ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC030553
Case Name	CLANCY, PATRICK v. LAKE BLUFF PARK DISTRICT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0075
Number of Pages of Decision	15
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	David Bawcum
Respondent Attorney	Patrick Healy

DATE FILED: 3/2/2022

/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 LAKE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify Temporary Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK CLANCY,

Petitioner,

vs. NO: 18 WC 30553

LAKE BLUFF 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 whether Petitioner sustained an accidental injury arising out of and occurring in the course of his employment; whether Petitioner's concussion, right shoulder, and low back conditions of ill-being are causally related to his work accident; entitlement to temporary total disability benefits; entitlement to incurred medical expenses; and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the Decision to properly identify Respondent's witnesses as James Lakeman and Micah Kamin.

Temporary Disability

Petitioner alleged entitlement to temporary total disability benefits from August 24, 2018 through September 4, 2018. Arb.'s Ex. 1. The Commission observes this corresponds to the 12-day period that Petitioner was authorized off work by the emergency room physician and Dr. Block. The Act provides that when the period of temporary total incapacity is less than 14 days, compensation begins "on the 4th day of such temporary total incapacity" (*820 ILCS 305/8(b)*), which herein is August 27, 2018. Utilizing the stipulated average weekly wage of $930.56,

Petitioner's TTD benefit rate is $620.37. Therefore, the Commission finds Petitioner is entitled to temporary total disability benefits of $620.37 per week for a period of 1 2/7 weeks, representing August 27, 2018 through September 4, 2018.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2020, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $620.37 per week for a period of 1 2/7 weeks, representing August 27, 2018 through September 4, 2018, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses detailed in Petitioner's Exhibit 4 (City of Lake Forest Fire Department $1,335.00; Advocate Condell Medical Center $29,034.00; Integrated Imaging $906.00; Infinity Health Care Physicians $1,516.00; Midwest Diagnostics $352.00; Dr. Robert Block $233.00), 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 $558.34 per week for a period of 15 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Attorney's Fees is denied.

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

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

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

March 2, 2022

/s/ *Deborah J. Baker*

DJB/mck

O: 1/26/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLANCY, PATRICK Case# **18WC030553**
Employee/Petitioner

LAKE BLUFF PARK DISTRICT
Employer/Respondent

On 3/31/2020, 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:

4583 SOFFIETTI JOHNSON TEEGAN ET AL
DAVID J BAWCUM
74 E GRAND AVE PO BOX 86
FOX LAKE, IL 60020

2567 PRETZEL & STOUFFER CHTD
PATRICK F HEALY
ONE S WACKER DR SUITE 2500
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Patrick Clancy
Employee/Petitioner
v.
Lake Bluff Park District
Employer/Respondent

Case # **18 WC 030553**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ARBITRATOR GLAUB**, Arbitrator of the Commission, in the city of **WAUKEGAN, IL**, on February 19, **2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other **WHAT IS THE NATURE AND EXTENT OF THE INJURY?**

Findings

On the date of accident, **August 23, 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 **$48, 389.14;** the average weekly wage was **$930.56.**

On the date of accident, Petitioner was **40** years of age, ***married*** with **3** dependent children.

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

Order

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 4. Specifically, Respondent shall pay the following medical bills, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: City of Lake Forest Fire Department in the amount of $1, 335.00, Advocate Condell Medical Center in the amount of $29, 034.00, Integrated Imaging in the amount of $906.00, Infinity Health Care Physicians in the amount of $1,516.00, Midwest Diagnostics in the amount of $352.00, and Dr. Block in the amount of $233.00.

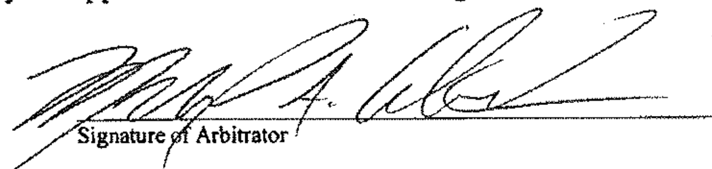
Respondent shall pay Petitioner temporary total disability benefits of $620.68/week for 1 week.

Petitioner's Motion for Attorney Fees and Penalties is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $558.34/week for 15 weeks, because the injuries sustained caused 3% loss of the person as a whole, as provided in Section 8(d)2 of the Act, for a total of $8,375.04.

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 27, 2020
Date

ICArbDec19(b)

MAR 3 1 2020

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick Clancy Petitioner	)	
	)	
vs.	)	Case No.: 18 WC 030553
	)	
Lake Bluff Park District Respondent	)	

DECISION OF ARBITRATOR

FINDINGS OF FACT

On August 23, 2018, Petitioner, **Patrick Clancy** ("Petitioner"), was employed by the Respondent, **Lake Bluff Park District** ("Respondent"), as a maintenance associate. Petitioner testified that his job duties included general maintenance and repair work around the Respondent's facilities. On that date, Petitioner was changing out light switches in the basement of a paddle hut facility which was owned and operated by Respondent. In order to perform his work and access the basement of the paddle hut, Petitioner had to climb up and down an aluminum ladder provided by Respondent that was affixed to the basement floor (Respondent's Ex #1).

That on such date, while performing his work, Petitioner fell off of the ladder. Petitioner testified that prior to the fall, he felt the ladder begin to slide underneath him. Petitioner testified that the next thing he remembered were Emergency Medical Technicians standing above him while performing a sternum rub on him as he laid on the basement floor. Petitioner testified that initially at the scene, he felt pain in his head, neck, back and his right shoulder and leg and that none of these problems predated the accident. Petitioner testified that at some point that evening he also vomited.

Following the accident, Petitioner was transported by the Lake Forest Fire Department to Advocate Condell Medical Center in Libertyville, Illinois (Petitioner's EX. #1)

At Condell, Petitioner reported that he had fallen from a 10 foot ladder and had complains of associated right shoulder pain, right knee pain, lower back pain, head pain, photophobia, bilateral hand and feet numbness, nausea and dizziness. Petitioner also reported that he was unable to recall any information regarding the fall and how long he was on the ground after the fall. (Petitioner's Ex. #2).

At Condell, Petitioner underwent a variety of different diagnostic testing which included CT scans of his cervical spine, chest, head and right shoulder. Petitioner also testified that because of his past history of diabetes, heart problems and a concern because over blood thinners that he was taking, for precautionary reasons, medical personnel at Condell also had him undergo an EKG of his heart, as well as blood and chemistry workup tests (Petitioner's Ex. #2).

In response to his complaints from the accident, Petitioner was diagnosed at Condell by Dr. Ronald Shenfeld with a: (1). concussion, (2). right shoulder contusion and (3) back pain. Upon discharge, Petitioner was given a prescription for Norco and advised to follow up with his family physician (Petitioner's Ex. #2).

In accordance with his discharge instructions, on August 28, 2018, Petitioner presented to his general family physician, Dr. Robert Block for followup. At that visit, Petitioner provided a history of falling off a ladder that collapsed at work and that he had a head injury and lost consciousness for 45 minutes. Petitioner reported that he still was suffering from headaches and nausea. Following examination, Dr. Block diagnosed Petitioner with a concussion, ordered him off work until September 5, 2018, and advised him to follow in 3 months or as needed. (Petitioner's Ex. #3).

At trial, Petitioner testified that while he continues to have headaches from time to time, he has not sought out or received any additional medical treatment related to the accident. Petitioner also testified that a couple of months after the accident, due to cutbacks, his job with Respondent was terminated and that he was provided a severance package by the Respondent. Petitioner testified that he currently works as the Director of Plant Operations at the Sheridan of Green Oaks in Lake Bluff, Illinois and that aside from the occasional headache, he does not have any issues or limitations in performing his work there.

Finally, Petitioner testified that he was off work due to the injuries that he sustained in this case from August 25, 2018, through September 4, 2018. Petitioner also testified that none of his medical bills for treatment he received in this case were paid for by Respondent (Petitioner's Ex. #4)

At trial, Respondent called Jim Lalema as one of its witnesses. Mr. Lalema was the Safety Coordinator for the Respondent at the time of the accident. Mr. Lalema testified that after the accident, he spoke to Petitioner who reported that at the time of the accident, he was climbing the ladder when he blacked out and fell to the floor. Mr. Lalema acknowledged that he did not witness the accident nor was he aware of anyone else who was a witness to the accident.

Respondent also called Micah Karmin as one of its witnesses at trial. Mr. Karmin was the Facility Maintenance Services Manager for the Respondent at that time. Mr. Karmin testified that after the accident he also spoke to Petitioner who reported that at the time of the accident, he was climbing the ladder when he blacked out and fell to the floor. Mr. Karmin also acknowledged that he did not witness the accident nor was he aware of anyone else who was a witness to the accident.

CONCLUSIONS OF LAW

As it relates to issue (C), "Accident," the Arbitrator concludes as follows:

An injury is compensable under the Act only if it arises out of and in the course of employment. 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. *Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill. 2d 38, 40; 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 or acts which the employee might reasonably be expected to perform incident to his assigned duties. (*Howell Tractor & Equipment Co. v. Industrial Comm'n* (1980), 78 Ill. 2d 567, 573.) 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. *Orsini v. Industrial Comm'n* (1987), 117 Ill. 2d 38, 45; *Caterpillar Tractor Co. v. Indus. Com*, 129 Ill. 2d 52, 58 (1989)

A claimant may not recover if the risk to which he was exposed was a risk personal to him. An idiopathic fall is a type of accident which results from an internal, personal weakness of the claimant. If the fall is unexplained, resultant injuries are compensable. If the fall is idiopathic, resultant injuries are not compensable unless the employment significantly contributed to the injury by placing claimant in a position of greater risk of injury from falling. *Elliot v. Industrial Comm'n,* 153 Ill. App. 3d 238, 242-44, 505 N.E.2d 1062, 1065-67, 106 Ill. Dec. 271 (1987); see also *Rockford Hotel Co. v. Industrial Comm'n,* 300 Ill. 87 (1921). (employee suffered epileptic fit and fell into ash pit at work).

In the instant case, it is undisputed that at the time of the accident, Petitioner was performing his regular job duties in the course of his employment for the Respondent. Petitioner testified that prior to the fall, he felt the ladder begin to slide underneath him.

While the Respondent presents evidence that the Petitioner may have lost consciousness before the fall, the Arbitrator finds that the photographs depicting both the ladder and the area where Petitioner fell (Respondent's Ex. #1), show that his employment significantly contributed to his injuries by placing him in a position of greater risk of injury from falling.

Based on the foregoing and having considered the totality of the credible evidence adduced at trial, the Arbitrator finds that on August 23, 2018, the Petitioner sustained accidental injuries which arose out of and in the coursed of his employment with Respondent.

As it relates to issue (F), is Petitioner's current condition of ill-being casually related to the injury, the Arbitrator concludes as follows:

Petitioner alleges that he sustained a concussion with brief loss of consciousness, a right shoulder contusion and a low back injury as a result of the August 23, 2018, accident. The Respondent fails to present any evidence to rebut that Petitioner sustained the aforementioned injuries as a result of the accident.

Therefore, based on the Arbitrator's above findings with respect to Accident and his review of Petitioner's medical records (Petitioner's Ex.'s #1-3), the Arbitrator finds that the Petitioner's concussion with brief loss of consciousness, right left shoulder contusion and a low back injury are casually related to the August 23, 2018, accident.

As it relates to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, the Arbitrator concludes as follows:

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

In light of the Arbitrator's above findings with respect to Accident and Casual Connection, the Arbitrator finds that medical services rendered on August 23, 2018, by the City of Lake Forest Fire Department, Advocate Condell Medical Center, Integrated Imaging, Infinity Health Care Physicians and Midwest Diagnostics were reasonable and necessary in Petitioner's care and treatment relative to his accident of August 23, 2018. The Arbitrator also finds that medical services rendered by Dr. Block on August 28, 2018, were reasonable and necessary in Petitioner's care and treatment relative to his accident of August 23, 2018.

Therefore, Respondent shall pay Petitioner an amount equal to the outstanding medical bills for all reasonable, necessary and related medical services rendered from by the aforementioned medical providers as set forth in Petitioner's Exhibit #4, pursuant to the fee schedule or lessor negotiated rates. Specifically, Respondent is liable for the medical bills from the City of Lake Forest Fire Department in the amount of $1, 335.00, Advocate Condell Medical Center in the amount of $29, 034.00, Integrated Imaging in the amount of $906.00, Infinity Health Care Physicians in the amount of $1,516.00, Midwest Diagnostics in the amount of $352.00, and Dr. Block in the amount of $233.00.

As it relates to issue (L), What temporary total disability benefits are in dispute, the Arbitrator concludes as follows:

Petitioner alleges entitlement to temporary total disability benefits from August 25, 2018, through September 4, 2018.

Based on the Arbitrator's above findings with respect to Accident, Casual Connection and his review of Petitioner's medical records contained in Petitioner's Exhibit(s) # 2 and 3, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from August 25, 2018, through September 4, 2018.

As it relates to issue (M), Should penalties or fees be imposed upon Respondent, the Arbitrator concludes as follows:

The Arbitrator finds that the respondent's denial of this claim was not unreasonable and vexatious. It appears petitioner may indeed have sustained an idiopathic fall. This was the basis for the respondent's denial of benefits. The Arbitrator ultimately found this to be a compensable claim because the nature of the petitioner's employment or job duties (descending a ladder) at the time of idiopathic incident placed the petitioner at a greater risk for injury than members of the general public and therefore caused or increased the severity of the injuries the petitioner sustained. The Arbitrator believes that this was a factual determination in this case and not a legal conclusion.

Based on the above, petitioner's attorney claim for penalties and attorney fees is denied

As it relates to issue (O), regarding the nature and extent of Petitioner's injury, the Arbitrator concludes finds as follows:

In applying the five factors in Section 8.1(b) of the Illinois Workers' Compensation Act, the Arbitrator finds as follows:

1. As to the AMA impairment rating, the Arbitrator notes that neither the Petitioner nor the Respondent admitted an AMA impairment rating into evidence in this case. As such, the Arbitrator gives this factor no weight.

2. As to the Petitioner's occupation, at trial, Petitioner testified that that he was working as a maintenance associate on the date of the accident. The Petitioner testified that his job duties included general maintenance and repair work around the Respondent's facilities. Petitioner testified that he currently works as the Director of Plant Operations at the Sheridan of Green Oaks in Lake Bluff, Illinois. The Arbitrator finds that this factor weighs in favor of increased permanence.

3. As to the Petitioner's age, the Petitioner was 40 years old at the time of his August 23, 2018, injuries. The petitioner is still in the earlier aspect of his work life expectancy and will have to work with the residuals of his work injury for a longer period. The Arbitrator finds that this factor weighs in favor of increased permanence.

4. As to the Petitioner's future earning capacity, the Arbitrator finds that the Petitioner's future earning capacity has not been diminished given the Petitioner's testimony that he is currently gainfully employed and has been since the date of accident and that that aside from the occasional headaches that he has no limitations in performing his current work for his employer. The Arbitrator finds that this factor weighs in favor of decreased permanence.

5. As to the evidence of disability in the medical records, the Arbitrator notes that as a result of the work incident on August 23, 2018, Petitioner sustained a concussion with brief loss of consciousness, a right left shoulder contusion and a low back injury. The medical treatment relative to Petitioner's injuries consisted of one emergency room visit to Advocate Condell Medical Center and a follow visit with his family physician Dr. Block. Petitioner reached maximum medical improvement on September 5, 2018. The Arbitrator finds that this factor weighs in favor of decreased permanence.

Based on all of the above, the Arbitrator finds that as a result of the August 23, 2018 work accident, Petitioner has sustained a loss of use, person as a whole, of 3% under Section 8(d)(2) relative to his concussion, sprains and contusions. Respondent shall pay Petitioner permanent partial disability benefits of $558.34/week for 15 weeks, for a total of $8,375.04.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC021717
Case Name	ADAMS, MARY (WIDOW OF TED ADAMS DECEASED) v. DOBBS TIRE & AUTO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0076
Number of Pages of Decision	9
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Eric Kirkpatrick
Respondent Attorney	Miles Cahill, Richard Day, Toney Tomaso

DATE FILED: 3/2/2022

/s/Deborah Simpson, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY ADAMS, WIDOW OF
TED ADAMS, DECEASED

Petitioner,

vs. NO: 18 WC 21717

DOBBS TIRE & AUTO,
AMERISURE PARTNERS INS., &
ILLINOIS INSURANCE GUARANTY FUND,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and PPD, and being advised of the facts and law, provides additional explanation for the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner did not sustain her burden of proving that her husband's death was causally related to a prior work-related injury on December 31, 1999. That accident required extensive cervical surgeries and left him permanently and totally disabled. Petitioner's theory of liability is that those work-related surgeries left Petitioner in a weaken state and unable to bend his neck to look down. Petitioner claims that Mr. Adams' inability to look down contributed to a fall while he was going down a set of stairs which eventually resulted in his death. The Arbitrator noted that the accident was not witnessed, Petitioner remained unresponsive from the accident to his death, and that any explanation for his fall was speculative and therefore idiopathic and not compensable.

The Commission agrees with the analysis of the Arbitrator. However, we also note that the medical records are unclear concerning the exact cause of decedent's death. The EMT report indicates that Petitioner was in full cardiac arrest, pulseless, and apneic when they arrived at the scene. The EMTs were able to regain vitals and transport him to hospital. Decedent died in a hospital without ever regaining consciousness.

Respondent's Section 12 medical examiner, Dr. Cantrell, noted that Petitioner's medical records showed that he "suffered from multiple pre-existing cardiac conditions including noted atherosclerotic heart disease of native coronary arteries in addition to atrial fibrillation that included his heart randomly beating quickly both at rest and on exertion and at times in association with complaints of palpitations described as feeling shortness of breath." We agree with Dr. Cantrell that it is unclear whether or not Petitioner sustained a fatal cardiac event which caused him to fall and in that instance the fall itself had nothing to do with his eventual death. Therefore, not only is the cause of the deceased fall speculative as noted by the Arbitrator, the actual cause of decedent's death is also speculative. In our opinion this factor provides additional support to affirm the Decision of the Arbitrator denying compensation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated April 21, 2020 is hereby affirmed and adopted with the explanation above.

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.

March 2, 2022

DLS/dw
O-1/12/22
46

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

ADAMS, MARY AS WIDOW OF ADAMS, TED Case# **18WC021717**
Employee/Petitioner

DOBBS TIRE AND AUTO ILLINOIS INSURANCE GUARANTEE FUND AND AMERISURE PARTNERS INSURABCE CO
Employer/Respondent

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPARTICK LAW OFFICES PC
ERIK KIRKPATRICK
#3 EXECUTIVE WOOD CT SUITE 100
SWANSEA, IL 62226

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY J TOMASO
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Mary Adams, As Widow of Ted Adams
Employee/Petitioner
v.
Dobbs Tire and Auto, Illinois Insurance Guarantee Fund And Amerisure Partners Insurance Co.
Employer/Respondent

Case # **18** WC **21717**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **William R. Gallagher**, Arbitrator of the Commission, in the city of **Collinsville**, on **February 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. [x] 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. [x] 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. [x] Who was dependent on Decedent at the time of death?

K. [x] 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 _____

FINDINGS

On the date of accident, **June 20, 2018**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

Decedent's death ***is not*** causally related to the accident.

In the year preceding the injury, Decedent earned $**66,073.80**; the average weekly wage was $**1,270.65**.

On the date of accident, Decedent was **64** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits (death benefits), for a total credit of $.

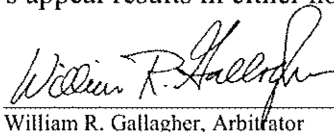
Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusion of Law attached hereto, 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

April 13, 2016
Date

APR 2 1 2020

Findings of Fact

The Petitioner, Mary Adams, the widow of Ted Adams, filed an Amended Application for Adjustment of Claim which alleged her husband, Ted Adams, died on June 20, 2018, because he sustained an accidental injury arising out of and in the course of his employment by Respondent. According to the Amended Application, Ted Adams died on June 20, 2018, because he "fell at home due to effects of 12/31/99 injury, case number 02 WC 63102/12 IWCC 12" (Arbitrator's Exhibit 2). Respondents disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

The deceased, Ted Adams, sustained a work-related accident on December 31, 1999. The case was tried in September/October, 2009, and the Decision of the Arbitrator was filed with the Commission on January 19, 2010. The Arbitrator found that Petitioner was permanently and totally disabled (Petitioner's Exhibit 2). Respondent filed a review of the Arbitrator's Decision, and, on January 6, 2012, the Commission affirmed the Arbitrator's Decision (Petitioner's Exhibit 3).

As a result of the accident of December 31, 1999, Ted Adams sustained significant injuries and underwent multiple surgeries. As was noted in the Arbitrator's Decision, three cervical fusion surgeries were performed on Ted Adams, a C5-C6 fusion on January 13, 2000; a C3-C6 fusion on November 11, 2004; and a C2-C7 fusion on October 19, 2006 (Petitioner's Exhibit 2).

The basis of the claim brought by Mary Adams was that the fusion surgeries performed on Ted Adams, caused his ability to move his head up/down was severely restricted and had worsened. Ted Adams sustained a fall down a flight of stairs on June 19, 2018, and he died the following day, June 20, 2018 (the date of accident alleged in the Amended Application). Petitioner contended that because of Ted Adams' inability to move his head up/down, he was unable to look at the stairs as he was descending them and this is what caused him to sustain the fall.

At trial, Mary Adams testified they lived in a one story ranch style house with a basement. A flight of stairs connected the main floor to the basement.

In regard to Ted Adams' ability to go up/down stairs, she testified that because he could not look down, Ted would go down the stairs sideways, putting each foot on a step one at a time. He removed his shoes prior to descending the steps so he could feel them and, because of his neck condition would look straight ahead. She stated he held onto the handrail with his right hand because his left arm had become useless. She testified that she had observed him going down the steps at home and, on a few occasions, saw him miss a step at the bottom of the stairs and fall.

Petitioner testified that, on June 19, 2018, Ted had not been acting unusual and did not complain of any chest pain or shortness of breath. At approximately 11:45 PM, Ted got up from bed and said he was going to talk to their granddaughter (who was in the basement). A few minutes later, Petitioner heard a loud noise and went to investigate. She saw Ted lying at the bottom of the stairs with his head bent to the extent his ear was touching his shoulder.

Petitioner immediately called 911, but Ted was unresponsive. He was taken to Anderson Hospital, but, because of the serious nature of his injuries, was transferred to Barnes Jewish Hospital. He died on June 20, 2018.

On cross-examination, Petitioner acknowledged she did not witness her husband falling down the stairs so she could not say exactly how he fell. She also agreed Ted was usually very careful when he went down the stairs.

Medical records of Dr. David Mitchell were received into evidence at trial. Dr. Mitchell was the primary care physician for Ted Adams from May, 2017, until June 12, 2018, to shortly prior to his death. Dr. Mitchell saw him for a variety of health issues including diabetes, hypertension, chest pain, anxiety, dizziness, shortness of breath, blurred vision, heart palpitations and numbness/tingling in the extremities (Petitioner's Exhibit 6).

In February, 2018, Ted Adams sought medical treatment at both St. Elizabeth's Hospital and Memorial Hospital. He was evaluated at St. Elizabeth's Hospital on February 5, 2018, for chest pain, heart palpitations and shortness of breath. It was noted Petitioner had a history of atherosclerotic heart disease, borderline diabetes, hypertension, cervical radiculopathy, functional bowel disorder, lung disease and hypercholesterolemia. Various tests were performed and Petitioner was discharged (Respondent's Exhibit 4).

On February 7, 2018, Ted Adams was admitted to Memorial Hospital, and he was hospitalized until February 13, 2018. He complained of chest pain and shortness of breath that been present for the last two to three years. He was diagnosed with anemia, pneumonia, sepsis, diabetes, cellulitis, hypertension, anxiety and chest pain (Respondent's Exhibit 6).

At the request of Respondent, Dr. Russell Cantrell, a physiatrist, reviewed medical records regarding treatment provided to Petitioner which included the surgeries performed on him subsequent to the accident of December 31, 1999. Dr. Cantrell opined it was possible Adams may have sustained a cardiac event on June 19, 2018, which caused him to sustain the fall, but opined the fall sustained by Adams was not caused in whole, or in part, by the weakened condition arising out of the multiple surgeries he had previously undergone (Respondent's Exhibit 1).

Dr. Cantrell was deposed on September 26, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Cantrell's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. When questioned about what caused Adams to sustain the fall on June 19, 2018, Dr. Cantrell responded it was "speculative", but said there were two possible reasons, namely, either an acute cardiac event or a mechanical fall (Respondent's Exhibit 2; pp 20-21).

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner failed to prove that the fall sustained by Ted Adams on June 19, 2018, was an accidental injury arising out of and in the course of his employment by Respondent.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that the deceased, Ted Adams, sustained a severe injury on December 31, 1999, which caused him to be permanently and totally disabled. Further, he underwent three fusion procedures in the cervical spine which caused him to have an extremely limited range of motion of his neck.

The testimony of Mary Adams regarding the manner in which Ted Adams descended stairs was unrebutted; however, she stated she never observed him falling down the stairs, but had seen him miss a step at the bottom of the stairs and fall afterward.

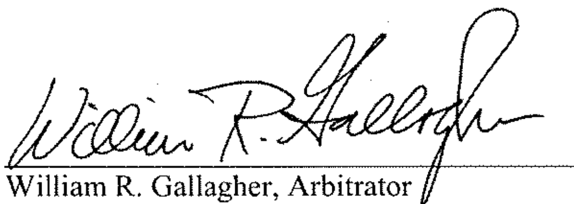
The fall sustained by Ted Adams was not witnessed by Petitioner or anyone else. Because Ted Adams was unresponsive, he could not state what caused him to fall.

As noted in the findings of fact, the deceased suffered from a number of health conditions, some of which may have been related to the injury he sustained on December 31, 1999, while others were not related.

The opinion of Dr. Cantrell as to what may have caused the deceased to sustain the fall was speculative; however, the theory that the deceased sustained the fall because of his inability to move his neck up/down is also speculative.

There are, in fact, any number of possible reasons the deceased sustained the fall on June 19, 2018.

Based on the preceding, the Arbitrator finds that there was insufficient evidence to conclude that the deceased's fall of June 19, 2018, was related to his cervical spine conditions/surgeries.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC030231
Case Name	JOHNSON, ALBERT v. MADDEN MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0077
Number of Pages of Decision	9
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Frank Kress
Respondent Attorney	Charlene Copeland

DATE FILED: 3/2/2022

/s/*Deborah Simpson, Commissioner*

Signature

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Albert Johnson,
Petitioner,

vs. NO: 18 WC 30231

Madden Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2021, is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

March 2, 2022

o2/23/22
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC030231
Case Name	JOHNSON, ALBERT v. MADDEN MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	William McLaughlin, Arbitrator

Petitioner Attorney	Frank Kress
Respondent Attorney	Alyssa Silvestri

DATE FILED: 9/7/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 31, 2021 0.05%

/s/ *William McLaughlin, Arbitrator*
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

September 7, 2021

/s/ *Brendon O'Rourke*

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Albert Johnson
Employee/Petitioner

v.

Madden Mental Health Center
Employer/Respondent

Case # **18** WC **030231**

Consolidated cases: ______

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **William McLaughlin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 28, 2021**. By stipulation, the parties agree:

On the date of accident, **7/28/2021**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**69,096.21**, and the average weekly wage was $**1,328.77**.

At the time of injury, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**797.26**/week for a further period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **5%** loss to the person as a whole.

Respondent shall pay Petitioner compensation that has accrued from **12/26/2018** through **7/28/2021**, and shall pay the remainder of the award, if any, in weekly payments.

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 an officer sergeant 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. Because the Petitioner is working the same job, without any reduction in wages, the Arbitrator therefore gives no 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 some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner has not suffered a diminution of wages as a result of his injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the MRI performed on October 10, 2018, clearly reveals tears to the right pectoral tendon, the biceps tendon, and a partial tear of the glenoid labrum. Because of the objective evidence of significant damage to the Petitioner's right shoulder, the Arbitrator therefore gives greater weight to this factor.

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

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

Signature of Arbitrator

SEPTEMBER 7, 2021

ICArbD

Findings of Facts

The Respondent in this matter is a facility that treats psychiatric patients. The Petitioner works as an officer sergeant for the Respondent. The Petitioner testified that his job duties included protect and secure the facility. This includes protecting staff from psychiatric patients by use of physical restraint. The Petitioner explained a job that is very physical in nature that requires the use of physical force to restrain adult psychiatric patients. The Petitioner explained that during a typical shift of 10:00 p.m. to 6:00 a.m., he is called upon at least six times to physically restrain a patient.

On September 25, 2018, the Petitioner was tasked with the job of restraining a nude patient who had become combative while staff was attempting to administer medication. In order to assist the staff, the Petitioner had to restrain the patient. The Petitioner testified that he and several officers moved to restrain the patient. While attempting to apprehend the patient, the Petitioner's right shoulder became entangled within the patient's body and those of the other officers. During the scuffle, the Petitioner injured his right shoulder. Immediately after this incident, the Petitioner experienced excruciating pain.

On September 25, 2018, the Petitioner reported to the emergency room at Elmhurst Hospital. (Pet. Ex. 1). The Elmhurst Hospital notes state that the Petitioner had presented to the emergency department with a chief complaint of pain in his right shoulder and that he works as a security guard at a psychiatric facility and had to restrain a patient earlier that day. (Pet. Ex. 1, P. 2).

On September 26, 2018, the Petitioner sought the care of his primary care doctor, Dr. William Boblick of Loyola University Medical Center. (Pet. Ex. 2, P. 62-63). Dr. Boblick also noted the work accident and recommended an MRI of the Petitioner's right upper extremity.

On October 2, 2018, the Petitioner followed up with Dr. Boblick again. (Pet. Ex. 2, P. 61). A nurse's note from that date indicates that the Petitioner did not have the recommended MRI yet because "he wanted an MRI of the entire right arm included with the right shoulder." (Pet. Ex. 2, P. 63). Following this subsequent visit to Dr. Boblick, the Petitioner had an MRI of his right upper extremity at Loyola University Medical Center on October 9, 2018. (Pet. Ex. 2, P. 66-67). The MRI revealed:

> 1.) a large amount of fluid noted in the right chest wall, along what is expected to be the pectoralis major muscle belly. 2.) diffuse tendinosis of the supraspinatus and infraspinatus distal tendon insertions, with a small partial-thickness articular surface tear of the supraspinatus insertion measuring 7 millimeters. AC joint osteophytes impinge the myotendinous junction of the supraspinatus tendon. 3.) low-grade intrasubstance partial tear of the subscapularis, with minimal subluxation of the biceps tendon at the rotator cuff interval. 4.) very subtle posterior superior glenoid labral tear. (Pet. Ex. 2, P. 66).

Following the MRI, the Petitioner had and initial orthopaedic evaluation with Dr. Kenneth Schiffman of Loyola University Medical Center on October 10, 2018. (Pet. Ex. 2, P. 58-61). Dr. Schiffman noted that the Petitioner was sent by Dr. Boblick for an evaluation of his right shoulder injury that occurred on September 25, 2018. (Pet. Ex. 2, P. 58). Dr. Schiffman diagnosed the Petitioner with a right shoulder pectoralis or partial muscle tear. (Pet. Ex. 2, P. 61). Dr. Schiffman noted that the injury would take months to totally recover and that he should continue resting with no lifting or gripping. *Id*.

On October 31, 2018, the Petitioner returned to see Dr. Schiffman. (Pet. Ex. 2, P. 55-57). Dr. Schiffman noted that the Petitioner had minimal pain, but did have stiffness. (Pet. Ex. 2, P. 55). Based upon his evaluation, Dr. Schiffman felt it was now appropriate to prescribe a regimen of physical therapy. (Pet. Ex. 2, P. 57).

On November 12, 2018, the Petitioner began a regimen of physical therapy at Loyola University Medical Center. (Pet. Ex. 2, P. 31). The Petitioner participated in ten sessions of physical therapy, concluding on December 17, 2018, when he had a final session of physical therapy. (Pet. Ex. 2).

On December 26, 2018, the Petitioner returned to see Dr. Schiffman again. (Pet. Ex. 2, P. 2-4). On this occasion, Dr. Schiffman released the Petitioner to full-duty work and advised him to follow up as needed (Pet. Ex. 2, P. 4).

Due to a dispute regarding the nature and extent of the Petitioner's injury, the litigation in this matter ensued.

Conclusions of Law

(Nature and Extent)

Because neither the Petitioner nor Respondent has provided evidence of an AMA impairment rating the Arbitrator assigns no weight to this factor.

Because the Petitioner sustained his accident subsequent to September 1, 2011, the Arbitrator must consider Section 8.1b of the Illinois Workers' Compensation Act when assessing the nature and extent of the Petitioner's injury.

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 an officer sergeant 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. Because the Petitioner is working the same job, without any reduction in wages, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner has not suffered a diminution of wages as a result of his injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the MRI performed on October 10, 2018 clearly reveals tears to the right pectoral tendon, the biceps tendon, and a partial tear of the glenoid labrum. Because of the objective evidence of significant damage to the Petitioner's right shoulder, the Arbitrator therefore gives greater weight to this factor.

Even though the Petitioner notes no pain on November 16, 2018, November 19, 2018, November 26, 2018, November 30, 2018, December 3, 2018, December 7, 2018, December 10, 2018, and December 17, 2018, Petitioner did testify to the following affects of the accident:

Petitioner continues to experience limitations due to his injury. Specifically, he explained that he was an avid weightlifter, but that he has altered his workout to avoid aggravating his shoulder. He testified that tension remained in his right side and, for that reason, even a simple push-up is more difficult.

Petitioner explained that even sleeping was more difficult because he is a natural side sleeper and lying on his right side is difficult. The Petitioner testified that the shoulder and the pectoral muscle on his right side become aggravated when sleeping on his side.

Petitioner also explained that household chores are more difficult. He explained that reaching for items, pushing a lawnmower, or even simple pulling is more difficult today as a result of the tears in his shoulder and chest.

Based on all of the above and the credibility of the Petitioner, the Arbitrator takes notice that, while Petitioner treated conservatively, objective tearing is visualized on the MRI of October 10, 2018 and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use to the person as a whole of pursuant to §8(d)2 of the ActecN&E p.2

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC002170
Case Name	JONES, MICHAEL v. CITY OF PEORIA
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0078
Number of Pages of Decision	9
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Stephen Kelly
Respondent Attorney	Ryan W. Kitzhaber

DATE FILED: 3/3/2022

/s/*Deborah Simpson, 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 PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Jones,
Petitioner,

vs. NO: 20 WC 2170

City of Peoria,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 6, 2021, is hereby affirmed and adopted.

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

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

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 3, 2022

o2/23/22
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC002170
Case Name	JONES, MICHAEL v. CITY OF PEORIA
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	8
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Stephen Kelly
Respondent Attorney	Ryan W. Kitzhaber

DATE FILED: 8/6/2021

/s/Bradley Gillespie, Arbitrator
Signature

INTEREST RATE WEEK OF AUGUST 3, 2021 0.05%

STATE OF ILLINOIS)

)SS.

COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MICHAEL JONES
Employee/Petitioner

Case # 20 WC 002170

v.

Consolidated cases:

CITY OF PEORIA
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Bradley Gillespie**, Arbitrator of the Commission, in the city of **Rock Island**, on **July 12, 2021**. By stipulation, the parties agree:

On the date of accident, **November 2, 2019**, Respondent was operating under and subject to the provisions of the Act.
On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**78,000.00**, and the average weekly wage was $**1,500.00**.

At the time of injury, Petitioner was **31** years of age, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$836.69**/week for a further period of **37.5 weeks**, totaling $31,375.88, because the injuries alleged by Petitioner resulted in 7.5% loss of use of the person-as-a-whole in accordance with Section 8(d)(2) of the Illinois Workers' Compensation Act.

Respondent shall pay all reasonable, necessary, and causally related medical and hospital bills from the date of the injury through the time of the trial.

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

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

/s/*Bradley D. Gillespie* **August 6, 2021**

Signature of Arbitrator

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL JONES,)
)
Petitioner,)
)
v.) Case No: 20 WC 002170
)
CITY OF PEORIA,)
)
Respondent.)
)

FINDINGS OF FACT

On November 2, 2019, Petitioner, Michael Jones, was a thirty-one (31) year-old police officer for the Respondent, City of Peoria Police Department, when he sustained a work-related accident. (PX #1). Petitioner worked as a patrol officer from 2015 through the date of accident. (Tr. p. 13) Petitioner testified that his job duties included responding to calls, making traffic stops and general law enforcement. (Tr. p. 13) Petitioner testified that he was responding to a traffic accident at War Memorial and Knoxville on November 2, 2019. (Tr. p. 15) As he approached the scene, Petitioner observed an open turn lane heading toward the accident. *Id.* Petitioner attempted to cross lanes of traffic with his lights and sirens activated when a motorist struck the driver's side of his vehicle. (Tr. p. 16) Petitioner's vehicle rotated counterclockwise and he hit the column above the driver's window with the top left side of his head. *Id*. Petitioner testified that he "felt fine" immediately after the accident but he later developed "a very uncomfortable headache." (Tr. pp. 16-17) Petitioner was taken to the emergency room from the scene of the accident for evaluation. (PX #4).

Petitioner was examined at OSF Emergency Department where he reported hitting the top left side of his head on the driver's side door. (PX #4) Petitioner's history of accident is consistent with his testimony at arbitration. *Id*. Petitioner complained of headache. *Id*. He denied loss of consciousness, nausea, vomiting, neck pain, back pain, and any numbness or tingling. *Id*. Petitioner reported getting himself out of the car. (PX #4) Petitioner was diagnosed with a closed head injury. (PX #4)

On November 4, 2019, Petitioner presented to Dr. Edward Moody at OSF Occupational Health. (PX #3) During this examination, Petitioner denied having any issues with vision, balance, hearing, memory, thought process, or dizziness. *Id*. Petitioner reported still having a headache, but stated it was better and rated it as mild. *Id*. Petitioner reported a history of prior head injuries in high school, requiring absences from school. (PX #3) Petitioner felt comfortable returning to regular duty and was discharged from care. *Id*.

Petitioner testified that he was suffering from constant headaches, memory problems and confusion. (Tr. p. 20) He indicated that he would "zone out" while driving and drive past calls that he was going to and not realize it. *Id.* Petitioner recounted going into a room and forgetting why he went there. *Id.*

Petitioner returned to see Dr. Moody on November 25, 2019 for complaints of daily headaches lasting approximately thirty (30) to sixty (60) minutes before resolving. (PX #3) Petitioner also reported he was having short-term memory limitations and navigational errors, but denied any blurring of vision, problems with confusion, sensory sensitivity or dizziness. *Id.* Due to Petitioner's continued complaints, Dr. Moody ordered a CT scan and placed Petitioner on light duty. *Id*.

Petitioner underwent a CT scan of his head and brain on December 3, 2019. The CT scan revealed no acute intracranial abnormalities. (PX #3)

On December 11, 2019, Petitioner returned to see Dr. Moody for continued complaints of headaches as well as limitations in concentration and short-term memory. Petitioner inquired about returning to regular duty, but Dr. Moody requested neurology clearance due to Petitioner's complaints of navigation errors. (PX #3).

On January 29, 202, Petitioner returned to OSF Occupational Health. He was continuing to have complaints of headaches and memory difficulties. (PX #3) Petitioner was still awaiting the neurologic consultation. *Id.* He reported that he would "space out" when driving for prolonged periods. *Id.*

Petitioner was evaluated by Dr. Aneesh Neekhra at UnityPoint Health Neurology on February 3, 2020. (PX #2) Petitioner reported cognitive lapses, memory issues, problems with his attention span and not feeling well or up to the best of his abilities. *Id.* He also reported missing turns, inability to concentrate and occasional headaches. *Id*. Due to Petitioner's complaints of cognitive lapses and decreased attention span, Dr. Neekhra ordered an EEG. *Id*. Dr. Neekhra diagnosed post-concussion syndrome and consciousness alteration. (PX # 2) Petitioner underwent the EEG on February 18, 2020. No significant abnormal activity was noted. *Id*.

On February 28, 2020, Petitioner underwent a neuropsychological evaluation with Dr. Drake Steed to ascertain Petitioner's neurocognitive status and aid in the assessment for a fitness for duty to return to work as a City of Peoria police officer. (PX #4) On examination, Petitioner indicated there was no alteration of consciousness or loss of consciousness at the moment of head impact or following the impact. *Id*. Petitioner denied significant confusion that would suggest any posttraumatic amnesia. *Id*. Petitioner stated he had memory lapses prior to the accident but expressed concern such symptoms had increased in frequency. *Id.* Petitioner had complaints of sleep disturbance, fatigue, and stress. (PX #4) He also reported starting treatment with testosterone injections about one (1) year ago to address fatigue and insomnia. *Id*. He reported a history of treatment with Lexapro during a stressful period in the summer of 2019, prior to the alleged work accident. *Id*. Petitioner stated he is independent in basic and instrumental activities of daily living and noted he had no problems with cognition at work. *Id*. Petitioner's sensory and motor functions were grossly normal upon observation. Speech and language functions were normal in conversation. (PX #4) His thought process was goal-directed, and his thought content was normal. *Id*. There was no evidence of psychotic features observed or described. *Id*.

Despite possible uneven test engagement potentially limiting the validity of test scores, Dr. Steed opined Petitioner's neurocognitive profile was normal. (PX #4) Petitioner's performances on measures typically affected by a brain injury were average and above, including processing speed, concentration, executive functioning, and memory. *Id*. Other domains assessed included general intellectual ability, expressive language, and visuospatial skills, which were within expected limits showing no impairments. *Id*. Based on the neuropsychological evaluation, Petitioner's neurocognitive profile showed no sign of residual cognitive deficit from the November 2, 2019 mild traumatic brain injury. *Id.* From a cognitive perspective, Dr. Steed felt Petitioner could perform his full, unrestricted job duties. (PX #4).

Petitioner underwent a driving evaluation at OSF Rehabilitation on March 31, 2020 to determine if he had the skills necessary to return to full duty as a police officer. (PX #3) Petitioner reported driving day and nighttime hours and had no issues driving in town or on the interstate. *Id.* Petitioner did well on all clinical testing for vision, memory, concentration, visual scanning, divided attention, visual closure, immediate recall, delayed recall, visual perception, and reaction times on the simulator. *Id.* Petitioner was able to safely merge on and off the interstate without difficulty, maintain appropriate speed and lane positions, and demonstrated the ability to maintain lane

positions with double turn lanes. *Id.* Petitioner was able to take the therapist back to the facility without any outside instruction and was able to identify shortcuts and where they would lead. (PX #3) Petitioner was able to maintain a conversation throughout the evaluation without loss of focus on the road. *Id.* Petitioner was considered a safe driving candidate and it was recommended Petitioner resume driving without restrictions. *Id.*

After reviewing the results of both the neurological psychological testing and the driving evaluation, Dr. Moody opined that Petitioner had reached maximum medical improvement. Dr. Moody returned Petitioner to full unrestricted duty on March 31, 2020. (PX #3).

Petitioner had a teleneurology visit with Dr. Neekhra on May 20, 2020. (PX #2) Petitioner stated his headaches were better with propranolol, but he was still having severe intensity headaches randomly approximately once a week. *Id.* Dr. Neekhra determined that an MRI would be helpful to determine whether the headaches were caused by trauma or could be influenced by the multiple hormone-based medications he was taking. *Id.*

Petitioner underwent a brain MRI on June 18, 2020, which revealed no acute or other suspicious intracranial findings. (RX #4)

Petitioner was working in his full unrestricted capacity as a City of Peoria police officer from approximately March 31, 2020 until his resignation on April 16, 2021. (Tr. p. 47) Petitioner testified he resigned, in part, because he was stressed working in the State of Illinois and City of Peoria in what he perceived to be anti-police culture. (Tr. p. 50) The Petitioner further testified his resignation didn't have anything to do with his alleged accident or related injuries. (Tr. p. 51)

At arbitration, Petitioner testified he had been working full duty as a City of Peoria police officer, without restrictions, since approximately March 31, 2020. (Tr. p. 47) Petitioner testified that he had not received any treatment or diagnostic studies for his alleged injuries since June 18, 2020. (Tr. p. 51) Petitioner testified he was still experiencing headaches, some memory problems, and issues with concentration but the symptoms were becoming less frequent. (Tr. p. 30) He stated that while he was still experiencing symptoms, it did not affect his work. *Id*. Petitioner testified that he now works for the City of Madison Police Department in Alabama and is employed in the same capacity he was with Respondent. (Tr. p. 51)

CONCLUSIONS OF LAW

The parties stipulated the sole issue in dispute is the nature and extent of Petitioner's alleged injuries.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L), WHAT IS THE NATURE AND EXTEND OF THE PETITIONER'S INJURY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Section 8.1b of the Illinois Workers Compensation Act requires consideration of the following enumerated factors in determining an employee's permanent partial disability:

(i) The reported level of impairment pursuant to an American Medical Association Impairment Rating;

(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.

Section 8.1b further provides no single factor shall be the sole determinant of disability. Additionally, Illinois Appellate Courts has affirmed the aforementioned factors are not exclusive, meaning the Commission is free to evaluate other relevant considerations. See *Flexible Staffing Services v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 151300WC. In accordance with Section 8.1b, the relevance and weight of any factors used in reaching a conclusion in this matter are set forth below.

(i) First, with regard to the reported level of impairment pursuant to the AMA 6th Edition Guidelines, an AMA impairment rating was not submitted by either party. Accordingly, the Arbitrator gives no weight to this factor.

(ii) Second, regarding the occupation of the injured employee, the Arbitrator notes Petitioner was a police officer for the City of Peoria Police Department at the time of the November 2, 2019 accident. He returned to full-duty as a police officer on April 2, 2020. The Arbitrator acknowledges the high demands required of police officers and gives some weight to this factor.

(iii) Third, regarding the age of the injured employee, the Arbitrator finds Petitioner was thirty-one (31) years old at the time of his work-injury. (Tr. p. 34) Petitioner indicated that he wished to continue as a police officer until retirement age. (Tr. p. 34) The Arbitrator places significant weight on this factor, as Petitioner has a relatively long occupational and nonoccupational life ahead of him.

(iv) Fourth, with regard to Petitioner's future earning capacity, the Arbitrator finds Petitioner presented no evidence of lost earning capacity. As such, the Arbitrator places no weight on this factor.

(v) Lastly, with regard to evidence of disability corroborated by the treating medical records, the Arbitrator notes the medical records entered into evidence establish Petitioner was involved in a work-related accident on November 2, 2019. Petitioner reported headache pain following his work-related motor vehicle accident and was diagnosed with a closed head injury. (PX #4) Petitioner was referred to neurologist, Dr. Neekhra, and he diagnosed post-concussive syndrome. (PX #2) The foregoing diagnoses were not present prior to the November 2, 2019 work injury. Petitioner testified credibly at arbitration. Petitioner testified that he continues to have headaches, some memory problems and difficulty concentrating but less frequently than before. (Tr. p. 30) He indicated that he continued to experience headaches every couple of weeks. (Tr. p. 35) The Arbitrator gives moderate 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 7.5% loss of use of the person-as-a-whole pursuant to §8(d)(2) of the Act. Respondent is ordered to pay 37.5 weeks of compensation at a rate of $836.69, totaling $31,375.88.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC000019
Case Name	FLORES, ALEXANDRO v. ATLAS EMPLOYMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0079
Number of Pages of Decision	22
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Frederick Glassman
Respondent Attorney	JASON ALLAIN

DATE FILED: 3/3/2022

/s/*Deborah Simpson, 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

Alexandro Flores,
Petitioner,

vs. NO: 16 WC 19

Atlas Employment 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 medical expenses, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 3, 2021, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,800,00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 3, 2022
o2/23/22
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC000019
Case Name	FLORES,ALEXANDRO v. ATLAS EMPLOYMENT
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	Frederick Glassman
Respondent Attorney	Jason Allain

DATE FILED: 5/3/2021

THE INTREST RATE FOR THE WEEK OF APRIL 27, 2021 0.03%

/s/*Molly Mason, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alexandro Flores
Employee/Petitioner
v.
Atlas Employment Services
Employer/Respondent

Case # **16** WC **19**

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 24, 2021**. After reviewing all-of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/09/2015**, 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.

Respondent stipulated to accident insofar as Petitioner's foot/ankle condition is concerned. See further below.

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

Respondent stipulated to causation insofar as Petitioner's foot/ankle condition is concerned. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner failed to establish causation as to his claimed lumbar spine condition.

In the year preceding the injury, Petitioner earned $**5,868.75**; the average weekly wage was $**391.25**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1 dependent child.**

Petitioner was temporarily totally disabled from December 9, 2015 through June 27, 2016, a period of 28 6/7 weeks.

Petitioner ***has*** received all reasonable and necessary medical services for the causally related foot/ankle condition.

For the reasons set forth in the attached decision, the Arbitrator declines to award the claimed $2,333.50 in outstanding medical expenses (PX 1). Respondent shall hold Petitioner harmless against the $24.20, $14.35 and $68.36 payments relating to foot and ankle care. PX 8, p. 7.

Respondent shall be given a credit of $**8,131.12** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,131.12.**

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits at the rate of $260.83/week from December 9, 2015 through June 27, 2016, a period of 28 6/7 weeks. Respondent shall receive credit for its stipulated payment of $8,131.12 in temporary total disability benefits. Arb Exh 1.

Respondent shall hold Petitioner harmless against the $24.20, $14.35 and $68.36 payments for foot/ankle care outlined in the Equian lien documents. PX 8, p. 7.

The Arbitrator finds that Petitioner established permanency equivalent to 12.5% loss of use of his right foot, representing 20.875 weeks of benefits under Section 8(e) of the Act. The Arbitrator awards permanency benefits at the applicable minimum rate of $253.00 per week, having found that Petitioner had one dependent child as of the accident. See the attached decision for further details.

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

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

Signature of Arbitrator

MAY 3, 2021

Alexandro Flores v. Atlas Employment Services, Inc.
16 WC 19

Summary of Disputed Issues

Petitioner claims he sustained foot, leg and back injuries at work on December 8, 2015, when he was struck by a forklift that was being operated in reverse. Petitioner testified he fell after being struck but the initial medical records contain no mention of a fall. They reflect that the forklift went over Petitioner's feet.

Petitioner testified he began experiencing low back and leg pain within several days of the accident. He claimed he relayed back and leg complaints early on but it was not until February 4, 2016 that any medical provider clearly documented such complaints. After Dr. Wojewnik prescribed a lumbar spine MRI, in June 2016, Respondent obtained a Section 12 examination by Dr. Weber. She found no causal relationship between the accident and Petitioner's back condition, citing the delay in documentation. Petitioner went on to have an emergency lumbar spine surgery July 8, 2016, after informing Dr. Wojewnik he had aggravated his back condition on July 4th, when he spent a significant amount of time on his feet. Dr. Wojewnik found a causal relationship between the work accident and Petitioner's lumbar spine condition based solely on Petitioner's history that he fell a significant distance after being struck and began experiencing leg and back symptoms within a couple of days of the accident.

Respondent does not dispute accident or causation insofar as Petitioner's ankles are concerned but does dispute these issues with respect to Petitioner's claimed low back condition. Also in dispute are medical expenses, temporary total disability, nature and extent and dependency/PPD rate. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner is not a native English speaker.

Petitioner testified he began working for Respondent a few months before December 8, 2015. T. 12. He worked at a warehouse, loading and unloading trucks. T. 12-13. On December 8, 2015, he was doing inventory inside a freezer, counting items in bins that were on racks. T. 13. The freezer was "foggy" inside. T. 13. A co-worker who was operating a forklift drove "really fast" into the freezer. Petitioner testified the forklift driver did not see him due to the fog. He screamed at the driver to warn him but the driver was wearing headphones and did not hear him. The forklift struck him, causing him to fall. The driver then drove over the top of Petitioner's legs. T. 13. Petitioner testified he passed out for a few seconds and then woke up. The co-worker jumped out of the forklift and came toward Petitioner. He apologized and told Petitioner he did not see him due to the fog. T. 14. Petitioner told him to get back in the forklift and maneuver it so that his legs would not be injured further. T. 14.

Petitioner testified he underwent treatment at Occupational Health Centers on the day of the accident. The records from this facility (PX 2) reflect that Petitioner saw Dr. Dovhyy that day. The doctor noted complaints of 7/10 pain in the right ankle and left great toe. He indicated that Petitioner "was at work when a co-worker ran him over with a forklift." He also indicated that the forklift ran over Petitioner's feet. On examination, he noted swelling and tenderness in various areas of the right foot and tenderness and small superficial lacerations of the lateral malleolus area of the left foot. He ordered

X-rays of both ankles. PX 2, pp. 32-35. In a "second opinion" radiological report dated December 10, 2015, Dr. Dalia noted large plantar and posterior calcaneal spurs bilaterally and additional spur formation at the medial malleoli, more pronounced on the right. He indicated he could not rule out the possibility of an avulsion fracture of one of the spurs at the medial malleolus of the right ankle. PX 2, p. 36. Dr. Dovhyy provided Petitioner with crutches. He prescribed Tramadol for pain and directed Petitioner to rest and keep his legs elevated. He took Petitioner off work and referred him to Dr. Poepping, an orthopedic surgeon. PX 2, pp. 32-35.

Dr. Poepping first saw Petitioner on December 10, 2015. T. 15. He noted that a forklift ran over Petitioner's feet two days earlier. He indicated that Petitioner complained of bilateral ankle pain and pain in the left forefoot. He noted that Petitioner was off work and relying on crutches. On right ankle examination, he noted mild medial and lateral swelling and tenderness, primarily over the distal portion of the medial malleolus. On left foot and ankle examination, he noted diffuse tenderness to palpation of the left ankle and forefoot with no obvious deformity or swelling. He interpreted the X-rays as showing no left ankle abnormalities and a small avulsion fracture at the tip of the right medial malleolus. PX 2, p. 37. He placed Petitioner's right ankle in a CAM walker boot, indicating Petitioner could bear weight as tolerated. He prescribed Tramadol and released Petitioner to seated work. PX 2, p. 38.

Petitioner testified he remained off work after seeing Dr. Poepping because Respondent was not able to accommodate the doctor's restrictions. Respondent began paying Petitioner temporary total disability benefits. Arb Exh 1. T. 15.

Petitioner testified that the CAM boot made his right foot feel worse. T. 15-16.

On December 14, 2015, Petitioner saw his primary care physician, Dr. Cabrera. The doctor described Petitioner as having chronic hypertension and chronic left wrist pain, with no history of extremity trauma. He described the wrist complaints as intermittent and starting more than one month earlier. He made no mention of the work accident. He directed Petitioner to add a low salt diet to his hypertension regimen and to see an orthopedic surgeon for evaluation of his left wrist. RX 5, pp. 10-11.

Petitioner returned to Dr. Poepping on December 31, 2015. The doctor noted that Petitioner felt as if the boot was making his pain worse. He also noted the following: "He is getting a lot of pain at night time and a little bit of [sic] are back now as he has been walking with the boot." On re-examination of the right ankle, Dr. Poepping noted some moderate lateral swelling and tenderness over the peroneal tendons and anterior lateral joint line. He diagnosed a "right foot crush injury." He directed Petitioner to discontinue the boot, wear regular shoes and start physical therapy. He dispensed some muscle rub and Motrin. He continued the previous restrictions. PX 2, p. 39.

Petitioner underwent an initial physical therapy evaluation on January 5, 2016. The therapist described the mechanism of injury as follows: "Pt reports a forklift ran over both his feet." He indicated that Petitioner complained of right ankle pain and swelling and "tingling and numbness in the last three toes and difficulty moving the little toe." T. 16. He described the left ankle range of motion as within normal limits. PX 2, pp. 40-43.

Petitioner continued attending therapy thereafter. On January 7, 2016, the therapist noted that Petitioner "didn't wear CAM boot into the clinic." PX 2, p. 44. On January 12, 2016, Petitioner informed the therapist his ankle had been very stiff and sore for the previous two days. The therapist again noted

that Petitioner "didn't wear CAM boot into the clinic." PX 2, p. 47. A week later, Petitioner reported that he was limping due to pain but that his ankle motion was improving. PX 2, p. 53.

Petitioner returned to Dr. Poepping on January 21, 2016. The doctor noted that Petitioner was still experiencing a lot of pain, both laterally and anteriorly, in the right ankle. On re-examination, he noted that the right ankle swelling was markedly diminished but that Petitioner was still tender over the anterior talofibular ligament and anterior joint line. He refilled the Motrin and prescribed more therapy. PX 2, p. 59.

On February 1, 2016, Petitioner underwent bilateral wrist X-rays at St. Elizabeth Hospital. The records identify Dr. Kuo as the ordering physician. They reflect a diagnosis of chronic bilateral wrist pain. The X-ray results were normal. PX 7, pp. 10, 24.

On February 4, 2016, the physical therapist at Concentra noted that Petitioner's ankle was better but that he was still limping and that he (Petitioner) felt this was "also bothering his hip and back." PX 2, p. 69. On February 15, 2016, the therapist indicated that Petitioner reported his ankle felt stiff and he (Petitioner) "doesn't know why he is still limping." PX 2, p. 78.

Petitioner returned to Dr. Poepping on February 18, 2016. The doctor noted that Petitioner felt much better but was still experiencing discomfort along the anterior ankle with stair climbing and heavy lifting. He directed Petitioner to remain off work and begin a course of work conditioning. PX 2, p. 86. T. 16-17.

On February 22, 2016, Petitioner underwent a work conditioning evaluation at Athletico. The evaluating therapist, Daniel Honan, PT, DPT, noted that Petitioner reported injuring his right ankle at work on December 8, 2015 when he was hit by a forklift. He also noted that Petitioner had undergone therapy for two months but denied benefit. He indicated that "in addition to the R ankle pain, the patient states he injured his L ankle and L wrist but is not actively receiving treatment for these symptoms." [The Arbitrator notes that Petitioner did not testify to injuring his left wrist in the work accident.] He noted that Petitioner denied any prior right ankle injuries but reported fracturing his left fourth and fifth metatarsals at age sixteen. He described Petitioner's gait as antalgic, noting a "premature heel raise on the R ankle." A pain diagram is marked with an "X" in the vicinity of the right ankle. PX 6, p. 55. Honan found Petitioner to be functioning at a medium physical demand level, noting that Petitioner's job was rated as heavy. PX 6, pp. 27-31.

On February 24, 2016, Honan noted improved gait mechanics but indicated Petitioner was still struggling to perform deep squats. On February 29, 2016, Honan noted complaints of bilateral thigh pain. PX 6, p. 23. On March 1, 2016, Honan noted that Petitioner complained of pain in his right ankle and knee and indicated his back also hurt. PX 6, p. 21. On March 4, 2016, Honan wrote to Dr. Poepping, indicating that Petitioner was still functioning at a medium physical demand level. PX 6, pp. 14-18.

On March 17, 2016, Dr. Poepping noted that Petitioner reported worsening of his right ankle symptoms secondary to work conditioning. On right ankle re-examination, he noted some mild swelling of the anterior lateral gutter and tenderness. He administered a Kenalog injection and directed Petitioner to return in two weeks, at which point he hoped to be able to release Petitioner to a trial of work. PX 6, p. 87.

