear that in reviewing all of the medical opinions in this case that no one is exactly sure what is going on inside the Petitioner's shoulder, but the continuity of complaints supports causation in this case given the noted MRI findings and various diagnoses.

Additionally, while it is certainly possible, if not likely, that Petitioner's weightlifting contributed to AC joint degeneration, there is no evidence that anything other than the work accident triggered symptoms. As is axiomatic in Illinois workers compensation, the Respondent takes the Petitioner as it finds him.

For these reasons, the Arbitrator finds the Petitioner has met his burden of proof that his right shoulder condition is and remains causally related to the 10/22/18 accident.

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

The Arbitrator notes that the only outstanding medical bill that was submitted into evidence is the 9/6/19 bill from Dr. Miller. It appears that this visit was partially paid by Blue Cross/Blue Shield, leaving a balance of $115.94. The amount billed was $239.00. The Arbitrator finds this date of service was reasonably necessary as it resulted in the referral to Dr. Garst. Respondent is ordered to pay for same.

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

The Arbitrator finds that the surgery recommended by Dr. Garst to be reasonable and necessary based on the preponderance of the evidence, and that the surgery is causally related to the 10/22/18 work accident. The Respondent shall authorize same.

While the Petitioner has shown significant improvement at times, he has now undergone approximately a year of conservative treatment with no lasting improvement. When he would have improvement, a return to regular work duties would result in an increase in symptoms. Based on the MRI and multiple examinations with various doctors, there is no clarity with regard to exactly what the problem is. However, what does appear clear is that the Petitioner has ongoing symptoms. Having found that the Petitioner's condition of ill-being is causally related to the work accident, the Arbitrator finds that the recommended surgical procedure is reasonably necessary in the treatment of that condition. Petitioner has undergone a year of conservative care without resolution of his symptoms. The surgery recommended by Dr. Garst involves acromioplasty, distal clavicle excision, debridement versus repair of the rotator cuff and possible labral repair. Essentially, this means he will be performing a decompression and an evaluation of the rotator cuff and labrum with plans to perform appropriate procedures depending on what is found. While Dr. Cohen questions such procedure as causally

related, he did agree that an AC joint resection could be reasonable. He also acknowledged that while he doesn't tend to perform surgeries without more specific findings, that if a shoulder condition is impacting one's work, surgery would be a reasonable option. The Arbitrator finds that at this point that Dr. Garst's recommended surgery is reasonable, and Respondent is ordered to authorize same.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC031710
Case Name	DANIEL,JOSEPH v. MADISON COUNTY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0378
Number of Pages of Decision	13
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Matthew Kelly

DATE FILED: 7/27/2021

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH DANIEL,

Petitioner,

vs. NO: 19 WC 31710

MADISON COUNTY,

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 whether Petitioner's current condition of ill-being is causally related to the September 21, 2019 accidental injury and whether the surgery recommended by Dr. Dy is causally related to the work accident, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 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 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.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

July 27, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 7/13/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

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

21IWCC0378

DANIEL, JOSEPH
Employee/Petitioner

Case# **19WC031710**

MADISON COUNTY
Employer/Respondent

On 10/15/2020, 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 0.11% 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 PC
NATHAN A BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

1001 SCHREMPF KELLY & NAPP LTD
MATTHEW KELLY
307 HENRY ST SUITE 415
ALTON, IL 62002

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)

Joseph Daniel
Employee/Petitioner

v.

Madison County
Employer/Respondent

Case # 19 WC 31710

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 August 28, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, September 21, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $58,449.04; the average weekly wage was $1,124.02.

On the date of accident, Petitioner was 51 years of age, single with 1 dependent child(ren).

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

Respondent shall be given a credit of $3,532.65 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,532.65. The parties stipulated TTD benefits were paid in full.

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, Petitioner's claim for prospective medical treatment is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 10, 2020
Date

OCT 15 2020

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on September 21, 2019. According to the Application, Petitioner was subduing a combative juvenile and sustained an injury to his right ring finger, right hand and right forearm (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for prospective medical treatment. Petitioner and Respondent stipulated Petitioner sustained a work-related accident and that temporary total disability benefits and medical had been paid in full. Respondent disputed Petitioner's entitlement to prospective medical treatment on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a juvenile detention officer. On September 21, 2019, Petitioner had to break up a fight between two juveniles and sustained an injury to his right ring finger. Petitioner did not experience any pain immediately afterward, but had pain while using the steering wheel when driving home. Petitioner reported the accident to Respondent the following day.

When Petitioner reported the accident to Respondent, he was directed to seek medical treatment at the ER of Anderson Hospital. At that time, Petitioner complained of right hand pain/swelling. An x-ray of Petitioner's right ring finger was ordered. According to the radiologist, it revealed a non-displaced fracture of the medial base of the distal phalanx and old fractures of the fourth metacarpal and proximal phalanx. Petitioner was directed to follow up with his prior hand doctor. (Petitioner's Exhibit 2).

On September 27, 2019, Petitioner was evaluated by Dr. Christopher Dy, an orthopedic surgeon, who had previously treated Petitioner. At that time, Dr. Dy noted he was seeing Petitioner for a "new issue" in regard to Petitioner's right ring finger. Dr. Dy noted he previously treated Petitioner for a right ring finger proximal phalanx fracture and had performed a metacarpal rotational osteotomy (Petitioner's Exhibit 3).

The medical records regarding the prior medical treatment provided by Dr. Dy were received into evidence at trial. Petitioner was first seen by Dr. Dy on August 15, 2016. At that time, Petitioner advised he sustained an injury to his right ring finger on July 4, 2016. Dr. Dy reviewed x-rays taken on July 29, 2016, and opined they revealed a proximal phalanx fracture. Dr. Dy opined the healing was in a shortened position with volar displacement of the distal fragment. Dr. Dy diagnosed Petitioner with a malunion with rotational deformity and shortening in addition to PIP joint stiffness. He ordered physical therapy, but noted that an osteotomy was probably indicated (Petitioner's Exhibit 4).

When Dr. Dy saw Petitioner on September 19, and October 17, 2016, Petitioner continued to have the rotational deformity. Dr. Dy recommended Petitioner undergo surgery consisting of rotational osteotomy through the metacarpal (Petitioner's Exhibit 4).

Dr. Dy performed surgery on October 25, 2016. The procedure consisted of a right ring finger metacarpal rotational osteotomy (Petitioner's Exhibit 4).

Following surgery, Dr. Dy saw Petitioner on November 10, and December 5, 2016. When Petitioner was seen on December 5, 2016, Dr. Dy noted the osteotomy was healing and Petitioner's condition had improved. He ordered continued therapy and indicated he would see Petitioner in six weeks time (Petitioner's Exhibit 4). Petitioner was not again seen by Dr. Dy until he saw him on September 27, 2019. At trial, Petitioner testified he did not return to Dr. Dy six weeks after the visit of December 5, 2016, because his finger was fine and it was a long drive to get to Dr. Dy's office.

At the time Petitioner was seen by Dr. Dy on September 27, 2019, Petitioner complained of pain in the DIP joint of the right ring finger. Petitioner did not complain of pain/tenderness in the metacarpal. Dr. Dy reviewed the x-rays of September 22, 2019, and confirmed there was a minimally displaced fracture of the distal phalanx of the ring finger. He also noted the metacarpal osteotomy still had a persistent fracture line and the distal screws were "backing out" (Petitioner's Exhibit 3).

Dr. Dy prescribed a splint and released Petitioner to return to work with no use of the right hand. Petitioner stated he wanted the screws removed because they were not causing him any pain and he was functioning well (Petitioner's Exhibit 3).

On September 27, 2019, Petitioner was seen at Athletico Physical Therapy and was diagnosed with a mallet right finger. Petitioner was fitted with a splint and was provided with instructions regarding same (Petitioner's Exhibit 5).

Dr. Dy subsequently saw Petitioner on October 25, 2019. At that time, Petitioner advised he had been wearing the splint and the distal portion of his right ring finger felt better. However, Petitioner advised that since the time of the accident and his prior visit with Dr. Dy, the rotational deformity had gotten worse and recurred. Dr. Dy opined the accident was the "prevailing factor" in the reoccurrence of the rotational deformity and that Petitioner had likely fractured through the prior osteotomy site. Dr. Dy recommended Petitioner undergo surgery consisting of an open reduction and internal fixation of the metacarpal nonunion with distal radius autographed (Petitioner's Exhibit 3). This was the prospective medical treatment sought by Petitioner.

At the direction of Respondent, Petitioner was examined by Dr. Mitchell Rotman, an orthopedic surgeon, on December 9, 2019. In connection with his examination of Petitioner, Dr. Rotman reviewed medical records and x-rays provided to him by Respondent. On examination, Dr. Rotman noted Petitioner had a slightly diminished range of motion of the DIP joint of the right ring finger, but no complaints of pain. In regard to the MP joint, Dr. Rotman noted there was a malrotation of the joint and Petitioner had minimal tenderness over the osteotomy site. Dr. Rotman opined Petitioner was at MMI in regard to the distal phalanx fracture (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to the metacarpal, Dr. Rotman agreed with Dr. Dy's treatment recommendation. However, Dr. Rotman opined that Petitioner's current condition in regard to the rotational deformity was not related to the accident of September 21, 2019. He noted Petitioner did not keep his follow-up appointment with Dr. Dy following the visit of December 5, 2016. Dr.

Rotman opined that over the next two and one-half years, the screws backed out and the plate came loose which caused it to lose some of the rotational correction. Dr. Rotman opined the x-rays revealed thickening of the bone over time. He also noted Petitioner had no complaints at the time of his initial visit following the accident with Dr. Dy and, when he examined Petitioner, Petitioner could not recall when he first started having symptoms at the site of the metacarpal osteotomy (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Dy was deposed on August 5, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Dy's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, Dr. Dy testified that the prior fracture and osteotomy had not completely healed. Dr. Dy stated Petitioner had a recurrence of the rotational deformity (Petitioner's Exhibit 6; pp 9-12, 16).

In regard to causality, Dr. Dy testified there was a causal relationship between the accident of September 21, 2019, and the recurrent rotational deformity. This was based on the fact that the prior rotational deformity was corrected when he last saw Petitioner on December 5, 2016, and there were no signs of hardware compromise. Petitioner had a new injury and a recurrence of the rotational deformity and signs of hardware compromise with the screws backing out. Dr. Dy testified the persistent fracture line observed in the x-rays of September 22, 2019, was caused by the accident; however, he could not testify that the accident caused the hardware to loosen and the screws to back out (Petitioner's Exhibit 6; pp 17-19).

On cross-examination, Dr. Dy agreed that when he first saw Petitioner on September 27, 2019, Petitioner had no complaints in regard to the proximal phalanx of the finger and the site of the osteotomy. Dr. Dy's findings on examination were limited to the distal phalanx of the right ring finger. Dr. Dy also agreed that if the accident had caused the screws to back out, Petitioner would have had signs of swelling and tenderness (Petitioner's Exhibit 6; pp 33, 37).

When interrogated about his opinion regarding causality, Dr. Dy testified the force of the injury would cause the distal phalanx fracture to import substantial stress to the area where a metacarpal osteotomy had been performed. Given the absence of any other trauma, Dr. Dy reaffirmed his opinion in regard to causality. However, Dr. Dy conceded that the findings in regard to the osteotomy site could have been the result of the natural progression of Petitioner's condition over time (Petitioner's Exhibit 6; pp 37-38, 42).

Dr. Rotman was deposed on August 11, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Rotman's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Rotman testified there was not a causal relationship between the rotational deformity of the metacarpal and the injury Petitioner sustained on September 21, 2019. Dr. Rotman noted the x-rays revealed a "halo" around the screws which was indicative of an old problem. There was also subsequent thickening of the bone and the metacarpal gradually returned to its prior position. Dr. Rotman also stated that if the accident of September 21, 2019, had caused the screws to back out, Petitioner would have had subjective complaints at that time. In regard to the force of impact to the tip of the finger transferring to the metacarpal, Dr. Rotman opined that most of the force would have been

dissipated where the fracture was sustained at the tip of the finger (Respondent's Exhibit 1; pp 15-20, 43).

At trial, Petitioner testified his right ring finger condition was "fine" and he experienced no symptoms subsequent to his visit with Dr. Dy of December 5, 2016, until he sustained the accident on September 21, 2019. Petitioner presently has complaints in regard to the rotational deformity and he wants to proceed with the surgery as recommended by Dr. Dy.

Jon Volkmar, Petitioner's supervisor, testified on behalf of Respondent. Volkmar testified he had a telephone conversation with Petitioner on November 5, 2019, and Petitioner informed him that, while he was walking his dog, his right hand started hurting and he needed to take the day off. Volkmar prepared a memo dated November 6, 2019, regarding the preceding conversation which was received into evidence (Respondent's Exhibit 2).

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of September 21, 2019.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on September 21, 2019.

There was no dispute Petitioner sustained a fracture to the distal phalanx of the right ring finger as a result of the accident of September 21, 2019.

In 2016, Petitioner sustained an injury to the PIP joint and metacarpal of the right ring finger which required surgery. Dr. Dy performed surgery on October 25, 2016, which consisted of a metacarpal rotational osteotomy.

Petitioner recovered from that prior surgery and following the examination with Dr. Dy on December 5, 2016, he was not seen again by Dr. Dy until September 27, 2019.

When Petitioner was seen by Dr. Dy on September 27, 2019, Petitioner's complaints were limited to the DIP joint of the right ring finger. While it was noted two of the screws from the prior surgery had "backed out", Petitioner had no complaints referable to the PIP joint or metacarpal.

It was not until Dr. Dy saw Petitioner on October 25, 2019, that Petitioner had complaints referable to the site of the prior osteotomy surgery. Dr. Dy opined Petitioner had a reoccurrence of the rotational deformity and Petitioner needed to undergo corrective surgery.

Dr. Dy opined Petitioner's recurrent rotational deformity was caused by the accident of September 21, 2019. This was based primarily on the fact Petitioner had no complaints from the time he last saw Dr. Dy on December 5, 2016, until after the accident.

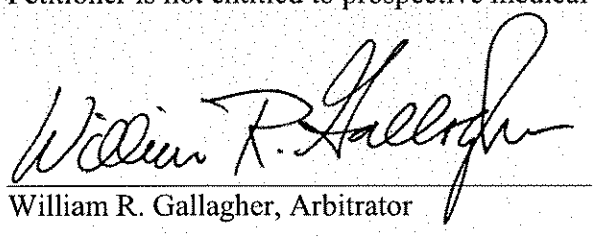
However, Dr. Dy could not testify that the accident of September 21, 2019, caused the screws to back out, and, if it had, it was likely Petitioner would have had signs of swelling and tenderness. Dr. Dy also agreed it was possible the findings in regard to the osteotomy site were a natural progression of Petitioner's prior condition.

Respondent's Section 12 examiner, Dr. Rotman, opined the rotational deformity was not related to the accident of September 21, 2019. He based this on the fact there was a "halo" around the screws, the thickness of the bone, and, if the accident of September 21, 2019, caused the screws to back out, Petitioner would have had complaints at that time. Further, Dr. Rotman opined there would not have been sufficient force transferred from the tip of the finger to the metacarpal to cause a re-injury.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Rotman be more persuasive than that of Dr. Dy in regard to causality.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F), the Arbitrator concludes Petitioner is not entitled to prospective medical treatment.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC035422
Case Name	WILLIAMS,JENNY v. VAN MATRE HEALTH S REHAB
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0379
Number of Pages of Decision	37
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Brad Reynolds
Respondent Attorney	Richard Lenkov

DATE FILED: 7/27/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)	☒ Affirm and adopt (no changes)
) SS.	☐ Affirm with changes
COUNTY OF)	☐ Reverse
WINNEBAGO)	
	☐ Modify

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER WILLIAMS,

Petitioner,

vs. NO: 15 WC 35422

VAN MATRE HEALTH
SOUTH REHABILITATION,

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, maintenance benefits, and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 26, 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 $ 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.

July 27, 2021

o: 7/14/21
BNF/kcb
045

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

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, JENNIFER
Employee/Petitioner

Case# **15WC035422**

HEALTH SOUTH
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:

1131 GESMER & REYNOLDS PC
BRAD A REYNOLDS
526 E JEFFERSON ST SUITE 118
ROCKFORD, IL 61107

2542 BRYCE DOWNEY & LENKOV LLC
RICH LENKOV
200 N LASALLE ST S700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JENNIFER WILLIAMS
Employee/Petitioner

v.

HEALTH SOUTH
Employer/Respondent

Case # **15** WC **035422**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Rockford**, on **June 16, 2020** & **September 15, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 **9-29-15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$54,232.36**; the average weekly wage was **$1,042.93**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **0** dependent children.

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, **$9,733.08** for maintenance, and **$15,730.02** for other benefits, for a total credit of **$25,463.10**.

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

ORDER

RESPONDENT TO PAY PETITIONER MAINTENANCE BENEFITS FROM 2-27-19 THROUGH 1-21-20 AT THE RATE OF $695.22 PER WEEK SUBJECT TO A CREDIT FOR ALL MAINTENANCE BENEFITS PAID BY RESPONDENT FOR THE SAME TIME PERIOD.

RESPONDENT TO PAY PETITIONER A 8(D)(1) WAGE DIFFERENTIAL BENEFITS FROM 1-18-20 THROUGH 9-15-20 AT THE RATE OF $507.42 PER WEEK SUBJECT TO A CREDIT FOR ALL WAGE DIFFERENTIAL BENEFITS PAID BY RESPONDENT FOR THE SAME TIME PERIOD.

RESPONDENT TO PAY PETITIONER A 8(D)(1) WAGE DIFFERENTIAL BENEFITS AT THE RATE OF $507.42 PER WEEK FROM 9-16-20 THROUGH THE DATE PETITIONER TURNS 67 YEARS OLD SUBJECT TO THE REVIEW PROVISIONS 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.

Michael A. Glaser

Signature of Arbitrator

10-26-20

Date

OCT 26 2020

IN AND BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER WILLIAMS	)	
	)	
Petitioner,	)	
	)	
v.	)	**Case No.: 15 WC 35422**
	)	
HEALTH SOUTH	)	
	)	
Respondent.	)	

PROCEDURAL HISTORY

This matter was previously tried pursuant to Section 19(b) of the Act on February 26, 2019. The Arbitration Decision awarded TTD benefits to the Petitioner. Respondent was further ordered to authorize vocational rehabilitation services and to begin maintenance benefits to Petitioner at the commencement of those services. The parties commenced a second hearing on all issues which began on June 16, 2020 in Rockford, Illinois. Due to COVID-19 Rules, the parties were not able to complete their hearing on June 16, 2020 and the matter was bifurcated. On September 15, 2020 the remaining witness testimony was completed, and all exhibits of both parties were entered into the record subject to various objections which were ruled upon at the conclusion of the hearing. The issues presented at the second hearing include causal relationship (only since the day after the parties' 19(b) hearing), maintenance benefits (liability) and nature and extent. See Arbitrator Exhibit 1, Trial Transcript pp. 4-7 day one.

FINDINGS OF FACT

TESTIMONY OF JENNIFER WILLIAMS

Petitioner testified since the parties' 19(b) hearing on February 26, 2019 there were no additional doctor visits. (T14). Petitioner testified she continues to have neck symptoms due to her work injury that radiate down her shoulders. (T14-15). Petitioner described her neck pain as constant but that radiation into her shoulders was intermittent. (T15). On a scale of 0 to 10 Petitioner characterized her usual or typical neck pain at the time of the hearing to be 6 out of 10. (T15). Petitioner also testified that she continues to experience bilateral shoulder pain since the Parties' 19(b) hearing. Petitioner described left shoulder pain, which was constant, pointing to the front part of her left shoulder where the arm starts to meet her collar bone. (T16). Petitioner described her left shoulder pain on a scale of 0 to 10 as typically between 5 to 6. (T16). Regarding her right shoulder, Petitioner characterized her right shoulder pain as constant. She described the same area on the right shoulder as she experienced with her left shoulder regarding the location of her pain. Like the left shoulder, she described right shoulder pain as 5 to 6 out of 10. (T17). Petitioner utilizes home remedies including Ibuprofen and ice on a regular basis to try to help control her neck and bilateral shoulder symptoms. (T17-18).

Petitioner graduated with a BSN from nursing school in 2007. Petitioner was a Registered Nurse for eight years at the time of her injury while working for Respondent. Petitioner testified she was familiar with the physical demands of the job of a floor nurse for Respondent. Petitioner testified at the time of the second hearing considering her neck and bilateral shoulder symptoms that she would not be able to perform the lifting aspects of her regular job as a floor nurse. Petitioner testified that her permanent work restriction was 5 pounds frequently and 10 pounds

occasionally. She further testified at the time of the hearing that she did not feel she could lift substantially more than the permanent restrictions placed by Dr. Milos at the time of the parties' previous 19(b) hearing. (T18-19).

Petitioner testified that Respondent did not authorize commencement of vocational services following the parties' 19(b) hearing until early October of 2019. (T19). Petitioner initially met with Vocamotive on October 15, 2019 to institute vocational rehabilitation services. (T20). Respondent commenced maintenance benefits to the Petitioner beginning with her meeting with Vocamotive on October 15, 2019. (T20). Petitioner testified that she had several meetings with Vocamotive prior to the commencement of actual job search activity. During these initial meetings (and before actual job searching began) Ms. Williams described the following vocational services that were provided by Vocamotive to her in anticipation of job searching:

1. Completion of advanced Word training;
2. Completion of Excel Basic and Intermediate training;
3. Keyboard testing and keyboard practicing which resulted in her completing between 70 to 80 words per minute which was an increase over her initial keyboard testing;
4. Completed an updated resume;
5. Participated in workshops regarding interview skills;
6. Vocational testing;

(T20-22). Petitioner testified that commencing on October 15, 2019 she worked daily on keyboarding, keypad exercises, and computer training work. She was in daily contact with Vocamotive regarding her progress. (T22).

Petitioner testified that job searching began at the end of November 2019. She described that her contact with Vocamotive once job searching began was on a daily basis and then at the end of each week she had a follow-up telephone conversation with Vocamotive to review the events of the week. Petitioner testified that Vocamotive set a weekly number of contacts for jobs (30 to 40) and that she met all her weekly contact goals. Petitioner testified she was provided job

leads by Vocamotive for jobs that were within her permanent work restrictions. Petitioner would then would make cover letters, apply for the jobs and conduct job follow-up. (T23-24).

Petitioner testified her first job interview was in January of 2020 with a prospective employer – Swedish American Hospital for a medical receptionist position. Petitioner initially completed a telephone interview for the medical receptionist position and then followed up with an in-person interview. Petitioner testified that after completion of an in-person interview, she shadowed the receptionist that was working on this day for 30 minutes. (T24-25). Petitioner testified that she was previously told the starting hourly wage for the medical receptionist position was $11.81 per hour. (T25). Petitioner subsequently received an offer of full-time employment for the medical receptionist position in the pulmonary department at Swedish American Hospital with an hourly rate of pay at $15.97 an hour. The increase in pay was due to her extensive experience as a nurse. (T24-26).

Petitioner then reported the offer of employment to Vocamotive. Petitioner testified that she did no further job searching through Vocamotive after the job at Swedish American Hospital pulmonary department receptionist was made. Petitioner testified she was directed by Vocamotive to cease job searching after Vocamotive notified the Respondent that the position of medical receptionist had been offered as a full-time job to the Petitioner. (T26). Petitioner testified between the time she was offered the full time position at Swedish American Hospital as a medical receptionist and through the date of the parties' hearing on June 16, 2020 she was not asked by the Respondent to recommence job searching efforts. (T26). Petitioner testified that she worked diligently to find alternative employment within her permanent restrictions throughout the time she worked with Vocamotive and until the offer of employment was made for the medical receptionist position at Swedish American Hospital in the pulmonary department. (T26-27).

Petitioner testified she benefitted by the support services provided by Vocamotive. (T27). Specifically, Petitioner testified that there were computer skills that she did not possess or needed to update that were gained through work with Vocamotive. (T27). She further identified their assistance in updating her resume as well as Vocamotive's providing her with job leads as explanations for why she benefitted from their rehabilitation services. (T27).

The medical receptionist position in the pulmonary department was to commence on February 3, 2020. It was a full-time position with benefits. Petitioner testified that she did not report for work in the position of medical receptionist on February 3, 2020 (or any subsequent time) because she felt that she observed a negative work environment (specifically too under staffed) during the time that she shadowed the receptionist in person. Petitioner also testified that she was aware of COVID-19, that it was coming from Europe to the United States and she was not comfortable working in a pulmonary department (with the pulmonary illness coming while having a young child at home). (T28-29). Petitioner testified at the time of commencement of the parties' second hearing that her son was two years old. (T30).

On cross-examination, Petitioner testified that the rehab services provided by Vocamotive prior to actual job searching lasted between six to eight weeks. (T33). Petitioner was asked whether she was proficient in typing before she did any keyboard work/practice for Vocamotive. Petitioner testified that although she typed in her previous jobs as a nurse that her typing skills assessment did not permit her to bypass typing practice. Petitioner explained that there was room for improvement with her typing skills, that it is easy to get used to typing with your smart phone and it was necessary for her to type again on an actual keyboard. (T35-36). Petitioner could not recall the exact number of job contacts she made each week while she worked with Vocamotive, but she testified that she completed the number of required contacts each week and that

Vocamotive maintained a record of all of her contacts. (T38). On cross-examination, Petitioner testified that the jobs she searched for through Vocamotive were ones within her permanent work restrictions. (T40). Petitioner testified that she was looking for RN positions while searching for work through Vocamotive but that no available jobs within her permanent work restrictions were identified and/or offered. (T40). On cross-examination, Petitioner reiterated that she did not accept the pulmonary receptionist position given what COVID-19 consisted of (pulmonary illness) and that it was not worth the risk of exposing her son. (T47). On cross-examination, Petitioner testified that she did not search for any other jobs after she declined to report for the pulmonary receptionist position because she was instructed by the Respondent to cease all job search activities. (T47-48).

Petitioner searched for jobs as directed by Vocamotive that were consistent with her 15-mile driving restriction placed by Dr. Hughes. Petitioner testified that driving a vehicle for more than 15 miles exacerbates her neck symptoms. (T53-54)

TESTIMONY OF KARI STAFSETH C.R.C.

Kari Stafseth testified in Petitioner's case in chief. At the time of the parties' second hearing Ms. Stafseth was Director of Case Management at Vocamotive. She was also a certified rehabilitation counselor since 2009. (T55-56). In her position as Director of Case Management for Vocamotive, Ms. Stafseth is responsible for the assessment of injured workers and oversite of education and retraining while they are participating in the vocational rehabilitation process in an attempt to get them back to work. Tr. p. 56.

Ms. Stafseth was familiar with the Petitioner as she was the author of initial vocational rehabilitation report regarding Petitioner and testified at the time of the parties' first hearing on

February 26, 2019. (T56). In addition to having authored a vocational assessment regarding Petitioner prior to the 19(b) hearing, Ms. Stafseth was responsible for directing the Petitioner's job search process beginning once Respondent authorized vocational rehabilitation services with Vocamotive commencing October 15, 2019. (T56-57). Ms. Stafseth testified Petitioner did a number of things that were part of her rehabilitation plan before actual job searching commenced. First, Petitioner underwent vocational testing to assess her aptitudes and interests. Additionally, Petitioner participated in computer training. She completed baseline testing to assess her knowledge of the Windows operating system and Microsoft Word at a basic level. Vocamotive then implemented training to consist of Microsoft Word at an intermediate level. Additionally, Petitioner underwent training in Excel at a basic level and then at an intermediate level. Petitioner passed all of those classes and received certifications for them upon completion. (T57-58). Ms. Stafseth testified that Petitioner gained skills at the intermediate level through the computer training programs that she did not possess prior to October 15, 2019. (T58-59). Vocamotive provided Petitioner with a laptop which was equipped with "Log Me In" software. Thois software allowed the Petitioner to log into a system where she was provided assistance remotely. There were also in-person meetings including a meeting to initiate services and then there were additional meetings at her local library to go through job seeking skills instruction, assisting her with development of a resume and going through interview preparation. (T59-60). Job searching activities commenced at the beginning of December 2019. (T60). Ms. Stafseth also completed a series of Vocamotive Progress Reports along with rehabilitation plans both before and after job searching activities commenced regarding the Petitioner. Those reports were true and correct and they summarized all activities completed by Petitioner before job searching began and after job searching began. Those reports also summarized all of her job contacts, job leads and follow-up

for all job leads provided to Petitioner with the last of the reports dated February 11, 2020. (T60-62).

Ms. Stafseth was asked to describe Petitioner's effort to find employment between commencement of rehabilitation services through the date of the final report documenting job searching efforts dated February 11, 2020. Ms. Stafseth testified that Petitioner fully participated in all aspects of the job search process. She completed all job leads that were provided to her, completed the appropriate amount of follow-up, and maintained daily communication with Vocamotive in regards to reports and what activities were completed. Petitioner properly documented all of her job search activities and submitted job search logs to Vocamotive. She was described as fully cooperative throughout the entire process. (T62-63). Vocamotive asked Petitioner to maintain job contacts between 30 to 40 per week. According to Ms. Stafseth there was only one week where Petitioner's job search activities fell below the parameter of 30-40 per week. That was the week of December 11 through December 19 where she obtained 21 contacts. (T64).

Ms. Stafseth testified as a result of her job search efforts, Petitioner did obtain a full time job offer of employment as a medical receptionist with a pay rate of $15.97 and that this offer of employment was extended to Petitioner on January 17, 2020. (T64). Ms. Stafseth confirmed that the medical receptionist position was within all of Petitioner's permanent work restrictions. (T 64). Ms. Stafseth testified that at no time after January 17, 2020 was Vocamotive directed by the Respondent to continue Petitioner's job searching. (T65). Instead, Vocamotive was directed by the Respondent to close their file once the medical receptionist position was offered to Petitioner. (T65). Ms. Stafseth testified that only nine weeks lapsed between when Petitioner began her actual job search and the first formal offer of employment that was within her

restrictions. Ms. Stafseth testified that Vocamotive maintains statistics on the length of a typical job search and that these statistics have been gathered and reviewed by Vocamotive for the past five years. Ms. Stafseth testified that at the end of 2019 Vocamotive's statistics for the duration of a typical job search from beginning to offer of employment was seven months. (T65-67).

Ms. Stafseth was asked to review her original vocational assessment and report dated November 18, 2016 at the time of the parties' second hearing. (T68). In that report, Ms. Stafseth identified the following positions that were within Petitioner's permanent work restrictions and most appropriate including triage coordinator, admissions coordinator, registrar, medical secretary, office clerk, dispatcher, ER case manager and similar positions. (T69). In her initial report, Ms. Stafseth summarized that the wages for those positions would likely fall somewhere between $13.00 and $16.00 per hour. (T69). When asked to compare the results of actual job searching to her initial vocational assessment, Ms. Stafseth testified that the medical receptionist position ($15.97 per hour) fell within the upper range of what was targeted at the time of the initial report back in 2016 and that medical receptionist position was one of the jobs that was identified in the preliminary report that was within petitioner's skill set and permanent restrictions. (T69-70).

Next Ms. Stafseth was asked to review a labor market survey completed by Comp Alliance Managed Care dated February 12, 2020. Ms. Stafseth went through each of the jobs that were identified in the Comp Alliance Report and listed her findings regarding each of those job leads in her report dated March 12, 2020. (T70-71). Ms. Stafseth concluded that based on follow-up for those positions identified in the labor market survey done by CompAlliance that would appear that Petitioner was not an appropriate candidate due to either her restrictions, her experience, and/or her lack of appropriate credentials. Additionally, some of the positions that were included in that

labor market survey were part-time. (T71-72), Day 1. According to Ms. Stafseth, nothing contained in the CompAlliance Managed Care Report dated February 12, 2020 caused her to change any of her opinions regarding Petitioner to a reasonable degree of vocational certainty. (T72-73).

Ms. Stafseth authored a second report following completion of job services dated June 12, 2020 where she was asked to offer an opinion about what a registered nurse in the Rockford area could earn per hour at the time of the parties' second hearing. (T73-74). (PX20). Ms. Stafseth researched multiple sources before authoring an opinion. Those sources included the United States Department of Labor, Bureau of Labor Statistics as far as what the current average wages of a nurse were in the Rockford area. Ms. Stafseth also reviewed information from Indeed.com, Monster.com, and LinkedIn. Additionally, there were phone calls that were placed to prospective employers in the Rockford Metropolitan area concerning what could be earned by someone with Petitioner's experience on an hourly rate as a nurse. (PX20). Ms. Stafseth noted that in regards of the occupational employment statistics published by the United States Department of Labor that nurses at the 75th percentile earned $35.60 per hour and that those nurses at the 90th percentile earned $39.67 per hour. Ms. Stafseth explained that the more experience you have within the profession the higher end of the wage-scale a nurse would be. Based on all data reviewed wages ranged anywhere between $27.00 to $45.00 an hour with an average or median range of $36.00 per hour. (T77) (PX20).

On cross examination, Ms. Stafseth testified that while it was true Petitioner did not report for the medical receptionist position in the pulmonary department for Swedish American Hospital, that ultimately the actual results of job searching showed that Petitioner was capable of getting a job and it showed what type of wage she had access to in the market in light of her permanent

work restrictions. (T78). Ms. Stafseth testified on cross-examination that Vocamotive was instructed by the Respondent to stop job searching because Vocamotive found her a job within her permanent restrictions. Ms. Stafseth further testified on cross-examination that Vocamotive would generally not continue job placement efforts after they found a client a job within their permanent work restrictions. (T79). Ms. Stafseth further testified on cross examination that Vocamotive would not reinstate efforts to find Petitioner a job unless they were specifically directed to do so by the party authorizing vocational services. (T80). On cross examination Ms. Stafseth confirmed that at the end of each week, Vocamotive would complete a recap with Petitioner and that a summary of all job contacts were listed in each report. While it was correct that the job logs themselves were not attached to the reports, Vocamotive reviewed all job contacts, all cover letters submitted and had access to her e-mail account to make sure of the numbers maintained each week. (T80-82).

On cross-examination Ms. Stafseth disagreed that Vocamotive was "focused exclusively on jobs that were well under $20.00 per hour." Ms. Stafseth testified that the focus of the job search was to find Petitioner a job within all of her actual permanent work restrictions. (T83). Ms. Stafseth testified that the only offer of fulltime employment that Petitioner received during her actual job search efforts was that of medical receptionist at $15.97 an hour. (T84). No other offers of employment were made for jobs that fell within Petitioner's permanent work restrictions. (T 84). Ms. Stafseth testified on cross examination that during job searching efforts they were not able to locate a position for Petitioner as a triage nurse or any other nursing position that fell within her permanent work restrictions. (T85-86). Ms. Stafseth testified that the majority of nursing positions fall within the light level physical demand which requires lifting of 20 pounds or more.

Those included case management positions. Furthermore, case management positions may require a credential (not held by Petitioner) as a case manager and those positions also involve travel. (T 86-87).

Ms. Stafseth was asked on cross examination about the position of school nurse. Ms. Stafseth testified that school nurse is considered to be at a light level of physical demand according to the Dictionary of Occupational Titles and therefore *outside* of Petitioner's permanent restrictions. (T87). Regarding the position of field nurse case manager, Ms. Stafseth testified that field nurse case managers drive as an essential function of their regular job. (T102). Ms. Stafseth testified that Ms. Williams did not qualify for the position of field nurse case manager because of the doctor-imposed limitation regarding how far she could drive. (T102-103). Regarding the position of telephonic nurse case manager Stafseth testified that not only were credentials required, but that the greatest number of positions were available within a more metropolitan area versus a rural area and for a job to have a stable labor market there would have to be a sufficient number of jobs in the area where the job searching is to be conducted- it can't just be one position out there for the individual. There has to be several jobs just in case the one that they get is no longer available to them. (T88-89, 103).

Regarding Petitioner's job search, Vocamotive did not target only jobs that paid less than $20.00 an hour. Instead, Vocamotive targeted any jobs that fell within her background looking at medical-related experience and looking at her permanent work restrictions. (T89). Ms. Stafseth testified that Vocamotive has not had as much success placing people back into jobs from February 2020 until the present time because of the COVID-19 pandemic. (T94-95).

TESTIMONY OF SHARON BABAT C.R.C.

Sharon Babat testified in Respondent's case in chief as a vocational consultant employed by CompAlliance Managed Care. (T113). Ms. Babat is a certified rehabilitation counselor who has been involved in job placement and labor market survey evaluations in Illinois working mostly for Respondents. (T114-115). Ms. Babat was retained by the Respondent and authored four reports concerning Petitioner. (T116). Ms. Babat's initial report dated December 9, 2019 included a review of information from Vocamotive including the initial vocational assessment as well as several progress reports and a rehabilitation plan. (T117). After review of that information, Ms. Babat opined in her initial report that Vocamotive underestimated Petitioner's wage potential considering her skillset, her education as a nurse and her opinion that Petitioner should be able to qualify for alternative jobs using her nursing skills. (T118). Ms. Babat testified that Petitioner's earning skills were at least what she was earning at the time of the original injury – $27.00 an hour. (T118-119). On direct examination, Ms. Babat criticized the rehabilitation plan put in place by Vocamotive urging that Petitioner required no additional keyboarding training and that more focus should have been placed on developing an updated resume at the commencement of services with an earlier start time to actual job searching. (T119-121). Ms. Babat testified that at her company she expects an employee searching for alternative light duty work to make between 25 to 35 contacts per week. (T123).

On direct exam Ms. Babat acknowledged that the Petitioner had a 15-mile driving maximum permanent work restriction placed by her primary care physician, Dr. Dornilla-Hughes. Although Ms. Babat testified on direct exam that she would defer to a doctor with regards to work restrictions placed on the Petitioner, she testified the driving restriction "did not appear to me to

be a physician-imposed restriction". (T124-125). Ms. Babat acknowledged that the 15-mile driving restriction would make finding a light duty job for the Petitioner absolutely harder. (T 126-127). Ms. Babat performed an aptitude profile as well as a transferable skills analysis regarding the Petitioner. (T128-129. Ms. Babat completed a report dated February 4, 2020 concluding Petitioner could work as a nurse within her permanent restrictions and recommended that a labor market survey be completed to actually find specific positions for which she could employed. (T130). Ms. Babat completed a labor market survey dated February 12, 2020 and identified ten jobs whose salary ranges were enumerated within the body of that report. (T131).

Ms. Babat completed a fourth report dated July 2, 2020 which was an update on her labor market survey using the same titles and DOT codes that she had used previously and re-contacting employers that were listing current openings at the time the report was completed. (T135). Ms. Babat acknowledged that some of the jobs identified require a renewal of Petitioner's RN license. (T136). Ms. Babat testified Petitioner would need to fill out paperwork and complete another 20 hours of continuing nursing education to be eligible for these nursing jobs. (T136-137).

On cross examination, Ms. Babat testified that she was retained by the Respondent approximately at the time of her first report dated December 9, 2019. Ms. Babat admitted that after she was retained she had no in person or e-mail communications whatsoever with Petitioner. (T141-142). Ms. Babat acknowledged that she did not oversee or supervise any of the Petitioner's actual job activities from October 15, 2019 through February 3, 2020. Ms. Babat testified in her experience that a typical job search for an injured worker with permanent restrictions whose employer was not willing to accommodate permanent light duty could range from anywhere between two weeks up to one year. (T142-143). Ms. Babat had no criticism of the timeframe it took Vocamotive to identify a bona fide light duty job for the Petitioner. (T143). Ms. Babat

testified in her professional opinion she did not see that COVID-19 would have a negative impact on how long it would take for an injured worker with permanent restrictions to find alternative light duty employment. (T143).

On cross examination. Ms. Babat admitted that she did not fully account for Petitioner's 15 mile driving restrictions when she offered her opinions concerning the Petitioner. (T144). Ms. Babat was unfamiliar with how much lifting and the amounts involved in Petitioner's regular job for Health South. When asked if Petitioner's permanent restrictions were preclusive of her work at Health South as a general floor nurse, Ms. Babat acknowledged that fact to be correct. (T145). Ms. Babat agreed that Petitioner could only perform a nursing job that fit within her permanent restrictions which was 5 pounds frequently and 10 pounds occasionally. (T145).