The following day, March 18, 2016, Petitioner sought treatment at Gottlieb Memorial Hospital's Emergency Room. The hospital records document a history of "right foot pain related to an accident at work." Petitioner indicated that a doctor had injected his right foot the previous day and that he was now experiencing 7/10 right foot pain. PX 4, pp. 16-17. T. 18. The examining physician, Dr. Desilva, noted tenderness to the dorsal aspect of the right foot over the tarsals and proximal metatarsals, along with tenderness over the medial malleolus. He obtained X-rays which showed a minimally displaced avulsion fracture of the caudal aspect of the medial malleolus. PX 4, p. 23. He prescribed Norco for pain and dispensed crutches to Petitioner. He recommended orthopedic follow-up with Dr. Schiffman. PX 4, pp. 19, 37.

On March 31, 2016, Petitioner saw Dr. Schiffman. The doctor noted that Petitioner had been injured at work in December 2015, when a forklift ran over his right foot. He also noted that Petitioner was "also c/o LBP recently without LE numbness or tingling." PX 4, p. 44. He injected the ankle and directed Petitioner to remain off work for two weeks. PX 4, p. 176.

Petitioner underwent an initial physical therapy evaluation at Gottlieb Memorial Hospital on April 12, 2016. The evaluating therapist recorded the following history: "Patient was working on the floor and another co-worker who was backing up with his fork lift hit him, striking him on the (R) side and the wheel of the fork lift ran over his (R) ankle temporarily." The therapist noted complaints of right ankle, leg and back pain along with right ankle swelling after approximately eight minutes of standing. PX 4, p. 58. She described Petitioner's gait as antalgic.

Petitioner continued attending therapy thereafter. On April 14, 2016, the therapist noted a pain rating of 7-8/10 in the right lower back radiating down the right leg, with Petitioner indicating he planned to "flip or change out his mattress at home." PX 4, p. 71. On April 22, 2016, Petitioner complained of 8/10 right-sided low back pain and 7/10 right knee pain. On April 27, 2016, Petitioner indicated his right ankle was "way better than before" but he continued to complain of back pain and pain radiating down his leg. PX 4, p. 99.

On April 28, 2016, Dr. Schiffman noted that Petitioner had attended six or seven therapy sessions. The doctor indicated that Petitioner described his ankle as "much improved" but that Petitioner was still experiencing back pain and pain radiating down his right leg. PX 4, p. 108. T. 19. He noted no abnormalities on right ankle examination. PX 4, p. 109. He described Petitioner's ankle condition as having resolved. He referred Petitioner to Dr. Wojewnik for his back and leg complaints. PX 4, p. 109.

On May 4 and 5, 2016, an investigator affiliated with PhotoFax, Inc. obtained surveillance footage of Petitioner. The Arbitrator has viewed this footage and has reviewed the accompanying report. Petitioner's counsel raised no objection to this evidence. The footage consists of approximately 25 minutes of Petitioner "sitting, standing, walking, utilizing a cellular device, conversing with unidentified individuals, entering his residence, driving, entering and exiting a vehicle, drinking from a can, holding a plastic bag and performing unidentified activities." In his report, the investigator indicated that Petitioner performed all of these activities in a fluid manner, demonstrating no signs of a limp and using no assistive devices. RX 2.

Petitioner saw Dr. Schiffman again on May 9, 2016. The doctor noted that Petitioner had a back-related appointment on May 12th. He also noted complaints of diffuse ankle pain and pain throughout the right leg "radiating from the back and up to the neck." PX 4, p. 130. On right ankle re-

examination, he again noted no abnormalities. PX 4, p. 132. He released Petitioner from his care with respect to the ankle and told Petitioner he would not be treating the back condition. PX 4, p. 132.

Petitioner continued attending therapy thereafter. On May 16, 2016, the therapist noted complaints of 9/10 right-sided low back pain and 5/10 right knee pain. She described Petitioner as "constantly com[ing] in late every session" and being given "a lot of chances to be able to complete his time session." She described Petitioner as continuing to exhibit an antalgic gait pattern. PX 4, p. 158.

Petitioner testified that, on June 10 [sic], 2016, he saw Dr. Wojewnik at Loyola for his lower back complaints. T. 20. Dr. Wojewnik took him off work and recommended a lumbar spine MRI. At this point, he was still receiving temporary total disability benefits. T. 21.

Records in PX 5 reflect that Petitioner saw Dr. Wojewnik at Loyola on June 8, 2016, with the doctor recording the following history:

> "This is a 42-year-old male who on 12/8/2015 was hit by a forklift, which caused him to fall a significant distance backwards. He sustained tendon rotation and per patient, needed a cast or splint to wear for this. Right away, he had leg symptoms; however, it was difficult to localize the symptoms given diffuse pain that he was having from the injury. He developed low back pain about [sic] days later. However, he felt the leg pain was there the whole time but it was hard to say if it was from his back or his tendon injury or foot injury at that time."

The doctor noted that Petitioner had undergone therapy for three or four months and had not undergone an MRI. He indicated that Petitioner's shooting leg pain was in what appeared to be an L5 distribution. On examination, he noted an antalgic gait, tenderness to palpation over the paraspinal musculature of the lower lumbar spine, 4/5 strength in the right tibialis anterior and EHL and intact sensation. He also noted positive straight leg raising on the right.

Dr. Wojewnik obtained X-rays of the pelvis, right hip and lumbar spine. He saw no significant arthritis on the pelvis and right hip films and mild degenerative changes at L5-S1 on the lumbar spine films. PX 5, pp. 25-26.

Dr. Wojewnik addressed causation as follows: "This is a 42-year-old male with right lower extremity pain that is likely radiculopathy with persistent symptoms after physical therapy, as well as some weakness on exam, with injury being secondary to his work injury and persistent symptoms at this point." He recommended a lumbar spine MRI and indicated Petitioner might require injections following this study. He prescribed Voltaren and renewed the Hydrocodone. He directed Petitioner to remain off work and return to him following the MRI. PX 5, pp. 22-23.

Petitioner returned to Dr. Cabrera on June 22, 2016. In his note of that date, the doctor indicated he was seeing Petitioner for chronic hypertension and chronic back pain that had started more than one month earlier. He described the back pain as radiating to the right thigh, knee and foot. He made no mention of the work accident. He directed Petitioner to continue his hypertension regimen and noted Petitioner was "under ortho care" for his back pain and radicular symptoms. RX 5, pp. 16-17.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Weber on June 27, 2016. T. 21. The doctor noted that, while Petitioner was working inside a refrigerator on December 8, 2015, a co-worker "was backing up a forklift" and hit Petitioner "from behind, knocking him approximately 10 feet." The doctor indicated that the forklift operator "kept going" and ran over Petitioner's feet and ankles. She described Petitioner as reporting that he developed lower back pain and right-sided radicular symptoms two to three days after the forklift incident. She indicated that Petitioner was currently seeing Dr. Wojewnik for his back complaints. She noted that Petitioner's ankles had improved but were "still painful" and that he rated his back and leg pain at 9/10.

Dr. Weber described Petitioner's gait as "significantly antalgic." On right ankle examination, she noted tenderness at the Achilles distally, the ATFL and the talar dome. On left ankle examination, she noted tenderness at the Achilles, the talar dome and the great toe dorsally. On lumbar spine examination, she noted a limited range of motion, complaints of pain with all range of motion testing, negative straight leg raising (with a complaint of "neck cracking" when she raised his right leg to 10 degrees), give way weakness with dorsiflexion and the ability to heel raise and toe tap without obvious deficit. Lumbar spine X-rays demonstrated mild narrowing of the disc space at L5-S1 and no abnormal motion with flexion-extension views. Bilateral ankle X-rays showed an old medial malleolus avulsion fracture on the right and bilateral changes at the insertion of the Achilles "consistent with chronic calcification changes."

Based on her examination and records review, Dr. Weber diagnosed a right ankle medial malleolus avulsion fracture which was "now healed," a left ankle contusion and non-specific low back pain. She described Petitioner as having a poor prognosis based on his continued complaints "despite no objective findings." She found a causal relationship between the work accident and the ankle conditions. She did not find causation with respect to the back, noting that, based on her records review, Petitioner "did not report any back complaints until at least 2-3 months following the incident." She saw no need for additional treatment. She indicated that any further pain-related back care "would not be related to the December 8, 2015 injury." She found Petitioner capable of resuming full duty with respect to his ankles and back. RX 1.

Petitioner testified that Respondent declined to authorize the recommended lumbar spine MRI following Dr. Weber's Section 12 examination. T. 21.

Petitioner returned to Dr. Wojewnik on July 7, 2016 and again complained of low back and right leg pain. Petitioner indicated his pain "was aggravated since 3 days ago." T. 21-22. He reported having seen another physician per workers' compensation and indicated he had not yet undergone the recommended lumbar spine MRI. On re-examination, Dr. Wojewnik noted that Petitioner was "weaker than last time." He noted 3/5 strength in the right tibialis anterior and 4/5 strength in the right EHL. He indicated Petitioner was "barely able to lift against gravity." He again attributed the weakness to the work injury. He recommended that Petitioner go to the Emergency Room and undergo an emergent lumbar spine MRI to check for neurological compression. PX 7, p. 35. The Emergency Room physician, Dr. Williams, described Petitioner as having experienced back and leg pain since a forklift-related injury. The emergent MRI, performed without contrast, showed moderate to severe foraminal stenosis on the right at L5-S1 and mild to moderate foraminal stenosis on the left at the same level. The study also showed a disc protrusion at that level toward the right and into the foramen and stenosis at L4-L5. After Dr. Wojewnik reviewed the MRI, he secured Petitioner's consent for emergent surgical L4-S1 decompression. PX 7, p. 53. An orthopedic resident, Dr. Sonn, noted that Petitioner described his

symptoms as having been "exacerbated on 7/4 after he spent a significant amount of time on his feet." PX 7, p. 54. Petitioner was admitted to the hospital. He underwent the recommended decompressive surgery on July 8, 2016. T. 22. Following the surgery, he underwent a physical therapy evaluation at the hospital. The therapist noted that he reported less leg pain than before the surgery.

Petitioner returned to Dr. Cabrera on August 10, 2016. The doctor indicated he was seeing Petitioner for chronic hypertension and chronic back pain that had started more than one month earlier. He noted that Petitioner had undergone a decompressive laminectomy on July 7, 2016 but was still in pain, although "much better than before." He recommended that Petitioner continue his hypertension regimen and follow up with his back surgeon on August 18, 2016. RX 5, pp. 22-23.

Petitioner saw Dr. Wojewnik on August 18, 2016 (T. 22) and reported that he was still experiencing low back and bilateral buttock pain but that his leg pain had resolved. Petitioner also reported that he was noticing increased balance problems as well as some occasional dexterity problems with his right upper extremity. The doctor prescribed a cervical spine MRI and physical therapy. He directed Petitioner to remain off work. PX 7, p. 262.

Petitioner testified that workers' compensation did not approve the recommended physical therapy. T. 23.

Petitioner saw Dr. Cabrera again on September 13, 2016, with the doctor recommending physical therapy for chronic back pain. RX 5, pp. 29-30.

On September 14, 2016, Dr. Wojewnik noted that Petitioner was experiencing worsening low back pain as well as numbness and tingling in both feet. He also noted that Petitioner had not undergone the recommended cervical spine MRI due to workers' compensation denial but that Petitioner had obtained a "medical card" and was trying to continue his treatment. On re-examination, the doctor noted 5/5 strength, no focal deficits in the upper or lower extremities and intact sensation. He again recommended a cervical spine MRI and physical therapy. He also prescribed Gabapentin and short-term Norco. He directed Petitioner to return in six weeks or earlier, if he was able to undergo the cervical spine MRI. PX 7, pp. 269-270.

On December 12, 2016, Petitioner returned to Dr. Cabrera. The doctor noted that Petitioner was now complaining of numbness and tingling in both arms as well as chronic back pain. He also noted that Petitioner's neurosurgeon at Loyola had recommended a cervical spine MRI but that this study had not been performed due to lack of coverage. He recommended physical therapy and a pain management consultation for the low back pain and re-ordered the cervical spine MRI. RX 5, pp. 43-44.

On April 5, 2017, Petitioner saw Dr. Cabrera again, with the doctor noting complaints of chronic low back pain, neck pain of three months' duration and tingling and numbness in both arms. The doctor noted that Petitioner had last seen a neurosurgeon in September 2016, with that individual recommending a repeat MRI. On re-examination, he noted positive straight leg raising on the right and decreased neck motion due to pain. He recommended a cervical spine MRI, a repeat lumbar spine MRI, continued Gabapentin and therapy and Norco for severe pain. PX 3, pp. 36-37. T. 23-24.

Petitioner underwent the recommended MRI scans on April 28, 2017. T. 24. The lumbar spine MRI, performed without contrast, showed evidence of the previous laminectomy at the L5 level and some disc bulging and spurring at the L4-L5 and L5-S1 levels. PX 3, pp. 100-101. PX 7, pp. 47-48.

On May 22, 2017, Dr. Cabrera noted that Petitioner reported feeling depressed during the preceding two to three months and wanted to see a psychiatrist. He also noted the MRI results. He recommended that Petitioner undergo pain management for his back and see a neurosurgeon for evaluation of his neck. PX 3, pp. 44-45.

On June 13, 2017, Dr. Cabrera noted that Petitioner's depression had improved. He recommended that Petitioner continue taking Zoloft pending a psychiatric evaluation. PX 3.

On August 16, 2017, Dr. Cabrera saw Petitioner for pre-operative clearance, pending a cervical spine discectomy and fusion. He cleared Petitioner for this surgery, noting ongoing complaints of neck and back pain causing some arm and leg weakness. PX 3, pp. 61-63.

On February 15, 2018, Petitioner underwent lumbar spine and cervical spine X-rays. The X-rays showed post-surgical changes and "no acute process." PX 7, p. 60.

On February 22, 2018, between 7:43 AM and mid-afternoon, investigators from PhotoFax, Inc. conducted additional surveillance at Respondent's request. The Arbitrator has viewed the video and has read the accompanying report. Petitioner's counsel raised no objection to this evidence. The footage lasts about ten minutes. It shows Petitioner walking, sitting in his vehicle, dropping two teenage males off at a school, traveling to several stores, raking a small area in his yard and carrying a five-gallon bucket. At only one point in the afternoon was Petitioner observed walking with a cane. RX 3.

Petitioner testified he was involved in a minor motor vehicle accident on September 23, 2018. He described his back and neck complaints as worsening after this accident. He testified the accident caused his back condition to "permanently" worsen. T. 25. He had a lot of back pain before the car accident but this pain "got kind of worse" afterward. T. 26.

Dr. Wojewnik testified by way of a Zoom evidence deposition on September 10, 2020. PX 9. Dr. Wojewnik testified he obtained his degree from Chicago Medical School. He did a residency at Illinois University, specializing in orthopedic surgery, and then underwent fellowship training in spine surgery at Atlanta Emory. He has been affiliated with Loyola since 2013. PX 9, pp. 5-6. He is board certified in orthopedic surgery. Dep Exh 1. He deals exclusively with spinal conditions. He sees approximately 150 to 200 patients per year. PX 9, p. 6.

Dr. Wojewnik testified he has no independent recollection of Petitioner. PX 9, p. 7. He referred to his records while responding to questions. Those records reflect he first saw Petitioner on June 8, 2016. On that date, Petitioner complained of low back and right leg pain. Petitioner indicated he had been struck by a forklift on December 8, 2015, with the impact causing him to fall a distance backwards. Petitioner reported having sustained a tendon injury and being placed in a cast. He also reported experiencing right leg symptoms "right away" after the accident but having difficulty localizing the symptoms given that he had diffuse pain from having injured his foot. By June 8, 2016, Petitioner had been doing therapy for three to four months. He had not undergone a back MRI or any back injections. He described his back pain as shooting down his right leg in what appeared to be an L5 distribution, meaning the pain was on the outside of the leg. He denied any significant improvement secondary to the therapy. PX 9, pp. 8-9.

Dr. Wojewnik testified that, on initial examination, he noted tenderness to palpation over the paraspinal musculature in the lower back, 4/5 weakness in the tibialis anterior and EHL on the right, positive straight leg raising on the right and no pain with range of motion of the hip. The doctor indicated he reviewed pelvic and lumbar spine X-rays. The lumbar spine films showed some degenerative changes at the L5-S1 level with no instability on flexion or extension. PX 9, pp. 9-10.

Dr. Wojewnik testified that, at the initial visit, he diagnosed right lower extremity pain, likely radiculopathy, with persistent symptoms following treatment and also weakness on examination. PX 9, p. 10. He attributed this diagnosis to the work accident, given that Petitioner's pain "started afterwards." He recommended a lumbar spine MRI and felt Petitioner might need injections, depending on the MRI results. He kept Petitioner off work as his pain was significant. He renewed the Hydrocodone and prescribed Voltaren. PX 9, p. 11.

Dr. Wojewnik testified he next saw Petitioner at the hospital, on July 7, 2016. When he re-examined Petitioner on that date, Petitioner's strength had decreased from 4/5 to 3/5. Petitioner was not able to resist him on examination so he recommended that Petitioner undergo an emergent MRI that day. He reviewed the MRI that day. It showed foraminal stenosis on the right at L5-S1 as well as mild to moderate foraminal stenosis on the left at the same level and severe right, moderate left, lateral recess stenosis at L4-L5. Basically, Petitioner had nerve compression at two levels, L4-L5 and L5-S1. PX 9, p. 13. Based on the MRI and progressive weakness, he recommended emergent surgery to decompress the nerves. He performed a laminectomy with partial medial facetectomy and foraminotomy from L4 to S1. In his opinion, the need for this surgery stemmed from the work accident. PX 9, pp. 13-14.

Dr. Wojewnik testified he next saw Petitioner on August 18, 2016. On that date, he prescribed a cervical spine MRI as well as physical therapy. He recommended the MRI because Petitioner was having occasional right upper extremity dexterity problems as well as increased balance problems. He wanted to make sure there was no spinal cord compression in the neck that could be contributing to those problems. It is difficult to say whether the problems were present before the surgery or stemmed from the surgery. Petitioner could have had pre-existing cervical spine pathology or the problems could be due to him lying on the table during the back surgery. PX 9, p. 15. He continued to keep Petitioner off work. PX 9, p. 15.

Dr. Wojewnik testified that he last saw Petitioner on September 14, 2016. Petitioner reported that his shooting leg pain had resolved but that he was experiencing worsening back pain, numbness and tingling in both feet, compression pain around the ankles and balance problems. Petitioner had not undergone the recommended cervical spine MRI. Dr. Wojewnik testified he again recommended this MRI and also prescribed therapy for the back pain. He prescribed Gabapentin and Norco for the exacerbation of the back pain. PX 9, p. 16. Petitioner did not return to him after September 14, 2016. He was unable to determine the source of Petitioner's cervical spine pain. He has no opinion regarding the cervical spine. PX 9, p. 17. He referred Petitioner back to his primary care physician with respect to the therapy and pain management. PX 9, p. 17.

Dr. Wojewnik opined that the treatment he provided to Petitioner was due to the work accident. PX 9, p. 17.

Under cross-examination, Dr. Wojewnik reiterated that, at the initial visit, Petitioner told him he experienced low back and right leg pain after being struck by a forklift, with the impact causing him

to fall a significant distance backwards. PX 9, p. 18. Petitioner did not tell him how fast the forklift was traveling or how far he traveled after being struck. Petitioner indicated that his right leg pain started right after the accident and that his back pain started within a few days of the accident. PX 9, p. 20. He relied on Petitioner's history. He did not review any other treatment records. PX 9, p. 20. Petitioner also told him he had been undergoing therapy for three to four months. He is not sure whether the therapy was for the low back or right ankle or both. PX 9, p. 20. He assumes Petitioner was referring to formal therapy because he would normally make a note if a patient was simply performing home exercises. PX 9, p. 21. It would not be unusual to see mild degenerative disc disease in someone of Petitioner's age. Degenerative disc disease is essentially "wear and tear on the discs and structures in the spine." It can occur with time, age and sometimes injury. It typically happens over time. PX 9, p. 23. Petitioner never underwent back injections. He restricted Petitioner from work due to Petitioner's pain. At the initial visit, on June 8, 2016, Petitioner did not complain of neck pain. PX 9, p. 23. He did not review any records of Petitioner's primary care physician covering the period between June 8, 2016 and July 7, 2016. PX 9, p. 24. When he saw Petitioner on July 7, 2016, Petitioner reported that his symptoms had increased on July 4th, when he spent a significant amount of time on his feet. He does not know what activities Petitioner engaged in on July 4th. Petitioner also reported having seen another physician at the direction of workers' compensation. He has not reviewed any Section 12 examination report. PX 9, p. 25. Petitioner's weakness had increased. His strength testing was now 3/5, meaning that he basically could not resist and was barely able to lift his foot against gravity. PX 9, pp. 25-26. At the initial visit, Petitioner's strength had been 4/5, meaning he was able to resist. Strength testing is subjective in the sense that a patient can elect not to try hard. PX 9, p. 26. The surgery he performed was intended to relieve Petitioner's leg pain and weakness. It was not intended to relieve Petitioner's low back pain. PX 9, pp. 27-28. He recommended that Petitioner undergo therapy postoperatively but he has no records indicating that Petitioner did so. If Petitioner did not undergo therapy, his outcome could be worse as far as return of symptoms. PX 9, p. 29.

Dr. Wojewnik reiterated that his causation opinion with respect to the low back is based on information that Petitioner provided to him. He has no causation opinion with respect to Petitioner's cervical spine condition. PX 9, p. 30.

On redirect, Dr. Wojewnik testified he recommended emergent surgery, rather than an injection, when he saw Petitioner in July 2016 because Petitioner's weakness had progressed. If, in July 2016, he had felt that Petitioner was not putting forth full effort during strength testing, he most likely would have documented that. PX 9, p. 31.

Under re-cross, Dr. Wojewnik testified that the need for emergent surgery was due to the progressive weakness. The need for surgery in general was because of weakness, pain and symptoms. PX 9, p. 32.

Dr. Weber testified by way of Zoom evidence deposition on September 23, 2020. RX 1. Dr. Weber testified she is a partner at Midwest Orthopedics at Rush. She is licensed to practice medicine in Illinois, California and Arizona. RX 1, p. 6. She attended Rush Medical College. She did a residency in internal medicine and then underwent fellowship training in sports medicine. She is board certified in sports medicine. RX 1, pp. 6-7. She sees approximately 100 to 120 patients per week. She does not perform surgery. RX 1, p. 7. She is a team physician for the Chicago White Sox, the Chicago Bulls and DePaul University. RX 1, p. 8.

Dr. Weber identified Weber Dep Exh 1 as an accurate copy of her CV. RX 1, p. 9.

Dr. Weber testified she examined Petitioner on June 27, 2016. She has no independent recollection of the examination. RX 1, p. 10. She prepared a report after examining Petitioner. Weber Dep Exh 2. The report reflects that Petitioner told her he was inside a refrigerator, stocking supplies, when a co-worker who was backing up a forklift struck him from behind, knocking him approximately ten feet. Petitioner reported landing on his side. He indicated the forklift continued to move and ran over his feet and ankles. RX 1, p. 11. Petitioner told her he sustained a "bad ankle fracture." RX 1, p. 12. He also informed her that he wore a CAM boot for two to three months, underwent physical therapy for his ankle and took medication. RX 1, p. 12.

Dr. Weber testified that, based on her report, Petitioner told her he began experiencing low back pain and right-sided radicular complaints two to three days after the accident. Petitioner reported having seen Dr. Wojewnik at Loyola, with that physician recommending a lumbar spine MRI and possibly a lumbar epidural steroid injection. RX 1, p. 13.

Dr. Weber testified she reviewed records from Occupational Health Centers, Dr. Mica, Dr. Schiffman and Dr. Wojewnik in connection with her examination. She also reviewed various physical therapy and work conditioning notes. RX 1, pp. 14-17.

Dr. Weber testified that Petitioner complained of 9/10 right-sided lower back pain in a right L5 distribution, right leg pain and numbness, ankle pain aggravated by standing and walking and left toe pain. Petitioner had a "significant antalgic gait." Dr. Weber testified she noticed "obvious tan lines consistent with wearing flip-flops." RX 1, p. 18. Petitioner was tender on the right Achilles distally, the anterior talofibular ligament and the talar dome. His left ankle was tender at the Achilles, talar dome and great toe on the top. Petitioner's ankle motion was equal bilaterally. He displayed weakness with dorsiflexion, plantar flexion, inversion and eversion bilaterally. He complained of pain with talar tilt on the right but not the left. The Tinel's sign was negative. Petitioner exhibited a reduced range of lumbar spine motion in all directions. Dr. Weber testified that, when she raised Petitioner's right leg to ten degrees, Petitioner complained of lower back pain and neck cracking. She noted voluntary giving way on strength testing. Petitioner was able to heel raise and toe tap without any obvious deficit. This did not correlate with the manual test results. Sensation was intact and reflexes were normal. RX 1, pp. 17-21.

Dr. Weber testified that range of motion results are subjective in nature in that a patient can voluntarily do a lot of range of motion or not. Petitioner's complaint of neck cracking with straight leg raising was non-physiological. The giving way on strength testing was also non-physiological. RX 1, p. 23.

Dr. Weber testified she obtained lumbar spine X-rays in her office. The films showed some mild narrowing in the L5-S1 disc space and no abnormal motion with flexion-extension views. RX 1, p. 25. The mild narrowing was a degenerative finding. RX 1, p. 26. She also obtained weightbearing ankle X-rays. The only thing she noted on the films was a "small, old medial malleolus avulsion fracture, which is just a fleck of bone that comes off." The films also showed some calcification at the insertion of both of the Achilles tendons. That calcification is a pre-existing finding. RX 1, pp. 26-27.

Dr. Weber testified that she diagnosed Petitioner with a right medial malleolus avulsion fracture, which had healed, a left ankle contusion and non-specific lower back pain. She found a causal

relationship between the work accident and the avulsion fracture. She also found causation as to the left ankle contusion, which had resolved. RX 1, p. 27.

Dr. Weber did not find any causal relationship between the work accident and the claimed lower back condition because Petitioner "did not report any back complaints at the time [of the accident] or shortly thereafter." The first report of back pain appears in the records about two to three months after the accident. She opined that Petitioner did not require any additional ankle or back treatment. If Petitioner continued to complain of back pain, any treatment for that pain would not be related to the work accident. RX 1, p. 28. In her opinion, Petitioner was at maximum medical improvement. RX 1, p. 29. She saw no need for work restrictions with respect to the ankles or back. RX 1, p. 29.

Under cross-examination, Dr. Weber testified she did not perform any residencies or undergo any fellowship training in spine surgery. She has "scrubbed in on" one back surgery during her career. RX 1, p. 30. If she saw a patient who needed spine surgery, she would refer that patient to one of the surgeons in her practice. RX 1, p. 31. She never reviewed Petitioner's lumbar spine MRI images. RX 1, p. 31. She is aware that Dr. Schiffman specializes in foot and ankle problems. RX 1, p. 31. The first mention of back pain she saw in Petitioner's records was Dr. Schiffman's note from late April 2016. If a trier of fact found that Petitioner had back pain shortly after the work accident, that could cause her causation opinion to change, depending on the mechanism of injury and the timing of the report of pain. RX 1, p. 32. Typically, if a person injures his back, without any head injury, you would expect the patient to report back pain within a few days of the incident. Even giving the benefit of the doubt, you would expect complaints within seven to ten days. RX 1, p. 33. On average, she performs between zero and six independent medical examinations per week. Her practice charges for those examinations and for deposition time. She does not know how much her practice charges. Most, if not all, of the examinations she performs are for employers or insurance carriers. RX 1, p. 34.

Petitioner testified he continues to experience low back pain and leg swelling. He uses a cane while walking because otherwise his leg problems would cause him to lose his balance. He has undergone cervical spine surgery. He is currently receiving Social Security disability benefits. T. 26.

Under cross-examination, Petitioner acknowledged that his Application for Adjustment of Claim reflects he was single and had one dependent as December 8, 2015. T. 27. He has a son named Alex Jr. He does not know his son's exact age. He thinks his son turned twenty in March. T. 27-28. As of December 8, 2015, his son lived with his (Petitioner's) brother. His brother paid for the son's living expenses. [At this point in the hearing, Respondent's counsel indicated he was disputing Petitioner's claim of a dependent son, indicating that the permanency rate would be affected if Petitioner in fact did not have a dependent as of the accident. The Arbitrator indicated the parties could address the issue of dependency in their proposed findings. T. 28-29.] Petitioner testified he was honest with all of his medical providers with respect to his symptoms and the location of his pain. He had no reason to lie to his providers. T. 32. When he first saw Dr. Wojewnik, in June 2016, he told him he developed back pain a few days after the December 8, 2015 work accident. T. 32-33. When he went to Concentra on the day of the accident, he relayed all of his symptoms. He indicated he was experiencing pain in both feet that had started four hours earlier, when he was struck by a forklift. T. 33. On that day, he underwent X-rays of his feet and ankles. He does not recall undergoing any low back X-rays that day. T. 34-35. He agreed that the initial Concentra records do not mention any low back complaints. At the initial visit, he was given a CAM boot and crutches. T. 35-36. When he went to Concentra on December 31, 2015, he complained that the CAM boot was causing his pain to worsen. T. 37. He was told to discontinue the boot. T. 37. If the records dated December 31, 2015 do not mention any low back pain, the records are

incorrect. If the records dated January 21, 2016 do not mention any low back pain, those records are also incorrect. T. 37-38. It was on the third day after the accident that he began complaining of low back and leg pain but "they [didn't] want to listen." T. 37, 40. At the time of the accident, he was working inside a big freezer that was "foggy." T. 40-41. A co-worker operating a forklift entered the freezer. The co-worker put some freight on the second rack. The co-worker then "reversed real fast," near where Petitioner was working. Petitioner screamed but the co-worker, who was using a Walkman and listening to music, did not hear him. T. 42. The forklift "[kept] on coming." T. 41. Petitioner testified he was facing a rack at that point. The forklift was coming from his left, in reverse. T. 44. At Concentra, he told the medical providers that the forklift ran over him. T. 45. At the Emergency Room, he said he had been run over. When he saw Dr. Wojewnik, he told him he fell a significant distance backwards after being struck. T. 45-46. When he saw Dr. Weber, he told her he was knocked ten feet backwards. T. 46. Before his back surgery, he reported having been struck in the back by a forklift. T. 46. At Concentra, on March 17, 2016, he indicated his foot pain had returned. They injected his foot. He went to Gottlieb the next day, due to his foot pain. At Gottlieb, he complained of foot pain. T. 47. At that point he was experiencing pain in his foot and back. T. 48. Personnel at Gottlieb referred him to Dr. Schiffman. When he saw Dr. Schiffman, on March 31, 2016, he complained of low back pain. At the next visit, on April 28, 2016, he told Dr. Schiffman his right ankle was feeling a lot better. He does not remember the doctor discharging him from care for his ankle. T. 49. Dr. Schiffman referred him to Dr. Wojewnik for his back. T. 50. He sees Dr. Cabrera, his family physician, for various health conditions, including hypertension. T. 50-51. In June 2016, prior to his back surgery, he told Dr. Cabrera his low back pain was a chronic issue. T. 51. He did not undergo physical therapy following his back surgery because it was not authorized. He did not ask the attorney who was then representing him where else he could go to undergo therapy. T. 53. He uses a cane for balance because he has pain and pressure in his low back. His legs are sometimes numb. T. 54. After the surgery, he initially used a walker. T. 55. Since discontinuing the walker, he has always used a cane. T. 54. He underwent neck surgery after the September 2018 motor vehicle accident. His pain was much worse after the motor vehicle accident. T. 56.

On redirect, Petitioner testified that, during the time his son lived with his brother, the arrangement was not pursuant to any legal order. T. 57. He last saw Dr. Schiffman on May 9, 2016, not April 28, 2016. The doctor told him there was nothing more he could do for the ankle condition but he should see someone for his back. T. 57-58. Following his surgery, he eventually qualified for Medicare. He uses his cane "all the time", even when he is inside his house.

Under re-cross, Petitioner testified he cannot recall exactly when he obtained Medicare coverage but it was approximately five years ago, before the work accident. T. 61.

Arbitrator's Credibility Assessment

Petitioner was a nervous, excitable witness. He is not fluent in English and occasionally had trouble making himself understood. Even after factoring this in, the Arbitrator had difficulty with his overall credibility. For example, his testimony concerning the mechanics of the December 8, 2015 accident is at odds with the accounts he provided to treating physicians and Dr. Weber. He testified he fell after being struck but his initial records contain no mention of a fall. He also testified he began relaying back and leg complaints to his providers about three days after the accident. The first note reflecting such complaints is dated February 4, 2016. Additionally, Petitioner insisted that, ever since he stopped using a walker, following his July 2016 back surgery, he has "always" used a cane, even when inside or near his home. Respondent's February 2018 surveillance footage, while brief, tells a different

story. That footage shows Petitioner exiting his home, driving to different locations, returning home and then raking and carrying a five-gallon bucket outside his home. It is only near the end that Petitioner can be seen walking with a cane. RX 1, 3.

The Arbitrator finds Respondent's examiner, Dr. Weber, more persuasive than Dr. Wojewnik on the issue of causation. Dr. Weber, unlike Dr. Wojewnik, conducted an extensive records review. She recognized that there was a delay in the recording of back complaints, although her timeline was flawed. She testified that the first mention of back complaints in Petitioner's records was Dr. Schiffman's note of April 28, 2016. In fact, a physical therapist clearly documented complaints of back and hip pain on February 4, 2016.

Dr. Wojewnik, in contrast, based his causation opinion solely on Petitioner's history. He assumed that Petitioner "fell a distance backwards" after being struck and that his leg and back complaints started within a few days of the accident. He acknowledged he did not review any treatment records pre-dating his initial, June 8, 2016 visit with Petitioner. Had he read those records, he would have seen that no fall is documented initially and that it was not until February 4, 2016, almost two months after the accident, that a provider documented back complaints. [Petitioner argues that radicular-type symptoms were noted earlier, in January 2016. Dr. Wojewnik, however, never expressed this opinion, having failed to review any records pre-dating June 8, 2016.]

Arbitrator's Conclusions of Law

<u>Did Petitioner establish a causal connection between the accident of December 8, 2015 and his current lower back condition of ill-being?</u>

The Arbitrator finds that Petitioner failed to establish causation as to his claimed lower back condition of ill-being. In so finding, the Arbitrator relies primarily on the initial treatment records, which do not document a fall or leg or back complaints. The Arbitrator again notes that it was not until February 4, 2016, almost two months after the accident, that a provider recorded a complaint of back pain. Even Petitioner's family physician, Dr. Cabrera, who saw Petitioner only six days after the accident, did not note any back or leg problems. Dr. Wojewnik, who ultimately operated on Petitioner's lumbar spine, based his causation opinion solely on Petitioner's history of having fallen a significant distance and developing leg and back symptoms shortly after the accident. This history is faulty.

<u>Is Petitioner entitled to reasonable and necessary medical expenses?</u>

Petitioner claims $2,333.50 in unpaid medical bills. PX 1. One of these bills is a $15.00 charge for a May 15, 2018 office visit to Dr. Cabrera. Petitioner saw Dr. Cabrera for back and neck pain as well as hypertension. PX 3, pp. 71-83. The Arbitrator has previously found that Petitioner failed to establish causation as to his back. The remaining bills also relate to treatment of Petitioner's disputed back condition. The Arbitrator declines to award the claimed $2,333.50.

Petitioner also seeks a hold harmless agreement with respect to the Equian lien for expenses paid by Medicaid. PX 8. Most of these expenses relate to lumbar spine treatment. The Arbitrator has previously found that Petitioner failed to establish causation as to this condition. The Arbitrator directs Respondent to hold Petitioner harmless against the $24.20, $14.35 and $68.36 payments made to providers who treated Petitioner's causally related foot/ankle condition. PX 8, p. 7.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from December 9, 2015 through September 14, 2016, the date of his last visit to Dr. Wojewnik. The parties agree that Respondent paid $8,131.12 in temporary total disability benefits. Arb Exh 1.

As noted earlier, Respondent does not dispute accident or causation insofar as Petitioner's foot and ankle problems are concerned. Petitioner last underwent treatment for these problems on May 9, 2016, at which point Dr. Schiffman noted no ankle abnormalities on examination. Dr. Schiffman referred Petitioner to Dr. Wojewnik for evaluation of his back pain and radicular complaints. The Arbitrator has previously found that Petitioner failed to establish causation as to his claimed lumbar spine condition. When Dr. Weber examined Petitioner on June 27, 2016, she concluded that Petitioner's avulsion fracture had resolved, that he was at maximum medical improvement with respect to his foot/ankle condition and that he required no work restrictions.

The Arbitrator finds that Petitioner was temporarily totally disabled from December 9, 2015 through June 27, 2016, a period of 28 6/7 weeks, with Respondent receiving credit for its stipulated payment of $8,131.12.

What is the nature and extent of the injury? What is Petitioner's permanency rate?

Respondent did not dispute causation insofar as Petitioner's foot/ankle condition is concerned. The records reflect that Petitioner initially complained of right foot/ankle and left ankle and great toe pain. Right ankle X-rays performed in December 2015 showed a small avulsion fracture at the tip of the right medial malleolus. In June 2016, Respondent's examiner obtained three weightbearing views of both ankles. She indicated that the right-sided films showed an old medial malleolus avulsion fracture. She opined that the accident caused the fracture as well as a left ankle contusion. She viewed the fracture as having healed. RX 1.

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. This section sets forth five factors to be considered in determining the nature and extent of an injury, with no single factor predominating. The Arbitrator assigns no weight to the first factor, any AMA Guides impairment rating, since neither party offered such a rating into evidence. The Arbitrator gives some weight to the second and third factors, Petitioner's age at the time of the accident and occupation. Petitioner was a 41-year-old warehouse worker as of the December 8, 2015 accident. The Arbitrator views him as a younger individual who, from a statistical perspective, could be expected to remain in the workforce for at least twenty more years. The Arbitrator also assigns some weight to the fourth factor, future earning capacity. There is no evidence suggesting that Petitioner's foot/ankle condition affected his earnings. When Dr. Schiffman last evaluated this condition, in April and May 2016, he noted no right ankle abnormalities on examination. While Petitioner testified he is currently receiving Social Security disability benefits, there is no evidence indicating that the award of these benefits stems from the foot/ankle condition. Petitioner underwent lumbar spine surgery in 2016 and cervical spine surgery the following year. The Arbitrator has found that Petitioner failed to establish causation as to his lumbar spine. Dr. Wojewnik declined to express any causation opinion relative to the cervical spine. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator notes the December 2015 and March 2016 right ankle X-ray results along with the examination findings of Drs. Poepping and Schiffman.

The Arbitrator, having considered the foregoing, finds that Petitioner established permanency equivalent to 12.5% loss of use of the right foot, representing 20.875 weeks of compensation under Section 8(e) of the Act. [The Arbitrator declines to award any permanency for the resolved left foot contusion.] The Arbitrator awards these benefits at the applicable minimal permanency rate of $253.00 per week. Petitioner testified he was single, with one dependent son, at the time of the accident. While he acknowledged that his son lived with his brother as of the accident, he clarified on redirect that this arrangement was not pursuant to any court order. The Arbitrator, taking guidance from Section 7, concludes that Petitioner was still "legally obligated to support" his son as of the accident, despite the informal living arrangement. The Arbitrator views the son as a dependent under the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC014162
Case Name	STEELE, RHONDA v. METRO LINK
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0080
Number of Pages of Decision	17
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Kenneth Capps

DATE FILED: 3/7/2022

/s/Thomas Tyrrell, Commissioner

Signature

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MADISON)	☐ 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

Rhonda Steele,

Petitioner,

vs. NO: 19 WC 014162

Metro/Bi-State Development Agency,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering causal connection, medical expenses, prospective medical treatment, and temporary total disability ("TTD") benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission reverses the Arbitrator's conclusion that Petitioner's current condition of ill-being is causally related to the work accident and requires prospective medical care. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner is a light rail operator for MetroLink. Surveillance video confirms that Petitioner sustained an accident on April 16, 2019, when she made an emergency stop due to a truck blocking the tracks. While the Commission affirms the Arbitrator's Decision that Petitioner sustained an accident that arose out of and in the course of her employment, the Commission views the severity of this incident differently.

Petitioner described this incident as "a very abrupt, hard stop." However, the surveillance video does not support this claim, nor the Arbitrator's conclusion that Petitioner's "head moved freely, causing her head to jerk forward and back twice." A plain viewing of the video shows the train come to a steady stop with very little movement, let alone jerking or snapping of her neck.

Following the accident, Petitioner presented to Multicare Specialists, P.C., on April 18, 2019. She reported the train stopped very abruptly and while she was able to brace herself, she did lunge forward from the stop. However, the video footage shows Petitioner barely moved as the train came to a halt.

Petitioner had a significant pre-existing condition. She testified to experiencing four to five out of ten pain prior to the accident on April 16, 2019. She was already limiting her shifts due to this pain, working the "extra-board" versus being assigned a regular run five days a week. During her testimony, Petitioner was unable to identify any change in her condition other than increased intensity of her pain.

The Commission is not persuaded by the opinion of Dr. Lee. As stated above, the Commission disagrees that the video of the incident shows "sufficient force" to have caused structural changes to Petitioner's cervical spine. Further, Dr. Lee's opinion regarding the cause of these structural changes is based upon an inaccurate history provided by Petitioner that there was "new onset" of symptoms. The record reflects that Petitioner had a history of neck pain radiating with numbness and tingling down the arm to the hand in 2015 and 2016. The record also reflects that Petitioner had a history of low back pain radiating down her legs in 2016.

The Commission finds Dr. Mirkin's analysis of the video as "not anything violent or severe" more credible. The Commission disagrees that Dr. Mirkin was biased from his prior 2016 Section 12 Examination, as he readily admitted he did not find any symptom magnification in 2019, compared to 2016. Dr. Mirkin's physical examination of Petitioner on July 29, 2019 was normal, apart from some complaints of mild tenderness to palpation. Provocative testing maneuvers were negative for nerve compression. Range of motion and neurologic examination were normal. Dr. Mirkin testified that it would be virtually impossible for this sort of incident to cause any significant injury or pathology. The evidence supports Dr. Mirkin's opinion that Petitioner sustained a transient aggravation of her pre-existing condition.

After considering the totality of the evidence, the Commission reverses the Arbitrator's conclusion that Petitioner met her burden of proving her current condition of ill-being is causally related to the April 16, 2019, work accident. The credible evidence shows that Petitioner sustained a temporary aggravation of her pre-existing condition and reached maximum medical improvement on July 29, 2019.

The Commission also vacates the Arbitrator's award of medical expenses and prospective medical treatment. The Commission finds that Petitioner is entitled to medical expenses through July 29, 2019.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 2, 2020, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being **is not** causally related to the April 16, 2019, work accident. Petitioner sustained a temporary aggravation of her pre-existing condition which reached maximum medical improvement on July 29, 2019.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $640.00/week for 6 weeks, commencing April 18, 2019 through May 28,

2019, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges incurred through July 29, 2019, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,900.00. 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.

March 7, 2022

o: 1/11/2022
TJT/ahs
51

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 22IWCC0080

NOTICE OF 19(b) ARBITRATOR DECISION

STEELE, RHONDA Case# **19WC014162**

Employee/Petitioner

METRO/BI-STATE DEVELOPMENT AGENCY

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:

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

0180 EVANS & DIXON LLC
KENNETH C CAPPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

- [ ] 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)

Rhonda Steele
Employee/Petitioner
v.
Metro/Bi-State Development Agency
Employer/Respondent

Case # **19** WC **14162**

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 **Jeanne AuBuchon**, Arbitrator of the Commission, in the city of **Collinsville**, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **April 16, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,920.00**; the average weekly wage was $**960.00**

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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 is ordered to pay Petitioner temporary total disability benefits pursuant to Section 8(b) of the Act for 6 weeks, from 4/18/19 through 5/28/19.

Respondent is ordered to pay the medical expenses contained in Petitioners Exhibit 6 pursuant to Section 8(a) of the Act and in accordance with the Medical Fee Schedule (Section 8.2) The Respondent shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

Respondent shall authorize and pay for the prospective treatment recommended by Dr. Lee.

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

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

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

Signature of Arbitrator

11/24/20
Date

DEC 2 - 2020

PROCEDURAL HISTORY

This matter proceeded to trial on October 28, 2020, pursuant to Sections 19(b) and 8(a) if the Illinois Workers' Compensation Act (hereinafter "the Act"). The issues in dispute are: 1) whether the Petitioner sustained accidental injuries that arose out of and in the course of her employment; 2) the causal connection between the accident and the Petitioner's cervical spine condition; 3) payment of medical bills; 4) entitlement to prospective medical care to the Petitioner's cervical spine; and 5) entitlement to TTD benefits from April 18, 2019 through May 28, 2019.

FINDINGS OF FACT

The Petitioner is employed by the Respondent, Metro/Bi-State Development Agency, as a MetroLink light rail operator. (T. 13) On April 16, 2019, she was operating a light rail train when she saw a truck on the rails and hit the emergency button to stop the train. Id. The train was traveling at 45 to 50 mph prior to the stop. (T. 15-16) The Petitioner testified that she braced herself and described the stop as being abrupt and hard. (T. 15) She said she immediately felt pain down the side of her jaw and in her neck, shoulders and back. (T. 17).

At arbitration, the Arbitrator viewed a video of the incident. It showed the Petitioner operating the train, a truck on the tracks ahead, the Petitioner pushing the emergency button and the train coming to a stop. (PX8) When the train stopped, the Petitioner's head jerked forward and back twice. *Id.* The Petitioner testified that she did not finish her shift after the accident but went to Barnes-Jewish Hospital. (T. 17-18) She left before being treated. *Id.*

The Arbitrator notes that because the disputed issues in this case concern the Petitioner's cervical spine, the findings and analysis herein will concentrate on that area of the body.

The Petitioner went to Multicare Specialists and saw Dr. Jonathon Brooks, a chiropractor, on April 18, 2019. (PX1) She complained of neck pain, headaches, mid back pain, low back pain, pain radiating into both legs and numbness in both legs. *Id.* Dr. Brooks believed the Petitioner may have been suffering from cervical disc protrusion, thoracic strain, lumbar disc protrusion, and right and left shoulder rotator cuff strain. *Id.* He recommended physical therapy and MRIs of the cervical and lumbar spine. *Id.* He recommended that the Petitioner remain off work, no lifting greater than 10 pounds, no repetitive lifting or bending and no pushing, pulling or climbing. *Id.* The Petitioner underwent physical therapy that day at Multicare Specialists with Corey Voss, a physical therapist. *Id.* She also had x-rays that were read by Dr. Kevin Bell, who found a cervical reversed curve, among other findings. *Id.*

On April 22, 2019, the Petitioner returned to Multicare Specialists, where Dr. Brooks noted no change in her condition. *Id.* The Petitioner had another physical therapy session that day. *Id.*

Dr. Brooks had the MRI results on the Petitioner's next visit on April 24, 2019. *Id.* Dr. Brooks said the MRI of the cervical spine revealed a small central right disc protrusion at C2-3, central right foraminal encroachment at C3-4 and C4-5, central left foraminal stenosis at C5-6 with protrusion, mild right foraminal stenosis at C3-4 and C4-5 and mild left foraminal stenosis at C5-6. *Id.* He noted no central canal stenosis at any level. *Id.* Dr. Brooks directed the Petitioner to continue physical therapy and referred her to Dr. Matthew Gornet. *Id.* Later, he referred her to Dr. Thomas Lee. *Id.* The Petitioner had eight additional physical therapy sessions from April 25, 2019, through May 20, 2019, and five sessions from July 18, 2019 through September 26, 2019. *Id.*

The Petitioner saw Dr. Lee on May 14, 2019. (PX2). She gave him a history of the accident, described her symptoms and a history of prior injuries. *Id.* At arbitration, the Petitioner

was very unsure of the details of her prior accidents and treatment. (T. 31-36) The Arbitrator summarizes those injuries as follows:

April 11, 2012 (RX3)
- Neck and shoulder pain after emergency stop while operating train
- Diagnosed with neck sprain
- Physical therapy
- Released with no restrictions May 7, 2012, but still experiencing aching pain

November 16, 2014
- Left shoulder, neck, arm and back pain after slip and fall on snowy terrain at work
- Initially diagnosed with shoulder sprain and later cervical and lumber strain
- Physical therapy, medications and trigger point injections
- Released with no restrictions January 19, 2015
- Further treatment (injections) beginning March 16, 2015
- Released with no restrictions June 2, 2015
- Further treatment (medications and strengthening exercises) September 28, 2015

February 2016
- Neck and low back pain after fall in yard at work
- Diagnosed August 22, 2016, with aggravation of underlying cervical and lumbar condition with new shoulder injury
- Lumbar surgery recommended
- Dr. Mirkin Section 12 exam found no need for surgery and return to work without restrictions

July 15, 2017
- Left upper extremity and mid and low back pain due to back and forth motion of train
- Diagnosed with low back pain, unspecified sprain of left shoulder joint and other muscle spasm
- Physical therapy
- No work restrictions

There was no evidence produced of any incidents or injuries to the Petitioner's cervical spine between August 2016 and April 2019.

At the Petitioner's first visit with Dr. Lee on May 14, 2019, Dr. Lee reviewed MRIs from April 23, 2019, and September 14, 2016, as well as cervical spine x-rays from May 14, 2019. (PX2). On the MRIs, he noted that the newer MRI showed disc protrusions on the right that are

significantly increased above the convexities seen on the prior MRI. *Id.* On the cervical spine x-rays, Dr. Lee noted mild spondylosis change at C6-7 and patent neural foramina. *Id.* He diagnosed herniation of the nucleus pulpopus (herniated discs) at C3-4, C4-5 and C5-6 with protrusion at C6-7. *Id.* He prescribed Meloxicam and Tizanidine and continued physical therapy and ordered the Petitioner off work. *Id.*

Dr. Matthew Ruyle performed and read the April 23, 2019, MRI, and Dr. David Wu performed and read the September 14, 2016, MRI. (PX5) In 2016, Dr. Wu found straightening of cervical lordosis and multilevel disc desiccation with facet arthropathy throughout the cervical spine. *Id.* He did not find spinal cord edema or demyelination. *Id.* He noted mild disc bulges without spinal canal or foraminal stenosis at all levels of the cervical spine. *Id.* In 2019, Dr. Ruyle found and measured disc protrusions at C2-3, C3-4, C4-5 and C5-6 – the largest being at C4-5 and C5-6. *Id.* He also found mild right foraminal stenosis at C3-4 and C4-5 and mild left foraminal stenosis at C5-6. *Id.*

The Petitioner testified that she returned to work on May 29, 2019, against Dr. Lee's orders because the Respondent did not pay her to be off work in compliance with Dr. Lee's orders and because the Respondent did not pay her medical bills and refused to authorize medical care. (T. 21).

On July 2, 2019, the Petitioner returned to Dr. Lee and complained of continuing pain in her neck and across her shoulders. (PX2). Dr. Lee prescribed an epidural injunction at C4-5 with C5-6 being a secondary level consideration. *Id.* Dr. Helen Blake administered the injection on October 8, 2019. (PX7).

Dr. Lee testified by way of deposition on December 10, 2019. (PX3) His testimony was consistent with his reports. (PX3, PX2). He testified to differences he saw in the MRIs of

September 14, 2016, and April 23, 2019, and pointed out those differences on the scans. (PX3 at 9-14 and Petitioner's deposition exhibits 3-6). He stated that on the films of C5-6 he found the amount of spinal fluid in front of the spinal canal between the disc was notably narrower and that the disc surface had more curvature in the later study. *Id.* In addition, he found an annular tear that was not present on the earlier study. *Id.* He believed the changes were acute in nature. (PX3 at 11-12) On the side view studies (Petitioner's deposition exhibits 5 and 6), Dr. Lee noted more of a peaked appearance to the discs at C3-4, C4-5 and C5-6 on the 2019 MRI than on the 2016 MRI. (PX3 at 14) He stated that these findings are consistent with the acute injury the Petitioner described to him than with a degenerative condition. *Id.* at 15. He also noted that the pathology he saw was not associated with bone spurs that often occur more with a degenerative process. *Id.*

Later, Dr. Lee observed the video of the incident (PX8). His report of May 21, 2020, stated that he observed the Petitioner press the brake button with her right hand, then brace herself. (PX4) He noted that her head and neck snap back and forth twice as the train came to a halt. *Id.* Dr. Lee wrote that the video does demonstrate a mechanism with sufficient force to have caused the findings on the most recent MRI. *Id.*

Dr. Peter Mirkin saw the Petitioner on July 29, 2019, for an examination pursuant to Section 12 of the Act. He previously conducted a Section 12 examination of the Petitioner on November 28, 2016, after the Petitioner's reported fall at work. The Arbitrator notes that Dr. Mirkin's reports were not submitted at arbitration as separate exhibits but as attachments to Dr. Mirkin's deposition. (RX1)

In his November 28, 2016, report, Dr. Mirkin stated that he reviewed x-rays of the Petitioner's cervical spine and found minimal spondylosis. (RX1, Respondent's deposition exhibit 2). He reviewed an MRI scan of the cervical spine dated January 13, 2015, and found degenerative

disc bulging, most severe in the mid cervical spine. *Id.* his impression was that the Petitioner has severe symptom magnification behavior and noted that her cervical radiographic studies were normal. *Id.*

In his July 29, 2019, report, Dr. Mirkin stated that he reviewed x-rays and an MRI report of the Petitioner's cervical spine. (RX1, Respondent's deposition exhibit 3). His findings from the x-rays were identical to his findings on November 28, 2016. *Id.* He said the MRI revealed spondylitic disease in the cervical spine at multiple levels without any central stenosis. *Id.* Dr. Mirkin stated that the Petitioner may have had a transient aggravation of her pre-existing condition. Id. He saw no indication for surgery or epidural injections. *Id.*

Dr. Mirkin viewed the video of the incident of April 16, 2019, and authored a letter stating he saw no evidence of trauma and that it would be virtually impossible for that sort of incident to cause any significant injury or pathology. Again, this letter was not submitted at arbitration as a separate exhibit, but as an attachment to Dr. Mirkin's deposition – Respondent's deposition exhibit 4.

Dr. Mirkin testified by way of deposition on January 10, 2020. (RX1) He testified consistently with his reports and letter, maintaining his opinion that it would be virtually impossible for the incident to have caused significant injury. *Id.*

CONCLUSIONS OF LAW

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

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

The video of the April 16, 2019 incident (PX8), shows the Petitioner operating the train and making an emergency stop. Although it appears she braced her body, her head moved freely. causing her head to jerk forward and back twice. Therefore, the Arbitrator finds that an accident did occur that arose out of and in the course of the Petitioner's employment.

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

An accident need not be the sole or primary cause as long as employment is a cause of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n,* 371 ILL. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill. 2d 30, 36 (1982).

The array of medical records show that the Petitioner had prior injuries to and degenerative conditions of her cervical spine and other body parts. The question is whether the incident on April 16, 2019, was a cause or aggravation of her current cervical condition.

Dr. Mirkin's opinion appears to be tainted by his previous encounter with the Petitioner. On the other hand, Dr. Lee provided a fresh perspective on the Petitioner's condition. Dr. Mirkin appears to have a "boy who cried wolf" mentality when it comes to the Petitioner's complaints. But the moral to that story is that the wolf eventually ate the boy.

Dr. Lee's opinions are more persuasive. He conducted detailed comparisons of the imaging studies and found marked differences between the studies conducted in 2016 and 2019. The only injuries the Petitioner suffered between those studies was exacerbation of her lower back condition in 2017. Dr. Lee believes the changes in the studies are acute rather than chronic. A comparison

of Dr. Wu's and Dr. Ruyle's imaging reports also appear to back up Dr. Lee's opinion. Dr. Wu noted only minor disc bulging in 2016, while Dr. Ruyle found measurable protrusions in 2019.

Therefore, the Arbitrator finds that the Petitioner's current cervical condition is causally related to the accident of April 16, 2019.

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

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 383, 902 N.E.2d 1269, 1273 (2009).

Faced with the facts surrounding the accident, including the video, and his comparison of prior and current imaging studies, it was reasonable for Dr. Lee to treat the Petitioner and order testing, physical therapy and injections. The Respondent has not paid for these medical services.

The Arbitrator orders the Respondent to pay the medical expenses contained in Petitioner's Exhibit 6 pursuant to Section 8(a) of the Act and in accordance with medical fee schedules. The Respondent shall have credit for any amounts already paid or paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

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).

The Petitioner quit treating and went back to work as a result of the Respondent's refusal to provide continuing medical care as recommended by Dr. Lee. She is entitled to further treatment by Dr. Lee and by practitioners to whom he refers the Petititioner. Her condition had not stabilized nor had she otherwise reached maximum medical improvement. Dr. Lee believes further treatment is necessary.

The Arbitrator finds that the Petitioner is entitled to prospective medical care, specifically further evaluation and execution of a treatment plan, as recommended by Dr. Lee, and the Respondent shall authorize and pay for such care.

<u>Issue (L)</u>: What temporary benefits are in dispute? (TTD)

The parties dispute temporary total disability benefits for the period of April 18, 2019, through May 28, 2019. An employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990).

As a result of the accident, both Dr. Brooks and Dr. Lee took the Petitioner off work. Dr. Although the Petitioner's return to work seemed to be more out of necessity than due to achieving maximum medical improvement, Dr. Lee did allow it. Therefore, the Petitioner is entitled to temporary total disability benefits pursuant to Section 8(b) of the Act for six weeks, from April 18, 2918, through May 28, 2019.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC016620
Case Name	RAY, BETH v. STATE OF ILLINOIS - MCFARLAND MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0081
Number of Pages of Decision	10
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Katherine Perry
Respondent Attorney	Suzanne Borland

DATE FILED: 3/8/2022

/s/Christopher Harris, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BETH RAY,

Petitioner,

vs. NO: 19 WC 16620

STATE OF ILLINOIS/
MCFARLAND MENTAL HEALTH CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 2021 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

March 8, 2022
CAH/pm
D: 3/3/2022
052

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC016620
Case Name	RAY, BETH v. STATE OF ILLINOIS/ MCFARLAND MENTAL HEALTH CENTER
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	Katherine Perry
Respondent Attorney	Richard Glisson

DATE FILED: 9/20/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 14, 2021 0.05%

/s/Dennis OBrien, Arbitrator
Signature

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

September 20, 2021

/s/ Brendon O'Rourke
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Beth Ray
Employee/Petitioner

v.

State of Illinois/McFarland Mental Health Center
Employer/Respondent

Case # **19** WC **016620**

Consolidated cases: ______

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **June 28, 2021**. By stipulation, the parties agree:

On the date of accident, **04/12/2019**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**199,600**, and the average weekly wage was $**2,300.00**.

At the time of injury, Petitioner was **52** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**33,579.51** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**33,579.51**.

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

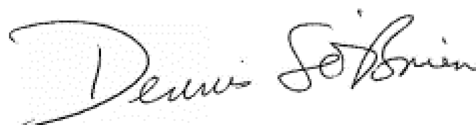
ORDER

Respondent shall pay Petitioner the sum of $**813.87**/week for a further period of **37.625** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **a 17 1/2 % loss of the right leg**.

By agreement of the parties, Respondent shall pay any and all reasonable and necessary medical expenses, as set forth in Petitioner's Exhibit 7, directly to the providers, according to the fee schedule, pursuant to Section 8.2 of the Act. Further, the Respondent shall receive a credit for any and all medical expenses paid by Petitioner's group health insurer, Healthlink, or any other group health insurance plan Petitioner received as part of her employment with Respondent.

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

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



Signature of Arbitrator

SEPTEMBER 20, 2021

ICArbDecN&E p.2

Beth Ray vs. State of Illinois/McFarland Mental Health Center 19 WC 016620

FINDINGS OF FACT

The Petitioner is currently a 53-year-old Registered Nurse employed by the Respondent to provided nursing services to mental health patients at its facility. The Petitioner received an Associates Degree in Nursing at Lincoln Land Community College in approximately 1997. She has been employed by the Respondent for over eleven years. Prior to becoming employed by the Respondent, the Petitioner worked at St. John's Hospital in the ICU and PACU, and had previously provided nursing home and home healthcare as an LPN.

On April 12, 2019, Petitioner was working a double shift for Respondent in Stevenson Hall. Respondent's facility has two types of units: civilian and forensic. Civilian units house and treat individuals who have been placed in their care following a civil commitment hearing. Forensic units house and treat individuals who have been court ordered into treatment after being found unfit to stand trial or not guilty by reason of insanity. Stevenson Hall is a civilian unit. During her 3:00 p.m. to 11:00 p.m. shift on April 12, 2019, Petitioner was passing medications when a patient started "going off trying to hit people and screaming and yelling." A code was called by one of the other nurses, which indicated that all employees needed to respond to assist in restraining the patient. Petitioner, along with the nurse manager and an on-unit security guard were the first to reach the patient and began the "take down" procedure to restrain the patient. Petitioner explained that during the process of restraining the patient, the patient was fighting and she and other employees moved around him, trying to hold down his limbs. Once the patient was subdued, Petitioner attempted to stand up from the ground and was unable to do so due to pain in her right knee. Petitioner leaned on a co-worker and was able to make it to her feet, but continued to have pain and limped with walking.

On April 16, 2019, Petitioner presented to the Springfield Clinic Ortho Walk-in Clinic for initial evaluation, where she was evaluated by Tara Jain, PA-C. Petitioner reported her pain was slightly better than initially after the accident, but that her knee hurt when she was on her feet. Exam of the right knee revealed tenderness to palpation over the medial joint line and medial meniscus. Petitioner further had mild pain with McMurray's test and valgus stress test at 30 degrees flexion. A right knee x-ray was ordered which revealed no fracture and mild joint effusion. PA-C Jain assessed Petitioner with right knee pain with concern for meniscal tear. Petitioner was instructed to use a hinged brace and was placed off work until April 19, 2019. She was further referred for physical therapy. Petitioner reported she was given a hinged knee brace, which she described spanned from mid-thigh to mid-calf and has a hinge so that the knee can only bend a certain amount.

The Petitioner subsequently transferred her care to the Orthopedic Center of Illinois and was seen by Nurse Practitioner (NP) Ryan Braner and Dr. Rodney Herrin on May 2, 2019. On exam, NP Braner noted grade 2 effusion on the right knee. Petitioner further exhibited stiffness in the knee due to swelling. She further had pain with palpation of the right medial joint line, lateral joint line, and patellofemoral joint. McMurray's test was positive on the right. X-rays of the right knee were taken in office which showed some mild medial compartment arthritic changes. NP Braner assessed right knee pain with concern for medial meniscus tear. NP Braner recommended an MRI of the right knee, discontinued physical therapy, and placed her off work until re-evaluation. Petitioner testified she was paid TTD benefits while she was restricted from work.

On May 8, 2019, Petitioner underwent an MRI of her right knee at Springfield MRI and Imaging Center. Px 2. The MRI revealed a horizontal tear of the posterior horn of the medial meniscus.

Petitioner was again evaluated by Dr. Herrin on May 16, 2019. Dr. Herrin examined Petitioner and reviewed her MRI. Based on the exam and imaging findings, Dr. Herrin recommended the Petitioner undergo a right knee arthroscopic medial menisectomy versus meniscus repair.

Prior to surgery Petitioner was required to undergo pre-operative testing, which was performed by Springfield Clinic on June 3, 2019. Due to abnormal findings on her EKG, Petitioner was referred to Cardiovascular consultants for further pre-operative work-up. She was seen by Andrea Bloodworth, APRN on June 12, 2019, and was ultimately cleared for surgery.

On June 14, 2019, Petitioner underwent a right knee arthroscopy with Dr. Herrin. The surgery confirmed a tear to the posterior horn of the medial meniscus, as well as some fraying of the central portion of the lateral meniscus. Dr. Herrin performed a partial medial meniscectomy.

Petitioner returned to NP Braner on June 20, 2019 for post-operative follow-up. She presented with some redness around her portal incisions without fever, chills, or drainage. Petitioner was prescribed Bactrim to address possible infection of the portal sites and was instructed to work on range of motion.

Petitioner continued to follow-up post-operatively with Dr. Herrin and NP Braner. On June 28, 2019, Dr. Herrin referred Petitioner for physical therapy. Petitioner underwent therapy at Athletico Physical Therapy. Petitioner was returned to work full duty by Dr. Herrin on August 1, 2019. Petitioner testified she was able to return to work for the Respondent at that time and had not returned to work previously.

Petitioner last saw Dr. Herrin on September 9, 2019. At that time, she reported doing better with physical therapy and working cautiously but at full duty. Physical examination of the knee was normal. Dr. Herrin instructed Petitioner to complete her course of physical therapy and subsequently continue home exercises. Dr. Herrin placed her at maximum medical improvement four weeks after September 9, 2019, or as of October 7, 2019. Petitioner testified that she completed her course of physical therapy and continued to perform home exercises for a period of time. She testified she does not continue to perform a home exercise program as most of the exercise are incorporated into her daily activities, such as going up steps and performing certain stretches.

Petitioner has continued to work in her position as a registered nurse for the Respondent since her return to work on August 1, 2019. The Petitioner testified that she still continues to have occasional pain in her right knee. She testified she did not have pain every day, but would have pain with changes in weather or if she turned her knee in a certain way. The Petitioner testified that prior to the accident, she ran and has not returned to that activity since her surgery out of an abundance of caution as she is concerned with reinjury. She testified that she is able to perform all work duties and daily activities, but that she is more careful with everything she does. The Petitioner testified that she has participated in additional code calls and physically subdued patients since returning to work. She testified that subduing patients is a physically demanding activity.

On cross-examination Petitioner said she was released by Dr. Herrin on September 9, 2019 on a PRN basis and had not returned or called Dr. Herrin since that date, nor has she been treated by any other doctor for her knee since that date. She agreed that she had told the physical therapist on August 1, 2019 that she was not experiencing any knee pain. She agreed that overall she was very happy with the outcome of her surgery. Petitioner agreed that on September 4, 2019 she told the therapist that she was feeling great and that she was back working double shifts. She said she continued to work double shifts and had received overtime work since that time, working overtime every opportunity she got. Petitioner testified that this accident had not affected her income in any way.

Petitioner agreed that part of her work was performed at a desk, filling out charts, and that she also distributed medications to patients who came up to a window.

CONCLUSIONS OF LAW

As the accident occurred after September 1, 2011, the nature and extent of the injury must be determined through the five-factor test set out in §8.1b(b) of the Act.

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 registered nurse in a secured, state run mental health facility at the time of the accident and that she is able to and has returned to work in her prior capacity. The Arbitrator notes that although much of Petitioner's position involves charting and dispensing medications, Petitioner must have a certain level of physical fitness and mobility to perform her job duties as she is required to restrain violent mental health patients as a core part of her job. Because Petitioner is required to, at least occasionally, perform physically demanding activities in the course of her employment as a registered nurse for Respondent, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 52 years old at the time of the accident. Based on her age, the Arbitrator notes that Petitioner is expected to work at least another ten years post-accident and will be required to work on her feet for that period of time. Because Petitioner is expected to continue to work for an extended period of time, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner has had no change in earning capacity based on the injury to her knee. Petitioner continues to be employed by Respondent in the same position, earning the same or greater pay. The Petitioner continues to regularly work overtime hours and double shifts, as set forth in Respondent's Exhibit 1. Petitioner testified that she worked overtime whenever she had the opportunity. Because Petitioner has had no change in earning

capacity and continues to earn a substantial wage, with overtime, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was last seen by her surgeon, Dr. Herrin, on September 9, 2019, at which time she reported improvement with physical therapy and working cautiously at fully duty. Exam findings on that date were normal. The Petitioner was last seen by physical therapy on September 12, 2019. In her final visit, the Petitioner reported only occasional twinges of pain in the medial knee that occurred during turning and pivoting and when sitting cross legged. She reported being uneasy and less confident with squats and had discomfort with kneeling tasks. Petitioner told the physical therapist on August 1, 2019 that she was not experiencing any knee pain. Petitioner on cross-examination said that overall she was very happy with the outcome of her surgery. On September 4, 2019 Petitioner told the physical therapist that she was feeling great and that she was back working double shifts. At Arbitration, the Petitioner testified that she has some occasional pain in her right knee, that were generally associated with turning her knee and changes in the weather. She further testified that she was cautious about the activities she performed with her knee out of concern for re-injury. The arbitrator finds that Petitioner's testimony at hearing is consistent with her final medical records. Because Petitioner continues to have minor, occasional pain in the right knee after her release from care, has sought no medical treatment in nearly two years following her release from care, and has sought and been able to work overtime whenever it is available, the Arbitrator therefore gives lesser weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17 ½ % loss of use of the right leg pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC006929
Case Name	GORBETT, PAMELA v. ILLINOIS GAMING BOARD
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0082
Number of Pages of Decision	11
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Ellen Bruce
Respondent Attorney	Kayla Koyne

DATE FILED: 3/8/2022

/s/*Christopher Harris, 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	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAMELA J. GORBETT,

Petitioner,

vs. NO: 14 WC 6929

STATE OF ILLINOIS,
ILLINOIS GAMING BOARD,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 22, 2019 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

March 8, 2022

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

CAH/tdm
O: 3/4/22
052

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GORBETT, PAMELA J
Employee/Petitioner

Case# **14WC006929**

14WC006930

ILLINOIS GAMING BOARD
Employer/Respondent

On 11/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4796 SGRO HANRAHAN DURR ET AL
ELLEN C BRUCE
1119 S 6TH ST
SPRINGFIELD, IL 62703

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

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

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

NOV 22 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PAMELA J. GORBETT
Employee/Petitioner
v.
ILLINOIS GAMING BOARD
Employer/Respondent

Case # **14** WC **6929**

Consolidated cases: **14-WC-6930**

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 **Springfield**, on **September 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **January 30, 2008, and January 30, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,088.00**; the average weekly wage was $**751.69**.

On the date of accident, Petitioner was **47 and 51** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

SEE ATTACHED.

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

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

Signature of Arbitrator

November 17, 2019
Date

NOV 22 2019

On January 30, 2008, and January 30, 2012, the petitioner, Pamela J. Gorbett, was employed by the respondent, Illinois Gaming Board. She began her employment with the State of Illinois in July of 1979, and she held several positions with the state and was an Office Associate at the time of her injuries. Her office was in Springfield, Illinois. While employed by the Illinois Gaming Board, Petitioner worked at the Willard Ice Building and the Illinois State Police building. Her supervisor was Kathy Spain. At the time of the injury, Petitioner worked Monday through Friday from 8:00 a.m. to 4:00 p.m. with two 15-minute breaks and a half hour lunch. Petitioner is currently Retired. Her general job duties included completing reports, filing and answering the telephones. Petitioner's average weekly wage was $751.69.

Petitioner testified that as an Office Associate her workstation consisted of a desk with a table, and the computer and keyboard placed on the table. When she moved to the Illinois State Police, she had a keyboard with a keyboard tray starting in 2010. She testified that some days she typed all day, except for her break or lunch time. Some of the reports that she typed were a paragraph while others were 10 pages. She also filed for approximately two hours a day and was always the main telephone contact, with approximately 20 calls a day at a minimum. She testified that she experienced numbness and tingling in her hands that worsened over the course of the day. She reported to Dr. Neumeister that her symptoms woke her up at night. (Px. 2, P. 48).

The Supervisor's Report of Injury or Illness completed by Kathy Spain (Px. Ex. 6) included a job description of typing, filing, opening and delivering mail, answering phones, and preparing mailings. The Demands of the Job includes a grading system and indicates six to eights hours of Petitioner's day was spent using her hands for gross and fine manipulation. (*Id.*).

Petitioner treated with Dr. Diane Widicus in February of 2008 for pain in her left wrist and elbow (Px. 4). She next treated with Dr. Edward Trudeau on January 30, 2008 where she reported that she had worsening of symptoms in both upper extremities, numbness in both hands, and progressive worsening by the end of her work shift. (Px. 3). Dr. Trudeau found that Petitioner had median neuropathy at the left wrist and ulnar neuropathy at the left elbow. (*Id.*). Petitioner then treated with Dr. Michael W. Neumeister on March 19, 2008 where she reported numbness and tingling in her hands. (Px. 2). Petitioner's next appointment with Dr. Neumeister occurred on August 30, 2010, for further evaluation of bilateral upper extremity nerve compression symptoms. (*Id.*). Petitioner had carpal and cubital tunnel surgery on her left side on December 14, 2010. (*Id.*). Petitioner had extensive follow up appointments with Dr. Neumeister and his office due to issues with the surgical site for the carpal tunnel surgery, including December 29, 2010, January 4, 2011, January 20, 2011, January 31, 2011, February 14, 2011, March 7, 2011, March 14, 2011, and April 14, 2011. On the last visit in April, Petitioner still had tenderness at the scars of the carpal tunnel site after a March 7, 2011 Botox injection and was released to return to work on April 18, 2011. (*Id.*). Petitioner attended hand therapy starting in February to work on range of motion, scar massage, desensitization and to increase strength. (Px. 7)

Dr. Neumeister testified that Petitioner was allowed to return to work after her March 14, 2011 appointment with right-handed work only. (Px. 2). Dr. Neumeister reviewed the "Demands of the Job" and when asked if Petitioner was using her hands for gross manipulation for six to eight hours a day whether it would cause or contribute to carpal tunnel in her left hand, he stated "I don't know if it exactly would be the cause. It could aggravate the carpal tunnel syndrome if the symptoms of numbness and tingling came on while she was doing those activities." (*Id.*, p. 31, lines 1-19). Similarly, Dr. Neumeister testified that in his opinion, fine manipulation and typing for six to eight hours a day could aggravate carpal tunnel. (*Id.*, p. 31-32). The gross and fine manipulation jobs could also impact Petitioner's cubital tunnel if she was grasping, rotating her wrist back and forth, extending and flexing her fingers or elbows, and that bending and extending the elbow could aggravate the nerve as it glides back and forth behind the elbow. (*Id.*, p. 32-33). Dr. Neumeister testified that there is not a required amount of time for an individual to have wrist flexion or extension for it to cause aggravation. (*Id.*, p. 33).

Dr. Neumeister concluded that if Petitioner's symptoms came on while she was performing job duties that included gross and fine manipulation for six to eight hours a day, that her job aggravated those symptoms. (*Id.*, p. 35).

On January 5, 2012, Petitioner treated with Dr. Greatting who noted she showed symptoms of right cubital tunnel syndrome and had numbness and tingling in her small fingers on her right hand and also had complaints with her left hand. (Px. 2). Dr. Greatting noted in his records that Petitioner worked at a station with her shoulders slightly abducted and elbows significantly flexed. Petitioner reported that she experienced increasing symptoms during work activities and had some weakness and clumsiness in the right hand. (*Id.*). He referred to the EMG performed by Dr. Trudeau on January 30, 2008 and noted that not all of the symptoms from her left arm had resolved at the time of the January 5, 2012 visit. Petitioner was sent to Dr. Trudeau for a new EMG. Petitioner was seen by Dr. Trudeau on January 30, 2012. He reviewed the previous records from Petitioner's January 30, 2008 records, and noted problems in her wrists, elbows and shoulders and noted repetitive motion work activities in the course of her employment activities. (Px. 3). Dr. Trudeau found ulnar neuropathy at the left wrist, moderately severe, median neuropathy at the left wrist, and ulnar neuropathy at the right elbow, moderately severe.

Petitioner was treated by Dr. Greatting on February 24, 2012. He noted in the records that she had chronic right cubital tunnel symptom and her symptoms were worsening based on her history. (Px. 2). Dr. Greattin stated, "I think her work activities have at least aggravated these symptoms. (*Id.*). Dr. Greatting performed right cubital tunnel surgery on March 2, 2012. Petitioner returned to Dr. Greatting's office for a follow up visit on April 25, 2012 and was released from care at MMI, with a notation that Petitioner may benefit from release on the left wrist. (*Id.*).

When Petitioner returned to work following right side cubital tunnel surgery, she testified that there were no accommodations and no job duty performance issues. Petitioner testified that she smoked throughout her treatment until an unrelated health event occurred in January 2013 that ultimately resulted in the loss of portions of her digits and feet.

Petitioner attended an examination under section 12 of the Act with Dr. James Williams on June 11, 2014. (Rx. 2). Dr. Williams evaluated Petitioner following the loss of her digits. (*Id.*, p. 8). When asked if Petitioner's "elbows were significantly flexed at her work station, could that have led to an aggravation of her cubital tunnel?" he responded, "that's possible, and if she wasn't - - if they were in that position and held in that position . . . that is possible." (*Id.*, p. 16). When asked about her workstation and whether Petitioner changed workstations during her employment, Dr. Williams testified that "she just said that at the present time the job she was in there wasn't any issue, but really she didn't state anything about before and obviously that's something that is an issue." (*Id.*, p. 17).

Petitioner received TTD for both surgeries and her medical bills were submitted to and paid through worker's compensation. Petitioner returned to work following both surgeries.

THE ARBITRATOR FINDS AS FOLLOWS:

I. <u>The accident arose out of and in the course of Petitioner's employment with Respondent.</u>

The evidence proves that injuries arose out of and in the course of Petitioner's employment, specifically Petitioner's left carpal tunnel syndrome, left cubital tunnel syndrome and right cubital tunnel syndrome. In order for an injury to arise out of employment 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. *Technical Tape Corporation v. The Industrial Commission*, 58 Ill.2d 226, 230 (IL. 1974). The evidence outlined above clearly shows that an accident arose out of Petitioner's employment. Petitioner was employed by the State of Illinois Respondent in hand intensive work duties beginning in July of 1979. Petitioner testified that she spent her day between typing, filing and answering the phone. From 1982 to 1992 she worked as a Clerk Typist III where she did typing, filing, time keeping, copying and faxing. (Rx. 1, P. 10). From 1992 to 2013 she worked for Respondent typing, filing, faxing copying and report preparation. (*Id.*).

Petitioner testified that she experienced pain while at work and during the performance of her job duties. The pain also interrupted her sleep. As stated above, Petitioner sought medical treatment for her pain and was treated by Drs. Widicus, Trudeau, Neumeister and Greatting. After attempts to resolve her issues conservatively, Dr. Neumeister performed left carpal tunnel release surgery and left cubital tunnel release surgery in December of 2010. Dr. Greatting performed right cubital tunnel release in March of 2012.

Petitioner performed the same tasks on a daily basis for the majority of her day for decades. Dr. Neumeister's testimony supports the conclusion that Petitioner's left carpal and cubital tunnel were at least aggravated by Petitioner's job duties when taken into consideration with Petitioner's testimony regarding the pain, numbness and tingling she experience performing her job duties. Dr. Greatting's medical records support the conclusion that Petitioner's injuries were at least aggravated by her job duties and as such, Petitioner's injuries arose out of an in the course of her employment with Respondent.

Dr. Williams met with Petitioner after she had an unrelated major health incident. Dr. Williams stated in his report that Petitioner had no problems with her workstation but conceded that Petitioner was not talking about her workstation while she was employed at the Illinois Gaming Board, but with a different employer, following her unrelated health incident.

II. Petitioner's injuries are causally connected to her employment with Respondent.

The Petitioner's testimony that a majority of her work duties were hand intensive, including typing, filing and answering the phone, and that she continued to work after reporting her injury, together with Dr. Neumeister's testimony that repetitive motion at work such as the work duties reported by Petitioner can aggravate carpal tunnel syndrome prove that Petitioner's accident arose out of and in the course of Petitioner's employment with Respondent. Furthermore, Dr. Greatting stated in his medical records that Petitioner's right cubital tunnel syndrome was aggravated by her job. Additionally, the facts in this case point to the logical conclusion that there is a causal connection between the Petitioner's employment and the injuries. In the case of *Caterpillar Tractor Company v. The Industrial Commission,* 129 Ill.2d 52 (1989), the Supreme Court wrote "typically an injury arises out of one's employment is, at the time of the occurrence, the employee was performing acts…which the employee might reasonably be expected to perform incident to assigned duties. A risk is incidental to employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." (citations omitted). Clearly, an Office Assistant who is performing hand intensive work for a majority of her day is performing a function connected with or incidental to her duties.

The *Caterpillar* Court went on to state that "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing her duties, and while she is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course and scope of employment." *Caterpillar*, 129 Ill.2d at 57. Based on the facts of this case, a causal connection exists, and the Petitioner's injuries arose out of and in the course of her employment with Respondent. The evidence supports a finding that Petitioner's condition of ill-being was, at a minimum, aggravated by her job duties. The evidence shows that the accidental injury aggravated the condition or accelerated the process that led to the Petitioner's current condition of ill-being.

Petitioner's injuries are causally connected to her employment. Petitioner experienced symptoms of carpal and cubital tunnel syndrome while working and her symptoms lessened when not at work. Petitioner's specific work duties included little variety. Petitioner performed the same actions approximately six hours each day. Petitioner did not experience these symptoms, or her symptoms lessened when she was not working.

III. Petitioner's medical services are reasonable and necessary.

Section 8(a) of the Illinois Workers' Compensation Act requires the employer to pay all medical services rendered to an employee who was injured during the course of employment. Respondent is responsible for her medical bills related to her work-related injuries. As set forth in Petitioner's exhibits submitted at Arbitration, employer shall reimburse Petitioner for any payments made by the Petitioner toward medical bills submitted at arbitration which are not already paid. Petitioner received TTD for both surgeries and her medical bills were submitted to and paid through worker's compensation.

IV. Nature and Extent

The petitioner testified that she continues to experience pain in her left hand, including numbness in the tips of her fingers. Additionally, Dr. Greatting's records note that Petitioner was still experiencing pain in her left wrist and recommended additional treatment. The testimony and medical evidence support a finding that the petitioner sustained permanent partial disability in her left hand of 12.5% loss of use; 12% loss of use of the left arm; and 12% loss of use of the right arm under section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC008800
Case Name	CONNELY, THADDEUS S v. NORTH AMERICAN LIGHTING, INC.
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0083
Number of Pages of Decision	16
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Molly Price
Respondent Attorney	Stephen Carter

DATE FILED: 3/8/2022

/s/Christopher Harris, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THADDEUS S. CONNELY,

Petitioner,

vs. NO: 21 WC 8800

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 7, 2021 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,200.00. 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.

March 8, 2022

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

CAH/tdm
O: 3/4/22
052

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC008800
Case Name	CONNELY, THADDEUS S v. NORTH AMERICAN LIGHTING, INC.
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Molly Price
Respondent Attorney	Stephen Carter

DATE FILED: 8/7/2021

INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

/s/ *Linda Cantrell, Arbitrator*

Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

AUGUST 7, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITIONER'S PROPOSED DECISION
19(b)

THADDEUS S. CONNELY
Employee/Petitioner

Case # **21** WC **008800**

v.

Consolidated cases: ______

NORTH AMERICAN LIGHTING, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 18, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☒ Is Respondent due any credit?

O. ☒ Other: **Whether Petitioner refused light-duty work.**

FINDINGS

On the date of accident, **January 25, 2021**, 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 $**26,662.30**; the average weekly wage was $**761.78**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**887.77** for medical expenses, for a total credit of $**887.77.**

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

ORDER

Respondent stipulated it would pay the only two outstanding medical expenses remaining, which is $19.62 due and owing Clinical Radiologists, which Respondent will pay directly to Petitioner, and $203.00 to Clay County Hospital and Medical Clinics, which Respondent will pay directly to the provider pursuant to the medical fee schedule. Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit 5, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits, which the parties stipulated was in the amount of $887.77 as of the date of arbitration. The Arbitrator finds Respondent is not entitled to an additional credit of $20.38 as said amount was a contractual insurance adjustment between Petitioner's group health carrier, BCBS, and Clinical Radiologists, and not a payment made by its group medical plan. Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall pay reasonable and necessary prospective medical care to Petitioner's right arm/elbow as recommended by Mr. Derek Storck, APRN-CNP, including, but not limited to, physical therapy, until Petitioner reaches maximum medical improvement.

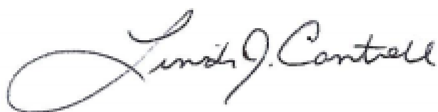
Respondent shall pay Petitioner TTD benefits of $507.85/week based on a stipulated average weekly wage of $761.78 (pursuant to Petitioner's attorney's email dated 5/28/21), commencing 2/25/21 through the date of arbitration, 5/18/21, representing 11-6/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay $30.00/day from 3/29/21 through 5/18/21, representing 51 days, in the amount of $1,530.00, pursuant to Section 19(l) of the Act. Respondent shall further pay penalties pursuant to Section 19(k) of the Act in the amount of $3,010.79, and attorney's fees pursuant to Section 16 of the Act in the amount of $1,204.32.

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

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

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



Arbitrator Linda J. Cantrell

Date: 08/07/21

ICArbDec19(b)

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on May 18, 2021 pursuant to Section 19(b) of the Act. The parties stipulated that on January 25, 2021 Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. The issues in dispute are causal connection, medical bills, 8(j) credit, prospective medical care, temporary total disability benefits and whether Petitioner refused light duty work, penalties pursuant to Sections 19(k) and (l) of the Act, and attorney's fees pursuant to Section 16 of the Act. On May 28, 2021, Petitioner's attorney emailed the Arbitrator and advised Petitioner's average weekly wage was no longer in dispute and Petitioner stipulated to an average weekly wage of $761.78. Petitioner also advised he no longer claims entitlement to temporary partial disability benefits. Petitioner's email dated 5/28/21 is attached to the Request for Hearing (Arbitrator's Exhibit 1) and is incorporated in the record. All other issues have been stipulated.

TESTIMONY

Petitioner was 39 years old, married, with one dependent child at the time of accident. Petitioner was employed by Respondent for five years as a material handler. He testified that on 1/25/21 he injured his right arm/elbow when he lost grip on a tub of glue and it jerked his arm down. He stated he felt a pop and immediately reported the accident to his acting supervisor. An Illinois Form 45: Employer's First Report of Injury was prepared by Ms. Carey Clements on 1/27/21.

Petitioner testified he was not able to undergo the recommended physical therapy because he no longer had a job and did not have the money to pay for treatment. He stated he left a voice message with Respondent on 2/23/21 requesting to use a vacation or paid-time-off day and his call was not returned. He stated he called again at 5:30 a.m. and received no answer. He testified he was terminated on 2/24/21 by his supervisor, Kevin Martin, who stated he could not accept Petitioner's time off on 2/23/21 because they were short staffed and he gave Petitioner a point that led to his termination. Petitioner stated he did not refuse to work. He has attempted to find employment but his restrictions prevent him from being hired.

Petitioner testified he still has issues with his right elbow, arm, and hand when doing simple duties in that his arm aches, hurts, and bothers him. His right arm hurts when he is doing the dishes, mowing the yard, and folding laundry. He has difficulty driving, pulling his belt tight, and with twisting and bending of his elbow. Petitioner's symptoms adversely affect his sleep and worsens with cold or rainy weather. He stated his hobbies are affected, including teaching his son the guitar, riding bikes with his kids and pushing them on swings, making cosplay costumes, and walking his dog. He cannot pull the starter on his mower to mow his yard. He stated any pressure on his right elbow causes pain. Petitioner testified he did not have any right arm/elbow symptoms prior to 1/25/21 and he sustained no new injuries since that date. Petitioner takes medication prescribed by his doctor, elevates his arm, and uses a heating pad to relieve his symptoms. Petitioner wants further treatment in order to obtain employment and provide for his family.

On cross-examination, Petitioner testified he read the employee handbook five years ago when he was hired. He stated a "point" is an unexcused call-in or missing an entire shift. You receive a half a point if you are late for work. He stated you are not given a point if you call in, the absence is approved, and you have benefits to cover the missed time. Petitioner testified he had 16 hours of PAD and 6 hours of vacation time when he called Respondent on 2/23/21. He disputes he did not have time on the books to cover his requested absence on 2/23/21. He stated Mr. Martin told him the reason he was terminated was because Respondent could not honor his time off request because they had four employees out that day. He denies Mr. Martin told him he did not have time to cover his missed shift. He testified he had 6.5 points on 2/23/21 when he called into work and understood that 7 points resulted in termination.

He agreed that Respondent did not dispute his elbow claim and paid his medical expenses. He returned to light duty work the day after his accident and was offered 40 hours per week. He worked approximately 20 hours per week for six weeks after the accident prior to his termination. Petitioner testified his arm was bothering him and he had the right to take off work because he had the time to cover the absences. He stated he called in on 2/22/21 because he had two flat tires. Petitioner identified a Facebook post he authored on 2/22/21 stating he attempted to go to work but had two flat tires. He testified Respondent approved his time off work on 2/22/21 and he did not receive a point. He stated he called Respondent on 2/23/21 and left a message that he was sick with diarrhea and his arm hurt and he was taking the day off. He denies telling Respondent again on 2/23/21 that he was not coming to work because of two flat tires. He stated he had 6.5 points prior to calling off work on 2/22/21 and 2/23/21. He agreed he received a verbal and written warning on 11/7/20, a written warning on 11/15/20, and a final warning on 1/8/21 for having too many points. Petitioner testified his points were due to attendance.

Petitioner testified he can only use his right elbow within his restrictions. Petitioner was shown a TikTok video of himself. (RX13, TikTok link https://vm.tiktok.com/ZMepDVY4W/ and https://vm.tiktok.com/ZMepDhyL9/). Petitioner testified he personally filmed the video approximately 1 to 2 months prior to arbitration and after his accident. The videos are dated 1/29/21 and 2/7/21. Petitioner is depicted in cosplay dress spinning a toy gun with his hand. Petitioner testified he was on work restrictions from 1/25/21 through the present that did not restrict the use of his right hand.

Respondent called Kevin Martin to testify as a witness. Mr. Martin was Petitioner's direct supervisor. He testified that Petitioner was an hourly employee and was expected to work 40 hours per week. Mr. Martin stated Petitioner was expected to (1) appear for work on all scheduled workdays, (2) "cover" any missed workdays or hours with benefit time, or (3) accrue point(s) – up to a maximum of 7 points, which would result in termination. Mr. Martin testified that Petitioner carried many points the entire time he worked for Respondent. Petitioner had sufficient benefit time to "cover" his absence from work on 2/22/21. Mr. Martin stated Petitioner did not have sufficient benefit time to "cover" his absence on 2/23/21 resulting in his termination.

Mr. Martin testified that Respondent accommodated Petitioner's work restrictions and Petitioner was expected to work light duty 40 hours per week. He testified that he met with Petitioner to discuss his accumulated points. Petitioner called off work on 2/22/21 and 2/23/21 and the message he received was that Petitioner would not appear at work due to car trouble. He

testified he did not receive a message that Petitioner missed work due to an illness or injury. Petitioner's absence on 2/23/21 resulted in a seventh point leading to his termination pursuant to company policy. Mr. Martin testified that Petitioner refused to perform the light duty work offered when he continuously called off work.

Respondent called Carey Clements to testify. Ms. Clements is an HR Supervisor for Respondent who manages all of Respondent's workers' compensation claims. Ms. Clements is familiar with Petitioner's claim. She testified that Petitioner had sufficient benefit time to "cover" his absence from work on 2/22/21, but insufficient benefit time to "cover" his absence on 2/23/21, resulting in a seventh point and Petitioner's termination. She testified it was her decision to deny Petitioner's claim for TTD benefits from 2/25/21 through the present because Petitioner refused to work light duty by continuously calling off work.

MEDICAL HISTORY

Petitioner sought emergent treatment at Clay County Hospital the day of the accident. He reported he was at work lifting a 50-pound object when he began losing grip and tried to catch the object, causing pain in his right elbow. He complained of paresthesia to the third, fourth, and fifth digits on his right hand and pain with resisted pronation of his right forearm. He rated his pain as an 8 out of 10. On examination, Dr. Larry Lambert noted Petitioner had pain on palpation of his posterior elbow region in the ulnar nerve groove and pain with resisted pronation. X-rays of the right elbow were negative. Dr. Lambert diagnosed right elbow pain and suspected lateral epicondylitis. Petitioner was placed on restrictions of no lifting more than 10 pounds until seen by an orthopedic doctor and prescribed Meloxicam.

On 2/1/21, Petitioner sought treatment with Mr. Derek Storck, APRN-CNP at Clay County Hospital Medical Clinic for continued right elbow symptoms. He complained of pain with repetitive motion. Nurse Storck noted Petitioner had pain in his right shoulder, pain in the medial and posterior aspect of his right elbow, more pronounced with pronation and elbow extension. Nurse Storck diagnosed a right elbow sprain, prescribed Naproxen, and instructed Petitioner to wear a compression brace, use ice, and avoid lifting more than five pounds and repetitive motions for one week.

On 2/5/21, Petitioner sought treatment from a physician/attendant at Respondent's facility. The record states that on 1/25/21 Petitioner was picking up a tub of glue when it slipped and he felt a pop and immediate pain in his right elbow. He complained of right elbow pain and occasional numbness and tingling. He reported using an arm strap, performing stretches, and taking over-the-counter Ibuprofen. Examination revealed decreased range of motion in the right elbow due to pain and pain with palpation over the medial epicondyle. He was diagnosed with right medial epicondylitis and was instructed to wear his wrist splint at night, use ice, take over-the-counter Ibuprofen, and wear his arm strap during the day. His work restrictions were continued.

On 3/10/21, Petitioner returned to Nurse Storck and reported limited use of his right arm and pain. He reported right elbow pain with little activity, his pain occasionally kept him up at night, that his work had been difficult even with restrictions, and that his pain radiated from his elbow to his hand. Nurse Storck noted tenderness in Petitioner's lateral epicondyle and posterior

elbow proximal to his epicondyle and pain with any resistance. Nurse Storck diagnosed sprain of the right elbow and symptoms suggestive of lateral epicondylitis. Nurse Storck referred Petitioner to physical therapy and stated an orthopedic referral would be made if his symptoms did not improve. Petitioner was placed on restrictions of right-hand use at ten reps per hour and/or 5 pounds of force grasping and restricted lifting with his right hand at ten reps per hour and/or five pounds. The light-duty work slip was amended on 3/24/21 to correct an error initially restricting Petitioner's *left* hand.

On 3/18/21, Petitioner called Nurse Storck's office and stated he was cancelling an appointment because he no longer had health insurance and was currently out of work. He stated he had not yet received approval for the recommended physical therapy.

CONCLUSIONS OF LAW

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

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant's ability to perform manual duties before accident and decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill.2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96-97, 197 Ill. Dec. 502, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 666, Ill. Dec. 347, 442 N.E.2d 908 (1982).

Petitioner was working full duty without incident for five years prior to the undisputed accidental injury on January 25, 2021. Petitioner credibly testified that prior to that date he suffered no injury or had symptoms in his right arm/elbow and did not sustain any injuries to his right arm/elbow since the date of accident. There is no evidence in the record that Petitioner had right arm/elbow symptoms or required any treatment or diagnostic studies prior to 1/25/21. Petitioner immediately reported the accident and sought emergent medical treatment. Petitioner was placed on light duty restrictions immediately after the accident which Respondent accommodated.

Following the accident Petitioner remained symptomatic and has yet to return to his pre-accident baseline. Physical therapy was ordered by Nurse Storck, an advanced practice registered nurse and certified nurse practitioner. Nurse Storck opined that an orthopedic evaluation would be appropriate if Petitioner's symptoms failed to improve with conservative treatment, specifically physical therapy. Petitioner was terminated on 2/24/21 and he testified that without health insurance and income he could not afford to seek medical treatment.

Respondent has paid or has agreed to pay all medical expenses outlined in Petitioner's Group Exhibit 5, which includes all of the medical treatment Petitioner has received to date related to his injuries on 1/25/21. However, Respondent has refused to authorize and pay for the recommended physical therapy. All of Petitioner's treating providers, including the physician's assistant at Respondent's facility, found objective evidence of a right arm/elbow injury.

Respondent did not submit a Section 12 report or other medical evidence to rebut the objective findings of injury.

Respondent submitted a link to two TikTok videos that were viewed by all parties at arbitration. The Arbitrator has had the pleasure of viewing the videos numerous times and makes the following observations and findings. As to the video identified as https://vm.tiktok.com/ZMepDhyL9, Petitioner is depicted wearing cosplay dress, quickly reaches in a waistbelt holster to remove a toy gun with his right hand, extends his right arm straight out in front of him, spins the gun several times with his right hand, and replaces the gun in the holster. In video https://vm.tiktok.com/ZMepDVY4W/, Petitioner is depicted wearing cosplay dress, holding a toy gun with his right hand, spinning the gun in his hand with his arm bent at the elbow, and then pointing the gun at the camera with his right arm stretch straight out in front of him. Petitioner testified he did not perform any activity in the video that was beyond his restrictions. The Arbitrator notes that Petitioner's last prescribed restrictions of 3/10/21 were right-hand use at ten reps per hour and/or 5 pounds of force grasping and restricted lifting with his right hand at ten reps per hour and/or five pounds. Petitioner did not testify, nor was he questioned, as to the weight of the toy guns used in the videos. It does not appear in either video that Petitioner lifted in excess of five pounds or performed any activity beyond his restrictions.

Based on the evidence, the Arbitrator finds Petitioner has met his burden of proof and finds Petitioner's current condition of ill-being in his right arm/elbow is causally related to the work accident of January 25, 2021.

Issue (J): **Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**
Issue (K): **Is Petitioner entitled to any prospective medical care?**
Issue (N): **Is Respondent due any credit?**

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).

The Arbitrator finds that the care and treatment Petitioner received has been reasonable and necessary. Respondent stipulated it would pay the only two outstanding medical expenses remaining, which is $19.62 due and owing Clinical Radiologists, which Respondent will pay directly to Petitioner, and $203.00 to Clay County Hospital and Medical Clinics, which Respondent will pay directly to the provider pursuant to the medical fee schedule.

Respondent shall therefore pay the medical expenses outlined in Petitioner's group exhibit 5 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, which the parties stipulated was in the amount of $887.77 at the time of arbitration. The Arbitrator finds

Respondent is not entitled to an 8(j) credit of $20.38 as said amount was a contractual insurance adjustment between Petitioner's group health carrier, BCBS, and Clinical Radiologists, and not a payment made by Respondent's group medical plan. Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

The Arbitrator further finds Petitioner has not reached maximum medical improvement and is entitled to receive the additional care recommended by Mr. Derek Storck, APRN-CNP. Respondent shall authorize and pay for all reasonable and necessary prospective medical care to Petitioner's right arm/elbow as recommended by Nurse Storck, including, but not limited to, physical therapy, until Petitioner reaches maximum medical improvement.

Issue (L): What temporary benefits are in dispute? (TTD)
Issue (O): Whether Petitioner refused light-duty work.

Respondent disputes liability for temporary total disability benefits based on Petitioner's termination of employment for cause. Respondent argues that Petitioner refused to work in a light duty capacity as offered by Respondent because he continuously took off work resulting in his termination. Although Petitioner argues he had sufficient benefits to take off work and his termination was not justified, the evidence strongly supports Petitioner accumulated seven points and his termination was appropriate. Petitioner testified he knew he had 6.5 points prior to his injury on 1/25/21 and prior to taking off work on 2/22/21 and 2/23/21.

Nevertheless, the issue is whether Petitioner is entitled to temporary total disability benefits under the Act as a result of his work-related injury when he was terminated from his employment for conduct unrelated to his injury. The Appellate Court of the Second District held the critical inquiry for the Commission when determining claimant's entitlement to TTD was whether his medical condition had stabilized and he had reached MMI. *Walter Matuszczak v. IWCC*, 2014 IL App (2d) 10532WC. The Petitioner in *Matuszczak* was terminated for theft and was aware that theft would result in termination of employment. In awarding TTD benefits, the Arbitrator noted Petitioner was subject to light duty restrictions that were being accommodated by Respondent at the time of termination, he did not return to work after being terminated, and Petitioner testified that he tried looking for work within his restrictions. The Arbitrator relied on *Interstate Scaffolding*, which held, "the employer was obligated to pay TTD benefits even when the employee has been discharged, whether or not the discharge was for cause, and that when an injured employee has been discharged by his employer the inquiry for deciding his entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. More to the point, the court noted that if the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to these benefits."

The Commission vacated the arbitrator's award of TTD in *Matuszczak*, stating claimant's TTD benefits may be terminated or suspended if he refuses to work within his physical restrictions and agreed with the employer's position that claimant's theft, coupled with his knowledge that theft could lead to termination, constituted refusal of work within his physical restrictions by claimant. The circuit court reversed the Commission's decision and the Appellate Court affirmed the circuit court's judgment and reinstated the arbitrator's TTD award.

"A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Westin Hotel v. Industrial Comm'n*, 372 Ill.App.3d 527, 542, 865 N.E.2d 342, 356 (2007). "It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.* whether the claimant has reached MMI." *Interstate Scaffolding*, 236 Ill.2d at 142, 923 N.E.2d at 271. Further, "to be entitled to TTD, a claimant must show not only that he did not work but that he could not work." *Residential Carpentry, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill.App.3d 975, 981, 910 N.E.2nd 109, 115 (2009). "TTD benefits may be suspended or terminated if the employee (1) refuses to submit to medical, surgical, or hospital treatment essential to his recovery; (2) fails to cooperate in good faith with rehabilitation efforts; or (3) refuses work falling within the physical restrictions prescribed by his doctor." *Interstate Scaffolding*, 236 Ill.2d at 146, 923 N.E.2d at 274.

The Supreme Court in *Interstate Scaffolding* rejected the Appellate Court's finding that the critical injury in determining a claimant's entitlement to TTD benefits when leaving the workforce was whether the departure was voluntary. The Supreme Court noted that "worker's compensation is a statutory remedy" and "[a]ny action taken by the Commission must be specifically authorized by statute." *Id.* at 145. In looking at the Act, the Court found no reasonable construction of its provisions to support a finding that TTD benefits may be denied an employee who remains injured yet has been discharged by his employer for "volitional conduct" unrelated to his injury. The Act does not condition TTD benefits on whether there has been 'cause' for the employee's dismissal. *Id.* at 146.

The Appellate Court in *Matuszczak*, citing the holding in *Insterstate Scaffolding*, found that an employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged - whether or not the discharge was for "cause" - and when an injured employee has been discharged by his employer, the determinative inquiry for deciding entitlement to TTD benefits remains, as always, *whether the claimant's condition has stabilized.*

Here, Respondent agrees Petitioner sustained a compensable work injury on 1/25/21. Also, it is undisputed that Petitioner was discharged for acts unrelated to his injury. Thus, the appropriate inquiry is whether Petitioner's medical condition had stabilized at the time of his termination. The undisputed facts show Petitioner was placed on light-duty work restrictions following his accident and he remained under light-duty restrictions after his February 2021 termination. The Arbitrator has determined herein that Petitioner is entitled to prospective medical treatment necessary to treat his work injury, that Petitioner has not reached MMI, and that Petitioner's condition has not stabilized. Thus, the evidence is sufficient to show, at the time of Petitioner's termination, he continued to be temporary totally disabled as a result of his work-related injury. Therefore, Petitioner is entitled to TTD benefits from the time of his termination to the date of arbitration. Whether Petitioner was appropriately discharged or knew he could be as a result of accumulating too many points, is not an appropriate consideration for the Arbitrator under the circumstances presented and the Arbitrator considers the conduct of Petitioner without reference to, or reliance on, his termination from employment.

Based upon the above finding as to causal connection and prospective medical care, Respondent is liable for payment of temporary total disability benefits. The parties stipulate that Petitioner's average weekly wage is $761.78 (pursuant to Petitioner's attorney's email dated 5/28/21), resulting in a TTD rate of $507.85. Respondent shall pay TTD benefits commencing 2/25/21 through the date of arbitration, 5/18/21, representing 11-6/7 weeks.

<u>Issue (M)</u>: Should penalties or fees be imposed upon respondent?

Petitioner requests attorney fees and penalties under Sections 16, 19(k), and 19(*l*) of the Act for Respondent's nonpayment of TTD benefits. The intent of sections 16, 19(k), and 19(*l*) is to implement the Act's purpose to expedite the compensation of industrial workers and to penalize employers who unreasonably, or in bad faith, delay or withhold compensation due an employee. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 301 (1980). Awards under section 16 and 19(k) are proper only if the employer's delay in making payment is unreasonable or vexatious. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 504-05 (1998). That is, the refusal to pay must result from bad faith or improper purpose. An award under section 19(*l*) is more in the nature of a late fee, so an award under that section is appropriate if an employer neglects to make payment without good and just cause. *McMahan*, 183 Ill. 2d at 515; *Dye v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110907WC, ¶15. The employer has the burden of showing that it had a reasonable belief that the delay was justified. *Roodhouse Envelope Co. v. Industrial Comm'n*, 276 Ill. App. 3d 576, 579 (1995).

Respondent denied liability for payment of TTD benefits based on Petitioner's termination of employment for "cause" which it alleges represents a refusal to work. On 3/29/21, Petitioner made a written demand for payment of TTD benefit from 2/24/21 until such time Petitioner was released to full duty work. Ms. Michelle Probert, Respondent's insurance adjuster, responded that Petitioner "voluntarily remov[ed] himself from employment" in that he "called into work, unexcused, and that was the reason he was terminated" and that temporary total disability benefits would not be issued. On 3/30/21, Petitioner's counsel emailed Respondent's counsel, providing the cases of *Interstate Scaffolding* and *Matuszczak* and again demanded payment of TTD benefits based on the case law and previously submitted light-duty work slips. Respondent's counsel replied he was aware of the cases cited by Petitioner; however, Respondent continued to deny TTD benefits. Based on the Arbitrator's award of TTD benefits and case law summarized in the above section, Respondent did not have a proper basis to deny payment of TTD benefits. Respondent's explanation for denying temporary total disability benefits focuses on the reason why Petitioner was discharged and not on whether Petitioner's condition had stabilized.

In considering penalties and their application to the case at bar, it must be noted that Respondent was fully aware of the holdings in *Matuszcak* and *Interstate Scaffolding*, yet for reasons not based in law, failed to pay Petitioner TTD benefits. This failure to pay TTD benefits was unreasonable. Further, Respondent stated in its Response to Petitioner's Section 19(b) Petition that it had not received a statement from a treating provider that Petitioner could not return to work. The record is clear that Petitioner was placed on light-duty restrictions and Respondent accommodated those restrictions through the date it terminated Petitioner's

employment. The record further reflects that Petitioner provided Respondent with documentation of light duty work restrictions.

In regard to Section 19(l), which is generally more in the form of a late fee, the statute states: "If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay . . . . [i]n 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.* (Emphasis Added).

Here, there is no evidence Respondent rebutted the presumption of unreasonable delay. In light of *Interstate Scaffolding* and *Matuszczak*, Respondent had no good-faith basis to withhold weekly benefits. Accordingly, Respondent shall pay $30.00/day from March 29, 2021 through May 18, 2021, representing 51 days, in the amount of $1,530.00, 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. *Compass Group v. Illinois Workers' Comp. Comm'n*, 28 N.E.3d 181, 190–91 (2nd Dist. 2014). While the burden is higher, the Arbitrator finds that Respondent's conduct in light of the underlying facts was vexatious and unreasonable. Petitioner's counsel provided Respondent's counsel with relevant case law which he indicated he was aware of the holdings. Respondent continued to deny payment of TTD benefits on the sole basis Petitioner was terminated for "cause", which is contrary to the law in Illinois. There is no question Respondent failed to act in good faith when it ignored the law and the facts of this case. Accordingly, the Arbitrator orders Respondent to pay penalties pursuant to Section 19(k) in the amount of $3,010.79 (50% of TTD benefits withheld), and attorney's fees pursuant to Section 16 in the amount of $1,204.32 (20% of the TTD withheld).

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

Arbitrator Linda J. Cantrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC032075
Case Name	WEEKS, SANDRA v. LORETTO HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0084
Number of Pages of Decision	28
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Gina LaRose
Respondent Attorney	James Clune

DATE FILED: 3/8/2022

/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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sandra Weeks,

Petitioner,

vs. NO: 18 WC 32075

Loretto Hospital,

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 May 25, 2021, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 8, 2022

DJB:yl
o 3/3/22
43

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC032075
Case Name	WEEKS, SANDRA v. LORETTO HOSPITAL
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	25
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	Gina LaRose
Respondent Attorney	James Clune

DATE FILED: 5/25/2021

INTEREST RATE FOR THE WEEK OF MAY 25, 2021 0.03%

/s/ *Joseph Amarilio, Arbitrator*
Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sandra Weeks
Employee/Petitioner
v.
Loretto Hospital
Employer/Respondent

Case # **18** WC **32075**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joseph Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **April 20, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 28, 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 $**77,422.28**; the average weekly wage was $**1,488.89**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**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 ***see below*** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $813.87/week for 20.5 weeks, because the injuries sustained caused the 10 % loss of the left hand, as provided in Section 8(e) of the Act.

The parties stipulated that all reasonable and necessary medical services incurred and related to the accident of August 28, 2018 have been paid as provided in Sections 8(a) and 8.2 of the Act.

The parties further stipulated that Respondent is entitled to a credit for all medical bills paid, if any, by Respondent's group coverage under Section 8(j) of the Act and for all medical bills heretofore paid pursuant to the workers' compensation coverage for the Respondent. And, that Respondent shall hold Petitioner harmless for medical paid.

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.

Joseph D. Amarilio

Signature of Arbitrator JOSEPH D. AMARILIO **MAY 25, 2021**

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sandra Weeks,)
)
Petitioner,)
)
vs.) No. 18 WC 032075
)
Loretto Hospital,)
)
Respondent.)

MEMORANDUM OF DECISION OF ARBITRATOR

I. PROCEDURAL HISTORY

This matter was heard before Arbitrator Joseph Amarilio ("Arbitrator") on April 20, 2021 in the City of Chicago, County of Cook and State of Illinois. Ms. Sandra Weeks ('Petitioner") testified in support of her claim. No witnessed testified on behalf of Loretto Hospital ("Respondent"). The submitted exhibits and the trial transcript have been examined by the Arbitrator. The parties proceeded to hearing on the following two (2) disputed issues: (1) whether Petitioner current claimed condition of ill-being is causally connected to the August 28, 2018 work accident with Respondent); and, (2) what is the nature and extent of the injury resulting from said accident. (Arb. Ex. 1).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

II. FINDINGS OF FACT

Petitioner has been employed as a registered nurse at Loretto Hospital for 15 - 1/2 years. (TA12-13). Petitioner's job duties include but are not limited to, taking blood work, lifting, moving, restraining, cleaning, and changing patients. (TA17-18).

On August 28, 2018, Petitioner was working the 7 :00 a.m. to 7:00 p.m. shift as a nurse at Loretto Hospital. (TA15). She was 51 years of age. (Px1). On that day around 5:00 p.m., Petitioner was tasked with taking care of a young woman who came into the hospital for a psychiatric evaluation. (TA15-16). The patient was delusional and uncooperative (TA16). The young woman became combative and started fighting. The patient was kicking as Petitioner was trying to change her into a gown and restrain her. The patient kicked Petitioner in her left hand. The patient's kick caused Petitioner's left little finger to snap back. Petitioner immediately started having pain, swelling, and throbbing in her left hand. She also noticed that she could not move her little finger. She reported the incident to her supervisor. Soon thereafter, Petitioner started having limitations with using her hand. (Id). She noticed she was having a hard time gripping, lifting and pulling as she continued to work in the emergency room. (TA17).

Petitioner had the doctor that was on duty at the time of the incident evaluate her hand. (TA19). The doctor suggested that she buddy tape it. (Id). Petitioner indicated that the buddy tape was intended to keep the fingers and the hand from moving too much. (TA19-20). To buddy tape, you connect your fingers together and wrap the tape around them. (TA20). The tape went around her fourth and fifth finger and then down around her palm. (TA22-23). Despite buddy taping her injured finger, Petitioner continued to have pain in her hand and fingers.

(TA23). The pain and swelling to her left hand caused limitations making her unable to use her hand. (Id).

On September 3, 2018. due to the pain, swelling, and limitations getting worse, Petitioner returned to the Emergency Room at Loretto Hospital to have her hand evaluated. (TA24). At that time, she noticed a deformity developing at the tip of her left little finger. (Id). Her finger started tilting over like a mallet. (Id). Additionally, Petitioner testified that se was having pain shooting down the side of her left hand. (Id). Following the examination and x-rays, the doctor prescribed a splint with buddy tape and recommended Petitioner see an orthopedic physician. (TA25-26). While wearing the splint and buddy tape, she was limited in her ability to move patients and open medications at work. (TA27). During this time, her supervisor gave her lighter assignments. (Id). She was also taking Motrin for the pain. (TA29).

On December 4,2018, Petitioner was seen by Dr. John Fernandez at Midwest Orthopaedics at Rush on December 4, 2018. (TA30). At that visit, she advised Dr. Fernandez that she had been kicked by a patient while at work and subsequently developed pain and swelling in her small finger. (Px2, Px3). Petitioner was still wearing the splint that was prescribed to her from the ER. (TA30). Dr. Fernandez performed a physical examination of her left hand and ordered new x-rays. (Id). The pertinent positives of the examination were pain at the level of the distal joint with a 20-degree extensor lag. (Px2). The x-rays demonstrated findings consistent with a mallet finger. (Px3). Dr. Fernandez diagnosed her with a left small finger bony mallet. (Px3). Dr. Fernandez explained a mallet finger is an injury to the distal joint in which there is a disruption in the extensor tendon as a result of a fracture or a tear at the tendon that results in the disconnect from the end of the tendons; which creates an extensor lag,

meaning the finger cannot fully straighten by the distal joint. (Px3). Dr. Fernandez prescribed a custom splint to maintain her finger in an extended position. (Px3). Petitioner was to wear that splint continuously for eight weeks. (Px3). Dr. Fernandez referred to see a physical therapist. (Px3). She was able to work with the restriction of wearing the splint and she would have to be able to engage in activities with the splint on. (Px3).

Petitioner had a follow-up visit on January 31, 2019. (Px3). She testified that at this time her finger looked like a hook. (TA35). She had worn the splint for eight weeks. (Px3). Dr Fernandez noted skin under the splint was irritated, which showed that she had been wearing the splint as instructed. (Px3). She had full extension of the finger. (Px3). New x-rays were taken which showed good reduction of the articular bony fracture. (Px3). He further testified that there was some dorsal prominence, which meant the bone was a little bit sticking out of the top. (Px3). The records indicated there was a gentle swan neck deformity. (Px2). Dr. Fernandez explained that as a form of compensating, her proximal knuckle went backwards slightly. (Px3). The proximal knuckle is the knuckle located in the middle of the finger and it normally stays straight in most people. (Px3). Dr. Fernandez testified that she had about an 8-degree lag and she had a 2-centimeter pulp-to-palm deficit, meaning the finger couldn't touch the palm by about an inch. (Px3). Dr. Fernandez explained that this meant instead of her finger being perfectly straight, it was slightly bent by about 5 to 8 degrees. (Px3). He testified that opposition of the small finger into the palm plays a vital role in an individual's ability to grip certain items and complete certain tasks. (Px3). He testified that an individual ends up losing a little bit of grip strength when they are unable to engage in a full grip. (Px3). Dr. Fernandez testified that each finger has a specific function in gripping and that the manual dexterity of each finger can play a

critical role depending on the type of item you're grabbing or the type of tasks you're completing. (Px3). The assessment and plan at that time was for Petitioner to enter a weaning program, which meant she would take off the splint and start engaging in increasing-range-of-motion activities. (Px3). This program was to last about four weeks. (Px3). Her work restrictions remained the same. (Px3).

Petitioner's last visit with Dr. Fernandez was on July 30, 2019. (Px2). At that time, she was still having pain and swelling in her finger. (Px3). She testified that her complaints at that time included pain shooting down the side of her hand when she used her hand, her finger was still getting stuck and her finger couldn't go down all the way. (TA37). She was working full duty but had deficits, as she had an extensor lag of about 20-degrees. (Px3). She also had a loss in flexion, which meant she was notable to flex her finger more than 60-degrees. (Px3). This was about a 20-degree loss compared to the normal side. (Px3). Dr. Fernandez explained that this meant she had the inability to straighten it out fully and she also had the inability to bend it fully. (Px3). On examination, she still had dorsal prominence and the joint was passively correctable. (Px3). Dr. Fernandez explained that passively correctable meant she would have to use her other hand to passively bring the joint out of the fixed position. (Px3). He further testified that in later stages the joint could become stiff and fixed and will not be passively correctable. (Px3). This type of progression over time could lead to further joint pain and loss of motion. (Px3). Dr. Fernandez's assessment at that time was one of residual pain and stiffness from traumatic mallet deformity with some degeneration. (Px3). He testified that at this point Petitioner had two options; (1) accept it for what it is with its limitations; or (2) proceeding with a fusion. (Px3). A fusion would entail welding the joint in an extended position to get rid of the

pain and improve the position. (Px3). A fusion would likewise limit her ability to make a full fist. (Px3). He testified that she was considered to be at MMI only because she had reached a plateau in terms of her functionality and explained that this didn't mean she's not entitled to further treatment. (Px3). He explained that she had just reached a plateau in terms of her functionality. (Px3). As far as work restrictions, she was able to continue to work with the limitations she had. (Px3). He testified it was more likely than not she would have residual symptoms and would have a residual deformity. (Px3). He further testified that the deformity was not going to get better and in fact was only more likely to get worse. (Px3).

The last x-rays Dr. Fernandez reviewed showed a fibrous union along the top of the joint. (Px3) He explained that this type of injury does not often heal bone-to-bone. He further explained that this could get worse over time. (Px3).

Dr. Fernandez explained that Jamar dynamometer is a device used by medical professionals to test the grip strength. (Px3). He testified that he had treated other patients with mallet finger injuries to their little fingers that subsequently developed a swan neck deformity like Petitioner. (Id). Additionally, he testified that he had treated other patients with the same type of flexion deformities as Petitioner (Id). He further testified that in his treatment of these other individuals with similar injuries, deformity and flexion limitations as Sandra, he had noted deficiencies in their grip strength. He did not use the Jamar dynamometer devise with the Petitioner. (Id).

Dr. Fernandez testified that based upon a reasonable degree of medical and surgical certainty Sandra's condition is causally related to her work injury on August 28, 2018. (Px3). He further explained that the basis for his opinion is that there is no evidence that she had a history of this problem prior to the reported injury on August 28, 2018. (Id). He testified that based upon a reasonable degree of medical and surgical certainty all the treatment rendered to Petitioner was reasonable and necessary to treat her work-related injury. (Id). He also testified that based upon a reasonable degree of medical and surgical certainty Petitioner's potential need for surgery in the future is causally related to her work accident on August 28, 2018. (Id).