On cross examination Ms. Babat testified that one of the jobs she identified that could be performed by the Petitioner within her permanent restrictions was that of medical receptionist. (T145-146). Ms. Babat acknowledged that the medical receptionist position (DOT Code 237367038) was a sedentary position that would fit within the 5-pound frequent 10-pound occasional lifting parameters for the Petitioner. (T146). Ms. Babat acknowledged that the full-time job that was offered to Petitioner to begin on February 3, 2020 by Swedish American Hospital was a position as a medical receptionist. (T146-147). When asked about her February 12, 2020 labor market survey, Ms. Babat acknowledged that she listed several jobs and their respective pay ranges which could be performed by the Petitioner considering her permanent work restrictions. (T147). This list included Healthcare Administrator Coordinator ($15.00 to $17.00 per hour), Health Unit Coordinator ($15 to $16.00 per hour), Medical Receptionist ($18.75) and Patient Registration Coordinator ($14.00 to $18.00 per hour). (T147-150). Ms. Babat acknowledged on cross examination that the position of medical receptionist within the Pulmonary Department at

Swedish American Hospital paying $15.97 per hour was only slightly less than the wages she projected for the same position. (T150-151). Regarding medical receptionist, Ms. Babat identified Brookside Specialty Clinic in her labor market survey from February 2020. Although she was not able to identify a specific wage for that job posting, she did find that Swedish American Hospital listed ranges of salary for medical receptionist up to $19.25 per hour. (T151). Ms. Babat further acknowledged that Position No. 6 on her Labor Market Survey – Belvidere Clinic Patient Care Receptionist also listed a salary at $18.75 per hour. (T151).

With regards to the position of nurse case manager, Ms. Babat admitted that nurse case managers spend a great deal of time driving to and from doctors' appointments that they are attending for injured workers. Caseloads could be up to 20 patients which would require multiple drives in the car to and from a physician's office for the injured workers. (T152).

Regarding nursing pay, Ms. Babat agreed that nurses who hold a BSN make more per hour than a nurse who holds a 2 year nursing degree. (T153). Ms. Babat further agreed that nursing salaries tend to go up as their experience increases and so a nurse with 10 years of experience might make more than a nurse with 5 years of experience. (T154). When asked what information should be reviewed in order to determine the median salary for a nurse in the Rockford area with Petitioner's experience, Ms. Babat agreed that the Occupational Employment Statistics published by the United States Department of Labor would be reasonable. Other sources including Indeed.com would be reasonable to consider. Ms. Babat further agreed that a current job posting from the Respondent as to what they paid a BSN would be reliable information in order to determine what Petitioner could make as a registered nurse/BSN in Rockford as of the time of the hearing. (T154-156). Ms. Babat admitted that she would have no reason to question occupational

employment statistics published by the US Department of Labor that a nurse average salary in the Rockford Illinois area at this time is $35.60. (T155).

TESTIMONY OF KEVIN KNOP

Kevin Knop also testified in Respondent's Case in Chief. Mr. Knop is a licensed private investigator who works for Delta Group. (T158). Mr. Knop performed surveillance at the request of the Respondent via remote intermittent surveillance using an unmanned camera set up on public property hidden in a construction cone and focused toward the Petitioner. (T159). Mr. Knop testified that surveillance was done of the Petitioner on September 26, 2019 as well as between March 2, 2020 through March 5, 2020. (T159-161). Under oath Mr. Knop verified that the subject of the surveillance videos was present in the courtroom and pointed directly to Petitioner. (T161-162).

The Arbitrator then proceeded to observe both videos in open court on Day 2 of the hearing in the presence of all parties.

TESTIMONY OF PETITIONER JENNIFER WILLIAMS – REBUTTAL

Petitioner was recalled in rebuttal by her counsel. Petitioner acknowledged that she had the opportunity to watch both surveillance videos in open court. (T167). Petitioner testified that both videos were obtained just outside of her apartment. (T168). Regarding the surveillance obtained on September 26, 2019 Petitioner testified that her two brothers, Justin and Josh, as well as her father were removing some furniture and other home belongings from Petitioner's apartment on that date which she no longer needed. (T168). Regarding the surveillance obtained covering the four days in early March of 2020 Petitioner testified that the object that she was seen carrying

and placing into her car was a small wall hanging (wall décor) that she had purchased from a local store but elected to return after bringing it home for viewing. Petitioner testified the wall hanging weighed less than 5 pounds. (T168-169)

CONCLUSIONS OF LAW

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

On the parties' stipulation sheet Respondent disputes causation (commencing with the day after the 19(b) proceeding). ArbEx1. Petitioner testified that there is no change in her symptomology regarding her neck and her bilateral shoulders since the parties' 19(b) hearing. Petitioner continues to suffer from severe neck and bilateral shoulder pain with radiation due to her work injury. Other than home remedies, Petitioner has had no additional medical treatment and she appears to have reached MMI for her injuries which includes permanent limitations regarding her ability to lift and to drive a vehicle. Although Respondent disputes causal connection to her current condition of ill being, Respondent offered no medical evidence in support of their denial of medical causation.

The only evidence to be considered in support of Respondent's dispute regarding causation is the surveillance videos contained at RX 8 and RX 9. The Arbitrator carefully reviewed the surveillance footage from September 26, 2019 and from March 2, 2020 through March 5, 2020. *There are no activities where Petitioner is seen performing any activity outside of her permanent work restrictions.* The only objects Petitioner is observed lifting other than a broom is a wall hanging which weighed less than 5 pounds. There is absolutely nothing on Respondent's

surveillance footage which suggests that Petitioner has the capacity to return to full time work as a floor nurse for the Respondent or any other employer. Nothing in the surveillance footage demonstrates petitioner's current lifting abilities exceed the 10-pound occasional 5-pound frequent limit previously set by Dr. Milos.

Based on the above, the Arbitrator finds that Petitioner's current condition of ill being regarding her neck and bilateral shoulders remains causally related to her date of injury of September 29, 2015.

K. What temporary benefits are in dispute? – Maintenance Benefits.

Respondent disputes their liability to pay maintenance benefits to Petitioner commencing with the day after the parties' previous 19(b) proceeding. ArbEx1. At the time of the parties' 19(b) Decision, Respondent was ordered to authorize vocational rehabilitation services and to pay maintenance benefits once those services began. Respondent then notified Petitioner and her counsel on October 7, 2019 that the Respondent was authorizing vocational rehabilitation through Vocamotive and maintenance effective on the start date. PX3. Respondent then commenced payment of maintenance benefits for the week of October 15, 2019 through October 21, 2019 upon confirmation that Petitioner attended her first in person vocational rehabilitation meeting with Vocamotive. PX2 & PX21. Petitioner then participated in formal vocational rehabilitation services through Vocamotive between October 15, 2019 until she was offered a position as a medical receptionist in the pulmonary department at Swedish American Hospital on January 17, 2020 at the hourly rate of pay of $15.97 per hour. See PX5, PX6, PX7, PX8, PX9, PX10, PX. 11, PX12, PX13, PX14 and PX15.

The Arbitrator finds that there is no evidence that Petitioner failed to fully cooperate with vocational rehabilitation. The Arbitrator specifically finds Petitioner cooperated with all aspects of vocational rehabilitation from the commencement of those services until she was extended an offer of employment in a fulltime position as a medical receptionist through Swedish American Hospital on January 17, 2020. Multiple reports from Vocamotive confirm that Petitioner consistently met her weekly requirement of 30-40 contacts per week. PX9, PX12, PX17, PX18. According to Ms. Stafseth, there was only one week (December 11, 2019 to December 19, 2019) where Petitioner failed to reach at least 30 contacts during vocational services. That week in particular she made 21 contacts. Respondent's own CRC (Sharon Babat) testified that her practice was 25 to 35 contacts per week. Considering that Petitioner fully cooperated with all aspects of vocational rehabilitation and further noting the short duration of time between when actual job searching began in early December 2019 and the offer of employment some six weeks later, the Arbitrator finds Petitioner is entitled to an award of maintenance benefits. The Arbitrator further rejects the Respondent's argument that computer training and keyboarding training completed by Petitioner before actual job searching began was unnecessary to her vocational rehabilitation plan. The Arbitrator finds that those services were necessary and that completion of those additional services likely contributed to the swiftness in which Petitioner identified a job within her actual permanent light duty restrictions. Therefore, the Arbitrator awards maintenance benefits from February 27, 2019 through the week ending January 21, 2020 at the rate of $695.22 per week. Respondent is entitled to a credit for all maintenance benefits previously paid to Petitioner during that same time period.

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

Petitioner claims an entitlement to an award of benefits pursuant to 8(d)(1) of the Act. Respondent disputes Petitioner is entitled to an 8(d)(1) award but instead alleges an award pursuant to 8(d)(2) of the Act. Alternatively, Respondent urges if the Petitioner is entitled to an 8(d)(1) award there is virtually no monetary difference between what the Petitioner was making at the time of her original injury and what she could earn at the time of the parties' hearing on all issues in some form of suitable alternative light duty employment. For the reasons set forth below, the Arbitrator finds that Petitioner sustained her burden of proving an entitlement to an 8(d)(1) award under the Act. The Arbitrator finds the Petitioner is entitled to an 8(d)(1) award as follows: $35.00 per hour less $15.97 per hour = $19.03 per hour. $19.03 X 40.00 hours = $761.20. $761.20 X .6666 equals $507.42 per week from January 18, 2020 through the date of this Decision and continuing until age 67 subject to review as set forth in the terms of the Act. Respondent is entitled to a credit for all 8(d)(1) benefits previously paid to Petitioner during that same time period. See PX21.

First there is no question that Petitioner has lost access to her usual and customary line of employment as a registered nurse due to the work injury. This finding is supported by the initial vocational assessment completed by Vocamotive dated November18, 2016. Respondent's witness C.R.C. Sharon Babat also acknowledged during her testimony that Petitioner's permanent lifting restriction of 10 pounds occasionally, 5 pounds frequently prohibited her from performing the demands of her regular job as a nurse for the Respondent.

Petitioner commenced formal vocational rehabilitation *services that were authorized by the Respondent through Vocamotive commencing on October 15, 2019.* Respondent was not required to authorize vocational rehabilitation services through Vocamotive simply because

Vocamotive performed an initial vocational evaluation at the request of Petitioner's counsel. Instead, Respondent has the right to select the vocational vender to prepare a vocational rehabilitation plan following the parties' 19(b) proceeding. See Broner v. Saks 5th Avenue, 28 ILWCLB 85(Ill. W.C. Comm. 2020). It was Respondent who authorized vocational services through Vocamotive as per PX3. The Arbitrator finds that Petitioner fully cooperated throughout all of vocational rehabilitation services rendered by Vocamotive including computer training, typing skills, resume building, interview skills workshops, and formal job placement which began in early December of 2019. With Petitioner's full cooperation, a bona fide light-duty job as a medical receptionist within the Pulmonary Department at Swedish American Hospital was offered to Petitioner on January 17, 2020. Although the job posting contemplated an hourly rate of $11.81, Petitioner was offered $15.97 per hour by Swedish American Hospital, factoring in her previous experience as a Registered Nurse. (T25). There is no dispute between the parties that the position of medical receptionist fell within Petitioner's *permanent lifting restrictions as well as her driving restriction.* There is also no dispute between the parties that the duration of time that elapsed between when Petitioner began her job search and when the offer of employment as a receptionist was extended to the Petitioner was a very reasonable amount of time in which to identify a bona fide offer of light-duty employment.

Respondent claims it did not learn for several months that Petitioner elected not to report for the job of Pulmonary Clinic Receptionist which was to begin on February 3, 2020. Respondent insists that upon learning that the Petitioner did not report for work at the job that was offered to her within her permanent work restrictions that Respondent is entitled to re-commence vocational efforts. The Arbitrator is not persuaded by Respondent's argument. Contrary to Respondent's belated argument, the focus is not on whether Petitioner actually performed the job

as a receptionist as of February 3, 2020, but rather the appropriate question that is required to be answered under the Act is whether the job offered to Petitioner was full time and within all of her permanent work restrictions? If the answer to these questions is yes, then the Arbitrator must next examine whether the criteria for National Tea was met in light of the bona fide offer of employment, namely whether this was a *reasonable job offer within Petitioner's permanent physical restrictions and vocational capabilities.* After considering all of the evidence, the Arbitrator finds that the position of medical receptionist within the Pulmonary Department at Swedish American Hospital was a reasonable job offer within Petitioner's permanent work restrictions and vocational capabilities. Vocamotive's initial assessment of the Petitioner listed medical receptionist as a position that petitioner could perform within her then skillset with jobs that paid within the range of $13.00 to $16.00 an hour. Respondent's second choice of a Certified Rehabilitation Counselor, Sharon Babat, authored multiple reports where she identified medical receptionist and other similar positions that fell within Petitioner's permanent restrictions and identified a pay range commensurate with the actual offer of employment received by the Petitioner at $15.97 per hour. See also PX11 where the results of vocational testing completed by the Eval Center lists among other positions that Petitioner could perform as medical secretary on Page 9, DOT Code 201.362-014.

Neither the Arbitrator nor the Commission can compel any injured worker to actually perform a bona fide light duty job that falls within his or her restrictions upon completion of a job search that culminates in a bona fide light duty offer of employment. Certainly if an injured worker declines to perform such a job after it has been offered the injured worker is waiving their entitlement to recoup those wages associated with the bona fide light duty job that typically would pay less per hour than the job that was performed by the injured worker at the time of the injury.

Neither Petitioner nor her counsel were required to notify the Respondent that the Petitioner elected not to report for the position of Pulmonary Receptionist. Instead under the Act, the Petitioner and her counsel were required to inform the Respondent of the fact a bona fide offer of light-duty employment was made, when the offer made and the wage that was offered. Petitioner satisfied this obligation as confirmed in an e-mail dated January 20, 2020 to defense counsel. See PX14. Vocamotive further notified the Respondent in their own separate e-mail dated January 20, 2020 of the offer of employment and its terms. PX15. It is undisputed that Respondent directed Vocamotive to close their file and cease all job searching following receipt of this information.

Although Respondent now urges a finding that Petitioner is capable of making substantially more than $15.97 per hour within her current skill set, this was not the position taken by the Respondent at the time that a bona fide offer of light-duty employment was extended to the Petitioner in mid-January of 2020. Respondent sought confirmation that job search activities had begun in an e-mail sent to Petitioner's counsel on November 20, 2019. PX7. Respondent threatened to discontinue TTD benefits in a separate e-mail directed to Petitioner's counsel absent evidence of "daily communication and follow ups on all job leads" on January 16, 2020. PX13. Clearly the evidence suggests an urgency directed towards Petitioner by Respondent that she identify a job within her permanent work restrictions *and that she do so quickly*. When Respondent was notified by Petitioner's counsel of the fact of a bona fide light duty job offer on January 17, 2020 Respondent did not instruct Petitioner to continue job searching. Respondent never directed Vocamotive to continue a job search on Petitioner's behalf on the grounds that the offer of employment was unreasonable and therefore should not be accepted by the Petitioner. Instead there was undisputed evidence that Vocamotive was directed immediately by the Respondent to

cease all job search activities. No further job searching was done by Petitioner and this was at the direction of the Respondent.

Respondent now contends at the parties' hearing on all issues that Petitioner's skill set permits her to earn much closer to $27.00 per hour than the job that was found for her by Vocamotive. Respondent retained a *different* CRC other than the one it initially directed to do job searching in order to make this claim. Nothing prevented Respondent from insisting that Petitioner continue job searching after January 17, 2020. Respondent's failure to do so at that time was precisely because the medical receptionist position fell within all of her permanent work restrictions and was within her skillset and considering her background as a nurse. There is nothing in the Act that requires the results of any injured worker's job search to be perfect. Instead, the Act only requires that Claimant cooperate with rehabilitation services and that the injured worker be presented with a *reasonable job opportunity*. If this were not the case, an injured worker could insist on continuation of a job search (where Respondent is paying ongoing TTD benefits and vocational rehabilitation services) without any end in sight, always with the ability to urge the Arbitrator to accept his or her argument that another potential bona fide light duty job that pays more than the one previously identified may be out there.

The Arbitrator notes that Petitioner is required to prove all elements of her claim. This includes proof of both her diminished earning capacity as well as evidence of what the Petitioner could earn in her usual and customary line of employment as a nurse at the time of the parties' hearing. The Arbitrator finds that the results of the Petitioner's actual job search determine what her wage would be in suitable alternative employment within her permanent work restrictions – namely, $15.97 per hour. Petitioner also offered additional evidence at the time of the hearing through testimony by C.R.C. Kari Stafseth that the Petitioner would be able to earn at least $35.00

per hour in the performance of her usual and customary job as a nurse considering her experience and education. See Vocamotive Report dated June 12, 2020 contained at Petitioner Exhibit 20. In addition to the sources cited by Ms. Stafseth, (which confirm Petitioner's evidence is not speculative) is an actual job posting by the Respondent advertising that Respondent was seeking *registered nurses and paying $35.00 per hour*. See PX16.

The Arbitrator finds Ms. Stafseth's opinions as well as Respondent's own job posting conclusive evidence that Petitioner could be earning $35.00 per hour in the performance of her regular job as a nurse at the time of the hearing but for her work injury. On cross examination, Sharon Babat agreed that the sources of information relied upon by Ms. Stafseth as well as the Respondent's own job posting were all reasonable sources of information in order to confirm what a registered nurse with Petitioner's experience would be making in the Rockford area at the time of the hearing. According to occupational employment statistics published by the United States Department of Labor – Bureau of Labor Statistics, the average wage for a registered nurse in the Rockford area was $31.03 per hour. Additionally, those at the 75th percentile earned $35.60 per hour and those at the 90th percentile earned $39.67 per hour. With Petitioner's experience as a registered nurse for more than 8 years, her salary would fall in the range of $35.60. See PX20.

The Arbitrator is not persuaded by Respondent's argument that Petitioner could find alternative suitable employment within all of her permanent restrictions at a salary close to what she was making as a nurse at the time of her injury. Vocamotive was asked to review the labor market survey completed by CompAlliance Managed Care dated February 12, 2020. In the Vocamotive report dated March 12, 2020, Vocamotive contacted all of the employers listed in Ms. Babat's first labor market survey to perform independent investigation. For instance, Ms. Stafseth attempted contact with Rochelle Community Hospital reporting an opening as a family health

receptionist with an offering salary of $29.00 to $34.00 per hour. Although she was unable to establish contact with this prospective employer, Ms. Stafseth questioned the reported pay rate, describing this as exceptionally high for a receptionist and further noting according to data published by the United States Bureau of Labor Statistics that the average salary for a receptionist in the Chicagoland area was $14.90 an hour. Furthermore Ms. Stafseth confirmed that this posting required the ability to lift up to 35 pounds which exceeded Petitioner's abilities.

For the position of patient care receptionist at Belvidere Clinic (with the reported salary of $18.75 per hour) Ms. Stafseth confirmed according to the posting that the ability to lift up to 50 pounds was required. Again, this far exceeds Petitioner's capabilities. Px19. The position of triage nurse with Heartland Hospital with a reported wage of $27.00 to $30.00 per hour was noted to be a work from home position. Vocamotive spoke with a recruiter with Heartland Hospital who advised *previous hospice experience was required for the position,* and that Petitioner did not report and did not have any hospice-related experience throughout participation in vocational rehabilitation services. Px19. It was further noted that a minimum of 6 months of institutional nursing experience within the past 3 years was required and that applicants needed to be licensed in all three states, Illinois, Wisconsin and Minnesota. Given these requirements, Petitioner would not be competitive for that position. Px19.

Vocamotive contacted hospice nurse case manager in Rockford and confirmed traveling was required which would be outside of Petitioner's 15-mile driving restriction. Px19. Vocamotive contacted Inclusa in Janesville, Wisconsin for a RN case manager position allegedly with the wage of $31.25 to $32.55 per hour. Vocamotive was notified that this position was no longer available at the time contact was made. Last, Vocamotive contacted Mercy Healthcare Systems in Rockford for a RN case navigator position reportedly paying $19.25 to $24.00 per

hour. Not only was that position no longer available, but it was also further noted to Vocamotive that lifting in that position required 25 pounds. Px19.

In summary, Vocamotive concluded the jobs identified by CRC Sharon Babat were not jobs that Petitioner would qualify for secondary to either her restrictions, experience and/or lack of appropriate credentials. Additionally, some of the positions identified were considered part time or less than full time. Positions such as field nurse case manager required travel which is outside of Petitioner's work restrictions. Respondent CRC Sharon Babat admitted that she did not fully consider Petitioner's permanent driving restriction when offering opinions regarding employability. Other positions such as telephone nurse case manager were not established to be more than an isolated posting and not clearly within all of Petitioner's restrictions. Sharon Babat admitted on cross examination that the majority of telephone nurse case manager positions would be found in larger metropolitan areas such as Chicago clearly outside of Petitioner's driving restrictions.

In conclusion, the Arbitrator rejects the Respondent's argument that Petitioner was capable of earning up to or near $27.00 per hour in alternative employment utilizing all of her nursing skills. The Arbitrator is substantially more persuaded by the actual results of job searching completed by a fully cooperative Petitioner whose results were signed off by the Respondent at the time a bona fide offer of employment within her permanent work restrictions was identified.

The Arbitrator does not find persuasive evidence that Petitioner could do substantially better than $15.97 per hour considering all the evidence presented at the time of the hearing. The Arbitrator is also aware of COVID-19 and its effects on the number of available positions in the economy and that Petitioner would be competing for those available positions within her skillset (and considering her permanent work restrictions) with a multitude of individuals who have no

work restrictions whatsoever. The Arbitrator does not find that a continuation of job searching activities would have resulted in a bona fide offer of light duty employment that was substantially greater than the outcome of Petitioner's actual job searching. To find otherwise would be speculative and not permitted under the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC004506
Case Name	REYNOLDS, TARA v. STATE OF ILLINOIS MURRAY DEVELOPMENTAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0380
Number of Pages of Decision	15
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	T. Fritz Levenhagen
Respondent Attorney	Kenton Owens

DATE FILED: 7/27/2021

/s/ Deborah Baker, 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

TARA REYNOLDS,

Petitioner,

vs. NO: 13 WC 04506

STATE OF ILLINOIS,
MURRAY DEVELOPMENTAL 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 causal connection of Petitioner's cervical spine condition of ill-being, entitlement to Temporary Total Disability benefits, entitlement to medical expenses, and entitlement to permanent partial disability 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. This case was consolidated for hearing with case numbers 13 WC 05578 and 18 WC 05337.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2020 is hereby affirmed and adopted.

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

July 27, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/22/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0380
NOTICE OF ARBITRATOR DECISION

REYNOLDS, TARA
Employee/Petitioner

Case# **13WC004506**

13WC005578
18WC005337

ST OF IL/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

On 2/4/2020, 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:

1459 LEVENHAGEN LAW FIRM PC
T FRITZ LEVENHAGEN
216 W POINT DR SUITE B
SWANSEA, IL 62226

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62704-9255

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN 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

FEB - 4 2020

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

Tara Reynolds
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center
Employer/Respondent

Case # 13 WC 04506

Consolidated cases: 13 WC 05578
18 WC 05337

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on December 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 _____

FINDINGS

On April 11, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $32,004.96; the average weekly wage was $615.48.

On the date of accident, Petitioner was 53 years of age, married with 0 dependent child(ren).

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

Based upon the Arbitrator's Conclusion of Law attached hereto, all benefits are awarded in case number 13 WC 05578 and 18 WC 05337.

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

January 31, 2020
Date

FEB 4 - 2020

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 13 WC 04506, the Application alleged Petitioner sustained a work-related accident on April 11, 2011. In case 13 WC 05578, the Application alleged Petitioner sustained a work-related accident on July 26, 2012. In case 18 WC 05337, the Application alleged Petitioner sustained a work-related accident on October 3, 2017. The three Applications all alleged that "Petitioner was injured during the course and scope of employment" and sustained "Multiple injuries" (Arbitrator's Exhibits 4, 5 and 6). In the three cases, Petitioner and Respondent stipulated Petitioner sustained work-related accidents, but Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibits 1, 2 and 3).

Petitioner worked for Respondent as a mental health technician. Petitioner testified her job duties required her to assist patients, many of whom had mental disabilities. The three accidents all occurred when Petitioner was attempting to assist a patient who assaulted her.

On April 11, 2011, Petitioner was in the process of assisting a patient who she had instructed to go to bed. The patient became combative and grabbed Petitioner by the hair which caused Petitioner to fall to the floor. The patient then started to hit and kicked Petitioner and also a bit Petitioner's left hand.

Following the accident, Petitioner was seen in the ER of St. Mary's Hospital. Petitioner was diagnosed with contusions to both knees, cervicalgia and a human bite (Petitioner's Exhibit 7).

On April 14, 2011, Petitioner was evaluated by Dr. Angela Freehill, an orthopedic surgeon. Dr. Freehill diagnosed Petitioner with bilateral knee contusions, a cervical spine strain and a low back sprain. Dr. Freehill prescribed medication and ordered physical therapy (Petitioner's Exhibit 9).

When Dr. Freehill saw Petitioner on June 2, 2011, Petitioner continued to complain of neck pain. Dr. Freehill ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on June 13, 2011. According to the radiologist, it was normal (Petitioner's Exhibit 8).

Dr. Freehill saw Petitioner on June 16, 2011, and reviewed the MRI. She continued to order physical therapy. When she saw Petitioner on August 18, 2011, Petitioner continued to have neck symptoms. Dr. Freehill referred Petitioner to Dr. Aiping Smith, a physiatrist, and one of Dr. Freehill's associates (Petitioner's Exhibit 9).

Dr. Smith evaluated Petitioner on September 7, 2011. At that time, Petitioner continued to complain of neck pain as well as numbness, tingling and weakness in both upper extremities. Dr. Smith diagnosed Petitioner with axial neck pain and noted the MRI was negative for degenerative disc disease. Dr. Smith changed Petitioner's medication and ordered additional

physical therapy. She also recommended Petitioner undergo medial branch blocks and possible rhizotomy (Petitioner's Exhibit 9).

From October 26, 2011, through April 16, 2012, Petitioner was treated by Dr. Smith. Dr. Smith performed a series of medial branch blocks, radiofrequency ablations and nerve blocks. When Dr. Smith saw Petitioner on April 16, 2012, she ordered additional physical therapy (Petitioner's Exhibit 9).

On July 26, 2012, Petitioner was assisting a coworker who was attempting to control a combative patient. The patient kicked Petitioner in the left side of her face and neck.

Following the accident Petitioner was seen in the ER of St. Mary's Hospital. A CT scan of the cervical spine was ordered which, according to the radiologist, was negative for fractures (Petitioner's Exhibit 8).

Petitioner was again seen by Dr. Smith on August 10, 2012. At that time, Petitioner advised her neck pain had improved following Dr. Smith's earlier treatment, but that she now had increased neck pain because of the accident of July 26, 2012. Dr. Smith opined Petitioner had sustained an exacerbation of the axial neck pain. She ordered physical therapy, but noted if Petitioner's symptoms persisted, a new MRI of the cervical spine and additional branch/nerve blocks and rhizotomies might be indicated. Dr. Smith subsequently ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on October 3, 2012. According to the radiologist, the MRI revealed a small disc bulge at C5-C6 and a small central disc protrusion at C6-C7 (Petitioner's Exhibit 9).

Dr. Smith saw Petitioner on October 12, 2012, and reviewed the MRI and opined that, when compared to the prior MRI of June, 2011, it revealed a new, but small central disc protrusion at C6-C7. Dr. Smith recommended Petitioner undergo a series of epidural steroid injections (Petitioner's Exhibit 9).

Dr. Smith administered epidural steroid injections at C6-C7 on October 24, November 7, and November 21, 2012. When Dr. Smith saw Petitioner on December 6, 2012, Petitioner advised the injections improved her pain symptoms, but only for about one week. Because Petitioner continued to complain of neck and bilateral trapezius pain, she referred Petitioner to Dr. Joon Ahn, an orthopedic surgeon, one of her associates (Petitioner's Exhibit 9).

Dr. Ahn evaluated Petitioner on January 14, 2013. Dr. Ahn opined the bilateral trapezius symptoms were coming from the neck area (Petitioner's Exhibit 9).

Dr. Smith administered medial branch blocks on January 23, and February 6, 2013. She recommended Petitioner undergo a facet rhizotomy, but Respondent declined to authorize same. Dr. Smith referred Petitioner to Dr. Don Kovalsky, an orthopedic surgeon, who is one of her associates (Petitioner's Exhibit 9).

Dr. Kovalsky evaluated Petitioner on July 25, 2013, and reviewed the MRI of October 12, 2012. He opined the MRI revealed a small central disc herniation at C6-C7. He diagnosed Petitioner with chronic neck pain and bilateral radicular arm pain. Based on the MRI, Dr. Kovalsky opined Petitioner was a candidate for a cervical discectomy and fusion at C6-C7, but wanted to obtain a new MRI (Petitioner's Exhibit 9).

The MRI was performed on September 20, 2013. According to the radiologist, the MRI revealed a very small central disc herniation at C6-C7 touching the anterior aspect of the spinal cord (Petitioner's Exhibit 9).

Dr. Kovalsky saw Petitioner on September 20, 2013, and reviewed the MRI scan that had just been performed. He opined it revealed disc dehydration of the discs at C4-C5, C5-C6 and C6-C7 as well as very slight bulging at C6-C7. He also opined it did not reveal any disc herniations and Petitioner may have had some element of thoracic outlet syndrome. He noted Petitioner was "large breasted" and recommended additional physical therapy (Petitioner's Exhibit 9).

On August 7, 2013, Petitioner was seen by Dr. James Schutzenhofer, her family physician. He diagnosed Petitioner with chronic neck pain and referred her to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 11).

Dr. Gornet evaluated Petitioner on June 23, 2014. At that time, Dr. Gornet reviewed the MRIs of June 13, 2011, and October 3, 2012. He opined they both revealed disc herniations at C6-C7. Petitioner complained of neck and bilateral trapezius pain. Dr. Gornet opined Petitioner's current symptoms were related to the work injuries of April, 2011, and July, 2012. He ordered a new MRI scan (Petitioner's Exhibit 5; Deposition Exhibit 3).

MRI scans of both the cervical and lumbar spine were performed on September 4, 2014. According to the radiologist, the MRI of the cervical spine revealed central broad-based herniations at C5-C6 and C6-C7. According to the radiologist, the MRI of the lumbar spine revealed disc bulging at L2-L3 and L4-L5 (Petitioner's Exhibit 3; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 4, 2014, and reviewed the MRIs. His interpretation of the MRIs was consistent with that of the radiologist. Dr. Gornet recommended Petitioner undergo epidural steroid injections in both the cervical and lumbar spine, but if she did not improve, he would proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell, a pain management physician. Dr. Boutwell saw Petitioner on September 24, 2014, and October 15, 2014, and administered epidural steroid injections at C6-C7 and L4-L5, respectively (Petitioner's Exhibit 5; Deposition Exhibit 3).

When Dr. Gornet saw Petitioner on November 3, 2014, Petitioner advised the injections only provided temporary relief. He opined Petitioner should proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on January 7, 2015. In connection with his examination of Petitioner, Dr. Petkovich reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Petkovich's findings on examination were normal and the MRIs revealed some mild degenerative changes in the cervical spine at C5-C6 and C6-C7. He opined Petitioner sustained a cervical strain and had degenerative changes at C5-C6 and C6-C7 which were not aggravated or accelerated by the two work-related accidents. He opined Petitioner was at MMI and no further medical treatment was indicated (Respondent's Exhibit 5).

Dr. Gornet saw Petitioner on May 28, 2015, and reviewed Dr. Petkovich's report. He noted that Dr. Petkovich opinion that the disc degeneration was not related to the accidents ignored the fact that the MRI studies revealed a disc injury. He also noted Dr. Petkovich did not have an explanation as to why Petitioner was asymptomatic prior to the first accident of April 12, 2011. Dr. Gornet renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on August 20, 2015. Again, he renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7. He ordered a new MRI scan. Further, because of Petitioner's continued shoulder complaints, he referred her to Dr. George Paletta, an orthopedic surgeon, who was one of his associates (Petitioner's Exhibit 5; Deposition Exhibit 3).

The MRI was performed on September 14, 2015. According to the radiologist, the herniations at C5-C6 and C6-C7 were stable when compared to the prior MRI (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 14, 2015, and reviewed the MRI. He indicated he was going to proceed with the disc replacement surgery and Petitioner was being seen by Dr. Paletta for her shoulder symptoms (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Paletta saw Petitioner on September 14, 2015, primarily for right shoulder symptoms. Dr. Paletta opined Petitioner had right shoulder pain, likely referred from the cervical region. He ordered an MRI arthrogram of Petitioner's right shoulder (Petitioner's Exhibit 12).

The MRI arthrogram of Petitioner's right shoulder was performed on September 17, 2015. According to the radiologist, the MRI arthrogram revealed some old post operative changes, but was otherwise normal (Petitioner's Exhibit 12).

Dr. Paletta reviewed the MRI arthrogram and subsequently saw Petitioner on November 16, 2015. His interpretation of the MRI arthrogram was consistent with the radiologist. However, he did administer a steroid injection into the right subacromial space (Petitioner's Exhibit 12).

On September 29, 2015, Dr. Gornet performed disc replacement surgery at C6-C7. In his surgical report, Dr. Gornet noted there was a large central disc herniation to the right which was easily removed (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner following surgery and, on January 18, 2016, noted she was doing well, although she still had some right shoulder symptoms. Dr. Gornet authorized Petitioner to return to work without restrictions effective January 31, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet again saw Petitioner on March 28, and September 29, 2016. Petitioner had returned to work at full duty and was doing well, but still had some right shoulder symptoms. Dr. Gornet opined Petitioner was at MMI as of September 29, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on September 28, 2017. Petitioner was doing well, but had some aches and pains which Dr. Gornet opined were age related (Petitioner's Exhibit 6).

On October 3, 2017, Petitioner took one of the patients to the hospital for an EEG. The patient became combative while lying on the examination table and kicked Petitioner in her right wrist, left abdomen and left upper arm. The patient also bit Petitioner's right hand.

Following the accident Petitioner was seen at SSM Medical Group/Express Clinic. Petitioner was given some medication and discharged (Petitioner's Exhibit 13).

Petitioner saw Dr. Schutzenhofer on October 30, 2017. At that time, Petitioner complained of neck pain. He again referred Petitioner to Dr. Gornet (Petitioner's Exhibit 11).

Dr. Gornet saw Petitioner on December 7, 2017. At that time, Petitioner informed Dr. Gornet of the most recent accident of October 3, 2017. Petitioner complained of pain referable to her neck, shoulder blades, right trapezius and right arm/hand. Dr. Gornet prescribed medication and ordered an MRI scan (Petitioner's Exhibit 6).

The MRI was performed on January 18, 2018. According to the radiologist, it revealed post operative changes at C6-C7, but was otherwise unremarkable (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on January 18, 2018, and reviewed the MRI. He opined the MRI may have indicated a subtle disc issue at C5-C6. He prescribed medication and ordered physical therapy (Petitioner's Exhibit 6).

Dr. Gornet subsequently saw Petitioner on March 22, 2018. At that time, Petitioner continued to complain of pain in the neck, right trapezius, shoulder and arm. He ordered an MRI arthrogram of Petitioner's right shoulder and recommended Petitioner undergo EMG/nerve conduction studies. He opined Petitioner's current symptoms were related to the most recent accident (Petitioner's Exhibit 6).

The MRI arthrogram was performed on July 31, 2018. According to the radiologist, there was tendinopathy, but no tears (Petitioner's Exhibit 6).

On September 24, 2018, Petitioner was evaluated by Dr. Daniel Phillips, a neurologist, who performed EMG/nerve conduction studies of Petitioner's right upper extremity. The studies were within the range of normal (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on September 24, 2018, and reviewed the diagnostic studies. Although Petitioner continued to complain of neck and right upper extremity symptoms, Dr. Gornet did not recommend any further surgery. He opined Petitioner probably aggravated an underlying condition, but she could continue to work full duty (Petitioner's Exhibit 6).

Dr. Petkovich was deposed on August 10, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, he testified Petitioner had sustained a cervical strain, was at MMI and disc replacement surgery was not indicated (Respondent's Exhibit 4; pp 22, 28, 37).

Dr. Gornet was deposed on March 29, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony regarding the medical treatment he provided to Petitioner up to that time was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, he related Petitioner's cervical spine disc injury to the accidents of April, 2011, and July, 2012. He testified Petitioner had an excellent surgical result with a significant improvement in her pain symptoms, although she still had some residual shoulder issues (Petitioner's Exhibit 5; pp 10-12).

At trial, Petitioner testified that prior to the disc replacement surgery she experienced constant pain in her neck. Although she continued to work, she regularly sought assistance from other employees. Petitioner stated that following surgery, Dr. Gornet authorized her to be off work from September 28, 2015, through January 30, 2016. Petitioner stated that her symptoms of neck pain had, to a large extent, resolved; but she still experiences some minor pain associated with weather changes and her neck hurts when she has to drive long distances.

Petitioner testified that it was her understanding Dr. Kovalsky did not want to proceed with surgery because she had large breasts. Petitioner testified this did not make any sense because she does not have large breasts and she wears a size "B" cup bra. Petitioner stated she ceased working on November 7, 2019, because of other health issues. Petitioner stated she has been diagnosed with Parkinson's disease.

Conclusion of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of April 11, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an injury to her neck/cervical spine as a result of the accident of April 11, 2011.

Following the accident of April 11, 2011, Petitioner received a significant amount of conservative treatment including medication, physical therapy, medial branch/nerve blocks and radiofrequency ablations.

It was subsequent to the accident of July 26, 2012, that Petitioner was treated by Dr. Gornet who performed disc replacement surgery at C6-C7. Dr. Gornet opined Petitioner's cervical spine condition was related to the accidents of April 11, 2011, and July 26, 2012.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law because these issues are addressed in case 13 WC 05578.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC005578
Case Name	REYNOLDS, TARA v. STATE OF ILLINOIS MURRAY DEVELOPMENTAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0381
Number of Pages of Decision	16
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	T. Fritz Levenhagen
Respondent Attorney	Kenton Owens

DATE FILED: 7/27/2021

/s/ Deborah Baker, 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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TARA REYNOLDS,

Petitioner,

vs. NO: 13 WC 05578

STATE OF ILLINOIS,
MURRAY DEVELOPMENTAL 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 causal connection of Petitioner's cervical spine condition of ill-being, entitlement to Temporary Total Disability benefits, entitlement to medical expenses, and entitlement to permanent partial disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 13 WC 04506 and 18 WC 05337.

Petitioner filed three Applications for Adjustment of Claim alleging injuries while in Respondent's employ: 13 WC 04506 – acute trauma on April 11, 2011; 13 WC 05578 – acute trauma on July 26, 2012; and 18 WC 05337 – acute trauma on October 3, 2017. The matters were consolidated for hearing at which time all three accidents were undisputed. The Arbitrator thereafter issued three separate decisions but ultimately assigned the totality of Petitioner's permanent disability to her July 26, 2012 accident. While the Commission agrees with the Arbitrator's §8.1b analysis as well as the resulting total percentage loss of use awarded, the Commission finds Petitioner's permanent disability is properly assigned to both her July 26, 2012 (13 WC 05578) and October 3, 2017 (18 WC 05337) work injuries.

The Commission notes apportioning permanent disability among claims is permissible in limited circumstances. Where a claimant has sustained "separate and distinct injuries to the same body part and the claims are consolidated for hearing and decision," the Commission is to consider all the evidence presented to determine the nature and extent of the claimant's permanent disability as of the date of the hearing unless there is some evidence presented at the consolidated hearing that would permit the Commission to delineate and apportion the nature and extent of permanency attributable to each accident. *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 265, 947 N.E.2d 863, 869 (2011). We find this to be such an instance.