On cross-examination, as well as on direct, the Petitioner confirmed that she had not scheduled surgery with Dr. Fernandez. The last time she had seen Dr. Fernandez was July 30, 2019. She has not called the doctor for any further appointments. Dr. Fernandez had advised that if she needed to come back to see him, she could do so. Particularly, she testified that if she had any further problems in the future, she could come back to see Dr. Fernandez. She had not returned to see Dr. Fernandez. Virtually all of the treatment she received following the accident involved her left small finger. (TR 45 – 46)

Respondent submitted the Section 12 examination report of Dr. Sam Biafora into evidence. Dr, Biafora examined the Petitioner at Respondent's request on December 19, 2019 and produced a report was dated January 7, 2020. The Petitioner provided a history that a combative patient struck her left hand, small finger. Symptoms and treatment thereafter were limited to the small finger. The effect of the injury was that the Petitioner suffered a bony mallet fracture with a resultant swan neck deformity. This resulted in a hyperextension of the proximal

interphalangeal joint resulting in an intermittent difficulty in initiating flexion at the proximal joint when attempting to grasp or make a full fist. Ultimately the Petitioner was able to reach the palmer crease with the finger. Dr. Biafora concluded that there was a causal relationship between the accident and the appearance of the finger. This would be permanent if the Petitioner chose not to obtain surgery to address the issue. His report indicated that Petitioner did have some residuals because of the work injury. She had some hyperextension at the PIP joint and residual DIP flexion. (Id). The hyperextension at the PIP joint results in intermittent difficulty in initiating flexion at the PIP joint when attempting to grasp or make a full fist. (Id). He agreed that it would be reasonable to consider surgery if she felt her symptoms were sufficiently symptomatic, and that the surgery would be causally related to the work incident. (RX 1)

Petitioner testified that because of this injury to her left little finger she had to learn to adjust her left hand in s certain way to lift. (TA38-39). She also testified that she had to adjust how she turned and twisted her left hand while completing tasks at work because she gets shooting throbbing pain that goes down the side of her hand. (TA39). She further testified that prior to this injury she would use her left hand as her dominant hand while performing CPR, but that she can no longer do that because of her injury. (TA39). As a result, she now usually just gets assigned to do the recording of the CPR. (Id). Petitioner testified that her left-hand grip is weaker because of the injury. (TA40). Her deformity has gotten worse. (Id). In her testimony she emphasized that the pain is not limited to her left little finger, but instead extends all the way through her left hand and palm. (TA41-42). Petitioner testified that she is concerned the surgery could further limit the use of her hand and her ability to work as a nurse at Loretto Hospital, but

she would like to get the surgery because her condition does not seem to be getting better. (TA43-44).

On March 30, 2021, .Petitioner injured her left little finger at work when her left hand was caught between a combative patient who fell while trying to leave and an emergency staff member that fell on top of the patient. Petitioner experienced some initial swelling and pain. She was seen in the emergency room. Petitioner testified that x-rays were taken and reported negative for a new fracture. Petitioner testified that the she still had the same pain since her first injury; it was a continuation of the same pain as the first injury. (TA, 50-55)

III. CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his or her 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). It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the

industry, nor by the public. Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable. *Shell Oil v. Industrial Comm'n,* 2 Ill.2nd 590, 603 (1954). Decisions of an Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Petitioner testified in open hearing before the Arbitrator who had opportunity to view Petitioner's demeanor under direct examination and under cross-examination. The Arbitrator finds the Petitioner was a sincere and credible witness. Her testimony overall was corroborated by the stipulated facts, the medical records and the record as a whole.

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

The Arbitrator adopts the above findings of fact in support of the conclusions of law set forth below. Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his or her 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). It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of

the industry, nor by the public. Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable. *Shell Oil v. Industrial Comm'n,* 2 Ill.2nd 590, 603 (1954). Decisions of an Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Petitioner testified in open hearing before the Arbitrator who had opportunity to view Petitioner's demeanor under direct examination and under cross-examination. The Arbitrator finds the Petitioner was a sincere and credible witness. Her testimony overall was corroborated by the stipulated facts, the medical records and the record as a whole.

The Arbitrator concludes that the Petitioner has proven by a preponderance of the evidence that her present condition of ill being relative to her left little finger and left hand are causally connected to the incident on August 28, 2018. This conclusion is based upon the credible and unrebutted testimony of the Petitioner, an examination of the medical records, the credible and unrebutted testimony of Dr. John Fernandez and the credible and unrebutted opinions of Dr. Sam Biafora. Her injury was sustained within the scope of her employment, as she was injured by a patient of the hospital while on duty as a nurse at Loretto Hospital at the time of the occurrence.

To establish causation under the Illinois Workers' Compensation Act, 820 ILCS 305/1 et seq. (2012), a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. It is not necessary to prove that the employment was the sole

causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453.

An injury arises out of a claimant's employment where it "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 203 (2003). Here, the Petitioner was working her scheduled shift as a nurse at Loretto Hospital when she was kicked in her left hand by a combative patient as she tried to assist the patient. To administer the necessary medical attention to this patient, Petitioner was required to help restrain her. Petitioner testified that restraining patients was a necessary part of her job. The risk of being injured by a combative and unstable patient is a risk distinctly associated with Sandra's employment as a nurse at Loretto Hospital.

Before the accident of August 28, 2018, Petitioner was working in a full duty capacity and credibly testified that she had no prior injuries or issues with her left hand and left fifth finger. It is evident that Sandra's current condition of ill-being is causally related to the incident of August 28, 2018.

The medical records and Petitioner's testimony are very consistent in that they indicate Sandra's current condition of ill-being is causally related to her work incident of August 28, 2018. Further, Dr. John Fernandez and Dr. Biafora agreed that, based upon a reasonable degree of medical and surgical certainty, Petitioner's condition is causally related to her work injury on August 28, 2018.

Presently, Petitioner is still suffering from the injury that resulted from the patient kicking her in her left fifth finger. Petitioner has followed doctors' orders and attended all forms of recommended treatment. She received multiple splints and special physical therapy, but thus far she has not been provided with full relief. Dr. Fernandez, a credible doctor with a specialty in orthopedic hand surgery, has indicated Petitioner could either live with the deformity and pain or proceed with a fusion of her finger. A fusion would help with correcting the deformity and pain but would not assist her in regaining full function of her fifth finger and left-hand grip. Dr. Biafora agreed with the surgical assessment from Dr. Fernandez. This recommendation remains unrebutted as there has not been any examiner that has disagreed with Dr. Fernandez's assessment. Further, Petitioner testified that she continues to have pain in her finger and hand and that her deformity continues to get worse with time. Dr. Fernandez testified that although it is possible that her condition may improve, it was more likely and probable than not that the deformity would continue to get worse with time.

The Arbitrator does not find the second accident of March 2019 to be an intervening cause sufficient to completely break the causal chain between the original work-related injury and the ensuing condition. It is well settled that when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. *See Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 87 (1995); *Vogel v. Illinois Workers' Compensation Comm'n* , 354 Ill. App. 3d 780, 787 (Ill. App. Ct. 2005) *; Lasley Construction Co. v. Industrial Comm'n*, 274 Ill. App. 3d 890, 893 (1995). "For an employer to be relieved of liability by virtue of an intervening cause, the intervening

cause must completely break the causal chain between the original work-related injury and the ensuing condition." Global Products, 392 Ill. App. 3d 408, 411 (2009)

The subsequent injury of March 30, 2019, just weeks before the April 20, 2021 trial in this matter, appears to have been limited to some soreness which was in addition to the pain about which the petitioner complained and which resulted from the first accident. The Arbitrator notes that neither party introduced and medical records or reports, regarding the March 30, 2021 work injury nor any evidence that Petitioner received a more medical treatment beyond an emergency room checkup. The second event does not appear to be significantly disabling and does not contribute much, if anything, to the Petitioner's overall condition at the time of the hearing. (TA, 50-.55)

In light of the above, the Arbitrator finds that the Petitioner has provided sufficient evidence to establish by a preponderance of the evidence that a causal relationship exists between Petitioner's current condition of ill-being and her work-related injury on August 28, 2018.

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

Based upon the unrebutted and credible testimony of Petitioner, her medical records, the unrebutted and credible testimony of Dr. John Fernandez and the unrebutted and credible opinions of Dr. Sam Biafora, the Arbitrator finds that the Petitioner has sustained injuries of the left hand and left little finger.

The Arbitrator finds the matter *Jerry Wooten v. City of Chicago*, *.2018 Ill. Wrk. Comp. LEXIS 654, *5, 18 IWCC 510,* to be instructive in the determination of the nature and extent of Petitioner's injury in instant case.

In *Jerry Wooten v. City of Chicago*, the Petitioner was 62 years old and working as a truck driver for the City of Chicago. He suffered a crush injury to the distal phalanx of his right little finger while at work. He underwent surgery and completed the recommended course of treatment. . He was seen by Dr. John Fernandez for a Section 12 examination at the request of the Respondent. Dr. Fernandez noted that although the Petitioner was discharged back to work, he continued to work with difficulties. The Petitioner had significant residual complaints of the right small finger pain. He also complained of swelling and deformity. However, his biggest complaint was stiffness to terminal flexion and closing his hand and the associated weakness with grasping. Dr. Fernandez indicated that the Petitioner was at maximum medical improvement, but not normal and limited to light to medium use of his right hand. Petitioner testified that he tries not to put any pressure on his right little finger, which cannot be straightened. Based on the residual weakness to pinch and grip, the fact that the injury still affected the way Petitioner worked, the fact Petitioner faced a slower healing process because of his age and the fact Petitioner tried to avoid putting pressure on the finger, which could not be straighten, the Arbitrator found the Petitioner in *Jerry Wooten v. City of Chicago* sustained permanent partial disability to the extent of 20% loss of the right hand. The Commission unanimously affirmed the Decision of the Arbitrator.

Petitioner, Nurse Weeks, was under the care of Dr. John Fernandez. He testified that each finger plays an important role in grip strength, and that in his treatment of individuals with a

similar injury, deformity and flexion limitation as Sandra, he had noted deficiencies in their grip strength. Petitioner demonstrated that she was still unable to touch the tip of her little finger to her palm. He testified that an individual's ability to make a full fist is dependent on their ability to touch the tips of their fingers to their palm, which he referred to as tip-to-palm. Dr. Fernandez explained that the fusion surgery would also limit Sandra's ability to make a full fist. Further, Dr. Fernandez never issued a free and clear full duty release. In fact, when he testified regarding her work restrictions, he always indicated that she was able to continue to work with the limitations that she had.

Just like the Petitioner in *Jerry Wooten v. City of Chicago*, Petitioner tries to avoid putting pressure on her finger, her finger cannot be straightened, and she has difficulty lifting, pulling, grasping and holding things tightly. Further, Petitioner also returned to work full duty, but the injury still affects the way she can work. Petitioner testified that she has had to modify the way she does certain work-related tasks such as lifting and moving patients, opening medication, and performing CPR. Petitioner no longer has ability to perform CPR at the level she was capable of prior to this injury. Loretto Hospital has accommodated this by assigning her to record the CPR instead of performing it. Her inability to adequately perform CPR could compromise her ability to obtain employment as a nurse elsewhere.

It is evident from the medical records, the credible and unrebutted testimony of the Petitioner and Dr. Fernandez and the credible and unrebutted opinions of Dr. Biafora, that due to her injury of August 28, 2018, the Petitioner has lost the ability to make a full fist with her left

hand and will require a fusion of her little finger to help alleviate her pain and to correct the deformity. She will never again have normal tip-to-palm function of her whole left hand.

As to permanent partial disability, the Arbitrator notes that the pathology of the injury is confined to the left fifth finger, but the net functional effect of the injury is not. Like the Petitioner in *Jerry Wooten v. City of Chicago* the functional effect of the injury results in a loss of use of the hand. The Arbitrator is mindful that Petitioner performs her duties as nurse in emergency care of patients, she may not be able to be as careful and cautious as she would like to protect her finger to avoid injury. And, that she is impaired in the defensive use of her left hand to avoid injury with combative patients. Thus, like the Arbitrator and all three members of the Commission in the matter of *Jerry Wooten v. City of Chicago*, the Arbitrator views this matter as injury to the hand. This conclusion is based upon viewing the Petitioner, considering her stoic and credible testimony, the medical records, Respondent's Section 12 report, and the testimony of Dr. John Hernandez.

The Arbitrator notes that the medical records, Respondent's Section 12 report and testimony of Dr. Hernandez is devoid any reference to symptom magnification, negative Waddell findings, or indication of issues for secondary gain.

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

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

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

(i) The reported level of impairment;

(ii) The occupation of the injured employee;

(iii) The age of the employee at the time of injury;

(iv) The employee's future earning capacity; and

(v) Evidence of disability corroborated by medical records.

With regards to paragraph (i) of Section 8.1(b) of the Act, the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. This factor carries no weight in the permanency determination.

With regards to paragraph (ii) of Section 8.1(b) of the Act, Petitioner is now, and was at the time of injury, employed a registered emergency room nurse in a position that requires frequent use of both hands, including administrating, CPR, which increases the symptoms in her left little finger and pain into base of her 5th finger and into the palm. She testified that her employment as an emergency room registered nurse does require frequent of use of her hands, including frequent lifting, pushing and pulling as well as using her hands defensively to protect

her from combative emergency room patients. This factor carries significant weight in the permanency determination

With regards to paragraph (iii) of Section 8.1(b) of the Act, Petitioner was 51 years old at the time of the accident. The Arbitrator considers the Petitioner to be an older individual and will likely have greater disability than a younger individual with the same injuries. The Arbitrator gives this factor moderate weight.

With regards to paragraph (iv) of Section 8.1(b) of the Act: Petitioner returned to her full duty work but with some limitations and no evidence was presented which would indicate that she sustained any loss of earning capacity as a result of this accident. This factor carries some weight in the permanency determination.

With regards to paragraph (v) of Section 8.1(b) of the Act, the evidence of Petitioner's injury in the medical records show that she sustained mallet deformity with objective pathology and deficits that will get worse in time. The left ring finger mallet deformity and swan neck deformity is adversely affecting Petitioner's use of her left hand. A hand that she uses in emergency situations for critical lifesaving care. Petitioner's deficits were fully documented and explained by Dr. Fernandez and confirmed by Respondent's Section 12 examiner.

Respondent submitted the Section 12 examination report of Dr. Sam Biafora who opined that the effect of the injury was that the Petitioner suffered a bony mallet fracture with a resultant swan neck deformity. This resulted in a hyperextension of the proximal interphalangeal joint resulting in difficulty in initiating flexion at the proximal joint when attempting to grasp or make a full fist. He opined that ultimately the Petitioner was able to reach the palmer crease with the finger. Dr. Biafora concluded that there was a causal relationship between the accident and the

appearance of the finger. This would be permanent if the Petitioner chose not to obtain surgery to address the issue. His report indicated that Petitioner did have some residuals because of the work injury. She had some hyperextension at the PIP joint and residual DIP flexion. The hyperextension at the PIP joint results in difficulty in initiating flexion at the PIP joint when attempting to grasp or make a full fist. Dr Biafora agreed that it would be reasonable to consider surgery if she felt her symptoms were sufficiently symptomatic, and that the surgery would be causally related to the work incident. The Arbitrator notes that the difficulties Petitioner experiences is not only the pathology of the injury but also the associated pain with use. (RX 1)

Petitioner's last visit with Dr. Fernandez was on July 30, 2019. (Px2). At that time, she was having pain and swelling in her finger. (Px3). She was working full duty but had deficits, as she had an extensor lag of about 20-degrees. (Px3). She also had a loss in flexion, which meant she was notable to flex her finger more than 60-degrees. (Px3). This was about a 20-degree loss compared to the normal side. (Px3). Dr. Fernandez explained that this meant she had the inability to straighten it out fully and she also had the inability to bend it fully. (Px3). On examination, she still had dorsal prominence and the joint was passively correctable. (Px3). Dr. Fernandez explained that passively correctable meant she would have to use her other hand to passively bring the joint out of the fixed position. (Px3). In the later stages the joint could become stiff and fixed and will not be passively correctable. (Px3). This type of progression over time could lead to further joint pain and loss of motion. (Px3). Dr. Fernandez's assessment at that time was one of residual pain and stiffness from traumatic mallet deformity with some degeneration. (Px3). He testified that at this point Petitioner had two options; (1) accept it for what it is with its limitations; or (2) proceeding with a fusion. (Px3). A fusion would entail

welding the joint in an extended position to get rid of the pain and improve the position. (Px3). A fusion would likewise limit her ability to make a full fist. (Px3). He testified that she was considered to be at maximum medical improvement only because she had reached a plateau in terms of her functionality and explained that this did not mean she's not entitled to further treatment. (Px3). He explained that she had just reached a plateau in terms of her functionality. (Px3). As far as work restrictions, she was able to continue to work with the limitations she had. (Px3). He testified it was more likely than not she would have residual symptoms and would definitely have a residual deformity. (Px3). He further testified that the deformity was not going to get better and in fact was only more likely to get worse. (Px3).

The last x-rays Dr. Fernandez reviewed showed a fibrous union along the top of the joint. (Px3) He explained that this type of injury does not often heal bone-to-bone. He further explained that this could get worse over time. (Px3).

Dr. Fernandez explained that Jamar dynamometer is a device used by medical professionals to test the grip strength. He had not performed one on the Petitioner. (Px3, Px 2)). He, however, testified that he had treated other patients with mallet finger injuries to their little fingers that subsequently developed a swan neck deformity like Petitioner. (Id). Additionally, he testified that he had treated other patients with the same type of flexion deformities as Petitioner (Id). He further testified that in his treatment of these other individuals with similar injuries, deformity and flexion limitations as Petitioner, he had noted deficiencies in their grip strength. (Id).

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all the above factors, the Arbitrator concludes that Petitioner has sustained a 10% permanent loss of the left hand under Section 8(e), or 20.50 weeks of permanent partial disability benefits because of the injury on August 28, 2018.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC035690
Case Name	WILLIAMS, MEEKO v. EXPRESS EMPLOYMNT PROFESSIONALS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0085
Number of Pages of Decision	20
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Jordan Browen
Respondent Attorney	James Murray

DATE FILED: 3/8/2022

/s/*Carolyn Doherty, Commissioner*

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MEEKO WILLIAMS,

Petitioner,

vs. NO: 17 WC 35690

EXPRESS EMPLOYMENT PROFESSIONALS - SOUTH HOLLAND,

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

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

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

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

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

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

March 8, 2022

o: 3/03/22
CMD/ma
045

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC035690
Case Name	WILLIAMS, MEEKO v. EXPRESS EMPLOYMENT PROFESSIONLS – SOUTH HOLLAND
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Paul Seal, Arbitrator

Petitioner Attorney	James Murray
Respondent Attorney	Jordan Browen

DATE FILED: 9/21/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 21, 2021

/s/ *Paul Seal, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Meeko Williams
Employee/Petitioner

v.

Express Employment Professionals - South Holland
Employer/Respondent

Case # 17 WC 035690

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 Chicago, IL, on June 23, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ____________

FINDINGS

On the date of accident, November 25, 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 $28,488.68; the average weekly wage was $547.09.

On the date of accident, Petitioner was 45 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 $11,457.30 for TTD, $0 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $11,457.30.

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

ORDER

Respondent shall pay Petitioner in the sum of $68,048.04, representing 186 4/7 weeks from November 26, 2017 through June 23, 2021 at the rate of $364.73, less Respondent's credit of $11,457.30, for TTD Benefits as outlined in Section L of the Arbitrator's Conclusions of Law.

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

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

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

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

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

Signature of Arbitrator

SEPTEMBER 21, 2021

FINDINGS OF FACTS

1. Accident and Treatment Chronology

On November 25, 2017, Petitioner was employed with Express Employment, South Holland – a staffing agency. Petitioner testified that she had worked as a driver for approximately seven years and on the date of accident was assigned to a facility called Automotive Warehouse Corporation ("AWC"). Petitioner testified that she worked a full-time shift that ran between 7:00 p.m. and 7:00 a.m. with job duties primarily involving shuttling employees to different locations.

In the early morning of November 25, 2017, Petitioner was returning to the warehouse after shuttling some employees and to take her break. She testified that while making a left turn enroute to AWC, the driver's seat of the van came loose from the floor of the vehicle. The force of the left turn caused her to fall to the right and out of her seat. Petitioner testified the vehicle did not have a seatbelt. Petitioner lost control of the vehicle and crashed into a ditch on the side of the road. During the crash, Petitioner testified that her knees slammed against the center console of the van. Petitioner immediately felt pain to her left knee, back, neck and bilateral upper extremities.

The same day, November 25, 2017, Petitioner presented to Ingalls Occupational Medicine at around 5:45 a.m. complaining of back, left arm, left upper leg, and left knee pain. (Petitioner's Exhibit 'Px' 1 at 15). Petitioner rated her pain a 10/10. (*Id.*). X-ray imaging of the lumbar spine demonstrated mild multilevel degenerative changes with endplate spurring and facet hypertrophy without evidence of a fracture or subluxation. (Px1 at 33). Petitioner received a diagnosis of low back sprain and was discharged with a prescription for cyclobenzaprine and ibuprofen. (Px1 at 32).

On November 28, 2017, Petitioner returned to Ingalls Occupational Medicine Clinic for a follow-up examination. Petitioner reported ongoing back pain, right upper arm pain, and left medial knee pain. (Px1 at 67). X-rays were taken of the left knee, which demonstrated moderate patellofemoral degenerative changes without acute fracture or dislocation. (Px1 at 71). Petitioner was diagnosed with muscle strain of the lower back, intervertebral disc degeneration in the lumbosacral region and unspecified pain in the left knee. (Px1 at 67). Petitioner was prescribed anti-inflammatory medication and a knee brace. Petitioner's work activity was restricted to 5-pound lifting/carrying, 10-pound pushing/pulling, and no-kneeling. (Px1 at 69).

On November 30, 2017, Petitioner presented to Dr. Darrel Saldanha with Midwest Anesthesia and Pain Specialists ("MAPS") for an initial evaluation. (Px2 at 21). Petitioner reported low back, left knee, left elbow pain and headaches. (*Id.*). Physical exam yielded normal sensory and neurological findings, but also positive facet loading with extension, tenderness over the lumbar paraspinous muscles, TPP over the left elbow lateral epicondyle and left knee TPP over the patellar tendon. (*Id*). Dr. Saldahna diagnosed petitioner with headaches, pain in the left elbow, pain in the low back and pain in the left knee. (*Id.*) Dr. Saldahna prescribed pain medications and physical therapy. Dr. Saldanha placed Petitioner off-work at this time. (Px2 at 22).

On December 1, Petitioner Presented to American United Physical Therapy Clinic for her initial physical therapy evaluation. Petitioner attended physical therapy sessions approximately three times a week through her final session on April 18, 2018. (Px3a at 26, Px3b at 390).

Petitioner followed up at MAPS on December 21, 2017, with continued low back, left knee and left elbow pain along with continued headaches. (Px2 at 25). Physical exam yielded positive a positive straight leg raise test and TPP over the patellar tendon and moderately positive McMurray's test. (Px2 at 26). Dr. Saldanha opined that Petitioner's headaches were cervicogenic in origin. (*Id.*). Dr. Saldahna recommended continued use of pain medications, continued physical therapy and an MRI of the lumbar spine, cervical spine, and left knee. (*Id.*). Petitioner was continued off-work. (Px2 at 26).

On January 3, 2018, Petitioner presented to MRAD imaging for MRI studies of her cervical spine, lumbar spine, and left knee. (Px4 at 7-11). With respect to the lumbar spine, the radiologist noted multilevel spondylosis with facet arthrosis and ligamentum flavum hypertrophy, a broad-based posterior herniation at L4-5 causing moderate neuro foraminal and mild central canal stenosis, and a disc bulge with posterior herniation at L5-S1 causing moderate neural foraminal and mild central canal stenosis. (Px4 at 8).

With respect to the cervical spine, the radiologist noted multilevel mild spondylotic changes from C4-C7, a posterior herniation at C5-6 causing mild to moderate foraminal and mild central canal stenosis, and strengthening of normal cervical lordosis, possibly representing muscle spasm versus strain. (Px4 at 10). With respect to the left knee, a horizontal posterior root tear of the medial meniscus was noted. (Px4 at 7).

On January 4, 2018, Petitioner returned to MAPS for a follow-up visit. Physical exam yielded a positive straight leg raise test and positive McMurray's test. (Px2 at 31). Dr. Saldanha recommended continued use of pain medications and physical therapy, as well as reiterated his recommendation for a lumbar spine MRI and Lumbar Epidural Steroid Injection. (Id). Further, Petitioner received a referral for an orthopedic surgical consultation for her continued left knee pain. (Px2 at 32, 33). Petitioner was continued off-work. (Px2 at 31).

On January 12, 2018, Petitioner presented to Dr. Chandrasekhar Sompalli at Elite Orthopedics & Sports medicine for an initial evaluation. (Px5 at 4). Petitioner reported 9/10 left knee pain, constant, sharp, and tight in quality radiating down and swelling at the left knee. (*Id.*). Petitioner reported that pain was aggravated with standing, all movement, walking, and transitioning from sitting to a standing position. (*Id.*). Dr. Sompalli noted that Petitioner walked with a limping gate and used a cane and knee brace to ambulate. (*Id.*). Petitioner additionally reported a 'buckling' and 'giving way' sensation particularly when climbing stairs. (*Id.*). Petitioner also reported minimal relief from physical therapy, home exercises, muscle relaxants and NSAIDs. (*Id.*). Physical exam noted tenderness, effusion, and limited range of motion. (*Id.*). Dr. Sompalli recommended continued physical therapy and ibuprofen. (*Id.*). Dr. Sompalli continued Petitioner's off-work restrictions at this visit. (*Id.*)

On January 25, 2018, Petitioner returned to MAPS with unchanged symptoms in her low back. (Px2 at 34). Physical exam once again yielded a positive straight leg raise test. (*Id.*). Dr. Saldanha recommended continued use of pain medications, physical therapy, and renewed his recommendation for a lumbar epidural steroid injection. (Px2 at 35). Dr. Saldanha continued Petitioner's off-work restrictions at this time. (*Id.*).

On February 13, 2018, Petitioner followed up with Dr. Sompalli, reporting continued severe left knee pain, sharp, stiff, and tight in quality with radiation into the calf area. (Px5 at 6). Petitioner again reported difficulty walking and climbing stairs with a knee brace and cane. (*Id.*). Dr. Sompalli performed a left knee bursa injection, recommended continued physical therapy and first discussed a possible surgical solution. Px5 at 7. (*Id.*).

On February 15, 2018, Petitioner returned to MAPS with continued complaints of low back pain. Physical exam once again yielded a positive straight leg test. (Px2 at 38). Dr. Saldanha again renewed his recommendation for pain medications, physical therapy, and a lumbar epidural steroid injection. (*Id.*). Dr. Saldanha also continued Petitioner's off work restrictions. (*Id.*).

On March 13, 2018, Petitioner returned to Dr. Sompalli reporting ongoing severe left knee pain and no relief from the left knee bursa injection. (Px5 at 8). Petitioner specifically noted continued sharp, stiff, and tight pain radiating into the calf area, aggravated by standing and all movement including walking and transitioning from sitting to standing. (*Id.*). At this time, Dr. Sompalli recommended a left knee arthroscopy, chondroplasty, and meniscectomy. (Px5 at 9).

On March 20, 2018, Petitioner returned to MAPS for a follow up exam. (Px2 at 41). Physical exam once again yielded positive straight leg raise. (Px2 at 42). Dr. Saldanha recommended continued use of muscle relaxants and NSAIDS (without renewing his prescription for Norco), physical therapy and a lumbar epidural steroid injection. (*Id.*). Further, Dr. Saldanha recommended an H-wave unit for home use. (Px2 at 46).

On March 19, 2018, Petitioner presented to Dr. Daniel Troy for a Section 12 examination. (Rx3). In his report, Dr. Troy noted a significant amount of guarding during the examination and reported the examination was 'significantly affected'. (*Id.*). Physical exam noted about fifty- percent flexion and pain with palpation to the cervical spine. (*Id.*). Regarding the low back, Petitioner had diffused pain in the low back, left greater than right. (*Id.*). Regarding the left knee and ankle, Petitioner exhibited limited range of motion, and Dr. Troy was unable to perform a McMurray's Maneuver. (*Id.*). Dr. Troy recommended Petitioner undergo a functional capacity evaluation. (*Id.*). Dr. Troy opined that Petitioner exhibited signs of symptom magnification and that her limited movement was 'self-induced', but that Petitioner needed to undergo an FCE to determine her work capabilities. (*Id.*). However, Dr. Troy opined that Petitioner suffered from severe degenerative changes in her cervical and lumbar spine. (*Id.*).

On April 10, 2018, Petitioner presented to Athletico Physical therapy for a functional capacity evaluation on the recommendation of Dr. Troy. (Px6). The test performance summary generated indicated a 38% consistency of effort, 100% quality of effort, 78% reliability of pain and receiving a combined total performance score of 78%. (Px6 at 4). Petitioner demonstrated, at

minimum, a capability to perform sedentary physical demand, though the FCE reports indicate that Petitioner was potentially capable of more demanding work tasks.

On April 17, Petitioner returned to Dr. Sompalli reporting continued severe left knee pain, sharp and stiff in quality with radiating pain into the calf area. (Px5 at 10). Dr. Sompalli reiterated his surgical recommendation and additionally recommended home exercises and strengthening. (Px5 at 10-11).

On April 26, 2018, Petitioner returned to MAPS for a follow up exam. (Px2 at 47). Physical exam yielded a positive straight raise test. Dr. Saldanha recommended continued use of muscle relaxants, NSAIDS, continued physical therapy, and an epidural steroid injection. (Px2 at 49). Dr. Saldanha also continued Petitioner's off-work restrictions. (*Id.*)

On May 24, 2018, Petitioner returned to Dr. Saldanha for a follow up exam. Once again, physical exam yielded positive straight leg raise. (Px2 at 51). Dr. Saldanha recommended continued muscle relaxants, NSAIDs, continued physical therapy and home exercises. (*Id.*). Dr. Saldanha noted that the lumbar epidural steroid injection was now approved. (*Id.*). Petitioner's off-work restrictions were renewed. (*Id.*)

On May 25, 2018, Petitioner followed up with to Dr. Sompalli reporting unchanged knee pain and ongoing reliance on a cane and brace for support. (Px5 at 12). Physical exam revealed limited range of motion, moderate effusion, and medial/lateral joint line tenderness. (*Id*). Dr. Sompalli recommended continued home exercises and reiterated his recommendation for surgery. (*Id.*).

On June 5, 2018, Petitioner presented for an L4-L5 lumbar epidural steroid injection at Hyde Park Surgical Center. (Px8 at 4). Petitioner then followed up with MAPS on June 21, 2018, reporting about 70% relief in her radicular symptoms. (Px2 at 54). Physical exam once again yielded a positive straight leg raise test. (*Id.*). Dr. Saldanha renewed recommendations for muscle relaxants, NSAIDS, physical therapy, home exercises and a repeat lumbar epidural steroid injection at L4-L5. (Px2 at 55).

On July 19, 2018, Petitioner returned to Dr. Saldanha for a follow up exam. (Px2 at 59). Once again, physical exam yielded positive straight leg raise. (*Id.*). Dr. Saldanha renewed his recommendations for continued use of pain medications, physical therapy, and additional lumbar epidural steroid injection. (*Id.*). Additionally, Dr. Saldanha continued Petitioner's off work restrictions. (Px2 at 60).

On July 20, 2018, Petitioner returned to Dr. Sompalli reporting continued sharp knee pain, weakness, instability, and difficulty ambulating. (Px5 at 14). Dr. Sompalli recommended continued home exercises and reiterated his recommendation for surgery. (Px5 at 15).

On August 23, 2018, Petitioner returned to MAPS. This was her final visit. Petitioner reported resolved lumbar pain and associated radicular symptoms. (Px2 at 62). Dr. Saldanha recommended continued home exercises and continued Petitioner off work for the knee, with instructions to return on an as-needed basis. (*Id.*).

On September 14, 2018, Petitioner returned to Dr. Sompalli reporting continued sharp knee pain, weakness, instability, and difficulty ambulating. (Px17). Physical exam revealed limited range of motion, moderate effusion, medial/lateral joint line tenderness. (*Id.*). Dr. Sompalli reiterated his recommendations for surgery and continued home exercises at this time. (Px5 at 20).

Petitioner followed up with Dr. Sompalli approximately every couple of months to end 2018 and into 2019. Both Petitioner's complaints and exam findings were unchanged. Dr. Sompalli continued to recommend the surgical procedure.

On August 2, 2019, Petitioner returned to Dr. Sompalli for her final visit prior to hearing, reporting severe left knee pain radiating into the rest her leg and with difficulty with all movement. (Px5 at 33). Physical exam once again yielded limited range of motion, moderate effusion, and medial/lateral joint line tenderness. (Px5 at 32). Dr. Sompalli reiterated his recommendations for home exercises and surgery. (Px5 at 35). Dr. Sompalli also placed Petitioner on light duty restrictions of no bending, twisting, squatting, kneeling, climbing, and 2-pound restrictions on lifting, carrying, pulling and pushing over two pounds. (Px5 at 36).

2. <u>Evidence Deposition of Dr. Chandrasekhar Sompalli</u>

On September 24, 2020, the parties took the evidence deposition of Dr. Chandrasekhar Sompalli. Dr. Sompalli testified that approximately seventy percent of his practice is arthroscopic surgery of the shoulders, knees, sports injuries, and traumatic injuries. (Px12 at 7). During his initial examination of petitioner, Dr. Sompalli testified he immediately noticed her limited range of motion from zero to 90 degrees. (*Id.*). Dr. Sompalli also testified that he observed moderate effusion, along with tenderness in the medial and lateral joint lines. (*Id.*). Dr. Sompalli opined that joint line tenderness indicates pain and the possibility of an abnormal finding. (*Id.*). Dr. Sompalli also opined that effusion means swelling, which can indicate something abnormal in the knee including severe arthritis, trauma, or a meniscal tear. (Px12, at 10).

Dr. Sompalli testified that prior to his second consultation with Petitioner in February of 2018, he received and reviewed Petitioner's MRI films. (Px12 at 11). Dr. Sompalli testified that he reviewed both the report and reviews the actual imaging themselves. (*Id.*). Dr. Sompalli also testified that when he reviewed the MRI films, he noted a medial meniscal root tear, bursitis, and mild chondromalacia. (Px12 at 12). Dr. Sompalli testified that he initially recommended more physical therapy to relieve some of her knee pain. (*Id.*). However, Dr. Sompalli testified that when therapy fails to relieve his patients' pain, he offers injections, just as he did for Petitioner in February of 2018. (Px12 at 14).

Dr. Sompalli further testified that during his third consultation with Petitioner in March of 2018, he noted essentially unchanged symptoms and that the injection did not help relieve her pain. (Px12 at 15). Dr. Sompalli testified that he noted unchanged symptoms during his follow-up visits with her in May, July, September, and December of 2018. (Px12 at 17).

When asked about Dr. Troy's IME report, Dr. Sompalli testified that Dr. Troy made an error– that Dr. Troy wrote that he recommended a *diagnostic* knee arthroscopy, not a knee arthroscopy and partial meniscectomy and chondroplasty. (Px12 at 17).

Dr. Sompalli testified that he believed her medial meniscal tear was caused by her work injury. (Px12 at 19). Dr. Sompalli also testified that his treatment of Petitioner was reasonable and necessary. Dr. Sompalli testified that if she still suffered from her knee locking and giving way, that she would require a left knee arthroscopy, partial medial meniscectomy, and chondroplasty. (Px12 at 19). Dr. Sompalli also testified that if she received the surgery, she would require eight weeks of physical therapy and achieve maximum medical improvement in eight to twelve weeks. (*Id.*). Dr. Sompalli testified that Petitioner's prognosis would be excellent. (Px12 at 21).

On cross examination, Dr. Sompalli testified that a meniscus root tear is more often traumatic than degenerative and that a degenerative root tear is unlikely for middle-aged women. (Px12 at 27). Specifically, Dr. Sompalli testified that middle-aged women with arthritis tend to get more mid-meniscal tears like a bucket handle tear or others, but that root tears are not typical in middle-aged women. (Px12 at 27). Dr. Sompalli testified that a degenerative root tear could be treated without surgery if they are asymptomatic. (Px12 at 27).

Further, Dr. Sompalli testified on cross-examination that he relied on Petitioner's subjective complaints and uses palpation to examine for tenderness to correlate with a patient's pain. (Px12 at 29). Dr. Sompalli testified that he relied on physical exam, along with the reading of her MRI and failure to improve with surgical treatment in concluding that Petitioner needed surgery. (Px12 at 29).

Further, Dr. Sompalli testified on cross-examination that he reviewed Petitioner's FCE performed at Athletico. (Px12 at 30). Dr. Sompalli acknowledged in the FCE that Petitioner' described her injuries as a "twisting" motion, a word not found in emergency records. However, Dr. Sompalli opined that based on the described mechanism of accident, her injury would necessarily involve a twisting element based on her posture sitting in the van's driver's seat. (Px12 at 32).

On re-direct examination, when asked about the FCE, Dr. Sompalli testified that he refers patients for FCE usually after they have surgery and finish postoperative therapy to see exactly what their job capabilities are. (Px12 at 35). Specifically, Dr. Sompalli testified that he does not use FCEs when patients are still treating or have significant pain because they're not functioning properly but uses an FCE ninety percent of the time after completing post-operative physical therapy to see how he can get his patients back to work. (Px12 at 36). Dr. Sompalli specifically testified that:

> "When somebody is in pain, they're not going to give a good 100 percent effort or even a 50 percent effort. When you are in pain, and in FCEs they put you through the wringer there with your extremities. So, when you're not able to give an

effort more commonly than not it's because you're
in pain and you can't do it." (Px12 at 37).

Finally, with respect to Ms. Williams' complex tear, Dr. Sompalli testified that he does not treat complex tears if they do not show symptoms or impact their lifestyle. (Px12 at 37). Dr. Sompalli testified that surgery is warranted if they are continuing to have significant pain, limping, and using a cane for stability. (*Id.*).

3. <u>Evidence Deposition of Dr. Daniel Troy</u>

On January 20, 2021, the parties took the deposition of Dr. Daniel Troy, Respondent's Section 12 examiner. Dr. Troy testified that he is a board-certified spinal surgeon. (Rx3 at 5). According to his CV, his current practice is called Advanced Orthopedics and Spine Care. Dr. Troy testified that on the date of the IME he was able to review the MRI films of Petitioner's left knee, which in his opinion showed a horizontal posterior root tear of the medial meniscus, as detailed in the report. (Rx12 at 14). Dr. Troy also opined that she had a disc bulge and posterior herniation at the L5-S1 level of her spine and L3-L4 level of her spine. (Rx12 at 15). Dr. Troy also acknowledged a posterior herniation at C5-C6 causing mild to moderate foraminal and mild central canal stenosis. (Rx12 at 16).

Dr. Troy found on the date of the IME appointment, that Petitioner was 70-80lbs overweight, making her morbidly obese. (Rx12 at 18). Dr. Troy reported that Petitioner could not perform strength testing because she had too much pain in the left side of her neck. (Rx12 at 20). Dr. Troy also testified that Petitioner would not let Dr. Troy perform a hip bending maneuver or take her knee past 40 degrees of flexion. (Rx12 at 21). As such, Dr. Troy testified that he was unable to perform the McMurray's maneuver. (*Id.*). Dr. Troy noted that during strength testing, she would simply 'give way', (Rx12 at 22). Dr. Troy testified that he believed Petitioner was 'not being forthright during her examination'. (*Id.*).

Regarding Petitioner's left knee MRI films, Dr. Troy opined that he did not appreciate a posterior horn root tear in Petitioner's left knee. (Rx12 at 23). Regarding the lumbar spine MRI films, Dr. Troy opined that there were diffuse degenerative changes in the lumbar spine. (Rx12 at 26). Regarding the cervical spine MRI films, Dr. Troy opined that there were no acute findings in the MRI, instead opining that there were mild degenerative changes in her cervical spine. Id.

Further, Dr. Troy opined that there were Waddell factors during Petitioner's exam. (Rx3 at 29). While Dr. Troy noted reduced strength and 'giving way', he noted that there was guarding and fighting during range of motion tests. (*Id.*). However, Dr. Troy could not explain why her strength was giving way. (Rx12 at 29). Dr. Troy then opined that there were also signs of symptom magnification and exaggeration with her left upper extremity, left side of her neck, low back and left knee. (Rx12 at 32).

On cross examination, Dr. Troy testified that knee treatment represents only 25 percent of his practice. (Rx12 at 37). Dr. Troy admitted that patients may have different pain thresholds. (Rx12 at 37). Dr. Troy also admitted it was possible that a patient could be asymptomatic with degenerative changes. (Rx12 at 37). However, Dr. Troy did also admit that patients with asymptomatic degenerative changes could become symptomatic due to a motor vehicle accident

in Petitioner's case. (Rx12 at 38). Further, Dr. Troy testified that there could be a six to eight-percent chance that a pathology may not appear on a diagnostic MRI which a diagnostic arthroscopy could reveal. However, Dr. Troy also admitted that he did not feel a diagnostic arthroscopy was necessary.

4. <u>Petitioner's Testimony at Trial</u>

Regarding the IME examination, Petitioner testified at trial that on the day of the exam, she experienced significant pain as she had not yet received the LESI, was unresponsive to the cortisone shot to the knee and overall had limited range of motion in her back, neck, arms, and knee. As such, Petitioner testified that she found Dr. Troy's tests during physical exam extremely difficult and despite her best efforts, had extremely limited range of motion in most of her body on that day.

Similarly, Petitioner testified that during the functional capacity evaluation, she was asked to undergo various exercises such as squatting, climbing stairs, and lifting heavy weights. Petitioner testified that the functional capacity evaluation's exercises exacerbated her already significant amount of pain, with stair climbing and transitioning from a laying-to-sitting-to-standing giving her the most trouble.

Regarding Petitioner's ability to work, she testified that since her final consultation with Dr. Sompalli, she has attempted to return to work numerous times without success. Following her release from MAPS, Petitioner testified that she contacted her supervisor who instructed her to apply online for a position with Respondent that could fit her light duty restrictions. However, Petitioner testified she never received an offer of employment through the online application process, nor any other formal offer of employment from Respondent. Moreover, Petitioner testified that since her accident, all available driver positions with Respondent now require a CDL license, which she does not have.

Petitioner also testified that at one point in 2019, she attempted to work as a cashier at a restaurant called Smokin' Pit. She earned $12 an hour and worked part time – consisting of a few days per week, working 5-hour shifts. Petitioner ultimately quit as the position required many hours of standing which exacerbated her knee pain to intolerable degrees. Petitioner testified she did not earn enough to report the income on her tax returns. Additionally, Petitioner testified that she applied to a position at the St. Joseph Carmelite Crisis home for boys and girls as a supervisor but did not receive an offer of employment.

Petitioner testified at trial that her knee pain causes significant difficulties with her normal activities of daily living. Petitioner testified she currently lives on a second-floor apartment and experiences significant pain climbing stairs when entering and exiting her home. Petitioner also testified that she now requires an electric scooter while grocery shopping, adding an additional hour to her shopping time. Additionally, Petitioner testified that doing laundry now takes a significantly longer amount of time than before.

Petitioner also testifies that she can no longer do some of the hobbies she enjoyed – particularly cooking. Petitioner used to cook five nights a week for her minor son, but now cannot cook as her knee pain prevents her from doing so.

Additionally, due to the increased burden and inability for Petitioner to find a job, Petitioner's adult daughter moved in with them to assist at home. Petitioner testified that her daughter worked at O'Hare airport before she was laid off. Petitioner testified that she and her minor son now depend on a share of Petitioner's daughter's unemployment benefits to get by financially.

Petitioner testified that she currently manages her pain with conservative home care including using a knee brace, icing and CBD creams and edible supplements. Petitioner testified that even with conservative home care, she remains in a significant amount of pain that is essentially unchanged from her final consultation with Dr. Sompalli. Petitioner testified that essentially any amount of walking exacerbates her pain, including her walk through the Daley Center to present in-person for trial. Ultimately, Petitioner testified she wishes to undergo Dr. Sompalli's recommended knee arthroscopy, chondroplasty, and meniscectomy.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues present at the hearing as follows:

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 causally related to the undisputed injury sustained on November 25, 2017.

In reaching his conclusion, the Arbitrator relies on Petitioner's credible testimony corroborated by the medical records from Ingalls Hospital, Ingalls Occupational Medicine, Midwest Anesthesia & Pain Specialists, MRAD Imaging and Elite Orthopedics & Sports Medicine. The Arbitrator further finds that the medical opinion of Dr. Sompalli is more credible, and therefore holds more weight than, the opinion of Dr. Troy, Respondent's IME physician.

The Arbitrator also finds that causal connection is established between Petitioner's current condition of ill-being and the undisputed November 25, 2017, work injury under the "chain of events" analysis frequently applied by the Commission and reviewing courts. *Martin Young enterprises, Inc. v. Industrial Com.,* 51 Ill.2d 149 (1972).

A. Petitioner's Credibility and Credibility of the Treating Physicians

The Arbitrator finds that Petitioner testified credibly at the Arbitration hearing. Her unrebutted testimony with respect to the mechanism of injury is further corroborated by the consistent and contemporaneous description of the accident memorialized in medical records of

Ingalls Hospital & Occupational Medicine, Midwest Anesthesia and Pain Specialists and Elite Orthopedics & Sports Medicine.

The Arbitrator also finds that Petitioner credibly established a history of ongoing low back and knee pain throughout the course of her treatment. Petitioner credibly testified that she experienced persistent knee and back pain throughout her treatment, which is well-documented in her treatment records. Further, Petitioner credibly corroborated the medical records which indicated that while she was somewhat responsive to her first and only lumbar epidural steroid injection, her knee pain was essentially unresponsive to all forms of treatment. Not only did Petitioner's testimony align with the subjective complaints documented in the medical records, but the Arbitrator also notes an extensive history of objective data from physical exam, including well-documented histories of positive straight leg tests, tenderness to the knee with palpation and limited range of motion in several areas of her body.

The Arbitrator also finds that Petitioner credibly testified without rebuttal that to date, she has trouble with activities of daily living such as grocery shopping and cooking, and essentially relies on her adult daughter to support her having not returned to work for Respondent.

Petitioner credibly testified to the most critical details regarding her medical treatment.

First, Petitioner underwent pain management treatment with Dr. Darrel Saldanha at Midwest Anesthesia & Pain Specialists which included an ESI that resolved most, but not all her back pain. This testimony is corroborated by Petitioner's evaluation immediately following the June 5, 2018 injection. The contemporaneous medical records indicated 70% improvement in her lumbar pain and resulted in a recommendation for a second lumbar epidural steroid injection. Meanwhile, Petitioner testified that her knee pain continued and remained essentially unchanged long after her lumbar treatment concluded, a fact that that is also documented extensively in the contemporaneous medical records.

Second, Petitioner testified she conducted approximately four months of physical therapy at American United Physical therapy which did not improve her knee or back pain, a fact that is repeated ad nauseum throughout the medical records of Drs. Saldanha and Sompalli.

Third, Petitioner testified that she underwent an IME which caused her a tremendous degree of pain. Although Dr. Troy was unsympathetic to Petitioner's pain upon physical exam, his recounting of her limited range of motion and guarded posture is entirely consistent with Petitioner's own testimony at trial, during which she admitted that she was in fact guarded and did in fact struggle through the IME exam due to the pain she was in.

Finally, Petitioner testified she underwent an FCE at Athletico Physical Therapy after treating for only five months and prior to undergoing surgery, and that the evaluation caused her a tremendous degree of pain as she was asked to lift weights, climb stairs and transition from laying to sitting to standing – all which she credibly testified caused her a significant degree of pain.

The Arbitrator finds the testimony of Dr. Sompalli to be more credible than the testimony of Dr. Troy and therefore affords Dr. Sompalli greater weight. The Arbitrator notes that after reviewing the testimony of each of the doctors' current practice and medical training, Dr. Sompalli is more experienced and a better authority for a knee injury. While Dr. Troy does treat knees in his practice, they are a smaller percentage and after review of his medical education, Dr. Troy has devoted more of his practice to conditions of the spine.

The Arbitrator also weighs heavily Dr. Sompalli's consistent and extensive treatment of Petitioner. A surgical solution was not recommended until all conservative options were exhausted.

Despite Dr. Troy's opinion that the FCE results correlate to his findings of symptom magnification, the Arbitrator was instead persuaded by Dr. Sompalli, who noted that FCE's are typically used to determine permanent restrictions after a patient has undergone surgery. Based on the fact that Petitioner has not undergone the recommended procedure, it is not surprising that Petitioner exhibited guarded behavior during both the IME and FCE.

The Arbitrator further finds Dr. Troy's opinion to be less credible than Dr. Sompalli due to his lack of attention to detail and misunderstanding of Dr. Sompalli's surgical recommendation. Dr. Troy opines that a diagnostic knee arthroscopy is not warranted. However, Dr. Sompalli did not recommend a diagnostic knee arthroscopy. Dr. Sompalli recommended a knee arthroscopy, chondroplasty, and meniscectomy.

Dr. Sompalli by comparison, credibly testified that his diagnosis and recommendation for the specific procedure was based on his reading of the MRI, his numerous physical examinations, and the failure of conservative treatment.

B. <u>Petitioner Met Her Burden of Proof Under a "Chain of Events" Analysis</u>

Petitioner's condition of ill-being with respect to her knee is causally related to the undisputed work accident under a "chain of events" analysis. A chain of events which demonstrates a previous condition of good health, an accident and subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and employee's injury. *Martin Young Enterprises*, at 155.

It is undisputed that Petitioner's low back and left knee were asymptomatic, and Petitioner was able to work full duty prior to her accident on November 25, 2017. After the undisputed injury, Petitioner testified to an immediate onset of back and knee pain.

Significantly, Petitioner's symptoms in her elbow, back and neck resolved with conservative treatment. Petitioner's left knee symptoms persist through the date of the hearing and have not resolved with extensive conservative treatment.

Petitioner has proved by a preponderance of the evidence (1) a relative condition of good health, (2) an accident and (3) a subsequent, persisting condition of ill being. As such, under this "chain of events" analysis, Petitioner's injuries were causally related to the accident.

Reviewing the evidence in its entirety, the Arbitrator finds Petitioner has met her burden, proving by a preponderance of the evidence that her left knee's current condition of ill-being is causally related to the work injury of November 25, 2017. Petitioner's unrebutted testimony correlates with subjective complaints of pain in the contemporaneous medical records and corresponding objective medical data. The opinions and recommendations of Dr. Sompalli are more credible and therefore given more weight than the opinions of Dr. Troy. Petitioner's back pain resolved, but her left knee has not returned to either maximum medical improvement or a preinjury baseline, satisfying causal connection under a "chain of events" analysis.

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?

At trial, Petitioner introduced the following unpaid medical bills into evidence:

	Provider	Amount
1.	Midwest Anesthesia & Pain Specialists	$2,600.00
2.	United Physical Therapy	$16,350.00
3.	MRAD Imaging	$4,800.00
4.	Elite Orthopedics	$523.71
5.	ADCO Billing Solutions	$2,683.46
6.	Hyde Park Surgery Center	$9,500.00
7.	Illinois Anesthesia Specialists	$1,248.00
8.	CM Healthcare Solutions	$599.18
9.	Windy City Medical Specialists	$22,020.00
	Total:	$60,324.35

The Arbitrator finds the medical treatment ordered and rendered by all the above-listed providers to be both reasonable and necessary and that Respondent has not paid all appropriate charges for Petitioner's reasonable and necessary medical services.

Having afforded little weight to the opinion of Respondent's Section 12 examiner, Dr. Troy, the Arbitrator instead relies on credible testimony from Petitioner and Drs. Saldanha and Sompalli that treatment rendered to date was reasonable and necessary.

The Arbitrator specifically notes that the nature of the treatment with Drs. Saldanha and Sompalli have been essentially maintenance care; medication refills and home exercises while the surgery remains disputed (with exception to physical therapy and a single LESI). Further, the Arbitrator finds that Petitioner made a diligent effort to avoid expensive medications, as the medical records indicate she ultimately transitioned away from Norco and Cyclobenzaprine to OTC NSAIDS and CBD supplements.

Accordingly, having found in Petitioner's favor on the issue of causal connection, and for the reasons outlined above, the Arbitrator finds Respondent liable for all outstanding and related medical charges.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator finds Petitioner is entitled to prospective medical care. Petitioner has not reached MMI as Dr. Sompalli has recommended a left knee arthroscopy and chondroplasty, along with corresponding post-operative physical therapy and follow-up care.

As previously noted, the Arbitrator finds Petitioner is a credible witness eager to undergo surgery, recover and work to provide for her family and perform activities of daily living without debilitating knee pain. As such, the Arbitrator finds that Petitioner is entitled to the recommended procedure as well as all reasonable and necessary post-operative treatment prescribed by Dr. Sompalli.

L. What temporary benefits are in dispute?

The Arbitrator finds that Petitioner is entitled to 186 4/7 weeks of TTD from November 26, 2017 through June 23, 2021. The parties stipulated that Respondent has paid $11,457.30 in TTD benefits through July 4, 2018.

The dispositive inquiry in deciding whether a Petitioner is entitled to 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, having found in favor of Petitioner on the issue of causal connection, agrees with the opinion of Dr. Sompalli that Petitioner's condition has not yet stabilized to her pre-injury capabilities or maximum medical improvement as of the hearing date of June 23, 2021. Petitioner has been totally temporarily disabled from the date of the accident through the 19b hearing.

At trial, Petitioner testified that she attempted work at a barbeque restaurant for several weeks but could not maintain the employment due to her knee pain. The Arbitrator specifically notes that she did not earn enough to report the income on her tax returns. As such, the Arbitrator finds these earnings to be incidental and does not reduce the TTD award in light of these minimal earnings.

At a TTD rate of $364.73, 186 and 4/7 weeks is a total award of $68,048.04. Respondent paid $11,457.30 in TTD benefits for which they are credited. Respondent therefore owes $56,590.74 in TTD benefits to Petitioner.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC034926
Case Name	RODRIGUEZ LOPEZ, LUIS C v. MG CONSTRUCTION/MATRIX BASEMENT SYSTEMS & IWBF
Consolidated Cases	
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0086
Number of Pages of Decision	7
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Chris Cooper
Respondent Attorney	David Clark, Rachel Peter

DATE FILED: 3/10/2022

/s/*Carolyn Doherty, Commissioner*
Signature

To STATE OF ILLINOIS)		
) SS.		
COUNTY OF DUPAGE)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LUIS RODRIGUEZ LOPEZ,

Petitioner,

vs. NO: 11 WC 34926

MG CONSTRUCTION,
MATRIX BASEMENT SYSTEMS, INC., AND
INJURED WORKERS' BENEFIT FUND

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein he requests review of the Arbitrator's order denying reinstatement of his case. The Commission, after considering the filings of the parties and the record, and being advised of the facts and law, reverses the Arbitrator's denial of reinstatement, reinstates the case and remands the matter to the Arbitrator for further proceedings. The Commission's findings of fact and conclusions of law are as follows.

I. STATEMENT OF FACTS

A. Procedural History

On September 12, 2011, Petitioner filed an Application for Adjustment of Claim alleging he sustained injuries while working on November 10, 2010. An Amended Application was filed on September 23, 2011, adding Respondent, Matrix Basements, Inc. This case has previously been dismissed twice and was reinstated on September 21, 2016 and January 22, 2018, respectively.

On March 28, 2019, the case was again dismissed for want of prosecution. On April 1, 2019, Petitioner received notice of the dismissal. On May 14, 2019, Petitioner timely filed a Motion for Reinstatement of the Case, which was to be presented at the June 19, 2019 status call. The motion was presented and set for hearing on June 27, 2019. The June 27, 2019 transcript of proceedings states that a record of the Arbitrator's denial was made at the request of Petitioner's

Counsel. Respondent's Counsel, who appeared earlier in the trial call on June 27, 2019, was not present for the hearing later that same day when the record was made. The Arbitrator maintained the denial of the Motion to Reinstate on the record.

On January 22, 2020, a Substitution of Attorney was filed, wherein a new attorney substituted in as attorney of record for Respondent, Matrix Basements. The substitution took place well after the hearing and denial of the motion to reinstate.

B. The Record of Proceedings on the Motion to Reinstate

The Motion for Reinstatement, filed on May 14, 2019, and presented on June 19, 2019, was heard by Arbitrator Ciecko on June 27, 2019. The case did not proceed to formal trial, rather a record, regarding the Arbitrator's denial, was created at the request of Petitioner. Petitioner's Counsel was present on the record; however, Respondent's Counsel at the time, was not present.

The Arbitrator began the record by noting that it was 12:02 p.m. The Arbitrator stated that earlier in the call "today," he was presented a Motion to Reinstate this case on the basis that the parties were in active settlement negotiations, movant believed the matter had been returned to the call on the scheduled trial date, and that communication between the parties was ongoing. Movant also advised that Petitioner had a meritorious cause of action as evidenced by the Application and that they had been diligent in the prosecution of this case. The Arbitrator stated that when the case was called earlier that morning, the Attorney for Respondent appeared alone and informed the Arbitrator of an objection to the reinstatement and that the case had been previously dismissed for want of prosecution in 2016. The Arbitrator also stated that Petitioner's Counsel did not appear to present the Motion for Reinstatement at the same time as Respondent's Counsel. When Petitioner's Counsel appeared before the Arbitrator later that morning, the Arbitrator advised Petitioner's Counsel that his opponent had already appeared and objected, at which point the Arbitrator denied the Motion for Reinstatement. The Arbitrator stated on the record that Petitioner's attorney "now wishes to make a record on that denial."

Petitioner's Counsel then spoke on the record stating the Motion for Reinstatement was timely filed on May 14, 2019. Petitioner's Counsel explained that he spoke with Respondent Counsel at some point the same morning and Respondent's Counsel informed him that Respondent did not have an objection to the Motion to Reinstate. Respondent's Counsel then signed his name and wrote "no objection" on the Motion for Reinstatement. In addition, Petitioner's Counsel asserted that medical records had been provided and Petitioner was awaiting a settlement offer from Respondent. Petitioner's Counsel argued that Petitioner had not lacked diligence in prosecuting the case and again noted the Motion to Reinstate was filed timely. Finally, with no objection from Respondent as indicated on the signed and noted Motion to Reinstate, Petitioner's Counsel did not see "any reasons why this case should not be reinstated." Petitioner's Counsel then offered into evidence Petitioner's "PX1," a copy of the motion with Respondent Counsel's signature and note of "no objection." The exhibit was admitted and attached to the transcript.

After Petitioner's Counsel spoke, the Arbitrator stated on the record that the signed motion with no objection was "after his initial appearance today." Petitioner's Counsel

responded that he was not there at the time Respondent's Counsel first presented, but Respondent's Counsel had just left the court call, and Respondent's Counsel told him that he did not have an objection and signed the motion. The Arbitrator then clarified on the record that when he received the reinstatement, the Arbitrator checked his own records, noting the case appeared on the March 19th status call and received a trial date of March 28th. The Arbitrator also recalled having an exceptionally heavy call on March 28th and at no point, did anyone appear on the case. As such the Arbitrator dismissed the case for want of prosecution. In response, Petitioner's Counsel advised the Arbitrator that his office was not apprised of that trial date due to clerical error, thus he did not appear. However, as soon as Petitioner received the notice of dismissal, Petitioner's Counsel filed a timely Motion to Reinstate for which there is no objection from Respondent. The record was then concluded by the Arbitrator.

II. CONCLUSIONS OF LAW

Petitioner's timely filed Petition requests the Commission review the Arbitrator's denial of reinstatement. "On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought." *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138, 804 N.E.2d 629, 631 (2004). "Whether to grant or deny a petition to reinstate rests within the sound discretion of the Commission." *Banks*, 345 Ill. App. 3d at 1140, 804 N.E.2d at 631; *see also Conley v. Industrial Comm'n*, 229 Ill. App. 3d 925, 930, 594 N.E.2d 730, 171 Ill. Dec. 586 (1992). On review, the Commission's determination will not be disturbed absent an abuse of that discretion. *TTC Illinois, Inc./Tom Via Trucking v. Illinois Workers' Compensation Comm'n*, 396 Ill. App. 3d 344, 355, 918 N.E.2d 570, 579, 335 Ill. Dec. 225 (2009). "The term abuse of discretion' has been defined as 'palpably erroneous, contrary to the manifest weight of the evidence, or manifestly unjust,' and as a decision with respect to which 'no reasonable person would take the view adopted by the trial court.'" *Village of Kildeer v. Schwake*, 162 Ill. App. 3d 262, 276-77 (1987) (quoting *Douglas Transit, Inc. v. Illinois Commerce Comm'n*, 145 Ill. App. 3d 115, 119-20 (1986)). In the administrative context, the term also tends to be equated with arbitrary and capricious decisions. *See Greer v. Illinois Housing Development Authority*, 122 Ill. 2d 462, 497 (1988).

In exercising its discretion regarding reinstatement, the Commission relies on the standards established in Commission Rule 9020.90, which states:

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed, and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition.

d) A cause shall be reinstated upon stipulation of the parties filed with the Commission, which will docket the stipulation.

e) Nothing in this Section abridges the rights found in the applicable Statute of Limitations of the Illinois Workers' Compensation Act (Section 6(d) of the Act) or Section 6(c) of the Illinois Occupational Diseases Act.

Based on our review of the Motion to Reinstate and the on the record as a whole as it pertains to the dismissal and the request for reinstatement, the Commissions finds that the Petitioner’s Motion for Reinstatement was timely pursuant to Section 9020.90(a). In addition, it should be noted that the timeliness of the Motion was never raised as an issue at the time of the hearing or on review. Further, as discussed by the Arbitrator on the record, the Motion advised that the parties were in active settlement negotiations, movant believed the matter had been returned to the call on the scheduled trial date, and that communication between the parties was ongoing. The Commission’s review of the Motion confirms the same. The Commission also finds proper notice as evidenced by the motion itself and the fact there were no notice objections raised at the June 27, 2019 hearing date. As such, the Commission concludes that the Motion to Reinstate also satisfied the requirements of 9020.90(b).

Based on the review of the transcript, the Arbitrator relied on Respondent’s oral objection earlier in the trial call and his dismissal at his March 2019 status call as the basis for the denial of reinstatement. On review, the Respondent makes similar arguments to support their position that the denial should be affirmed. As such, the disputes and issues in this matter arise from the Arbitrator’s application of Rule 9020.90(c) and whether there was an abuse of discretion. For purposes of context, it should be noted that if a dismissal for want of prosecution was the determinative factor as to whether a case should be reinstated, there would be no need for Rule 9020.90. In addition, the Commission notes that both parties were not simultaneously present at the time and date set for hearing on the Motion to Reinstate. Rather, each party expressed its position at separate times on June 27, 2019, and only Petitioner’s counsel was present at the time the Petition for Reinstatement was actually heard and a record was made.

On June 27, 2019, Petitioner’s Counsel appeared and provided the basis for the reinstatement of this case. His statements on the record were consistent with the substance of the timely filed Motion, advising the Arbitrator that medical records had been tendered and Petitioner was awaiting a settlement offer from Respondent. More importantly, Petitioner’s Counsel testified that he spoke to Respondent’s Counsel at the trial call on June 27, 2019, clearly after Respondent’s counsel spoke to the Arbitrator expressing an objection to the motion, and at that time Respondent’s Counsel told him there was no objection. Respondent’s Counsel confirmed

the lack of objection, by writing "no objection" and signing his name to the motion before leaving court. Petitioner's Counsel offered the motion into evidence as Petitioner's Exhibit 1 (hereinafter "PX1"). The Commission finds that the signature and notation on PX1 is proof of an unrebutted agreement between Petitioner and Respondent regarding the reinstatement of this matter. As such, we reasonably infer that Respondent's Counsel chose not to reappear before the Arbitrator with Petitioner's Counsel after signing and notating the motion because the parties expected the Arbitrator to reinstate the case. The transcript is clear that it was Petitioner who asked for a record to be made because the Arbitrator denied the reinstatement, despite there being "no objection" as evidenced by PX1. If the Arbitrator did not believe in the veracity of PX1 and believed the motion to be "contested" based on the initial verbal objection he received, it was incumbent on the Arbitrator to have a formal hearing with both parties present in compliance with Section 9020.90 (c). It should also be noted that, on review, the Attorney General, representing the Injured Worker's Benefit Fund, advised that it does not have an objection to the reinstatement. Further, Respondent, MG Construction did not raise an objection at the June 27, 2019, hearing nor did they file a brief on review.

Further, looking to Rule 9020.90(d), the Commission finds that in the context of this case, PX1 representing "no objection" from Respondent's counsel is tantamount to a stipulation by the parties. As discussed above, PX1 is an unrebutted, written agreement between the parties regarding the Motion for Reinstatement. While not "filed," PX1 was admitted into the record of the case on June 27, 2019 without objection. Here, the attorneys reached an agreement that the case would be reinstated without objection from the Respondent as evidenced by PX1.

Finally, to the extent that Respondent asserts Petitioner failed to diligently pursue the review before the Commission after timely filing the Petition for Review, the Commission finds that any delays during the review process of this case were administrative in nature and not solely within the control of the Petitioner. As such, the delays will not be used to prejudice the Petitioner nor benefit the Respondent as it relates to the merits of this case.

In exercising its discretion and applying standards of fairness pursuant to Rule 9020.90, the Commission gives weight to PX1, which evidences the parties' agreement to reinstate on June 27, 2019 and satisfies section (d) of Rule 9020.90. In addition, as previously discussed, the Petitioner complied with sections (a), (b) and (c) of Rule 9020.90, which provides additional support to the Commission's reinstatement. Therefore, having considered the totality of evidence, the Commission concludes that the Arbitrator erred in denying reinstatement of the case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Motion to Reinstate is reversed, that this matter is reinstated, and that this matter is remanded to the Arbitrator for a full hearing and disposition on the merits.

March 10, 2022

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

o: 03/09/22
CMD/jjm

045

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC022537
Case Name	SLOAT, RONNIE v. NORTH AMERICAN LIGHTING
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0087
Number of Pages of Decision	29
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Stephen Carter

DATE FILED: 3/11/2022

/s/Thomas Tyrrell, 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 JEFFERSON	)	☒ Reverse (Accident)	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronnie Sloat,

Petitioner,

vs. NO: 19 WC 22537

North American Lighting,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering all issues, and after being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of Fact

On August 2, 2019, Petitioner filed an Application for Adjustment of Claim alleging he developed left epicondylitis due to repetitive trauma as a result of his job duties on June 17, 2019. Petitioner testified that on June 17, 2019, he worked for Respondent as an operator on the 241 RCL sub line. The company assembles vehicle taillights. He testified:

> "Well, I was changing over because the girl that I work with wasn't tall enough to do the changeover, so I was doing the changeover. And the supervisor rushes you to get it done because they want the numbers. I [sic] rushing to get it done. There was a screw underneath one of the changeover things, and it kind of stuck, and I just shoved it in."

(Tr. at 21). Petitioner testified that he immediately felt a shock through his left arm and a knot developed on his forearm. He testified that he continued working and reported his condition to Bill Thompson, his supervisor, once his shift ended. Petitioner identified RX 11 as the accident report he completed electronically the morning of June 17, 2019. He testified that he personally typed in all the information. (Tr. at 36-37). Petitioner testified that Mr. Thompson sat next to him as he completed the accident report. The report lists a creation date of June 18, 2019, and lists the date and time of injury as June 17, 2019, at 6:50 a.m. Petitioner testified that his injury occurred at

approximately 3:00 a.m. or 3:30 a.m. He testified that he was unable to complete the report until the end of his shift because Mr. Thompson told him to wait until the end of his shift to submit the report. Petitioner later testified that he started his shift at 10:00 p.m. or 10:30 p.m. on June 17, 2019, and his shift ended the morning of June 18, 2019. However, he later testified again that his injury occurred the morning of June 17, 2019, not June 18, 2019. Petitioner could not explain why the report says it was created on June 18, 2019. He denied entering that date. Petitioner testified that he did not know what Mr. Thompson may have done to the report once Petitioner submitted it. In the accident report, Petitioner denied that his injury was caused by repetitive or overuse, lifting, moving, pushing, or pulling.

Petitioner testified that he visited Human Resources ("HR") following his shift on June 17, 2019. Petitioner testified that he asked when the company nurse would be on the premises. Petitioner testified that he spoke with Darlene Pollard in HR that morning. Respondent submitted contemporaneous documentation written by Darlene Pollard and Dana DeMaris, both employees of Respondent, stating Petitioner visited HR to report his alleged injury on June 18, 2019. (RX 14, 15). When asked about the note from Ms. Pollard stating Petitioner visited HR on June 18, 2019, Petitioner testified, "No. I went in right after I got off the belt." (Tr. at 24). He testified that he visited HR, talked to Mr. Thompson, and completed the accident report electronically all on the date of his injury, June 17, 2019.

Petitioner testified that he sometimes performs changeovers two or three times per shift. He testified that someone tells the workers when to change to the right-hand or left-hand side of the machine. He described the changeover procedure as follows: "You got the left hand sitting here and empty tray sitting there. You have to move that full one out and then move the empty one in and slide the one full one in and shove them in." (Tr. at 27). He testified that he felt a shock and tingling in his left arm when he performed the changeover. Petitioner testified that since the accident his left ring and pinky fingers sometimes go numb.

Under cross-examination, Petitioner testified that Dr. McIntosh told him that his condition was caused by repetitive trauma. Petitioner also knew that Dr. McIntosh testified that Petitioner's mechanism of injury was caused by repetitive trauma. When asked if he knew what repetitive trauma is, Petitioner testified:

> "Yes. When you do 30 parts an hour and are forced to do changeovers and 30 parts an hour, you got two people on the line, it's impossible."

(Tr. at 29-30). Petitioner denied telling Dr. Young, Respondent's Section 12 examiner, that Dr. McIntosh changed his mechanism of injury and that Dr. McIntosh told Petitioner that his injury was due to repetitive trauma. Petitioner initially testified that he could not recall sitting in Dr. McIntosh's office; however, under further questioning, he testified that he was in the doctor's office four or five times. He later testified that he did recall Dr. McIntosh telling him that his condition was due to repetitive trauma. (Tr. at 32). Petitioner denied that he had a conversation with Dr. Young about his mechanism of injury. He testified that Dr. Young did not say much during the examination. When asked if Dr. Young asked him about his mechanism of injury and repetitive trauma, Petitioner testified: "No. All he did was just wrote [sic] down stuff on paper and

looked at my arm, and that was it, went home." (Tr. at 32). Petitioner did not know why Dr. Young would write that any conversation occurred.

Petitioner continued to testify that he completed the accident report on June 17, 2019. Petitioner initially testified that he could not remember if Mr. DeMaris was with Ms. Pollard in HR when Petitioner asked about the company nurse's schedule. He then testified that he believed Mr. DeMaris was by his desk during Petitioner's conversation with Ms. Pollard. Petitioner agreed that Mr. DeMaris probably heard his conversation with Ms. Pollard, but denied Mr. DeMaris participated in the conversation. The following exchange occurred regarding Petitioner's conversation with Ms. Pollard:

> Q. Now you're saying this all happened on the day of the accident?
> A. Yes.
> Q. Are you sure?
> A. Yes.
> Q. If the employer's records show you left work on June 17 reporting nothing, can you explain that?
> A. I didn't leave work. I went right in there right at 7:00 because I filled the accident report out at 6:50, because you leave the line, you get in trouble. That's why I didn't go in there right when it happened.

(Tr. at 35-36). Petitioner testified that he visited HR and spoke to Ms. Pollard within 10 minutes after he completed the accident report. He could not recall whether Ms. Pollard asked him whether his condition was work-related or personal. Petitioner denied telling Ms. Pollard and Mr. DeMaris that his injury was not work-related.

Petitioner denied that he told Nurse Vetter at the company clinic that he had no prior injuries and further testified that he told the nurse that he had carpal tunnel surgery twenty years earlier. He testified that he did not deny undergoing any prior relevant surgeries when he saw Dr. McIntosh. He testified that Dr. McIntosh never asked about his surgical scars. Under further questioning, Petitioner agreed that he told Dr. McIntosh that he had no prior injuries or surgeries. (Tr. at 46). Petitioner testified that Dr. Young never asked him about any prior left hand and/or arm surgeries. The following exchange occurred regarding the information Petitioner disclosed about his prior surgeries on his bilateral hands and arms:

> Q. Isn't it true that you did not tell any doctor, when you went to Nurse Vetter, when you went to Dr. McIntosh, when you saw Dr. Young, isn't it true that you specifically told each and every one of them that you never had an elbow surgery specifically?
> A. They didn't ask.
> Q. Well, if their records suggest they did ask and that you answered you did not, can you explain that?
> A. No.
> Q. Can you explain if you filled out a piece of paper saying what kind of surgeries you had, if you told them by a piece of paper that you didn't have surgeries, my question to you is this, you definitely

> had a left elbow surgery in the past?
> A. Yes, they should know that. They got my medical records.
> Q. Who is they?
> A. Dr. Young got my medical records, McIntosh can get them, anybody can get them that's a doctor.

(Tr. at 48-49). Petitioner testified that Dr. McIntosh never looked at his elbow. Petitioner agreed that he previously underwent a left cubital tunnel surgery performed by Dr. Beatty in 1999. He testified that he did not disclose his prior left elbow injury and surgery because it was an entirely different injury.[1] Under additional questioning, Petitioner again denied that anyone specifically asked him about any prior left elbow injuries or surgeries. An additional exchange occurred regarding Petitioner's lack of disclosure of his prior left elbow injury and treatment:

> Q. Dr. Young did not specifically ask you?
> A. I think he only asked two questions, my name, what am I here for, and I told him right here…That's all he said.
> Q. If Dr. Young's report in his deposition indicated that he was concerned that you were not telling him the truth about that, and that you didn't tell the truth about that until he specifically asked you about that and about the scar on your arm, do you dispute that's what happened?
> A. Yes.
> Q. You dispute that?
> A. I think if he—you know, if the doctor is in there, he is going to see my arms and examine them, and he is going to ask what the scars are, and how am I going to lie about them.
> Q. And you're suggesting that conversation with Dr. Young did not happen?
> A. No, no.
> Q. And you're saying that conversation with Nurse Vetter didn't happen?
> A. No.
> Q. And that conversation with Dr. McIntosh didn't happen?
> A. No.
> Q. And if all of their records say the same thing, that you denied having the surgery which is represented by the scar on the arm, my last question about that is, can you explain that?
> A. No.

(Tr. at 50-52).

Petitioner testified that he saw Nurse Vetter twice at the company clinic. He testified that the nurse first examined him less than an hour after he spoke with Ms. Pollard in HR. Petitioner

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1 The Commission take Official Notice that on September 8, 1999, Petitioner settled a workers' compensation claim against Cambridge Industries, Inc. in Case No. 98 WC 67057. Pursuant to the settlement agreement, Petitioner in relevant part received compensation for 20% loss of use of the left arm.

further testified that the nurse restricted him to light duty work during the initial visit and released him from light duty restrictions during his second office visit. Petitioner could not explain why the clinic's records do not reveal any evidence of Petitioner visiting the clinic a second time. Petitioner testified that he discussed his job duties with Dr. McIntosh. Petitioner then testified that he did not discuss his specific job duties with the doctor; instead, he simply told the doctor he was an operator. (Tr. at 71-72). Petitioner testified that he assembles taillights. He agreed that the changeover involves essentially a table or cart on wheels. The following exchange took place regarding the details regarding the changeovers Petitioner performed:

> Q. And what you're doing when you're changing over is you're simply taking one table that's on wheels and putting it square up against another table that's on wheels?
> A. Yes.
> Q. It rolls right up to it?
> A. Yes.
> Q. You make sure they're level?
> A. Yes.
> Q. You pull out a couple pins?
> A. Yes.
> Q. And the device that you're moving from one table, to another, is on ball bearings, it rolls?
> A. Yes.
> Q. And then you simply put the—you switch it out, and you put the pins in, and that's it?
> A. Yes.
> Q. Okay. You don't lift?
> A. No.
> Q. And that's what you admitted in your accident report?
> A. Lift the totes.
> Q. You lift—
> A. Totes on the line.
> Q. Well, my question is this, you're not saying that the injury—your testimony was not that you were injured lifting totes. Your testimony was that you were allegedly injured while doing a changeover?
> A. Yeah. When it gets stuck on a screw underneath it, and you have to shove it, yeah.
> Q. And this is on ball bearings?
> A. Yes, and it gets stuck all the time when a screw falls in there, and I didn't see it because I was rushing to get it done, so I did it.
> Q. And that's how you're saying it happened?
> A. Yes.

(Tr. at 73-75). Petitioner denied discussing the details of his job as an operator with Dr. Young during the Section 12 examination, and testified that he simply told him he was an operator.

Dana DeMaris Testimony

Mr. DeMaris testified on behalf of Respondent. He has worked for Respondent for over 6.5 years. He is currently the plant safety supervisor and testified that he was originally hired as an operator in assembly. Mr. DeMaris testified that he previously worked on the highest volume lines as a main line operator, a sub line operator, and a relief operator. He testified that as a relief operator he was able to work on many different lines. Mr. DeMaris testified that operators perform changeovers no more than three times during a shift. He testified that he has performed several hundred changeovers during his time working for Respondent. Mr. DeMaris testified that he previously worked with Petitioner in assembly for a while and he also knows Petitioner through his job as a safety supervisor due to an unrelated prior alleged work injury in 2018 regarding Petitioner's low back.

Mr. DeMaris testified that he investigated this current claim. He testified that after reviewing Petitioner's accident report he inspected the 241 sub line to evaluate the equipment and make sure the equipment worked properly and met appropriate ergonomic standards. (Tr. at 88-89). He testified that he examined all the changeover tables on the line to make sure there were no issues with any of them. Mr. DeMaris testified that he did not find anything sticking or otherwise wrong with the table Petitioner used that day. He testified that Petitioner's testimony during the hearing was the first time there was any mention of a screw or something getting stuck under the table.

Mr. DeMaris testified that the changeover occurs so the line can change from making, for example, the right rear lamp and begin making the left rear lamp. Mr. DeMaris provided a very thorough explanation of the steps an operator would take to perform the changeover. (Tr. at 92-94). Mr. DeMaris estimated that the tables each weigh around 15 pounds and that it takes less than 5 pounds of force to pull the pins out. He testified that his investigation revealed no evidence of any of the pins sticking in the table used by Petitioner. He further testified that in his experience, the pins do not stick. He testified that the pins are small steel pins that weigh less than a quarter of a pound. He also testified that the pins come out freely and that the pins are not screwed or hammered into the tables. Mr. DeMaris testified, "They usually come very—you know, at most, you actually just kind of grab the fixture a little bit, and it would pull freely out. There are normally not any issues there." (Tr. at 95).

Mr. DeMaris testified that when an employee completes an accident report, the system immediately emails a copy of the report to him. Once an employee submits the report it cannot be changed in the system. He testified that he personally met with Petitioner the same day Petitioner submitted the accident report. He testified that when Petitioner visited HR at around 7:00 a.m. on June 18, 2019, he stepped out of his cubicle. He testified that Petitioner came in almost immediately after HR opened that morning and spoke with both him and Ms. Pollard. He estimated during the conversation he was standing approximately 7-12 feet away from Petitioner. Mr. DeMaris could not remember who specifically asked if Petitioner's injury was work-related, but he remembered that Petitioner replied that the injury was personal. Mr. DeMaris testified that he told Petitioner that because it was a personal issue, Petitioner could visit the local clinic. He testified that he did not know Petitioner completed an accident report that day until he turned on his computer once Petitioner left. Mr. DeMaris testified that he then tried to call Petitioner to

discuss the alleged work accident, but Petitioner did not answer, and his phone did not accept voicemails.

Mr. DeMaris testified that he inspected the equipment within 25 minutes after he saw Petitioner's accident report. As part of the investigation, he normally would interview workers to see if anyone had any issues that day with the machines. He testified that no one reported having any trouble. He testified that Petitioner did not identify which specific jig or changeover table caused his injury, so Mr. DeMaris examined all the equipment on the line. He testified that at most, a worker would perform three changeovers a day. If there are three or four machines, a worker might at most perform a changeover 12 times over the entire shift. He testified that an operator on a sub line might make 30-32 items an hour or 200 taillights during a shift. He testified that the operators do not work with any heavy items as the largest finished good Respondent produces weighs less than 4.5 pounds, and the subcomponents weigh much less than that. Mr. DeMaris testified that operators on the sub line do not use vibratory tools and generally rotate jobs every few hours.

Under cross-examination, Mr. DeMaris testified that he did not document his findings after he inspected the sub line on June 18, 2019. Under additional questioning, he testified that there were no abnormalities found during his investigation so there was nothing for him to document. He testified that when he conducted his investigation of the equipment and Petitioner's claim, he was unaware that Petitioner claimed a screw or pin was stuck in the changeover table. He testified that he first learned Petitioner identified a stuck screw or pin as a cause of Petitioner's injury during Petitioner's testimony that morning. He testified that if he had discovered an abnormality or problem with any of the equipment during his investigation, he would have documented the issues.

Medical Treatment

Petitioner visited the health clinic within a few hours after his shift ended on June 18, 2019. The nurse recorded the following history: "He states he was at work last night when he was pushing forward to change over an assembly line. He had a sudden pain in his left elbow area that felt like electricity. A few hours later he noticed swelling to the left elbow." (PX 1). Petitioner also complained of occasional numbness and tingling in the left hand and denied any prior injuries to his left arm. The exam revealed swelling and tenderness at the medial epicondyle. The nurse diagnosed left tennis elbow (left medial epicondylitis). He was cleared to return to work with restrictions. Petitioner was to return on July 13, 2019, but there is no evidence that he ever returned to the clinic.

Dr. McIntosh first examined Petitioner on July 11, 2019. The doctor recorded a history of Petitioner injuring his left elbow in June "…when he was changing over machinery from left to right and felt an electric shock going down the inside of his elbow with pain in the medial aspect of the elbow." (PX 3). Petitioner denied any prior treatment or surgeries to the doctor. Dr. McIntosh's exam revealed tenderness to palpation at the medial epicondylar region and swelling over the anteromedial aspect of the elbow. There was no tenderness posteriorly, anteriorly, or laterally. Petitioner complained of intermittent numbness in his arm and hand. The doctor diagnosed left medial epicondylitis and ordered a brace, medication, and occupational therapy. Left elbow x-rays taken that day revealed an old impaction deformity of the left radial head/neck

junction, and mild degenerative arthrosis at the left humeral-ulnar articulation. Two weeks later, Dr. McIntosh ordered an MRI of the left elbow. The August 16, 2019, left elbow MRI had the following impression: 1) focal intrasubstance tear of the common flexor or tendon insertion at the medial humeral epicondyles; 2) tendinosis of the common extensor origin tendon insertion at the lateral humeral epicondyles; and 3) thickening and increased T2 signal in the ulnar nerve cephalad to the cubital tunnel without obvious entrapment. The doctor interpreted the MRI as showing tearing of the flexor pronator mass. Petitioner complained of increasing numbness and tingling in the distribution of the left ulnar nerve. Dr. McIntosh also noted a positive left Tinel's test and positive elbow flexion test. In August 2019, Dr. McIntosh suspected Petitioner also suffered from cubital tunnel syndrome and ordered an EMG/NCS.

The August 26, 2019, EMG/NCS of the left arm revealed: 1) moderate left ulnar neuropathy at the elbow with no denervation changes but mild loss of motor unit recruitment seen in the left ulnar innervated muscles in forearm; and 2) left median digital sensory distal latencies that were mildly prolonged and amplitudes that were mildly decreased with correlation recommended for possible minimal left carpal tunnel syndrome. After reviewing the results of the EMG/NCS, Dr. McIntosh recommended Petitioner undergo a left cubital tunnel decompression and flexor pronator repair and a medial epicondylectomy. Petitioner has not returned to Dr. McIntosh since August 29, 2019. He testified that he would like to proceed with the recommended surgery.

Expert Opinions and Testimony

Dr. Jeffrey McIntosh—Treater

Dr. McIntosh testified via evidence deposition on behalf of Petitioner on February 18, 2020. (PX 7). He is a general orthopedic surgeon and treats knees, shoulders, hips, wrists, and elbows as long as the case is not too complicated. His testimony was generally consistent with his medical records. The doctor testified that he believed Petitioner performed a significant amount of repetitive work; however, he admitted that he did not know the specifics of Petitioner's job duties. He testified that the electric shock Petitioner described is consistent with ulnar nerve neuritis as a causative force regarding his injuries. Dr. McIntosh did not believe Petitioner ever suffered from these problems previously. He testified, "So from a causation standpoint…I feel that this maneuver of changing over the machinery and the onset of pain and symptoms as he was doing this or immediately afterwards would be certainly a cause of this patient's problems." *Id*. at 18.

Dr. McIntosh testified that he was unaware that Petitioner underwent prior bilateral carpal tunnel and cubital tunnel surgeries; however, he then testified that the existence of the prior surgeries does not change his causation opinion. He testified:

> "So the speculation that he does repetitive work according to what you've described to me probably as somewhere in the job description certainly puts him at risk for overuse. And once the tendons become stressed or fatigued, then they become more susceptible to injury, and the injury that he sustained I think was secondary to that type of scenario where over the time period he was

> there he probably…got to a point where the muscles were or the tendons were fatigued and eventually the flexor pronator tendon failed, and again the electric shock that he felt was mostly a inflammation of the nerve causing neuritis and subsequent evidence of compression."

Id. at 20.

Under cross-examination, Dr. McIntosh agreed that he did not discuss Petitioner's job duties or discuss any repetitive duties or actions Petitioner performed at work in any of the office visit notes. He also agreed that he did not know any details regarding the amount of weight Petitioner had to lift or push, the position of his arm or elbow as he lifts, or details regarding the assembly line on which Petitioner worked. Dr. McIntosh testified that he did not ask Petitioner for details regarding his job duties as he did not believe those details were important for treating Petitioner's condition. The doctor testified that the fact that Petitioner underwent surgeries for bilateral carpal tunnel syndrome and cubital tunnel syndrome in the past strengthened his opinion regarding causation. He testified that Petitioner was a poor historian, but Petitioner's failure to disclose his prior left cubital tunnel treatment did not cause him to question Petitioner's credibility.

Dr. Jason Young—Respondent's Section 12 Examiner

Dr. Young examined Petitioner on May 26, 2020, at Respondent's request. (RX 8). Petitioner complained of sharp, throbbing pain and tingling as well as weakness in the arm. Dr. Young noted that Petitioner did not disclose any prior surgeries or relevant injuries on his intake form. The doctor recorded the following history:

> "He was working on line #241 subline doing taillight assembly for approximately six to eight months handling taillights that he claims to have been around 10 pounds. He states he would handle the housings and place them into a machine/robot, which would then do assembly and he stated he would have to place them into the housing 32 times per hour. He states he is not repetitively reaching over his head or out away from his body, but it is at waist level. He will reach forward and place them into the machine and then hit the button. He states they do a change over between right and left so the housing/fitting has to be pushed into position one or two times per night. It is on wheels and it is slid into the machinery."

Id. at 2. Dr. Young reviewed the official job description, medical records, and Dr. McIntosh's deposition transcript. Petitioner reported to Dr. Young that his injury occurred on June 17, 2019, and that he was injured while pushing the changeover table. The doctor wrote that Petitioner only disclosed that he previously suffered from left cubital tunnel syndrome and underwent surgery in 1999 after Dr. Young asked very pointed questions about his relevant medical history. Dr. Young wrote:

> "I discussed specifically with the patient that he reported one

> particular episode from June 17, 2019 when he was pushing the assembly on wheels that he pushed it until it clicks. He said he started to feel some pain, but then stated Dr. McIntosh told him the symptoms were from repetitive motions. Clearly, the patient is not describing a repetitive activity, but he claims the pain started in one particular instant."

Id. at 3.

Dr. Young diagnosed left elbow recurrent cubital tunnel syndrome and chronic common flexor/extensor tendinosis that was asymptomatic. He wrote that he was concerned that Petitioner did not report "very important preexisting conditions and prior surgeries" on numerous occasions throughout his treatment and initially during the Section 12 examination. *Id*. at 6. He wrote, "…that is clearly concerning given the fact that the symptoms are involving a nerve that has had previous surgery and therefore when asked about it, there is a level of dishonesty and credibility." *Id*. Dr. Young opined that the stated mechanism of injury of reloading the assembly would not cause the chronic changes seen on the diagnostic studies at the level of the medial epicondyle and the ulnar nerve. He opined that ulnar nerve symptoms do not occur from "…any particular one instance such as pushing relatively gently on an assembly line to get it to lock in place." *Id*. He further opined that the thickening of the nerve seen on the diagnostic studies would develop from highly repetitive activities, heavy usage of vibratory tools, a significant direct blow to the arm, and/or idiopathic reasons including a prior surgery.

Finally, Dr. Young opined that Petitioner's reported job duties and the length of time he spent in the position were not highly repetitive and would not cause the ulnar thickening or cubital tunnel symptoms. He opined that Petitioner's work duties did not cause, contribute to, or aggravate the tendinosis of the common flexor/extensor or recurrent cubital tunnel syndrome diagnosed by Dr. McIntosh. He opined that Petitioner's position as an operator did not accelerate or worsen Petitioner's condition.

Dr. Young testified via evidence deposition on Respondent's behalf on September 11, 2020. (RX 9). His testimony was consistent with his narrative report. He is a board-certified orthopedic surgeon and has treated patients with issues such as tendon tears, epicondylitis, and cubital tunnel syndrome. Regarding the importance of a doctor having accurate information regarding prior treatment, he testified:

> "It definitely makes that very complicated because you're…relying on a mechanism as described as well as understanding other etiologies of the condition you're analyzing, so if someone doesn't disclose that they've had a prior surgery which has a known consequence of having residual deficits, particularly with the ulnar nerve, then you may think or interpret their mechanism to be the sole and only cause of that condition when, in fact, the changes that you're seeing could be postsurgical."

Id. at 12. He testified that he disagreed with Dr. McIntosh's opinion that Petitioner's condition

could be the result of repetitive trauma because pushing or pulling a 10-pound load is not a cause or aggravator of cubital tunnel syndrome. Dr. Young further testified that over-compression to the cubital tunnel requires a forceful blow to the elbow, resting your elbow repetitively, or repetitive use of highly vibratory tools like jackhammers and weed trimmers. Dr. Young testified that one cannot make a causation opinion of repetitive trauma without knowing the details of the patient's job duties. He testified that his knowledge of Petitioner's job duties comes from the details Petitioner provided of working on the line as well as the job description he received. He testified that he reviewed the official job description with Petitioner during his examination. Dr. Young testified that Dr. McIntosh's recommended surgery is not appropriate because the doctor did not realize Petitioner had already undergone cubital tunnel surgery. He testified that a patient in Petitioner's position instead required a transposition.

Dr. Young testified that he had previously visited Respondent's plant to observe employees performing various job duties. He testified: "…I actually personally inspected these changeover jigs and saw them being removed and inserted, and it's a very low resistance maneuver because they're on wheels, and so you simply slide them into place, and there's a…palpable click, and…that's it." *Id*. at 40. He testified this visit occurred in either 2018 or early 2019.

Under cross-examination, the doctor agreed that Petitioner's claim of feeling an electric shock in his arm is a common symptom regarding the ulnar nerve. He testified that sometimes if the ulnar nerve is compressed and "angry" a patient can get intermittent sharp pains if they overly compress it by doing things like leaning on the elbow, or falling on it. The doctor testified that other than an idiopathic cause, people can develop thickening around the ulnar nerve from a forceful impact on the medial side of the elbow such as a fall from a height. He further testified that thickening can also be caused over a long period of time due to repetitive use of high velocity, high force, and vibratory tools.

Dr. Young testified that the thickening seen on Petitioner's MRI takes years to form. He referred to it as neuroma which is "chronic scarring around the nerve which slows the conduction of the nerve and causes these symptoms." *Id*. at 75. Dr. Young testified that recurrent cubital tunnel in cases such as Petitioner's is fueled by the specific types of activities the doctor identified. Finally, he testified that while the causes of cubital tunnel syndrome are multifactorial, the mechanism of injury described by Petitioner is not an aggravating factor.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). He must show by a preponderance of the evidence that he suffered a disabling injury which both arose out of and in the course of his employment. *Id*. An accidental injury must be traceable to a definite time, place, and cause. *Interlake Steel Co. v. Industrial Comm'n*, 136 Ill. App. 3d 740, 743 (1985). Before the Commission can consider whether an accidental injury arose out of and in the course of Petitioner's employment, Petitioner must first prove that a work-related accident occurred. *Elliott v. Industrial Comm'n*, 303 Ill. App. 3d 185, 188 (1999). After carefully considering the totality of the evidence the Commission finds Petitioner did not meet his burden of proving an accident occurred that arose out of and in the course of his employment on June 17, 2019.

The Arbitrator determined that Petitioner proved he sustained an injury due to a compensable work-related accident on June 17, 2019. In reaching this conclusion, the Arbitrator determined that Petitioner's credible testimony and the medical evidence supported a finding that Petitioner's left elbow condition is the result of his job duties. Respectfully, the Commission views the evidence much differently than the Arbitrator. After carefully reviewing and weighing the evidence, the Commission finds Petitioner's testimony as well as his reports to various medical providers lacked credibility. The Commission further finds that due to Petitioner's lack of credibility, Petitioner was unable to meet his burden of proving he sustained an injury that arose out of and in the course of his employment on June 17, 2019.

A close examination of the evidence reveals that Petitioner's testimony was riddled with contradictions. However, Petitioner's credibility was most undermined by his flagrant failure to disclose his prior history of previously sustaining an injury resulting in a diagnosis of left cubital tunnel syndrome to any of his medical providers. In fact, Petitioner not only repeatedly failed to disclose this prior diagnosis, but he also failed to disclose that he underwent left cubital tunnel release surgery in 1999. The credible medical evidence reveals that Petitioner visited the company clinic on June 18, 2019. The examining nurse recorded the history provided by Petitioner and wrote that Petitioner denied any prior injuries to his left arm. Petitioner then visited Dr. McIntosh on July 11, 2019. Dr. McIntosh recorded the history provided by Petitioner and wrote that Petitioner denied any prior treatment to his left arm. Petitioner even responded "none" to the question regarding prior surgeries on the doctor's intake form. Dr. McIntosh testified that he was unaware that Petitioner previously underwent left cubital tunnel release surgery. Dr. Young, Respondent's Section 12 examiner, wrote that Petitioner initially did not disclose any prior surgeries. Petitioner also denied undergoing any prior surgeries on the Dr. Young's intake form. Petitioner only admitted to the earlier left cubital tunnel surgery after Dr. Young continued to ask Petitioner very specific questions regarding his medical history. Dr. Young was understandably very concerned about Petitioner's repeated failure to disclose important preexisting conditions and prior surgeries during the Section 12 examination and throughout Petitioner's visits with his medical providers.

During the hearing, Petitioner testified that no one, including the clinic nurse, and Drs. McIntosh and Young, ever asked him about any prior left arm conditions or surgeries. Petitioner would like the Commission to believe that he did not deny his prior left cubital tunnel diagnosis and treatment to any medical providers. When confronted with the ample evidence that Petitioner actively denied undergoing any prior surgeries or sustaining any prior injuries to his left arm, Petitioner continued to insist that he never discussed his prior left cubital tunnel release surgery because no one ever questioned him about his relevant medical history. Upon further questioning, Petitioner indicated that he did not disclose this important information because any doctor could obtain his prior medical records and learn his history. Petitioner was unable to provide any explanation regarding why the company nurse wrote that Petitioner denied any prior left arm injuries. He was unable to provide an explanation regarding why Dr. McIntosh testified that Petitioner denied any prior left arm treatment and why the doctor's medical records reveal the same. Likewise, Petitioner could provide no explanation for why Dr. Young's report and testimony reveal that Petitioner initially denied any prior surgeries and that Petitioner only admitted to his 1999 left cubital tunnel surgery after Dr. Young continued to question Petitioner. The Commission does not believe that each medical provider and Respondent's Section 12 examiner failed to ask

the routine questions regarding Petitioner's relevant medical history. Likewise, the Commission does not believe that these medical professionals for unfathomable reasons wrote that Petitioner denied any relevant medical conditions or surgeries if the statement was not true.

The Commission also finds Petitioner's testimony regarding the Section 12 examination conducted by Dr. Young very revealing. Petitioner testified that Dr. Young not only did not ask him about any relevant prior medical treatment, but that the doctor did not ask any questions about Petitioner's alleged mechanism of injury. Petitioner also testified that he did not discuss the details of his job duties with Dr. Young. In contrast to Petitioner's testimony that he did not have any discussion with Dr. Young, the doctor's report provides ample details regarding his discussion with Petitioner regarding his alleged mechanism of injury, his relevant medical history, his job duties as an operator, and the changeover procedure Petitioner performed. Dr. Young also testified credibly regarding these topics. Petitioner had no explanation for why Dr. Young's report would include such a detailed recitation of the doctor's discussion with Petitioner. The Commission finds it beyond belief that Dr. Young would simply manufacture the details of his discussion with Petitioner. After considering the evidence, the Commission finds the medical records and Dr. Young's report and testimony are more credible than Petitioner's testimony.

Petitioner's problematic testimony did not end with the topic of his deliberate failure to disclose his relevant medical history. Petitioner also failed to testify credibly regarding the events on June 17, 2019, and his mechanism of injury. Petitioner repeatedly testified that he developed left arm symptoms and developed a knot on the arm a few hours before his shift ended on June 17, 2019. To be clear, Petitioner is adamant, despite all credible evidence to the contrary, that his injury occurred in the early morning hours of June 17, 2019, not June 18, 2019. Petitioner unequivocally testified that on the alleged date of accident the following occurred: 1) he sustained an injury; 2) he submitted an accident report immediately following the end of his shift; 3) he visited HR; and 4) he visited the company clinic and was examined by the nurse. However, the credible evidence overwhelmingly supports a finding that Petitioner submitted the accident report, visited HR, and sought treatment at the company clinic on June 18, 2019.

Absent Petitioner's testimony, there is absolutely no evidence that Petitioner reported an injury on June 17, 2019. The credible evidence reveals that Petitioner submitted the accident report on June 18, 2019. When faced with this evidence, Petitioner insinuated that his supervisor, or perhaps an unknown person, altered the date his accident report. Petitioner unequivocally testified that within minutes of filing his accident report, he visited HR to find out when the company nurse would be on site. However, Petitioner's testimony is the only evidence that this visit occurred on June 17, 2019. Mr. DeMaris credibly testified that Petitioner visited HR at around 7:00 a.m. on June 18, 2019. Additionally, the contemporaneous notes of Mr. DeMaris and Ms. Pollard indicate Petitioner's visit occurred the morning of June 18, 2019. When asked about this discrepancy, Petitioner once again had no explanation regarding why Mr. DeMaris and Ms. Pollard would state that he spoke to them on June 18, 2019. The Commission notes that Petitioner offered contradictory testimony regarding whether Mr. DeMaris was present when Petitioner visited HR. Petitioner initially denied that Mr. DeMaris was in the HR office; however, under further examination, he admitted that Mr. DeMaris was present and was not standing far from Petitioner and Ms. Pollard. Likewise, Petitioner gave conflicting testimony regarding the date of his visit to the company clinic. He repeatedly testified that he visited the clinic a short time after he left work

on June 17, 2019; however, at one point he agreed that he visited the clinic on June 18, 2019. Petitioner had no explanation for why the office visit note indicated his visit occurred on June 18, 2019, when his visit occurred the previous day.

Finally, the totality of the evidence reveals that Petitioner was unable to identify a consistent and credible mechanism of injury. Petitioner identified conflicting mechanisms of injury throughout the record. In the accident report, Petitioner wrote that he noticed a knot on his left forearm while performing a changeover. Petitioner denied his injury was the result of repetition or overuse, lifting, pushing, pulling, or moving anything. Petitioner reported to the clinic nurse that his symptoms suddenly arose when he was pushing forward to perform a changeover. Likewise, he reported to Dr. McIntosh that he sustained his injury while performing a changeover. In both histories, Petitioner did not mention anything about a screw or pin becoming stuck and Petitioner having to forcefully shove the table in place. After Dr. McIntosh testified that Petitioner's injury was the result of repetitive trauma, Petitioner then told Dr. Young during the Section 12 examination that his injury was the result of repetitive trauma. He also reported to Dr. Young that his symptoms began when he noticed a knot on his left forearm while performing a changeover. During his detailed discussion with Dr. Young, Petitioner did not mention anything about a stuck screw or pin causing him to forcefully push the table in place to complete the changeover. After Dr. Young provided his credible opinion that Petitioner's position did not meet the requirements of repetitive or forceful use that is required to cause or aggravate cubital tunnel syndrome, Petitioner suddenly presented a new mechanism of injury.

During the hearing, Petitioner testified that a screw became stuck, and he had to shove the table into position during the changeover. The evidence shows that Petitioner never reported a stuck screw causing him to forcefully shove the table into place before the arbitration hearing. Mr. DeMaris credibly testified that he first learned that Petitioner claimed a screw was stuck while he listened to Petitioner's testimony that morning. At best, Petitioner's changing mechanism of injury is simply the result of him trying to provide all the necessary details that may have contributed to his injury. At worst, Petitioner appears to be tailoring his testimony to overcome Dr. Young's credible opinions. After all, Dr. Young thoroughly explained why Petitioner's job duties in general, and performing the changeover, could not cause, contribute to, or aggravate his left cubital tunnel syndrome. Dr. Young also credibly explained why Petitioner's job duties as an operator could not have caused repetitive trauma that resulted in his left cubital tunnel diagnosis because his job duties lacked the required repetitive actions and necessary force or vibration. Petitioner then testified to a mechanism of injury that he presumably hoped would account for the use of force necessary to discredit the opinions of Dr. Young and to meet his burden of proving he sustained a work-related injury.

After weighing the evidence, the Commission cannot find that Petitioner was a credible witness. There are simply too many inconsistencies and conflicting statements for the Commission to find that Petitioner met his burden of proving he suffered a compensable work-related injury on June 17, 2019.

For the foregoing reasons, the Commission denies benefits because Petitioner failed to prove he sustained an injury arising out of and in the course of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 8, 2021, is reversed in its entirety and all benefits are 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.

March 11, 2022

o: 1/11/22
TJT/jds
51

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

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

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

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

SLOAT, RONNIE
Employee/Petitioner

Case# **19WC022537**

NORTH AMERICAN LIGHTING
Employer/Respondent

On 1/8/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

5791 LAW OFFICE OF STEPHEN CARTER
PO BOX 934
MINOOKA, IL 60447

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RONNIE SLOAT
Employee/Petitioner
v.
NORTH AMERICAN LIGHTING
Employer/Respondent

Case # **19** WC **22537**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **October 9, 2020.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,902.56**; the average weekly wage was $**594.28**.

On the date of accident, Petitioner was **53** years of age, **married** with **0** children under 18.

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

Respondent shall be given a credit of $**No lost time** for TTD, $**No lost time** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**3,771.00** under Section 8(j) of the Act.

ORDER

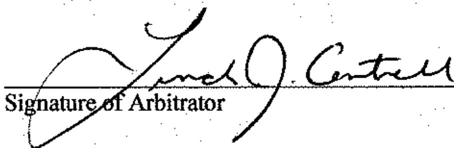
Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibit 8, pursuant to the medical fee schedule, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit. Respondent shall further hold Petitioner harmless from any and all subrogation claims that have been or will be asserted by Blue Cross Blue Shield.

Respondent shall authorize and pay for the treatment recommended by Dr. Jeffrey McIntosh, including, but not limited to, a left cubital tunnel decompression, flexor pronator repair, and medial epicondylectomy.

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

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

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



Signature of Arbitrator

1/4/21

Date

JAN - 8 2021

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RONNIE SLOAT,)
)
Employee/Petitioner,)
)
v.) Case No.: 19-WC-22537
)
NORTH AMERICAN LIGHTING,)
)
Employer/Respondent.)

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Mt. Vernon on October 9, 2020 pursuant to Section 19(b) of the Act. The issues in dispute are accident, causal connection, medical expenses, and prospective medical care. All other issues have been stipulated.

TESTIMONY

Petitioner was 53 years old, married, with no dependent children at the time of his alleged accident on June 17, 2019. Petitioner testified he worked as an operator on the 241 RCL sub line. Petitioner was rushing to perform a changeover when he shoved a stuck screw in and felt a shock through his left arm and a knot popped up on his forearm. Petitioner testified he spoke to his supervisor, Bill Thompson, at approximately 3:30 a.m. (on 6/18/19) when the accident occurred and Mr. Thompson told him to wait until his shift ended at 6:50 a.m. on 6/18/19 to fill out an accident report. Petitioner testified he completed an electronic accident report in Mr. Thompson's office immediately after his shift ended. Petitioner testified he then returned to his line for final inspection and went to the Human Resource office and spoke to Darlene Pollard. Mrs. Pollard told Petitioner the company nurse was not in and ordered him to go to Express Care. He recalls that Respondent's safety representative, Mr. DeMaris, was at his desk and could have overheard his conversation with Mrs. Pollard. He denies having any conversation with Mr. DeMaris that morning. He denies telling Mrs. Pollard that his injury was not work-related.

Petitioner testified he performed machine changeovers two to three times per shift that involved pushing trays in and out and he "did" 30 parts per hour that he described as impossible. During the changeover on 6/18/19, Petitioner testified he felt a shock and tingling into his left arm and numbness down his arm to his small and ring fingers.

Petitioner testified he was not asked by the nurse at Express Care, Dr. Young, or Dr. McIntosh if he had any prior injuries or surgeries to his left or right arms. He denies that Dr. McIntosh examined his left elbow or asked him about his prior surgical scar. He denies discussing with Dr. McIntosh his specific job duties. He denies discussing with Dr. Young that his injury occurred while performing a changeover. Petitioner testified the changeover table is on wheels. He removes a couple of pins and transfers a device onto the changeover table that rolls on ball bearings. Petitioner testified that screws get stuck and he pushed on the screw causing his injury.

Petitioner testified he stated on the accident report he had a knot on his left forearm but did not report an electric shock sensation or pain and numbness in his fingers. He denied that his injury was caused by lifting, moving, pushing, or pulling. He is currently off work due to a work-related back injury. He last treated with Dr. McIntosh a year ago and was working full duty without restrictions until his back injury in June 2018.

Respondent's plant safety supervisor, Dana DeMaris, was called as a witness. Mr. DeMaris was hired as an operator approximately six years ago and was promoted to safety manager in January 2016. Mr. DeMaris has performed hundreds of line changeovers during his employment with Respondent. Mr. DeMaris testified he investigated Petitioner's alleged accident of June 2019 and inspected the changeover table, pins, and fixtures that Petitioner was operating during his alleged accident within 25 minutes of receiving the accident report. He found no issues with any of them. Mr. DeMaris testified he inspected the entire line because Petitioner did not specify on his accident report how he injured himself other than stating it occurred during a changeover. Mr. DeMaris testified he had never heard that Petitioner handled a stuck screw until Petitioner's testimony at arbitration that morning.

Mr. DeMaris testified the changeover tables roll freely on wheels and the pins require ten to fifteen pounds of force or less to remove. The steel pins are very small and come freely out of the machine. Mr. DeMaris testified he has removed hundreds, if not thousands, of pins and they do not stick. He testified he receives accident reports electronically the instant an employee completes and submits them and begins investigating any accident within a couple of hours after receiving the report.

Mr. DeMaris testified he met with Petitioner when he came to the HR Office to speak to Mrs. Pollard at 7:00 a.m. on 6/18/19. He had a direct conversation with Petitioner and he and Mrs. Pollard recorded the conversation in writing within 20 minutes of Petitioner leaving the office. Petitioner requested to see the nurse and they were not sure of her schedule because she is only on site every two weeks. Either he or Mrs. Pollard asked Petitioner if it was work related and Petitioner responded it was personal. Mr. DeMaris recommended Petitioner go to a local clinic as it was a personal medical matter and Petitioner left the office. Mr. DeMaris then walked approximately seven feet to his desk and booted up his computer as it was the beginning of his shift. It was then he noticed Petitioner's electronic accident report. Mr. DeMaris testified that Petitioner never mentioned during their conversation that he was injured at work or that he submitted an accident report 15 minutes prior. Mr. DeMaris immediately called Petitioner's cell phone

and went to voicemail that was not set up to leave a message. Mr. DeMaris testified he does not recall Petitioner telling him or Mrs. Pollard what his specific medical condition was, just that he wanted to see the nurse.

MEDICAL HISTORY

Petitioner submitted an electronic accident report on 6/18/19. Petitioner reported he injured his left arm/forearm at 6:50 a.m. on 6/17/19 while changing over and noticed a knot on his left forearm. Petitioner testified he worked the evening shift which began at 10:30 p.m. on 6/17/19 and ended the morning of 6/18/19 at which time he reported the accident. Petitioner reported his accident was not a result of repetitive/overuse activity or lifting/moving/pushing/pulling. Petitioner did not reference an electrical sensation, pain, tingling, or numbness in his left hand in the accident report.

Respondent's Human Resource Coordinator, Darlene Pollard, authored an Accident Addendum marked Respondent's Exhibit 14. Mrs. Pollard stated Petitioner came to the HR Office the morning of 6/18/19 and asked when the doctors would be there. Petitioner showed her a bump on his forearm and he told her it was a personal matter. Mrs. Pollard informed Petitioner that the doctors would not be at the facility until next week and Petitioner was not satisfied. Mrs. Pollard informed Petitioner he could go to an express care clinic at the hospital if he required treatment sooner. Darlene Pollard did not testify at arbitration.

Petitioner's supervisor, Dana DeMaris, authored an Accident Addendum on 6/18/19 consistent with his testimony at arbitration. Mr. DeMaris summarized Petitioner's conversation with Mrs. Pollard which he overheard. Mr. DeMaris gave Petitioner directions to the express clinic. Petitioner left the HR Office and Mr. DeMaris opened his email and saw Petitioner's accident report he filled out five minutes prior to coming to the HR Office. Mr. DeMaris attempted to call Petitioner because it appeared to be a work-related injury. Mr. DeMaris was not able to leave a message because Petitioner's voice messaging was not set up.

Petitioner was examined at SSM Health Medical Group on 6/18/19 and was diagnosed with left medial epicondylitis. The Arbitrator notes that Petitioner's Exhibit 1 contains only a Patient After Visit Summary and work status report regarding this medical visit and no patient history or physical examination findings are contained therein. Petitioner was placed on work restrictions of the left upper extremity, limited lift/push/pull of 5 pounds, limited outstretched motion/lift, limited repetitive motion, and was ordered to rest and ice and take over-the-counter Ibuprofen. The Arbitrator notes that Respondent's Exhibit 5 contains the office visit notes from SSM Health Medical Group on 6/18/19, including a history of accident, past medical history, physical examination findings, and treatment recommendations. Petitioner presented to SSM Health less than two hours of leaving Respondent's HR Office the morning his shift ended on 6/18/19. Petitioner reported left arm pain and a knot on his left forearm. He reported he was at work last night when he was pushing forward to change over an assembly line. He had a sudden pain in his left elbow area that felt like electricity. A few hours later he noticed swelling to the left elbow. He complained of numbness and tingling to his left hand occasionally. Petitioner denied any previous injuries to his left arm; however, relevant past medical history

included carpal tunnel surgery in 2001. Physical examination revealed left elbow/epicondyle pain, swelling, and tenderness, normal range of motion, and positive for tingling. Petitioner was diagnosed with left medial epicondylitis. He was prescribed a left elbow sleeve and Flexeril. He was ordered to ice, take over-the-counter Ibuprofen, and to follow up in two weeks at Respondent's facility.

On 7/11/19, Petitioner was examined by Dr. Jeffrey McIntosh of the Neuromuscular Orthopaedic Institute which is located at Salem Township Hospital for left elbow pain. Petitioner provided a history of working for Respondent as an operator for five years and injured his left elbow in June when he was changing over a line and felt an electric shock on the inside of his elbow with medial pain. He reported he followed up with the company nurse two weeks after the injury and was told to follow up with a physician. He was returned to full duty work at that time. Dr. McIntosh noted tenderness and swelling to the left medial epicondyle with complaints of intermittent numbness in the left arm and hand. Dr. McIntosh noted a completely unremarkable past medical history except for an intolerance to codeine. On Petitioner's Patient Medical History form, "None" is written across two categories requesting information regarding medical illnesses and past surgeries. The record is not clear who wrote "None" on the form and the form is not signed by Petitioner. The form indicates that Kendra Bowen is Petitioner's primary care physician. Dr. McIntosh ordered a left elbow x-ray that was performed the same day. The Imaging Report provides a history of bilateral carpal tunnel surgery in 1999. The x-ray revealed a minimal old impaction deformity of the left radial head/neck junction and mild degenerative arthrosis of the humeral-ulnar articulation, with no comparison exam. Dr. McIntosh assessed medial epicondylitis and prescribed a steroid pack, followed by an anti-inflammatory medicine and topical, a counterforce brace, and occupational therapy. Petitioner was returned to light duty with a five-pound restriction of the left upper extremity. The work slip states work restrictions of right-handed work only. He was ordered to return in two weeks.

Petitioner returned to Dr. McIntosh on 7/25/19 reporting no change in symptoms. Petitioner stated his therapist did not feel he/she could help him after three sessions. Petitioner was not interested in corticosteroid injections and Dr. McIntosh ordered an MRI due to persistent swelling and pain at the elbow. Petitioner was ordered to return to full duty work on 8/8/19 and continue wearing the brace and anti-inflammatory medications.

The MRI was performed on 8/16/19 at Salem Township Hospital. The MRI Procedure Screening Form indicates Petitioner underwent bilateral carpal tunnel surgeries and bilateral elbow surgeries in 1998. The form indicates it was completed by Petitioner and he signed the form on 8/16/19. The MRI revealed a focal intrasubstance tear of the common flexor or tendon insertion at the medial humeral epicondyles, tendinosis of the common extensor origin tendon insertion at the lateral humeral epicondyles, and thickening and increased T2 signal in the ulnar nerve cephalad to the cubital tunnel, without obvious entrapment. The MRI Imaging Report further provides a history of left elbow nerve surgery in 1998.

Petitioner returned to Dr. McIntosh on 8/22/19 and noted Petitioner was having increased numbness and tingling in the left ulnar nerve distribution. Petitioner had a positive Tinel's test and positive elbow flexion test. Petitioner complained that the numbness increased as his workday progressed and the numbness in his small and ring fingers were persistent with rest. Dr. McIntosh assessed cubital tunnel syndrome and medial epicondylitis and recommended surgical intervention for both conditions. He recommended nerve conduction studies and noted Petitioner could continue working 40-hour work weeks with the brace. On 8/29/19, Dr. McIntosh noted the EMG/NCS revealed moderate left ulnar nerve neuropathy. He noted Petitioner continued to have worsening symptoms of numbness and tingling in the small and ring fingers. He recommended a cubital tunnel decompression and flexor pronator repair and medial epicondylectomy. Petitioner was continued on a 40-hour work week pending surgery. On 9/12/19, Dr. McIntosh continued Petitioner on a 40-hour work week until his surgery scheduled on 10/10/19.

Dr. Jeffrey B. McIntosh testified by way of evidence deposition on 2/18/20. Dr. McIntosh is a board-certified orthopedic surgeon. Dr. McIntosh testified there is an interplay between the flexor pronator tendon and the ulnar nerve. Where Petitioner had a traumatic injury and felt a tear, he had most likely at the same time irritated the ulnar nerve so it became inflamed and worsened as Petitioner continued to work full duty.

Dr. McIntosh testified he took a tour of Respondent's facility years ago and opined Petitioner does a significant amount of repetitive work although he is not certain of his specific job duties as an operator. He testified that Petitioner provided a history of an electric shock in his left arm and pain in the inner aspect of his elbow when he was changing over a machine. Dr. McIntosh testified that Petitioner's accident would certainly be consistent with ulnar nerve neuritis as a causative force. Dr. McIntosh testified he was not aware of any previous similar injuries and opined that Petitioner's injuries were causally connected to the accident due to the sudden onset of pain and symptoms.

Dr. McIntosh testified his causation opinion and diagnoses would not change if Petitioner had prior bilateral carpal tunnel releases and bilateral arm surgeries. Dr. McIntosh testified he was not aware of Petitioner's prior surgeries because he did not disclose same on the intake questionnaire. Dr. McIntosh's understanding was that Petitioner worked for Petitioner for five years. He did not question Petitioner about his work history prior to his employment with Respondent because Petitioner reported a sudden onset injury. Dr. McIntosh was asked whether Petitioner's repetitive work would have any impact on his diagnosed conditions. He testified that doing repetitive activities puts stress on the musculoskeletal system and causes fatigue that makes certain parts of the body more susceptible to injury, especially if there is a sudden change in what you are doing. Dr. McIntosh testified that if Petitioner does repetitive work as described to him by hypothetical, he is at risk for overuse and once the tendons become stressed or fatigued they become more susceptible to injury. He testified that Petitioner's injury was secondary to repetitive activity causing his flexor pronator tendon to fail. He opined that the electric shock Petitioner felt was mostly inflammation of the nerve causing neuritis and subsequent evidence of compression. Dr. McIntosh noted Petitioner had epicondylitis on

the medial side and the tear is part of the same spectrum causing two conditions to include cubital tunnel syndrome.

On cross-examination, Dr. McIntosh clarified that Petitioner's report of injury in his left forearm was consistent with injury to the flexor tendon mass which is located in the forearm, so it was not unusual Petitioner reported injury to his forearm as opposed to his elbow. Dr. McIntosh testified that Petitioner's injury occurred in the elbow and it is not unlikely Petitioner would feel pain in his forearm when the injury occurred. Dr. McIntosh found Petitioner to be credible and relied on his history of accident and objective diagnostic tests in rendering his opinion as to causation. Dr. McIntosh testified he released Petitioner to full duty work on 8/8/19 per Petitioner's request to prevent Petitioner from losing his job.