Following Petitioner's undisputed April 11, 2011 injury, she commenced an extensive course of conservative cervical spine treatment which included physical therapy as well as interventional pain management in the form of medial branch blocks, radiofrequency ablations, and nerve blocks. Pet.'s Ex. 9. In April 2012, Dr. Smith ordered physical therapy with the caveat that further pain management interventions would be considered pending a neurology clearance for an unrelated condition and completion of therapy. Pet.'s Ex. 9. On May 7, 2012, Dr. Smith reiterated her order for additional physical therapy. Pet.'s Ex. 10.

On July 26, 2012, prior to commencement of the physical therapy prescribed by Dr. Smith, Petitioner sustained a second undisputed work accident and further injured her cervical spine. At that time, there had been no medical opinion of maximum medical improvement relative to the 2011 injury before Petitioner sustained the second injury to her cervical spine. The July 26, 2012 accident ultimately resulted in surgery: Dr. Gornet performed an anterior cervical discectomy and disc replacement at C6-7 on September 29, 2015. Pet.'s Ex. 5, Dep. Ex. 3. Post-operatively, Petitioner attended routine follow-up appointments with Dr. Gornet. She was released to resume full duty work on January 31, 2016; and on September 29, 2016, Dr. Gornet opined Petitioner had reached maximum medical improvement. Pet.'s Ex 5, Dep. Ex. 3. Over the next year, Petitioner worked full duty without requiring further medical care.

This status quo continued until the undisputed October 3, 2017 accident where Petitioner injured her cervical spine once again. Petitioner thereafter worked full duty while undergoing conservative care with medication management and additional diagnostic workup at the direction of Dr. Gornet. Thereafter, Dr. Gornet concluded Petitioner had discogenic neck pain but no new disc pathology. Dr. Gornet released Petitioner from care on September 24, 2018. Pet's. Ex. 6.

The Commission observes Petitioner's treatment from her first accident had not concluded prior to her second accident, however Petitioner had been at maximum medical improvement for a year prior to sustaining her third accident. Therefore, the Commission finds Petitioner's permanent disability is properly assigned to both the July 26, 2012 and October 3, 2017 accidents.

The Commission finds Petitioner's permanent disability as to her July 26, 2012 accidental injury is 13% loss of use of the person as a whole.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 4, 2020, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $479.79 per week for a period of 17 6/7 weeks, representing September 28, 2015 through January 30, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses incurred through October 2, 2017 as detailed in Petitioner's Exhibit 1, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $431.81 per week for a period of 65 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 13% loss of use of the person as a whole.

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

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

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

July 27, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/22/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, TARA
Employee/Petitioner

Case# **13WC005578**

13WC004506
18WC005337

ST OF IL MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

On 2/4/2020, 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:

1459 LEVENHAGEN LAW FIRM PC
T FRIYZ LEVENHAGEN
216 W POINTE DR SUITE B
SWANSEA, IL 62226

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62704-9255

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN 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

FEB -4 2020

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

Tara Reynolds
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center
Employer/Respondent

Case # 13 WC 05578

Consolidated cases: 13 WC 04506
18 WC 05337

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on December 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 _____

FINDINGS

On July 26, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $37,423.36; the average weekly wage was $719.69.

On the date of accident, Petitioner was 54 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 for medical services provided to Petitioner from July 26, 2012, through October 2, 2017, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $479.79 per week for 17 6/7 weeks commencing September 28, 2015, through January 30, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $431.81 per week for 75 weeks because the injury sustained caused the 15% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

William R. Gallagher, Arbitrator
ICArbDec p. 2

January 31, 2020
Date

FEB 4 - 2020

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 13 WC 04506, the Application alleged Petitioner sustained a work-related accident on April 11, 2011. In case 13 WC 05578, the Application alleged Petitioner sustained a work-related accident on July 26, 2012. In case 18 WC 05337, the Application alleged Petitioner sustained a work-related accident on October 3, 2017. The three Applications all alleged that "Petitioner was injured during the course and scope of employment" and sustained "Multiple injuries" (Arbitrator's Exhibits 4, 5 and 6). In the three cases, Petitioner and Respondent stipulated Petitioner sustained work-related accidents, but Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibits 1, 2 and 3).

Petitioner worked for Respondent as a mental health technician. Petitioner testified her job duties required her to assist patients, many of whom had mental disabilities. The three accidents all occurred when Petitioner was attempting to assist a patient who assaulted her.

On April 11, 2011, Petitioner was in the process of assisting a patient who she had instructed to go to bed. The patient became combative and grabbed Petitioner by the hair which caused Petitioner to fall to the floor. The patient then started to hit and kicked Petitioner and also a bit Petitioner's left hand.

Following the accident, Petitioner was seen in the ER of St. Mary's Hospital. Petitioner was diagnosed with contusions to both knees, cervicalgia and a human bite (Petitioner's Exhibit 7).

On April 14, 2011, Petitioner was evaluated by Dr. Angela Freehill, an orthopedic surgeon. Dr. Freehill diagnosed Petitioner with bilateral knee contusions, a cervical spine strain and a low back sprain. Dr. Freehill prescribed medication and ordered physical therapy (Petitioner's Exhibit 9).

When Dr. Freehill saw Petitioner on June 2, 2011, Petitioner continued to complain of neck pain. Dr. Freehill ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on June 13, 2011. According to the radiologist, it was normal (Petitioner's Exhibit 8).

Dr. Freehill saw Petitioner on June 16, 2011, and reviewed the MRI. She continued to order physical therapy. When she saw Petitioner on August 18, 2011, Petitioner continued to have neck symptoms. Dr. Freehill referred Petitioner to Dr. Aiping Smith, a physiatrist, and one of Dr. Freehill's associates (Petitioner's Exhibit 9).

Dr. Smith evaluated Petitioner on September 7, 2011. At that time, Petitioner continued to complain of neck pain as well as numbness, tingling and weakness in both upper extremities. Dr. Smith diagnosed Petitioner with axial neck pain and noted the MRI was negative for degenerative disc disease. Dr. Smith changed Petitioner's medication and ordered additional

physical therapy. She also recommended Petitioner undergo medial branch blocks and possible rhizotomy (Petitioner's Exhibit 9).

From October 26, 2011, through April 16, 2012, Petitioner was treated by Dr. Smith. Dr. Smith performed a series of medial branch blocks, radiofrequency ablations and nerve blocks. When Dr. Smith saw Petitioner on April 16, 2012, she ordered additional physical therapy (Petitioner's Exhibit 9).

On July 26, 2012, Petitioner was assisting a coworker who was attempting to control a combative patient. The patient kicked Petitioner in the left side of her face and neck.

Following the accident Petitioner was seen in the ER of St. Mary's Hospital. A CT scan of the cervical spine was ordered which, according to the radiologist, was negative for fractures (Petitioner's Exhibit 8).

Petitioner was again seen by Dr. Smith on August 10, 2012. At that time, Petitioner advised her neck pain had improved following Dr. Smith's earlier treatment, but that she now had increased neck pain because of the accident of July 26, 2012. Dr. Smith opined Petitioner had sustained an exacerbation of the axial neck pain. She ordered physical therapy, but noted if Petitioner's symptoms persisted, a new MRI of the cervical spine and additional branch/nerve blocks and rhizotomies might be indicated. Dr. Smith subsequently ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on October 3, 2012. According to the radiologist, the MRI revealed a small disc bulge at C5-C6 and a small central disc protrusion at C6-C7 (Petitioner's Exhibit 9).

Dr. Smith saw Petitioner on October 12, 2012, and reviewed the MRI and opined that, when compared to the prior MRI of June, 2011, it revealed a new, but small central disc protrusion at C6-C7. Dr. Smith recommended Petitioner undergo a series of epidural steroid injections (Petitioner's Exhibit 9).

Dr. Smith administered epidural steroid injections at C6-C7 on October 24, November 7, and November 21, 2012. When Dr. Smith saw Petitioner on December 6, 2012, Petitioner advised the injections improved her pain symptoms, but only for about one week. Because Petitioner continued to complain of neck and bilateral trapezius pain, she referred Petitioner to Dr. Joon Ahn, an orthopedic surgeon, one of her associates (Petitioner's Exhibit 9).

Dr. Ahn evaluated Petitioner on January 14, 2013. Dr. Ahn opined the bilateral trapezius symptoms were coming from the neck area (Petitioner's Exhibit 9).

Dr. Smith administered medial branch blocks on January 23, and February 6, 2013. She recommended Petitioner undergo a facet rhizotomy, but Respondent declined to authorize same. Dr. Smith referred Petitioner to Dr. Don Kovalsky, an orthopedic surgeon, who is one of her associates (Petitioner's Exhibit 9).

Dr. Kovalsky evaluated Petitioner on July 25, 2013, and reviewed the MRI of October 12, 2012. He opined the MRI revealed a small central disc herniation at C6-C7. He diagnosed Petitioner with chronic neck pain and bilateral radicular arm pain. Based on the MRI, Dr. Kovalsky opined Petitioner was a candidate for a cervical discectomy and fusion at C6-C7, but wanted to obtain a new MRI (Petitioner's Exhibit 9).

The MRI was performed on September 20, 2013. According to the radiologist, the MRI revealed a very small central disc herniation at C6-C7 touching the anterior aspect of the spinal cord (Petitioner's Exhibit 9).

Dr. Kovalsky saw Petitioner on September 20, 2013, and reviewed the MRI scan that had just been performed. He opined it revealed disc dehydration of the discs at C4-C5, C5-C6 and C6-C7 as well as very slight bulging at C6-C7. He also opined it did not reveal any disc herniations and Petitioner may have had some element of thoracic outlet syndrome. He noted Petitioner was "large breasted" and recommended additional physical therapy (Petitioner's Exhibit 9).

On August 7, 2013, Petitioner was seen by Dr. James Schutzenhofer, her family physician. He diagnosed Petitioner with chronic neck pain and referred her to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 11).

Dr. Gornet evaluated Petitioner on June 23, 2014. At that time, Dr. Gornet reviewed the MRIs of June 13, 2011, and October 3, 2012. He opined they both revealed disc herniations at C6-C7. Petitioner complained of neck and bilateral trapezius pain. Dr. Gornet opined Petitioner's current symptoms were related to the work injuries of April, 2011, and July, 2012. He ordered a new MRI scan (Petitioner's Exhibit 5; Deposition Exhibit 3).

MRI scans of both the cervical and lumbar spine were performed on September 4, 2014. According to the radiologist, the MRI of the cervical spine revealed central broad-based herniations at C5-C6 and C6-C7. According to the radiologist, the MRI of the lumbar spine revealed disc bulging at L2-L3 and L4-L5 (Petitioner's Exhibit 3; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 4, 2014, and reviewed the MRIs. His interpretation of the MRIs was consistent with that of the radiologist. Dr. Gornet recommended Petitioner undergo epidural steroid injections in both the cervical and lumbar spine, but if she did not improve, he would proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell, a pain management physician. Dr. Boutwell saw Petitioner on September 24, 2014, and October 15, 2014, and administered epidural steroid injections at C6-C7 and L4-L5, respectively (Petitioner's Exhibit 5; Deposition Exhibit 3).

When Dr. Gornet saw Petitioner on November 3, 2014, Petitioner advised the injections only provided temporary relief. He opined Petitioner should proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on January 7, 2015. In connection with his examination of Petitioner, Dr. Petkovich reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Petkovich's findings on examination were normal and the MRIs revealed some mild degenerative changes in the cervical spine at C5-C6 and C6-C7. He opined Petitioner sustained a cervical strain and had degenerative changes at C5-C6 and C6-C7 which were not aggravated or accelerated by the two work-related accidents. He opined Petitioner was at MMI and no further medical treatment was indicated (Respondent's Exhibit 5).

Dr. Gornet saw Petitioner on May 28, 2015, and reviewed Dr. Petkovich's report. He noted that Dr. Petkovich opinion that the disc degeneration was not related to the accidents ignored the fact that the MRI studies revealed a disc injury. He also noted Dr. Petkovich did not have an explanation as to why Petitioner was asymptomatic prior to the first accident of April 12, 2011. Dr. Gornet renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on August 20, 2015. Again, he renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7. He ordered a new MRI scan. Further, because of Petitioner's continued shoulder complaints, he referred her to Dr. George Paletta, an orthopedic surgeon, who was one of his associates (Petitioner's Exhibit 5; Deposition Exhibit 3).

The MRI was performed on September 14, 2015. According to the radiologist, the herniations at C5-C6 and C6-C7 were stable when compared to the prior MRI (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 14, 2015, and reviewed the MRI. He indicated he was going to proceed with the disc replacement surgery and Petitioner was being seen by Dr. Paletta for her shoulder symptoms (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Paletta saw Petitioner on September 14, 2015, primarily for right shoulder symptoms. Dr. Paletta opined Petitioner had right shoulder pain, likely referred from the cervical region. He ordered an MRI arthrogram of Petitioner's right shoulder (Petitioner's Exhibit 12).

The MRI arthrogram of Petitioner's right shoulder was performed on September 17, 2015. According to the radiologist, the MRI arthrogram revealed some old post operative changes, but was otherwise normal (Petitioner's Exhibit 12).

Dr. Paletta reviewed the MRI arthrogram and subsequently saw Petitioner on November 16, 2015. His interpretation of the MRI arthrogram was consistent with the radiologist. However, he did administer a steroid injection into the right subacromial space (Petitioner's Exhibit 12).

On September 29, 2015, Dr. Gornet performed disc replacement surgery at C6-C7. In his surgical report, Dr. Gornet noted there was a large central disc herniation to the right which was easily removed (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner following surgery and, on January 18, 2016, noted she was doing well, although she still had some right shoulder symptoms. Dr. Gornet authorized Petitioner to return to work without restrictions effective January 31, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet again saw Petitioner on March 28, and September 29, 2016. Petitioner had returned to work at full duty and was doing well, but still had some right shoulder symptoms. Dr. Gornet opined Petitioner was at MMI as of September 29, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on September 28, 2017. Petitioner was doing well, but had some aches and pains which Dr. Gornet opined were age related (Petitioner's Exhibit 6).

On October 3, 2017, Petitioner took one of the patients to the hospital for an EEG. The patient became combative while lying on the examination table and kicked Petitioner in her right wrist, left abdomen and left upper arm. The patient also bit Petitioner's right hand.

Following the accident Petitioner was seen at SSM Medical Group/Express Clinic. Petitioner was given some medication and discharged (Petitioner's Exhibit 13).

Petitioner saw Dr. Schutzenhofer on October 30, 2017. At that time, Petitioner complained of neck pain. He again referred Petitioner to Dr. Gornet (Petitioner's Exhibit 11).

Dr. Gornet saw Petitioner on December 7, 2017. At that time, Petitioner informed Dr. Gornet of the most recent accident of October 3, 2017. Petitioner complained of pain referable to her neck, shoulder blades, right trapezius and right arm/hand. Dr. Gornet prescribed medication and ordered an MRI scan (Petitioner's Exhibit 6).

The MRI was performed on January 18, 2018. According to the radiologist, it revealed post operative changes at C6-C7, but was otherwise unremarkable (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on January 18, 2018, and reviewed the MRI. He opined the MRI may have indicated a subtle disc issue at C5-C6. He prescribed medication and ordered physical therapy (Petitioner's Exhibit 6).

Dr. Gornet subsequently saw Petitioner on March 22, 2018. At that time, Petitioner continued to complain of pain in the neck, right trapezius, shoulder and arm. He ordered an MRI arthrogram of Petitioner's right shoulder and recommended Petitioner undergo EMG/nerve conduction studies. He opined Petitioner's current symptoms were related to the most recent accident (Petitioner's Exhibit 6).

The MRI arthrogram was performed on July 31, 2018. According to the radiologist, there was tendinopathy, but no tears (Petitioner's Exhibit 6).

On September 24, 2018, Petitioner was evaluated by Dr. Daniel Phillips, a neurologist, who performed EMG/nerve conduction studies of Petitioner's right upper extremity. The studies were within the range of normal (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on September 24, 2018, and reviewed the diagnostic studies. Although Petitioner continued to complain of neck and right upper extremity symptoms, Dr. Gornet did not recommend any further surgery. He opined Petitioner probably aggravated an underlying condition, but she could continue to work full duty (Petitioner's Exhibit 6).

Dr. Petkovich was deposed on August 10, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, he testified Petitioner had sustained a cervical strain, was at MMI and disc replacement surgery was not indicated (Respondent's Exhibit 4; pp 22, 28, 37).

Dr. Gornet was deposed on March 29, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony regarding the medical treatment he provided to Petitioner up to that time was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, he related Petitioner's cervical spine disc injury to the accidents of April, 2011, and July, 2012. He testified Petitioner had an excellent surgical result with a significant improvement in her pain symptoms, although she still had some residual shoulder issues (Petitioner's Exhibit 5; pp 10-12).

At trial, Petitioner testified that prior to the disc replacement surgery she experienced constant pain in her neck. Although she continued to work, she regularly sought assistance from other employees. Petitioner stated that following surgery, Dr. Gornet authorized her to be off work from September 28, 2015, through January 30, 2016. Petitioner stated that her symptoms of neck pain had, to a large extent, resolved; but she still experiences some minor pain associated with weather changes and her neck hurts when she has to drive long distances.

Petitioner testified that it was her understanding Dr. Kovalsky did not want to proceed with surgery because she had large breasts. Petitioner testified this did not make any sense because she does not have large breasts and she wears a size "B" cup bra. Petitioner stated she ceased working on November 7, 2019, because of other health issues. Petitioner stated she has been diagnosed with Parkinson's disease.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of July 26, 2012.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an injury to her neck/cervical spine as a result of the accident of July 26, 2012.

The MRI performed on June 13, 2011 (following the accident of April 11, 2011) was interpreted by the radiologist to be normal; however, multiple MRIs performed after July 26, 2012, revealed disc pathology at C5-C6 and C6-C7, but primarily at C6-C7.

When Dr. Kovalsky reviewed the MRI of October 12, 2012, he opined it revealed a small central disc herniation at C6-C7 and recommended Petitioner undergo a cervical discectomy and fusion at C6-C7. Dr. Kovalsky ordered a new MRI which was performed on September 20, 2013, and the radiologist opined it revealed a very small disc herniation at C6-C7.

However, when Dr. Kovalsky reviewed the MRI of September 20, 2013, he opined it only revealed slight bulging at C6-C7, but no disc herniation. He did not reaffirm his prior surgical recommendation and noted Petitioner was "large breasted."

Dr. Gornet, Petitioner's primary treating physician, reviewed MRIs obtained on various dates and he opined they all revealed a disc herniation at C6-C7. In regard to the MRIs obtained after July 26, 2012, Dr. Gornet's interpretation of them was consistent with that of the radiologist who performed them.

Dr. Petkovich, Respondent's Section 12 examiner, opined the MRIs revealed degenerative changes at C5-C6 and C6-C7 which were not aggravated or accelerated by the two work-related accidents. However, he did not note that the studies revealed a disc injury at those levels.

At trial, Petitioner testified she was not large breasted and that she wore a size "B" cup bra.

Dr. Gornet performed disc replacement surgery at C6-C7 and Petitioner had a good surgical result with most of her complaints referable to her neck resolving.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Gornet be more persuasive than that of Dr. Kovalsky and Dr. Petkovich in regard to Petitioner's diagnosis and causality.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner from July 26, 2012, through October 2, 2017, was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services for medical services provided to Petitioner from July 26, 2012, through October 2, 2017, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 17 6/7 weeks commencing September 28, 2015, through January 30, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under active medical treatment and authorized to be off work during the aforestated period of time.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

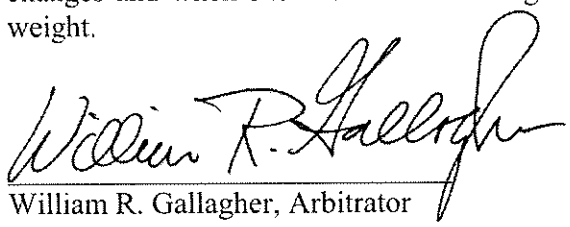
Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner was employed as a mental health technician at the time of the accident. As the circumstances of all three accidents clearly indicated, Petitioner was required to deal with individuals who have mental disabilities who could injure her. The Arbitrator gives this factor moderate weight.

Petitioner was 54 years old at the time of the accident of July 26, 2012. She will have to live with the effects of this injury for the remainder of her natural life. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner was diagnosed with a disc herniation at C6-C7 which required disc replacement surgery at that level. Petitioner had a good surgical result and most of her complaints of neck pain resolved; however, Petitioner still experiences some minor pain associated with weather changes and when she has to drive a long distance. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC005337
Case Name	REYNOLDS, TARA v. STATE OF ILLINOIS MURRAY DEVELOPMENTAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0382
Number of Pages of Decision	16
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	T. Fritz Levenhagen
Respondent Attorney	Kenton Owens

DATE FILED: 7/27/2021

/s/ Deborah Baker, 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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TARA REYNOLDS,

Petitioner,

vs. NO: 18 WC 05337

STATE OF ILLINOIS,
MURRAY DEVELOPMENTAL 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 causal connection of Petitioner's cervical spine condition of ill-being, entitlement to Temporary Total Disability benefits, entitlement to medical expenses, and entitlement to permanent partial disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 13 WC 04506 and 13 WC 05578.

Petitioner filed three Applications for Adjustment of Claim alleging injuries while in Respondent's employ: 13 WC 04506 – acute trauma on April 11, 2011; 13 WC 05578 – acute trauma on July 26, 2012; and 18 WC 05337 – acute trauma on October 3, 2017. The matters were consolidated for hearing at which time all three accidents were undisputed. The Arbitrator thereafter issued three separate decisions but ultimately assigned the totality of Petitioner's permanent disability to her July 26, 2012 accident. While the Commission agrees with the Arbitrator's §8.1b analysis as well as the resulting total percentage loss of use awarded, the Commission finds Petitioner's permanent disability is properly assigned to both her July 26, 2012 (13 WC 05578) and October 3, 2017 (18 WC 05337) work injuries.

The Commission notes apportioning permanent disability among claims is permissible in limited circumstances. Where a claimant has sustained "separate and distinct injuries to the same body part and the claims are consolidated for hearing and decision," the Commission is to consider all the evidence presented to determine the nature and extent of the claimant's permanent disability as of the date of the hearing unless there is some evidence presented at the consolidated hearing that would permit the Commission to delineate and apportion the nature and extent of permanency attributable to each accident. *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 265, 947 N.E.2d 863, 869 (2011). We find this to be such an instance.

Following Petitioner's undisputed April 11, 2011 injury, she commenced an extensive course of conservative cervical spine treatment which included physical therapy as well as interventional pain management in the form of medial branch blocks, radiofrequency ablations, and nerve blocks. Pet.'s Ex. 9. In April 2012, Dr. Smith ordered physical therapy with the caveat that further pain management interventions would be considered pending a neurology clearance for an unrelated condition and completion of therapy. Pet.'s Ex. 9. On May 7, 2012, Dr. Smith reiterated her order for additional physical therapy. Pet.'s Ex. 10.

On July 26, 2012, prior to commencement of the physical therapy prescribed by Dr. Smith, Petitioner sustained a second undisputed work accident and further injured her cervical spine. At that time, there had been no medical opinion of maximum medical improvement relative to the 2011 injury before Petitioner sustained the second injury to her cervical spine. The July 26, 2012 accident ultimately resulted in surgery: Dr. Gornet performed an anterior cervical discectomy and disc replacement at C6-7 on September 29, 2015. Pet.'s Ex. 5, Dep. Ex. 3. Post-operatively, Petitioner attended routine follow-up appointments with Dr. Gornet. She was released to resume full duty work on January 31, 2016; and on September 29, 2016, Dr. Gornet opined Petitioner had reached maximum medical improvement. Pet.'s Ex 5, Dep. Ex. 3. Over the next year, Petitioner worked full duty without requiring further medical care.

This status quo continued until the undisputed October 3, 2017 accident where Petitioner injured her cervical spine once again. Petitioner thereafter worked full duty while undergoing conservative care with medication management and additional diagnostic workup at the direction of Dr. Gornet. Thereafter, Dr. Gornet concluded Petitioner had discogenic neck pain but no new disc pathology. Dr. Gornet released Petitioner from care on September 24, 2018. Pet's. Ex. 6.

The Commission observes Petitioner's treatment from her first accident had not concluded prior to her second accident, however Petitioner had been at maximum medical improvement for a year prior to sustaining her third accident. Therefore, the Commission finds Petitioner's permanent disability is properly assigned to both the July 26, 2012 and October 3, 2017 accidents.

The Commission finds Petitioner's permanent disability as to her October 3, 2017 accidental injury is 2% loss of use of the person as a whole.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2020, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses incurred on and after October 3, 2017 as detailed in Petitioner's Exhibit 1, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $492.40 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 2% loss of use of the person as a whole.

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

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

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

July 27, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/22/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, TARA
Employee/Petitioner

Case# **18WC005337**

13WC004506
13WC005578

ST OF IL/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

On 2/4/2020, 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:

1459 LEVENHAGEN LAW FIRM PC
T FRITZ LEVENHAGEN
216 W POINT DR SUITE B
SWANSEA, IL 62226

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62704-9255

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN 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

FEB - 4 2020

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

Tara Reynolds
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center
Employer/Respondent

Case # 18 WC 05337

Consolidated cases: 13 WC 04506
13 WC 05578

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on December 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 _____

FINDINGS

On October 3, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $42,674.60; the average weekly wage was $820.67.

On the date of accident, Petitioner was 59 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 for medical services provided to Petitioner from October 3, 2017, and thereafter as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Based upon the Arbitrator's Conclusion of Law attached hereto, all benefits are awarded in case number 13 WC 05578.

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

January 31, 2020
Date

FEB 4 - 2020

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 13 WC 04506, the Application alleged Petitioner sustained a work-related accident on April 11, 2011. In case 13 WC 05578, the Application alleged Petitioner sustained a work-related accident on July 26, 2012. In case 18 WC 05337, the Application alleged Petitioner sustained a work-related accident on October 3, 2017. The three Applications all alleged that "Petitioner was injured during the course and scope of employment" and sustained "Multiple injuries" (Arbitrator's Exhibits 4, 5 and 6). In the three cases, Petitioner and Respondent stipulated Petitioner sustained work-related accidents, but Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibits 1, 2 and 3).

Petitioner worked for Respondent as a mental health technician. Petitioner testified her job duties required her to assist patients, many of whom had mental disabilities. The three accidents all occurred when Petitioner was attempting to assist a patient who assaulted her.

On April 11, 2011, Petitioner was in the process of assisting a patient who she had instructed to go to bed. The patient became combative and grabbed Petitioner by the hair which caused Petitioner to fall to the floor. The patient then started to hit and kicked Petitioner and also a bit Petitioner's left hand.

Following the accident, Petitioner was seen in the ER of St. Mary's Hospital. Petitioner was diagnosed with contusions to both knees, cervicalgia and a human bite (Petitioner's Exhibit 7).

On April 14, 2011, Petitioner was evaluated by Dr. Angela Freehill, an orthopedic surgeon. Dr. Freehill diagnosed Petitioner with bilateral knee contusions, a cervical spine strain and a low back sprain. Dr. Freehill prescribed medication and ordered physical therapy (Petitioner's Exhibit 9).

When Dr. Freehill saw Petitioner on June 2, 2011, Petitioner continued to complain of neck pain. Dr. Freehill ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on June 13, 2011. According to the radiologist, it was normal (Petitioner's Exhibit 8).

Dr. Freehill saw Petitioner on June 16, 2011, and reviewed the MRI. She continued to order physical therapy. When she saw Petitioner on August 18, 2011, Petitioner continued to have neck symptoms. Dr. Freehill referred Petitioner to Dr. Aiping Smith, a physiatrist, and one of Dr. Freehill's associates (Petitioner's Exhibit 9).

Dr. Smith evaluated Petitioner on September 7, 2011. At that time, Petitioner continued to complain of neck pain as well as numbness, tingling and weakness in both upper extremities. Dr. Smith diagnosed Petitioner with axial neck pain and noted the MRI was negative for degenerative disc disease. Dr. Smith changed Petitioner's medication and ordered additional

physical therapy. She also recommended Petitioner undergo medial branch blocks and possible rhizotomy (Petitioner's Exhibit 9).

From October 26, 2011, through April 16, 2012, Petitioner was treated by Dr. Smith. Dr. Smith performed a series of medial branch blocks, radiofrequency ablations and nerve blocks. When Dr. Smith saw Petitioner on April 16, 2012, she ordered additional physical therapy (Petitioner's Exhibit 9).

On July 26, 2012, Petitioner was assisting a coworker who was attempting to control a combative patient. The patient kicked Petitioner in the left side of her face and neck.

Following the accident Petitioner was seen in the ER of St. Mary's Hospital. A CT scan of the cervical spine was ordered which, according to the radiologist, was negative for fractures (Petitioner's Exhibit 8).

Petitioner was again seen by Dr. Smith on August 10, 2012. At that time, Petitioner advised her neck pain had improved following Dr. Smith's earlier treatment, but that she now had increased neck pain because of the accident of July 26, 2012. Dr. Smith opined Petitioner had sustained an exacerbation of the axial neck pain. She ordered physical therapy, but noted if Petitioner's symptoms persisted, a new MRI of the cervical spine and additional branch/nerve blocks and rhizotomies might be indicated. Dr. Smith subsequently ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 9).

The MRI was performed on October 3, 2012. According to the radiologist, the MRI revealed a small disc bulge at C5-C6 and a small central disc protrusion at C6-C7 (Petitioner's Exhibit 9).

Dr. Smith saw Petitioner on October 12, 2012, and reviewed the MRI and opined that, when compared to the prior MRI of June, 2011, it revealed a new, but small central disc protrusion at C6-C7. Dr. Smith recommended Petitioner undergo a series of epidural steroid injections (Petitioner's Exhibit 9).

Dr. Smith administered epidural steroid injections at C6-C7 on October 24, November 7, and November 21, 2012. When Dr. Smith saw Petitioner on December 6, 2012, Petitioner advised the injections improved her pain symptoms, but only for about one week. Because Petitioner continued to complain of neck and bilateral trapezius pain, she referred Petitioner to Dr. Joon Ahn, an orthopedic surgeon, one of her associates (Petitioner's Exhibit 9).

Dr. Ahn evaluated Petitioner on January 14, 2013. Dr. Ahn opined the bilateral trapezius symptoms were coming from the neck area (Petitioner's Exhibit 9).

Dr. Smith administered medial branch blocks on January 23, and February 6, 2013. She recommended Petitioner undergo a facet rhizotomy, but Respondent declined to authorize same. Dr. Smith referred Petitioner to Dr. Don Kovalsky, an orthopedic surgeon, who is one of her associates (Petitioner's Exhibit 9).

Dr. Kovalsky evaluated Petitioner on July 25, 2013, and reviewed the MRI of October 12, 2012. He opined the MRI revealed a small central disc herniation at C6-C7. He diagnosed Petitioner with chronic neck pain and bilateral radicular arm pain. Based on the MRI, Dr. Kovalsky opined Petitioner was a candidate for a cervical discectomy and fusion at C6-C7, but wanted to obtain a new MRI (Petitioner's Exhibit 9).

The MRI was performed on September 20, 2013. According to the radiologist, the MRI revealed a very small central disc herniation at C6-C7 touching the anterior aspect of the spinal cord (Petitioner's Exhibit 9).

Dr. Kovalsky saw Petitioner on September 20, 2013, and reviewed the MRI scan that had just been performed. He opined it revealed disc dehydration of the discs at C4-C5, C5-C6 and C6-C7 as well as very slight bulging at C6-C7. He also opined it did not reveal any disc herniations and Petitioner may have had some element of thoracic outlet syndrome. He noted Petitioner was "large breasted" and recommended additional physical therapy (Petitioner's Exhibit 9).

On August 7, 2013, Petitioner was seen by Dr. James Schutzenhofer, her family physician. He diagnosed Petitioner with chronic neck pain and referred her to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 11).

Dr. Gornet evaluated Petitioner on June 23, 2014. At that time, Dr. Gornet reviewed the MRIs of June 13, 2011, and October 3, 2012. He opined they both revealed disc herniations at C6-C7. Petitioner complained of neck and bilateral trapezius pain. Dr. Gornet opined Petitioner's current symptoms were related to the work injuries of April, 2011, and July, 2012. He ordered a new MRI scan (Petitioner's Exhibit 5; Deposition Exhibit 3).

MRI scans of both the cervical and lumbar spine were performed on September 4, 2014. According to the radiologist, the MRI of the cervical spine revealed central broad-based herniations at C5-C6 and C6-C7. According to the radiologist, the MRI of the lumbar spine revealed disc bulging at L2-L3 and L4-L5 (Petitioner's Exhibit 3; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 4, 2014, and reviewed the MRIs. His interpretation of the MRIs was consistent with that of the radiologist. Dr. Gornet recommended Petitioner undergo epidural steroid injections in both the cervical and lumbar spine, but if she did not improve, he would proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell, a pain management physician. Dr. Boutwell saw Petitioner on September 24, 2014, and October 15, 2014, and administered epidural steroid injections at C6-C7 and L4-L5, respectively (Petitioner's Exhibit 5; Deposition Exhibit 3).

When Dr. Gornet saw Petitioner on November 3, 2014, Petitioner advised the injections only provided temporary relief. He opined Petitioner should proceed with disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on January 7, 2015. In connection with his examination of Petitioner, Dr. Petkovich reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Petkovich's findings on examination were normal and the MRIs revealed some mild degenerative changes in the cervical spine at C5-C6 and C6-C7. He opined Petitioner sustained a cervical strain and had degenerative changes at C5-C6 and C6-C7 which were not aggravated or accelerated by the two work-related accidents. He opined Petitioner was at MMI and no further medical treatment was indicated (Respondent's Exhibit 5).

Dr. Gornet saw Petitioner on May 28, 2015, and reviewed Dr. Petkovich's report. He noted that Dr. Petkovich opinion that the disc degeneration was not related to the accidents ignored the fact that the MRI studies revealed a disc injury. He also noted Dr. Petkovich did not have an explanation as to why Petitioner was asymptomatic prior to the first accident of April 12, 2011. Dr. Gornet renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on August 20, 2015. Again, he renewed his recommendation Petitioner undergo disc replacement surgery at C6-C7. He ordered a new MRI scan. Further, because of Petitioner's continued shoulder complaints, he referred her to Dr. George Paletta, an orthopedic surgeon, who was one of his associates (Petitioner's Exhibit 5; Deposition Exhibit 3).

The MRI was performed on September 14, 2015. According to the radiologist, the herniations at C5-C6 and C6-C7 were stable when compared to the prior MRI (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on September 14, 2015, and reviewed the MRI. He indicated he was going to proceed with the disc replacement surgery and Petitioner was being seen by Dr. Paletta for her shoulder symptoms (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Paletta saw Petitioner on September 14, 2015, primarily for right shoulder symptoms. Dr. Paletta opined Petitioner had right shoulder pain, likely referred from the cervical region. He ordered an MRI arthrogram of Petitioner's right shoulder (Petitioner's Exhibit 12).

The MRI arthrogram of Petitioner's right shoulder was performed on September 17, 2015. According to the radiologist, the MRI arthrogram revealed some old post operative changes, but was otherwise normal (Petitioner's Exhibit 12).

Dr. Paletta reviewed the MRI arthrogram and subsequently saw Petitioner on November 16, 2015. His interpretation of the MRI arthrogram was consistent with the radiologist. However, he did administer a steroid injection into the right subacromial space (Petitioner's Exhibit 12).

On September 29, 2015, Dr. Gornet performed disc replacement surgery at C6-C7. In his surgical report, Dr. Gornet noted there was a large central disc herniation to the right which was easily removed (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet saw Petitioner following surgery and, on January 18, 2016, noted she was doing well, although she still had some right shoulder symptoms. Dr. Gornet authorized Petitioner to return to work without restrictions effective January 31, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet again saw Petitioner on March 28, and September 29, 2016. Petitioner had returned to work at full duty and was doing well, but still had some right shoulder symptoms. Dr. Gornet opined Petitioner was at MMI as of September 29, 2016 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on September 28, 2017. Petitioner was doing well, but had some aches and pains which Dr. Gornet opined were age related (Petitioner's Exhibit 6).

On October 3, 2017, Petitioner took one of the patients to the hospital for an EEG. The patient became combative while lying on the examination table and kicked Petitioner in her right wrist, left abdomen and left upper arm. The patient also bit Petitioner's right hand.

Following the accident Petitioner was seen at SSM Medical Group/Express Clinic. Petitioner was given some medication and discharged (Petitioner's Exhibit 13).

Petitioner saw Dr. Schutzenhofer on October 30, 2017. At that time, Petitioner complained of neck pain. He again referred Petitioner to Dr. Gornet (Petitioner's Exhibit 11).

Dr. Gornet saw Petitioner on December 7, 2017. At that time, Petitioner informed Dr. Gornet of the most recent accident of October 3, 2017. Petitioner complained of pain referable to her neck, shoulder blades, right trapezius and right arm/hand. Dr. Gornet prescribed medication and ordered an MRI scan (Petitioner's Exhibit 6).

The MRI was performed on January 18, 2018. According to the radiologist, it revealed post operative changes at C6-C7, but was otherwise unremarkable (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on January 18, 2018, and reviewed the MRI. He opined the MRI may have indicated a subtle disc issue at C5-C6. He prescribed medication and ordered physical therapy (Petitioner's Exhibit 6).

Dr. Gornet subsequently saw Petitioner on March 22, 2018. At that time, Petitioner continued to complain of pain in the neck, right trapezius, shoulder and arm. He ordered an MRI arthrogram of Petitioner's right shoulder and recommended Petitioner undergo EMG/nerve conduction studies. He opined Petitioner's current symptoms were related to the most recent accident (Petitioner's Exhibit 6).

The MRI arthrogram was performed on July 31, 2018. According to the radiologist, there was tendinopathy, but no tears (Petitioner's Exhibit 6).

On September 24, 2018, Petitioner was evaluated by Dr. Daniel Phillips, a neurologist, who performed EMG/nerve conduction studies of Petitioner's right upper extremity. The studies were within the range of normal (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on September 24, 2018, and reviewed the diagnostic studies. Although Petitioner continued to complain of neck and right upper extremity symptoms, Dr. Gornet did not recommend any further surgery. He opined Petitioner probably aggravated an underlying condition, but she could continue to work full duty (Petitioner's Exhibit 6).

Dr. Petkovich was deposed on August 10, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, he testified Petitioner had sustained a cervical strain, was at MMI and disc replacement surgery was not indicated (Respondent's Exhibit 4; pp 22, 28, 37).

Dr. Gornet was deposed on March 29, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony regarding the medical treatment he provided to Petitioner up to that time was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, he related Petitioner's cervical spine disc injury to the accidents of April, 2011, and July, 2012. He testified Petitioner had an excellent surgical result with a significant improvement in her pain symptoms, although she still had some residual shoulder issues (Petitioner's Exhibit 5; pp 10-12).

At trial, Petitioner testified that prior to the disc replacement surgery she experienced constant pain in her neck. Although she continued to work, she regularly sought assistance from other employees. Petitioner stated that following surgery, Dr. Gornet authorized her to be off work from September 28, 2015, through January 30, 2016. Petitioner stated that her symptoms of neck pain had, to a large extent, resolved; but she still experiences some minor pain associated with weather changes and her neck hurts when she has to drive long distances.

Petitioner testified that it was her understanding Dr. Kovalsky did not want to proceed with surgery because she had large breasts. Petitioner testified this did not make any sense because she does not have large breasts and she wears a size "B" cup bra. Petitioner stated she ceased working on November 7, 2019, because of other health issues. Petitioner stated she has been diagnosed with Parkinson's disease.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of October 3, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an injury to her neck/cervical spine as a result of the accident of October 3, 2017.

The accident of October 3, 2017, occurred subsequent to Petitioner having undergone cervical disc replacement surgery. The accident of October 3, 2017, was an aggravation of that underlying condition which required conservative treatment. However, no additional surgery was either recommended or performed.

Petitioner was able to continue to work following the accident of October 3, 2017.