Petitioner was examined by Dr. Jason Young pursuant to Section 12 of the Act on 5/26/20. Dr. Young reported he had concerns Petitioner was not reporting pre-existing conditions and prior surgeries. Petitioner did not disclose to him or Dr. McIntosh that he had a prior nerve decompression surgery in 1998. He testified that the mechanism of reloading the assembly would not cause the chronic changes seen at the level of the medial epicondyle and ulnar nerve. First, ulnar nerve symptoms and tendinosis are not caused by a single event. Dr. Young opined that Petitioner's symptoms are predominantly related to the recurrent cubital tunnel syndrome and not from the tendinosis seen over the medial or lateral side of the elbow. He did not feel the common extensor was markedly symptomatic on examination and it was mostly consistent with ulnar nerve symptoms of the cubital tunnel.

Dr. Young testified by way of evidence deposition on 9/11/20. Dr. Young is a board-certified orthopedic surgeon. Dr. Young testified he was concerned that Petitioner had not disclosed prior surgeries until he was questioned about a scar over his left elbow. Dr. Young testified that Petitioner told him his left elbow pain started after performing a changeover on 6/17/19 and he subsequently noticed a lump or swelling. Dr. Young testified that nerve injury is not caused from a single event and Petitioner's prior cubital tunnel nerve decompression left him at risk for recurrent cubital tunnel syndrome. Dr. Young reviewed Petitioner's job duties and concluded he did not perform repetitive activities that would cause or contribute to cubital tunnel syndrome. Dr. Young opined that the MRI shows thickening of the nerve and clear postsurgical changes, but the radiologist did not know Petitioner had prior surgery and therefore did not comment on it.

Dr. Young testified he did not diagnose Petitioner with medial epicondylitis because Petitioner did not exhibit pain over the flexor pronator but was specific to the ulnar nerve. Dr. Young reviewed the x-ray and MRI films and concluded the common extensor and flexor degenerative changes are normal and there is no evidence of a partial tear that is akin to medial or lateral epicondylitis. He does not agree with Dr. McIntosh's surgical recommendation for a medial epicondylectomy or a flexor debridement as there is no evidence of tendinitis. Dr. Young opined Petitioner has chronic nerve changes, scar tissue from prior surgery, and still had compression from incompleteness of the prior surgery that caused ulnar nerve symptoms. He diagnosed Petitioner with recurrent cubital tunnel

syndrome and chronic common flexor and extensor tendinosis. Dr. Young felt Petitioner should undergo a nerve transposition as opposed to another decompression.

Dr. Young testified that Petitioner has sensitivity around the ulnar nerve and paresthesias in the ulnar two digits. He testified that some patients have muscle spasms they may interpret as a "knot", but Petitioner described swelling and Dr. Young did not see any knots on Petitioner's forearm. Dr. Young agreed that having an electric shock sensation is a common symptom of an ulnar nerve condition. Dr. Young agreed Petitioner gave a history of having those symptoms during the changeover assembly activity at work. Dr. Young also agreed that sharp pain occurs when the ulnar nerve is compressed and angry and intermittent sharp pains can occur if the nerve is overly compressed. Dr. Young testified that thickening around the ulnar nerve can occur from prolonged compression, no activity, acute trauma, and repetitive activity. Dr. Young testified that the nerve thickening found in Petitioner's objective tests developed over many years of compression.

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 falls within the definition of an accident within the meaning of the Act. Petitioner was rushing to perform a changeover when he shoved a stuck screw in and felt a shock through his left arm and a knot popped up. He filled out an accident report at the end of his work shift and immediately sought treatment for his symptoms the morning of his accident. The Arbitrator notes that Petitioner began his work shift the evening of 6/17/19 and reported the accident at the end of shift the morning of 6/18/19.

The Arbitrator finds that Petitioner was performing a task distinctly related to his employment when the accident occurred. The incident is corroborated by consistent accounts throughout his medical records. The unrebutted evidence shows Petitioner was able to perform his work duties prior to 6/17/19 without incident. Based on the credible testimony of Petitioner and treating records, the Arbitrator finds that Petitioner sustained his burden of proof in establishing that he suffered an accident that arose out of and in the course of his employment

with Respondent. However, based on Petitioner's testimony and the accident report prepared by Petitioner, the correct date of accident is June 18, 2019.

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

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 197 Ill.Dec. 502, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 66 Ill.Dec. 347, 442 N.E.2d 908 (1982).

When a preexisting is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition". St. Elizabeth's Hospital v. Workers' Comp. Comm'n, 864 N.E.2d 266, 272-273 (5th Dist. 2007). Accidental injury need only be a causative factor in the resulting condition of ill-being. Sisbro, Inc. v. Indus. Comm'n, 797 N.E.2d 665, 672 (Ill. 2003) (emphasis added). Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. Sisbro, Inc. v. Indus. Comm'n, 797 N.E.2d 665 (Ill. 2003).

Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. Land & Lakes Co. v. Indus. Comm'n, 834 N.E.2d 583 (2d Dist. 2005). Employers are to take their employees as they find them. A.C.& S. v. Industrial Comm'n, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999) citing General Electric Co. v. Industrial Comm'n, 433 N.E.2d 671, 672 (1982). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. Rock Road Constr. v. Indus. Comm'n, 227 N.E.2d 65, 67-68 (Ill. 1967); see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n, 362 N.E.2d 339 (Ill. 1977).

The record shows Petitioner was able to perform his job duties without incident prior to his accidental work injury on 6/18/19. Although Petitioner has a history of left ulnar nerve decompression approximately twenty years ago, the record demonstrates he had not treated for left elbow symptoms since his surgical release.

Dr. McIntosh testified there is an interplay between the flexor pronator tendon and the ulnar nerve. Where Petitioner had a traumatic injury and felt a tear, he had most likely at the same time irritated the ulnar nerve so it became inflamed and worsened as Petitioner continued to work full duty. He testified that Petitioner provided a history of an electric shock in his left arm and pain in the inner aspect of his elbow when he was changing over a machine. Dr. McIntosh testified that Petitioner's accident would certainly be consistent with ulnar nerve neuritis as a causative force. Dr. McIntosh testified he was not aware that

Petitioner had a previous left elbow surgery when he rendered his diagnosis and causation opinion. However, he testified his causation opinion and diagnoses would not change if Petitioner had prior bilateral carpal tunnel releases and bilateral arm surgeries.

The Arbitrator specifically notes that the x-rays ordered by Dr. McIntosh at his initial office visit on 7/11/19 provides a history of bilateral carpal tunnel surgery in 1999. The MRI ordered by Dr. McIntosh was performed on 8/16/19 and also discloses a history of prior surgeries. The MRI Procedure Screening Form indicates Petitioner underwent bilateral carpal tunnel surgeries and bilateral elbow surgeries in 1998. The form indicates it was completed by Petitioner and he signed the form on 8/16/19. The MRI Imaging Report further provides a history of left elbow nerve surgery in 1998. Both diagnostic studies were received and reviewed by Dr. McIntosh. Further, although Dr. McIntosh's initial office notes of 7/11/19 indicate Petitioner's prior medical history was completely unremarkable except for an intolerance to codeine, the record is not clear where Dr. McIntosh obtained this information. On Petitioner's Patient Medical History form, "None" is written across two categories requesting information regarding medical illnesses and past surgeries. The record is not clear who wrote "None" on the form and it is not signed by Petitioner. The form appears to contain handwriting from two different individuals. There is no evidence to suggest Petitioner was not being truthful to his treating physicians or that he intentionally failed to disclose prior surgeries to his left elbow/arm. The MRI and x-ray reports suggest the opposite.

Dr. McIntosh testified that Petitioner reported a sudden onset injury. However, Dr. McIntosh provided opinions as to repetitive trauma based on a hypothetical that was posed. He clarified that doing repetitive activities puts stress on the musculoskeletal system and causes fatigue that makes certain parts of the body more susceptible to injury. Dr. McIntosh testified that if Petitioner does repetitive work as described to him by hypothetical, he is at risk for overuse and once the tendons become stressed or fatigued they become more susceptible to injury. He testified that Petitioner's injury was secondary to repetitive activity causing his flexor pronator tendon to fail on 6/17/19 when he had a sudden onset of pain while performing the specific activity of changeover.

The Arbitrator finds Dr. McIntosh's opinions more credible than those of Dr. Young in light of the chain of events and the objective medical evidence. Dr. Young opined that the MRI shows thickening of the nerve and clear postsurgical changes, but the radiologist did not know Petitioner had prior surgery and therefore did not comment on it. Once again, Respondent's attempt to discredit Petitioner is misplaced. The MRI Procedure Screening Form indicates Petitioner underwent bilateral carpal tunnel surgeries and bilateral elbow surgeries in 1998. The MRI Imaging Report states a history of left elbow nerve surgery in 1998. The radiologist that performed the MRI on 8/16/19 was the same radiologist that performed the left elbow x-rays on 7/11/19, which also disclosed a history of bilateral carpal tunnel surgery in 1999. It is not clear why the radiologist did not comment on the prior surgeries as suggested by Dr. Young.

Dr. Young agreed that Petitioner has sensitivity around the ulnar nerve and paresthesias in the ulnar two digits. That it was not uncommon for patients to interpret

muscle spasms as a knot as Petitioner described. Dr. Young agreed that having an electric shock sensation is a common symptom of an ulnar nerve condition, which Petitioner reported he experienced while performing the changeover. Dr. Young also agreed that Petitioner's complaints of sharp pain are consistent with ulnar nerve compression.

Therefore, the Arbitrator finds Petitioner's current condition of ill-being is causally related to the injury that occurred on June 18, 2019.

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

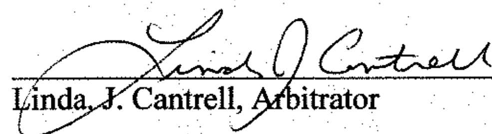
Issue (K): Is Petitioner entitled to any prospective medical care?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001). Specific procedures or treatments that have been prescribed by a medical service provider are "incurred" within the meaning of section 8(a) even if they have not been performed or paid for. *Dye v. Illinois Workers' Comp. Comm'n*, 2012 IL App (3d) 110907WC, ¶ 10, 981 N.E.2d 1193, 1198.

Based upon the above findings as to causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits. Respondent shall therefore pay outstanding medical bills contained in Petitioner's Exhibit 8, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall further hold Petitioner harmless from any and all subrogation claims that have been or will be asserted by Blue Cross Blue Shield.

Further, Petitioner has not exhausted all means to relieve the effects of his injury without lasting relief and has not reached maximum medical improvement pursuant to the medical records and McIntosh's opinion. Respondent shall authorize and pay for the treatment recommended by Dr. Jeffrey McIntosh, including, but not limited to, a left cubital tunnel decompression, flexor pronator repair, and medial epicondylectomy.

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



Linda J. Cantrell, Arbitrator

1/4/21
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC029526
Case Name	HOWARD, IRIS v. NAVISTAR
Consolidated Cases	15WC009943 19WC003473
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0088
Number of Pages of Decision	28
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	RICHARD JOHNSON
Respondent Attorney	Linda Robert

DATE FILED: 3/14/2022

/s/Deborah Baker, Commissioner

Signature

22IWCC0088

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IRIS HOWARD,

Petitioner,

vs. NO: 13 WC 29526

NAVISTAR,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein with oral arguments waived, and notice given to all parties, the Commission, after considering the issues of causal connection to Petitioner's current right knee and right hand conditions of ill-being, incurred medical expenses, prospective medical care, entitlement to temporary total disability benefits, and the nature and extent of Petitioner's injuries, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. FINDINGS OF FACT

The decision of the Arbitrator delineates the facts of the case in detail. As it pertains to the issues on review, the Commission finds as follows:

A. Pre-Accident Medical History

The record reflects that prior to the stipulated October 20, 2012, work accident, Petitioner underwent arthroscopic left knee surgery to repair a meniscal tear on March 15, 2006.

Petitioner underwent arthroscopic left knee surgery on March 24, 2010 due to an unrelated work injury. Petitioner also underwent arthroscopic right knee surgery in 2010 due to an unrelated work injury. Petitioner was returned to full duty February 6, 2012.

B. Accident

Petitioner was employed by Respondent and was operating a crankshaft on the date of the stipulated October 20, 2012 work accident. On this date, a medical record from Dr. Priti Khanna at Advanced Occupational Medicine Specialists reveals that Petitioner was turning a 500-pound crankshaft, when it slipped off a hook and fell on Petitioner, striking her on her left forearm area, left thigh and bilateral knees. The Application for Adjustment of Claim alleges work-related injuries to "both knees, arm and body."

C. Medical Care

On the same day as the stipulated work accident, Petitioner treated with Dr. Khanna, complaining of 5 out of 10 left forearm pain, 4 out of 10 left elbow pain, 6 out of 10 left wrist pain, 4 out of 10 left lower back pain, 10 out of 10 left thigh and left knee pain, and tenderness to palpation in her knees bilaterally at the medial joint line. No right hand nor right arm pain was noted.

On October 24, 2012, Petitioner visited Dr. Thomas K. Ehni at Navistar Medical Department. She treated for right neck, left shoulder, left forearm, left thigh and left knee pain. She did not treat for her right knee during this visit.

On October 29, 2012, Petitioner treated with Dr. Pietro M. Tonino at Loyola Medical Center for her left knee and bilateral shoulders. Petitioner testified that Dr. Tonino completed a pain diagram after questioning Petitioner about her main locations of pain. The diagram shows right trapezius, left shoulder, left forearm, left knee, and left lower back pain. Petitioner testified the note does not indicate right knee pain, likely due to the fact that Dr. Tonino had only questioned her about her *main* pain complaints:

Q. Okay, so you completed that; and then did you complete this pain diagram for him as well? Did you mark that you have pain on your left knee?
A. I didn't do those marks. He might have marked that but I did not.

Q. Okay, but he marked what you reported to him?
A. He might have asked what is paining you the most now, is what they usually ask.

Q. Okay, and then he marked what you told him?
A. Yes ma'am. (Transcript of Arbitration proceedings at 40).

On November 29, 2012, Petitioner followed up with Dr. Tonino complaining of right knee problems. Upon examination, Dr. Tonino found the right knee tenderness was over the proximal and medial tibia, was superficial, and did not involve the right knee joint. The record is silent as to whether any right knee diagnostics were performed at this time.

Subsequently, Petitioner's treatment largely consisted of treating her complaints for body parts other than her right knee. On February 18, 2013, Petitioner underwent a Section 12 examination at Respondent's request with Dr. Troy R. Karlsson for her left knee. The record

reflects that during this examination, Petitioner informed Dr. Karlsson that she was injured on the date in question when a crankshaft fell and struck her on her left arm, the top of her left knee and the side of her right knee.

On May 7, 2013, Dr. Tonino performed a *left* knee arthroscopy with partial medial meniscectomy and arthroscopic chondroplasty, and microfracture of the medial femoral condyle. Subsequently, Petitioner was off work until she returned to light duty work on June 25, 2013, and underwent left knee physical therapy through August 2013.

On July 16, 2013, a right knee MRI revealed medial and lateral meniscus tears with medial joint line pain.

On August 12, 2013, Dr. Tonino reviewed the July 16, 2013 right knee MRI, and also found medial and lateral meniscus tears. Dr. Tonino noted that Petitioner had mentioned right knee pain during her second visit with him after the October 20, 2012 injury (November 29, 2012). He examined the right knee which revealed continued medial joint line tenderness with a positive McMurray's test. Due to the ongoing nature of Petitioner's symptoms, it appeared to Dr. Tonino that Petitioner's right knee condition was related to said injury, when something fell on her legs. He opined Petitioner was a candidate for a right knee arthroscopy and arthroscopic partial medial and lateral meniscectomies. Dr. Tonino also noted the possibility of further surgery should this procedure be unsuccessful.

Arthroscopic right knee partial medial and partial lateral meniscectomies and arthroscopic chondroplasty were performed on October 22, 2013. Subsequently the record reflects Petitioner was off work through January 13, 2014, when she was returned to full duty work.

Subsequent to a stipulated accident on April 8, 2014 for which she claimed injuries to her right shoulder and bilateral knees (*see* the Commission's decision in case no. 15 WC 09943), Petitioner continued treating for her knees bilaterally, complaining of pain and swelling. However, she routinely refused cortisone injections.

On January 11, 2018, Dr. Tonino noted Petitioner's pain and discomfort in her knees bilaterally. She had no mechanical symptoms such as locking or giving way, but did feel some catching in her left knee when going up and down stairs. Petitioner had patellofemoral crepitus, no significant effusion of either knee, stable ligaments and no evidence of any meniscal pathology. He opined that most of Petitioner's symptoms were related to arthritis, and that she may need to be seen by a total joint specialist for both knees.

On February 15, 2019, Dr. Karlsson performed a records review at Respondent's request. He opined that the October 22, 2013 right knee surgery was not related to the October 20, 2012 accident. Dr. Karlsson acknowledged that Petitioner had been struck on both knees at the time of injury, but stated that the immediate medical records on the date of accident did not mention any right knee pain, nor did the records mention any continued right knee problem. Dr. Karlsson claimed that it was not until October 29, 2012 that the records made any mention of bilateral knees. Dr. Karlsson noted that a November 29, 2012 record clearly documented tenderness on the right side, but that it was located below the knee rather than at the knee joint itself. Dr. Karlsson

acknowledged that a July 16, 2013 MRI revealed tears to the medial and lateral menisci along with advanced cartilage degeneration. Regardless, Dr. Karlsson did not believe the October 22, 2013 right knee surgery was causally related to the instant accident. Dr. Karlsson opined it was possible Petitioner may need bilateral knee replacements in the future if conservative methods such as activity modification, anti-inflammatories and injections fail. Notwithstanding, Dr. Karlsson opined that if Petitioner did require bilateral knee replacements, neither would be related to the October 20, 2012 accident.

On May 13, 2019, Dr. Karlsson performed a second Section 12 examination at Respondent's request. The record reflects that Petitioner had last seen Dr. Paley the week prior, and that Dr. Paley was treating her for both knees and both shoulders. Regarding her bilateral knees, Petitioner informed Dr. Karlsson that "she was told she might need surgery, but they are not sure what surgery would need to be done, and that she would need more x-rays." Petitioner informed Dr. Karlsson that knee replacement had never been suggested or offered. Dr. Karlsson reiterated his opinions from his prior records review, adding that it was possible Petitioner may need future knee replacements "if her pain and disease progress and are not amenable to more conservative treatments, but according to the Petitioner she is not interested in knee replacements and does not believe these have even been discussed with her."

At arbitration, Petitioner testified that she still has pain and swelling in her knees bilaterally, but that her right knee symptoms are not as bad as the symptoms in her left knee. Petitioner testified that Dr. Jonathan J. Paley has recommended bilateral knee replacements.[1]

II. CONCLUSIONS OF LAW

A. Causal Connection to Current Right Knee *Condition of Ill-Being*

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 Comm'n*, 79 Ill. 2d 249, 253 (1980). This includes the burden of establishing some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989). "Preponderance of the evidence is proof that leads the trier of fact to find that the existence of the fact in issue is more probable than not." *In re C.C.*, 224 Ill. App. 3d 207, 215 (1st Dist. 1991). A claimant must prove that some act or phase of his employment was *a* causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2d Dist. 2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205.

Our supreme court has held that "medical evidence is not an essential ingredient to support the conclusion of the [Commission] that an industrial accident has caused the disability," but

[1] It appears both parties are of the opinion that Dr. Paley recommended bilateral knee replacement surgeries, but the record does not contain this medical record.

rather, "[a] chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in a disability" may be sufficient to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). Proof of prior good health and change immediately following an injury may establish that an impaired condition was due to the injury. *Navistar International Transportation Corp.*, 315 Ill. App. 3d 1197, 1206 (1st Dist. 2000). A causal connection between work duties and a condition may be established by a chain of events, including a claimant's ability to perform duties prior to the accident and inability to do the same following the accident. *Id*.

The Arbitrator found that the October 22, 2013 right knee surgery was not related to the instant accident. The Arbitrator found that Petitioner did not complain of right knee pain immediately after the accident, that examinations of the right knee were normal, that Petitioner's treating physician documented that her right leg pain on November 29, 2012 was not in the joint, and that it was not until July 2013 that Petitioner was even prescribed diagnostic knee testing. The Arbitrator found the opinions of Dr. Karlsson more credible than those of Dr. Tonino, as the Arbitrator found Dr. Karlsson's opinions were supported by objective medical findings.

The Commission views the evidence differently than the Arbitrator, and finds that Petitioner's current right knee condition and the October 22, 2013 right knee surgery are causally related to the instant stipulated accident. The record reflects that Petitioner did exhibit immediate right knee symptomatology following the accident, as Dr. Khanna found tenderness to palpation in Petitioner's knees bilaterally at the medial joint line. Additionally, while the pain diagram completed by Dr. Tonino on October 29, 2012 does not indicate right knee pain, Petitioner credibly testified that this was likely due to the fact that Dr. Tonino had only questioned her about her *main* pain complaints. During Petitioner's next visit with Dr. Tonino on November 29, 2012, a physical exam revealed right knee tenderness over the proximal and medial tibia, albeit, Dr. Tonino did not believe it involved the right knee joint at that time. However, after a July 16, 2013 right knee MRI revealed medial and lateral meniscus tears, Dr. Tonino updated his opinion, opining that it appeared Petitioner's right knee condition and candidacy for right knee surgery *was* causally related to her October 20, 2012 accident, as Petitioner had mentioned right knee pain to Dr. Tonino during her second visit with him after the accident.

Reading these records in conjunction with Petitioner's unrebutted and credible testimony, the Commission finds it more likely than not that Petitioner's right knee injury was contemporaneously present, although secondary to her more severe competing injuries, and that the eventual diagnostic evidence of the injury was appropriately found to be causally related to the instant accident by Dr. Tonino. Petitioner testified that after bilateral knee surgical intervention, Petitioner's left knee complaints still overshadowed her right knee complaints. Further, the Commission places less emphasis on the time period between the accident and the first right knee diagnostic test than does the Arbitrator. The record reflects that this time period between Petitioner's initial complaints regarding her right knee and the right knee MRI was not due to a lack of right knee symptoms, as both Dr. Khanna and Dr. Tonino noted such symptoms after the accident. Instead, the Commission finds that the time period is explained by the fact that the record indicates Petitioner's left knee complaints overshadowed her right knee complaints. Further, the Commission notes Petitioner pursued treatment for her right knee as soon as the majority of left knee treatment had been completed.

For these reasons the Commission finds that based on the preponderance of the evidence, Petitioner has established that her current right knee condition is causally related to the October 20, 2012 work accident. Prior to this work accident, Petitioner had undergone arthroscopic right knee surgery in 2010, but was able to return to full duty work for Respondent, and had been doing so for over eight months leading up to the instant accident. There is no evidence in the record that Petitioner's right knee was symptomatic and/or required treatment leading up to the instant work accident. On October 20, 2012, Petitioner suffered an undisputed accident with a heavy crankshaft slipping off a hook, falling and striking Petitioner on several body parts, including her right knee. Petitioner had right knee complaints contemporaneous to the accident which were overshadowed by more severe competing injuries, primarily to her left knee. After the heavy crankshaft fell and struck Petitioner's right knee, Petitioner had complaints of medial joint line tenderness in her right knee. This condition deteriorated to a state of disability, which was verified by a right knee MRI revealing medial and lateral meniscus tears. This establishes a chain of events, thus supporting a finding of causal connection between the instant accident and Petitioner's current right knee condition. Moreover, Dr. Tonino opined that Petitioner's condition was causally related to the accident, noting that Petitioner complained of right knee pain to him during her second visit with him. The Commission finds Dr. Tonino's opinions credible and persuasive based on the totality of the evidence and further finds that Dr. Karlsson's opinions are belied by the evidence, rendering them unpersuasive. Based on the above, the Commission finds that Petitioner has established a causal connection between the October 20, 2012, work accident and her current right knee condition.

B. Medical Expenses

In accordance with the above findings and conclusions with respect to causal connection, the Commission also modifies the medical expenses award. With causal connection to Petitioner's current right knee condition being found, the Commission herein awards Petitioner reasonable and necessary medical expenses related to treatment of her right knee condition.

C. Prospective Medical Care

Petitioner argues that the Commission should award future medical care for both knees,[2] as Petitioner may need knee replacements in the future. With Petitioner's documented history of refusing cortisone injections in her knees, the Commission is reluctant to award a much more invasive treatment. Further, the Commission notes Petitioner did not testify that she wanted to undergo bilateral knee replacement surgeries and the Commission finds it premature to award this invasive treatment when conservative measures, specifically cortisone injections, have not been attempted. Thus, the Commission declines to award prospective medical care.

D. Temporary Total Disability

Also in accordance with the above findings and conclusions with respect to causal connection, the Commission herein modifies the Arbitrator's award of temporary total disability benefits. The Arbitrator awarded benefits from May 6, 2013 through June 24, 2013. However, based on the aforementioned causal connection finding, the Commission extends the award for

[2] *See* footnote 1.

temporary total disability benefits from October 22, 2013 through January 13, 2014, the date when Petitioner was returned to regular duty.

E. Permanent Partial Disability

In accordance with the above findings and conclusions with respect to causal connection, the Commission also modifies the Arbitrator's award of permanent partial disability benefits to include an award for Petitioner's right knee. Pursuant to section 8.1b of the Act, the Commission weighs the criteria in determining Petitioner's level of permanent partial disability. 820 ILCS 305/8.1b(b) (West 2018).

With regard to subsection (i) of §8.1b (b), the Commission notes there was no AMA impairment rating provided. Therefore, no weight is given to this factor.

With regard to subsection (ii) of §8.1b (b), the occupation of the injured employee, the Commission notes Petitioner was employed as a laborer at the time of accident. She was taken off work after undergoing right knee surgery, but was eventually released to full duty. The Commission gives moderate weight to this factor.

With regard to subsection (iii) of §8.1b (b), the age of the employee at the time of the injury, Petitioner was 58 years of age at the time of accident. The Commission gives some weight to this factor.

With regard to subsection (iv) of §8.1b (b), the employee's future earning capacity, the Commission finds no evidence that the injury resulted in loss of earning capacity. The Commission gives no weight to this factor.

With regard to subsection (v) of §8.1b (b), evidence of disability corroborated by the treating medical records, the record reflects that a July 16, 2013 right knee MRI revealed medial and lateral meniscal tears, which were treated with arthroscopic right knee partial medial and partial lateral meniscectomies and arthroscopic chondroplasty. Petitioner was eventually released to full duty, but credibly testified that she still suffers from pain and swelling in the right knee, and takes 800mg Ibuprofen. The Commission gives substantial weight to this factor.

The Commission finds that the above analysis supports a finding that Petitioner suffered a 17.5 percent loss of use of her right leg as a result of the October 20, 2012 accident.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, as modified above, is hereby affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that as found by the Arbitrator, Petitioner proved causal connection between the stipulated October 20, 2012 work-related accident and her current left shoulder, left knee and left hand conditions of ill-being by a preponderance of the evidence.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved causal connection between the October 20, 2012 stipulated work-related accident and her current right knee condition of ill-being by a preponderance of the evidence.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's right knee through the date when Petitioner reached maximum medical improvement, January 13, 2014, pursuant to §8(a) and subject to §8.2 of the Act. 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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that prospective medical care is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $776.09 per week for a period of 7 weeks, representing May 6, 2013 through June 24, 2013, and the sum of $776.09 for a period of 12 weeks, representing October 22, 2013 through January 13, 2014, these being the periods of temporary total incapacity for work under §8(b) of the Act. Respondent shall have credit of $5,432.63 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.48 per week for a period of 32.25 weeks, as provided in section 8(e) of the Act, for the reason that the injuries sustained caused a 15% loss of use of Petitioner's left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.48 per week for a period of 4.10 weeks, as provided in section 8(e) of the Act, for the reason that the injuries sustained caused a 2% loss of use of Petitioner's left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.48 per week for a period of 10 weeks, as provided in section 8(d)(2) of the Act, for the reason that the injuries sustained caused a 2% loss of use of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.48 per week for a period of 37.625 weeks, as provided in section 8(e) of the Act, for the reason that the injuries sustained caused a 17.5% loss of use of Petitioner's right leg.

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.

March 14, 2022

D: 1/12/22
DJB/wde
043

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

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWARD, IRIS
Employee/Petitioner

Case# **13WC029526**

INTERNATIONAL TRUCK & ENGINE CORP
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA ROBERT
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

IRIS HOWARD,
Employee/Petitioner

Case # **13 WC 29526**

v.

Consolidated cases:

INTERNATIONAL TRUCK & ENGINE CORPORATION,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **WILLIAM MCLAUGHLIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **February 24, 2020** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/20/2012**, 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 $60534.76; the average weekly wage was $1164.13.

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

Respondent shall be given a credit of $5,432.63 for TTD, $0 for TPD, $0 for maintenance, and $0. for other benefits, for a total credit of $**5,432.63.**

Respondent is entitled to a credit for payments made under Section 8(j) of the Act.

ORDER

Credits

Respondent shall be given a credit of $5,432.63 for TTD, $0 for TPD, and $0 for maintenance benefits, for a total credit of $**5,432.63** .

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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $776.09/week for 7 weeks, commencing May 6, 2013 through June 24, 2013, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $0, as provided in Section 8(a) of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $**698.48**/week for **32.25** weeks, because the injuries sustained caused the **15** % loss of the **left leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**698.48**/week for **4.10** weeks, because the injuries sustained caused the **2** % loss of the **left hand**, as provided in Section 8(e) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $ **698.48** /week for **10** weeks, because the injuries sustained caused the **2** % loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

April 9, 2020
Date

APR 14 2020

FINDINGS OF FACT

The Petitioner, Iris Howard, was 57 years old and employed by the Respondent on October 20, 2012. On that day, she was working with a crankshaft. The crankshaft struck the Petitioner's left side, including her left shoulder, left knee, and left hand. Petitioner did not fall to the ground and she did not strike her knees to the ground.

Petitioner sought treatment with Advanced Occupational Medicine Specialist on October 20, 2012. The Petitioner reported pain in her left forearm, left elbow, left wrist, left thigh and left knee pain. PX 1. Both of Petitioner's knees were examined; however, only the left knee had positive findings including a positive Lachman's test and quadriceps test. Petitioner was diagnosed with a left forearm contusion, left wrist pain and left thigh/knee contusion. (PX 1). There were no complaints to the Petitioner's right hand, right knee or right shoulder.

The Petitioner then presented to Navistar's medical department on October 24, 2012. Petitioner complained of right neck pain and trapezius pain as well as left shoulder, left forearm, left thigh and left knee pain. There is no mention of any right knee pain or right shoulder pain. Petitioner had numbness and tingling in her hands. Petitioner did not complain of right knee or right shoulder pain. (PX 5). Petitioner did report prior surgeries to her left knee, right knee and right shoulder. The Petitioner underwent left knee arthroscopic surgery in 2006 for a tear of the lateral meniscus and in 2010 for a left anterior horn tear, medial meniscus resection and fibrillated tear and lateral meniscus resection. The Petitioner also underwent removal of the plica and large suprapatellar plica. (PX 5) Petitioner testified that she underwent arthroscopic surgery to

her right knee in 2010. She also testified that she underwent right shoulder rotator cuff repair in 1998 and right shoulder manipulation in 2009.

When the Petitioner presented to Dr. Tonino on October 29, 2012, the Petitioner complained of pain to both shoulders and left knee. The pain diagram completed that day indicated some pain over the upper trapezius near the neck on the right and no pain indicated in the right shoulder. There was pain over the left shoulder and left knee but no pain indicated in the area of the right knee. (Rx 1). Dr. Tonino did not diagnose the Petitioner with any condition to the right knee. He diagnosed the Petitioner with a strain of both shoulders and left knee contusion. (PX 2).

The Petitioner began a course with Doctors of Physical Therapy for her left knee and left wrist. (PX 5). When Petitioner presented to Dr. Tonino on November 29, 2012, is the first time she mentioned problems with the right knee. On exam, she had full range of motion of both shoulders and her rotator cuff testing was withing normal limits. Dr. Tonino noted superficial tenderness over the proximal and medial right tibia which was very superficial that did not involve the right knee joint itself. (PX 2).

The Petitioner returned to Dr. Tonino on January 14, 2013, she did not complain of right knee pain. Dr. Tonino recommended arthroscopic surgery for the left knee. (PX 2).

On February 19, 2013, the Petitioner presented to Dr. Bednar for evaluation of her numbness and tingling in the hands. Dr. Bednar diagnosed the Petitioner with bilateral carpal tunnel syndrome. He was also concerned that Petitioner may have a partial tear of the biceps tendon off of the radius. Petitioner was to be sent for an EMG nerve conduction study. Petitioner

reported that a splint was only giving her partial relief of symptoms. Dr. Bednar also prescribed an MRI to assess her biceps. (PX 2).

At the request of the Respondent, the Petitioner was examined by Dr. Troy Karlsson on February 20, 2013. Dr. Karlsson diagnosed the Petitioner with a pre-existing condition to her left knee and found that the meniscal tear to the left knee was causally related to the work accident. He recommended that the Petitioner undergo surgery to the left knee. (RX 2).

Petitioner underwent an MRI of the left elbow on March 13, 2013. The MRI revealed medial epicondylitis, trace elbow joint effusion, and an intact biceps tendon. (PX 2).

Petitioner presented for an electromyography test at Loyola Medicine performed by Dr. Gregory Gruener at the request of Dr. Michael Bednar. The nerve stimulation studies demonstrated normal motor and sensory amplitudes, latencies and nerve conduction velocities. The orthodromically recorded mixed nerve responses which showed no latency difference following median versus ulnar nerve stimulation on either side. An EMG was not performed pursuant to the Petitioner's request. Petitioner's neurodiagnostic study was considered normal. (PX 2).

On May 2, 2013, the Petitioner returned to Dr. Bednar for evaluation. He noted a change in the Petitioner's symptoms since his last examination. Petitioner complained of more pain of the wrist over the radial aspect of the wrist. He also stated it was worse with pinching. Petitioner did not have elbow pain but it was

over the posterior aspect of the elbow and present on both sides. Numbness and tingling were not a significant component for the Petitioner. Upon physical examination, Dr. Bednar noted that pain was present at the CMC joints of the thumbs with crepitus at the location, worse on the right than the left. Petitioner did have an EMG nerve conduction study which was read as normal. Dr. Bednar gave the Petitioner bilateral hand-based thumb spica splints. Petitioner was to return in six weeks. (PX 2).

Petitioner underwent left knee surgery on May 7, 2013 for her medial meniscal tear. Petitioner's post-operative diagnosis was medial meniscal tear of the left knee and chondromalacia of the medial femoral condyle of the left knee. Petitioner underwent a partial medial meniscectomy and chondroplasty and micro fracture of the medial femoral condyle. (PX 2) Petitioner received postoperative physical therapy. On June 24, 2013, the Petitioner was released to work with restrictions. (PX 2).

On July 16, 2013 the Petitioner underwent an MRI of her right knee which revealed tears to the medial and lateral menisci and tricompartmental articular cartilage degeneration at the patellofemoral joint. The Petitioner underwent surgery to her right knee on October 22, 2103. Surgery consisted of an arthroscopic partial medial and partial lateral meniscectomies and arthroscopic chondroplasty of the right knee. Petitioner underwent post-operative physical therapy. Petitioner was released to work full duty as of February 21, 2014. (PX 2).

Petitioner testified that on April 8, 2014 she tripped over the lip on stairs and fell striking her knees.

The Petitioner presented to Loyola Medicine on April 28, 2014 complaining of pain to both knees and right shoulder. Petitioner reported a fall on both of her knees and landing on her knees. She complained of bilateral knee pain and right shoulder pain. Petitioner has a positive impingement sign of the right shoulder. Petitioner was offered cortisone injections for her knees and shoulder. Petitioner deferred. (PX 2).

Petitioner did not return to Dr. Tonino until December 23, 2014. Petitioner complained of bilateral knee pain and right shoulder pain. The Petitioner was again offered injections to her knees and shoulder. Petitioner refused.

On March 3, 2016 Petitioner testified that she suffered an injury while working using a hoist in Ohio. There are no medical records immediately following the injury.

Petitioner underwent an MRI of the right shoulder on May 27, 2016. The MRI revealed a partial tear of the distal supraspinatus suspected with abnormal signal in the supraspinatus and infraspinatus. There was marked deformity of the humeral head with prominent degenerative narrowing and osteophyte formation of the glenohumeral joint, possible ossific density in the axillary recess region and impingement with the acromioclavicular joint hypertrophy. (PX 2).

The Petitioner began treatment with Dr. Paley on June 21, 2016. The Petitioner reported that she was working on an air hoist when the air hoist jerked and fell to the right. Petitioner applied ice and returned to work. Petitioner reported an injury in 1998 and manipulation in 2006 but nothing else. Petitioner did not mention any injury to the right shoulder in 2012 or 2014. Petitioner also complained of back pain. Dr. Paley recommended an injection but the Petitioner refused. Petitioner continued with conservative care for the right shoulder and low back. The Petitioner underwent an MRI

of the lumbar spine but it only revealed degenerative changes. Dr. Paley's records are silent on causation. (PX 3).

Dr. Tonino examined the Petitioner on January 11, 2018. Dr. Tonino recommended right shoulder arthroplasty. He also diagnosed the Petitioner with arthritis of her bilateral knees and recommended evaluation with a total joint specialist for her knees as well.

On January 2, 2019, Dr. David C. Randolph authored a report regarding the Petitioner's disability in her Ohio claim. Dr. Randolph agreed with Dr. Ahmad that the Petitioner's right shoulder condition was due to factors, issues, and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part. (Rx 5)

At the request of the Respondent, Dr. Karlsson conducted a record review on February 19, 2019. Dr. Karlsson upon review of the medical records noted that the October 20, 2012 was not an injury to the shoulder. He found that there was no mention of a right shoulder injury initially. He also noted that the Petitioner's pain diagram on October 29, 2012 did not indicate any shoulder pain but rather trapezius pain and right neck pain. He also found that Petitioner had shoulder pain on January 13, 2014 well in advance of her April 8, 2014 injury.

Dr. Karlsson also found that the Petitioner's right knee surgery and condition were unrelated to an injury at work. He noted that the first mention of right knee pain was on November 29, 2012 and Dr. Tonino documented pain below the knee and not at the knee joint itself. He opined that bilateral knee replacements were not related to Petitioner's work injuries. (RX 3)

Dr. Karlsson examined the Petitioner on May 13, 2019. He was provided additional medical records including medical records following her alleged injury of March 3, 2016. He opined that the Petitioner's March 3, 2016 did not cause the need for right shoulder arthroplasty or bilateral knee replacement He found no evidence of structural changes after the March 3, 2016 to support a finding that she suffered an injury on that day.

Petitioner testified that she was hired by the Respondent in Ohio in June 1998 and was laid off in 2002. She then applied for a position with the Respondent in 2004. Petitioner was transferred to Springfield Ohio in 2014. The Petitioner continues to work for the Respondent with restrictions. She has not suffered any economic loss as a result of her permanent restrictions. She takes ibuprofen 800 mg as needed for her pain.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The medical records clearly support a finding that the Petitioner had significant pre-existing conditions to her bilateral knees and right shoulder. Prior to the claims at bar, Petitioner had undergone two surgeries to her left knee, surgery to the right knee and a surgery and manipulation to the right shoulder. Petitioner had documented evidence of arthritis in all her joints prior to the incident of October 20, 2012.

The Arbitrator finds that the only objective change that occurred following the October 20, 2012 injury was the finding of a medial meniscal tear of the left knee. The Arbitrator finds that the Petitioner's need for a partial arthroscopy of the left knee was causally related to the injury of October 20, 2012.

The Petitioner's right knee surgery on October 22, 2013 is not related to the injury of October 20, 2012. Petitioner did not complain of right knee pain immediately after the accident. Her treating physician noted right leg pain on November 29, 2012; however, he clearly documented that it was not in the joint. Examinations of the right knee were normal. It was not until July 2013 that the Petitioner was even prescribed any diagnostic testing for the right knee.

Dr. Tonino makes a statement that the Petitioner did complain of right pain and that the surgery was related to the incident of October 20, 2012; however, his records do not

support his statement. The Arbitrator finds Dr. Karlsson's opinion regarding the right knee to be more credible as his opinions are supported by the objective medical findings.

As for the right shoulder, the Arbitrator finds that the Petitioner failed to prove that she suffered an injury to the right shoulder as a result of the incident on October 20, 2012. The initial records of October 20, 2012 do not mention any right shoulder pain. Subsequent records suggest right sided neck pain and pain in the trapezius but no pain in the right shoulder joint. Dr. Tonino did not diagnose the Petitioner with any condition to the right shoulder following the injury of October 20, 2012.

The Petitioner complained of right shoulder pain on January 13, 2014 without any evidence of an injury to the right shoulder. Dr. Karlsson provides a careful analysis of the Petitioner's records and her treatment to the right shoulder. He opined that the right shoulder was not causally related to the injury of October 20, 2012. Dr. Tonino does not provide a causal connection opinion regarding the right shoulder. Therefore, the Arbitrator finds that the Petitioner did not suffer an injury to her right shoulder subsequent to the accident on October 20, 2012.

The Petitioner did complain of left shoulder, left hand and forearm pain following the accident of October 20, 2012. Petitioner received conservative treatment. All diagnostic testing performed by Dr. Bednar for the Petitioner's left arm and hand were negative.

In relation to K what temporary benefits are in dispute and whether the petitioner is entitled to additional TTD as a result of the injury on October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner was entitled to temporary total disability benefits from May 6, 2013 through June 24, 2013. Respondent has paid TTD benefits for this period of lost time following her left knee surgery and her return to work light duty.

The Arbitrator finds that the Petitioner did not suffer an injury to her right knee as a consequence of the October 20, 2012. Therefore, the Arbitrator denies any further claimed TTD benefits as the claimed lost time is related to the Petitioner's right knee treatment/surgery.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on October 20, 2012, Case. No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered a compensable injury to her left knee on October 20, 2012. As a result of this injury, the Petitioner underwent a partial meniscectomy. The Arbitrator finds that the Petitioner had a pre-existing condition to her left knee and any recommendation for left knee total replacement is not causally related to the Petitioner's injury of October 20, 2012. The Arbitrator awards the Petitioner 15% loss of use of the left leg or $22,525.98.

The Arbitrator also finds that the Petitioner suffered an injury to left shoulder and left arm following the injury of October 20, 2012. The medical records suggest she suffered a left shoulder strain based on her initial complaints and treatment. Petitioner received

minimal and conservative treatment for her left shoulder. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the whole person or $6,984.80.

The Arbitrator also finds that the Petitioner suffered an injury to her left hand. She received conservative treatment including physical therapy. Her diagnostic tests were negative. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the left hand or $2,863.77.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of April 8, 2014, Case No. 15 WC 9943, the Arbitrator finds the following:

The medical records establish that the Petitioner had significant treatment to her left knee, right knee and right shoulder prior to the accident on April 8, 2014 when she tripped and fell. The Petitioner had undergone surgery to both her knees prior to April 8, 2014 and had complained of right shoulder pain just months before this incident post accident. There were no changes on her examinations to suggest that the Petitioner's pre-existing conditions to her left knee, right knee and right shoulder were aggravated, exacerbated or accelerated. The Arbitrator finds no causal relationship between Petitioner's injuries and recommended need for future treatment to her right shoulder, right knee and left knee to the injury at work on April 8, 2014.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on April 8, 2014, Case. No. 15 WC 9943, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered no permanent injury as a result of the accident on April 8, 2014. The Petitioner had two visits to her doctor over the course of 8 months. She suffered no lost time and refused cortisone injections that were offered to her. There was no evidence presented to document a change in her pre-existing condition. Therefore, the Arbitrator does not award any permanent partial disability for this injury.

CONCLUSIONS OF LAW

In relation to (O) whether there is Jurisdiction, the Arbitrator finds the following:

Petitioner testified that she was originally hired in Ohio but was then laid off. She was then rehired in Illinois with a day 1 senority. Therefore, pursuant to the contract for hire, Illinois has jurisdiction. See, *Mahoney v. Industrial Commission*, 843 N.E. 2d 317 (2006).

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of March 3, 2016, Case No. 19 WC 3473, the Arbitrator finds the following:

The Petitioner received conservative treatment and there is no evidence of any objective changes in Petitioner's right shoulder or lumbar spine. The evidence supports a finding that the Petitioner's right shoulder and lumbar findings were due to the natural progression of her aging. Dr. Randolph opined that the MRI scan showed evidence of congenital spinal stenosis from L3-S1 with evidence of facet arthropathy at the same levels. Dr. Randolph and Dr. Ahmad concluded that "her problems with respect to her right shoulder were due to factors, issues and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part." (RX 5).

Therefore, the Arbitrator finds no causal relationship to the need for surgery to the right shoulder as a consequence of the accidental injury of March 3, 2016.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on March 3, 2016, Case. No. 19 WC 3473, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner failed to prove that she suffered any permanent injury as a result of the incident on March 3, 2016. Her treating physicians and Respondent's examining physician all agree that the Petitioner's treatment and need for additional treatment is not related to the work injury of March 3, 2016.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC009943
Case Name	HOWARD, IRIS v. NAVISTAR
Consolidated Cases	13WC029526 19WC003473
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0089
Number of Pages of Decision	22
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	RICHARD JOHNSON
Respondent Attorney	Linda Robert

DATE FILED: 3/14/2022

/s/*Deborah Baker, Commissioner*

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IRIS HOWARD,

Petitioner,

vs. NO: 15 WC 09943

NAVISTAR,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein with oral arguments waived, and notice given to all parties, the Commission, after considering the issues of causal connection to Petitioner's current right shoulder and bilateral knee conditions of ill-being and the nature and extent of Petitioner's injuries, and being advised of the facts and law, affirms and adopts, with the following changes, the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Although we affirm the Decision of the Arbitrator, we change it to include the requisite analysis under Section 8.1b of the Act, as Petitioner's alleged accident occurred after September 1, 2011.

Pursuant to Section 8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. *820 ILCS 305/8.1b*. The

Act provides that, "No single enumerated factor shall be the sole determinant of disability." *820 ILCS 305/8.1b(b)(v)*.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Commission notes Petitioner was a laborer at the time of accident and lost no time from work as a result thereof. Substantial weight is given to this factor.

With regard to subsection (iii) of §8.1b(b), the Commission notes Petitioner was 59 years of age at the time of the accident. Some weight is given to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Commission finds no credible evidence of reduced earning capacity contained in the record. Petitioner testified she continued to receive the raises she was entitled to per union contract. 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 record reflects no changes in Petitioner's bilateral knee diagnoses after the accident, nor any discernable treatment for either of her knees or right shoulder with the exception of physical therapy. Petitioner also refused cortisone injections. Substantial weight is given to this factor.

Based upon the foregoing evidence and factors, the Commission finds that, at most, Petitioner suffered a temporary aggravation of her preexisting bilateral knee conditions, as well as temporary right shoulder symptomatology, which returned to baseline shortly thereafter. The Commission affirms the Arbitrator's denial of permanent partial disability benefits as it pertains to the April 8, 2014 accident.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, as changed above, is hereby affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner failed to prove causal connection between the April 8, 2014 work-related accident and her current right shoulder and bilateral knee conditions of ill-being by a preponderance of evidence.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner failed to prove entitlement to permanent partial disability benefits.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit

for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. 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.

March 14, 2022

D: 1/12/22
DJB/wde
043

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

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWARD, IRIS
Employee/Petitioner

Case# **15WC009943**

INTERNATIONAL TRUCK & ENGINE CORP
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA ROBERT
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

IRIS HOWARD,
Employee/Petitioner

Case # **15 WC 09943**

v.

Consolidated cases:

INTERNATIONAL TRUCK & ENGINE CORPORATION,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **WILLIAM MCLAUGHLIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **February 24, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/8/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $60,534.76; the average weekly wage was $1,164.13.

On the date of accident, Petitioner was **59** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Denial of benefits

No benefits are awarded.

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

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

April 9, 2020

Signature of Arbitrator Date

APR 14 2020

FINDINGS OF FACT

The Petitioner, Iris Howard, was 57 years old and employed by the Respondent on October 20, 2012. On that day, she was working with a crankshaft. The crankshaft struck the Petitioner's left side, including her left shoulder, left knee, and left hand. Petitioner did not fall to the ground and she did not strike her knees to the ground.

Petitioner sought treatment with Advanced Occupational Medicine Specialist on October 20, 2012. The Petitioner reported pain in her left forearm, left elbow, left wrist, left thigh and left knee pain. PX 1. Both of Petitioner's knees were examined; however, only the left knee had positive findings including a positive Lachman's test and quadriceps test. Petitioner was diagnosed with a left forearm contusion, left wrist pain and left thigh/knee contusion. (PX 1). There were no complaints to the Petitioner's right hand, right knee or right shoulder.

The Petitioner then presented to Navistar's medical department on October 24, 2012. Petitioner complained of right neck pain and trapezius pain as well as left shoulder, left forearm, left thigh and left knee pain. There is no mention of any right knee pain or right shoulder pain. Petitioner had numbness and tingling in her hands. Petitioner did not complain of right knee or right shoulder pain. (PX 5). Petitioner did report prior surgeries to her left knee, right knee and right shoulder. The Petitioner underwent left knee arthroscopic surgery in 2006 for a tear of the lateral meniscus and in 2010 for a left anterior horn tear, medial meniscus resection and fibrillated tear and lateral meniscus resection. The Petitioner also underwent removal of the plica and large suprapatellar plica. (PX 5) Petitioner testified that she underwent arthroscopic surgery to

her right knee in 2010. She also testified that she underwent right shoulder rotator cuff repair in 1998 and right shoulder manipulation in 2009.

When the Petitioner presented to Dr. Tonino on October 29, 2012, the Petitioner complained of pain to both shoulders and left knee. The pain diagram completed that day indicated some pain over the upper trapezius near the neck on the right and no pain indicated in the right shoulder. There was pain over the left shoulder and left knee but no pain indicated in the area of the right knee. (Rx 1). Dr. Tonino did not diagnose the Petitioner with any condition to the right knee. He diagnosed the Petitioner with a strain of both shoulders and left knee contusion. (PX 2).

The Petitioner began a course with Doctors of Physical Therapy for her left knee and left wrist. (PX 5). When Petitioner presented to Dr. Tonino on November 29, 2012, is the first time she mentioned problems with the right knee. On exam, she had full range of motion of both shoulders and her rotator cuff testing was withing normal limits. Dr. Tonino noted superficial tenderness over the proximal and medial right tibia which was very superficial that did not involve the right knee joint itself. (PX 2).

The Petitioner returned to Dr. Tonino on January 14, 2013, she did not complain of right knee pain. Dr. Tonino recommended arthroscopic surgery for the left knee. (PX 2).

On February 19, 2013, the Petitioner presented to Dr. Bednar for evaluation of her numbness and tingling in the hands. Dr. Bednar diagnosed the Petitioner with bilateral carpal tunnel syndrome. He was also concerned that Petitioner may have a partial tear of the biceps tendon off of the radius. Petitioner was to be sent for an EMG nerve conduction study. Petitioner

reported that a splint was only giving her partial relief of symptoms. Dr. Bednar also prescribed an MRI to assess her biceps. (PX 2).

At the request of the Respondent, the Petitioner was examined by Dr. Troy Karlsson on February 20, 2013. Dr. Karlsson diagnosed the Petitioner with a pre-existing condition to her left knee and found that the meniscal tear to the left knee was causally related to the work accident. He recommended that the Petitioner undergo surgery to the left knee. (RX 2).

Petitioner underwent an MRI of the left elbow on March 13, 2013. The MRI revealed medial epicondylitis, trace elbow joint effusion, and an intact biceps tendon. (PX 2).

Petitioner presented for an electromyography test at Loyola Medicine performed by Dr. Gregory Gruener at the request of Dr. Michael Bednar. The nerve stimulation studies demonstrated normal motor and sensory amplitudes, latencies and nerve conduction velocities. The orthodromically recorded mixed nerve responses which showed no latency difference following median versus ulnar nerve stimulation on either side. An EMG was not performed pursuant to the Petitioner's request. Petitioner's neurodiagnostic study was considered normal. (PX 2).

On May 2, 2013, the Petitioner returned to Dr. Bednar for evaluation. He noted a change in the Petitioner's symptoms since his last examination. Petitioner complained of more pain of the wrist over the radial aspect of the wrist. He also stated it was worse with pinching. Petitioner did not have elbow pain but it was

over the posterior aspect of the elbow and present on both sides. Numbness and tingling were not a significant component for the Petitioner. Upon physical examination, Dr. Bednar noted that pain was present at the CMC joints of the thumbs with crepitus at the location, worse on the right than the left. Petitioner did have an EMG nerve conduction study which was read as normal. Dr. Bednar gave the Petitioner bilateral hand-based thumb spica splints. Petitioner was to return in six weeks. (PX 2).

Petitioner underwent left knee surgery on May 7, 2013 for her medial meniscal tear. Petitioner's post-operative diagnosis was medial meniscal tear of the left knee and chondromalacia of the medial femoral condyle of the left knee. Petitioner underwent a partial medial meniscectomy and chondroplasty and micro fracture of the medial femoral condyle. (PX 2) Petitioner received postoperative physical therapy. On June 24, 2013, the Petitioner was released to work with restrictions. (PX 2).

On July 16, 2013 the Petitioner underwent an MRI of her right knee which revealed tears to the medial and lateral menisci and tricompartmental articular cartilage degeneration at the patellofemoral joint. The Petitioner underwent surgery to her right knee on October 22, 2103. Surgery consisted of an arthroscopic partial medial and partial lateral meniscectomies and arthroscopic chondroplasty of the right knee. Petitioner underwent post-operative physical therapy. Petitioner was released to work full duty as of February 21, 2014. (PX 2).

Petitioner testified that on April 8, 2014 she tripped over the lip on stairs and fell striking her knees.

The Petitioner presented to Loyola Medicine on April 28, 2014 complaining of pain to both knees and right shoulder. Petitioner reported a fall on both of her knees and landing on her knees. She complained of bilateral knee pain and right shoulder pain. Petitioner has a positive impingement sign of the right shoulder. Petitioner was offered cortisone injections for her knees and shoulder. Petitioner deferred. (PX 2).

Petitioner did not return to Dr. Tonino until December 23, 2014. Petitioner complained of bilateral knee pain and right shoulder pain. The Petitioner was again offered injections to her knees and shoulder. Petitioner refused.

On March 3, 2016 Petitioner testified that she suffered an injury while working using a hoist in Ohio. There are no medical records immediately following the injury.

Petitioner underwent an MRI of the right shoulder on May 27, 2016. The MRI revealed a partial tear of the distal supraspinatus suspected with abnormal signal in the supraspinatus and infraspinatus. There was marked deformity of the humeral head with prominent degenerative narrowing and osteophyte formation of the glenohumeral joint, possible ossific density in the axillary recess region and impingement with the acromioclavicular joint hypertrophy. (PX 2).

The Petitioner began treatment with Dr. Paley on June 21, 2016. The Petitioner reported that she was working on an air hoist when the air hoist jerked and fell to the right. Petitioner applied ice and returned to work. Petitioner reported an injury in 1998 and manipulation in 2006 but nothing else. Petitioner did not mention any injury to the right shoulder in 2012 or 2014. Petitioner also complained of back pain. Dr. Paley recommended an injection but the Petitioner refused. Petitioner continued with conservative care for the right shoulder and low back. The Petitioner underwent an MRI

of the lumbar spine but it only revealed degenerative changes. Dr. Paley's records are silent on causation. (PX 3).

Dr. Tonino examined the Petitioner on January 11, 2018. Dr. Tonino recommended right shoulder arthroplasty. He also diagnosed the Petitioner with arthritis of her bilateral knees and recommended evaluation with a total joint specialist for her knees as well.

On January 2, 2019, Dr. David C. Randolph authored a report regarding the Petitioner's disability in her Ohio claim. Dr. Randolph agreed with Dr. Ahmad that the Petitioner's right shoulder condition was due to factors, issues, and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part. (Rx 5)

At the request of the Respondent, Dr. Karlsson conducted a record review on February 19, 2019. Dr. Karlsson upon review of the medical records noted that the October 20, 2012 was not an injury to the shoulder. He found that there was no mention of a right shoulder injury initially. He also noted that the Petitioner's pain diagram on October 29, 2012 did not indicate any shoulder pain but rather trapezius pain and right neck pain. He also found that Petitioner had shoulder pain on January 13, 2014 well in advance of her April 8, 2014 injury.

Dr. Karlsson also found that the Petitioner's right knee surgery and condition were unrelated to an injury at work. He noted that the first mention of right knee pain was on November 29, 2012 and Dr. Tonino documented pain below the knee and not at the knee joint itself. He opined that bilateral knee replacements were not related to Petitioner's work injuries. (RX 3)

Dr. Karlsson examined the Petitioner on May 13, 2019. He was provided additional medical records including medical records following her alleged injury of March 3, 2016. He opined that the Petitioner's March 3, 2016 did not cause the need for right shoulder arthroplasty or bilateral knee replacement He found no evidence of structural changes after the March 3, 2016 to support a finding that she suffered an injury on that day.

Petitioner testified that she was hired by the Respondent in Ohio in June 1998 and was laid off in 2002. She then applied for a position with the Respondent in 2004. Petitioner was transferred to Springfield Ohio in 2014. The Petitioner continues to work for the Respondent with restrictions. She has not suffered any economic loss as a result of her permanent restrictions. She takes ibuprofen 800 mg as needed for her pain.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The medical records clearly support a finding that the Petitioner had significant pre-existing conditions to her bilateral knees and right shoulder. Prior to the claims at bar, Petitioner had undergone two surgeries to her left knee, surgery to the right knee and a surgery and manipulation to the right shoulder. Petitioner had documented evidence of arthritis in all her joints prior to the incident of October 20, 2012.

The Arbitrator finds that the only objective change that occurred following the October 20, 2012 injury was the finding of a medial meniscal tear of the left knee. The Arbitrator finds that the Petitioner's need for a partial arthroscopy of the left knee was causally related to the injury of October 20, 2012.

The Petitioner's right knee surgery on October 22, 2013 is not related to the injury of October 20, 2012. Petitioner did not complain of right knee pain immediately after the accident. Her treating physician noted right leg pain on November 29, 2012; however, he clearly documented that it was not in the joint. Examinations of the right knee were normal. It was not until July 2013 that the Petitioner was even prescribed any diagnostic testing for the right knee.

Dr. Tonino makes a statement that the Petitioner did complain of right pain and that the surgery was related to the incident of October 20, 2012; however, his records do not

support his statement. The Arbitrator finds Dr. Karlsson's opinion regarding the right knee to be more credible as his opinions are supported by the objective medical findings.

As for the right shoulder, the Arbitrator finds that the Petitioner failed to prove that she suffered an injury to the right shoulder as a result of the incident on October 20, 2012. The initial records of October 20, 2012 do not mention any right shoulder pain. Subsequent records suggest right sided neck pain and pain in the trapezius but no pain in the right shoulder joint. Dr. Tonino did not diagnose the Petitioner with any condition to the right shoulder following the injury of October 20, 2012.

The Petitioner complained of right shoulder pain on January 13, 2014 without any evidence of an injury to the right shoulder. Dr. Karlsson provides a careful analysis of the Petitioner's records and her treatment to the right shoulder. He opined that the right shoulder was not causally related to the injury of October 20, 2012. Dr. Tonino does not provide a causal connection opinion regarding the right shoulder. Therefore, the Arbitrator finds that the Petitioner did not suffer an injury to her right shoulder subsequent to the accident on October 20, 2012.