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 from October 3, 2017, and thereafter was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services for medical services provided to Petitioner from October 3, 2017, and thereafter, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (L) the Arbitrator makes no conclusion of law because all permanent partial disability benefits were awarded in 13 WC 05578.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	01WC026682
Case Name	MARSZALEK,JAMES J AS v. BELL ENTERTAINMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0383
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	James Marszalek
Respondent Attorney	Miles Cahill

DATE FILED: 7/28/2021

/s/ Marc Parker, 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

James J. Marszalek, Executor
of the Estate of Myles Bell, Deceased,

Petitioner,

vs. NO: 01 WC 26682

Bell Entertainment,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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.

July 28, 2021

MP:yl
o 7/15/21
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

MARSZALEK, JAMES J EXECUTOR OF THE ESTATE OF BELL, MYLES DECEASED
Employee/Petitioner

Case# **01WC026682**

02WC054561
12WC039144
12WC039145

BELL ENTERTAINMENT
Employer/Respondent

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

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

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
KATERINA D KYROS
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

JAMES J. MARSZALEK, Executor of the estate of Myles Bell, Deceased
Employee/Petitioner

v.

BELL ENTERTAINMENT
Employer/Respondent

Case # **01** WC **26682**

Consolidated cases: **02WC 54561, 12WC 39144, 12WC 39145**

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 **04/16/19 and 08/19/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **01/19/1999**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***was not*** causally related to the accident of 1/19/99.

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children. ARB EX 1

No further findings were made.

ORDER

Based on the Arbitrator's finding of no causal connection between Mr. Bell's condition of ill-being and the accident of January 19, 1999, no award of benefits is made. All remaining issues are moot and no further findings are made.

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. Wheeler

Signature of Arbitrator

10/16/19
Date

OCT 16 2019

FINDINGS OF FACT

The Arbitrator notes that four consolidated matters were presented for trial. The trial started on 4/16/19 and proofs were closed on 8/19/19. In case 01 WC 26682, the alleged date of accident is January 19. 1999. ARB EX 1. In case 02 WC 54561, the alleged date of accident is August 4, 2002. ARB EX 2. In case 12 WC 39145, a request for funeral expenses is made in connection with case 01 WC 26682. ARB EX 3. In case 12 WC 39144 funeral expenses are requested in connection with case 02 WC 54561. ARB EX 4. Myles Bell, the decedent, passed away on February 9, 2011. James J. Marszalek became the executor of the estate of Myles Bell and presented these matters for trial.

At trial of these consolidated four matters, Petitioner presented the testimony of Debra Harper. Ms. Harper testified that she was employed by Bell Entertainment from 1997 to October 1999 and then again from 2001 to 2003. She testified that Bell Entertainment operated a restaurant and steakhouse known as Bellini's. Myles Bell was the owner and operator of Bell Entertainment and Bellini's. Ms. Harper worked as the general manager for the business. T. 24. Her duties required her to run the restaurant and manage the staff, banquets, billing and payroll. T. 25. She testified that Myles Bell oversaw the daily operations of the restaurant. He was present at the restaurant every day. T. 25. She testified that Mr. Bell received a yearly salary of $75,000. T. 26.

Ms. Harper testified that on January 19, 1999, she drove with Myles Bell from the restaurant in Libertyville to his home in Lake Forest in order to retrieve papers needed by the accountant for quarterly tax purposes. She also testified that they were going to get space heaters to bring back to the restaurant to be used in the bar as the furnace had gone out. T. 27. She further testified that it was common for her to accompany Myles Bell to his home in order to retrieve paperwork for the business as he "kept a lot of stuff at his home, because at the time was limited office space, so all important papers he kept at his residence." T. 29.

Ms. Harper testified that the driveway of the home was icy and when Petitioner got out of the car he "stepped on ice and he slipped right out from under him." T. 28. She then observed Mr. Bell get up from the ground and noted the he grabbed his back. She asked him if he was okay and he replied that he was. T. 29. She testified that they retrieved what they needed from the home and returned to the restaurant. She testified that later that evening she noticed he was moving a little slower up the stairs and that the next day Myles Bell came in later than usual to the restaurant. The next day she noticed Petitioner moving very slowly and stating "I think I really jacked up my back." T. 30. After January 1999, Ms. Harper noticed that he started coming in later to the restaurant and that he limited his physical abilities as to what he would do around the restaurant. She testified that he no longer helped her move tables and that the bus boys now moved the tables. T. 31.

In reviewing the medical records submitted at trial, the Arbitrator notes that Petitioner sought no medical treatment after the January 19, 1999 fall on his driveway. In addition, no report of injury was made at that time in January 1999. The first mention of a fall in January 1999 was made to Mr. Bell's primary doctor, Dr. Kyncl on March 30, 1999. PX 8. That record states, "Jan … fell- fell again- work."

Ms. Harper testified that Petitioner in fact fell again in March 1999 when he slipped on oil in his garage at home. She was not present and did not provide any additional details about the circumstances of the fall in March 1999. She testified that Petitioner exhibited signs of extreme back pain after March 1999 and that he limited his physical activity and carried himself differently. He was also unable to sit for long periods of time.

Lake Forest Hospital emergency room records dated 3/25/99 indicate, "This is a 47 year old male who presents complaining of left lower back pain. The patient states that he fell in his garage on an [sic] slick oil spot earlier today landing on his back. He states the he had done this two months ago in January, landing on the ice, but his pain was not as severe. He was not evaluated for that incident. However, he continued to have some pain in his back and falling today made it worse. He denies any other injury or pain. ... no numbness or weakness in his legs." PX 10. Petitioner was diagnosed with a lumbar contusion and given pain medication. He was to follow up with his personal doctor in 3-4 days. PX 10.

Petitioner first sought medical attention from his primary doctor, Dr. Kincyl, on March 30, 1999. Dr. Kincyl made the above brief notations and diagnosed Mr. Bell with sciatica. Petitioner complained of pain down the left leg. Mr. Bell underwent lumbar x-rays on 3/25/99 which showed narrowing of interspaces of L4-S1 and L5-S1 with associated moderate hypertrophic degenerative changes as well as mild to moderate facet arthritis. Conservative care including physical therapy was recommended. Petitioner attended physical therapy in April 1999 where he reported both the fall in January 1999 and in March 1999.

On May 8, 1999 Petitioner was admitted to Lake Forest Hospital by Dr. Kyncl noting that "the patient fell in January and sustained a back injury and recovered from this. He fell again about a month ago on some oil and had a lot of pain for which he needed some medicine. He again had a worsening about a week ago when he developed some abdominal flue and had severe nausea and vomiting. He was vomiting for four days straight and strained his back with all of his and has been having severe back pain since then. ... the pain got out of hand and he came in yesterday with intractable back pain going down his left leg." PX 10. Petitioner was admitted for testing. A May 11, 1999 Lumbar myelogram and CT showed broad based left lateral disc protrusion at the L4-5 level projecting into the inferior portion of the left L4-5 neuroforamen and flattening the left anterolateral aspect of the thecal sac along with moderately severe right and mild to moderate left L5-S1 facet joint overgrowth with mild encroachment upon the neuorforamen bilaterally and lateral recesses. PX 6 PX 10. Petitioner underwent epidural steroid injections on 5/13/99. PX 10. Petitioner was referred to Dr. Bauer.

On 6/25/99, Dr. Bauer reviewed the lumber myelogram and noted his impression of spinal canal of normal size with an anterior indentation of the anterior epidural space mainly at L4-L5 and to a lesser degree at L2-3. PX 6. On July 1, 1999, Dr. Bauer noted that Mr. Bell "... was well until January 1999 when he slipped on the ice and fell onto his tailbone at home. In March 1999 he fell and slipped in his garage because his foot was weak. He went to Lake Forest Hospital and had x-rays performed. Since then he has undergone a CT scan and myelogram. He is unable to do an MRI scan. He had physical therapy and while standing on a teeter-totter he aggravated the pain in his leg about 1 ½ weeks ago. He has had continued pain in the sciatic distribution of his left leg down to his lateral ankle but not into his toes. He ahs weakness and drags his left foot. He has a sense of numbness and tingling. He has a history of back pain but never lost time from

work due to this or has he had treatment. His pain has been acutely exacerbated recently. … he has dull aching back pain. His leg pain is sharp, however." PX 6.

Dr. Bauer reviewed the CT scan and myelogram and found evidence of a herniated disc at L4-5 with foraminal stenosis. He diagnosed a left, L5 radiculopathy due to a herniated disc and foraminal stenosis. Dr. Bauer recommended surgery. PX 6. Dr. Bauer performed a micro lumbar diskectomy left L4-L5 with microdissection on July 20, 1999. The post op diagnosis was left L4-5 herniated disk. PX 6. Petitioner attended physical therapy post op as well. Mr. Bell continued to treat periodically for low back pain and radiating left leg pain complaints through June 2002.

On 10/5/99, Mr. Bell filed a First Report of Injury claiming an accident date of "3-99" when he fell in his garage while at home retrieving paperwork. Resp 1 RX 1. On March 24, 2006, Dr. Ghanayem opined that the reported January 1999 injury was self limited and did not result in disability or structural/traumatic changes in his lumbar spine and that it did not require any medical care. He further opined that the second accident in March 1999 severed any causal connection between the January event and his subsequent care. His opinion is based on Petitioner's report that the symptoms were more severe and required care after the March 1999 fall. Resp 1 RX 2.

Mr. Bell's representatives also called Jill Bell to testify. She is the ex wife of Myles Bell. They were married on June 8, 2003 and divorced on August 9, 2009- 2 years before the death of Myles Bell. T. 64-65. They had no children and to her knowledge Mr. Bell never had children. Mr. Bell was never married before Jill Bell nor re-married after their divorce. T. 65.

Ms. Bell began working for Bell Entertainment in March, 1997. She worked as a hostess, until January 1, 1998. She became the night time full-time bartender. She worked as a bartender for six months and then was promoted to the assistant manager in charge of the bar and bartenders. Ms. Bell worked six or seven days a week, 80 hours a week. She testified that Mr. Bell was the president of Bell Entertainment and the owner of Bellini's Italian Restaurant and Steakhouse. He oversaw the entire restaurant, bar and banquet hall.

In January, 1999 she was the restaurant's assistant manager. She was aware of the January 1999 accident in which Mr. Bell slipped on ice in his driveway while going to his house to get paperwork for the restaurant. Subsequent to this January 1999 incident, she noticed Mr. Bell was in pain. He had trouble bending, stooping and lifting. She testified that Mr. Bell had surgery and was taking a lot of prescription medicine.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law in Cases **01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident.** ARB EX 1 and ARB EX 3. The other two consolidated matters 02 WC 54561 and 12 WC 39144 are handled under separate Decisions.

A: Was there an employment relationship? B: Did an accident occur arising out of and in the course of Petitioner's employment with Respondent? C: Was timely notice provided?

Based on the record in its entirety, the Arbitrator finds that Respondent was operating and subject to the Illinois Workers' Compensation Act and that an employer/employee relationship existed between the Respondent and Mr. Bell. In support of this finding, the Arbitrator notes the unrebutted testimony of Debra Harper, a former manager for the Respondent and Jill Bell, a former assistant manager for the Respondent. Both witnesses testified that Myles Bell was the Owner, Operator and President of Bell Entertainment. Bell Entertainment operated a restaurant and bar named Bellini's Italian Restaurant and Steakhouse. Mr. Bell oversaw the entire restaurant, bar and banquet hall in Libertyville. Ms. Harper testified that alcoholic beverages were served to the general public for consumption on the premises at Bellini's. The provisions of the Act are automatically applied to an establishment that it is open to the general public and alcoholic beverages are sold to the general public for consumption on the premises pursuant to Section 3(12) of the Act.

The Arbitrator further finds that based upon a preponderance of the credible evidence, Myles Bell sustained an accident arising out of and in the course of his employment on January 19, 1999. The Arbitrator finds that although he was at home when he slipped on ice, Mr. Bell frequently traveled home to obtain work related documents and space heaters for the bar as per the testimony of his assistant Ms. Harper. Ms. Harper testified that such trips were common as office space was limited and Mr. Bell kept some of the important documents at home. The Arbitrator finds that Mr. Bell's presence at his home for a work related purpose was reasonable, foreseeable and related to his employment duties such that his accident arose out of his employment under the Act.

The Arbitrator further finds that Respondent had timely notice of the accident of January 19, 1999. This conclusion is based upon the testimony of Respondent's general manager, Debra Harper. She indicated that she was present when Mr. Bell slipped and fell in his driveway on January 19, 1999. She noticed he grabbed his back after he fell and then was moving slowly later that day and the day following the accident. Thus, the Arbitrator finds that Respondent's general manager Debra Harper was a witness to and had knowledge of his fall. Additionally, Mr. Bell was the President of the Respondent and was obviously aware of his fall and subsequent back pain.

F: Is Petitioner's condition of ill-being casually connected to the injury? O: Funeral Expenses

The Arbitrator finds that based on the evidence in its entirety, Petitioner's condition of ill-being does not result and is not causally related to the fall on January 19, 1999. Short of Ms. Harper's testimony that Mr. Bell "jacked his back" in the January 1999 fall, the record is devoid of any credible complaint made or documentation of any treatment sought by Mr. Bell for any symptoms at any point after the January 1999 fall. Rather, the only treatment sought by Mr. Bell was after a non work-related fall on March 25, 1999. The Arbitrator finds that the record as a whole supports a finding that the March 25, 1999 fall was sufficient to sever any causal connection between Petitioner's claimed condition of ill-being and the fall in January 1999.

In so finding, the Arbitrator specifically finds persuasive that no complaint of back pain or injury was documented, reported or treated at the time of or after January 1999. In fact, no medical care at all was sought by Mr. Bell between January 1999 and March 25 1999. Although the medical records after the March 25, 1999 non work related fall clearly indicate that Mr. Bell reported a prior fall in January 1999, the records indicate his reports that he either recovered from any complaints or that the symptoms had subsided such that he was at baseline when he fell again in March 1999. Clearly, Mr. Bell suffered symptoms that required immediate ER care after the March 1999 fall. Shortly thereafter, his condition required surgery again clearly indicating that the condition was much worse than in January 1999 when Mr. Bell sought no treatment for any complaint.

Accordingly, the Arbitrator finds that although Petitioner sustained a work related fall in January 1999, no injury requiring treatment resulted therefrom. Rather, the record in its entirety supports the finding that Petitioner's injury for which he received care and treatment including surgery in July 1999 was solely causally related to the intervening non work related fall on March 25, 1999.

Accordingly, no benefits, including the requested funeral expenses, are awarded in 01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident. All requests for benefits in these matters is denied and all other issues in cases 01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident are moot. No further findings are made.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	02WC054561
Case Name	MARSZALEK,JAMES, EXECUTOR OF v. BELL ENTERTAINMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0384
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	James Marszalek
Respondent Attorney	Stuart Pellish

DATE FILED: 7/28/2021

/s/ Marc Parker, 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

James J. Marszalek, Executor
of the Estate of Myles Bell, Deceased,

Petitioner,

vs. NO: 02 WC 54561

Bell Entertainment,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 4, 2019, is hereby affirmed and adopted.

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

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

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.

July 28, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 7/15/21
68

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MARSZALEK, JAMES J, EXECUTOR OF THE ESTATE OF BELL, MYLES DECEASED
Employee/Petitioner

Case# **02WC054561**

01WC026682
12WC039144
12WC039145

BELL ENTERTAINMENT
Employer/Respondent

On 11/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
KATERINA D KYROS
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

JAMES J. MARSZALEK, executor of the estate of Myles Bell, Deceased,

Case # **02** WC **54561**

Employee/Petitioner
v.
BELL ENTERTAINMENT
Employer/Respondent

Consolidated cases: **01 WC 26682, 12 WC 39144, 12 WC 39145**

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 **04/16/19 and 08/19/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **estoppel, laches, due process, affect of 03-16-10 order of discharge, Statute of Limitations, exceeds choice of physicians**

FINDINGS

On **8/4/2002**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Mr. Bell's condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Mr. Bell earned $**75,000.00**; the average weekly wage was $**1,442.30**.

On the date of accident, Mr. Bell was **50** years of age, ***single*** with **0** dependent children.

Respondent shall receive credit for TTD paid in the stipulated amount of $18,956.06. ARB EX 1.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical expenses incurred in connection with the care and treatment Mr. Bell received for his causally related injury pursuant to Section 8 for bills incurred prior to January 31, 2006 and pursuant to Sections 8 and 8.2 for bills incurred after February 1,2006. Respondent shall receive credit for amounts paid, if any. SEE DECISION

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $961.53 /week for 64 5/7 weeks, commencing 08/04/02 through 10/31/03, as provided in Section 8(b) of the Act. Respondent shall receive credit for TTD paid in the stipulated amount of $18,956.06. ARB EX 1.

Permanent Partial Disability

Respondent shall pay Petitioner $542.17 max ppd rate per week as Petitioner sustained 40% loss of use of the person as a whole 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.

Carolyn M. Doherty

Signature of Arbitrator

11/4/19
Date

NOV - 4 2019

FINDINGS OF FACT

The Arbitrator notes that four consolidated matters were presented for trial. The trial started on 4/16/19 and proofs were closed on 8/19/19. In case 01 WC 26682, the alleged date of accident is January 19. 1999. ARB EX 1. In case 02 WC 54561, the alleged date of accident is August 4, 2002. ARB EX 2. In case 12 WC 39145, a request for funeral expenses is made in connection with case 01 WC 26682. ARB EX 3. In case 12 WC 39144 funeral expenses are requested in connection with case 02 WC 54561. ARB EX 4. Myles Bell, the decedent, passed away on February 9, 2011. James J. Marszalek became the executor of the estate of Myles Bell and presented these matters for trial.

At trial of these consolidated four matters, Petitioner presented the testimony of Debra Harper. Ms. Harper testified that she was employed by Bell Entertainment from 1997 to October 1999 and then again from 2001 to 2003. She testified that Bell Entertainment operated a restaurant and steakhouse known as Bellini's. Myles Bell was the owner and operator of Bell Entertainment and Bellini's. Ms. Harper worked as the general manager for the business. T. 24. Her duties required her to run the restaurant and manage the staff, banquets, billing and payroll. T. 25. She testified that Myles Bell oversaw the daily operations of the restaurant. He was present at the restaurant every day. T. 25. She testified that Mr. Bell received a yearly salary of $75,000. T. 26.

Ms. Harper testified that on January 19, 1999, she drove with Myles Bell from the restaurant in Libertyville to his home in Lake Forest in order to retrieve papers needed by the accountant for quarterly tax purposes. She also testified that they were going to get space heaters to bring back to the restaurant to be used in the bar as the furnace had gone out. T. 27. She further testified that it was common for her to accompany Myles Bell to his home in order to retrieve paperwork for the business as he "kept a lot of stuff at his home, because at the time was limited office space, so all important papers he kept at his residence." T. 29.

Ms. Harper testified that the driveway of the home was icy and when Petitioner got out of the car he "stepped on ice and he slipped right out from under him." T. 28. She then observed Mr. Bell get up from the ground and noted the he grabbed his back. She asked him if he was okay and he replied that he was. T. 29. She testified that they retrieved what they needed from the home and returned to the restaurant. She testified that later that evening she noticed he was moving a little slower up the stairs and that the next day Myles Bell came in later than usual to the restaurant. The next day she noticed Petitioner moving very slowly and stating "I think I really jacked up my back." T. 30. After January 1999, Ms. Harper noticed that he started coming in later to the restaurant and that he limited his physical abilities as to what he would do around the restaurant. She testified that he no longer helped her move tables and that the bus boys now moved the tables. T. 31.

In reviewing the medical records submitted at trial, the Arbitrator notes that Petitioner sought no medical treatment after the January 19, 1999 fall on his driveway. In addition, no report of injury was made at that time in January 1999. The first mention of a fall in January 1999 was

made to Mr. Bell's primary doctor, Dr. Kyncl on March 30, 1999. PX 8. That record states, "Jan ... fell- fell again- work."

Ms. Harper testified that Petitioner in fact fell again in March 1999 when he slipped on oil in his garage at home. She was not present and did not provide any additional details about the circumstances of the fall in March 1999. She testified that Petitioner exhibited signs of extreme back pain after March 1999 and that he limited his physical activity and carried himself differently. He was also unable to sit for long periods of time.

Lake Forest Hospital emergency room records dated 3/25/99 indicate , "This is a 47 year old male who presents complaining of left lower back pain. The patient states that he fell in his garage on an [sic] slick oil spot earlier today landing on his back. He states the he had done this two months ago in January, landing on the ice, but his pain was not as severe. He was not evaluated for that incident. However, he continued to have some pain in his back and falling today made it worse. He denies any other injury or pain. ... no numbness or weakness in his legs." PX 10. Petitioner was diagnosed with a lumbar contusion and given pain medication. He was to follow up with his personal doctor in 3-4 days. PX 10.

Petitioner first sought medical attention from his primary doctor, Dr. Kincyl, on March 30, 1999. Dr. Kincyl made the above brief notations and diagnosed Mr. Bell with sciatica. Petitioner complained of pain down the left leg. Mr. Bell underwent lumbar x-rays on 3/25/99 which showed narrowing of interspaces of L4-S1 and L5-S1 with associated moderate hypertrophic degenerative changes as well as mild to moderate facet arthritis. Conservative care including physical therapy was recommended. Petitioner attended physical therapy in April 1999 where he reported both the fall in January 1999 and in March 1999.

On May 8, 1999 Petitioner was admitted to Lake Forest Hospital by Dr. Kyncl noting that "the patient fell in January and sustained a back injury and recovered from this. He fell again about a month ago on some oil and had a lot of pain for which he needed some medicine. He again had a worsening about a week ago when he developed some abdominal flue and had severe nausea and vomiting. He was vomiting for four days straight and strained his back with all of his and has been having severe back pain since then. ... the pain got out of hand and he came in yesterday with intractable back pain going down his left leg." PX 10. Petitioner was admitted for testing. A May 11, 1999 Lumbar myelogram and CT showed broad based left lateral disc protrusion at the L4-5 level projecting into the inferior portion of the left L4-5 neuroforamen and flattening the left anterolateral aspect of the thecal sac along with moderately severe right and mild to moderate left L5-S1 facet joint overgrowth with mild encroachment upon the neuorforamen bilaterally and lateral recesses. PX 6 PX 10. Petitioner underwent epidural steroid injections on 5/13/99. PX 10. Petitioner was referred to Dr. Bauer.

On 6/25/19, Dr. Bauer reviewed the lumber myelogram and noted his impression of spinal canal of normal size with an anterior indentation of the anterior epidural space mainly at L4-L5 and to a lesser degree at L2-3. PX 6. On July 1, 1999, Dr. Bauer noted that Mr. Bell "... was well until January 1999 when he slipped on the ice and fell onto his tailbone at home. In March 1999 he fell and slipped in his garage because his foot was weak. He went to Lake Forest Hospital and had x-rays performed. Since then he has undergone a CT scan and myelogram. He is unable to

do an MRI scan. He had physical therapy and while standing on a teeter-totter he aggravated the pain in his leg about 1 ½ weeks ago. He has had continued pain in the sciatic distribution of his left leg down to his lateral ankle but not into his toes. He has weakness and drags his left foot. He has a sense of numbness and tingling. He has a history of back pain but never lost time from work due to his or has he had treatment. His pain has been acutely exacerbated recently. … he has dull aching back pain. His leg pain is sharp , however." PX 6.

Dr. Bauer reviewed the CT scan and myelogram and found evidence of a herniated disc at L4-5 with foraminal stenosis. He diagnosed a left, L5 radiculopathy due to a herniated disc and foraminal stenosis. Dr. Bauer recommended surgery. PX 6. Dr. Bauer performed a micro lumbar diskectomy left L4-L5 with microdissection on July 20, 1999. The post op diagnosis was left L4-5 herniated disk. PX 6. Petitioner attended physical therapy post op as well. Mr. Bell continued to treat periodically for low back pain and radiating left leg pain complaints through June 2002.

Between August 1999 and August 2002, Petitioner continued to receive medical care from his primary physician, Dr. Kincyl for complaints of back pain which Dr. Kincyl categorized as chronic following his surgery. A repeat lumbar MRI on May 6, 2000 noted the July 1999 surgery and the persistent low back pain thereafter. The MRI indicated post surgical changes and mild disc bulge at L4-5 with slight encroachment. Petitioner received multiple epidural steroid injections in 2000 and 2001 to the lumbar spine and the histories noted less than one year relief from the 1999 surgery followed by recurrent low back and left leg radicular pain which was severe in nature. PX 8. PX 11. Petitioner was taking Flexeril, Ambien and Vicodin during this time period as well. PX 11.

Mr. Bell received an injection from Dr. Primack on June 25, 2002, in an attempt to alleviate continued left leg radiculopathy. PX 8. On that date, Dr. Primack noted the prior surgery in 1999 and noted that "Although the pain was better than before surgery, he has never been asymptomatic since then and has persistent left leg pain ever since." PX 8.

Petitioner's next alleged accident date is August 4, 2002, the subject of 02 WC 54561. Ms. Harper testified that on August 4, 2002, Mr. Bell went downstairs to his office in the restaurant at closing time. He was fine when he went down the stairs. When he came back up the stairs she noticed he was moving very slowly and that it took him a long time to come back up. She stated Mr. Bell was angry because no one hear him calling for help and he stated that he had fallen down the stairs to the lower level of the restaurant where the banquet room and his office was located. She testified that he would use the stairs about 10 to 15 times per day or more in the natural course of running the restaurant. She testified that Mr. Bell never returned to work thereafter and the restaurant closed in January 2003.

Petitioner was seen at Lake Forest Hospital ER on 8/6/02 stating that he fell landing on his buttocks and sacrum two days prior. He reported low back pain and radiating left leg pain. He was given pain medication and discharged with instructions to follow up with Orthopedic surgery. PX 11. Records from Lake Forest hospital dated 8/9/2002 indicate that Mr. Bell was admitted for low back pain. The record indicates "the patient is known to have had surgery on L4 diskectomy with good results. However, he fell down a few days prior to the admission, straight on the back, and since then has had very severe pain going across to the lower back, not much to the legs. He is admitted for observation, control of the pain and MRI." PX 8. An

additional history from August 9, 2002 indicates that Mr. Bell fell on the "3rd of this month while cleaning up at work" and the his pre-existing symptoms were exacerbated by the fall. Petitioner reported that his pre-existing pain was now constant in the low back radiating down the left leg. PX 11. The discharge summary dated 8/17/02 notes that Mr. Bell noted radicular pain one month after his 1999 surgery and subsequent treatment with injections and pain medication for chronic pain. The notes indicates, "the patient still has pain in the left leg though 2 weeks ago he fell down resulting in incapacitating back pain in addition to the exacerbation of his leg pain. ... left leg is entirely numb." Subsequent MRI on 8/9/02 showed L4-5 disk herniation with significant degenerative disease. PX 8.

Mr. Bell underwent a lumbar laminectomy L4-5 bilateral instrumented fusion L4-S1 and right iliac crest bone graft performed by Dr. Tack on 9/19/02. PX 11. After this second surgery, Petitioner was treated for chronic low back pain and left leg radiculopathy with chronic pain medication. As of December 20, 2002, Petitioner was seen for a Section 12 exam performed by Dr. Skaletsy who indicated that Petitioner had done well initially after surgery but that his pain was worsening post surgery. Dr. Skaletsky opined that his condition was not related to the fall of August 2002 as the condition was long standing, required treatment up to the time of fall in August 2002 and the MRI did not show any additional changes or acute or traumatic findings. He opined Petitioner sustained a back strain and that the need for surgery did not result from the August 2002 fall. PX 8. RX 2.

Dr. Tack continued to treat Petitioner post surgery in 2003. Dr. Tack noted his disagreement with Dr. Skaletsky calling his opinion "almost nonsensical." Dr. Tack noted that Dr. Skaletsky did not properly consider the fusion surgery or Petitioner's continued symptoms post surgery. PX 12. On October 31, 2003, Dr. Tack noted continued slow improvement and ordered symptomatic treatment with progressive activities as tolerated. He noted that Petitioner could see Dr. Kincyl for medication management. Dr. Tack would see Mr. Bell as needed. PX 12.

On October 27, 2003, Mr. Bell visited Dr Scott Kale who specializes in Internal Medicine and Rheumatology, at the request of the State of Illinois Department of Human Services, Division of Disability Determination Services. At the initial visit, Mr. Bell provided the following history to Dr. Kale: "While working on 08-04-02 while working in his restaurant, he fell three or four feet directly onto his buttocks from a stairwell, at which time he experienced pain with radiation of that pain into his left leg." Mr. Bell elected to commence treatment with Dr. Kale. He saw Dr. Kale regularly through January 26, 2011. Dr. Kale diagnosed chronic low back pain with failed low back pain syndrome with severe pain, depression and drug addiction. He prescribed Mr. Bell narcotic analgesics to help relieve the pain in addition to sleeping medications. (Petitioner's Exhibit #14, pages 9 to 18).

Petitioner suffered from depression along with chronic pain. In 2008, he was admitted to the hospital with a self inflicted gun-shot wound. PX 10. Mr. Bell died on February 9, 2011. The cause of death was listed as morphine and benzodiazepine overdose. PX 2.

Mr. Bell's representatives also called Jill Bell to testify. She is the ex wife of Myles Bell. They were married on June 8, 2003 and divorced on August 9, 2009- 2 years before the death of Myles Bell. T. 64-65. They had no children and to her knowledge Mr. Bell never had children. Mr. Bell was never married before Jill Bell nor re-married after their divorce. T. 65.

Ms. Bell began working for Bell Entertainment in March, 1997. She worked as a hostess, until January 1, 1998. She became the night time full-time bartender. She worked as a bartender for six months and then was promoted to the assistant manager in charge of the bar and bartenders. Ms. Bell worked six or seven days a week, 80 hours a week. Mr. Bell was the president of Bell Entertainment and the owner of Bellini's Italian Restaurant and Steakhouse. He oversaw the entire restaurant, bar and banquet hall.

In January, 1999 she was the restaurant's assistant manager. She was aware of the January 1999 accident in which Mr. Bell slipped on ice in his driveway while going to his house to get paperwork for the restaurant. Subsequent to this January 1999 incident, she noticed Mr. Bell was in pain. He had trouble bending, stooping and lifting. She testified that Mr. Bell had surgery and was taking a lot of prescription medicine.

Ms. Bell was working on August 4, 2002. On the evening of August 3rd, when Mr. Bell started working, he appeared to be alright. Subsequent to the fall on August 4, 2002, Ms. Bell noticed Mr. Bell could not walk at all. Bellini had 3 flights of stairs; you would climb a level of stairs, there would be a landing up to the foyer of the restaurant, and then up again into the restaurant. The main level is the bar and the main part of the restaurant. There is a banquet hall downstairs along with Mr. Bell's office.

In the lower/basement level was the banquet room, Mr. Bell's office, a kitchen and bathrooms. Going up the stairs, there is a bar to the right, the restaurant on the left, bathrooms and the main kitchen in the back. If a guest came into the main entrance, they would have to go upstairs to the restaurant or bar. Alternatively, they could go down the stairs to the banquet room. Ms. Bell estimated Mr. Bell would go up and down the stairs 30-40 times a day in order to oversee the bar and restaurant.

Subsequent to August 4, 2002, Mr. Bell never returned to work. Mr. Bell had another back surgery and was taking a lot of prescription medication. Ms. Bell testified that after the second surgery, Mr. Bell always needed help. He was never without his cane. At first, he was in a wheelchair for a while, then started using a walker, and then started using a cane. Mr. Bell did not go anywhere without his cane. Ms. Bell observed Mr. Bell had a high tolerance for pain medications.

Ms. Bell last saw Mr. Bell on October 9, 2008. Mr. Bell was taking medications. Mr. Bell appeared very bitter and very unhappy.

Ms. Bell identified Petitioner's Exhibits 28 through 29, and 39 through 45 are the prescription records of all the pills taken by Mr. Bell. Ms. Bell ran the household and paid the co-payments identified on the identified exhibits. Ms. Bell acknowledged she has not received any bills or any demands for payment of any medical bills pertaining to Mr. Bell's medical care.

Ms. Bell testified she and Mr. Bell filed separate bankruptcy petitions. Ms. Bell filed her bankruptcy petition before she divorced. On her bankruptcy petition she listed all of the incurred medical bills. She testified that she believed all of the medical bills were wiped out because of bankruptcy.

Ms. Bell was aware of the first probate estate but was not involved in its filing. She was involved in the reopening of Mr. Bell's estate in March, 2018.

Ms. Bell in June/July 2002 was aware Mr. Bell was taking pain medications. He was having sciatic issues. Mr. Bell complained of pain in his lower back and down his left leg. Ms. Bell testified Mr. Bell worked an average of 12 hours per day, 6 days per week. Bellini's was closed on Mondays.

She further testified there was more than one way to go from the lower banquet level to the restaurant and bar level. There was a stairway going from the banquet level kitchen to the upstairs kitchen. She testified that Mr. Bell mostly used the front stairwell, but sometimes he would use the back stairs. If he was going to the main kitchen he would go through the downstairs kitchen because that was the fastest way to go, depending on what area he was going to.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law in cases **02 WC 54561 and 12 WC 39144** for the alleged **August 4, 2002 accident date.** ARB EX 2 and ARB EX 4. The other two consolidated matters **01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident** are handled under separate Decisions.

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

To be compensable under the Act, a claimant must prove, by a preponderance of the evidence, that the accidental injury was one arising out of and in the course of the employment. *Sisbro, Inc. vs. Industrial Comm'n,* 207 Ill.2d 193, 203 (2003). For an injury to 'arise out of' the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. The initial step in considering the "arising out of" component of a worker's compensation claim is to determine the type of risk to which the claimant was exposed at the time of his injury. *Baldwin vs. Illinois Worker's Compensation Comm'n,* 409 Ill.App.3d 472, 478 (2011). "Risks to employees fall into three groups: (1) risks distinctly associated with the employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics." *Id.* A risk "distinctly associated" with a claimant's employment is a risk that is peculiar to the claimant's work or incurred as the result of a defect in the employer's premises. *Orsini vs. Industrial Comm'n,* 117 Ill.2d 38, 45 (1987); *First Cash Financial Services vs. Industrial Comm'n,* 367 Ill.App.3d 102, 106 (2006). A neutral risk is one having no particular employment or personal characteristic. "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago vs. Illinois Worker's Compensation Comm'n,* 407 Ill.App.3d 1010, 1014 (2011). The increased risk may be either qualitative, in that some aspect of the employment contributed to the risk, or quantitative, in that the employee is exposed to the common risk more frequently than the general public. *Id.*

In the instant case, the record supports a finding that Petitioner's fall down the stairs at work on August 4, 2002, was the result of an increased risk faced by Petitioner thus making his fall compensable. The Arbitrator finds that both Ms. Harper and Ms. Bell testified that Mr. Bell used the stairs multiple times per day in order to travel between the bar and restaurant area and to his office in the basement in order to meet the daily needs of the restaurant. Ms. Bell testified that he used the stairs as much as 30 to 40 times per day. The Arbitrator finds that in so using the stairs, Mr. Bell faced a risk of injury greater than that facing the general public in using stairs. His use of the stairs was not occasional or unnecessary. Rather, his use of the stairs was constant and clearly required in the daily management of the restaurant and bar. Accordingly, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on August 4, 2002.

Is Petitioner's condition of ill being causally related to injury?

Based on the record in its entirety, it is clear that Mr. Bell was continuously symptomatic following the July 1999 surgery up to the time of the August 4, 2002 fall at work. Between 1999 and 2002, Mr. Bell continuously received pain medication and underwent 6 steroid injections in an attempt to alleviate his pain. He was seen by Dr. Primack in late June 2002 and received another a lumbar epidural steroid injection.

Nevertheless, the Arbitrator further notes that after his fall on August 4, 2002, Mr. Bell's symptoms, although similar in nature to the pre-fall symptoms, significantly increased. Two days after the fall of August 4, 2002 incident, Mr. Bell was seen at Lake Forest Hospital. He was subsequently admitted with severe back pain on August 9, 2002. The treating records from Lake Forest subsequent to the August 4, 2002 fall clearly indicate an increase in the well documented pre-existing symptoms, including an increase in the left leg radiculopathy. The record indicates "the patient is known to have had surgery on L4 diskectomy with good results. However, he fell down a few days prior to the admission, straight on the back, and since then has had very severe pain going across to the lower back, not much to the legs. He is admitted for observation, control of the pain and MRI." PX 8. An additional history from August 9, 2002 indicates that Mr. Bell fell on the "3rd of this month while cleaning up at work" and his pre-existing symptoms were exacerbated by the fall. Petitioner reported that his pre-existing pain was now constant in the low back radiating down the left leg. PX 11. The discharge summary dated 8/17/02 notes that Mr. Bell noted radicular pain one month after his 1999 surgery and subsequent treatment with injections and pain medication for chronic pain. The notes indicate, "the patient still has pain in the left leg though 2 weeks ago he fell down resulting in incapacitating back pain in addition to the exacerbation of his leg pain. … left leg is entirely numb." PX 11. Subsequent MRI on 8/9/02 showed L4-5 disk herniation with significant degenerative disease. PX 8. One month after the August 2002 fall, Mr. Bell underwent a prescribed fusion surgery, which was not previously prescribed or anticipated.

Based on the foregoing, the Arbitrator finds causal connection between Mr. Bell's increased low back and left leg symptoms necessitating the fusion surgery in September 2002 and the fall at work on August 4, 2002.

What is the AWW?

The Arbitrator finds that Mr. Bell's average weekly wage is $1,442.30 with yearly earnings of $75,000.00. This finding is based upon Petitioner's Exhibit #5, a Travelers' Insurance wage statement form indicating that Mr. Bell earned $2,884.62 biweekly from August 4, 2001 through August 1, 2002, which results in an AWW of $1,442.30. Both Debra Harper, Respondent's General Manager, and Jill Bell, an Assistant Manager testified that Mr. Bell was paid a salary of $75,000.00 per year.

What is the TTD owed?

The Arbitrator finds that Myles Bell was temporarily and totally disabled for 64 and 5/7ths weeks from August 4, 2002 to October 31, 2003. Both Debra Harper and Jill Bell testified that Mr. Bell never returned to work after August 4, 2002. Mr. Bell treated with his surgeon post fusion through October 31, 2003 at which time Dr. Tack noted continuing slow improvement. An MRI ordered by Dr. Kyncl demonstrated appropriate implant position and decompression at L4 to S1. Dr. Tack recommended purely symptomatic treatment with progressive activities as tolerated. (Petitioner's Exhibit #12). Respondent shall receive credit for TTD paid in the stipulated amount of $18,956.06. ARB EX 1.

What medical expenses are due and owing?

The Petitioner claimed that the Respondent in this case is liable for medical bills that were incurred after August 4, 2002. The Respondent raised a foundational objection to those bills. The Arbitrator finds that sufficient corresponding medical records were admitted into evidence as well as the testimony of Dr. Scott Kale to establish that Exhibits 30 through 34 were for medical treatment related to the alleged injuries in this case. These records provide a description and dates of treatment and they are a reliable indication of the treatment rendered and the charges incurred. Additionally, Exhibits 30, 37, 38 and 46 were either certified or received pursuant to subpoena and are therefore admissible under Section 16 of the Act. In addition, Exhibits #39 through 45 were identified by Jill Bell as prescription records that were paid by her or Mr. Bell.

Respondent has also disputed whether or not Mr. Bell exceeded his choice of two medical providers or providers within a chain of referrals. ARB EX 2. After the August 4, 2002 accident, Mr. Bell was initially seen in the emergency room at Lake Forest Hospital. He followed up there again on August 9, 2002 and was admitted through August 17, 2002. During that admission he was seen by Dr. Miloslava Kyncl, his primary care physician and Dr. Stanford Tack who performed a consultative exam. He followed up with Dr. Kyncl and Dr. Tack who performed surgery on September 17, 2002 at Lake Forest Hospital. Exhibits 31 through 35 are for services peripheral to his treatment at Lake Forest Hospital and with doctors Kyncl and Tack.