The Petitioner did complain of left shoulder, left hand and forearm pain following the accident of October 20, 2012. Petitioner received conservative treatment. All diagnostic testing performed by Dr. Bednar for the Petitioner's left arm and hand were negative.

In relation to K what temporary benefits are in dispute and whether the petitioner is entitled to additional TTD as a result of the injury on October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner was entitled to temporary total disability benefits from May 6, 2013 through June 24, 2013. Respondent has paid TTD benefits for this period of lost time following her left knee surgery and her return to work light duty.

The Arbitrator finds that the Petitioner did not suffer an injury to her right knee as a consequence of the October 20, 2012. Therefore, the Arbitrator denies any further claimed TTD benefits as the claimed lost time is related to the Petitioner's right knee treatment/surgery.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on October 20, 2012, Case. No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered a compensable injury to her left knee on October 20, 2012. As a result of this injury, the Petitioner underwent a partial meniscectomy. The Arbitrator finds that the Petitioner had a pre-existing condition to her left knee and any recommendation for left knee total replacement is not causally related to the Petitioner's injury of October 20, 2012. The Arbitrator awards the Petitioner 15% loss of use of the left leg or $22,525.98.

The Arbitrator also finds that the Petitioner suffered an injury to left shoulder and left arm following the injury of October 20, 2012. The medical records suggest she suffered a left shoulder strain based on her initial complaints and treatment. Petitioner received

minimal and conservative treatment for her left shoulder. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the whole person or $6,984.80.

The Arbitrator also finds that the Petitioner suffered an injury to her left hand. She received conservative treatment including physical therapy. Her diagnostic tests were negative. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the left hand or $2,863.77.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of April 8, 2014, Case No. 15 WC 9943, the Arbitrator finds the following:

The medical records establish that the Petitioner had significant treatment to her left knee, right knee and right shoulder prior to the accident on April 8, 2014 when she tripped and fell. The Petitioner had undergone surgery to both her knees prior to April 8, 2014 and had complained of right shoulder pain just months before this incident post accident. There were no changes on her examinations to suggest that the Petitioner's pre-existing conditions to her left knee, right knee and right shoulder were aggravated, exacerbated or accelerated. The Arbitrator finds no causal relationship between Petitioner's injuries and recommended need for future treatment to her right shoulder, right knee and left knee to the injury at work on April 8, 2014.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on April 8, 2014, Case. No. 15 WC 9943, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered no permanent injury as a result of the accident on April 8, 2014. The Petitioner had two visits to her doctor over the course of 8 months. She suffered no lost time and refused cortisone injections that were offered to her. There was no evidence presented to document a change in her pre-existing condition. Therefore, the Arbitrator does not award any permanent partial disability for this injury.

CONCLUSIONS OF LAW

In relation to (O) whether there is Jurisdiction, the Arbitrator finds the following:

Petitioner testified that she was originally hired in Ohio but was then laid off. She was then rehired in Illinois with a day 1 senority. Therefore, pursuant to the contract for hire, Illinois has jurisdiction. See, *Mahoney v. Industrial Commission*, 843 N.E. 2d 317 (2006).

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of March 3, 2016, Case No. 19 WC 3473, the Arbitrator finds the following:

The Petitioner received conservative treatment and there is no evidence of any objective changes in Petitioner's right shoulder or lumbar spine. The evidence supports a finding that the Petitioner's right shoulder and lumbar findings were due to the natural progression of her aging. Dr. Randolph opined that the MRI scan showed evidence of congenital spinal stenosis from L3-S1 with evidence of facet arthropathy at the same levels. Dr. Randolph and Dr. Ahmad concluded that "her problems with respect to her right shoulder were due to factors, issues and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part." (RX 5).

Therefore, the Arbitrator finds no causal relationship to the need for surgery to the right shoulder as a consequence of the accidental injury of March 3, 2016.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on March 3, 2016, Case. No. 19 WC 3473, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner failed to prove that she suffered any permanent injury as a result of the incident on March 3, 2016. Her treating physicians and Respondent's examining physician all agree that the Petitioner's treatment and need for additional treatment is not related to the work injury of March 3, 2016.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC003473
Case Name	HOWARD, IRIS v. NAVISTAR
Consolidated Cases	13WC029526 15WC009943
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0090
Number of Pages of Decision	26
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	RICHARD JOHNSON
Respondent Attorney	Linda Robert

DATE FILED: 3/14/2022

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IRIS HOWARD,

Petitioner,

vs. NO: 19 WC 03473

NAVISTAR,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein with oral arguments waived, and notice given to all parties, the Commission, after considering the issues of accident, causal connection to Petitioner's current right shoulder condition of ill-being and the nature and extent of Petitioner's injuries, and being advised of the facts and law, reverses in-part and otherwise affirms and adopts, with the following changes, the Decision of the Arbitrator that denied Petitioner's claim in its entirety, which is attached hereto and made a part hereof, as stated below.

I. FINDINGS OF FACT

The record reflects that Petitioner underwent a right shoulder rotator cuff repair in 1998 and a right shoulder manipulation in 2009. On March 3, 2016, Petitioner was 61-years-old and worked for Respondent as a laborer. Petitioner testified that on that day, while working for Respondent, she was using a hoist that jerked her right arm. The medical records corroborate Petitioner's testimony and indicate that Petitioner sustained a right shoulder injury on March 3, 2016 when a hoist broke, dropping an item toward her right side. Respondent did not call any witnesses to testify. The Application For Adjustment of Claim alleges work-related injuries to "R Shoulder, Back, and Body."

A right shoulder MRI dated May 27, 2016, revealed a partial tear of at least the distal supraspinatus tendon, marked deformity of the humeral head with prominent degenerative narrowing and osteophyte formation at the glenohumeral joint and impingement with

acromioclavicular joint hypertrophy.

On June 21, 2016, Petitioner treated with Dr. Jonathan J. Paley at Dayton Ortho Surgery. Dr. Paley noted a mechanism of injury that Petitioner was working on an air hoist when the air hoist jerked and fell to the right. Dr. Paley noted Petitioner's shoulder pain which had begun radiating down her arm. Petitioner informed Dr. Paley that although she had previously undergone a right rotator cuff surgery and a subsequent manipulation, she had recovered fine and was able to return to work afterward. Dr. Paley reviewed the MRI and found an acute partial tearing of the supraspinatus tendon. He diagnosed a right rotator cuff tear, right trapezial sprain and lumbar sprain. Medication and physical therapy were prescribed.

Petitioner followed up with Dr. Paley on July 25, 2016, who acknowledged Petitioner's pre-accident right shoulder history, but also noted that Petitioner's pain had increased since the instant accident, stating: "However, since the injury from five months ago, she is having fairly significant right shoulder pain and problems." Petitioner complained of pain that woke her up at night. She had been on shutdown for a period, which somewhat improved her pain. An examination revealed very stiff passive and active range of motion with crepitus. X-rays revealed significant degenerative changes of the right glenohumeral joint. Type II to Type III acromion was noted, as was AC joint arthropathy. Dr. Paley opined that Petitioner had fairly advanced arthritic changes in her right shoulder and that she may have substantially aggravated a preexisting right shoulder arthritis. Additional physical therapy was prescribed.

On August 29, 2016, Petitioner still had very stiff active and passive range of motion in her right shoulder with tenderness over the anterior and lateral aspect. Dr. Paley recommended a right shoulder glenohumeral corticosteroid injection, which was not authorized.

On October 18, 2016, Petitioner returned to Dr. Paley and reported she had difficulty with any activities over the shoulder level. An examination revealed spasm in the posterior deltoid and trapezius muscle on the right. She exhibited guarded limited motion with active and passive movements, and significant limited motion with internal and external rotation. She also had severe crepitations with active and passive movement. Right shoulder therapy was continued.

On December 30, 2016, Dr. Paley noted: "She states that she was doing well until the most recent injury on 03/03/2016." Petitioner still complained of limited and painful range of motion, difficulty resting at night, and inability to perform overhead activity. Dr. Paley noted that his previously recommended corticosteroid injection was apparently not authorized. Dr. Paley prescribed pain medication and opined "it is clear that this patient [Petitioner] had a pre-existing condition that was substantially aggravated and made worse by this 03/03/2016 injury."

On February 27, 2017, Dr. Paley noted that Petitioner had been attending physical therapy, which improved function and movement in her shoulder, but she continued having significant pain. Dr. Paley reiterated that Petitioner was doing well prior to this injury and opined, "I feel that she has substantial aggravation of pre-existing glenohumeral arthrosis of the right shoulder which is directly related to her work injury." Petitioner was continued on restricted duty.

On January 11, 2018, Petitioner treated with Dr. Pietro M. Tonino for her right shoulder,

which was still painful. Petitioner complained of difficulty sleeping on her shoulder and pain when she elevated her arm above her head. Dr. Tonino diagnosed Petitioner with right shoulder degenerative changes and arthritis, and opined Petitioner was a candidate for right shoulder arthroplasty. He did not think arthroscopic surgical intervention would be of any benefit to Petitioner.

On January 2, 2019, Dr. David C. Randolph, a Fellow at the American Academy of Disability Evaluating Physicians, reviewed medical records regarding Petitioner's right shoulder and lumbar spine. At the outset, Dr. Randolph stated in his report: "Medical records were submitted for review on the above-referenced claim [claim # 17-212605]. It is to be noted that claim #17-212605 as listed allowed conditions of 'sprain/strain, right shoulder/trapezius, sprain/strain low back.' For purposes of this report, these claim allowances are accepted." Dr. Randolph noted a September 28, 2018 record from a physician named "Dr. Ahmad," (whose medical records are not included in the record), which noted a mechanism of injury of putting a large roof on a platform with a hoist when the air went out of the hoist leaving the weight of the roof on Petitioner, which quickly jerked her arms down mainly to her right side almost to the ground. Due to Petitioner's history of rotator cuff surgery and manipulation, Dr. Randolph would not expect Petitioner to have a normal range of motion in her shoulder. Dr. Randolph noted the May 27, 2016 right shoulder MRI, which showed "abnormal signals in the distal rotator cuff and a suspected partial tear of the supraspinatus tendon" as well as a deformity of the humeral head, and opined that "These conditions are not allowed in the claim." Thus, Dr. Randolph agreed with Dr. Ahmad's opinion that Petitioner's right shoulder condition was due to factors, issues, and conditions unrelated to the "instant event" and due to an ordinary disease of life and natural deterioration of tissue, organ or body part. Accordingly, Dr. Randolph agreed with Dr. Ahmad's right shoulder impairment rating of 0 percent for the accepted "claim allowances" he noted at the outset of his report.

On May 13, 2019, Dr. Troy R. Karlsson performed a Section 12 examination of Petitioner at Respondent's request. He was also provided medical records and diagnostic reports subsequent to the instant accident, which were described as Petitioner using a hoist to carry a large truck roof, when the air went out of the hoist and pulled her down and to her right side. Petitioner continued holding the auto part until she got help. Petitioner indicated she would not like to proceed with a right shoulder replacement. Petitioner complained of pain in the front and back of her shoulder which occasionally radiated to her neck. She had decreased range of motion and popping. X-rays revealed severe loss of clear space with areas of full thickness loss. Some irregularity and remodeling of the humeral and glenoid surfaces, consistent with severe arthritis. There was also moderate degenerative change at the AC joint. Dr. Karlsson diagnosed Petitioner with severe degenerative osteoarthritis of the right shoulder, opining that it was unrelated to the instant accident. Dr. Karlsson opined that a total right shoulder replacement would be reasonable, but that it would not be related to the instant accident. Based on his review of the July 25, 2016 X-rays taken by Dr. Paley, Dr. Karlsson acknowledged tendinitis changes and partial thickness tearing of the rotator cuff, but opined that Petitioner's overwhelming problem was the severe degenerative glenohumeral arthropathy and irregularity of the humeral head and glenoid.

II. CONCLUSIONS OF LAW

A. Accident

Under the Illinois Workers' Compensation Act ("Act"), in order to obtain compensation, 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). 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 (2003).

"In the course of" refers to the time, place and circumstances surrounding the injury. *Scheffler Greenhouses, Inc. v. Industrial Comm'n*, 66 Ill. 2d 361, 366 (1977); *see* also *Lee v. Industrial Comm'n*, 167 Ill.2d 77, 81 (1995). An injury arises out of one's employment if it originates from a risk connected with, or incident to, the employment, involving a causal connection between the employment and the accidental injury. *Baggett v. Industrial Comm'n (Marion Community School District No. 2)*, 201 Ill. 2d 187, 194 (2002); *see* also *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. *McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848, ¶¶ 36; *see* also *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. *McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848, ¶¶ 36-40; *see* also *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 58 (1989).

The Commission acknowledges the Arbitrator found that Petitioner did sustain an accident arising out of and in the course of her employment with Respondent on March 3, 2016, within the "Findings" section of the Decision in case no. 19 WC 03473. However, the Commission clarifies and expounds on this finding. The Commission notes Petitioner's testimony regarding the mechanism of injury was unrebutted and is further supported by medical records. Petitioner testified that she injured her right shoulder when she was using a hoist that broke, releasing an item or equipment that fell toward her right side and jerked her right shoulder. Throughout her treatment with Dr. Paley, Petitioner continuously noted her right shoulder injury and its relation to the March 3, 2016 work accident. Of further note, Dr. Karlsson's May 13, 2019 Section 12 examination report notes the March 3, 2016 accident and describes a mechanism of injury in line with Petitioner's testimony and prior medical records. Accordingly, the Commission finds that the record as a whole supports a finding of accident by the preponderance of evidence.

B. Causal Connection to Current Right Shoulder *Condition of Ill-Being*

The Arbitrator found no evidence of any objective changes in Petitioner's right shoulder, and ruled that her right shoulder findings were due to the natural progression of her aging, relying

on the opinions of Dr. Randolph, and Dr. Ahmad whose reports and/or medical records are not included in the record. The Commission views the evidence differently than the Arbitrator and finds that Petitioner's current right shoulder condition is causally related to the instant accident.

It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accident 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. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 204-05 (2003). It is axiomatic 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, recovery for an accidental injury will not be denied as long as it can be shown that the employment was *a* causative factor. *Id.* at 205. In other words, an employee need only prove that some act or phase of his employment was *a* causative factor of the resulting injury; 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).

The Commission finds that the March 3, 2016 accident aggravated and accelerated Petitioner's preexisting right shoulder condition. The post-accident right shoulder MRI indicated a partial tear of the supraspinatus tendon. The record does not reflect that this diagnosis was present prior to the accident. However, the record does reflect that Petitioner's condition worsened after the accident to the point that she could no longer work. Petitioner's testimony and the medical records demonstrate that she had problems with the right shoulder before the March 3, 2016 work accident; however, she was "doing well" until the accident. After the accident, her right shoulder complaints increased and Dr. Paley recommended a right shoulder glenohumeral corticosteroid injection, which was never authorized. The Commission finds persuasive and credible Dr. Paley's opinion that Petitioner suffered an acute injury on March 3, 2016, which substantially aggravated her preexisting condition. The Commission is not persuaded by Dr. Karlsson's opinion that Petitioner's severe preexisting arthropathy was her overwhelming problem. The Commission finds it much more likely than not that, per the opinions of Dr. Paley, Petitioner suffered a substantial aggravation to her preexisting arthritis which was directly caused by the instant accident and has subsequently worsened her right shoulder condition. Moreover, the Commission finds that Dr. Karlsson's opinion dismissing causation of Petitioner's right shoulder condition with respect to the March 3, 2016 accident was conclusory and lacking in supportive reasoning. The Commission finds Dr. Karlsson's opinion both ignores and contradicts the evidence, particularly the MRI finding of a partial tear of the supraspinatus tendon, which was characterized as acute by Dr. Paley. Accordingly, the Commission reverses the Arbitrator's denial of causal connection with respect to Petitioner's right shoulder condition and finds that Petitioner has proven causation by a preponderance of evidence. The Commission affirms the Arbitrator's denial of benefits as to any lumbar spine/lower back injuries to the extent Petitioner is claiming entitlement to benefits for such injuries.

C. Permanent Partial Disability

Pursuant to Section 8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of

impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. *820 ILCS 305/8.1b*. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." *820 ILCS 305/8.1b(b)(v)*.

With regard to subsection (i) of §8.1b(b), the Commission notes that Respondent submitted an impairment rating offered by Dr. Randolph, who opined that Petitioner's impairment rating was 0 percent. The Commission notes that Dr. Randolph's impairment rating, which appears to have been the same rating initially given by a physician named Dr. Ahmad whose records are not included in the record, was only given for the following conditions which had been accepted by the workers' compensation insurance carrier at the time: "sprain/strain, right shoulder/trapezius, sprain/strain low back." The Commission gives no weight to this factor as the partial rotator cuff tear documented in the MRI was not considered.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Commission notes Petitioner was a laborer at the time of accident and lost no time from work as a result thereof. However, she was given work restrictions by her physicians, which Respondent accommodated. Substantial weight is given to this factor.

With regard to subsection (iii) of §8.1b(b), the Commission notes Petitioner was 61 years of age at the time of the accident. Some weight is given to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Commission finds no credible evidence of reduced earning capacity contained in the record. Petitioner testified she continues to receive raises she's entitled to per union contract. 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 record reflects substantial change in Petitioner's diagnosis after the accident. Subsequent to the accident, Petitioner was diagnosed with a partial rotator cuff tear after a right shoulder MRI on May 27, 2016. She suffers from decreased range of motion, increased pain, difficulty sleeping and crepitus. Dr. Paley opined Petitioner suffered a substantial aggravation of her preexisting condition and found the rotator cuff tear to be acute in nature. As stated in Petitioner's brief, she has elected to treat her condition conservatively. Petitioner testified to right shoulder pain while sitting, clicking when lifting her arm, and pain if she sleeps on her shoulder. The pain wakes her up at night. She takes 800mg Ibuprofen for multiple conditions, including the right shoulder. While the records show Dr. Tonino recommended a right shoulder arthroplasty in one note, the record is devoid of an expert opinion relating the need for the arthroplasty to the March 3, 2016 accident. Substantial weight is given to this factor.

Based on the foregoing factors, the Commission awards permanency of a 5 percent loss of use of a person as a whole for injuries sustained as provided in Section 8(d)(2) of the Act. The Arbitrator's ruling regarding Petitioner's lumbar spine condition is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

Arbitrator filed April 14, 2020 is reversed-in-part with respect to the right shoulder condition as stated above. Otherwise, the Decision of the Arbitrator, as changed above, is affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved causal connection between the March 3, 2016 work-related accident and her current right shoulder condition of ill-being by a preponderance of the evidence.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $698.48 per week for a period of 25 weeks, as provided in Section 8(d)(2) of the Act, for the reason that the injuries sustained caused a 5 percent loss of use of Petitioner's 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 $17,600.00. 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.

March 14, 2022

D: 1/12/22
DJB/wde
043

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

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWARD, IRIS
Employee/Petitioner

Case# **19WC003473**

NAVISTAR
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA ROBERT
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

IRIS HOWARD,
Employee/Petitioner

Case # **19 WC 03473**

v.

Consolidated cases:

NAVISTAR,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **WILLIAM MCLAUGHLIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **February 24, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/3/2016**, 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 $60,534.76; the average weekly wage was $1,164.13.

On the date of accident, Petitioner was **61** years of age, ***single*** with **2** dependent children.

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

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

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

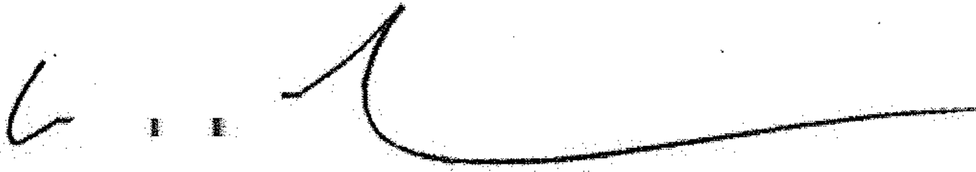
Respondent is entitled to a credit for all benefits paid under Section 8(j) of the Act.

ORDER

No benefits are awarded.

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

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



Signature of Arbitrator | April 9, 2020
Date

APR 14 2020

FINDINGS OF FACT

The Petitioner, Iris Howard, was 57 years old and employed by the Respondent on October 20, 2012. On that day, she was working with a crankshaft. The crankshaft struck the Petitioner's left side, including her left shoulder, left knee, and left hand. Petitioner did not fall to the ground and she did not strike her knees to the ground.

Petitioner sought treatment with Advanced Occupational Medicine Specialist on October 20, 2012. The Petitioner reported pain in her left forearm, left elbow, left wrist, left thigh and left knee pain. PX 1. Both of Petitioner's knees were examined; however, only the left knee had positive findings including a positive Lachman's test and quadriceps test. Petitioner was diagnosed with a left forearm contusion, left wrist pain and left thigh/knee contusion. (PX 1). There were no complaints to the Petitioner's right hand, right knee or right shoulder.

The Petitioner then presented to Navistar's medical department on October 24, 2012. Petitioner complained of right neck pain and trapezius pain as well as left shoulder, left forearm, left thigh and left knee pain. There is no mention of any right knee pain or right shoulder pain. Petitioner had numbness and tingling in her hands. Petitioner did not complain of right knee or right shoulder pain. (PX 5). Petitioner did report prior surgeries to her left knee, right knee and right shoulder. The Petitioner underwent left knee arthroscopic surgery in 2006 for a tear of the lateral meniscus and in 2010 for a left anterior horn tear, medial meniscus resection and fibrillated tear and lateral meniscus resection. The Petitioner also underwent removal of the plica and large suprapatellar plica. (PX 5) Petitioner testified that she underwent arthroscopic surgery to

her right knee in 2010. She also testified that she underwent right shoulder rotator cuff repair in 1998 and right shoulder manipulation in 2009.

When the Petitioner presented to Dr. Tonino on October 29, 2012, the Petitioner complained of pain to both shoulders and left knee. The pain diagram completed that day indicated some pain over the upper trapezius near the neck on the right and no pain indicated in the right shoulder. There was pain over the left shoulder and left knee but no pain indicated in the area of the right knee. (Rx 1). Dr. Tonino did not diagnose the Petitioner with any condition to the right knee. He diagnosed the Petitioner with a strain of both shoulders and left knee contusion. (PX 2).

The Petitioner began a course with Doctors of Physical Therapy for her left knee and left wrist. (PX 5). When Petitioner presented to Dr. Tonino on November 29, 2012, is the first time she mentioned problems with the right knee. On exam, she had full range of motion of both shoulders and her rotator cuff testing was withing normal limits. Dr. Tonino noted superficial tenderness over the proximal and medial right tibia which was very superficial that did not involve the right knee joint itself. (PX 2).

The Petitioner returned to Dr. Tonino on January 14, 2013, she did not complain of right knee pain. Dr. Tonino recommended arthroscopic surgery for the left knee. (PX 2).

On February 19, 2013, the Petitioner presented to Dr. Bednar for evaluation of her numbness and tingling in the hands. Dr. Bednar diagnosed the Petitioner with bilateral carpal tunnel syndrome. He was also concerned that Petitioner may have a partial tear of the biceps tendon off of the radius. Petitioner was to be sent for an EMG nerve conduction study. Petitioner

reported that a splint was only giving her partial relief of symptoms. Dr. Bednar also prescribed an MRI to assess her biceps. (PX 2).

At the request of the Respondent, the Petitioner was examined by Dr. Troy Karlsson on February 20, 2013. Dr. Karlsson diagnosed the Petitioner with a pre-existing condition to her left knee and found that the meniscal tear to the left knee was causally related to the work accident. He recommended that the Petitioner undergo surgery to the left knee. (RX 2).

Petitioner underwent an MRI of the left elbow on March 13, 2013. The MRI revealed medial epicondylitis, trace elbow joint effusion, and an intact biceps tendon. (PX 2).

Petitioner presented for an electromyography test at Loyola Medicine performed by Dr. Gregory Gruener at the request of Dr. Michael Bednar. The nerve stimulation studies demonstrated normal motor and sensory amplitudes, latencies and nerve conduction velocities. The orthodromically recorded mixed nerve responses which showed no latency difference following median versus ulnar nerve stimulation on either side. An EMG was not performed pursuant to the Petitioner's request. Petitioner's neurodiagnostic study was considered normal. (PX 2).

On May 2, 2013, the Petitioner returned to Dr. Bednar for evaluation. He noted a change in the Petitioner's symptoms since his last examination. Petitioner complained of more pain of the wrist over the radial aspect of the wrist. He also stated it was worse with pinching. Petitioner did not have elbow

pain but it was over the posterior aspect of the elbow and present on both sides. Numbness and tingling were not a significant component for the Petitioner. Upon physical examination, Dr. Bednar noted that pain was present at the CMC joints of the thumbs with crepitus at the location, worse on the right than the left. Petitioner did have an EMG nerve conduction study which was read as normal. Dr. Bednar gave the Petitioner bilateral hand-based thumb spica splints. Petitioner was to return in six weeks. (PX 2).

Petitioner underwent left knee surgery on May 7, 2013 for her medial meniscal tear. Petitioner's post-operative diagnosis was medial meniscal tear of the left knee and chondromalacia of the medial femoral condyle of the left knee. Petitioner underwent a partial medial meniscectomy and chondroplasty and micro fracture of the medial femoral condyle. (PX 2) Petitioner received postoperative physical therapy. On June 24, 2013, the Petitioner was released to work with restrictions. (PX 2).

On July 16, 2013 the Petitioner underwent an MRI of her right knee which revealed tears to the medial and lateral menisci and tricompartmental articular cartilage degeneration at the patellofemoral joint. The Petitioner underwent surgery to her right knee on October 22, 2103. Surgery consisted of an arthroscopic partial medial and partial lateral meniscectomies and arthroscopic chondroplasty of the right knee. Petitioner underwent post-operative physical therapy. Petitioner was released to work full duty as of February 21, 2014. (PX 2).

Petitioner testified that on April 8, 2014 she tripped over the lip on stairs and fell striking her knees.

The Petitioner presented to Loyola Medicine on April 28, 2014 complaining of pain to both knees and right shoulder. Petitioner reported a fall on both of her knees and landing on her knees. She complained of bilateral knee pain and right shoulder pain. Petitioner has a positive impingement sign of the right shoulder. Petitioner was offered cortisone injections for her knees and shoulder. Petitioner deferred. (PX 2).

Petitioner did not return to Dr. Tonino until December 23, 2014. Petitioner complained of bilateral knee pain and right shoulder pain. The Petitioner was again offered injections to her knees and shoulder. Petitioner refused.

On March 3, 2016 Petitioner testified that she suffered an injury while working using a hoist in Ohio. There are no medical records immediately following the injury.

Petitioner underwent an MRI of the right shoulder on May 27, 2016. The MRI revealed a partial tear of the distal supraspinatus suspected with abnormal signal in the supraspinatus and infraspinatus. There was marked deformity of the humeral head with prominent degenerative narrowing and osteophyte formation of the glenohumeral joint, possible ossific density in the axillary recess region and impingement with the acromioclavicular joint hypertrophy. (PX 2).

The Petitioner began treatment with Dr. Paley on June 21, 2016. The Petitioner reported that she was working on an air hoist when the air hoist jerked and fell to the right. Petitioner applied ice and returned to work. Petitioner reported an injury in 1998 and manipulation in 2006 but nothing else. Petitioner did not mention any injury to the right shoulder in 2012 or 2014. Petitioner also complained of back pain. Dr. Paley recommended an injection but the Petitioner refused. Petitioner continued with conservative care for the right shoulder and low back. The Petitioner underwent an MRI

of the lumbar spine but it only revealed degenerative changes. Dr. Paley's records are silent on causation. (PX 3).

Dr. Tonino examined the Petitioner on January 11, 2018. Dr. Tonino recommended right shoulder arthroplasty. He also diagnosed the Petitioner with arthritis of her bilateral knees and recommended evaluation with a total joint specialist for her knees as well.

On January 2, 2019, Dr. David C. Randolph authored a report regarding the Petitioner's disability in her Ohio claim. Dr. Randolph agreed with Dr. Ahmad that the Petitioner's right shoulder condition was due to factors, issues, and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part. (Rx 5)

At the request of the Respondent, Dr. Karlsson conducted a record review on February 19, 2019. Dr. Karlsson upon review of the medical records noted that the October 20, 2012 was not an injury to the shoulder. He found that there was no mention of a right shoulder injury initially. He also noted that the Petitioner's pain diagram on October 29, 2012 did not indicate any shoulder pain but rather trapezius pain and right neck pain. He also found that Petitioner had shoulder pain on January 13, 2014 well in advance of her April 8, 2014 injury.

Dr. Karlsson also found that the Petitioner's right knee surgery and condition were unrelated to an injury at work. He noted that the first mention of right knee pain was on November 29, 2012 and Dr. Tonino documented pain below the knee and not at the knee joint itself. He opined that bilateral knee replacements were not related to Petitioner's work injuries. (RX 3)

Dr. Karlsson examined the Petitioner on May 13, 2019. He was provided additional medical records including medical records following her alleged injury of March 3, 2016. He opined that the Petitioner's March 3, 2016 did not cause the need for right shoulder arthroplasty or bilateral knee replacement He found no evidence of structural changes after the March 3, 2016 to support a finding that she suffered an injury on that day.

Petitioner testified that she was hired by the Respondent in Ohio in June 1998 and was laid off in 2002. She then applied for a position with the Respondent in 2004. Petitioner was transferred to Springfield Ohio in 2014. The Petitioner continues to work for the Respondent with restrictions. She has not suffered any economic loss as a result of her permanent restrictions. She takes ibuprofen 800 mg as needed for her pain.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The medical records clearly support a finding that the Petitioner had significant pre-existing conditions to her bilateral knees and right shoulder. Prior to the claims at bar, Petitioner had undergone two surgeries to her left knee, surgery to the right knee and a surgery and manipulation to the right shoulder. Petitioner had documented evidence of arthritis in all her joints prior to the incident of October 20, 2012.

The Arbitrator finds that the only objective change that occurred following the October 20, 2012 injury was the finding of a medial meniscal tear of the left knee. The Arbitrator finds that the Petitioner's need for a partial arthroscopy of the left knee was causally related to the injury of October 20, 2012.

The Petitioner's right knee surgery on October 22, 2013 is not related to the injury of October 20, 2012. Petitioner did not complain of right knee pain immediately after the accident. Her treating physician noted right leg pain on November 29, 2012; however, he clearly documented that it was not in the joint. Examinations of the right knee were normal. It was not until July 2013 that the Petitioner was even prescribed any diagnostic testing for the right knee.

Dr. Tonino makes a statement that the Petitioner did complain of right pain and that the surgery was related to the incident of October 20, 2012; however, his records do not

support his statement. The Arbitrator finds Dr. Karlsson's opinion regarding the right knee to be more credible as his opinions are supported by the objective medical findings.

As for the right shoulder, the Arbitrator finds that the Petitioner failed to prove that she suffered an injury to the right shoulder as a result of the incident on October 20, 2012. The initial records of October 20, 2012 do not mention any right shoulder pain. Subsequent records suggest right sided neck pain and pain in the trapezius but no pain in the right shoulder joint. Dr. Tonino did not diagnose the Petitioner with any condition to the right shoulder following the injury of October 20, 2012.

The Petitioner complained of right shoulder pain on January 13, 2014 without any evidence of an injury to the right shoulder. Dr. Karlsson provides a careful analysis of the Petitioner's records and her treatment to the right shoulder. He opined that the right shoulder was not causally related to the injury of October 20, 2012. Dr. Tonino does not provide a causal connection opinion regarding the right shoulder. Therefore, the Arbitrator finds that the Petitioner did not suffer an injury to her right shoulder subsequent to the accident on October 20, 2012.

The Petitioner did complain of left shoulder, left hand and forearm pain following the accident of October 20, 2012. Petitioner received conservative treatment. All diagnostic testing performed by Dr. Bednar for the Petitioner's left arm and hand were negative.

In relation to K what temporary benefits are in dispute and whether the petitioner is entitled to additional TTD as a result of the injury on October 20, 2012, Case No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner was entitled to temporary total disability benefits from May 6, 2013 through June 24, 2013. Respondent has paid TTD benefits for this period of lost time following her left knee surgery and her return to work light duty.

The Arbitrator finds that the Petitioner did not suffer an injury to her right knee as a consequence of the October 20, 2012. Therefore, the Arbitrator denies any further claimed TTD benefits as the claimed lost time is related to the Petitioner's right knee treatment/surgery.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on October 20, 2012, Case. No. 13 WC 29526, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered a compensable injury to her left knee on October 20, 2012. As a result of this injury, the Petitioner underwent a partial meniscectomy. The Arbitrator finds that the Petitioner had a pre-existing condition to her left knee and any recommendation for left knee total replacement is not causally related to the Petitioner's injury of October 20, 2012. The Arbitrator awards the Petitioner 15% loss of use of the left leg or $22,525.98.

The Arbitrator also finds that the Petitioner suffered an injury to left shoulder and left arm following the injury of October 20, 2012. The medical records suggest she suffered a left shoulder strain based on her initial complaints and treatment. Petitioner received

minimal and conservative treatment for her left shoulder. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the whole person or $6,984.80.

The Arbitrator also finds that the Petitioner suffered an injury to her left hand. She received conservative treatment including physical therapy. Her diagnostic tests were negative. Therefore, the Arbitrator awards the Petitioner 2% loss of use of the left hand or $2,863.77.

CONCLUSIONS OF LAW

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of April 8, 2014, Case No. 15 WC 9943, the Arbitrator finds the following:

The medical records establish that the Petitioner had significant treatment to her left knee, right knee and right shoulder prior to the accident on April 8, 2014 when she tripped and fell. The Petitioner had undergone surgery to both her knees prior to April 8, 2014 and had complained of right shoulder pain just months before this incident post accident. There were no changes on her examinations to suggest that the Petitioner's pre-existing conditions to her left knee, right knee and right shoulder were aggravated, exacerbated or accelerated. The Arbitrator finds no causal relationship between Petitioner's injuries and recommended need for future treatment to her right shoulder, right knee and left knee to the injury at work on April 8, 2014.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on April 8, 2014, Case. No. 15 WC 9943, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered no permanent injury as a result of the accident on April 8, 2014. The Petitioner had two visits to her doctor over the course of 8 months. She suffered no lost time and refused cortisone injections that were offered to her. There was no evidence presented to document a change in her pre-existing condition. Therefore, the Arbitrator does not award any permanent partial disability for this injury.

CONCLUSIONS OF LAW

In relation to (O) whether there is Jurisdiction, the Arbitrator finds the following:

Petitioner testified that she was originally hired in Ohio but was then laid off. She was then rehired in Illinois with a day 1 senority. Therefore, pursuant to the contract for hire, Illinois has jurisdiction. See, *Mahoney v. Industrial Commission*, 843 N.E. 2d 317 (2006).

In relation to (F) is the Petitioner's current condition of ill-being causally related to the injury of March 3, 2016, Case No. 19 WC 3473, the Arbitrator finds the following:

The Petitioner received conservative treatment and there is no evidence of any objective changes in Petitioner's right shoulder or lumbar spine. The evidence supports a finding that the Petitioner's right shoulder and lumbar findings were due to the natural progression of her aging. Dr. Randolph opined that the MRI scan showed evidence of congenital spinal stenosis from L3-S1 with evidence of facet arthropathy at the same levels. Dr. Randolph and Dr. Ahmad concluded that "her problems with respect to her right shoulder were due to factors, issues and conditions unrelated to the instant event and due to an ordinary disease of life and natural deterioration of tissue, organ or body part." (RX 5).

Therefore, the Arbitrator finds no causal relationship to the need for surgery to the right shoulder as a consequence of the accidental injury of March 3, 2016.

In relation to L, what is the nature and extent of the injury suffered by Petitioner on March 3, 2016, Case. No. 19 WC 3473, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner failed to prove that she suffered any permanent injury as a result of the incident on March 3, 2016. Her treating physicians and Respondent's examining physician all agree that the Petitioner's treatment and need for additional treatment is not related to the work injury of March 3, 2016.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC015607
Case Name	LIST, CHRISTINE v. WEISS MEMORIAL HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0091
Number of Pages of Decision	18
Decision Issued By	Kathryn Doerries, Commissioner, Thomas Tyrrell, Commissioner

Petitioner Attorney	RAYMOND M. SIMARD
Respondent Attorney	Susan Walsh

DATE FILED: 3/14/2022

/s/Kathryn Doerries, Commissioner

Signature

DISSENT

/s/Thomas Tyrrell, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTINE LIST,

Petitioner,

vs. NO: 18 WC 015607

WEISS MEMORIAL HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of benefit rates, temporary disability, maintenance, permanent disability, and other issues including Respondent's credit and evidence, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's Decision with the exception of the issue of benefit rates, the Arbitrator's calculation of average weekly wage, and the consequent adjustment to the award of permanent partial disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Average Weekly Wage

Section 10 of the Act states, in pertinent part:

> 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. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. *820 ILCS 305/10*

The courts have further outlined the average weekly wage computations in several cases:

> Pursuant to section 10 of the Act (820 ILCS 305/10 (West 2002)), a claimant's average weekly wage may be calculated according to one of four methods. The first two methods each require a claimant to be employed for a period of 52 weeks prior to the date [***27] of injury, ***See *820 ILCS 305/10* (West 2002); *Sylvester*, 197 Ill. 2d at 230. Under the third method, "where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed." *820 ILCS 305/10 (*West 2002). *Greaney v. Indus. Comm'n* (*Michel Masonry Co.*), 358 Ill. App. 3d 1002, 832 N.E.2d 331, 2005 Ill. App. LEXIS 628, 295 Ill. Dec. 180

In the subject case, the Petitioner was employed with Respondent for less than 52 weeks prior to the date of accident. While the Commission agrees with the Arbitrator's method of calculating the Petitioner's average weekly wage, (AWW) by applying the third method of computing AWW laid out in *Sylvester*, the Commission does not agree with the Arbitrator's calculations. The Arbitrator's Decision finds that according to the wage statement, Petitioner earned a total of $72,123.76 for the period October 25, 2015, to August 13, 2016, which is 42-2/7 weeks resulting in an AWW of $1,705.62, temporary total disability (TTD) rate of $1,137.07 and maximum permanent partial disability rate (PPD) of $775.18. (Pet. Ex. 13)

The Arbitrator's calculation of the weeks and parts thereof began on October 25, 2015, which was eight days before Petitioner was hired, as noted on the wage statement certified by Respondent. (Pet. Ex. 13) The Arbitrator's calculation concluded on August 13, 2016, which was 11 days after the accident. The finding that Petitioner earned a total of $72,123.76 included earnings through August 13, 2016, nine days after the accident. Therefore, the Commission strikes the Section entitled "Average Weekly Wage" under the Conclusions of Law in the Arbitrator's Decision and substitutes the following:

Petitioner was hired on November 2, 2015, according to the wage statement and that was

the second of a two week pay period; she was paid for working one week only in the week ending November 7, 2015, and she worked full-time until the date of accident, August 2, 2016, a period of 39-2/7 weeks. Her initial hourly pay scale is $44.50 per hour ($1,780.00 per week) however, according to the wage statement, she was given a raise beginning the week of April 10, 2016, and she started earning $45.06 per hour ($1,802.40 per week) at that time. In the absence of any evidence to the contrary, the Commission infers that all the wages listed were regular wages and based upon a 40 hour work week. Thus, Petitioner earned $70,321.36 in the weeks preceding her accident pursuant to Section 10 of the Act. $70,321.36 divided by 39-2/7 weeks (the weeks and parts thereof that she worked) results in an AWW of $1,789.99 with a corresponding TTD rate of $1,193.39 and a PPD maximum rate of $775.18.

Further, the Commission modifies the sixth sentence in the Arbitrator's Findings on page two so that the sentence reads as follows: In the year preceding the injury, Petitioner earned $70,321.36; the average weekly wage is $1,789.99.

Permanent Disability

The Commission finds that since the Respondent paid TTD at a rate of $1,137.07, there was a total underpayment of $2,791.84 representing a weekly underpayment of $56.32 per week for the 49-4/7 weeks for which TTD was paid i.e. the periods between August 11, 2016, through November 27, 2016 (15-4/7/ weeks), March 16, 2017, through May 11, 2017 (8-1/7 weeks) and July 11, 2019 through January 6, 2020 (25-5/7 weeks).

Therefore, the Commission modifies the Arbitrator's Decision in the first sentence in the Section entitled "Permanent Partial Disability" to read as follows:

As a result of the permanent restrictions imposed by Dr. Cohen, Petitioner is entitled to an award of 40% under Section 8(d)(2) of the Act plus $2,791.84 for the Respondent's underpayment of TTD, less the overpayment of maintenance benefits totaling $70,010.54 (January 7, 2020, to March 12, 2021, or 61-4/7 weeks paid at a rate of $1,137.07).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on June 11, 2021, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 200 weeks, representing a 40% loss under §8(d)(2) of the Act, plus $2,791.84 for the Respondent's underpayment of TTD, less Respondent's credit for overpayment of maintenance benefits totaling $70,010.54 (January 7, 2020, to March 12, 2021, or 61-4/7 weeks paid at a rate of $1,137.07).

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, including for TTD and maintenance paid of $124,992.25, 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.

March 14, 2022

KAD/bsd
O012522
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/s/*Kathryn A. Doerries*
Kathryn A. Doerries

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

DISSENT AND PARTIAL CONCURRENCE

After carefully considering the totality of the evidence, I concur with the majority with respect to all issues, except I respectfully dissent from the opinion of the majority and would reverse the Decision of the Arbitrator on the issue of duration of maintenance benefits.

Section 8(a) of the Act requires an employer to pay for an employee's necessary physical, mental, and vocational rehabilitation, including the costs and expenses of maintenance. 820 ILCS 305/8(a) (West 2006). Maintenance is awarded under Section 8(a) of the Act incidental to vocational rehabilitation. *W. B. Olson v. Ill. Workers' Comp. Comm'n*, 2012 IL App (1st) 113129WC, ¶ 39. Therefore, an employer is obligated to pay maintenance only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *Id*.

"A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity." *Greaney v. Indus. Comm'n*, 358 Ill. App. 3d 1002, 1019 (2005). The primary goal of rehabilitation is to return the injured employee to work. *Schoon v. Indus. Comm'n*, 259 Ill. App. 3d 587, 594 (1994). Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising a job search program, and vocational retraining including education at an accredited learning institution. 820 ILCS 305/8(a) (West 2006). An employee's self-initiated and self-directed job search or vocational training may constitute a "vocational-rehabilitative program" under section 8(a). *Roper Contracting v. Indus. Comm'n*, 349 Ill. App. 3d 500, 506 (2004). Additionally, "rehabilitation efforts may be undertaken even though the extent of the permanent disability cannot yet be determined." *Freeman United Coal Mining Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 180 (2000).

Petitioner's last office visit with Dr. Cohen was December 9, 2019. Petitioner made a written request upon Respondent for initial vocational rehabilitation assessment and payment of maintenance benefits on December 16, 2019. Petitioner submitted to an initial vocational interview with Respondent's expert, Mr. Conway, on January 13, 2020. Petitioner attended an

assessment with Susan Entenberg at her attorney's request on April 15, 2020.

She was not contacted by Respondent's expert, Mr. Conway, until late April 2020. On May 18, 2020, he began providing links to jobs that were outside of her restrictions. Petitioner submitted job logs through September 28, 2020. On October 11, 2020, Ms. Heather Mueller forwarded Petitioner's attorney 15 job leads. Ms. Mueller never met with Petitioner. Petitioner lacked the qualifications or the physical ability to do any of the 15 jobs listed. Petitioner provided notes of her contacts with the listed employers.

Petitioner participated in the vocational rehabilitation process with Respondent's hires through October 11, 2020, thus she is entitled to maintenance benefits through said date.

For the forgoing reasons, I dissent.

o: 01/25/2022
TJT/ahs
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/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC015607
Case Name	LIST,CHRISTINE v. WEISS MEMORIAL HOSPITAL
Consolidated Cases	
Proceeding Type	
Decision Type	Corrected Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	12
Decision Issued By	Charles Watts, Arbitrator

Petitioner Attorney	Raymond M. Simard
Respondent Attorney	Susan Walsh

DATE FILED: 6/11/2021

INTEREST RATE FOR THE WEEK OF JNE 8, 2021 0.04%

/s/ *Charles Watts, Arbitrator*
Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTEDARBITRATION DECISION

Christine List
Employee/Petitioner

Case # **18 WC 15607**

v.

Consolidated cases:

Weiss Memorial Hospital
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Charles Watts, Arbitrator of the Commission, in the city of Chicago, on March 12, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 2, 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 $72,123.76; the average weekly wage was $1705.62 .

On the date of accident, Petitioner was **57** 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 TTD and maintenance, and for a total credit of $**124,992.25** .

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

ORDER

Petitioner is entitled to an award of 40% under Section 8(d)(2) of the Act (200 weeks x $775.18 = $155,036.00) less Respondent's credit for overpayment of maintenance benefits totaling $70,010.54 (1/7/20 to 3/12/21 or 61 4/7 weeks).

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

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

JUNE 11, 2021

Signature of Arbitrator

ICArbDec19(b)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christine List,	)	
	)	
Petitioner,	)	
	)	
v.	)	**Case No. 18 WC 15607**
	)	
Weiss Memorial Hospital,	)	
	)	
Respondent.	)	

DECISION OF ARBITRATOR

Regarding the disputed threshold issues of average weekly wage, temporary total disability ("TTD"), maintenance and nature and extent of the injury, after observing the witness and reviewing the evidence, the Arbitrator finds that Petitioner is entitled to an award of 40% person as a whole under Section 8(d)(2) of the Act (200 weeks x $775.18 = $155,036.00) less Respondent's credit for overpayment of maintenance benefits totaling $70,010.54 (1/7/20 to 3/12/21 or 61 4/7 weeks). The Arbitrator's decision is based upon the following evidence:

FINDINGS OF FACT

Prior Medical Care and Restrictions

Prior to the accident in question, Petitioner underwent ten 10 spinal surgeries. Her spine was fused from L3 to S1. A dilaudid pump was implanted in 2005. (Tr. 10). When she was hired by Weiss Memorial Hospital ("Weiss"), she had permanent restrictions of no bedside nursing, no lifting, no bending and to change positions every hour. (Tr. 60) At trial, Petitioner testified to additional permanent restrictions of no picking up anything from the ground, no stretching, no lifting greater than ten pounds and no excessive walking. (Tr. 11)

Petitioner's Educational History and Prior Work Experience

Petitioner testified that she was licensed by the State of Illinois as a registered nurse in 1979 and had worked as a RN for 41 years. (Tr. 9). She obtained her bachelor's degree in Nursing in 2016. (Tr. 51) She has an extensive work history. (Tr. 52) She initially worked as a RN for Ingalls Memorial Hospital ("Ingalls") and was promoted to Supervisor of the ICU nurses. (Tr. 52) After 17 years of employment with Ingalls, she accepted a position with Christ Hospital in the intensive care unit. (Tr. 52) She was employed by United Healthcare as a telephonic nurse case manager for 4 years. (Tr. 14; 52-53) From 2004-2007, Petitioner was employed by Rush as a Research Coordinator on the pulmonary hypertension team. (Tr. 15; 54) Her duties as a Research Coordinator included education and instruction. (Tr. 54-55) She was employed by Heart Care Research Foundation as a Clinical Research Coordinator. (Tr. 55) Thereafter, she was employed by MetroSouth Hospital as a House Supervisor. According to her testimony, she educated other nurses frequently. (Tr. 77).

Accident

Petitioner injured her right wrist on August 2, 2016 while assisting with a patient transfer. (Tr. 12; 19).

As a nursing supervisor, she was responsible for staffing, assisting units with any family member issues, placing patients who were admitted through the emergency room, attending committee meetings to improve quality of care for the patients, assisting staff with procedures, teaching, monitoring patient transfers and writing reports for patients with sudden cardiac arrest. (Tr. 12-13; 18-19; 59)

Medical History

Petitioner went directly to the emergency room at Respondent where she complained of pain in her right forearm, wrist and thumb. (PX1) Petitioner had pain on flexion of the wrist and extension of the right thumb. The x-rays were negative for fracture. Her right wrist and forearm were placed in a thumb spica splint and she was advised to follow-up with an orthopedic surgeon. (PX1)

Dr. Mark Gonzalez, an upper extremity specialist, examined Petitioner on August 3, 2016. (PX2) Dr. Gonzalez noted exquisite tenderness over the scaphoid and the snuffbox. He prescribed continued use of the spica splint and restricted Petitioner to no work with the right hand. On August 10, 2016, the x-rays showed a widening of the space in the scapholunate region, which indicated an injury to the scapholunate ligament. Dr. Gonzalez took Petitioner to surgery on August 22, 2016. Surgery consisted of a repair of a complete rupture of the dorsal scapholunate interosseous ligament with instability and subluxation of both the scaphoid and lunate. (PX1) The repair required three suture anchors and the K-wires. Petitioner continued to experience pain and swelling following the repair. Dr. Gonzalez removed the pins on October 26, 2016 and applied a short arm cast. Petitioner attended occupational therapy and was released to return to work on November 28, 2016.

Petitioner returned to Dr. Gonzalez on December 16, 2016 complaining of a burning type of pain in her right wrist. He re-applied the thumb spica splint and advised Petitioner to ice her wrist and to take medication as needed. Petitioner failed to improve. On February 10, 2017, he advised Petitioner to continue wearing the splint and to consider undergoing a proximal row carpectomy. (PX2)

Petitioner sought a second opinion on January 17, 2017 from Dr. Mark Cohen at Midwest Orthopedics at Rush. (PX3) Dr. Cohen obtained x-rays of the right wrist, which showed widening of the scapholunate area with a collapse deformity of the carpus. A CT scan performed on February 22, 2017 indicated a ligamentous injury in the scapholunate interval. Dr. Cohen recommended surgery and on March 16, 2017 performed a right proximal row carpectomy, an extradural transection of the radial nerve and a tenolysis of the extensor pollicis congus tendon. (PX3) Petitioner underwent a six-month course of occupational therapy. On November 10, 2017, Petitioner complained to Dr. Cohen of the inability to perform certain loading activities. Dr. Cohen examined Petitioner and released her to return to work on a full duty basis. (PX3)

Petitioner testified that she worked full duty until April 24, 2018 when she sustained an off-the-job injury to her left ankle, which required surgery. She developed a MRSA infection following surgery, which required several hospitalizations. Her infection did not clear until July, 2019. She received group disability benefits from Respondent while treating for the ankle injury.

Petitioner continued to see Dr. Cohen while receiving treatment for her ankle. On May 16, 2018, she returned to Dr. Cohen complaining of increased pain with any movement of the right wrist and with writing. The x-rays taken that day showed a distal radiolunar arthritis. Dr. Cohen injected cortisone into the right wrist. Petitioner returned on July 6, 2018 with worsening right wrist and thumb pain when she moved her fingers or thumb. Dr. Cohen stated that Petitioner had arthritis in her thumb CMC joint, which was exacerbated by the injury. Petitioner experienced worsening pain in her right wrist and thumb. Dr. Cohen took Petitioner to surgery on July 11, 2019. Dr. Cohen performed a total right wrist fusion, a tenolysis of the extensor pollicis tendon, and a carpal tunnel release. Respondent resumed paying temporary total disability benefits on July 11, 2019. Petitioner underwent a course of post-operative occupational therapy from July 31, 2019 to October 16, 2019.

Petitioner saw Dr. Cohen for the last time on December 9, 2019. Petitioner complained of right wrist pain with a burning sensation over the ulnar aspect of her wrist as well as thumb CMC joint pain. Grip strength was 30 pounds on the right and 60 pounds on the left. Dr. Cohen placed Petitioner at maximum medical improvement and discharged Petitioner with permanent restrictions of limited use of the right hand, no lifting over 2 pounds, no repetitive pushing, pulling, grasping, and twisting. Dr. Cohen added "no repetitive work. Paper work only. Must have breaks every 3 hours." (PX5) On June 8, 2020, Dr. Cohen advised that Petitioner cannot return to a full-time keyboarding position. (PX6)

There is no dispute regarding Petitioner's medical history. Prior to the accident in question, Petitioner had permanent restrictions of no bedside nursing, no lifting, no bending and to change positions every hour. (Tr. 60) On December 9, 2019, Dr. Cohen imposed permanent restrictions of no lifting greater than 2 pounds with the right arm; no lifting/loading/carrying with the right arm; no repetitive work; paperwork only; and must have break every 3 hours. (Pet. Ex. 5) On June 8, 2020, Dr. Cohen updated the permanent restrictions to include "no full-time keyboarding." (Pet. Ex. 6)

Petitioner was off work for approximately 1 ½ years beginning April 23, 2018 due to an unrelated ankle injury. (Tr. 60-61; 70). Respondent terminated Petitioner in May 2019. On December 16, 2019, Petitioner made a written request upon Respondent for an initial vocational rehabilitation assessment and the payment of maintenance benefits. (PX8)

Vocational Rehabilitation

On cross-examination, Petitioner admitted that she did not submit any job applications from December 2019 through the date of trial. (Tr. 67) Likewise, she never sought any type of work outside the medical field. (Tr. 74).

Petitioner met with Patrick Conway ("Conway"), at the Respondent's request, on January 8, 2020 who obtained a medical and occupational history. (Tr.32-33) Petitioner testified that Conway sent her monthly job leads through August 2020 which she estimated, in total, were 100. (Tr. 34; 67) She admitted that did not apply for any of the jobs leads sent by Conway. (Tr. 67) She also admitted that she never reached out to Conway again. (Tr. 66).

Petitioner was provided job leads at Lurie Children Hospital, Family Health Network, Amita Health, Cook County, MetroSouth, BRIA, OSF, RiverEdge Hospital, Radius Foundation, Elite Ambulance, Lasik Plus, VES Group, Skilled Facility Chicago, LaRabidia, Franciscan Health, TMAC, Aetna, University of Chicago Hospital, VNA in Bolingbrook, St. Anthony, Residential Home Health, DuPage County Health and Palos Health. Petitioner admitted that she did not contact most of these potential employers to inquire about available positions and/or the requirements of same because she could not perform CPR. (Tr. 76-83; 86-89).

At her attorney's request, Petitioner met with Susan Entenberg on April 15, 2020. (Tr. 33) On October 11, 2020, Heather Mueller ("Mueller") forwarded Petitioner's attorney 15 job leads. (Tr. 36)

Petitioner admitted that she has not conducted any type of job search since October 2020. (Tr. 62; 73-74) She only produced job logs from May 24, 2020 though September 28, 2020. (Tr. 74; Resp. Ex. 4)

Heather Mueller- MedVoc Rehabilitation

Heather Mueller ("Mueller") testified that she obtained her Masters of Science in Rehabilitation and Mental Health Counseling from IIT in 2018. She was certified as a vocational rehabilitation counselor in 2019. In addition to working for MedVoc as a case manager/job placement specialist, she works for the Social Security Administration as a vocational expert. To be certified as a vocational rehabilitation expert, an individual must have a master' degree in psychology and undergo testing to receive certification.

Mueller prepared a labor market survey on October 9, 2020. In conjunction with preparation of the LMS, she reviewed Dr. Cohen's restrictions dated December 20, 2019; Dr. Cohen's updated restrictions dated June 8, 2020; Petitioner's vocational rehabilitation expert's reports; and reports prepared by Conway from Genex; which included a transferable skills analysis and labor market survey. Mueller testified that Petitioner was well-educated and had an extensive nursing background. In her expert opinion, a stable labor market existed for Petitioner despite her permanent restrictions. She cited potential jobs such as a utilization review nurse, telephonic nurse case manager and nurse consultant. She believed that Petitioner could find work at an entry-level wage of $27.27 per hour based upon her contact with 15 potential employers. She testified that she spoke to each of these employers to inquire whether the positions identified required full-time keyboarding. (Resp. Ex. 3).

Patrick Conway- Genex Services

Conway testified that he has a bachelor's degree in Communications and received certification as a rehabilitation specialist over 20 years prior. He had over 15 years of case

management experience and 10 years or more of outside field case management. He worked for Genex Services since 2003.

Conway met with Petitioner and her attorney on January 13, 2020. At that time, he obtained information to complete a vocational rehabilitation evaluation and transferable skills analysis including details regarding Petitioner's work history and educational background. Conway testified that Petitioner had an extensive healthcare background.

Conway drafted his initial report on January 30, 2020 which included a transferable skills analysis. He identified 21 directly transferrable occupations. He also completed a labor market survey. He contacted 15 employers to obtain job specifics and who had either current openings, recently filed jobs or if the employer anticipated hiring in the future. The hourly rates varied between $12 and $43 per hour or yearly earnings between $59,000.00 and $81,000.00. All the jobs identified were within Petitioner's permanent restrictions. He testified that a stable marketplace existed for Petitioner. Conway attempted to proceed with direct job search assistance by asking Petitioner to meet at her local library. He also left voicemails for opposing counsel and Petitioner; however, neither returned his calls. He forwarded her weekly job logs beginning May 18, 2020.

Conway reviewed Petitioner's expert's reports. He disagreed with the opinion that a stable labor market did not exist for Petitioner. The basis of his disagreement was Petitioner did have transferable skills. There were job titles cited in the transfer skills analysis in the healthcare field in a supervisory/administrative capacity and many nursing positions which Petitioner would be able to perform with her permanent restrictions. Conway addressed Dr. Cohen's updated restrictions dated June 8, 2020 in which he opined that Petitioner was unable to return to a full-time keyboarding position. None of the jobs he identified would entail full time keyboarding. (Resp. Ex. 1)

Susan Entenberg-Rehabilitation Services Associates

Susan Entenberg ("Entenberg"), Petitioner's expert, testified that Petitioner was a nurse her entire life. She opined that she unable to return to her former occupation due her permanent restrictions which prevented her from keyboarding and performing CPR. She indicated that she was a poor candidate for vocational rehabilitation, re-training and she had no transferable skills. She believed her work life expectancy was six years. She concluded that no stable labor market existed for Petitioner. (Pet. Ex. 7)

Petitioner's Testimony & Surveillance Video

Petitioner testified that during her day-to-day activities, she experienced more pain in her back, wrist, hips and down her legs. (Tr. 46). "I have walked more than a block but not in the last four to five years." She testified that if she walks a block she has "pain in my legs and numbness in my feet, and I know that my body is telling me that I need to slow down and stop or go back home." (Tr. 47) With respect to her wrist she testified, "I have to have my husband do a lot of things such as opening a bottle of water, opening the door if it's a doorknob. I can lift things out

of the refrigerator but I have dropped them." (Tr. 48) She admitted that she has no driving restrictions. (Tr. 68)

Surveillance video of Petitioner was produced at trial and provides additional evidence as to Petitioner's physical ability.

On January 7, 2020, surveillance video showed that Petitioner went grocery shopping, opened the car trunk with her right hand, placed several bags in her trunk and returned the shopping cart. (Resp. Ex. 5: 1/7/120 at 6:27 p.m.)