There is a notation in Dr. Tack's August 27, 2002 office note that Mr. Bell had, "a second opinion of sorts with Dr. Jonathan Citow which he found to be somewhat unhelpful." (Petitioner's Exhibit #12). There was no testimony, medical records or reports presented to establish if fact Dr. Citow ever provided treatment to Mr. Bell, when he saw him or for what reason. Consequently, the Arbitrator finds there is insufficient evidence in the record to establish that Dr. Citow was Mr. Bell's second choice of medical providers. Rather, the Arbitrator finds that Mr. Bell's second choice of provider was Dr. Kale as of October 27, 2003. (Petitioner's Exhibit #14, 37).

Lastly, Mr. Bell also saw Dr. Reuben Wiesz for an evaluation primarily for right upper extremity symptoms. The Arbitrator finds this treatment is not related to the lumbar injury that occurred on August 4, 2002 and that Petitioner's Exhibit #36 is denied.

Accordingly, based on the Arbitrator's findings on the issue of accident and causal connection, the Arbitrator further finds that Respondent shall pay the reasonable and necessary medical expenses incurred by Mr. Bell in the care and treatment of his causally related injury as shown in PX 30 through 35 and 37 through 46. The bills incurred from August 6, 2002 through January 31, 2006 are awarded pursuant to Section 8(a) of the Act. The bills incurred after February 1, 2006, are awarded pursuant to Sections 8(a) and 8.2 of the Act.

To the extent Respondent has paid any or all of these bills, Respondent shall receive credit for amounts paid. Respondent does not claim credit under Section 8(j). ARB EX 2. The Arbitrator further notes that the 2007 Bankruptcy Petition and Discharge Order filed in March 2008 do not clearly indicate or address the medical bills awarded herein. RX 1. Accordingly, the Arbitrator makes no finding regarding the effect of the Bankruptcy Petition and Discharge Order on the medical bills awarded herein.

What is the nature and extent of the injury?

The Arbitrator notes the date of accident on August 4, 2002 – well pre-dating the Amended Act of 2011 requiring impairment analysis under Section 8.1b of the Act.

It is clear to the Arbitrator that Mr. Bell had significant ongoing, long-standing disability prior to and at the time of the work accident of August 4, 2002. As noted above, Mr. Bell continued to receive treatment for his pre-existing low back and left leg symptoms well prior and up to the August 4, 2002 accident at work. Dr. Primack administered an epidural injection into the lumbar spine on June 25, 2002, 6 weeks before the accident of August 4, 2002. However, given the exacerbation of the pre-existing symptoms resulting in the need for a fusion surgery following the work accident of August 4, 2002, the Arbitrator finds that Mr. Bell sustained some increase in his pre-existing disability. Following the fusion surgery in September 2002, Mr. Bell was treated with medication and additional conservative care for his continued pain as well as for numerous unrelated health issues contained in the medical records including depression, cardiac and abdominal issues. The Arbitrator does note that Mr. Bell never returned to work after the accident of August 4, 2002.

Based on the foregoing, and on the record in its entirety, the Arbitrator finds that Mr. Bell sustained 40% of the person as a whole under Section 8(d)(2) of the Act.

Are funeral expenses due and owing?

The estate of Mr. Bell seeks the entry of an award for funeral benefits in case 12 WC 39144. That claim is denied. Both Ms. Harper and Ms. Bell testified Mr. Bell was taking medications prior to August 4, 2002. The record is insufficient for the Arbitrator to conclude as to which medications might have contributed to Mr. Bell's death. The Arbitrator has nothing credible on which to base a finding that the death was caused by medication prescribed as a result of a work accident of August 4, 2002 or that those medications were a causative factor in Mr. Bell's death. Mr. Bell has failed to meet his burden in establishing and award of funeral benefits.

O: Other issues

On ARB EX 2 Respondent placed the doctrines of estoppel, laches, due process and the statute of limitations in dispute. Respondent did not present any argument on these issues. Accordingly, the Arbitrator makes no findings on these issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC039144
Case Name	COLLINS,CARY EXECUTOR OF v. BELL ENTERTAINMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0385
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	James Marszalek
Respondent Attorney	Stuart Pellish

DATE FILED: 7/28/2021

/s/ Marc Parker, 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

James J. Marszalek, Executor
of the Estate of Myles Bell, Deceased,

Petitioner,

vs. NO: 12 WC 39144

Bell Entertainment,

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, permanent partial disability, and funeral 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 October 16, 2019, is hereby affirmed and adopted.

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

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

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.

July 28, 2021

MP:yl
o 7/15/21
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

MARSZALEK, JAMES J, EXECUTOR OF THE ESTATE OF BELL, MYLES DECEASED
Employee/Petitioner

Case# **12WC039144**

01WC026682
02WC054561
12WC039145

BELL ENTERTAINMENT
Employer/Respondent

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

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

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
STUART PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

JAMES J. MARSZALEK, executor of the estate of Myles Bell, Deceased,

WC Employee/Petitioner
v.
BELL ENTERTAINMENT
Employer/Respondent

Case # 12 WC 39144
Consolidated cases: **01 WC 26682, 02 WC 54561, 12 WC 39145**

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 **04/16/19 and 08/19/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. xx Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. xx 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. xx 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. xx What was Petitioner's age at the time of the accident?
I. xx 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 – FUNERAL EXPENSES

FINDINGS

On **8/4/2002**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Mr. Bell's death was not causally connected to the accident of 8/4/02

ORDER

In support of the Arbitrator's decision concerning the estate's entitlement to an award of benefits under Section 7 of the Act, the Arbitrator finds the following:

The Arbitrator finds in this matter 12 WC 39144 that the decedent's death was not causally related to the accident of August 4, 2002. Accordingly, no benefits are awarded to Mr. Bell's estate under Section 7 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.

Carolyn M. Doherty

Signature of Arbitrator

10/16/19
Date

OCT 16 2019

FINDINGS OF FACT

The Arbitrator notes that four consolidated matters were presented for trial. The trial started on 4/16/19 and proofs were closed on 8/19/19. In case 01 WC 26682, the alleged date of accident is January 19. 1999. ARB EX 1. In case 02 WC 54561, the alleged date of accident is August 4, 2002. ARB EX 2. In case 12 WC 39145, a request for funeral expenses is made in connection with case 01 WC 26682. ARB EX 3. In case 12 WC 39144 funeral expenses are requested in connection with case 02 WC 54561. ARB EX 4. Myles Bell, the decedent, passed away on February 9, 2011. James J. Marszalek became the executor of the estate of Myles Bell and presented these matters for trial.

At trial of these consolidated four matters, Petitioner presented the testimony of Debra Harper. Ms. Harper testified that she was employed by Bell Entertainment from 1997 to October 1999 and then again from 2001 to 2003. She testified that Bell Entertainment operated a restaurant and steakhouse known as Bellini's. Myles Bell was the owner and operator of Bell Entertainment and Bellini's. Ms. Harper worked as the general manager for the business. T. 24. Her duties required her to run the restaurant and manage the staff, banquets, billing and payroll. T. 25. She testified that Myles Bell oversaw the daily operations of the restaurant. He was present at the restaurant every day. T. 25. She testified that Mr. Bell received a yearly salary of $75,000. T. 26.

Ms. Harper testified that on January 19, 1999, she drove with Myles Bell from the restaurant in Libertyville to his home in Lake Forest in order to retrieve papers needed by the accountant for quarterly tax purposes. She also testified that they were going to get space heaters to bring back to the restaurant to be used in the bar as the furnace had gone out. T. 27. She further testified that it was common for her to accompany Myles Bell to his home in order to retrieve paperwork for the business as he "kept a lot of stuff at his home, because at the time was limited office space, so all important papers he kept at his residence." T. 29.

Ms. Harper testified that the driveway of the home was icy and when Petitioner got out of the car he "stepped on ice and he slipped right out from under him." T. 28. She then observed Mr. Bell get up from the ground and noted the he grabbed his back. She asked him if he was okay and he replied that he was. T. 29. She testified that they retrieved what they needed from the home and returned to the restaurant. She testified that later that evening she noticed he was moving a little slower up the stairs and that the next day Myles Bell came in later than usual to the restaurant. The next day she noticed Petitioner moving very slowly and stating "I think I really jacked up my back." T. 30. After January 1999, Ms. Harper noticed that he started coming in later to the restaurant and that he limited his physical abilities as to what he would do around the restaurant. She testified that he no longer helped her move tables and that the bus boys now moved the tables. T. 31.

In reviewing the medical records submitted at trial, the Arbitrator notes that Petitioner sought no medical treatment after the January 19, 1999 fall on his driveway. In addition, no report of injury was made at that time in January 1999. The first mention of a fall in January 1999 was made to Mr. Bell's primary doctor, Dr. Kyncl on March 30, 1999. PX 8. That record states, "Jan … fell- fell again- work."

Ms. Harper testified that Petitioner in fact fell again in March 1999 when he slipped on oil in his garage at home. She was not present and did not provide any additional details about the circumstances of the fall in March 1999. She testified that Petitioner exhibited signs of extreme back pain after March 1999 and that he limited his physical activity and carried himself differently. He was also unable to sit for long periods of time.

Lake Forest Hospital emergency room records dated 3/25/99 indicate , "This is a 47 year old male who presents complaining of left lower back pain. The patient states that he fell in his garage on an [sic] slick oil spot earlier today landing on his back. He states the he had done this two months ago in January, landing on the ice, but his pain was not as severe. He was not evaluated for that incident. However, he continued to have some pain in his back and falling today made it worse. He denies any other injury or pain. ... no numbness or weakness in his legs." PX 10. Petitioner was diagnosed with a lumbar contusion and given pain medication. He was to follow up with his personal doctor in 3-4 days. PX 10.

Petitioner first sought medical attention from his primary doctor, Dr. Kincyl, on March 30, 1999. Dr. Kincyl made the above brief notations and diagnosed Mr. Bell with sciatica. Petitioner complained of pain down the left leg. Mr. Bell underwent lumbar x-rays on 3/25/99 which showed narrowing of interspaces of L4-S1 and L5-S1 with associated moderate hypertrophic degenerative changes as well as mild to moderate facet arthritis. Conservative care including physical therapy was recommended. Petitioner attended physical therapy in April 1999 where he reported both the fall in January 1999 and in March 1999.

On May 8, 1999 Petitioner was admitted to Lake Forest Hospital by Dr. Kyncl noting that "the patient fell in January and sustained a back injury and recovered from this. He fell again about a month ago on some oil and had a lot of pain for which he needed some medicine. He again had a worsening about a week ago when he developed some abdominal flue and had severe nausea and vomiting. He was vomiting for four days straight and strained his back with all of his and has been having severe back pain since then. ... the pain got out of hand and he came in yesterday with intractable back pain going down his left leg." PX 10. Petitioner was admitted for testing. A May 11, 1999 Lumbar myelogram and CT showed broad based left lateral disc protrusion at the L4-5 level projecting into the inferior portion of the left L4-5 neuroforamen and flattening the left anterolateral aspect of the thecal sac along with moderately severe right and mild to moderate left L5-S1 facet joint overgrowth with mild encroachment upon the neuorforamen bilaterally and lateral recesses. PX 6 PX 10. Petitioner underwent epidural steroid injections on 5/13/99. PX 10. Petitioner was referred to Dr. Bauer.

On 6/25/19, Dr. Bauer reviewed the lumber myelogram and noted his impression of spinal canal of normal size with an anterior indentation of the anterior epidural space mainly at L4-L5 and to a lesser degree at L2-3. PX 6. On July 1, 1999, Dr. Bauer noted that Mr. Bell "... was well until January 1999 when he slipped on the ice and fell onto his tailbone at home. In March 1999 he fell and slipped in his garage because his foot was weak. He went to Lake Forest Hospital and had x-rays performed. Since then he has undergone a CT scan and myelogram. He is unable to do an MRI scan. He had physical therapy and while standing on a teeter-totter he aggravated the pain in his leg about 1 ½ weeks ago. He has had continued pain in the sciatic distribution of his left leg down to his lateral ankle but not into his toes. He has weakness and drags his left foot. He has a sense of numbness and tingling. He has a history of back pain but never lost time from

work due to his or has he had treatment. His pain has been acutely exacerbated recently. … he has dull aching back pain. His leg pain is sharp , however." PX 6.

Dr. Bauer reviewed the CT scan and myelogram and found evidence of a herniated disc at L4-5 with foraminal stenosis. He diagnosed a left, L5 radiculopathy due to a herniated disc and foraminal stenosis. Dr. Bauer recommended surgery. PX 6. Dr. Bauer performed a micro lumbar diskectomy left L4-L5 with microdissection on July 20, 1999. The post op diagnosis was left L4-5 herniated disk. PX 6. Petitioner attended physical therapy post op as well. Mr. Bell continued to treat periodically for low back pain and radiating left leg pain complaints through June 2002.

Between August 1999 and August 2002, Petitioner continued to receive medical care from his primary physician, Dr. Kincyl for complaints of back pain which Dr. Kincyl categorized as chronic following his surgery. A repeat lumbar MRI on May 6, 2000 noted the July 1999 surgery and the persistent low back pain thereafter. The MRI indicated post surgical changes and mild disc bulge at L4-5 with slight encroachment. Petitioner received multiple epidural steroid injections in 2000 and 2001 to the lumbar spine and the histories noted less than one year relief from the 1999 surgery followed by recurrent low back and left leg radicular pain which was severe in nature. PX 8. PX 11. Petitioner was taking Flexeril, Ambien and Vicodin during this time period as well. PX 11.

Mr. Bell received an injection from Dr. Primack on June 25, 2002, in an attempt to alleviate continued left leg radiculopathy. PX 8. On that date, Dr. Primack noted the prior surgery in 1999 and noted that "Although the pain was better than before surgery, he has never been asymptomatic since then and has persistent left leg pain ever since." PX 8.

Petitioner's next alleged accident date is August 4, 2002, the subject of 02 WC 54561. Ms. Harper testified that on August 4, 2002, Mr. Bell went downstairs to his office in the restaurant at closing time. He was fine when he went down the stairs. When he came back up the stairs she noticed he was moving very slowly and that it took him a long time to come back up. She stated Mr. Bell was angry because no one hear him calling for help and he stated that he had fallen down the stairs to the lower level of the restaurant where the banquet room and his office was located. She testified that he would use the stairs about 10 to 15 times per day or more in the natural course of running the restaurant. She testified that Mr. Bell never returned to work thereafter and the restaurant closed in January 2003.

Petitioner was seen at Lake Forest Hospital ER on 8/6/02 stating that he fell landing on his buttocks and sacrum two days prior. He reported low back pain and radiating left leg pain. He was given pain medication and discharged with instructions to follow up with Orthopedic surgery. PX 11. Records from Lake Forest hospital dated 8/9/2002 indicate that Mr. Bell was admitted for low back pain. The record indicates "the patient is known to have had surgery on L4 diskectomy with good results. However, he fell down a few days prior to the admission, straight on the back, and since then has had very severe pain going across to the lower back, not much to the legs. He is admitted for observation, control of the pain and MRI." PX 8. An additional history from August 9, 2002 indicates that Mr. Bell fell on the "3rd of this month while cleaning up at work" and the his pre-existing symptoms were exacerbated by the fall. Petitioner reported that his pre-existing pain was now constant in the low back radiating down the left leg. PX 11. The discharge summary dated 8/17/02 notes that Mr. Bell noted radicular pain one

month after his 1999 surgery and subsequent treatment with injections and pain medication for chronic pain. The notes indicates, "the patient still has pain in the left leg though 2 weeks ago he fell down resulting in incapacitating back pain in addition to the exacerbation of his leg pain. ... left leg is entirely numb." Subsequent MRI on 8/9/02 showed L4-5 disk herniation with significant degenerative disease. PX 8.

Mr. Bell underwent a lumbar laminectomy L4-5 bilateral instrumented fusion L4-S1 and right iliac crest bone graft performed by Dr. Tack on 9/19/02. PX 11. After this second surgery, Petitioner was treated for chronic low back pain and left leg radiculopathy with chronic pain medication. As of December 20, 2002, Petitioner was seen for a Section 12 exam performed by Dr. Skaletsy who indicated that Petitioner had done well initially after surgery but that his pain was worsening post surgery. Dr. Skaletsky opined that his condition was not related to the fall of August 2002 as the condition was long standing, required treatment up to the time of fall in August 2002 and the MRI did not show any additional changes or acute or traumatic findings. He opined Petitioner sustained a back strain and that the need for surgery did not result from the August 2002 fall. PX 8. RX 2.

Dr. Tack continued to treat Petitioner post surgery in 2003. Dr. Tack noted his disagreement with Dr. Skaletsky calling his opinion "almost nonsensical." Dr. Tack noted that Dr. Skaletsky did not properly consider the fusion surgery or Petitioner's continued symptoms post surgery. PX 12. On October 31, 2003, Dr. Tack noted continued slow improvement and ordered symptomatic treatment with progressive activities as tolerated. He noted that Petitioner could see Dr. Kincyl for medication management. Dr. Tack would see Mr. Bell as needed. PX 12.

On October 27, 2003, Mr. Bell visited Dr Scott Kale who specializes in Internal Medicine and Rheumatology, at the request of the State of Illinois Department of Human Services, Division of Disability Determination Services. At the initial visit, Mr. Bell provided the following history to Dr. Kale: "While working on 08-04-02 while working in his restaurant, he fell three or four feet directly onto his buttocks from a stairwell, at which time he experienced pain with radiation of that pain into his left leg." Mr. Bell elected to commence treatment with Dr. Kale. He saw Dr. Kale regularly through January 26, 2011. Dr. Kale diagnosed chronic low back pain with failed low back pain syndrome with severe pain, depression and drug addiction. He prescribed Mr. Bell narcotic analgesics to help relieve the pain in addition to sleeping medications. (Petitioner's Exhibit #14, pages 9 to 18).

Petitioner suffered from depression along with chronic pain. In 2008, he was admitted to the hospital with a self inflicted gun-shot wound. PX 10. Mr. Bell died on February 9, 2011. The cause of death was listed as morphine and benzodiazepine overdose. PX 2.

Mr. Bell's representatives also called Jill Bell to testify. She is the ex wife of Myles Bell. They were married on June 8, 2003 and divorced on August 9, 2009- 2 years before the death of Myles Bell. T. 64-65. They had no children and to her knowledge Mr. Bell never had children. Mr. Bell was never married before Jill Bell nor re-married after their divorce. T. 65.

Ms. Bell began working for Bell Entertainment in March, 1997. She worked as a hostess, until January 1, 1998. She became the night time full-time bartender. She worked as a bartender for six months and then was promoted to the assistant manager in charge of the bar and bartenders. Ms. Bell worked six or seven days a week, 80 hours a week. Mr. Bell was the president of Bell

Entertainment and the owner of Bellini's Italian Restaurant and Steakhouse. He oversaw the entire restaurant, bar and banquet hall.

In January, 1999 she was the restaurant's assistant manager. She was aware of the January 1999 accident in which Mr. Bell slipped on ice in his driveway while going to his house to get paperwork for the restaurant. Subsequent to this January 1999 incident, she noticed Mr. Bell was in pain. He had trouble bending, stooping and lifting. She testified that Mr. Bell had surgery and was taking a lot of prescription medicine.

Ms. Bell was working on August 4, 2002. On the evening of August 3rd, when Mr. Bell started working, he appeared to be alright. Subsequent to the fall on August 4, 2002, Ms. Bell noticed Mr. Bell could not walk at all. Bellini had 3 flights of stairs; you would climb a level of stairs, there would be a landing up to the foyer of the restaurant, and then up again into the restaurant. The main level is the bar and the main part of the restaurant. There is a banquet hall downstairs along with Mr. Bell's office.

In the lower/basement level was the banquet room, Mr. Bell's office, a kitchen and bathrooms. Going up the stairs, there is a bar to the right, the restaurant on the left, bathrooms and the main kitchen in the back. If a guest came into the main entrance, they would have to go upstairs to the restaurant or bar. Alternatively, they could go down the stairs to the banquet room. Ms. Bell estimated Mr. Bell would go up and down the stairs 30-40 times a day in order to oversee the bar and restaurant.

Subsequent to August 4, 2002, Mr. Bell never returned to work. Mr. Bell had another back surgery and was taking a lot of prescription medication. Ms. Bell testified that after the second surgery, Mr. Bell always needed help. He was never without his cane. At first, he was in a wheelchair for a while, then started using a walker, and then started using a cane. Mr. Bell did not go anywhere without his cane. Ms. Bell observed Mr. Bell had a high tolerance for pain medications.

Ms. Bell last saw Mr. Bell on October 9, 2008. Mr. Bell was taking medications. Mr. Bell appeared very bitter and very unhappy.

Ms. Bell identified Petitioner's Exhibits 28 through 29, and 39 through 45 are the prescription records of all the pills taken by Mr. Bell. Ms. Bell ran the household and paid the co-payments identified on the identified exhibits. Ms. Bell acknowledged she has not received any bills or any demands for payment of any medical bills pertaining to Mr. Bell's medical care.

Ms. Bell testified she and Mr. Bell filed separate bankruptcy petitions. Ms. Bell filed her bankruptcy petition before she divorced. On her bankruptcy petition she listed all of the incurred medical bills. She testified that she believed all of the medical bills were wiped out because of bankruptcy.

Ms. Bell was aware of the first probate estate but was not involved in its filing. She was involved in the reopening of Mr. Bell's estate in March, 2018.

Ms. Bell in June/July 2002 was aware Mr. Bell was taking pain medications. He was having sciatic issues. Mr. Bell complained of pain in his lower back and down his left leg. Ms. Bell testified Mr. Bell worked an average of 12 hours per day, 6 days per week. Bellini's was closed on Mondays.

She further testified there was more than one way to go from the lower banquet level to the restaurant and bar level. There was a stairway going from the banquet level kitchen to the upstairs kitchen. She testified that Mr. Bell mostly used the front stairwell, but sometimes he would use the back stairs. If he was going to the main kitchen he would go through the downstairs kitchen because that was the fastest way to go, depending on what area he was going to.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law in cases **02 WC 54561 and 12 WC 39144** for the alleged **August 4, 2002 accident date.** ARB EX 2 and ARB EX 4. The other two consolidated matters **01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident** are handled under separate Decisions.

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

To be compensable under the Act, a claimant must prove, by a preponderance of the evidence, that the accidental injury was one arising out of and in the course of the employment. *Sisbro, Inc. vs. Industrial Comm'n,* 207 Ill.2d 193, 203 (2003). For an injury to 'arise out of' the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. The initial step in considering the "arising out of" component of a worker's compensation claim is to determine the type of risk to which the claimant was exposed at the time of his injury. *Baldwin vs. Illinois Worker's Compensation Comm'n,* 409 Ill.App.3d 472, 478 (2011). "Risks to employees fall into three groups: (1) risks distinctly associated with the employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics." *Id.* A risk "distinctly associated" with a claimant's employment is a risk that is peculiar to the claimant's work or incurred as the result of a defect in the employer's premises. *Orsini vs. Industrial Comm'n,* 117 Ill.2d 38, 45 (1987); *First Cash Financial Services vs. Industrial Comm'n,* 367 Ill.App.3d 102, 106 (2006). A neutral risk is one having no particular employment or personal characteristic. "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago vs. Illinois Worker's Compensation Comm'n,* 407 Ill.App.3d 1010, 1014 (2011). The increased risk may be either qualitative, in that some aspect of the employment contributed to the risk, or quantitative, in that the employee is exposed to the common risk more frequently than the general public. *Id.*

In the instant case, the record supports a finding that Petitioner's fall down the stairs at work on August 4, 2002, was the result of an increased risk faced by Petitioner thus making his fall compensable. The Arbitrator finds that both Ms. Harper and Ms. Bell testified that Mr. Bell used the stairs multiple times per day in order to travel between the bar and restaurant area and to his

office in the basement in order to meet the daily needs of the restaurant. Ms. Bell testified that he used the stairs as much as 30 to 40 times per day. The Arbitrator finds that in so using the stairs, Mr. Bell faced a risk of injury greater than that facing the general public in using stairs. His use of the stairs was not occasional or unnecessary. Rather, his use of the stairs was constant and clearly required in the daily management of the restaurant and bar. Accordingly, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on August 4, 2002.

Is Petitioner's condition of ill being causally related to injury?

Based on the record in its entirety, it is clear that Mr. Bell was continuously symptomatic following the July 1999 surgery up to the time of the August 4, 2002 fall at work. Between 1999 and 2002, Mr. Bell continuously received pain medication and underwent 6 steroid injections in an attempt to alleviate his pain. He was seen by Dr. Primack in late June 2002 and received another a lumbar epidural steroid injection.

Nevertheless, the Arbitrator further notes that after his fall on August 4, 2002, Mr. Bell's symptoms, although similar in nature to the pre-fall symptoms, significantly increased. Two days after the fall of August 4, 2002 incident, Mr. Bell was seen at Lake Forest Hospital. He was subsequently admitted with severe back pain on August 9, 2002. The treating records from Lake Forest subsequent to the August 4, 2002 fall clearly indicate an increase in the well documented pre-existing symptoms, including an increase in the left leg radiculopathy. The record indicates "the patient is known to have had surgery on L4 diskectomy with good results. However, he fell down a few days prior to the admission, straight on the back, and since then has had very severe pain going across to the lower back, not much to the legs. He is admitted for observation, control of the pain and MRI." PX 8. An additional history from August 9, 2002 indicates that Mr. Bell fell on the "3rd of this month while cleaning up at work" and his pre-existing symptoms were exacerbated by the fall. Petitioner reported that his pre-existing pain was now constant in the low back radiating down the left leg. PX 11. The discharge summary dated 8/17/02 notes that Mr. Bell noted radicular pain one month after his 1999 surgery and subsequent treatment with injections and pain medication for chronic pain. The notes indicate, "the patient still has pain in the left leg though 2 weeks ago he fell down resulting in incapacitating back pain in addition to the exacerbation of his leg pain. … left leg is entirely numb." PX 11. Subsequent MRI on 8/9/02 showed L4-5 disk herniation with significant degenerative disease. PX 8. One month after the August 2002 fall, Mr. Bell underwent a prescribed fusion surgery.

Based on the foregoing, the Arbitrator finds causal connection between Mr. Bell's increased low back and left leg symptoms necessitating the fusion surgery in September 2002 and the fall at work on August 4, 2002.

What is the AWW?

The Arbitrator finds that Mr. Bell's average weekly wage is $1,442.30 with yearly earnings of $75,000.00. This finding is based upon Petitioner's Exhibit #5, a Travelers' Insurance wage statement form indicating that Mr. Bell earned $2,884.62 biweekly from August 4, 2001 through August 1, 2002, which results in an AWW of $1,442.30. Both Debra Harper, Respondent's General Manager, and Jill Bell, an Assistant Manager testified that Mr. Bell was paid a salary of $75,000.00 per year.

What is the TTD owed?

The Arbitrator finds that Myles Bell was temporarily and totally disabled for 64 and 5/7ths weeks from August 4, 2002 to October 31, 2003. Both Debra Harper and Jill Bell testified that Mr. Bell never returned to work after August 4, 2002. Mr. Bell treated with his surgeon post fusion through October 31, 2003 at which time Dr. Tack noted continuing slow improvement. An MRI ordered by Dr. Kyncl demonstrated appropriate implant position and decompression at L4 to S1. Dr. Tack recommended purely symptomatic treatment with progressive activities as tolerated. (Petitioner's Exhibit #12).

What medical expenses are due and owing?

The Petitioner claimed that the Respondent in this case is liable for medical bills that were incurred after August 4, 2002. The Respondent raised a foundational objection to those bills. The Arbitrator finds that sufficient corresponding medical records were admitted into evidence as well as the testimony of Dr. Scott Kale to establish that Exhibits 30 through 34 were for medical treatment related to the alleged injuries in this case. These records provide a description and dates of treatment and they are a reliable indication of the treatment rendered and the charges incurred. Additionally, Exhibits 30, 37, 38 and 46 were either certified or received pursuant to subpoena and are therefore admissible under Section 16 of the Act. In addition, Exhibits #39 through 45 were identified by Jill Bell as prescription records that were paid by her or Mr. Bell.

Respondent has also disputed whether or not Mr. Bell exceeded his choice of two medical providers or providers within a chain of referrals. ARB EX 2. After the August 4, 2002 accident, Mr. Bell was initially seen in the emergency room at Lake Forest Hospital. He followed up there again on August 9, 2002 and was admitted through August 17, 2002. During that admission he was seen by Dr. Miloslava Kyncl, his primary care physician and Dr. Stanford Tack who performed a consultative exam. He followed up with Dr. Kyncl and Dr. Tack who performed surgery on September 17, 2002 at Lake Forest Hospital. Exhibits 31 through 35 are for services peripheral to his treatment at Lake Forest Hospital and with doctors Kyncl and Tack.

There is a notation in Dr. Tack's August 27, 2002 office note that Mr. Bell had, "a second opinion of sorts with Dr. Jonathan Citow which he found to be somewhat unhelpful." (Petitioner's Exhibit #12). There was no testimony, medical records or reports presented to establish if fact Dr. Citow ever provided treatment to Mr. Bell, when he saw him or for what reason. Consequently, the Arbitrator finds there is insufficient evidence in the record to establish that Dr. Citow was Mr. Bell's second choice of medical providers. Rather, the Arbitrator finds that Mr. Bell's second choice of provider was Dr. Kale as of October 27, 2003. (Petitioner's Exhibit #14, 37).

Lastly, Mr. Bell also saw Dr. Reuben Wiesz for an evaluation primarily for right upper extremity symptoms. The Arbitrator finds this treatment is not related to the lumbar injury that occurred on August 4, 2002 and that Petitioner's Exhibit #36 is denied.

Accordingly, based on the Arbitrator's findings on the issue of accident and causal connection, the Arbitrator further finds that Respondent shall pay the reasonable and necessary medical expenses incurred by Mr. Bell in the care and treatment of his causally related injury as shown in PX 30 through 35 and 37 through 46. The bills incurred from August 6, 2002 through January

31, 2006 are awarded pursuant to Section 8(a) of the Act. The bills incurred after February 1, 2006, are awarded pursuant to Sections 8(a) and 8.2 of the Act.

To the extent Respondent has paid any or all of these bills, Respondent shall receive credit for amounts paid. Respondent does not claim credit under Section 8(j). ARB EX 2. The Arbitrator further notes that the 2007 Bankruptcy Petition and Discharge Order filed in March 2008 do not clearly indicate or address the medical bills awarded herein. RX 1. Accordingly, the Arbitrator makes no finding regarding the effect of the Bankruptcy Petition and Discharge Order on the medical bills awarded herein.

What is the nature and extent of the injury?

The Arbitrator notes the date of accident on August 4, 2002 – well pre-dating the Amended Act of 2011 requiring impairment analysis under Section 8.1b of the Act.

It is clear to the Arbitrator that Mr. Bell had significant ongoing, long-standing disability prior to and at the time of the work accident of August 4, 2002. As noted above, Mr. Bell continued to receive treatment for his pre-existing low back and left leg symptoms well prior and up to the August 4, 2002 accident at work. Dr. Primack administered an epidural injection into the lumbar spine on June 25, 2002, 6 weeks before the accident of August 4, 2002. However, given the exacerbation of the pre-existing symptoms resulting in the need for a fusion surgery following the work accident of August 4, 2002, the Arbitrator finds that Mr. Bell sustained some increase in his pre-existing disability. Following the fusion surgery in September 2002, Mr. Bell was treated with medication and additional conservative care for his continued pain as well as for numerous unrelated health issues contained in the medical records including depression, cardiac and abdominal issues. The Arbitrator does note that Mr. Bell never returned to work after the accident of August 4, 2002.

Based on the foregoing, and on the record in its entirety, the Arbitrator finds that Mr. Bell sustained 40% of the person as a whole under Section 8(d)(2) of the Act.

Are funeral expenses due and owing?

The estate of Mr. Bell seeks the entry of an award for funeral benefits in case 12 WC 39144. That claim is denied. Both Ms. Harper and Ms. Bell testified Mr. Bell was taking medications prior to August 4, 2002. The record is insufficient for the Arbitrator to conclude as to which medications might have contributed to Mr. Bell's death. The Arbitrator has nothing credible on which to base a finding that the death was caused by medication prescribed as a result of a work accident of August 4, 2002 or that those medications were a causative factor in Mr. Bell's death. Mr. Bell has failed to meet his burden in establishing and award of funeral benefits.

O: Other issues

On ARB EX 2 Respondent placed the doctrines of estoppel, laches, due process and the statute of limitations in dispute. Respondent did not present any argument on these issues. Accordingly, the Arbitrator makes no findings on these issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC039145
Case Name	COLLINS,CARY EXECUTOR OF v. BELL ENTERTAINMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0386
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	James Marszalek
Respondent Attorney	Miles Cahill

DATE FILED: 7/28/2021

/s/ Marc Parker, 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

James J. Marszalek, Executor
of the Estate of Myles Bell, Deceased,

Petitioner,

vs. NO: 12 WC 39145

Bell Entertainment,

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, permanent partial disability, and funeral 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 October 16, 2019, is hereby affirmed and adopted.

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

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

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.

July 28, 2021

MP:yl
o 7/15/21
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

MARSZALEK, JAMES J, EXECUTOR OF THE ESTATE OF BELL, MYLES DECEASED
Employee/Petitioner

Case# **12WC039145**

01WC026682
12WC039144
02WC054561

BELL ENTERTAINMENT
Employer/Respondent

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

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

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

1872 SPIEGEL& CAHILL PC
MILES P CAHILL
15 PINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

JAMES J. MARSZALEK, Executor of the estate of Myles Bell, deceased
Employee/Petitioner
v.

Case # **12** WC **39145**

Consolidated cases: **01 WC 26682; 12 WC 39144; 02 WC 54561**

BELL ENTERTAINMENT
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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Waukegan**, on **4/16/19 and 8/19/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 current condition of ill-being causally related to the injury?
G. ☒ What were Decedent's earnings?
H. ☒ What was Decedent's age at the time of the accident?
I. ☒ What was Decedent's marital status at the time of the accident?
J. ☒ Who was dependent on Decedent at the time of death?
K. ☒ 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?
L. ☒ What compensation for permanent disability, if any, is due?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Funeral Expenses**

FINDINGS

On the date of accident, **1/19/19**, 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 not*** causally related to the accident.

ORDER

In support of the Arbitrator's decision concerning the estate's entitlement to an award of benefits under Section 7 of the Act, the Arbitrator finds the following:

Based upon the findings of the Arbitrator in 01 WC 26682 that Mr. Bell's condition of ill-being was not causally related to the accident of January 19, 1999, the Arbitrator finds in this matter 12 WC 39145 that the decedent's death was not causally related to the accident of January 19, 1999. Accordingly, no benefits are awarded to Mr. Bell's estate under Section 7 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.

Carolyn M. Doherty

Signature of Arbitrator

10/16/19

Date

OCT 16 2019

FINDINGS OF FACT

The Arbitrator notes that four consolidated matters were presented for trial. The trial started on 4/16/19 and proofs were closed on 8/19/19. In case 01 WC 26682, the alleged date of accident is January 19. 1999. ARB EX 1. In case 02 WC 54561, the alleged date of accident is August 4, 2002. ARB EX 2. In case 12 WC 39145, a request for funeral expenses is made in connection with case 01 WC 26682. ARB EX 3. In case 12 WC 39144 funeral expenses are requested in connection with case 02 WC 54561. ARB EX 4. Myles Bell, the decedent, passed away on February 9, 2011. James J. Marszalek became the executor of the estate of Myles Bell and presented these matters for trial.

At trial of these consolidated four matters, Petitioner presented the testimony of Debra Harper. Ms. Harper testified that she was employed by Bell Entertainment from 1997 to October 1999 and then again from 2001 to 2003. She testified that Bell Entertainment operated a restaurant and steakhouse known as Bellini's. Myles Bell was the owner and operator of Bell Entertainment and Bellini's. Ms. Harper worked as the general manager for the business. T. 24. Her duties required her to run the restaurant and manage the staff, banquets, billing and payroll. T. 25. She testified that Myles Bell oversaw the daily operations of the restaurant. He was present at the restaurant every day. T. 25. She testified that Mr. Bell received a yearly salary of $75,000. T. 26. Ms. Harper testified that on January 19, 1999, she drove with Myles Bell from the restaurant in Libertyville to his home in Lake Forest in order to retrieve papers needed by the accountant for quarterly tax purposes. She also testified that they were going to get space heaters to bring back to the restaurant to be used in the bar as the furnace had gone out. T. 27. She further testified that it was common for her to accompany Myles Bell to his home in order to retrieve paperwork for the business as he "kept a lot of stuff at his home, because at the time was limited office space, so all important papers he kept at his residence." T. 29.

Ms. Harper testified that the driveway of the home was icy and when Petitioner got out of the car he "stepped on ice and he slipped right out from under him." T. 28. She then observed Mr. Bell get up from the ground and noted the he grabbed his back. She asked him if he was okay and he replied that he was. T. 29. She testified that they retrieved what they needed from the home and returned to the restaurant. She testified that later that evening she noticed he was moving a little slower up the stairs and that the next day Myles Bell came in later than usual to the restaurant. The next day she noticed Petitioner moving very slowly and stating "I think I really jacked up my back." T. 30. After January 1999, Ms. Harper noticed that he started coming in later to the restaurant and that he limited his physical abilities as to what he would do around the restaurant. She testified that he no longer helped her move tables and that the bus boys now moved the tables. T. 31.

In reviewing the medical records submitted at trial, the Arbitrator notes that Petitioner sought no medical treatment after the January 19, 1999 fall on his driveway. In addition, no report of injury was made at that time in January 1999. The first mention of a fall in January 1999 was made to Mr. Bell's primary doctor, Dr. Kyncl on March 30, 1999. PX 8. That record states, "Jan ... fell- fell again- work."

Ms. Harper testified that Petitioner in fact fell again in March 1999 when he slipped on oil in his garage at home. She was not present and did not provide any additional details about the circumstances of the fall in March 1999. She testified that Petitioner exhibited signs of extreme back pain after March 1999 and that he limited his physical activity and carried himself differently. He was also unable to sit for long periods of time. Lake Forest Hospital emergency room records dated 3/25/99 indicate, "This is a 47 year old male who presents complaining of left lower back pain. The patient states that he fell in his garage on an [sic] slick oil spot earlier today landing on his back. He states the he had done this two months ago in January, landing on the ice, but his pain was not as severe. He was not evaluated for that incident. However, he continued to have some pain in his

back and falling today made it worse. He denies any other injury or pain. ... no numbness or weakness in his legs." PX 10. Petitioner was diagnosed with a lumbar contusion and given pain medication. He was to follow up with his personal doctor in 3-4 days. PX 10.

Petitioner first sought medical attention from his primary doctor, Dr. Kincyl, on March 30, 1999. Dr. Kincyl made the above brief notations and diagnosed Mr. Bell with sciatica. Petitioner complained of pain down the left leg. Mr. Bell underwent lumbar x-rays on 3/25/99 which showed narrowing of interspaces of L4-S1 and L5-S1 with associated moderate hypertrophic degenerative changes as well as mild to moderate facet arthritis. Conservative care including physical therapy was recommended. Petitioner attended physical therapy in April 1999 where he reported both the fall in January 1999 and in March 1999.

On May 8, 1999 Petitioner was admitted to Lake Forest Hospital by Dr. Kyncl noting that "the patient fell in January and sustained a back injury and recovered from this. He fell again about a month ago on some oil and had a lot of pain for which he needed some medicine. He again had a worsening about a week ago when he developed some abdominal flue and had severe nausea and vomiting. He was vomiting for four days straight and strained his back with all of his and has been having severe back pain since then. ... the pain got out of hand and he came in yesterday with intractable back pain going down his left leg." PX 10. Petitioner was admitted for testing. A May 11, 1999 Lumbar myelogram and CT showed broad based left lateral disc protrusion at the L4-5 level projecting into the inferior portion of the left L4-5 neuroforamen and flattening the left anterolateral aspect of the thecal sac along with moderately severe right and mild to moderate left L5-S1 facet joint overgrowth with mild encroachment upon the neuorforamen bilaterally and lateral recesses. PX 6 PX 10. Petitioner underwent epidural steroid injections on 5/13/99. PX 10. Petitioner was referred to Dr. Bauer.

On 6/25/99, Dr. Bauer reviewed the lumber myelogram and noted his impression of spinal canal of normal size with an anterior indentation of the anterior epidural space mainly at L4-L5 and to a lesser degree at L2-3. PX 6. On July 1, 1999, Dr. Bauer noted that Mr. Bell "... was well until January 1999 when he slipped on the ice and fell onto his tailbone at home. In March 1999 he fell and slipped in his garage because his foot was weak. He went to Lake Forest Hospital and had x-rays performed. Since then he has undergone a CT scan and myelogram. He is unable to do an MRI scan. He had physical therapy and while standing on a teeter-totter he aggravated the pain in his leg about 1 ½ weeks ago. He has had continued pain in the sciatic distribution of his left leg down to his lateral ankle but not into his toes. He ahs weakness and drags his left foot. He has a sense of numbness and tingling. He has a history of back pain but never lost time from work due to this or has he had treatment. His pain has been acutely exacerbated recently. ... he has dull aching back pain. His leg pain is sharp, however." PX 6.

Dr. Bauer reviewed the CT scan and myelogram and found evidence of a herniated disc at L4-5 with foraminal stenosis. He diagnosed a left, L5 radiculopathy due to a herniated disc and foraminal stenosis. Dr. Bauer recommended surgery. PX 6. Dr. Bauer performed a micro lumbar diskectomy left L4-L5 with microdissection on July 20, 1999. The post op diagnosis was left L4-5 herniated disk. PX 6. Petitioner attended physical therapy post op as well. Mr. Bell continued to treat periodically for low back pain and radiating left leg pain complaints through June 2002.

On 10/5/99, Mr. Bell filed a First Report of Injury claiming an accident date of "3-99" when he fell in his garage while at home retrieving paperwork. Resp 1 RX 1. On March 24, 2006, Dr. Ghanayem opined that the reported January 1999 injury was self limited and did not result in disability or structural/traumatic changes in his lumbar spine and that it did not require any medical care. He further opined that the second accident in March 1999 severed any causal connection between the January event and his subsequent care. His opinion is based on

Petitioner's report that the symptoms were more severe and required care after the March 1999 fall. Resp 1 RX 2.

Mr. Bell's representatives also called Jill Bell to testify. She is the ex wife of Myles Bell. They were married on June 8, 2003 and divorced on August 9, 2009- 2 years before the death of Myles Bell. T. 64-65. They had no children and to her knowledge Mr. Bell never had children. Mr. Bell was never married before Jill Bell nor re-married after their divorce. T. 65.

Ms. Bell began working for Bell Entertainment in March, 1997. She worked as a hostess, until January 1, 1998. She became the night time full-time bartender. She worked as a bartender for six months and then was promoted to the assistant manager in charge of the bar and bartenders. Ms. Bell worked six or seven days a week, 80 hours a week. She testified that Mr. Bell was the president of Bell Entertainment and the owner of Bellini's Italian Restaurant and Steakhouse. He oversaw the entire restaurant, bar and banquet hall.

In January, 1999 she was the restaurant's assistant manager. She was aware of the January 1999 accident in which Mr. Bell slipped on ice in his driveway while going to his house to get paperwork for the restaurant. Subsequent to this January 1999 incident, she noticed Mr. Bell was in pain. He had trouble bending, stooping and lifting. She testified that Mr. Bell had surgery and was taking a lot of prescription medicine.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law in Cases **01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident.** ARB EX 1 and ARB EX 3. The other two consolidated matters 02 WC 54561 and 12 WC 39144 are handled under separate Decisions.

A: Was there an employment relationship? B: Did an accident occur arising out of and in the course of Petitioner's employment with Respondent? C: Was timely notice provided?

Based on the record in its entirety, the Arbitrator finds that Respondent was operating and subject to the Illinois Workers' Compensation Act and that an employer/employee relationship existed between the Respondent and Mr. Bell. In support of this finding, the Arbitrator notes the unrebutted testimony of Debra Harper, a former manager for the Respondent and Jill Bell, a former assistant manager for the Respondent. Both witnesses testified that Myles Bell was the Owner, Operator and President of Bell Entertainment. Bell Entertainment operated a restaurant and bar named Bellini's Italian Restaurant and Steakhouse. Mr. Bell oversaw the entire restaurant, bar and banquet hall in Libertyville. Ms. Harper testified that alcoholic beverages were served to the general public for consumption on the premises at Bellini's. The provisions of the Act are automatically applied to an establishment that it is open to the general public and alcoholic beverages are sold to the general public for consumption on the premises pursuant to Section 3(12) of the Act.

The Arbitrator further finds that based upon a preponderance of the credible evidence, Myles Bell sustained an accident arising out of and in the course of his employment on January 19, 1999. The Arbitrator finds that although he was at home when he slipped on ice, Mr. Bell frequently traveled home to obtain work related documents and space heaters for the bar as per the testimony of his assistant Ms. Harper. Ms. Harper testified that such trips were common as office space was limited and Mr. Bell kept some of the important documents at home. The Arbitrator finds that Mr. Bell's presence at his home for a work related purpose was reasonable, foreseeable and related to his employment duties such that his accident arose out of his employment under the Act.

The Arbitrator further finds that Respondent had timely notice of the accident of January 19, 1999. This conclusion is based upon the testimony of Respondent's general manager, Debra Harper. She indicated that she was present when Mr. Bell slipped and fell in his driveway on January 19, 1999. She noticed he grabbed his back after he fell and then was moving slowly later that day and the day following the accident. Thus, the Arbitrator finds that Respondent's general manager Debra Harper was a witness to and had knowledge of his fall. Additionally, Mr. Bell was the President of the Respondent and was obviously aware of his fall and subsequent back pain.

F: Is Petitioner's condition of ill-being casually connected to the injury? O: Funeral Expenses

The Arbitrator finds that based on the evidence in its entirety, Petitioner's condition of ill-being does not result and is not causally related to the fall on January 19, 1999. Short of Ms. Harper's testimony that Mr. Bell "jacked his back" in the January 1999 fall, the record is devoid of any credible complaint made or documentation of any treatment sought by Mr. Bell for any symptoms at any point after the January 1999 fall. Rather, the only treatment sought by Mr. Bell was after a non work-related fall on March 25, 1999. The Arbitrator finds that the record as a whole supports a finding that the March 25, 1999 fall was sufficient to sever any causal connection between Petitioner's claimed condition of ill-being and the fall in January 1999.

In so finding, the Arbitrator specifically finds persuasive that no complaint of back pain or injury was documented, reported or treated at the time of or after January 1999. In fact, no medical care at all was sought by Mr. Bell between January 1999 and March 25 1999. Although the medical records after the March 25, 1999 non work related fall clearly indicate that Mr. Bell reported a prior fall in January 1999, the records indicate his reports that he either recovered from any complaints or that the symptoms had subsided such that he was at baseline when he fell again in March 1999. Clearly, Mr. Bell suffered symptoms that required immediate ER care after the March 1999 fall. Shortly thereafter, his condition required surgery again clearly indicating that the condition was much worse than in January 1999 when Mr. Bell sought no treatment for any complaint.

Accordingly, the Arbitrator finds that although Petitioner sustained a work related fall in January 1999, no injury requiring treatment resulted therefrom. Rather, the record in its entirety supports the finding that Petitioner's injury for which he received care and treatment including surgery in July 1999 was solely causally related to the intervening non work related fall on March 25, 1999.

Accordingly, no benefits, including the requested funeral expenses, are awarded in 01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident. All requests for benefits in these matters is denied and all other issues in cases 01 WC 26682 and 12 WC 39145 for the alleged January 19, 1999 accident are moot. No further findings are made.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC011703
Case Name	WALKER-JACKSON,SHAROL v. CHICAGO TRIBUNE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0387
Number of Pages of Decision	28
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Karolina Kuczmanski
Respondent Attorney	James Toomey

DATE FILED: 7/28/2021

/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

SHAROL WALKER-JACKSON,

Petitioner,

vs. NO: 18 WC 11703

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission provides further analysis on the award of temporary total disability. Petitioner consulted Dr. Peter McQueen on December 19, 2017 for a progression of her complaints of bilateral hand pain and numbness. Petitioner was referred to Dr. McQueen by her primary care provider. Petitioner testified that at the time of her appointment with Dr. McQueen she spent 10-15 minutes explaining her job duties as a press operator. Dr. McQueen ordered an EMG.

On January 5, 2018 Petitioner returned to Dr. McQueen following the EMG performed on her bilateral upper extremities. At this time, Dr. McQueen informed her of the results of the EMG that suggested bilateral carpal tunnel syndrome. Dr. McQueen at that time, imposed 5 lb, work restrictions on pushing and pulling, and rare repetitive activities involving Petitioner's hands. Dr. McQueen recommended bilateral carpal tunnel release surgeries. The work restrictions imposed by Dr. McQueen were recommended to prevent exacerbation of Petitioner's

symptoms pending surgery. Dr. McQueen's clinical note of January 5, 2018 states that Petitioner's bilateral carpal tunnel syndrome was caused by the repetitive nature of her job.

Petitioner reported her diagnosis and restrictions to Respondent upon her return to work on January 9, 2018, which was her first workday following the appointment with Dr. McQueen. On January 10, 2018 Petitioner provided a note from Dr. McQueen detailing her work restrictions. On January 10, 2018 Respondent informed Petitioner that they could not accommodate her work restrictions and sent her home.

Petitioner was initially paid temporary total disability benefits by Respondent in the amount of $688.11. Petitioner subsequently underwent a Section 12 examination at the request of Respondent with Dr. Sam Biafora. On April 9, 2018 Dr. Biafora issued a report stating that Petitioner's condition of bilateral carpal tunnel syndrome was idiopathic in origin and most likely not work-related.

Respondent thereafter denied Petitioner's claim for benefits and terminated the payment of TTD benefits. Per RX7 Respondent issued the last TTD check to Petitioner on April 10, 2018 in the amount of $688.11. Thereafter, Petitioner received short term disability payments followed by long-term disability for the time she was off work.

Petitioner received short term disability benefits from August 22, 2018 through February 12, 2019. RX6. Petitioner received long-term disability payments commencing March 6, 2019 through June 6, 2019.

Petitioner elected to undergo the carpal tunnel release surgeries recommended by Dr. McQueen and submitted her medical bills through her group health insurance plan. Petitioner was initially scheduled to have the right carpal tunnel release on September 10, 2018. The procedure was delayed however because her blood glucose was elevated due to poor control of her diabetes. She was referred to an endocrinologist and the right carpal tunnel release was eventually performed by Dr. McQueen on November 5, 2018 after her diabetes was stabilized.

Petitioner had physical therapy prescribed by Dr. McQueen following her right carpal tunnel release. On March 4, 2019 Petitioner underwent a left carpal tunnel release performed by Dr. McQueen. Following surgery, she underwent a course of physical therapy on her left hand. Upon completion of therapy Dr. McQueen released Petitioner to return to full duty work.

Dr. McQueen's work restrictions remained in effect throughout her course of treatment as she awaited surgeries and participated in physical therapy. Petitioner therefore remained off work from January 10, 2018 until her release by Dr. McQueen to return to work on June 7,2018. Dr. McQueen recommended the continuation of occupational therapy to follow her work release. Petitioner testified that she returned to work for Respondent as a press operator on June 11,2019 with no work restrictions. At the time of hearing she was working full-time and performing the same duties as she had performed prior to January 10, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 17, 2020 is hereby affirmed with the foregoing further analysis on the issue of temporary total disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits at the rate of $688.11 per week commencing January 10, 2018 through June 10, 2019, with Respondent receiving credit for its temporary total disability payment of $8,945.43 and Section 8(j) credit for its disability payment of $30,438.22. AX1.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the claimed medical expenses (PX4-5) subject to the fee schedule and with Respondent receiving Section 8(j) credit for its stipulated medical payment of $39,784.15. AX1.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner permanent partial disability benefits to the extent of 12.5% loss of use of her right hand and 12.5% loss of use of her left hand (a total of 47.5 weeks at the 190-week hand value) pursuant to Section 8(e)(9) 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 $23,500. 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.

July 28, 2021

o-6/9/21
SM/msb
44

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

/s/ *Deborah Baker*
Deborah Baker

/s/ *Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0387

WALKER-JACKSON, SHAROL Case# **18WC011703**

Employee/Petitioner

CHICAGO TRIBUNE

Employer/Respondent

On 6/17/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5755 COSTA IVONE LLC
KAROLINA KUCZMANSKI
311 N ABERDEEN ST SUITE 100B
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
JAMES P TOOMEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

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

Sharol Walker-Jackson
Employee/Petitioner

v.

Chicago Tribune
Employer/Respondent

Case # 18 WC 11703

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Mason, Arbitrator of the Commission, in the city of Chicago, on March 13, 2020 and June 17, 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 January 9, 2018, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current post-operative bilateral carpal tunnel syndrome condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $53,672.58; the average weekly wage was $1,032.16.

On the date of accident, Petitioner was 51 years of age, married, with two 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 $8,945.43 for TTD, $0.00 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $8,945.43. Arb Exh 1.

Respondent is entitled to credit of $39,784.15 (group medical payments) and $30,438.22 (short- and long-term disability payments) under Section 8(j) of the Act. Arb Exh 1. Respondent is to hold Petitioner harmless against any claims made by the entities making such payments, in accordance with Section 8(j).

ORDER

Respondent shall pay Petitioner temporary total disability benefits at the rate of $688.12/week from January 10, 2018 through June 10, 2019, with Respondent receiving credit for its temporary total disability payment of $8,945.43 and Section 8(j) credit for its disability payment of $30,438.22. Arb Exh 1.

Respondent shall pay the claimed medical expenses (PX 4-5), subject to the fee schedule and with Respondent receiving Section 8(j) credit for its stipulated medical payment of $39,784.15. Arb Exh 1.

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of her right hand and 12.5% loss of use of her left hand (a total of 47.5 weeks at the 190-week hand value) pursuant to §8(e)(9) of the Act.

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

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

Signature of Arbitrator

6/17/20
Date

JUN 17 2020

Sharol Walker-Jackson v. Chicago Tribune
18 WC 11703

Summary of Disputed Issues

Petitioner began working as a press operator for Respondent in July 1985. Her job duties included manually removing 64 plates from press cylinders and putting new plates on. She testified she performed this task between two and six times per shift, three out of every four shifts. She worked 37.5 regular hours plus about 10 hours overtime per week. She testified she began experiencing numbness in her hands about three years before January 9, 2018. She claims bilateral carpal tunnel syndrome manifesting January 9, 2018. She underwent a right carpal tunnel release in November 2018 and a left-sided release in March 2019. She resumed full duty in June 2019.

Petitioner's former supervisor, Stewart Erskine, called by Respondent, testified on direct examination that a press operator could be required to change out plates as many as eight to ten times per shift, twice weekly, and that "you have to press on a plate to click it into place." Erskine also acknowledged that a press operator could have to use force while using a rag to clean cylinders at the end of a shift if the cylinders were particularly dirty.

Petitioner's surgeon, Dr. McQueen, found a causal relationship between Petitioner's press operator duties and her bilateral carpal tunnel syndrome. Respondent's Section 12 examiner, Dr. Biafora, agreed with the carpal tunnel diagnosis and need for surgery but did not find causation, citing various risk factors, including uncontrolled diabetes, and based on his conclusion that the manual tasks Petitioner performed did not require force.

The disputed issues include accident, notice, causal connection, medical expenses, temporary total disability and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified that, as of January 9, 2018, she had worked as a press operator for Respondent for 33 years. T. 12. She "basically prints the newspaper." Once she receives an assignment, she "spots" plates, meaning that she puts plates on a press in accordance with the assignment's layout. There are 64 plates on each color unit. When she starts her shift, she has to remove the 64 plates used on the "older run" and then applies 64 plates for the "new run." She typically does 2 to 6 units per day. T. 13-14. Before January 9, 2018, she worked 10 hours per day, four days per week. She typically performed the plate aspect of the job three out of every four days. T. 14. A plate is approximately the size of a newspaper page. A stack of 64 plates weighs maybe 16 to 17 pounds. T. 16. Another duty she performed was "color." This involved using a computer inside the "quiet room." She performed this task rarely, maybe once a week. T. 15-16. On a day that she performed "color" she would also perform the plate aspect of the job.

Petitioner explained that when she worked on the "color unit," each unit consisted of four colors. One plate represented each color. She needed to place 32 plates on the top half of the press, representing two colors, and another 32 plates, representing red and blue, on the bottom. T. 17. To remove plates that were already in place, she had to press an "inch button" on the side of the press to move the cylinder around to a position where the plates could be removed. The plates were held down with clips. She had to use her thumb to "pop the end of the plate off" and then hit the "inch button" again. She continued this process until she removed all of the plates from the entire cylinder. She then had to press the new plates onto the rollers and again use the "inch button" to advance the plates to a certain position and the lock them in place, using her hands. She believes the plates are made of metal. T. 18-19.

Petitioner testified she also performed assignments in the "reel room." That task involved loading 2-ton rolls onto a unit and making patterns. Before January 9, 2018, she worked in the "reel room" maybe once a week. T. 20.

Petitioner testified she also sometimes worked on the "folder" but, for the most part, her job consisted of plate duty or using the color. T. 21.

Petitioner testified her regular workweek consisted of 37.5 hours but she also worked varying amounts of overtime. Overtime was "pretty much mandatory." On average, she worked 10 hours of overtime per week. T. 21-22.

Petitioner testified her physical health before January 9, 2018 was "decent," with the exception of hand problems and the fact she was not getting enough sleep due to those problems. T. 22. Her hands started bothering her about three years before January 9, 2018. She started to notice that her hands were really stiff when she woke up in the morning. At first, she thought she might have slept on her hands but then the symptoms started happening more often. At work, she would notice symptoms when using a very heavy shaft in the "reel room" and when changing the plates. Over time, she started performing more "changeovers" and this "started to get to" her. Her hands started hurting more often but she "had to keep working." Eventually, she saw her primary care physician, Dr. Carlon.

Records in RX 2A reflect that Petitioner saw Dr. Carlon on October 14, 2013 for a routine visit. The doctor noted that Petitioner was seeing Dr. Washington, an endocrinologist, for her diabetes. She also noted that Petitioner "has carpal tunnel more in right" and "hasn't seen ortho yet."

Petitioner returned to Dr. Carlon on January 24, 2014. The doctor noted that Petitioner had recently undergone surgery due to cholecystitis and that it "took a couple of days to get sugars under control" prior to the surgery. RX 2A.

On February 7, 2014, Petitioner returned to Dr. Carlon due to chest pain and for follow-up after the January surgery. In addressing the issue of "return to work," the doctor noted that

Petitioner's job involved heavy lifting: "depending up to 50 lbs, plates are 50+ pounds – changing reels, reel arms pushing 2-ton rolls." RX 2A.

On July 7, 2014, Dr. Carlon noted that Petitioner described herself as "not good with the food part of" diabetes management. She also noted that Petitioner reported taking her diabetes medication but was "not checking blood sugars." The doctor assessed Petitioner as having "controlled Type 2 diabetes with retinopathy." RX 2A.

On December 16, 2014, Dr. Carlon noted that Petitioner was deriving some benefit from wearing braces but was still experiencing bilateral hand numbness. She recommended that Petitioner see a rheumatologist. RX 2A.

Petitioner testified that, at some point, Dr. Carlon recommended she wear braces at night. Her hand symptoms seemed to go away for a while but then "started to ramp up again," affecting her sleep. She would wake up at night and have to shake her hands to get the feeling back into them. She returned to Dr. Carlon, who referred her to Dr. McQueen. T. 22-23.

On October 19, 2015, Petitioner returned to Dr. Carlon and reported that she was now taking Tanzeum and her fasting blood sugar levels were "now 130s and used to be 200s." Petitioner also reported right shoulder pain of two months' duration. She indicated that she still had hand issues but they were "not as bad." She reported wearing braces "now and then." The doctor recommended exercise, weight loss and a consultation with a dietician. RX 2A.

On February 6, 2017, Petitioner returned to Dr. Carlon and reported that her insurance had changed twice in the last six months, that none of her medication was covered and that, even if it was covered, she could not afford them due to a $3700 deductible. Petitioner indicated she had been off Insulin for a few months because she "couldn't afford it." The doctor provided Petitioner with a coupon card for free Farxiga and discussed various dietary modifications. RX 2A.

On March 6, 2017, Petitioner saw Dr. Carlon and reported that Dr. Washington had put her on 50:50 insulin. Petitioner also reported that her job had changed and she had been "moved up to a different printer." Petitioner indicated she was keyboarding and "not moving plates." The doctor described her as having uncontrolled Type 2 diabetes with diabetic neuropathy. RX 2A.

On December 11, 2017, Petitioner saw Dr. Carlon and reported difficulty obtaining diabetes medication due to financial issues. The doctor noted that Petitioner reported numbness in her hands but not her feet. She also noted that the splints were "not working." She recommended that Petitioner see a rheumatologist for a possible steroid injection. RX 2A.

Petitioner first saw Dr. McQueen on December 19, 2017. The doctor noted a complaint of bilateral wrist and hand numbness, left worse than right, "for over 3 years now." He also noted that Petitioner "works as a press operator for Tribune which involves lots of repetitive

motion." He indicated that Petitioner described the numbness as bothering her at work. He noted a history of diabetes, hypertension and "HLD." On examination, he noted no significant thenar atrophy, positive Phalen's and positive Durkan's. He recommended an EMG and bilateral proflex wrist braces. PX 1. RX 8, 10.

Dr. Halwaji, a chiropractic neurologist, performed the recommended EMG on December 28, 2017. T. 28-29. Dr. Halwaji described Petitioner as right-handed. He noted complaints of bilateral wrist pain and bilateral hand numbness. He also noted that Petitioner described these symptoms as starting two to three years earlier. On examination, he noted tenderness with muscle spasm in the wrists and neck and positive Tinel's at the left wrist and left elbow.

Dr. Halwaji described Petitioner's symptoms as "consistent with a possible peripheral neuropathy and/or radiculopathy." He found the EMG results to be suggestive of carpal tunnel syndrome affecting the median nerves to a greater degree on the left. RX 2A.

Petitioner returned to Dr. McQueen on January 5, 2018. The doctor noted the EMG results. He also noted that Petitioner "has not initiated a workers' compensation claim but is interested in doing so after today's visit." He addressed causation as follows:

> "The patient has worked as a printing press operator for the Chicago Tribune for years which includes repetitive tasks, and over time the repetitive nature of these tasks has caused her to develop bilateral carpal tunnel syndrome, which has been worsening in severity over the past year. Because her carpal tunnel syndrome has been caused by the repetitive nature of her job, she will be contacting her HR department at work to initiate a workers' compensation claim."

The doctor imposed restrictions of no pushing, pulling or carrying over 5 pounds and rare repetitive use of the hands at work. He indicated he was imposing these restrictions "because patient should not exacerbate symptoms prior to surgery." PX 1, RX 10.

Petitioner testified she and other Respondent employees were off work for several days after her January 5, 2018 visit to Dr. McQueen. She first reported her injury to Respondent when she arrived at work at 5 AM on the Tuesday after January 5th. This was her first day back at work. After she reported the injury, she was told to bring in her restrictions. T. 29-30.

A telephone note in Dr. McQueen's chart reflects that Petitioner called the doctor's office on January 9, 2018. The employee who fielded the call noted that Petitioner had "started paperwork to initiate WC case" and was "looking for a letter indicating her restrictions so they can find her a position that will not aggravate her CTS until issue is resolved." The employee contacted Dr. McQueen to ask him to "create work status letter." PX 1.

Petitioner testified she provided Respondent with Dr. McQueen's restrictions at about 9 AM on January 10, 2018. She then returned to her work area because "they were still scrambling around [to] figure out" what tasks she could perform within the restrictions. At about 11 AM, she was in the lunchroom, eating lunch, when a woman tapped her on the shoulder and told her to go home because her restrictions could not be accommodated. She gathered up her things and went home. T. 30-31.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Biafora on April 3, 2018. Petitioner testified she described her job duties to Dr. Biafora. She then underwent X-rays, in another room, and returned to the examination room, where she and the doctor again discussed her injuries. All in all, she met with the doctor for about 30 minutes. T. 31-32. [See below for a summary of Dr. Biafora's findings and opinions.]

Petitioner testified that, after she saw Dr. Biafora, she received a letter notifying her that her claim was denied. It is her recollection that the doctor agreed with her carpal tunnel diagnosis but, based on a video, concluded she did not develop this condition due to her job. T. 32. At this point, she still wanted to try to have the surgery, regardless of the denial. T. 32. She decided to contact an attorney. T. 33.

On April 19, 2018, Petitioner filed an Application for Adjustment of Claim alleging she developed bilateral carpal tunnel syndrome manifesting on January 9, 2018 secondary to "repetitive trauma as a press operator, placing 64 plates on and off for 3-8 runs a day" and removing and cleaning 8 blankets per run. Arb Exh 2.

A telephone note in Dr. McQueen's chart reflects that Petitioner called the doctor's office on June 20, 2018 and reported that she was still off work and wanted to proceed with surgery through her health insurance "since WC denied surgery." PX 1.

Petitioner returned to Dr. McQueen on August 15, 2018. The doctor noted that Petitioner remained symptomatic and wanted to proceed with surgery using her health insurance. He scheduled the surgery for September 10, 2018. RX 10. Petitioner testified the surgery did not take place on this date because her blood sugar level was "9 or something like that" and had to be at 8 or lower. At her doctor's recommendation, she saw an endocrinologist. T. 34.

On September 21, 2018, Petitioner saw a nurse practitioner for nutritional counseling, in connection with her diabetes. The nurse practitioner noted that Petitioner "has had diabetes since 2005" and needed "better blood sugar control" in order to undergo carpal tunnel surgery. RX 2A.

Petitioner also saw an ophthalmologist, Dr. Springer, on September 21, 2018, for a diabetic retinopathy check. The doctor noted that Petitioner's vision tended to fluctuate depending on her blood sugar levels. RX 2A.

Petitioner returned to Dr. McQueen on October 26, 2018. Petitioner reported that she was now experiencing more pronounced symptoms in her right hand and wanted to have that hand operated on first. The doctor scheduled a right carpal tunnel release for November 5, 2018. PX 1. RX 10.

Dr. McQueen performed an open right carpal tunnel release on November 5; 2018. PX 1. T. 34. Petitioner testified she opted to have her right hand operated on first because, at that point, the symptoms in that hand were worse than those in her left hand. T. 35.

At the first post-operative visit, on November 13, 2018, Petitioner reported gradual improvement but noted right hand weakness and stiffness of the thumb and fingers. T. 35. Dr. McQueen directed Petitioner to remain off work and begin occupational therapy. RX 8, 10.

Petitioner testified she began attending occupational therapy at Athletico on November 19, 2018. T. 36.

On November 20, 2018, Petitioner returned to Dr. McQueen and reported having started therapy the previous day. Petitioner complained of right wrist pain and reduced right hand strength. The doctor recommended that she remain off work and continue attending therapy. RX 8, 10.

On November 27, 2018, Petitioner reported gradual improvement but indicated she was experiencing random pain in the palm of her right hand and persistent finger stiffness. Dr. McQueen directed her to remain off work and continue attending therapy. RX 8, 10.

At Dr. Carlon's referral, Petitioner saw an endocrinologist, Dr. Onyenwenyi, on December 10, 2018. The doctor described Petitioner as having experienced gestational diabetes when she was pregnant in 1999 and 2001 with that condition progressing to "overt" diabetes in approximately 2006. The doctor also indicated that Petitioner's diabetes was "uncontrolled" and that Petitioner was not able to tolerate Metformin. She further described Petitioner as having bilateral carpal tunnel syndrome and awaiting a left-sided release. She indicated that Petitioner "believes CTS is related to her work at Chicago Tribune but workers' compensation was denied." She noted a blood sugar level of 142 in her office. She changed some of Petitioner's medication and advised her to "continue to watch diet and exercise as able." RX 2A.

Petitioner returned to Dr. McQueen on December 18, 2018 and complained of some incisional soreness and finger stiffness. The doctor recommended that she continue right-sided therapy before scheduling the left-sided carpal tunnel release. RX 8, 10.

Petitioner returned to Dr. Onyenwenyi on February 11, 2019. The doctor noted that, since the last visit, Petitioner had run out of Trulicity and could no longer afford this medication, citing a $6700 deductible. The doctor increased Petitioner's Metformin dose and recommended that she watch her diet. RX 2A.

Dr. Biafora testified by way of evidence deposition on February 27, 2019. RX 1. Dr. Biafora identified Biafora Dep Exh 1 as his current CV. He is board certified in orthopedic surgery and has a subspecialty certificate in hand surgery. RX 1, p. 5.

Dr. Biafora testified he examined Petitioner on April 3, 2018, at the request of Gallagher Bassett. He devotes 5 to 10 percent of his practice to medical-legal work. RX 1, p. 6. He has no independent recollection of Petitioner. RX 1, pp. 6-7.

Dr. Biafora identified Biafora Dep Exh 2 as the report he generated on April 9, 2018. RX 1, p. 7. Petitioner told him she began experiencing bilateral hand numbness approximately two years before he examined her. Petitioner indicated she saw her primary care physician at that time and was told she might have carpal tunnel syndrome. Her symptoms worsened, prompting her to return to her primary care physician a few months before the examination. The primary care physician referred her to another physician, who recommended an EMG. Following that study, Petitioner was told she needed bilateral carpal tunnel releases. RX 1, pp. 8-9.

Dr. Biafora testified that Petitioner complained of constant numbness and tingling in her left hand and intermittent numbness and tingling in her right hand. She indicated she had been wearing wrist splints but did not note improvement. RX 1, p. 9. She provided a history of diabetes and hypertension. RX 1, p. 9. She also indicated she had worked as a printing press operator for 33 years, typically working 8 to 10 hours per day, five days per week. She reported occasionally working double shifts. She described having to change 64 plates up to 40 times per day. Each plate weighed less than one pound. She also described pushing sheets between two rollers and then pulling them. She indicated this did not require significant force. She reported having last worked in January 2018. RX 1, p. 10.

Dr. Biafora described Petitioner's elbow examination as normal. On bilateral wrist examination, he noted positive Tinel's, median nerve compression and Phalen's. He noted no intrinsic or thenar atrophy. Hand strength was good bilaterally. RX 1, pp. 11-12. Bilateral hand X-rays revealed no significant abnormalities. RX 1, p. 12.

Dr. Biafora testified he reviewed a First Report of Injury dated January 10, 2018 along with primary care physician notes, Romano Orthopedics Center notes, numerous photographs and a job video in connection with his examination. The primary care physician notes were from the period between October 14, 2013 and December 11, 2017. RX 1, p. 13. The note dated December 16, 2014 indicated that Petitioner was already using braces and had seen a rheumatologist. That note also described Petitioner as having uncontrolled diabetes with diabetic neuropathy. Petitioner was "nonadherent" to medication secondary to the cost of the medication. RX 1, pp. 13-14. The orthopedic records included an EMG that suggested carpal tunnel syndrome, worse on the left side. RX 1, p. 14.

Dr. Biafora testified he reviewed a one-minute video clip of a male employee inserting a plate into a press machine. That employee used his fingertips to clip the plates to the press. The plates "were malleable and appeared to be light." The employee then pushed a button to advance the plates through the press. As the plates advanced, the employee clipped a new set of plates into place, again using his fingertips. RX 1, p. The next video segment showed the same employee pulling plates off the press and reclipping them onto a different section of the press at about the level of his head, again using the very tips of his fingers. That segment lasted one minute, twenty seconds. RX 1, p. 15. The next segment showed the same employee placing a large roll of paper into the machine. He pushed the roll into place, using the open palm of his hand. For the most part, he pushed buttons on the machine, using his right hand, to place the roll. RX 1, p. 16. He used a knife to remove an outer layer of paper or cardboard and then seemed to be taking measurements. The final segment showed the same employee taking a perforated edge of paper off of a roll and removing tape. This did not seem to require any significant force. This segment lasted two minutes and thirty-five seconds. RX 1, p. 16.

Dr. Biafora testified that, after reviewing the materials and examining Petitioner, he arrived at a diagnosis of bilateral carpal tunnel syndrome. RX 1, p. 17. He does not believe that Petitioner's job caused or in any way aggravated this condition. RX 1, p. 17. He sees carpal tunnel syndrome almost every day. It usually has no known cause. A person's activities can contribute to the syndrome but those activities would involve forceful use of the hands in a gripping-type fashion all day. RX 1, p. 18. Assembly workers using power or vibratory tools could develop work-related carpal tunnel syndrome. He saw no such activity on the videos and Petitioner did not describe any such activity to him. RX 1, p. 18. Petitioner's verbal description of her duties seemed to match the video. RX 1, p. 18.

Dr. Biafora testified there are certain known risk factors for the development of carpal tunnel syndrome. Those risk factors include gender (female gender specifically), age, elevated body mass index, smoking, diabetes, rheumatoid arthritis and thyroid disorders. RX 1, pp. 18-19. Petitioner has some of these risk factors, specifically gender, elevated body mass index and diabetes. RX 1, p. 19.

Dr. Biafora opined that it would be reasonable for Petitioner to undergo bilateral carpal tunnel releases, given the passage of time and her failure to respond to conservative care. He does not link the need for this surgery to her work. RX 1, p. 19. Based on his review of the video and Petitioner's own description, he felt Petitioner could resume full duty. RX 1, pp. 19-20. He thinks of the term "MMI," or maximum medical improvement, as applying to work-related conditions and thus inapplicable in this case but, regardless of causation, Petitioner has additional treatment options, such as surgery. RX 1, p. 20.

Dr. Biafora testified he issued a second report (Biafora Dep Exh 3) on November 20, 2018, after watching an additional job video. The video showed a worker placing a solution on a rag and then using the right hand in an open position to wipe the rag against rollers. It did not appear to him as if any significant gripping was required. The wrist was "in a slightly extended position" during the wiping process. RX 1, p. 21. The video was two minutes long.

The accompanying cover letter indicated that the rollers had to be cleaned at the end of each shift four to five days per week and that it took about twenty minutes to clean the four cylinders properly. RX 1, pp. 21-22. The additional video did not prompt him to change any of his previous opinions. The video showed wiping rather than scrubbing or a forceful gripping-type activity. RX 1, p. 22.

Under cross-examination, Dr. Biafora testified he received a cover letter along with records, etc. He reviewed what he was given. RX 1, pp. 24-25. He disposed of the records he reviewed. RX 1, p. 25. In the cover letter, Respondent's counsel provided him with information concerning Petitioner's health coverage. He did not rely on the letter alone. He always reviews the medical records. RX 1, p. 27. He did not review any of the photographs or videos with Petitioner. He thus did not ask Petitioner whether the items accurately depicted her job duties. RX 1, pp. 27-28. The individual shown in the first clip is clearly not Petitioner. The plates that are hanging on the press are at about the individual's waist. Dr. Biafora acknowledged he does not know how the plates got into that position. RX 1, pp. 28-29. The individual in the video is not wearing gloves. He does not know whether Petitioner wore gloves but he does not think that has any relevance. RX 1, pp. 29-30. All in all, the videos he reviewed lasted a little over ten minutes. None of them depicted Petitioner. RX 1, p. 30. Repetitious flexion and extension of the hand could "potentially" contribute to the development of carpal tunnel syndrome. RX 1, p. 31. He does not recall whether any of the footage he saw showed work being performed on an upper level. RX 1, p. 31. The additional video he reviewed in November 2018 showed an employee working at ground level. Three cylinders are visible. The lowest cylinder is roughly at shoulder height. RX 1, p. 32. He asked Petitioner about the frequency with which she performed the tasks she described. RX 1, p. 34. The term "idiopathic" does not mean there is no cause. It just means the cause is unknown. RX 1, p. 34. He would have arrived at the same conclusions regardless of the video. Petitioner's own description of her duties would have led him to the same conclusions. RX 1, p. 35. Petitioner did not describe wiping the cylinders. RX 1, p. 35. He does not recall exactly how much time he spent having Petitioner describe her job but he "spent a pretty decent amount of time." The amount of time he spends varies from case to case, depending on the examinee's occupation. RX 1, p. 36. He used Petitioner's own words in his report. He did not utilize Respondent's counsel's description. RX 1, pp. 36-37. He did not describe any particular hand position because he did not feel positioning was relevant, "as there was no force" applied to the hands or wrists. RX 1, p. 37. If Petitioner performed other activities that she did not describe or that are not shown in the videos, that could prompt him to change his opinion. RX 1, p. 37.

On redirect, Dr. Biafora testified that Petitioner did not describe the process of "washing blankets" to him at the time of the examination. One of the photographs he reviewed showed a plate hanging on a metal rack. Another showed metal plates hanging on a rack. The cylinders shown in the photographs seem to be the same type that the woman was cleaning in the fourth video. RX 1, p. 39. He needs to review medical records in order to render an opinion. RX 1, p. 40.

Dr. McQueen performed a left open carpal tunnel release on March 4, 2019. T. 36. PX 1.

On March 12, 2019, Petitioner saw Dr. McQueen's assistant, Subin George, PA-C. Petitioner reported a pain level of 2/10 and indicated she had transitioned off the Tylenol with Codeine. George recommended that the surgical sutures be left in until the next visit. He directed Petitioner to start occupational therapy. PX 1.

On March 22, 2019, Dr. McQueen removed the surgical sutures and directed Petitioner to continue attending therapy. PX 1. T. 37.

On April 19, 2019, Dr. McQueen noted that Petitioner was experiencing aching 5/10 pain over the incision site and occasional numbness in her left middle finger. He directed Petitioner to continue attending therapy. PX 1.

At the next visit, on May 10, 2019, Dr. McQueen noted that Petitioner was experiencing constant numbness in her left middle finger. On re-examination, he noted subjectively decreased sensation in the left middle finger at the ulnar border. He recommended that Petitioner continue attending therapy, noting she might require a wrist MRI. PX 1. RX 9.

A therapy note dated June 5, 2019 reflects that Petitioner reported improvements in left wrist and hand strength but was still experiencing left middle finger numbness. PX 3.

On June 7, 2019, Dr. McQueen noted that Petitioner had improved but was still experiencing some numbness and tingling in half of her left middle finger. He recommended that Petitioner return in six weeks for consideration of a repeat EMG or wrist MRI. PX 1. RX 9.

A therapy note dated June 7, 2019 reflects that Petitioner reported she could not continue attending therapy "secondary to insurance issues" and was returning to work the following week. PX 3.

Petitioner testified she resumed her regular work duties at Respondent on June 11, 2018. T. 38.

On July 31, 2019, Petitioner returned to Dr. McQueen. She reported that she "did not continue OT due to maxing out sessions through insurance." She also reported no improvement of her left middle finger numbness. The doctor recommended that she return in six weeks for consideration of an MRI or repeat EMG. RX 9.

Based on a bill in RX 10, it appears Petitioner returned to Dr. McQueen on September 11, 2019. No records concerning this visit are in evidence.

Petitioner returned to Dr. McQueen on October 4, 2019, having earlier undergone a left wrist MRI at his direction. The doctor noted that he had ordered the MRI "to evaluate for

possible neuroma within the median nerve that could be causing" Petitioner's ongoing left-sided symptoms. He also noted that the MRI was negative for a neuroma but showed "signs of early Kienbock disease involving the lunate." He recommended that Petitioner see a hand specialist for this disorder. He also noted "minimal symptoms" consistent with right thumb triggering. He indicated that Petitioner declined an injection to address the triggering. RX 10.

Petitioner acknowledged she has not pursued Dr. McQueen's recommendation that she see a hand specialist. T. 76-77.

Petitioner testified she is still working as a press operator for Respondent. She works four 10-hour shifts per week. T. 38. Her hands have improved since the surgeries but "not at a hundred percent." She still drops things and finds it difficult to pick things up. She continues to perform home exercises to help her hands improve. Overall, she is able to perform her job. T. 39-40.

Under cross-examination, Petitioner testified she started working for Respondent on July 26, 1985. She has worked as a press operator since that date. T. 41. Technology has evolved over the years. The plates she uses now are a little thinner and lighter in weight than the plates she used at the beginning. T. 41-42. The rolls of paper are pretty much the same. T. 42. When she first started experiencing hand symptoms, about three years before she filed her claim, she thought she had maybe slept on her hands. At that time, she "never correlated" her symptoms to her job. She did not know what was causing the symptoms. T. 42-43. She had gestational diabetes during her pregnancies in 1999 and 2001. She was diagnosed with Type 2 diabetes in 2006. T. 43. Since that time, it has been a struggle to keep her diabetes under control. T. 44. When she saw Dr. Carlon on October 14, 2013, the doctor suggested she might have carpal tunnel. Dr. Carlon is not a specialist. She "suggested maybe wearing splints at the time." T. 45. Petitioner testified she has no reason to question the doctor's note of October 14, 2013 if it shows her glucose reading was 258. T. 45. She has undergone several diabetes-related laser eye surgeries. T. 46. As of October 14, 2013, she was on medication for diabetes, high blood pressure and high cholesterol. T. 46. She underwent gall bladder surgery in January 2014. If her hospital records show that this surgery was delayed because her glucose reading was 455, she would not disagree, although she does not remember this. T. 47. She has never been on Prilosec and has never had a hiatal hernia. T. 47. The plates she used at work weigh much less than 50 pounds on an individual basis. T. 48-49. Dr. Carlon discussed her diet with her in 2014. She explained to Dr. Carlon that her work schedule affected her intake, due to having to start her shift at 5 AM and variation in her assigned lunch time. If Dr. Carlon noted that she was not checking her glucose levels regularly, that is correct. This was also due to her work schedule. T. 50. In December 2014, Dr. Carlon noted her hands were still numb and she was using braces. She purchased the braces on her own. T. 51. She does not recall Dr. Carlon recommending she see a rheumatologist. She did not see a rheumatologist. T. 52. If Dr. Carlon noted, in May 2015, that she did not follow up with an ophthalmologist because the co-pay was over one thousand dollars, that could be correct. T. 53. She complained of right shoulder pain to Dr. Carlon in October 2015. At that point, she was an avid bowler. She used her right hand when bowling. She did not experience right hand or wrist symptoms when she bowled. T. 53.

Her health insurance with Respondent changed in 2017. She switched to a health savings account, which has a $6700 deductible. T. 55. Due to the change in insurance and the deductible, she could not see Dr. Washington and could no longer use coupons to obtain diabetes medication. As a result, her glucose levels fluctuated. T. 56. As of her February 2017 visit to Dr. Carlon, she was experiencing some skin issues with her toes and some leg swelling. T. 57. She never underwent the shoulder therapy that Dr. Carlon recommended, due to her insurance issues. T. 57-58. At the September 2017 visit, she told Dr. Carlon she was not compliant with her diabetes medication due to the cost of that medication. T. 58. She had not seen Dr. Washington in a year or two. She stopped seeing Dr. Washington because that doctor was doing the same things that Dr. Carlon was doing. She would not disagree with Dr. Carlon's notes if they reflect she was 5 feet, 1 ½ inches tall and weighed 188 pounds as of December 11, 2017. T. 59. On that same date, Dr. Carlon also noted she had run out of some of her medication due to cost issues. T. 59. The doctor might have warned her she was at risk for a stroke. T. 60. It would be fair to say she had carpal tunnel symptoms for longer than three years before January 2018 but she "didn't have a name for what [she] had." Dr. Carlon "said what it was but it wasn't like a definitive diagnosis." T. 60. When she first saw Dr. McQueen, on December 19, 2017, she spent about ten minutes explaining her job duties to him. She would agree that the doctor's note of that date does not mention specific activities she performed at work. T. 62-63. As of the next visit, on January 5, 2018, she was interested in pursuing a workers' compensation claim because she believed the injury was work-related. Dr. McQueen did not suggest she file a claim. T. 63. The doctor might have said the condition was due to repetitive work. T. 64. She thinks she told the doctor she had symptoms before October 14, 2013. T. 64. Initially, he recommended she try the splints again and wear them at night. He also discussed injections versus surgery, indicating he could not guarantee the shots would help but he could "almost" guarantee the surgery. T. 64-65. He imposed a 5-pound restriction with rare repetitive activities and no pushing or pulling. It would be difficult to accommodate these restrictions for a press operator. T. 65. Her group health deductible renewed as of January 1, 2018. She is not sure what deductible she had to meet to undergo the surgery in January 2018. T. 65-66. She mentioned her hand symptoms to co-workers before January 2018 but she did not mention them to a boss or supervisor. T. 67. If Dr. Biafora's report reflects she had to change plates 40 times per day that is not correct. She does not even have 40 runs per day. T. 68. If Dr. Biafora indicated that each plate weighs less than one pound, that is correct. T. 68. If Dr. Biafora testified that she told him placing and removing the plates did not require much force that is accurate. She had to load rolls of paper into the unit. A 2-ton roll would be sitting on wheels and she had to push that roll into the unit. "That might have been the hardest part, just pushing the roll into the unit." T. 70. If she ran two units, each of those units carried three rolls. Each roll represents maybe 20,000 copies so, if you had one hundred thousand to run, you would need at least five rolls. The average was two units per day but you might have to run three. T. 70-71. Dr. Biafora did not tell her she could continue to perform full duty. She learned of this when she read the letter that Respondent sent her. T. 71. She was off work between January and April, before she saw Dr. Biafora, and opted to remain off work after she saw him, per Dr. McQueen. T. 72. She returned to work for Respondent on June 11, 2019. T. 72. She received short-term disability benefits but Respondent deducted money from the checks for medical premiums. She later received long-term disability from Lincoln Financial. T.

74. She continued to experience right middle finger numbness after the carpal tunnel surgeries. Dr. McQueen recommended she undergo an EMG but she did not undergo this study. Dr. McQueen also recommended a wrist MRI. T. 75. When she last saw Dr. McQueen, on October 4, 2019, he told her she had Kienbock's disease and recommended that she see a hand surgeon. She has not gone to this surgeon. He did not tell her that the Kienbock's disease is job-related. T. 76-77. He also noted popping and clicking in her right thumb. She did not have this before the carpal tunnel surgery. T. 77. Her blood sugar levels have been running between 150 and 200 of late. She is scheduled to undergo testing the Monday after the hearing. She is currently 53 years old. She is 5 feet, 1 ½ inches tall and weighs 185 pounds. T. 78. She is getting her job done at Respondent but "at a slower pace." Respondent laid off about ten people in her department so she has to do more. The number of runs she performs on any given day depends on the day of the week. On her shift, she prints various neighborhood papers published by the Pioneer Press. She might do ten runs a day, with each run consisting of different numbers of papers. On average, she does between five and eight runs per day. T. 80.

On redirect, Petitioner testified she demonstrated the process of putting on plates to Dr. McQueen. Before January 8, 2018, she bowled maybe once a week. She did not bowl in 2019. She tried to bowl this year but, overall, is "not a heavy bowler at all." T. 81.

Stewart Erskine testified on behalf of Respondent. Erskine testified he retired from Respondent on February 28, 2020, after 20 or 24 years as product supervisor. T. 84. His job involved overseeing the press room, dealing with attendance and scheduling issues. T. 85. He knows Petitioner. They worked on the same crew for a while and then he supervised her on the first shift. As of his retirement, Respondent had ten presses in the press room. Sixteen press operators worked on the first shift. It takes more than one person to operate a press. T. 86.

Erskine testified he participated in the preparation of several photographs and job videos on February 23, 2018. Respondent's counsel was present on that date, as were Mark Wethington and Tiffini Thomas. Wethington and Thomas no longer work for Respondent. T. 86-87. The photographs (RX 3) are accurate. The first page of RX 3 shows a stack of plates. The second page shows plates hanging on a rack. A CPT machine creates the plates. A computer makes an image on a plate and the plate then goes through a bender. T. 89. Page five of RX 3 shows a blue cylinder. The plates are already on the press and can be seen at the top of the photo. Three of the units, numbers 1, 9 and 10 are called "towers" and are three stories tall. T. 92. Another page in RX 3 shows the "quiet room," where the computer is located. T. 92. The computer adjusts the ink and water. T. 93. The first video shows Mark Wethington at a press. He is mounting plates onto cylinders. He mounts four plates on the "OP" and another four on the "drive." The plates "click" into place. You have to push down on a plate to get it to click. T. 96. Wethington also uses an "inch button" to advance the cylinder. T. 97. The second video shows Wethington loosening the top of the plate and reversing the cylinder to the point where he can pull the plate out. Wethington is taller than Petitioner. Petitioner is able to use a metal step while putting the plates on. There are eight cylinders on a unit and 64 plates per unit. T.

98-99. The plates can be taken on and off once or twice per shift or up to eight to ten times per shift. T. 99. Certain products are printed in small quantities, maybe a few hundred or a few thousand at a time. Press operator crews rotate every three months. T. 99. Some crews have more changeovers than others. T. 99-100. The plate changing process takes place two days per week. A changeover could involve all 64 plates or fewer, depending on the product. The third video shows rolls of newsprint. A full roll weighs 2,000 pounds. T. 101. The video shows a roll coming in on a 4-wheel dolly. The roll then has to pushed on to the "TU," or "transfer unit." There is a "dog" on the transfer unit that grips the dolly. T. 102-103. There are four buttons that can be pressed to perform different functions, such as moving the roll in various directions. The press operator has to use a "stripper" to remove a brown paper wrapper from each roll. The press operator also has to check each roll to make sure it is not nicked. An operator could perform this task between five and twelve times per shift, depending on how many rolls have to be used. T. 104. The fourth video shows Wethington making a pattern and applying tape to a roll so the sensor can sense it and "tell the roll when to paste." T. 106.

Erskine testified that Respondent's counsel contacted him again in 2018 and asked him to make another video. The fifth video was prepared on November 2, 2018. It shows an "ink room person" named Janise wiping a cylinder with a rag to remove the dust that builds up. A press operator performs this task at the end of the shift, cleaning eight cylinders. Force could be required "if the blankets are real dirty." T. 108-109. It takes 30 to 40 minutes to clean all eight blanket cylinders. T. 109.

Erskine testified that he is not aware of Petitioner complaining to him about her wrists before January 10, 2018. Petitioner returned to work in June 2019. He does not remember Petitioner complaining of hand or wrist problems after she resumed working. T. 110-111.

Under cross-examination, Erskine testified that the photograph on the last page of RX 3 shows the part of the plate that has to be clipped into the cylinder. T. 111. Mark Wethington is probably 5 feet, 10 ½ inches or 5 feet, 11 inches tall. He does not know whether Petitioner would be working at the same height as Wethington if she used the step. He does not know how tall Janise is. She might be a couple of inches taller than Petitioner. T. 113.

On redirect, Erskine testified that it is the last job video, marked #5, that shows Janise. T. 114.

Arbitrator's Credibility Assessment

Petitioner came across as an honest, hard-working individual. The fact that she has worked for Respondent for over thirty years weighs in her favor, credibility-wise. Her testimony concerning her schedule and duties was detailed and believable. Her surgeon's records fully support her notice-related testimony.

Respondent's Section 12 examiner, Dr. Biafora, agreed that Petitioner has bilateral carpal tunnel syndrome but did not find a causal relationship between this condition and

Petitioner's work. In his view, the manual tasks that Petitioner performed required no force. At the hearing, however, Petitioner's former supervisor, Stewart Erskine, conceded, on direct examination, that a press operator could be required to change out 64 plates as many as eight to ten times per shift and that "you have to push down on a plate to get it to click" into place. Erskine also acknowledged that a press operator spends about 30 minutes per shift using a rag to clean cylinders and that this task would require force if the cylinders were particularly dirty. The Arbitrator finds Dr. Biafora's causation opinion unpersuasive, in light of Erskine's testimony.

Arbitrator's Conclusions of Law

Did Petitioner sustain injuries secondary to repetitive trauma manifesting on January 9, 2018? Did Petitioner establish a causal connection between her bilateral carpal tunnel syndrome and her work duties?

The Arbitrator finds that Petitioner developed bilateral carpal tunnel syndrome secondary to repetitive trauma, with this condition manifesting on January 9, 2018, the date on which Dr. McQueen recommended surgery and imposed work restrictions. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning her schedule, which regularly included overtime, and the manual tasks she performed. The Arbitrator also relies on Erskine's concessions that Petitioner changed out 64 plates between one and ten times per shift, twice a week, that "you have to push" to click a plate into place and that the daily task of cleaning cylinders could involve the use of force.

The Arbitrator recognizes that Petitioner did not perform the same task all day, every day. "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." Edward Hines Precision Components v. Industrial Commission, 356 Ill.App.3d 186, 193-194 (2nd Dist. 2005). In City of Springfield v. IWCC, 388 Ill.App.3d 297, 314 (4th Dist. 2009), the Appellate Court upheld a finding that the claimant's bilateral carpal tunnel syndrome was causally related to his job even though the claimant performed a variety of manual tasks.

The Arbitrator views January 9, 2018 as an appropriate manifestation date, applying the standard of "flexibility and fairness" set forth in Durand v. Industrial Commission, 224 Ill.2d 53 (2007). Manifestation of a repetitive trauma injury occurs when both the fact of injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. Peoria County Belwood Nursing Home v. Industrial Commission , 115 Ill.2d 524, 531 (1987). The date on which the employee becomes unable to work, due to physical collapse or medical care, helps determine the manifestation date but "the standard remains flexible." While Dr. Carlon's October 2013 note refers to carpal tunnel syndrome, there is no indication that the doctor imposed restrictions or informed Petitioner her hand complaints stemmed from her job. Petitioner credibly testified that she initially attributed her symptoms to non-work factors such as sleeping with her hands in an awkward position. She continued working for Respondent despite her symptoms. She should not be penalized for "diligently work[ing] through progressive pain," Durand v. Industrial Commission,

115 Ill.2d 524, 531 (1987). It was not until January 5, 2018 that Dr. McQueen imposed restrictions, pending surgery, and not until January 9, 2018 that the doctor clarified the precise nature of the restrictions.

The Arbitrator also finds that the manual tasks Petitioner performed for Respondent contributed to her bilateral carpal tunnel syndrome condition of ill-being. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning her schedule, including the regularity of her overtime, and the nature of the tasks she performed for Respondent. The Arbitrator also relies on Erskine's testimony that certain of Petitioner's tasks could require the use of force and the causation-related opinions set forth in Dr. McQueen's records.

Respondent maintains, in part, that Petitioner's job did not cause her symptoms because those symptoms worsened after she went off work in January 2018. Specifically, Respondent argues that it was only after January 2018 that any medical provider noted a complaint of hand or wrist pain. In fact, Dr. Halwaji, the neurologist who examined Petitioner in December 2017 noted a complaint of bilateral wrist pain. RX 2A.

The Arbitrator recognizes that certain non-work-related factors, including Petitioner's diabetes, could have also contributed to the development of her bilateral carpal tunnel syndrome. Under Illinois law, an injury need not be the sole, or even the primary, cause of a condition, as long as it is a causative factor. Even when other, non-occupational factors contribute to the condition, a claimant need only show that some act or phase of the employment was a causative factor of the resulting injury. Fierke v. Industrial Commission, 309 Ill.App.3d 1037 (3rd Dist. 2000). An employer takes an employee as it finds her. A.C.& S. v. Industrial Commission, 710 N.E.2d 837 (Ill. App.1st Dist. 1999), citing General Electric Co. v. Industrial Commission, 433 N.E.2d 671, 672 (1982). The Arbitrator views Petitioner's bilateral carpal tunnel syndrome as multi-factorial, with her press operator duties playing a role.

Finally, the Arbitrator finds that Petitioner did not establish causation as to the Kienbock's disease and right thumb triggering that Dr. McQueen noted in October 2019. RX 10. Petitioner did not offer any opinion linking these conditions to her job.

Did Petitioner provide Respondent with timely notice?

Petitioner testified she reported her injury to Respondent on January 9, 2018, the first date she was scheduled to work after her January 5, 2018 visit to Dr. McQueen. Petitioner also testified she provided Respondent with Dr. McQueen's restrictions on January 10, 2018 and was then sent home. T. 29-31. Respondent's sole witness did not contradict this testimony. The testimony is fully supported by Dr. McQueen's chart notes. It is also supported by Dr. Biafora's reference to a First Report of Injury dated January 10, 2018.

The purpose of the Act's notice requirement is to enable an employer to investigate an alleged accident and to protect employers from unjust or fraudulent claims. Gano Electrical Contracting v. Industrial Commission, 631 N.E.2d 724, 727 (Ill. App.. 4th Dist. 2004). Section 6(c)

of the Act provides that notice can be given orally or in writing and that "no defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings." The Arbitrator finds that Petitioner provided timely oral notice of her injury, some four days after learning that her condition was work-related and that she required surgery and work restrictions. There is no evidence suggesting that Respondent was prejudiced in any way by the reporting. Respondent had every opportunity to investigate Petitioner's claim and in fact obtained a Section 12 examination in early April 2018, before Petitioner retained counsel and filed her Application.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the itemized bills in PX 4 and PX 5. These bills relate to services provided by Romano Orthopedics (through June 7, 2019), University Anesthesiologists, Athletico and Rush Oak Park Hospital. They reflect charges, a September 8, 2016 patient credit card payment of $102.41 to Rush Oak Park, various Blue Cross payments and a bankruptcy adjustment. [It is not clear why the hospital applied a September 8, 2016 Visa card payment to the charges relating to the March 2019 carpal tunnel release.] The Arbitrator has previously found in Petitioner's favor on the threshold issues of accident, notice and causal connection. There is no dispute as to Petitioner's diagnosis or the need for the carpal tunnel releases performed in 2018 and 2019. Respondent's examiner, Dr. Biafora, did not contest any aspect of Petitioner's care. The Arbitrator finds the treatment to be reasonable, necessary and causally related to the injury. The Arbitrator awards the claimed medical bills, subject to the fee schedule and with Respondent receiving Section 8(j) credit for its medical payments of $39,784.15, in accordance with the parties' stipulation. Arb Exh 2. Respondent is to hold Petitioner harmless against any claims made by its group carrier pursuant to Section 8(j).

What is the nature and extent of the injury?

Because Petitioner's condition manifested after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act in determining nature and extent. That section sets forth five factors to be considered when assessing permanency, with no single factor predominating. The Arbitrator assigns no weight to the first factor, i.e., any AMA impairment rating, since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's occupation and age as of the manifestation date. Petitioner, a longtime press operator, was born on May 7, 1966. Following her carpal tunnel releases, she resumed full duty in June 2019, at which point she was 53. The Arbitrator views her as an older individual who could reasonably be expected to remain in the workforce for another ten to twelve years. Her post-operative hand symptoms could affect her ability to continue working during that time. The Arbitrator assigns no weight to the fourth factor, future earning capacity, since there is no evidence indicating the injury affected Petitioner's rate of pay. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator notes that Petitioner required bilateral open carpal tunnel releases and was continuing to experience some symptoms as of her most recent visits to her surgeon, Dr. McQueen.

Based on the foregoing, along with Petitioner's credible testimony concerning her persistent hand weakness and "slower pace" at work, the Arbitrator finds that Petitioner established permanency equivalent to 12.5% loss of use of each hand.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC034416
Case Name	HEINE,TARA v. AEROTEK INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b-1)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0388
Number of Pages of Decision	30
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Joseph P. Brancky
Respondent Attorney	Quinn Brennan

DATE FILED: 7/30/2021

/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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tara Heine,

Petitioner,

vs. No. 18 WC 34416

Aerotek,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B-1)

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 39-year-old Patient Access Specialist, testified that on November 2, 2018 she tripped over a floor mat in her building's lobby, falling and striking her knees, elbow and head. Immediately prior to her fall, she had gone outside her building to make phone calls on her unpaid lunch break; she fell while returning to her office.

Petitioner was immediately taken to the emergency room of Northwestern Memorial Hospital with complaints of pain to her knees, wrists, elbows and head. She was diagnosed with multiple bruises, treated and released. Petitioner tried to work but had to go home. Later that evening, she felt nauseous and went to the emergency room of UIC Hospital. She also had complaints of severe pain in her head, and pain to her neck and right ankle. Petitioner was

diagnosed with an acute head injury, multiple contusions and an avulsion fracture of her right ankle. She was authorized off work, treated with an ace wrap and air cast, and instructed to see her primary care physician and an orthopedic surgeon.

The following day, on November 3, 2018, Petitioner sought treatment at Rush University Medical Center for headaches, dizziness, neck and shoulder pain, and blurred vision. There, she was diagnosed with a closed head injury and multiple contusions, and told to follow-up with her primary doctor. On November 6, 2018, Petitioner saw Dr. Ahn with complaints of right ankle pain for the past four days. Dr. Ahn found Petitioner's right medial malleolar area to be tender and edematous.

Records indicate Petitioner's pain and symptoms progressed. By November 21, 2018, she was experiencing low back, band-like pain radiating into her right leg, and severe left-sided neck pain along with daily headaches. Petitioner underwent MRI's of her cervical and lumbar spines on December 19, 2018 which, the radiologist reported, showed protrusions at C2-3, C4-5, C7-T1, L4-5 and L5-S1. Dr. Rhode confirmed a 3-level cervical disc herniation and a 2-level lumbar disc herniation. Dr. Rhode reported Petitioner's symptoms were new in onset after her work injury. He recommended therapy, epidural injections, and possible surgery. On January 24, 2019, Dr. Rhode took Petitioner completely off work.

Petitioner continued medical care for her injuries, undergoing chiropractic treatment and lumbar injections. On February 11, 2019, Dr. Levy documented Petitioner's ongoing complaints of neck and back pain, noting that she was also experiencing tingling down her right leg and left arm. On May 10, 2019, Petitioner saw Dr. Sinha, who prescribed pain management treatment and concurred with the recommendation for cervical spine surgery. At Respondent's request, Petitioner saw Dr. Gleason in June 2019. At her attorney's request, she saw Dr. Graf in October 2019. Petitioner continued treating with Dr. Patel and Dr. Sinha throughout the summer and fall of 2019, undergoing injections to her cervical and lumbar spines, trapezius, buttocks and sacroiliac joint.

In 2016, prior to her work accident, Petitioner experienced episodes of right-sided neck and shoulder pain; however, she attributed that to a flu shot she had received years earlier. That neck and shoulder pain often resolved after Petitioner took muscle relaxers. X-rays taken at that time revealed no acute osseous abnormalities. That same year, Petitioner also experienced right-sided lumbar pain. However, the record shows she received little if any treatment for that condition at that time, and there is no evidence that Petitioner missed any work as a result of her condition at that time.

Since November 2, 2019, Petitioner's neck and back have been very painful. The treatment she received through arbitration failed to provide long-lasting relief. She now has more anxiety and difficulty with activities of daily living than prior to her accident. Her shoulders hurt and her low back locks up. Petitioner gets tension headaches, and still experiences tingling down her left arm and right leg. Her pain flares up with activity, and never

goes away. Now, she takes multiple medications including Hydrocodone, Ibuprofen, Baclofen, Cymbalta, Famotidine, and Hydroxyzine. Petitioner still sees Dr. Rhode every month, and has not undergone the recommended surgeries.

The Arbitrator found that Petitioner failed to prove an accident arising out of and occurring in the course of her employment. The Arbitrator did not find Petitioner to be credible, based upon inconsistencies between her testimony and her records as well as his observations of her at the hearing. The Arbitrator noted Petitioner produced no other witnesses to verify she had an accident or how it may have occurred. The Arbitrator noted Petitioner's medical records gave different descriptions of the condition of the mats on which she tripped as being, "overlapped," "bunched," or simply, "present on the floor." The Arbitrator observed that when Petitioner was testifying, her voice sometimes trailed off and her pitch changed. He found it significant that before Petitioner answered questions, she looked down or away and made, "variable and unpredictable," eye contact.

The Arbitrator also did not believe Petitioner's fall arose out of or occurred in the course of her employment because she was returning from an unpaid lunch break, and fell in an area open to the general public. The Arbitrator also did not believe that if floor mats were overlapped, that presented a hazard, noting that, "in general, floor mats are placed in a lobby to make it more safe."

The Commission views the evidence differently than the Arbitrator, and finds Petitioner did prove an accident which arose out of and occurred in the course of her employment. In so concluding, the Commission notes that Petitioner's records document her multiple bruises and contusions immediately after her accident. Petitioner's testimony describing the fall on floor mats was uncontradicted and corroborated by her contemporaneous medical records. The Commission finds it to be insignificant that one medical record may have described the mats as, "overlapped," while another, "bunched up" – especially given the absence of any evidence that the condition of the mats was not the cause of Petitioner's fall. Floors mats that do not lay flat on the floor beneath, quite plausibly present a hazard that can cause the type of fall described by Petitioner. Given the record as a whole, the Commission finds that Petitioner's testimony is generally consistent with the descriptions recorded in the medical records, finds her testimony regarding the condition of the mats to be credible, and finds that the floor mats presented a hazardous condition at the time of Petitioner's fall.

In addition, the Commission considers other aspects of Petitioner's condition, though not related to her claimed accident, in finding her to be credible overall. The record reflects that before and at the time of her accident, Petitioner had been under the care of a psychiatrist and was taking medications for anxiety, depression and bipolar disorder – conditions which may have affected her demeanor and presentation at trial. Petitioner's focus, variable eye contact, and pitch changes are not signs of untrustworthiness when considering the psychiatric conditions from which she suffered for years, and for which she had been under active medical treatment. The Commission finds Petitioner's testimony to have been credible and consistent with the

objective findings and subjective complaints documented in her contemporaneous medical records.

Turning to the accident analysis, under the personal comfort doctrine an injury is not deemed to occur outside of the course of employment if it occurs during certain acts relating to the personal comfort of the employee. The personal comfort doctrine has been applied to cases involving lunchtime injuries. Other acts, beside eating during break times in the employment, have also been held to be acts of personal comfort. The Illinois Supreme Court has held that, in lunch hour cases, the most critical factor in determining whether the accident arose out of and occurred in the course of employment is the location of the occurrence. Thus, where the employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incident to the employment, even where the lunch break is unpaid, the employee is not under the employer's control, and the injury was not caused by a hazard of the employment. *Eagle Discount Supermarket v. Industrial Comm'n*, 82 Ill. 2d 331, at 338-339 (1980).

In the present case, the Commission finds the personal comfort doctrine applicable. Petitioner's accident and injuries occurred in the lobby of the building where she worked, as she was returning to her office following a 30-minute lunch break. The Commission finds Petitioner's accident arose out of and occurred in the course of her employment on November 2, 2018.

Next, the Commission addresses causal connection. After finding that Petitioner did not prove accident, the Arbitrator then found Petitioner had not proven causal connection of her injuries, or entitlement to medical expenses, prospective medical treatment or temporary total disability benefits. The Commission, however, finds that Petitioner did prove the following conditions were causally related to her November 2, 2018 accident: a concussion, injury to her right ankle medial malleolus, cervical and lumbar radiculopathy, and herniated discs at C4-C7 and L4-L5.

With regard to Petitioner's right ankle injury, the Commission acknowledges that Petitioner sustained a prior injury to that ankle in June 2017, when an individual threw a potted plant at her. However, x-rays of her right ankle taken then failed to disclose any acute displaced fracture or dislocation.

In contrast, Petitioner's November 2, 2018 right ankle x-ray report documented an irregularity along her right inferior medial malleolus, and that report questioned the existence of an avulsion fracture of indeterminate age. The emergency room physician diagnosed a right ankle avulsion fracture, and provided Petitioner with an air cast and ortho shoe. On November 6, 2018, Dr. Ahn found Petitioner's right malleolus to still be tender and swollen, and he recommended Petitioner see a podiatrist. On January 22, 2019, Dr. Hugh diagnosed Petitioner with a right ankle fracture. Whether or not Petitioner's right medial malleolus was fractured in her November 2, 2018 accident, the Commission finds that the accident caused an injury, or

aggravation of a prior condition to Petitioner's right medial malleolus, with an immediate onset of symptoms, clinically correlated objective evidence of trauma, and the need for medical treatment.

In finding that Petitioner proved a causal relationship between her accident and her cervical and lumbar spine conditions, the Commission notes that before her accident Petitioner was not under treatment for any neck, cervical or lumbar issues, and she was able to perform all of her work duties without problem. The Commission also relies upon Petitioner's treating medical records in finding a causal relationship. The UIC Hospital record dated November 2, 2018 recorded that Petitioner sustained an acute head injury and complained of severe head pain and neck pain. Those complaints were consistently documented thereafter in her records.

Although some of Petitioner's symptoms were not present immediately after her accident, they developed within days or weeks of it. Dr. Graf testified that following some injuries, many patients do not develop the immediate onset of radicular symptoms. The Commission finds that Petitioner's conditions caused by her accident progressed and worsened thereafter as corroborated by objective medical evidence. MRI's taken a few weeks after Petitioner's accident revealed multiple herniated cervical and lumbar discs. Records from Dr. Rhode's office show that Petitioner complained of lumbar radiculopathy into her right leg on November 19, 2018 after which he recommended therapy, injections and possible surgery. On May 10, 2019, Dr. Sinha also determined that Petitioner would likely require cervical spine surgery. At his November 2, 2019 examination, Dr. Sinha recorded that Petitioner's neck pain had worsened, and she had pain in both arms which radiated into her shoulder blades. He opined that Petitioner's examination, history, and radiographs were compatible with cervical radiculopathy, myelopathy, cervical stenosis and lumbar radiculopathy. Dr. Sinha found her need for surgery to be more urgent, and recommended she undergo it as soon as possible.

While Respondent's Section 12 examiner, Dr. Gleason, opined Petitioner's spine injuries were only soft tissue and temporary, he acknowledged that Petitioner had complained of pain continuously since her accident. He also admitted he had not reviewed Petitioner's MRI films at the time of his June 11, 2019 exam. When questioned at his April 2020 deposition, Dr. Gleason was admittedly unaware that Petitioner had undergone follow-up MRI's in November 2019 and testified that he had not reviewed them. Dr. Gleason also admitted that Petitioner's 2018 cervical spine MRI showed right-sided protrusions and spinal cord compression, but he then testified that her MRI showed no obvious acute findings. Moreover, Dr. Gleason was the only doctor who recorded Petitioner's complaints of leg pains in her left leg, as opposed to her right leg. In light of the limited, or lack of, information on which Dr. Gleason based his opinions, the Commission affords them no weight in this case.

The Commission finds Dr. Graf's opinions to be more persuasive than Dr. Gleason's opinions. Dr. Graf opined that Petitioner's cervical and lumbar radiculopathy and disc herniations were causally related to her work injury, and that she likely will require lumbar and cervical spine surgery. In so concluding, the Commission notes that Dr. Graf had the

opportunity to review Petitioner's diagnostic films, medical records, and had a more complete and accurate understanding of the mechanism of injury and Petitioner's medical treatment when he reached his conclusions.

Dr. Graf noted that the extensive conservative care Petitioner received since her accident did not improve her condition. He noted that her subjective complaints were objectively substantiated, not only by her MRI findings, but also by a positive straight leg raise on the right and a positive Spurling's maneuver. Dr. Graf denied that Petitioner demonstrated any inconsistencies or nonorganic pain signs during his examination. The Commission finds Dr. Graf's opinions to be persuasive.

With regard to Petitioner's medical expenses, the Commission finds Petitioner did prove that the medical treatment she received for her concussion, injury to her right ankle medial malleolus, cervical radiculopathy, lumbar radiculopathy, and herniated discs at C4-C7 and L4-L5, was reasonable, necessary and causally related to her November 2, 2018 work accident. The Commission finds Petitioner entitled to the medical expenses for such treatment rendered to her for those conditions between November 2, 2018 and January 28, 2021.

With regard to prospective medical care, the Commission finds Petitioner did prove a need for further medical treatment recommended by Dr. Sinha and Dr. Graf, and that the need for such treatment was causally related to her November 2, 2018 work accident. The Commission finds Petitioner entitled to prospective medical care in the form of the recommended anterior cervical decompression and fusion at C4-5, C5-6, and possibly C6-7, as well as a lumbar decompression and discectomy at L4-5.

With regard to temporary total disability benefits, the Commission finds Petitioner did prove she was authorized off work as a result of her work injuries by Dr. Sinha and Dr. Rhode, and that she was given work restrictions which Respondent did not accommodate. The Commission finds Petitioner entitled to temporary total disability between January 9, 2019 and January 28, 2021, a period of 107-2/7 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 19, 2021, is hereby vacated. The Commission finds Petitioner has proven she sustained an accident arising out of and occurring in the course of her employment by Respondent on November 2, 2018, and that her following conditions of ill-being are causally related to that accident: a concussion, injury to her right ankle medial malleolus, cervical and lumbar radiculopathy, and herniated discs at C4-C7 and L4-L5.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $425.12 per week for a period of 107-2/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the outstanding reasonable and necessary medical expenses incurred in treating Petitioner's aforesaid conditions between November 2, 2018 and January 28, 2021, as provided by §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the reasonable and related prospective care for Petitioner's cervical and lumbar spine injuries as recommended by Dr. Sinha and Dr. Graf, including an anterior cervical decompression and fusion at C4-5, C5-6, and possibly C6-7, as well as a lumbar decompression and discectomy at L4-5.

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

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

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

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

July 30, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-07-01-21
068

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

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

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

21IWCC0388

HEINE, TARA
Employee/Petitioner

Case# **18WC034416**

AEROTEK
Employer/Respondent

On 3/19/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2) Certifies that he or she has paid the court reporter $ 1519.80 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 0.05% 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:

0926 LEONARD LAW GROUP
JOSEPH P BRANCKY
325 S PAULINA ST
CHICAGO, IL 60612

0766 HENNESSY & ROACH PC
QUINN BRENNAN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

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

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

Tara Heine
Employee/Petitioner
v.
Aerotek
Employer/Respondent

Case # **18** WC **34416**
Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **November 23, 2020**. Respondent filed a *Response* on **December 17, 2020 and an amended Response on January 12, 2021**. The Honorable **Charles Watts**, Arbitrator of the Commission, held a pretrial conference on **December 23, 2020**, and a trial on **January 28, 2021**, in the city of **Chicago, IL**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 2, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**33,159.36**; the average weekly wage was $**637.68**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**8,873.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,873.00**.

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

ORDER

Because the Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment for Respondent, benefits are denied.

Because the Petitioner failed to prove that her current condition of ill-being is causally connected to her alleged work accident, all medical services and prospective medical care are denied.

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

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

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

Charles M Watts

Signature of Arbitrator

March 17, 2021
Date

MAR 19 2021

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE STATE OF ILLINOIS WORKERS' COMPENSATION COMMISSION

TARA HEINE,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 18 WC 34416
	)	
AEROTEK,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FACTS

On November 2, 2018, the date of the alleged accident, Petitioner was 39 years old and employed by the Respondent Aerotek as a Patient Access Specialist. She testified that her job responsibilities included registering patients, verifying insurance, communicating messages between the care team and patients, and scheduling. (Test. at 13-14).

Respondent Aerotek is a staffing agency. (Test. at 12; RX 7). Respondent hired Petitioner in August 2018 and placed Petitioner to work at Northwestern Memorial Hospital, at the Arkes Pavilion in Chicago, IL. (Test. at 12-13; RX 7). Petitioner's office where she worked was located on Floor 11 or 12. The general public has access to the lobby of the Arkes Pavilion. In the lobby of the Arkes Pavilion, Petitioner testified that there is a security checkpoint before the elevator bank, but that people are not required to check in to gain access to the building or to any of its floors. (Test. at 41-42). Instead, Petitioner is required to show her credentials to enter her office at the office entrance on the office floor level. (Test. at 41-42). During a single work shift, Petitioner was allotted two 15-minute breaks as well as one 30-minute lunchbreak. (RX 7). Employees could spend their breaks however they wanted. (Test. at 42). All breaks were unpaid breaks. (Test. at 42; RX 7).

Petitioner alleges on November 2, 2018, between 1pm and 2pm, while returning from her un-paid lunchbreak, she tripped over floor mats just inside the Arkes Pavilion lobby floor. (Test. at 14, 43-45). Petitioner alleges these mats were overlapped. (Id.) Petitioner testified that she knew the carpets were overlapped because as she was falling, she looked not in the direction she was falling but looked down towards her feet and saw her foot entangled in one of the carpets. (Test. at 43-45). Petitioner testified that she fell onto her knees, then elbows and hands before striking her head on the ground. (Test. at 14). She testified that she went directly to the emergency room across the street at Northwestern Memorial Hospital. (Test. at 15-16).

Petitioner filled out a handwritten accident report on December 26, 2019 (RX1). Petitioner represented that on November 2, 2018, that "the carpets were overlapped and my shoe lifted one and I fell face forward walking into the Arkes Pavilion after lunch. Another manager Brandy Jones came down to assist me. I reported it to Jamie Zethemel that afternoon when I got released from the emergency room." On this date, she reported "headaches, blurred vision, nausea, neck and right shoulder pain; back pain, tingling and numbness down left arm and right leg. Unsteady gait. Neck cracks a lot too." She reported that there were witnesses, but that she did not get any names because she was in shock and pain. Petitioner also reported that "I am a victim of identify theft that includes stolen IDs and medical insurance fraud. I am 100% drug free. Always have been, always will be. However, I cannot guarantee my medical records will confirm that at this time. I am willing to take … a test. Anytime." (RX1).

Following the occurrence, Petitioner presented to the emergency room at Northwestern at 1:39 pm for evaluation. (PX2). She was noted to have a history of ADHD and anxiety. She reported left knee, right ankle, and left wrist pain and a mild frontal headache following a fall. She reported that her "shoes got caught on carpet, lifted up the carpet and fell forward right away." She reported that she fell forward onto flexed knees, elbows and wrist. She reported that she struck her forehead with no loss of consciousness, confusion, dizziness, visual changes, n/v, paresthesia or weakness. She had no midline neck/back pain. She had no chest, back, or abdominal pain. No saddle anesthesia/weakness. She was unable to bear full weight on her left lower extremity. She had no limitations in range of motion to her upper and lower extremities. The assessment and plan section noted that Petitioner's chief complaints were pain in her left wrist, left knee and right ankle. A second pain notes chart indicates Petitioner complained of bilateral knee pain, bilateral wrist pain and elbow pain, and left forehead discomfort. Petitioner underwent x-rays of her left wrist and left knee which were normal. The x-ray of her right ankle showed "no acute fracture or malalignment" and "ossific densities at the distal aspect of the medial malleolus likely represent sequela of prior trauma." Petitioner was diagnosed with multiple contusions. She was provided with a work status allowing her to return to work on 11/6/2018. She was discharged from the ER at 4:02pm. (PX2).

Petitioner testified that she went back to work following her discharge from the emergency room. (Test. at 17). She testified that she reported the accident to Aerotek at that time. (Test. at 17). She testified that when she got home, she had continued issues with nausea, her head, and her right ankle, so she had arranged for a babysitter before going to another hospital's emergency room. (Test. at 17-18).

At 7:16pm, Petitioner presented to the emergency room at UIC Medical Center for an examination. (PX5). She reported a fall earlier in the day at approximately 1:30pm, where she tripped over a rug and fell forward, hitting her head. She was not sure if she lost consciousness. She reported one episode of vomiting and blurred vision at approximately 4:15pm, which had since resolved. She reported head, left wrist, left elbow, left knee, right ankle and right foot pain. She also complained of neck pain, which was noted to be more muscular on exam. She reported no history of trauma or surgery to these areas. At the time of her presentation, she had mild nausea. She reported no back pain, and no numbness/tingling to her lower and upper extremities. With possible TBI/SAH, she was recommended for CTs of her head and cervical spine. The CT scans

were interpreted no acute intracranial abnormalities, paranasal sinus disease, no cervical fractures or dislocations, and moderate degenerative change of the lower cervical spine. Petitioner also underwent x-rays of her left wrist, left knee, right ankle, and right foot. All x-rays were normal with the exception of the right ankle, which showed a possible avulsion fracture of indeterminate age. Petitioner requested 7 days off starting Monday (11/5/18). Instead she was offered three days, with instructions to follow up with her PCP for longer time off work. Petitioner's diagnoses included acute head injury, contusion upper extremity, contusion of right lower extremity, and avulsion fracture of right ankle. She was discharged at 11:08pm. (PX5).

On November 3, 2018 at 1:54pm, Petitioner presented to the emergency room at Rush University Medical Center with complaints of headache, nausea, dizziness, and neck pain since the day prior. (PX8). She stated that she tripped over overlapping carpet landing on her hands, knees, and forehead. She could not remember if she had a loss of consciousness. She stated that her left knee took most of the impact but she hit both knees, left arm and head. She stated that she was seen at the ER at UIC and had a CT scan of her brain, which she was told showed no bleeding. She also reported x-rays of her knees, and her right ankle which showed an avulsion fracture. She stated that her left elbow hurt but that it was not imaged. She stated that she experienced headaches, blurred vision, dizziness, and neck/shoulder pain. Petitioner told Dr. Patel that she was having continued headaches, blurry vision and had an episode of nausea and vomiting before presenting to the ER. She stated that she had a history of migraines and that her headache felt similar to previous migraine episodes. Labwork detected the presence of amphetamine in her system. Petitioner told Dr. Patel that Norco made her nauseous and requested stronger pain medications. Dr. Patel told her that there was no indication for narcotic pain medications. She was instructed to follow up with her PCP for migraines and anxiety disorder. Dr. Patel ultimately discharged the Petitioner from the ER at 5:04pm after her headache resolved with medication. She still had ankle pain, no bony tenderness, full range of motion, able to ambulate. (PX8).

Petitioner testified that she could not remember if she had seen Dr. Patel at Rush before. (Test at 55-56). She testified that she "never had a migraine in [her] life." (Test. at 57). Petitioner testified that Norco does make her nauseous, but that she never told Dr. Patel that and that she did not ask for stronger pain medications. (Test. at 58 and 62). She testified that the presence of methamphetamine in her system was due to her use of the medication Vyvanse. (Test. at 58). No evidence to support this contention other than Petitioner's testimony was offered.

On November 6, 2018 at 8:40am, Petitioner presented to Dr. Phillip Ahn at Mercy Hospital & Medical Center for a Level 4 office visit. (PX10). Petitioner testified he was her primary care physician, but this is the only time the Petitioner was seen by Dr. Ahn. The prior medical records show that the Petitioner did not have an established PCP, and the records reflect that the Petitioner never followed up with Dr. Ahn. She was noted to have right ankle pain after a sprain while falling on her break at work four days prior. She had joint pain, muscle pain, decreased range of motion, trauma. No other complaints were noted. The Petitioner was discharged at 10:01am. The diagnoses included: allergic rhinitis due to pollen, ADHD, avulsion fracture of left (sp) ankle, concussion, generalized anxiety disorder, other obesity due to excessive calories, right knee degenerative joint disease, and tobacco abuse. The plan was to rest, ice, compression and elevation (RICE). She was referred to a podiatrist. She was instructed to follow up with her psychiatrist. She was instructed to follow up in ten days, or as needed. (PX10).

Petitioner testified that per Dr. Ahn, that she followed up with her psychiatrist and that she followed up with a podiatrist. (Test. at 67-68). The medical records lack evidence of these alleged follow ups. Petitioner never followed up with Dr. Ahn. However, Petitioner testified that Dr. Ahn released her to return to work as soon as her presentation to the podiatrist was complete. (Test. at 87). Petitioner testified that Dr. Ahn took her off work. (Test. At 88). Petitioner missed the subsequent week from work following her accident from 11/5/18 through 11/9/18. She returned to work on November 12, 2018.

On November 16, 2018, Petitioner signed a handwritten Application for Adjustment of Claim, at which point she was represented by the Ankin Law Office. On the Application, Petitioner alleged "severe and permanent" injuries to her "right ankle, back, neck" after she tripped on a folded mat while walking into building for work.

On November 19, 2018, Petitioner presented to Dr. Blair Rhode's P.A. Dr. Vera Nisavic at Orland Park Orthopedics for an evaluation. (PX21). There is no evidence of a referral. Petitioner testified that each time she saw Dr. Nisavic that it would be at the 700 W. Van Buren location in Chicago. Petitioner presented with low back pain, neck pain, right ankle pain and bilateral knee pain due to a slip and fall at work on November 2, 2018. She stated that she was returning from lunch, entering the revolving doors into the building at Northwestern when she suddenly tripped and fell. She stated that, she hit the floor knees first, then braced herself from the fall with both hands and hitting her forehead as she landed. She reported that she felt immediate pain to her head/neck and right foot. She stated that a security guard and coworkers helped her into a wheelchair, and when they looked back to see what tripped her up, they saw the carpet floor runner was overlapping/buckling with each other. She stated that her right foot was caught in the carpet which brought her down. Her PCP reportedly referred her to a podiatrist for follow up care. It had been 17 days since the accident and her pain had progressed to a heightened level. She had severe left sided neck pain, daily headaches, low back pain that radiated into her right leg, both of her knees were tender and sore, and her right forearm hurt. She could not sleep and was experiencing spasms. All activities were difficult for her to perform. This examination focused on the Petitioner's lower back. Her complaints were most consistent with a lumbar spine strain. She was given light-duty work restrictions, referred for MRIs of her neck and low back, and referred for a course of physical therapy, 2-3 times weekly for a month. (PX21).

On November 20, 2018, Petitioner initiated physical therapy at ATI Physical Therapy, 3008 S. Halsted. (PX21). Petitioner reported that she chose this location given its proximity to her residence. Petitioner reported increased nausea and neck pain. She stated that she had increased difficulty with looking at computer and turning her head to look over her shoulders. She reported increased numbness into the first fingers. She underwent physical therapy on this day and on November 26, 2018. (PX21).

On December 3, 2018, Petitioner was discharged from physical therapy at ATI Physical Therapy. (PX21). She had completed two physical therapy sessions with signs and symptoms consistent with physician's diagnosis of cervicalgia. She had been non-compliant with the physical therapy. She missed multiple appointments and did not return phone calls. She was discharged on this date. (PX21).

On December 15, 2018, Petitioner was arrested for criminal damage to property and for assault. (RX4). The police report indicates that the Petitioner was observed kicking in a victim's front door on security camera causing damage to the wood door jam / stop. The Petitioner was also noted to have used expletives and made threats to the victim. The Petitioner was arrested for this occurrence. (RX4). On cross-examination, Petitioner acknowledged that the threatened the victim but denied kicking in the victim's door. (Test. at 82-83).

On December 19, 2018 Petitioner underwent MRIs of her lumbar and cervical spines at Orland Park Orthopedics. (PX21).

On January 7, 2019, Petitioner presented to Dr. Blair Rhode for the first time at Orland Park Orthopedics for an examination. (PX21). She had severe cervical and low back pain. She had bilateral thigh symptoms, right greater than left. She experienced bilateral upper extremity numbness and tingling. She had a motor vehicle accident in the 1990s with bilateral ankle fractures. She was not treated for her neck or back. She experienced low back pain over the course of years for pulled muscles. She treated with OTC medications. Her symptoms would resolve. Dr. Rhode opined that "her current symptoms are new in onset following the work injury." Dr. Rhode interpreted the MRI of the cervical spine to show herniations at C4-5, C5-6, and C6-7. He interpreted the MRI of the lumbar spine as "L4-5 and L5-S1 disc." Dr. Rhode explained that the Petitioner had a three-level cervical disc herniation and a two-level lumbar disc herniation. He recommended a "therapy program." Dr. Rhode discussed the need for epidural injections and possible surgery. He gave the Petitioner a full duty release, but limited her to 32 hours. (PX21). Petitioner testified that Dr. Rhode really wanted to keep her off work because of risk of further injury but that she convinced Dr. Rhode to let her go back to work with the aforementioned limitations. (Test. At 92).

On January 8, 2019, Petitioner was terminated from her employment for unprofessional conduct. (RX7). Petitioner testified that she was fired because she refused to sign paperwork that was given to her by Aerotek. (Test. at 23, 93). She testified that she could not read the documentation because her headaches were bad and the print was small, and that she represented that she would not feel comfortable signing without having it reviewed by her attorney. Petitioner testified that she was fired on this day after this transaction. (Test. at 23, 93).

On January 16, 2019, Petitioner was seen by Dr. Nisavic. She reported severe cervical and low back pain. She presented to schedule physical therapy and requested stronger medications. The report noted Petitioner was no longer working. She was prescribed Norco and given a prescription for physical therapy 2-3 times weekly for one month. (PX21).

Later on January 16, 2019, Petitioner presented to Bridgeport Pain Control for chiropractic treatment. (PX16). There is no evidence of a referral. Petitioner testified that Dr. Rhode prescribed her chiropractic treatment. She completed a handwritten intake form, where she expressed complaints of headaches, blurred vision, neck pain, back pain, right shoulder pain, numbness in left arm with tingling, pain and tingling down the right leg, and fatigue. She reported that on November 2, 20118, that she fell. She explained that carpets were buckled and that her shoe got caught under it, lifting it enough to make her fall forward. She reported that she fell

forward fracturing her right ankle, hitting both knees, both elbows, wrists, and head, in that order. She underwent abbreviated chiropractic treatment on this day, and the following dates: 1/17, 1/22, 1/24, 2/1, 2/5 and 2/8/2019. On the last treatment date, Petitioner reported that her neck felt better. (PX16).

On January 22, 2019, Petitioner presented to Dr. Alexander Hugh at 735 W. 35th Street in Chicago for an examination. (RX9). She complained of headaches, dizziness, blurred vision, neck, lower back with radiation to the right leg with pain. She reported that her entire left arm was tingling. She reported that on 11/2/2018, that she was walking into the entrance and her shoe got caught in the carpet and she fell to the ground. She reported that she was seen at Northwestern, and she had x-rays of her right ankle and wrist. Dr. Hugh diagnosed Petitioner with a lumbar spine strain, a cervical spine strain, a knee contusion, and a fracture of her right ankle. He prescribed Petitioner Motrin and physical therapy. Dr. Hugh authored a letter to the Leonard Law Group dated March 15, 2019, where he represented that he was "the treating physician [for Petitioner] for work related injuries sustained on 11/2/2018" and requested payment for services. (RX9). Petitioner testified that she had never seen Dr. Hugh and that this was a case of identity fraud. (Test. at 97-99).

On January 23, 2019, Petitioner presented to physical therapist Rebecca Smith at Orland Park Orthopedics to begin physical therapy. (PX21). Petitioner testified that all her therapy that she received through Orland Park Orthopedics was at the 700 W. Van Buren location. She tolerated treatment well, but with limitations. She was instructed to remain in physical therapy 2 times weekly for four weeks. (PX21).

On January 24, 2019, Petitioner presented to Dr. Rhode for follow up. She reported bilateral shoulder, cervical and lumbar pain. (PX21). Her right shoulder was worse than her left. Her back was more painful than her neck. She had right lateral thigh pain with tingling. Dr. Rhode characterized Petitioner as "significantly symptomatic." Since she had right lumbar radicular complaints, he would consider a lumbar epidural steroid injection. He took Petitioner "off work," instructed her to continue with physical therapy and follow up in two weeks. (PX21).

On January 29 and February 4, 2019, Petitioner underwent physical therapy at Orland Park Orthopedics. (PX21).

On February 4, 2019 at 9:05am, Petitioner was also seen by Dr. Nisavic. She reported continued symptoms. It was noted Petitioner was "off work" and scheduled to see Dr. Rhode on February 7. Dr. Nisavic instructed Petitioner to continue physical therapy and wrote her a refill prescription for Norco. (PX21).

On February 7, 2019, Petitioner's current legal representation filed a substitution into the pending litigation.

Petitioner underwent physical therapy at Orland Park Orthopedics on February 7, 12, 19 and 21. (PX21).

On February 11, 2019, Dr. Paul Levy and Dr. Boryong Kim at Bridgeport Pain Control authored a report after Petitioner completed 7 sessions of chiropractic treatment. (PX1 6). The report indicates that the Petitioner brought in a prescription for therapy "from a doctor's office in Orland Park." At the conclusion of chiropractic treatment, they diagnosed the Petitioner with 1) post-traumatic lumbar sprain and strain, radiculopathy and disc syndrome with underlying degenerative changes; 2) post-traumatic cervical disc syndrome, sprain and strain and radiculopathy with underlying degenerative changes; and 3) post-concussion syndrome. The doctors opined that there was improvement in Petitioner's condition, but it was "far from resolved" as of her last visit. They opined that Petitioner's injuries "were caused by the incident that occurred at work on November 2, 2018." (PX16).

On February 21, 2019, Petitioner presented to Dr. Rhode for follow up. She reported continued bilateral shoulder, cervical and lumbar pain. She had significant low back pain that radiated down her right lateral/anterior thigh. Dr. Rhode recommended they proceed with a right L4-5 lumbar epidural steroid injection. Petitioner was "off work" and instructed to follow up in two weeks. (PX21).

Petitioner underwent physical therapy at Orland Park Orthopedics on February 28 and March 5. (PX21).

On March 18, 2019, Petitioner presented Dr. Kern Singh at Midwest Orthopedics at Rush. (RX8). It is unclear as to whether Petitioner saw Dr. Singh for treatment, or for an IME at the request of her attorney, but the report is directed to Petitioner's attorney. Dr. Singh noted that Petitioner is "currently on light duty and subsequently has been switched to off duty." The Petitioner stated that on the accident date, that "she tripped over carpet." Petitioner told Dr. Singh that she experienced "immediate neck pain, low back pain, and ankle pain." She stated that she had chronic flare-ups of low back pain over the past 20 years. Her neck pain was 4/10. She reported numbness and tingling into the left lateral arm into the 4th and 5th digits. Her back pain was 4/10. The pain radiated into her right lateral buttock and into her thigh. She stated that her back pain was her worst symptom. She reported that she was treated with an Aircast for her right ankle. She was taking ibuprofen, muscle relaxers, gabapentin and Norco. The report notes 15 sessions of "non-McKenzie-based physical therapy for her neck and her back at Blair Rhode Ortho." Dr Singh reviewed Petitioner's cervical and lumbar MRIs from 12/19/2019. He interpreted the cervical MRI to read "central cord compression, disk collapse, HNP at C4 to C7" and the lumbar MRI to read "mild diffuse spondylosis." Dr. Singh referred Petitioner to Dr. Buvanaendran for a cervical epidural steroid injection. He opined that Petitioner was capable of returning to full duty work. He opined Petitioner had reached maximum medical improvement. The Quick Report form indicates that Petitioner's diagnosed condition is causally related to the alleged work accident. He also noted that Petitioner "became irate during her visit and stormed out of the office using expletives." He indicated that "explanation of the treatment was not able to be performed." He discharged Petitioner from Midwest Orthopedics at Rush. (RX8).

Petitioner testified that she never saw Dr. Singh, but that she went to Dr. Singh's office where she waited for a long time, never seeing Dr. Singh in person. (Test. at 103-107). Petitioner testified that she talked to Dr. Singh's nurse practitioner who reportedly told her that because the insurance company was more likely to approve treatment of her neck, the neck would be treated

first with a referral to pain management. (Test. At 103-7). She testified that she got angry because Dr. Singh would not treat her low back at that time. (Test. At 103-08)

On March 20, 2019, Petitioner was seen by Dr. Nisavic. The plan was to proceed with a right L4-5 lumbar epidural steroid injection. Dr. Nisavic instructed Petitioner to continue with physical therapy and follow up in two weeks. Dr. Nisavic refilled Petitioner's medications. (PX21).

On March 26, 2019, Petitioner underwent physical therapy at Orland Park Orthopedics. Rebecca Smith noted that it had been three weeks since her last appointment, and that she continued to demonstrate compensations with ambulation and functional transfers secondary to low back pain which was likely contributing to her complaint of increased bilateral hip pain. She was instructed to continue with physical therapy. (PX21).

On April 6, 2019, Petitioner received a lumbar epidural steroid injection on the right side at L4-L5. (PX21).

On April 17, 2019, Petitioner was seen by Dr. Nisavic. She reported some relief following the LESI. She no longer had bilateral radiation to her lower extremities. She reported a flare-up of pain on 4/12/19 and that she had to go to the emergency room on 4/13/19 for lumbar pain and a panic attack. Dr. Nisavic felt Petitioner was experiencing panic attacks with her lumbar pain, so prescribed Ativan. She prescribed one month of physical therapy as well. It was noted that Petitioner would see Dr. Rhode on May 2. (PX21).

Petitioner was unable to recall which emergency room she went to that she reported to Dr. Nisavic. (Test. at 107-111). The medical record lacks evidence of an ER visit at or around this time.

On April 24, 2019 at 11:12 am, Petitioner was again seen by Dr. Nisavic. Petitioner received a refill on her medications. Petitioner subsequently presented for physical therapy while there. Rebecca Smith noted that this was the first time Petitioner presented for physical therapy since her LESI on 4/6/19. Her complaints were unchanged since her last visit. (PX21).

Petitioner underwent physical therapy at Orland Park Orthopedics on 4/26 and on 4/30. On April 30th, Petitioner had difficulty tolerating weight bearing exercises. She experienced right hip pain and sensation of "trembling" during the introduction of carioca walks, so exercise was terminated early. (PX21).

On May 2, 2019, Petitioner presented to Dr. Rhode for follow up. Petitioner reported that the injection provided relief. She continued to report right-sided radicular symptoms. Dr. Rhode recommended a second lumbar epidural steroid injection. He prescribed continued physical therapy, which the Petitioner underwent after the visit. (PX21).

On May 8, 2019, Petitioner was seen by Dr. Nisavic. She had continued complaints. She now had right knee pain, worse than the left over the past couple of weeks. She had pain with stairs and her knees were making noises. Dr. Nisavic instructed the Petitioner to continue with

physical therapy and refilled her pain medications. The Petitioner underwent therapy while there. (PX21).

On May 10, 2019, Petitioner was seen by Dr. Rhode's PA Dr. Mark Bordick. (PX21). The Petitioner testified that Dr. Bordick was working as the nurse for Dr. Sinha. (Test. at 11 5). This report indicated that Petitioner continued to experience radicular symptoms "to both arm and leg." The plan was to proceed with a second lumbar epidural steroid injection. He refilled medications for Petitioner. (PX21).

On May 10, 2019, Petitioner also presented to Dr. Swastik Sinha for consultation. (PX21). His medical records indicate that he is an orthopedic surgeon in Carbondale, IL affiliated with the Orthopaedic Institute of Southern Illinois and Western Kentucky. Petitioner testified that Dr. Sinha operates out of Orland Park Orthopedics two times per week. (Test. at 26). The report reflects that this consultation was done at the referral of Dr. Rhode. Dr. Sinha noted that the Petitioner "experienced immediate pain across the neck and low back" after she slipped and fell at work on 11/2/18. Petitioner reported that the neck pain radiated to both shoulder blades with left arm pain greater than the right. She reported hand clumsiness and weakened grip strength. She also reported that she was not "able to walk straight" with gait instability. She reported that the pain in her back radiated to the right leg, lateral leg and calf. Dr. Sinha noted that Petitioner had a previous x-ray and an MRI. Dr. Sinha also noted Petitioner had been prescribed naproxen and Flexeril, and had undergone physical therapy. On review of systems, Petitioner did not have blurred vision and she did not have difficulty walking. Dr. Sinha reviewed the cervical and lumbar MRIs. He recommended an L4-L5 epidural steroid injection. He recommended a C7-T1 epidural injection as well, but opined Petitioner would likely require cervical spine surgery. Dr. Sinha further opined that "neck surgery would be ACDF C4-7 PEEK, morselized allograft, instrumentation." He opined Petitioner had "significant cord compression and signs of myelopathy along with severe, multilevel foraminal stenosis." Dr. Sinha opined that the Petitioner "failed PT, NSAIDs and will undergo an injection at C7-T1 to help her symptomatically until she can proceed with neck surgery." (PX21).

Petitioner underwent physical therapy at Orland Park Orthopedics on May 21 and 23. (PX21).

On May 24, 2019, Petitioner was seen by Dr. Nisavic who refilled Petitioner's pain medications as well as gave her a new prescription for Ativan for her anxiety. She was instructed to continue in physical therapy. (PX21).

On June 3, 2019, Petitioner presented to Dr. Udit Patel at the Pain & Spine Institute in Joliet, IL. (PX14). The note indicates Petitioner was referred from Dr. Sinha for a C7-T1 epidural steroid injection. Petitioner testified that she was referred to Dr. Patel because he would perform medical treatment without insurance approval. (Test. at 126). The insurance reads "Test BC." Petitioner complained of pain located on the right neck, bilateral right greater than left, lower back. Petitioner reported a work accident on 11/2/2018. Petitioner reported that she was walking in from her lunch break when she tripped on carpet. Petitioner ended up seeing Dr. Rhode who sent the Petitioner for physical therapy and imaging. She had pain in her bilateral shoulders, left upper extremity and from the lumbar spine, it went down to her buttocks, hip and right lower extremity

in an anterior lateral fashion. Petitioner had a lumbar injection with significant relief of pain for six weeks. She had both lumbar spine pain and neck pain and wished to address both. She was currently pending surgery for the cervical spine once authorized, but was sent for pain control by way of epidural steroid injections. Dr. Patel told Petitioner that he could address the muscle pain in the neck and lower back which may improve her pain somewhat. The Petitioner was scheduled for trigger point injections. (PX14).

On June 7, 2019, Petitioner was seen by Dr. Nisavic. (PX21). She reported that she had an extreme flareup of lumbar radicular pain the week before which required her to go to the emergency room for immediate care. It was noted that Petitioner had an IME scheduled for 6/11/19 and trigger point injections scheduled for both cervical and lumbar spines on 6/19/19. Dr. Nisavic refilled Petitioner's medications. Dr. Nisavic instructed Petitioner to continue with physical therapy. (PX21).

Petitioner was unable to recall which emergency room she went to that she reported to Dr. Nisavic. (Test. at 122-123). The medical record lacks evidence of an ER visit at or around this time.

On June 11, 2019, Petitioner underwent an independent medical examination with Dr. Thomas Gleason at the request of the Respondent. (RX5). Petitioner reported that on 11/2/2018, that she was walking into a building after her lunch break and tripped after her left leg went out and her right foot got caught on the carpet that overlapped. She reported that she experienced neck and right ankle pain as a result. Dr. Gleason outlined all of the medical records he reviewed in advance of the IME, which lack medical records from Dr. Sinha and Dr. Patel. He also conducted a physical examination of Petitioner. Dr. Gleason opined that Petitioner's subjective complaints were outweighed and not supported by the objective findings. Dr. Gleason opined that Petitioner has no condition of ill-being causally connected to her employment. He opined that the alleged incident "may have caused neck and right ankle pain related to a soft tissue type strain and a temporary aggravation of a preexisting condition, given this [Petitioner] the benefit of the doubt, there is no current symptomatic condition causally related to the [work accident]." He opined that the medical treatment rendered up to the date of his examination had been "excessive and largely unnecessary as related to the [work injury]." He opined that the condition at the most would have been a soft tissue type strain or temporary exacerbation which would have resolved within 2-3 months, at which time not additional medical treatment would be necessary. Dr. Gleason opined that in regard to her right foot, she had reached MMI as of 11/13/18. He opined Petitioner would have reached MMI for the cervical spine by 8 weeks. Dr. Gleason concluded that Petitioner had reached maximum medical improvement. (RX5).

On June 13, 2019, Petitioner presented to Dr. Blair Rhode for reevaluation. Dr. Rhode noted that Petitioner had undergone an IME but the report was not yet available. He also noted that Dr. Patel had recommended trigger injections. (PX21).

On June 19, 2019, Petitioner presented to Dr. Patel for follow-up. Petitioner received trigger point injections for myofascial muscle pain. (PX14).

On June 24, 2019, Petitioner was seen by Dr. Nisavic. She reported that she underwent trigger point injections on 6/19/19 and stated that she was walking and sleeping better. At this visit, she had no radicular right leg pain. She reported that she was still symptomatic with left neck and low back pain. Dr. Nisavic gave the Petitioner a refill on her medications. (PX21).

On July 2, 2019, Petitioner presented to Dr. Patel for follow-up. The injection provided 50% relief. She had complete relief of any lower extremity pain, most of her pain was now in the neck and lower back to the right buttock. Dr. Patel recommended Petitioner return to physical therapy. He noted that she had not been to PT in a "few weeks" because she was in the middle of a move and she had a flare up. Petitioner was to get back to physical therapy to see if she could improve now that she had relief with the injection. (PX14).

On July 9, 2019, Petitioner underwent physical therapy at Orland Park Orthopedics. Rebecca Smith noted that it had been 6.5 weeks since Petitioner's last appointment. Petitioner had attended regular appointments with her physician who had recommended she continue physical therapy, but the Petitioner stated that she was unable to resume treatment until this date for personal reasons. (PX21).

On July 11, 2019, Petitioner underwent physical therapy at Orland Park Orthopedics. Later, she saw Dr. Rhode with complaints of bilateral knee pain, lumbar and cervical pain. He noted that Petitioner was treating with Dr. Patel for her cervical spine. Dr. Rhode refilled Petitioner's medications and instructed Petitioner to continue with physical therapy. (PX21).

On July 16, 2019, Petitioner underwent physical therapy at Orland Park Orthopedics. This was the last date Petitioner attended physical therapy. (PX21). Petitioner testified that she was scheduled to undergo physical therapy the day following arbitration, on January 29, 2021. (Test. at 127).

On July 26, 2019, the Petitioner was seen by Dr. Nisavic. She continued with bilateral knee pain. She had undergone trigger point injections to her cervical spine with relief. Dr. Nisovic refilled her medications and instructed the Petitioner to continue with physical therapy. (PX21).

On July 30, 2019, the Petitioner presented to Dr. Patel for follow-up. Her pain had returned. Dr. Patel recommended a sacroiliac joint injection. (PX14).

On August 8, 2019, the Petitioner presented to Dr. Rhode for reevaluation. Dr. Rhode reviewed Dr. Gleason's IME report, and noted that in Dr. Gleason's physical exam there was a negative Spurling test bilaterally; that he found that the [Petitioner] had a negative pelvic compression test but had complaints above the iliac crest; that he felt the [Petitioner] had no positive objective findings to correlate with her subjective complaints; and that Dr. Gleason found no causal connection to a work-related injury. Dr. Rhode noted that the Petitioner reported relief with her L4-5 lumbar epidural and that the Petitioner felt that the trigger point injections provided by her pain medicine doctor provided relief. Dr. Rhode also noted that Dr. Sinha had recommended an SI injection. Dr. Rhode opined: "The [Petitioner] has a documented work-related injury where she fell at work. She sought immediate medical attention for which she has consistently complained of radicular complaints to both her cervical lumbar spine. Her MRI

studies document structural abnormalities. The [Petitioner] has a past medical history of a motor vehicle accident with bilateral knee fractures. We have not treated the [Petitioner] for her knee injuries subsequent to her work related accident. I believe that Dr. Gleason's opinion runs in conflict to all 3 medical treaters for this patient." Dr. Rhode refilled Petitioner's medications and instructed her to continue with physical therapy. (PX21).

On August 14, 2019, Petitioner received an SI joint injection with Dr. Patel. (PX14).

On August 22, 2019, Petitioner presented to Dr. Rhode for reevaluation. She underwent an SI injection and reported relief. She also continued with symptoms. Dr. Rhode refilled Petitioner's medications. He was waiting on Dr. Sinha's recommendations. He kept Petitioner "off work" and instructed her to follow up in 2-4 weeks. He instructed Petitioner to remain in physical therapy. (PX21).

On September 6, 2019, Petitioner was seen by Dr. Nisavic. No medications were dispersed. Rather, she was given a prescription to get Norco and Ibuprofin at Walgreen's. (PX21).

On September 10, 2019, Petitioner presented to Dr. Patel for follow-up. She reported 75% improvement in the SI joint area. She had spasms in her neck that she wished to address. Dr. Patel recommended trigger point injections. (PX14).

On September 18, 2019, Petitioner received trigger point injections from Dr. Patel. (PX14).

On September 19, 2019, Petitioner presented to Dr. Rhode for reevaluation. Petitioner reported that the trigger point injections helped her right side. Dr. Rhode recommended that Petitioner manage her pain medications with her psychiatrist. They would await Dr. Sinha's recommendations. (PX21).

On September 27, 2019, Petitioner presented to Dr. Sinha for reevaluation. (PX21). She reported that the pain in her neck radiates to both shoulder with left arm pain greater than the right. She reported hand clumsiness and weakness with grip. She reported that she was not "able to walk straight" with gait instability. The pain in her back radiated to her right leg, lateral leg and calf. Dr. Sinha opined that Petitioner's "findings [were] compatible with cervical radiculopathy, myelopathy, and cervical stenosis along with lumbar radiculopathy, strain due to her work-related accident." He noted that Petitioner's neck pain had worsened and that more importantly, her left arm pain and weakness had worsened since he last saw [Petitioner] in May as documented in her physical exam; that Petitioner was left-handed; and that this prompted a recent ER visit. Dr. Sinha recommended Petitioner work in physical therapy to maintain her left arm function and he prescribed Lyrica for pain. Dr. Sinha opined that the Petitioner "will need surgery as soon as possible." He noted that "if not approved in the next few weeks, may require urgent surgery." Dr. Sinha then articulates that he reviewed the Petitioner's cervical and lumbar MRI films from 12/19/2018, which he had not done previously. (PX21).

The Petitioner was unable to recall which emergency room she went to that she reported to Dr. Sinha. (Test. at 128-129). The medical record lacks evidence of an ER visit at or around this time.

On October 8, 2019, Petitioner presented to Dr. Patel for follow-up. She stated that the TPI helped on the right side but she still had pain on the left. She reported improvement. The note indicates that the Petitioner had been getting medications from her primary care physician. She was placed on Norco and Clonazepam (from psychiatry). Petitioner saw Dr. Rhode and was told she cannot take Norco and a benzo (benzodiazepine), which Dr. Patel noted was correct. Petitioner asked Dr. Patel to take over her medications. Dr. Patel indicated that he would do a UTS at this visit and see her in one week. (PX14).

On October 14, 2019, Petitioner underwent an independent medical examination with Dr. Carl Graf at the request of her attorney. (PX1). The bulk of Dr. Graf's report is Petitioner's medical chronology. Dr. Graf recommended new MRIs of Petitioner's lumbar and cervical spines with higher resolution to better evaluate the condition.

On October 15, 2019, Petitioner presented to Dr. Patel for follow-up. Her pain was unchanged. She had a UTS that Dr. Patel reviewed with her. He indicated that he would take over Petitioner's medications at this point and continue to monitor. Petitioner stated that she was taking Norco 10 with no side effects or complications on the medications. Dr. Patel prescribed the Petitioner Norco. She was instructed to follow-up in 4 weeks for medication management. (PX14).

On November 2, 2019, Petitioner presented to Dr. Rhode for reevaluation. She continued with periscapular pain. He kept Petitioner "off work." (PX21).

Petitioner was also reportedly evaluated by Dr. Sinha on November 2, 2019 as well. Dr. Sinha's report is an exact duplicate to his 9/27/2019 report. He maintained the recommendation for cervical surgery. He also maintained "if not approved in the next few weeks, may require urgent surgery." (PX21).

On November 20, 2019, Petitioner presented to Dr. Rhode for follow up. She continued with left periscapular pain and lateral shoulder pain. Dr. Rhode gave the Petitioner an arthrocentesis injection in her left shoulder. He recommended an MRI of the lumbar spine, and prescribed the Petitioner lidocaine topical and Mobic. He kept Petitioner "off work" and instructed her to follow up in 2-4 weeks. This was the last time Petitioner presented to Dr. Rhode or Orland Park Orthopedics. (PX21).

At this point, Petitioner regularly followed up with Dr. Patel until the in-person visits were ruled out by the Covid-19 pandemic. Petitioner was able to refill her medications regularly until July 2, 2020, which is the last documented date of medical treatment. Petitioner testified that after this date, that she went back to her primary care physician, Dr. Jacqueline Leavitt at Rush for pain medication. There are no medical treatment records from Dr. Leavitt that were admitted into the record.

On January 14, 2020, Dr. Graf authored an addendum report after reviewing updated MRIs. He diagnosed Petitioner with cervical radiculopathy secondary to herniated discs at C5-6 and C6-7. He also diagnosed the Petitioner with a large herniated disc at L4-5 with L5 radiculopathy. He opined that it would be "reasonable" for Petitioner to undergo an anterior cervical decompression

and fusion at C4-5, C5-6 and possibly C6-7. In regard to the lumbar spine, Dr. Graf opined that it would be "reasonable" for the Petitioner to undergo a lumbar decompression and discectomy on the right at L4-5. Dr. Graf opined that the Petitioner's current condition of ill-being was causally connected to the alleged work accident.

The parties completed the evidence depositions of Dr. Carl Graf on March 10, 2020. and Dr. Thomas Gleason on April 14, 2020. (PX1 And RX6). Both doctors testified consistently with their IME reports.

In August 2020, this matter was specially set for hearing by agreement of the parties for October 2, 2020 before the arbitrator assigned to the case. Petitioner elected to continue the case at that time, opting to proceed under Section 19(b)1 of the Act. The Petitioner testified that she chose to proceed this way after going on ABA "Ask An Attorney." (Test. at 129-133).

This matter proceeded to arbitration before Arbitrator Watts on January 28, 2020 pursuant to Petitioner's Section 19(b)1 motion, under the Special Circumstances Rules. The basis for Petitioner's motion under an emergency basis was for the payment of TTD benefits, payment by Respondent for outstanding medical bills, and the authorization of "ACDF C4-7 PEEK, morselized allograft, instrumentation" recommended by Dr. Sinha. The Petitioner testified at the conclusion of trial that she does want to undergo surgery with Dr. Sinha, and that she "want[s] somebody who is good because [she] want[s] it to work." (Test. at 135).

CONCLUSIONS OF LAW

The Arbitrator adopts the Statement of Facts in support of the Conclusions of Law.

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

To obtain compensation under the act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980) including that the accidental injury both arose out of and occurred in the course of his employment (Horvath v. Industrial Commission, 96 Ill.2d. 349 (1983)) and that there is some causal relationship between the employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, I29 Ill. 2d 52, 63 (1998). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of her right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause

connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with her actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980). The mere existence of testimony does not require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much her testimony might be contradicted by the evidence, or how evidence it might be that his story is a fabricated afterthought. U.S. Steel v. Industrial Commission, 44 Ill2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill. App. 3d 284, 574 N.E.2d 1244 (1991). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009).

The Petitioner 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). "Liability under the Workmen's Compensation Act may not be based on imagination, speculation, or conjecture, but must have a foundation of facts established by a preponderance of the evidence..." Shell Petroleum Corp. v. Industrial Commission, 10 N.E.2d 352 (1937). The burden of proof is on a claimant to establish the elements of her right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment there is no right to recover. Revere Paint & Varnish Corp. v. Industrial Commission, 41 Ill.2d. 59 (1968). Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. Spankroy v. Alesky, 45 Ill. App.3d 432 (1st Dist. 1977).

Petitioner testified in open hearing before the Arbitrator who viewed her demeanor under direct examination and under cross-examination. Petitioner's manner of speech, body language, and flow of answers to questions was, in totality, so troubling that the Arbitrator cannot believe a word of her testimony unless there is other evidence in the record to support any specific statement she made during live testimony. Her voice would trail off at times and her pitch regularly changed. Petitioner's eye contact was variable and unpredictable. She would often look down or away before answering a question as if searching for what to say. The pace at which she spoke changed throughout her testimony. She fidgeted often in a manner suggesting restlessness, not physical

discomfort. There are so many instances where Petitioner disagreed with what was written in a medical record. There was not a single instance where her disagreement with what was written in the medical records disfavored her claims. All of this matters because there was no witness produced other than Petitioner to verify that there was an accident, to verify how the alleged accident occurred, and back up any factual assertion made by Petitioner. In short, the Arbitrator finds Petitioner to have no credibility. It is only because Petitioner presented to the emergency room across the street that the Arbitrator's Findings of Fact and Conclusions of Law continues beyond this point.

(C) IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER THE PETITIONER SUSTAINED AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that the Petitioner did not sustain an accident that arose out of and in the course of her employment under Section 1(d) of the Act. The Arbitrator finds that the act of tripping over a floor mat in the lobby of a building open to the general public, while returning from an unpaid lunchbreak, is an occurrence that does not arise out of and in the course of the Petitioner's employment.

Section 1(d) states that "To obtain compensation under this Act, an employee bears the burden of showing, by the preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment." The controlling case on this issue is Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52 (1989).

For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee performing acts he was instructed to perform by his employer, acts which he had a common law duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. Id.

In this case, the Petitioner was returning from an unpaid lunchbreak. She testified that she entered the building where she worked through a revolving door into the ground floor lobby that was open to the general public. Upon passing through the revolving door and into the building, she testified that she encountered floor mats. There are differing explanations throughout the records and Petitioner's testimony as to the position of the mats – whether they were overlapped, bunched, or simply present on the floor. Petitioner predictably asks the Arbitrator to pick her most recent account – that the mats were overlapped is such a manner that they were a hazard – rather than pick an account where the mats are simply present. As explained above, the Arbitrator is unwilling to believe Petitioner's testimony without other solid evidence to back it up. Petitioner named an occurrence witness who did not testify or sign an affidavit. Petitioner's various medical histories, while inconsistent, are her own version of the events as interpreted by medical providers. Petitioner's testimony that while falling forward she looked at her feet rather than where she was falling is absurd on its face because it makes no sense and when one considers the totality of all of

the inconsistent testimony and lack of credibility, the only explanation as to why Petitioner would state that she looked at her feet was to concoct a hazardous condition. If the facts are undisputed and are susceptible to only a single reasonable inference, the question of whether an injury arose out of the claimant's employment is one of law to be reviewed de novo. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 60, 541 N.E.2d 665 (1989). However, if more than one inference may be drawn from the undisputed facts, the Commission's determination will not be disturbed unless it is against the manifest weight of the evidence. Brady v. Louis Ruffolo & Sons Construction Co., 143 Ill. 2d 542, 549, 578 N.E.2d 921 (1991). The Arbitrator finds that Petitioner failed to prove that there was a hazardous condition present which means that there was no risk present at all.

Caterpillar also states that "If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable." Id. The only evidence to rely upon that floor mats were overlapped before the Petitioner fell was the Petitioner's testimony that as she was falling, that she looked down and saw her foot entangled in the floor mats. Given the general credibility issues of the Petitioner described above combined with Petitioner's testimony that she could not remember if she lost consciousness or not, there is no credible evidence to establish the floor mats were overlapped. Also, the overlapping of two floor mats on a lobby floor is not a hazard just because Petitioner claims they were overlapped. Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn. Carter v. Azaran, 332 Ill. App. 3d 948, 961, 774 N.E.2d 400 (2002); Wiegman v. Hitch-Inn Post of Libertyville, 308 Ill. App. 3d 789, 795-96, 721 N.E.2d 614 (1999). In this case in particular, there would have to be additional and credible evidence that overlapped mats were a hazard because of all of the aforementioned credibility problems with Petitioner and because, in general, floor mats are placed in a lobby to make it more safe.

For the reasons outlined above, the Arbitrator concludes that the Petitioner failed to establish by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment.

(F) IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that Petitioner did not meet her burden of proof in regard to accident and therefore Petitioner's current condition is not causally related to a work accident.

(J) IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER MEDICAL TREATMENT WAS REASONABLE AND NECESSARY; AND WHETHER THE RESPONDENT PAID ALL APPROPRIATE CHARGES, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that Petitioner did not meet her burden of proof in regard to accident and therefore the medical services incurred were not a result of the alleged work accident.

(K) IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that Petitioner did not meet her burden of proof in regard to accident and therefore is not entitled to prospective medical care.

(L) IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER PETITIONER IS ENTITLED TO TEMPORARY BENEFITS, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that Petitioner did not meet her burden of proof in regard to accident and therefore is not entitled to temporary total disability benefits.