In surveillance taken September 16, 2020, Petitioner walked to her car with her grandchild. Petitioner bent over, extended her arms, and placed the child in her car seat. (Resp. Ex. 5: 9/16/20 at 11:14 a.m.) Petitioner testified that her granddaughter was 2 years old at the time and weighted approximately 27 pounds. (Tr. 92-93) When she arrived at home, she bent and lifted her grandchild out of the car set (Resp. Ex. 5: 9/16/20 at 11:33 a.m.) The child was in a car toy which Petitioner controlled with a remote. (*Id* at 2:34 p.m.*)* They walked several blocks and she pushed/guided her granddaughter on her bike for approximately 8 minutes. She then began pulling her granddaughter's bike with her right hand for several minutes. (Tr. 94-96) (*Id* at 3:22-3:29 p.m.) She waved her right arm with a bubble wand. (*Id* at 3:39 p.m.) Petitioner ran after her grandchild and later ran from her car to her house and back. (*Id* at 4:58 p.m.) Petitioner admitted to babysitting her granddaughter twice a month. (Tr. 99)

Surveillance taken on September 18, 2020, revealed Petitioner carrying a bag and a box. She placed the box on the hood of her car. Moments later, she picked up the box and picked up something on the ground. (Resp. Ex. 5: 9/18/20 at 4:22 p.m.) She went grocery shopping and placed items in her cart (*Id* at 4:42 p.m.) She placed several bags of groceries in her trunk. (*Id* at 5:05 p.m.)

On September 23, 2020, video reveals Petitioner taking out the garbage and closing the garbage can with her right hand. (Resp. Ex. 5: 9/23/20 at 1:00 p.m.)

As recently as February 15, 2021, Petitioner was videotaped bending and removing a snowbrush from her backseat and using her hand to remove snow from her windshield, pushing a grocery cart, bending and lifting. (Resp. Ex. 5; 2/15/21 at 2:23; 2:29-2:40 p.m.)

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

Credibility is the quality of a witness which renders her 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 her 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 her 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).

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 gave the Arbitrator pause. Petitioner's 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. These observations were completely confirmed while watching Petitioner's reaction to surveillance video Respondent showed at trial. As described above, there is a dramatic difference between what Petitioner testified on direct that she was physically capable of doing and activities she admitted performing while having to watch this

surveillance. To the Arbitrator, Petitioner was simply caught in a lie in true Perry Mason form. In short, the Arbitrator finds Petitioner to have no credibility. This finding matters particularly on the nature and extent of the injury and whether Petitioner's testimony regarding searching for another job is to be believed.

Both Respondent and Petitioner presented vocational rehabilitation experts. The Arbitrator believes all testified truthfully based on what they knew at the time of their depositions and when writing reports. None of the testimony is as compelling as the surveillance video and that falsity of Petitioner's testimony on direct as to her physical capacity.

Average Weekly Wage

According to the wage statement, Petitioner earned a total of $72,123.76 for the period October 25, 2015 to August 13, 2016 which is 42 2/7 weeks resulting in an average weekly wage of $1705.62, temporary total disability rate of $1137.07 and maximum permanent partial disability rate of $775.18. (Pet. Ex. 13)

TTD/Maintenance Payments

The parties stipulated that Respondent paid a total of $124,992.95 in TTD/maintenance benefits. The Arbitrator finds that Respondent is entitled to a credit for overpayment of maintenance benefits paid at $1137.07 per week for the period January 7, 2020 through March 12, 2021 (61 4/7 weeks) for the following reasons:

1. Petitioner admitted that she did not submit *any* job applications from December 2019 through the date of trial;
2. Petitioner admitted that she has not conducted any type of job search since October 2020; .
3. She refused formal job placement assistance from Genex;
4. Despite being provided job leads at Lurie Children Hospital, Family Health Network, Amita Health, Cook County, MetroSouth, BRIA, OSF, RiverEdge Hospital, Radius Foundation, Elite Ambulance, Lasik Plus, VES Group, Skilled Facility Chicago, LaRabidia, Franciscan Health, TMAC, Aetna, University of Chicago Hospital, VNA in Bolingbrook, St. Anthony, Residential Home Health, DuPage County Health and Palos Health, Petitioner admitted that she did not contact any of these potential employers to inquire about available positions and/or the requirements of same.
5. Surveillance reveals that Petitioner is quite active and is able to perform activities outside her "permanent restrictions;" and
6. Upon review of the surveillance video and the opinions of Entenberg, Mueller and Conway, the Arbitrator is compelled to choose the opinions of Respondent's experts.

Permanent Partial Disability

As a result of the permanent restrictions imposed by Dr. Cohen, Petitioner is entitled to an award of 40% person as a whole under Section 8(d)(2) of the Act less the overpayment of maintenance benefits. Petitioner's testimony regarding her current abilities was not credible and

was contradicted by her activities during surveillance. The Arbitrator finds that Petitioner is well-educated, has a substantial prior work history and is capable of finding alternative work within her permanent restrictions. She has failed to prove that she is entitled to an award under Section 8(d)(1) due to failure to conduct a job search or cooperate with formal job placement efforts.

CONCLUSION

For the foregoing reasons, the Arbitrator finds that Petitioner is entitled to an award of 40% person as a whole under Section 8(d)(2) of the Act less Respondent's credit for overpayment of maintenance benefits based upon Petitioner's lack of job search.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC023588
Case Name	WILSON, JIMMY v. AMERICAN COAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0092
Number of Pages of Decision	18
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Julie Webb

DATE FILED: 3/15/2022

/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

JIMMY WILSON,

Petitioner,

vs. NO: 16 WC 23588

AMERICAN COAL,

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 an occupational disease arising out of and occurring in the course of his employment, notice, whether his current condition of ill-being is causally related to the occupational disease, 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 March 13, 2020 is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 15, 2022

/s/ *Deborah J. Baker*

DJB/lyc

O: 2/23/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, JIMMY
Employee/Petitioner

Case# **16WC023588**

AMERICAN COAL [THE AMERICAN COAL COMPANY]
Employer/Respondent

On 3/13/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jimmy Wilson
Employee/Petitioner

Case # 16 WC 23588

v.

Consolidated cases: ______

American Coal [The American Coal Company]
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on January 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On May 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 not sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $2,272.19.

On the date of accident, Petitioner was 62 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of $0.00 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

March 11, 2020
Date

MAR 13 2020

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart. The Application alleged a date of last exposure of May 4, 2015, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust including but not limited to, coal dust, rock dust, fumes and vapors for a period in excess of 35 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 67 years of age. Petitioner has a high school diploma and attended SIC in Harrisburg from 1970 to 1971. In August 1971 Petitioner joined the Navy and served until June, 1974. From June, 1975, through May, 1976, Petitioner attended SI School of Technical Careers and received an Associate's Degree in tool and manufacturing technology as well as welding. From June, 1976, to May, 1977, Petitioner was a machinist and welder for Ajax Engineering. From June, 1977, through May, 1980, he attended the University of Missouri at Rolla and received his degree in mine engineering. From May, 1980, through August, 1981, Petitioner worked at Pittsburg and Midway Coal Company in Pittsburgh, Kansas. In August, 1981, Petitioner started working for Kerr McGee Coal in Oklahoma City. He transferred from there to the Galatia Mine in May, 1992. Kerr McGee was eventually bought out by Respondent.

Petitioner worked approximately 35½ years in coal mine employment. Petitioner had about six and a half years working above ground and 29 years underground. Petitioner's last day of coal mine employment was May 4, 2015, at Respondent's Galatia mine. He was 62 years of age on that date. On that date Petitioner's job title was surface safety compliance manager. He testified that his duties included walking the belt line to check for any problems. In the preparation plant he checked for safety issues. He was basically in charge of all the surface safety for both of Respondent's Galatia mines. He also traveled with the state and federal inspectors. Petitioner testified that he was exposed to and breathed coal dust on his last day of employment. Petitioner testified that he retired on that date because he just figured it was time. He testified that his health may have played a little bit of a role in his decision to retire. He testified that he was getting older and he did not have the strength and could not do as much as he used to. He figured it was time to get out so he could do some things on his own for a change. Petitioner has not worked since leaving Respondent.

When Petitioner started his career in the coal mines, he started as an engineer. Petitioner testified that as an engineer at the Galatia mine he started during the construction of the mine. He was in charge of making sure that the buildings were built to specifications on both sides as well as the preparation plant and the silos. In January, 1984, Petitioner decided he did not want to be an engineer anymore and became a coal miner. He started as a laborer at Kerr McGee. He was a laborer until November, 1987, when he became a foreman underground. In 1992 he became a mine manager. He then switched back and forth from mine manager to assistant mine manager and back to mine manager through 2009. In July, 2010, he became a safety manager on top and continued in that position until he retired in 2015. As a mine manager and assistant mine manager, he would find out what was to be done that day and then would assign jobs to the men on his crew. Once he got underground, it was his job to check all the units to make sure they were running properly and had everything they needed. He also walked the beltlines to make sure they were running properly. It was also his job to walk the returns to make sure the returns were up to

snuff in case there was an accident and people had to get out. As assistant mine manager and mine manager, he walked from a couple miles to five or six miles per day. He testified that it was pretty rough walking at times. There would be holes, rocks, rash from the roofs and sometimes it would be muddy.

Petitioner testified that there was a fire underground when the mine was still owned by Kerr McGee. He testified that he was mine manager at the time and had to fight the fire. Petitioner testified that as mine manager and assistant mine manager, if he saw someone who needed help, he would help them. He testified that at times he would run the continuous miner or the ram car during lunch so that the workers could get a lunch break. Petitioner testified that they tried their best to keep the dust down, but with a coal mine there was no way to keep it all down. He testified that when he walked the returns coming off the unit, he was in some coal dust. He testified that it was so fine it looked like a little haze when walking through it. He testified that fine coal would come off the beltlines. His job as a mine manager and assistant mine manager was an underground position.

Petitioner testified that as a safety manager on the surface he probably walked three to four miles a day. Petitioner testified that he would have to walk to the top of the silos which were 200 feet tall. He testified that he usually walked through the plant at least twice a day. He testified that the prep plant was five floors. He would go to one floor and walk through it and then go up to the next floor. Petitioner testified that in the last two to three years that he worked he was not able to walk from the bottom to the top of the plant. He testified that he would start getting winded. He testified that he did not know what was causing it and thought maybe he was just getting older. He thought he was in pretty good shape. Petitioner testified that when working underground he worked 12 to 16 hours per day. They had a schedule where they worked seven days on, two days off and then seven days on and three days off. He testified that sometimes he would have to work on his day off. While working above ground he put in 10 to 12 hours per day. He testified that toward the end of his career it took him longer to get things done and he had to spend a little more time at work. He worked five and half to six days per week as safety manager.

Petitioner testified that at the time of trial, he felt he had a breathing problem. He first noticed breathing problems during the last couple years of his coal mine employment. Petitioner testified that if he were to walk on level ground at a normal pace he could walk about a half mile before he started breathing a lot heavier. He testified that if he climbed three or four sets of stairs, he would have to stop. It was getting harder to catch his breath. Petitioner testified that since he first noticed his breathing problems until the time of trial they have not gotten any better. He could not say that they were any worse. Petitioner was not taking any breathing medications. Petitioner testified that his breathing problems affect his activities of daily life. He testified that when he mowed his yard or used the weed eater, it seemed like he could go on forever but now after push mowing or weed eating for about 15 minutes or so he has to stop and try to catch his breath. Petitioner also helps his 90-year-old mother out around her house. Petitioner testified that he lives on a farm with about 26 acres and 18 acres of that is farmed. He testified that he and his brother farm that together. They raise corn and beans. He has farmed that property for about 30 years. It is harder today to get the jobs done on the farm. He testified that it takes longer. He has to stop every now and then to catch his breath. He testified that he just gets tired. Petitioner

testified that he does some deer hunting. In 2019 he killed a doe and buck. He testified that he was able to get those animals out of the woods, but it was not nearly as easy as it used to be. Petitioner either gets help to drag the animals out of the woods or he gets the four wheeler to drag them out.

Petitioner testified that Dr. Alexander was his treating physician until he retired from the coal mine and started treating at the VA. He testified that he was never examined for black lung at the VA and was never treated there for a breathing problem. Petitioner testified that he has never smoked. Other than his breathing issues, Petitioner has had an aortic aneurysm and valve replacement. He has also had a hernia repair and some intestinal stomach issues. Petitioner has also had elbow surgery. Because of his heart issues he takes blood pressure and cholesterol medication as well as a blood thinner. Petitioner testified that at the end of his career he was able to complete his job; it just took longer. Petitioner testified that as of the time of trial, it would be tough to get everything done to complete his job. He could not do what he normally would do in one day, and it would have take him part of a second day to finish.

Petitioner testified that when he retired he was a couple weeks shy of his 63rd birthday. At that time he signed up for Social Security. He also had a 401(k) for retirement through Kerr McGee and Respondent. Petitioner testified that both of the mines where he worked for Respondent have now closed. Petitioner testified that he was always honest with the VA in answering questions about his health including what symptoms he had and did not have. Petitioner testified that he had a problem with his aortic valve. It was aneurysmal. He testified that was diagnosed in 2018. Because of that condition he had CTs taken of his chest on multiple occasions because they were wanting to track the aneurysm. Petitioner had the valve replaced at St. Louis University in September, 2018. Subsequent to that surgery he developed atrial flutter.

From time to time while he was employed at the mine, Petitioner underwent NIOSH x-ray screening for black lung. After he would have those x-rays taken, they would write to him and tell him what the film revealed. Petitioner did not bring any of those letters with him to trial.

Petitioner visits his son who lives in Phoenix once every year or two. He also has three daughters. He testified that it seems like they always have something they need help doing. He said he gets requests to come and fix things that are in need of repair.

Dr. Suhail Istanbouly examined Petitioner on May 23, 2017, at the request of Petitioner's counsel. Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. Dr. Istanbouly testified that roughly 30% of his patient census deals with the care and treatment of coal miners. He has conducted black lung examinations for the U.S. Department of Labor. Dr. Istanbouly has been the medical director of the pulmonary department of Herrin Hospital since 2005. Dr. Istanbouly performs five to seven examinations such as that performed on Petitioner every month (Petitioner's Exhibit 1, pp 5-7, 17).

Dr. Istanbouly noted that Petitioner worked as a coal miner for 36 years with 29 of those years being underground. His last month of coal mine employment was in May, 2015. In the last year of his employment he was a surface safety and compliance manager which according to

Petitioner's description was quite a physical job. Petitioner reported that he never smoked. Petitioner mentioned chronic intermittent cough for the past three years which was mild to moderate in intensity with mild thick brownish sputum. He also mentioned mild exertional dyspnea. He would get short of breath by walking for half of a mile (Petitioner's Exhibit 1, p 8).

Physical examination of Petitioner's chest was within normal limits. Dr. Istanbouly performed pulmonary function testing which was within normal limits. Dr. Istanbouly testified that having pulmonary function studies within the range of normal does not mean the lungs have not been damaged. Dr. Istanbouly reviewed Petitioner's chest x-ray taken on June 27, 2016. He testified that the x-ray he reviewed was of diagnostic quality. He testified that the chest x-ray revealed mild bilateral interstitial changes. Dr. Istanbouly testified that he diagnosed Petitioner with coal workers' pneumoconiosis which was caused by his long term coal dust inhalation (Petitioner's Exhibit 1, pp 9-13).

Dr. Istanbouly described coal workers' pneumoconiosis as fine particles being inhaled into the deep parts of the airways ending in the alveoli creating a local irritation or inflammation that ends up with tiny scars which were seen as small, round opacities on the chest x-ray. The tiny scars replace the normal lung tissue and affect the gas exchange to the vascular parenchymal barrier. The scarring and fibrosis of coal workers' pneumoconiosis are permanent. The scarring and fibrosis of coal workers' pneumoconiosis cannot carry on the function of normal healthy lung tissue. By definition, if one has coal workers' pneumoconiosis, he has an impairment in the function of his lungs at least at the site of the scar or fibrosis (Petitioner's Exhibit 1, pp 13-14).

Dr. Istanbouly testified that Petitioner had clinically significant pulmonary impairment based on his chronic cough, sputum production and exertional dyspnea. The cause of the clinically significant impairment was long term coal dust inhalation. Dr. Istanbouly testified that Petitioner could not have any additional exposure to coal dust without endangering his health (Petitioner's Exhibit 1, pp 15-16).

Petitioner did not identify any triggers for his intermittent cough. He did not relate his cough being triggered by smoke, dust or fumes. Dr. Istanbouly testified that mild exertional dyspnea can be due to causes other than pulmonary disease. Dr. Istanbouly testified that this is also true of cough. Petitioner did not relate a history of having taken breathing medication in the past. Dr. Istanbouly did not review any treatment records regarding Petitioner (Petitioner's Exhibit 1, pp 18-19).

Dr. Istanbouly testified that the B-reading of the chest x-ray by Dr. Smith was presented to him prior to his examination of Petitioner. Dr. Istanbouly did not use the ILO standard films for comparison purposes when he read the film for black lung. He testified that there were no other chest x-ray interpretations provided to him. Dr. Istanbouly testified that Petitioner's physical exam was within normal limits and there was no sign of respiratory disease. Petitioner did not tell Dr. Istanbouly that he left the mine at the time he did due to respiratory disease or symptoms. Petitioner did not relate to Dr. Istanbouly that he had any difficulty in performing the physical demands of his last job in the mine. Dr. Istanbouly testified that Petitioner's forced vital capacity of 108% of predicted indicated there was no restriction in Petitioner. His forced expiratory

volume in one second was 107% of predicted which was also normal. Dr. Istanbouly testified that the FEV1/FVC ratio was 75%, which was normal. He testified there was no evidence of an obstruction in Petitioner (Petitioner's Exhibit 1, pp 19-21).

Dr. Istanbouly is not an A or a B-reader of films. He does not provide profusion ratings on the films he interprets for black lung. He decides whether black lung is present or not and if it is present, he classifies it as mild, moderate or severe. He cannot say that the film he reviewed of Petitioner had a 1/0 or a 0/1 profusion (Petitioner's Exhibit 1, p 21).

Dr. Henry K. Smith is a diagnostic radiologist. Dr. Smith has been board certified in radiology since 1973. He first took the B-reader exam in 1987 and has been continually certified as a B-reader since that time. Dr. Smith testified that he failed the B-reading recertification exam twice somewhere around 1999. He failed because of overreading the films. He testified that he was finding more disease than was present on the standard films. Dr. Smith received his Doctor of Osteopathic Medicine in 1968 from Kirksville College of Osteopathic Medicine. Dr. Smith did a rotating general internship at Carson City Hospital in Carson City, Michigan, and a radiology residency at Memorial Osteopathic Hospital in York, Pennsylvania. Dr. Smith operated his own private radiology practice from 1988 to 2016. Since closing his practice, he has been doing consulting work in the field of radiology including a lot of B-readings (Petitioner's Exhibit 2, pp 4, 10-11, 46; Petitioner's Exhibit 2, Deposition Exhibit 1).

Dr. Smith testified that in performing a B-reading, he starts with determining the quality of the film. The next step is to determine if there are any small opacities present. If opacities are present, he determines if there are enough to be called pneumoconiosis. If so, then he determines whether they are round or linear opacities and categorizes them by size. Dr. Smith testified that with coal workers' pneumoconiosis, the preponderance of small opacities are round. He testified that with other kinds of pneumoconiosis such as asbestos related, they are linear or irregular opacities. In coal workers' pneumoconiosis opacities occur primarily in the upper to mid lung zones. With asbestosis, it predominantly occurs in the mid to lower lung zones. The next thing the B-reader considers is the profusion which is the concentration or density of the findings in the lungs. Dr. Smith testified that the profusion tells the reader what degree of involvement is present. Dr. Smith testified that the last thing included in completing the B-reading form is the obligatory findings which are things that need to be recorded other than the findings of black lung. Dr. Smith described an opacity as a small, abnormal density that one would not see on a normal chest x-ray. It is often seen with people who have occupational lung disease or pneumoconiosis. Dr. Smith testified that mottle on a film is a pixely type of look. Dr. Smith testified that it may look like there is a disease there, but the reader is getting a false sense of there being opacities present because of the mottled appearance (Petitioner's Exhibit 2, pp 20-23, 25-26, 28-29).

Dr. Smith reviewed a chest x-ray of Petitioner dated June 27, 2016, at the request of Petitioner's counsel. Dr. Smith testified that the chest x-ray was quality 1. His interpretation of the film was interstitial fibrosis of classification P/P involving all six lung zones of profusion 1/0. There were mild thickened interlobar fissures. Dr. Smith testified that Petitioner had coal workers' pneumoconiosis. Because of that coal workers' pneumoconiosis, Petitioner had damage to his lungs (Petitioner's Exhibit 2, pp 35-36).

From 1988 to 2016, Smith Radiology was a freestanding diagnostic, walk in medical facility. Dr. Smith testified that Smith Radiology was netting $1.25 million in annual income after expenses. He testified that of that income maybe 5% was for medical legal exams or interpretations. Dr. Smith testified that he has interpreted chest x-rays for black lung for over 20 different law firms. He testified that 80% of those firms represent claimants. Dr. Smith testified that presently he is reviewing films for black lung for five firms that represent claimants. Dr. Smith testified that one of those firms is Petitioner's counsel. He is also reviewing films for Culley & Wissore. He testified that he has read more than 345 films for Culley & Wissore or Petitioner's counsel. When he received films from Culley & Wissore, he would get two or three films at a time on a frequency of twice a month. He might receive a tiny bit more than that from Petitioner's counsel. Dr. Smith testified that at his peak he was interpreting 2,000 films a year for law firms. Presently he is interpreting about 1,500 films a year (Petitioner's Exhibit 2, pp 49-57).

Dr. Smith has never sat on any committee with NIOSH. Dr. Smith has not held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. Dr. Smith testified that the syllabus that he uses to study for the B-reading exam he pretty much takes as gospel. He testified that the panel that puts that together are the peers that he aspires to be. The leaders in the field have been chosen to put that syllabus together. Dr. Smith testified that a new syllabus has been authored for NIOSH and that Dr. Cris Meyer was one of the authors of that syllabus. Dr. Smith testified that he agrees with the current B-reading syllabus that small opacities associated with the exposure to silica and coal dust are usually rounded. Dr. Smith testified that simple pneumoconiosis is unlikely to progress once the exposure ceases. Dr. Smith testified that pulmonary impairment is determined by appropriate valid pulmonary function testing and not by chest x-ray. Dr. Smith testified that in his interpretation of the chest imaging of Petitioner, he assigned a profusion rating of 1/0. There is no lower profusion rating that he could assign for that film and it remain positive for pneumoconiosis (Petitioner's Exhibit 2, pp 59-67).

Dr. Smith did not know whether the monitors that he uses for interpreting chest x-rays meet the guidelines that are set forth in the Code of Federal Regulations. He did not know whether his equipment complied with the DICOM standard that is set forth in the Code of Federal Regulations (Petitioner's Exhibit 2, p 66).

Dr. Cristopher Meyer reviewed a PA chest radiograph for Petitioner from Ferrell Hospital dated June 27, 2016. Dr. Meyer testified that the film was quality 2 due to quantum mottle. Dr. Meyer noted that there was a single calcified granuloma in the right apex, but no small opacities. He testified that there was mild eventration of the right diaphragm, which is a thinning of the diaphragm and a little contour abnormality. He testified that this finding had nothing to do with Petitioner's dust exposure and should not have any effect on pulmonary function for him. Dr. Meyer's interpretation of the film was that the lungs were clear. Dr. Meyer testified that he reviewed Dr. Smith's interpretation of the chest x-ray and disagreed with it. With regard to Dr. Smith and Dr. Rosenberg's finding that the film was quality 1, Dr. Meyer testified that there is a fair amount of variability between interpreters of chest radiographs with regard to quality. He testified that he was not surprised that Dr. Smith did not identify quantum mottle as he was less familiar with radiographic technique. Dr. Meyer testified that he had seen many reports from Dr.

Smith and had almost never seen him describe a film as less than a quality 1. Dr. Meyer testified that mottle can make the film look grainy. If the image has sort of a grainy appearance and that grainy appearance extends out of the chest over the soft tissues, then it is clearly related to image noise. Dr. Meyer testified that mottle can simulate small opacities (Respondent's Exhibit 1, p 27, 40-43).

Dr. Meyer has been board certified in radiology since 1992. Dr. Meyer has been a B-reader since 1999. Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee who designed the teaching course which is called the B-reader program. Dr. Meyer has recently been asked to have a more academic role in the B-reader program. He is on the ACR Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the training module and exam. Dr. Meyer testified that to become a B-reader one takes the weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. Dr. Meyer testified that the faculty for the B-reading course is typically experienced senior level B-readers. Typically after one takes the course, he then takes the B-reading exam. The certifying exam is six hours long with 120 chest x-rays to be categorized. The pass rate of the examination runs roughly 60%. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making the distinction between a 0/1 and 1/0 film. He testified that this is a point of emphasis in the B-reading course. Dr. Meyer testified that a 0/1 profusion means that the film is negative but the reader consider that it could be positive. A 1/0 profusion indicates that the radiologist decided that there was enough abnormality there to consider it an abnormal examination, but it was borderline enough that he at least entertained the idea that it might be a normal exam. In Petitioner's case, Dr. Meyer did not find any small opacities so it was a 0/0 profusion (Respondent's Exhibit 1, p 7, 19-21, 32-35, 52-53).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or linear opacities and based on the size and appearance of those small opacities they are given a letter score. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper lung zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of the lung involvement or the so-called profusion. Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. A negative film for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer testified that many coal miners who have had negative chest x-rays for coal workers' pneumoconiosis actually have it pathologically on autopsy or biopsy (Respondent's Exhibit 1, pp 22-23, 28, 30, 47).

At the request of Respondent's counsel, Dr. David Rosenberg reviewed medical records and a chest x-ray regarding Petitioner. Dr. Rosenberg has been board certified in internal medicine since 1977. After graduating from medical school he did a pulmonary fellowship at the National Institute of Health in Bethesda, Maryland. Dr. Rosenberg received his board certification in pulmonary disease in 1980. In 1995, he received his board certification in occupational medicine. Dr. Rosenberg has been a B-reader since July, 2000. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians and the American College of Occupational and Environmental Medicine. Dr. Rosenberg has lectured by invitation on a number of subjects through the years. These topics include interstitial lung disease, chronic obstructive lung disease, pulmonary stress testing, pulmonary function testing, exercise testing and occupational lung disease. Dr. Rosenberg has patients in his clinical practice who have black lung (Respondent's Exhibit 2, pp 4, 5, 7, 9-11).

Dr. Rosenberg reviewed a chest x-ray of Petitioner dated June 27, 2016. Dr. Rosenberg found the film to be quality 1. He interpreted the chest x-ray as 0/0 profusion with eventration of the right hemidiaphragm. There were no pleural abnormalities and there was some scattered granulomatous changes. Dr. Rosenberg testified that for a positive reading of a chest x-ray for pneumoconiosis, a reading of 1/0 or greater in terms of profusion is required. Dr. Rosenberg testified that profusion is the intensity of the changes that are observed. He testified that it is also important to indicate opacity type and lung zone involvement. Dr. Rosenberg testified that profusion is important because minimal changes can be caused by many different factors. He testified that a 0/1 profusion means that the initial impression was negative. To make a diagnosis of coal workers' pneumoconiosis, there would have to be category 1/0 profusion with micronodular changes which are predominantly in the upper lung zones, but can go on to involve all lung zones as the disease potentially progresses. Dr. Rosenberg testified that the diagnosis of coal workers' pneumoconiosis cannot be based upon history of exposure alone. He testified that in addition to the appropriate exposures one must develop the various objective findings related to coal workers' pneumoconiosis. He testified that symptoms are not enough to make the diagnosis of coal workers' pneumoconiosis because symptoms are non-specific complaints. Most respiratory disorders have similar types of symptoms. These symptoms include cough, sputum and shortness of breath. He testified that one can see these types of symptoms in individuals that have no respiratory disease (Respondent's Exhibit 2, pp 16-19).

Dr. Rosenberg testified that it is unlikely that simple pneumoconiosis will progress once the exposure ceases. Dr. Rosenberg agrees with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible dust exposure levels in the mine until he reaches retirement age. Dr. Rosenberg testified that Petitioner's treatment records did not outline chronic respiratory problems of shortness of breath, cough or sputum production. Dr. Rosenberg testified that the spirometry performed as part of Dr. Istanbouly's examination revealed no obstruction or restriction. Petitioner's diffusing capacity measurement was normal. Petitioner had no restriction given his forced vital capacity was normal. His normal diffusing capacity indicated that the alveolar capillary bed within his lungs was intact. Dr. Rosenberg testified that Petitioner did not have any findings of a pneumoconiosis related to past coal mine dust exposure. The records contained no history of asthma or COPD. There was no evidence to conclude that Petitioner had a respiratory

condition caused or aggravated by past coal mine dust exposure (Respondent's Exhibit 2, pp 18-21).

Dr. Rosenberg reviewed the spirometry performed as part of Dr. Istanbouly's examination. He testified that according to the American Thoracic Society, the two best forced vital capacities are to be used in calculating the FEV1/FVC ratio. In Dr. Istanbouly's testing the best FEV1 was 3.78 liters rather than 3.68 liters as reported by Dr. Istanbouly. Dr. Rosenberg testified that taking the best FEV1 from Dr. Istanbouly's testing and comparing it to Petitioner's best forced vital capacity, the ratio would be 77% which is normal. Dr. Rosenberg testified that there was no evidence of chronic bronchitis in the treatment records that he reviewed. The American Thoracic Society requires cough on a regular basis for three months per year for two consecutive years to make a diagnosis of chronic bronchitis. Dr. Rosenberg testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that when he applied the results from the pulmonary function testing performed on Petitioner to Table 5-4 of the *Guides*, Petitioner would fall in Class 0 impairment (Respondent's Exhibit 2, pp 15-16).

Dr. Rosenberg testified that there is no cure for coal workers' pneumoconiosis. The scarring and fibrosis of coal workers' pneumoconiosis are permanent and represent an alteration in the structure of the tissue involved. Dr. Rosenberg testified that a person can have coal workers' pneumoconiosis without having chest x-ray evidence of the disease (Respondent's Exhibit 2, p 27).

Medical records of Harrisburg Medical Center were admitted into evidence. Petitioner underwent a chest x-ray on January 5, 2007, which was interpreted as normal. A chest x-ray was performed on March 4, 2011, and was interpreted as revealing mild bilateral pulmonary hyperinflation and as negative for pneumoconiosis. Petitioner was seen for his yearly check up on July 8, 2011. His review of systems pulmonary revealed no dyspnea, cough or wheeze. Physical examination of the chest was normal with no adventitious sounds (Respondent's Exhibit 5, pp 48-53, 55, 77).

Petitioner was seen for a general physical on March 28, 2013. He denied dyspnea. His review of systems pulmonary revealed no dyspnea or cough. Physical examination of the chest was normal with no adventitious sounds. Petitioner was seen on January 30, 2014 for recheck of a knot on his face. Physical examination of the chest revealed no adventitious sounds. Petitioner was seen for a DOT physical on May 28, 2014. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds (Respondent's Exhibit 5, pp 12-15, 19-22, 23-27).

Petitioner was seen on March 9, 2015, by Dr. Alexander for his yearly check. On that date for active problems the doctor listed bradycardia, cervical disc displacement, coal workers' pneumoconiosis, general osteoarthrosis, hearing loss and hyperlipidemia. The doctor recorded that Petitioner had been employed underground for 28 years and had chest pain and shortness of breath on occasion. His review of systems respiratory revealed shortness of breath but no cough or wheezing. Physical examination of the chest revealed the lungs to be clear to auscultation with no adventitious sounds (Respondent's Exhibit 5, pp 3-8).

Medical records of VA Medical Center were admitted into evidence. Petitioner was seen on December 2, 2015. On that date he denied shortness of breath. His review of systems respiratory was negative for shortness of breath or cough. Petitioner was noted to be a retired coal miner (Respondent's Exhibit 4, pp 804-808). Petitioner underwent a chest x-ray on December 14, 2015, which was interpreted as revealing no acute cardiopulmonary process (Respondent's Exhibit 4, p 791). In a history and physical dated December 21, 2015, Petitioner denied shortness of breath. Physical examination of the chest revealed the lungs to be clear to auscultation (Respondent's Exhibit 4, pp 783-787).

Petitioner was seen for an annual visit on December 2, 2016. He reported he was doing well with no major concerns. On that date Petitioner denied any shortness of breath. His review of systems was negative with no cough or phlegm. The records indicated Petitioner was not a smoker. Physical examination of the lungs showed bilateral equal and fair air entry with no crackles or rhonchi (Respondent's Exhibit 4, pp 659-664).

On January 30, 2017, Petitioner was seen with complaints of head pressure, cough and sinus congestion. His cough was dry with rare phlegm of mostly clear drainage. He denied any shortness of breath. Physical examination of the lungs showed bilateral equal and fair air entry with no crackles or rhonchi. Assessment was sinusitis and cough (Respondent's Exhibit 4, pp 648-652).

Petitioner returned for a routine annual visit on January 10, 2018. He was generally doing well. Petitioner denied shortness of breath. Physical examination of the lungs showed bilateral equal and fair air exchange with no crackles or rhonchi (Respondent's Exhibit 4, pp 633-637). On January 16, 2018, a CT of the thorax was taken for a history of the five centimeter aneurysm found on echo. The impression was aneurysmal dilation of the aortic root with a maximal diameter of 5.9 x 5.7 cm. There were no pulmonary masses or infiltrates. There was focal calcification in the posterior aspect of the right upper lung (Respondent's Exhibit 4, p 624). On February 2, 2018, Petitioner was transferred to St. Louis University Hospital for the ascending aortic aneurysm. On review of systems respiratory Petitioner denied wheezing, cough, and shortness of breath. Physical examination respiratory showed his chest was clear to auscultation bilaterally with no wheezes, rales or rhonchi (Respondent's Exhibit 4, pp 546-551). When seen at the VA on February 2, 2018, review of systems respiratory revealed no shortness of breath, cough or sputum production. Physical examination respiratory revealed the lungs were clear to auscultation bilaterally without wheezes, rales or crackles (Respondent's Exhibit 4, pp 595-600). Petitioner underwent a CT of the chest on February 3, 2018. Same revealed the aneurysmal aortic root and ascending aorta. There was no acute process in the chest, abdomen or pelvis. There was a calcified granuloma in the right upper lobe but no suspicious nodule was identified (Respondent's Exhibit 4, pp 542-543). Petitioner was seen at the VA on February 7, 2018. At that time he denied shortness of breath, cough and phlegm. Physical examination of the lungs showed they were clear to auscultation (Respondent's Exhibit 4, pp 525-529).

Petitioner was seen on April 3, 2018, through cardiology for follow up of the aneurysm and bicuspid aortic valve. He had not had any shortness of breath. He reported being minimally active in part because of the weather and in part because he was instructed not to lift anything over 40 pounds or to push or pull anything over 40 pounds as a consequence of his aneurysm. Physical examination of the lungs showed they were clear with slightly prolonged expiratory phase (Respondent's Exhibit 4, pp 501-504). Petitioner was seen for three month routine visit on May 8, 2018. He felt that he was out of shape. On review of systems respiratory he denied any shortness of breath, cough or phlegm. Physical examination of the chest showed the lungs were clear to auscultation (Respondent's Exhibit 4, pp 469-473). On July 18, 2018, Petitioner returned to SLU Care for follow up of his aneurysm. His review of systems pulmonary showed that he denied any cough, wheezing, asthma or emphysema. Physical examination of the lungs showed the chest was clear to auscultation bilaterally without wheezes, crackles or rhonchi (Respondent's Exhibit 4, pp 440-442). On August 18, 2018, Petitioner underwent spirometry testing. Petitioner indicated that he became short of breath with heavy exercise but not with walking, climbing stairs, bathing or dressing. He did not have any chronic or frequent cough, never wheezed and did not take any breathing medications. The impression given on August 21, 2018, was no obstructive airflow limitation by spirometry. The lung volume measurements were normal. His diffusion capacity was moderately reduced. Overall, the pulmonary function test was compatible with no evidence of obstructive lung disease, no evidence of restrictive lung process and moderate reduction of DLCO (Respondent's Exhibit 4, pp 408-412). On September 11, 2018, Petitioner was seen through SLU to undergo a replacement of the aortic valve. Review of systems respiratory at that time showed that he was positive for dyspnea on exertion but denied any wheezing, chronic cough, dyspnea at rest and chronic lung disease. Physical examination of the chest showed the lungs were clear to auscultation bilaterally with unlabored respirations (Respondent's Exhibit 4, pp 389-391). A chest x-ray taken on September 13, 2018, showed the lungs were hypoinflated resulting in vascular crowding. There were bibasilar opacities representing atelectasis or consolidation that had not changed (Respondent's Exhibit 4, p 341). A chest x-ray on September 14, 2018, showed that the bilateral interstitial infiltrates appeared overall unchanged and likely represented edema or infection (Respondent's Exhibit 4, p 336). At the time of discharge home on September 15, 2018, Petitioner's lungs were clear to auscultation bilaterally and respirations were unlabored (Respondent's Exhibit 4, pp 311-315).

Petitioner was seen on October 4, 2018, complaining of rapid pulse for the prior 10 days. He denied shortness of breath. Review of systems respiratory was negative for any shortness of breath, cough or sputum production. Physical examination respiratory showed the lungs were clear to auscultation bilaterally without wheezes or crackles. A CT of the thorax revealed mild superimposed air-trapping versus emphysematous lung changes. He was diagnosed with atrial flutter and was admitted to the hospital for further follow up (Respondent's Exhibit 4, pp 294-298). On October 5, 2018, Petitioner underwent a TEE/cardioversion (Respondent's Exhibit 4, pp 218-219). Petitioner was seen for a cardiology consultation regarding atrial flutter on October 25, 2018. He believed his activities were limited by his atrial flutter. Physical examination of the chest showed that the lungs remained clear (Respondent's Exhibit 4, pp 142-145). Petitioner was seen on November 2, 2018, and indicated that he was feeling well. His review of systems respiratory showed he denied any shortness of breath or cough. Physical examination of the chest showed the lungs remained clear to auscultation (Respondent's Exhibit 4, pp 135-139). Petitioner

was seen on November 28, 2018, for increased abdominal pain. He denied any shortness of breath, cough or sputum at that time. His lungs remained clear to auscultation (Respondent's Exhibit 4, pp 111-116). When seen in follow up on December 4, 2018, December 7, 2018 and December 14, 2018, his review of systems respiratory remained negative and his physical examination of the chest remained normal (Respondent's Exhibit 4, pp 74-77, 86-90, 97-102).

Petitioner was seen on January 4, 2019, for GI consultation. Review of systems respiratory at that time was negative for cough and dyspnea. Physical examination respiratory showed normal respiratory rate and pattern with no distress, rales/crackles or rhonchi (Respondent's Exhibit 4, pp 61-64). When seen at follow up on January 18, 2019, Petitioner was noted to be in atrial flutter. His lungs remained clear to auscultation bilaterally (Respondent's Exhibit 4, pp 45-50). Petitioner was seen on March 5, 2019 through Gastroenterology Care Southern Illinois. His review of systems respiratory remained negative. His physical examination respiratory was also normal (Respondent's Exhibit 4, pp 31-34). Petitioner returned for evaluation of his atrial flutter on March 28, 2019. He was asymptomatic and could do his activities of daily living without chest, arm or neck discomfort. Physical examination of the lungs remained clear (Respondent's Exhibit 4, pp 16-19). On June 18, 2019, he was seen for follow up of his GI symptoms. Review of systems respiratory remained negative (Respondent's Exhibit 4, pp 4-7).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent.

In support of this conclusion the Arbitrator notes the following:

The spirometry performed as part of Dr. Istanbouly's examination was normal. It revealed no signs of obstruction or restriction. Dr. Rosenberg testified that there was no evidence that Petitioner had a respiratory condition caused or aggravated by past coal mine dust exposure and he had no associated impairment or disability. In his report of May 23, 2017, Dr. Istanbouly noted that Petitioner mentioned chronic intermittent cough for the past three years which was mild to moderate in intensity with mild thick brownish sputum. Dr. Istanbouly, however, did not include chronic bronchitis as a diagnosis in his report. Dr. Rosenberg testified that cough and sputum production were not outlined in the treatment records he reviewed and neither was dyspnea on exertion.

Dr. Smith, a B-reader, interpreted the chest x-ray of June 27, 2016, as positive for coal workers' pneumoconiosis. Dr. Meyer and Dr. Rosenberg reviewed the chest x-ray of June 27, 2016, and found the chest x-ray to have no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer testified that the chest x-ray that he reviewed was quality 2 due to mottle. Dr. Smith failed to note the limitations in film quality and take those limitations into account when making his interpretation. Dr. Smith's finding of opacities in the middle and lower lung zones bilaterally to the exclusion of upper lung zones was not consistent with the usual pattern of pneumoconiosis as

described by the experts in this case. Dr. Smith testified that coal workers' pneumoconiosis opacities occur primarily in the upper to mid lung zones. Dr. Meyer testified that coal workers' pneumoconiosis is generally an upper lung zone predominant process. Dr. Rosenberg testified that the micronodular changes of coal workers' pneumoconiosis are predominantly in the upper lung zones but can go on to involve all lung zones as the disease potentially progresses.

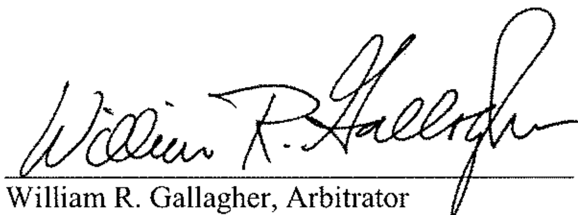
Dr. Rosenberg described the protocol for proper reading of a chest x-ray for pneumoconiosis. He also testified that profusion is important because that is what determines whether a chest x-ray is category 0/1 profusion or 1/0 profusion. Dr. Istanbouly did not follow this protocol and did not know the profusion of the film that he reviewed.

The Arbitrator notes that Dr. Alexander included coal workers' pneumoconiosis under Petitioner's active problems at an office visit on March 10, 2015. Dr. Alexander recorded that Petitioner had 28 years in underground coal mining and had shortness of breath on occasion. Dr. Rosenberg testified that the diagnosis of coal workers' pneumoconiosis cannot be based upon history of exposure or respiratory symptoms.

The Arbitrator finds the opinions of Dr. Meyer and Dr. Rosenberg to be more persuasive than those of Dr. Istanbouly, Dr. Smith and Dr. Alexander.

Petitioner testified that he first noticed breathing problems during the last couple years of his coal mine employment. Petitioner did not relate to Dr. Istanbouly that he left the mine at the time he did due to respiratory disease or symptoms or that he had any difficulty in performing the physical demands of his last job in the mine. At the time of his examination by Dr. Istanbouly, Petitioner did not identify any triggers for his intermittent cough and he did not relate that his cough was triggered by smoke, dust or fumes. As of the time of trial, Petitioner was not taking any breathing medications. He testified that he was able to maintain his own yard, help his brother farm and deer hunt although it was harder for him to get those jobs done.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC035191
Case Name	SIMMONS, TIMOTHY v. NORTHWESTERN UNIVERSITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0093
Number of Pages of Decision	25
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Richard Victor
Respondent Attorney	Matthew Novak

DATE FILED: 3/15/2022

/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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY SIMMONS,

Petitioner,

vs. NO: 18 WC 35191

NORTHWESTERN UNIVERSITY,

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 September 27, 2018, entitlement to incurred medical expenses, entitlement to Temporary Total Disability benefits, and whether continuing treatment with Dr. Sclamberg 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 22, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $475.20 per week for a period of 98 6/7 weeks, representing September 28, 2018 through October 21, 2018 and November 20, 2018 through September 17, 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 sum of $4,431.04 for medical expenses as detailed in Petitioner's Exhibit 2 and Petitioner's Exhibit 3, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective care in the form of the right shoulder surgery recommended by Dr. Sclamberg 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.

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

March 15, 2022

/s/ *Deborah J. Baker*

DJB/lyc

O: 2/23/22

43

/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 22IWCC0093
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

SIMMONS, TIMOTHY Case# **18WC035191**
Employee/Petitioner

NORTHWESTERN UNIVERSITY
Employer/Respondent

On 10/22/2020, 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1109 GAROFALO SCHREIBER STORM
MATTHEW NOVAK
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)/8(A)

Timothy Simmons
Employee/Petitioner

Case # **18** WC **035191**

v.

Consolidated cases: D/N/A

Northwestern University
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason,** Arbitrator of the Commission, in the city of **Chicago**, on **9/17/20**. 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, **9/27/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,065.60**; the average weekly wage was $**712.80**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**41,698.80** in non-occupational indemnity disability benefits. Arb Exh 1.

Respondent is entitled to a credit of $**41,698.80** in non-occupational indemnity disability benefits under Section 8(j) of the Act. Arb Exh 1.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $4,431.04, as provided in Sections 8(a) and 8.2 of the Act. PX 2, 3.

Respondent shall be given a credit in an amount to be determined for medical benefits that have been paid, and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Arb Exh 1.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $475.20/week during two intervals: from 9/28/18 through 10/21/18 and from 11/20/18 through the hearing of 9/17/20, a total of 98 6/7 weeks, as provided in Section 8(b) of the Act.

Prospective Care

Respondent shall authorize and pay for prospective care in the form of the right shoulder surgery recommended by Dr. Sclamberg.

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

10/22/20
Date

ICArbDec19(b)

OCT 22 2020

Timothy Simmons v. Northwestern University
18 WC 35191

Summary of Disputed Issues

Petitioner, an animal care technician, claims he injured his right shoulder on September 27, 2018, while pulling racks and changing out cages. Petitioner had previously injured the same shoulder at work in September 2016. He underwent a rotator cuff repair in December 2016. RX 7, pp. 94-95. He settled the 2016 injury claim with Respondent in August 2017 (with the settlement representing 25% loss of use of the right arm, RX 1) but continued seeing his surgeon, Dr. Sclamberg, and Dr. Padron, a pain management physician, through September 18, 2018. As of August 24, 2018, Dr. Sclamberg was restricting Petitioner to "800 cage responsibility" (meaning Petitioner was responsible for checking and potentially cleaning 800 cages on a day-to-day basis) and no lifting over 75 pounds. RX 7. Petitioner testified his shoulder felt "stable" as of August 24, 2018 but acknowledged that he needed to take pain medication in order to perform his job duties. Dr. Padron refilled his Norco on September 18, 2018. Petitioner described his pain as dramatically worsening after the accident of September 27, 2018. He returned to Dr. Sclamberg after this accident. Dr. Sclamberg ordered an MRI, which showed a re-tear of the supraspinatus and a possible labral tear. Dr. Sclamberg subsequently recommended another surgery. He testified that the September 27, 2018 accident caused a re-tear. Respondent's examiner, Dr. Verma, agreed with the need for revision surgery but opined that the September 27, 2018 accident did not cause any structural change to Petitioner's shoulder.

Respondent's manager of husbandry operations testified that Petitioner worked within his restrictions prior to April 2018. She also testified that Respondent's Office of Equity became involved in the issue of Petitioner's need for accommodation in April 2018 and, on September 25, 2018, shared its determination with Petitioner and Respondent's human resources department. She described the racks as wheeled and easy to move, as demonstrated in a video she oversaw. RX 4.

On rebuttal, Petitioner testified that, although the Office of Equity approved his restrictions, his supervisor, Chad Martin, was requiring him to take care of approximately 1,000 cages during the period preceding the September 27, 2018 accident. Martin did not testify. Respondent offered into evidence Martin's report of September 28, 2018, indicating that, while Petitioner had reported right arm pain the previous day, he first reported a work accident on the 28th. Martin also described the wheeled racks as requiring little force to move. RX 3.

The disputed issues include accident, causal connection, medical expenses, temporary total disability benefits and prospective care. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent in November 2012. T. 12.

Petitioner acknowledged injuring his right shoulder at work on September 19, 2016. Following this injury, he was off work from October 25, 2016 until July 2, 2017. T. 16. Dr. Sclamberg operated on his shoulder on December 12, 2016. He underwent therapy following the surgery and then saw Dr. Padron for pain management. He settled his claim with Respondent. An arbitrator approved the contracts on August 11, 2017. T. 16. The settlement represented 25% loss of use of his right arm. T. 17. He continued undergoing treatment for his shoulder through August 24, 2018. Dr. Sclamberg did not recommend a shoulder injection or surgery on that date. He prescribed Oxycodone and continued a 75-pound lifting restriction. He also continued a previous "800 cage responsibility" restriction.

Records in RX 7 reflect that a right shoulder MRI performed on October 5, 2016 showed a partial thickness articular surface tear of the supraspinatus tendon superimposed on mild tendinosis, an interstitial tear of the infraspinatus tendon superimposed on mild to moderate tendinosis, mild thinning of the glenohumeral articular cartilage, a "diminutive posterior superior labrum" (with the radiologist indicating that signal intensity in the superior labrum could represent degeneration) and mild subacromial subdeltoid bursitis. RX 7, pp. 99-100. Dr. Sclamberg performed a right shoulder arthroscopy, rotator cuff repair, subacromial decompression and synovectomy and debridement on December 12, 2016. In his operative report, he documented labral fraying, hypertrophic synovitis and partial thickness high grade rotator cuff tearing in the supraspinatus distribution. RX 7, pp. 94-95. Petitioner underwent therapy and work conditioning following this surgery. An Athletico "work conditioning functional status report" dated June 19, 2017 reflects that Petitioner was functioning at a medium physical demand level. The therapist referenced a job description "provided by employer," noting that Petitioner's job was categorized as "heavy physical demand level." The therapist found Petitioner capable of 90.91% of his job demands. He recommended six additional work conditioning sessions. RX 7, pp. 102-106. On June 22, 2017, Dr. Sclamberg noted that Petitioner was "feeling a lot better" but still had some stiffness and weakness. RX 7, pp. 23-24. On August 22, 2017, Dr. Sclamberg noted that Petitioner had resumed full duty and had "developed some pain since returning to work." He imposed a restriction of "limit of 700 cages of responsibility." RX 7, pp. 18-21. On February 23, 2018, Dr. Sclamberg noted that Petitioner was using a TENS machine and taking Oxycodone 10 mg and wanted to have his restrictions updated. The doctor imposed the following restrictions: "limit of 800 cage responsibility," no lifting over 75 pounds and maximum overhead lifting of 25 pounds. He directed Petitioner to continue his home exercises and return in six months. RX 7, pp. 13-17. On August 24, 2018, he noted that Petitioner was experiencing some pain at night when sleeping on his right side and was taking Norco as needed. He also noted that Petitioner's Oxycodone prescription was due to end on January 3, 2019. On examination, he noted a diminished range of active motion (160/45/Sa), external rotation weakness with 4/5 strength and supraspinatus weakness 4/5. He continued the previous restrictions and directed Petitioner to perform home exercises and return in six months. RX 7, pp. 8-12. On September 18, 2018, Dr. Padron noted that Petitioner was still symptomatic but that his "symptoms [were] controlled with medication." He refilled the Norco. RX 6, pp. A7-A8.

Petitioner testified that, in August and September 2018, he was assigned to two animal handling rooms, numbered 503 and 517. During this time, he was responsible for 1100 cages. T. 17, 19. His duties included checking the animals' health, cleaning cages that needed to be cleaned, transferring animals from dirty cages to clean ones, providing food and water and cleaning the rooms. He had to unlatch the cages to move them and also had to move racks of cages to perform cleaning. T. 18.

Petitioner testified that his right shoulder hurt but felt "stable" during the period preceding the September 27, 2018 accident. His shoulder was "okay" but he needed to take Oxycodone for pain in order to perform his job duties. T. 20. He would take half a pill at work and a whole pill after he arrived home. T. 21. His shoulder pain was 4/10 before he took the medication. During the three weeks preceding September 27, 2018 he typically experienced pain at the end of a workday. The pain was "sharp" but he managed to work consistently, including on weekends. T. 22.

Petitioner testified he injured his right shoulder again on September 27, 2018, while changing out Room 503, the larger of his two rooms. T. 22. During this particular week, he had to "change out the room completely," meaning he had to transfer all of the animals from dirty cages to clean ones. He also had to sweep and mop the rooms. T. 23. As he was pulling out a rack, he experienced a "sharp shooting pain" down his arm. He was unable to finish cleaning. He called for help because he was not allowed to leave the animals unattended. T. 23. He had never had to call for help before the accident. T. 25.

Respondent offered into evidence a "Workers' Compensation Employee Accident Statement Form" dated September 28, 2018. On this form, Petitioner indicated that, on September 27, 2018, he was in his assigned room, pulling racks off the wall to clean behind them, when he "felt a sharp pain in [his] right shoulder up to [his] neck." Petitioner also indicated he reported this injury to Chad Martin. RX 2.

Respondent also offered into evidence a "Supervisor's Injury or Illness Investigation Report. This report is not dated. It identifies Chad Martin as Petitioner's supervisor. The report reflects that, at approximately 12:30 PM on September 27, 2018, Petitioner reported that his right arm hurt and that, at that point, Petitioner "did not explain involvement with on-the-job injury." The supervisor went on to state that, the following day, Petitioner "reported the injury occurred as a result of pulling an animal rack, causing a sharp pain from R shoulder to neck." He indicated the wheel locking mechanism was off, that no malfunction was noted, that Petitioner had previously undergone training on how to move animal racks and that, "with attention to detail" and "normal pace," the racks could be moved "with no strain to employee." He described the racks as having wheels and requiring "very little effort/force to move." RX 3.

On September 28, 2018, Petitioner saw Kaitlyn Masland, a nurse practitioner, at Northwestern Medicine Corporate Health. T. 26. In her note of that date, Masland indicated that Petitioner reported having felt "shooting pain from R neck to R deltoid" the previous day, while pulling a rack that holds animal cages. Masland also noted that Petitioner was taking

Norco due to an "old shoulder injury." She described Petitioner's prior injury and its aftermath as follows:

> "On 9/16/2016 – pt was carrying feed bags at work when he felt pain in R shoulder, dropped bags, came to CH, referred to ortho – saw surgeon – MRI – shoulder R rotator cuff tear, did PT, minimal improvement, tried injection, still had pain, had surgery 12/2016, did PT for 6 months, work conditioning for 6-8 weeks, Came back to work w/ restrictions which were accommodated. Pt completed PT but was still having daily pain, was originally on Oxy from pain mgmt. but then on Norco – taking Norco for significant pain only (would need this on heavy work weeks – for instance, the past week he's been working between 2 rooms so he's had increased work and has had R shoulder pain so has needed Norco daily – taking 2 pills (10-325mg x 2 in morning at work) – minimal improvement. Additionally, in Feb 2018 – had new management – told pt that he needed to go through Occ Office of Equity to get approved for restrictions, went through this office – has been going back and forth for months. Ortho gave restrictions – pt told by Office of Equity that this could not be accommodated (800 cages max, lifting limits) but pt allowed to work with lifting limits, just couldn't accommodate cages – pt continued to work." However, yesterday, after his injury, pain severe. Came to CH but was unable to wait, scheduled for today."

Masland described Petitioner as having "acute on chronic" right arm pain and being unable to actively move his right shoulder. She expressed concern about his developing "frozen shoulder." She recommended that he return to his orthopedic surgeon as soon as possible, using his own health insurance while awaiting approval. She also recommended that Petitioner discontinue the Norco and start taking Ibuprofen 600-800 mg every six hours. She indicated that Petitioner could take Norco per his pain management physician if his pain was excruciating but that he "must call off work if taking within 8 hours of work." She took Petitioner off work that day and noted he was scheduled to be off work during the coming weekend. She imposed restrictions of no use of the right arm as of the following Monday.

In a subsequent note, bearing the same date, Masland described Petitioner as guarding his right arm throughout the visit, "making exam very difficult." She indicated that, on passive range of motion, Petitioner was "barely able to abduct/flex/extend" without reporting severe pain and needing to stop.

Petitioner returned to Northwestern Medicine Corporate Health on October 16, 2018. T. 26. He provided Dr. Cullen with a history of the previous surgery and the September 27, 2018 accident. He complained of 6/10 pain. The doctor noted that Petitioner described his pain as "different from rotator cuff" and radiating from his neck to his shoulder.

Dr. Cullen noted that Petitioner had "never been full duty" since the 2016 surgery and that he was restricted to 800 cages per day. She also noted that, at Respondent's request, Petitioner had seen Dr. Sclamberg "to reassess" the restrictions but that the doctor "kept them the same" from February 2018 to September 27, 2018. She indicated that, according to Petitioner, he was "supposed to be on restrictions" as of the accident but "had to lift a 1000 which was split between 2 rooms." She noted that Petitioner "worked with office of equity who said [Respondent] would not be able to accommodate indefinitely 8/2018" so, in August, Petitioner "decided to do full cage count" but Respondent "did honor" his lifting restrictions.

On examination, Dr. Cullen noted a full range of motion with minimal pain with left lateral motion, 5/5 upper extremity strength and limited motion with grimacing with all movement. She described Petitioner as "jumping" with very light touch and "not wanting to be touched." She noted that Petitioner was seeing Dr. Sclamberg later that day. She warned Petitioner about frozen shoulder and recommended that he perform Codman's exercises twice daily. She restricted Petitioner to desk work and no lifting past the shoulder on the right. PX 6.

Later that same day, Petitioner saw Dr. Sclamberg. T. 26. Petitioner reported having injured his right shoulder on September 27, 2018, while pulling a heavy rack at work. The doctor noted that Petitioner had previously undergone a right rotator cuff repair on December 12, 2016. He noted that Petitioner reported experiencing increased pain "when his work had him return to no cage lifting restrictions." He noted no abnormalities on left shoulder examination. On right shoulder examination, he noted a diminished active range of motion, 160/45/Sa, and a diminished passive range of motion. He also noted external rotation weakness with 4/5 strength and supraspinatus weakness 4/5. He recommended a right shoulder MRI. He took Petitioner off work pending the results of that study. PX 1.

On October 16, 2018, a claim manager affiliated with Respondent authorized the proposed right shoulder MRI. PX 1.

Petitioner underwent the MRI on October 17, 2018. T. 27. The interpreting radiologist indicated he compared the images with a prior right shoulder MRI performed on October 5, 2016. He noted post-surgical changes, "mild to moderate tendinosis and post-operative signal change in the supraspinatus tendon and a superimposed small interstitial tear (re-tear) in the mid to posterior fibers of the distal tendon", mild bursitis, "increased compared to the prior MRI", an increased signal in the superior and posterior-superior labrum, "increased compared to the prior MRI and suggestive of labral tear" and minimal degenerative change at the acromioclavicular joint. PX 1.

Petitioner returned to Dr. Padron on October 19, 2018. Petitioner reported worsening right shoulder pain and indicated his restrictions were "not respected at work." Dr. Padron noted that "a repeat MRI demonstrates a repeat tear." He refilled the Oxycodone. RX 6, pp. A9-A10.

Petitioner also returned to Dr. Sclamberg on October 19, 2018 and reported ongoing right shoulder pain. The doctor's examination findings were unchanged. After reviewing the MRI, he imposed restrictions of "700 cage responsibility," no lifting over 75 pounds and no overhead lifting over 25 pounds. He administered an injection and prescribed physical therapy. T. 27. PX 1.

Petitioner testified he resumed working on October 22, 2018. He testified that his assigned duties exceeded Dr. Sclamberg's restrictions. He asked for lighter duty but was told it was not available. He experienced excruciating right shoulder pain all day. He last worked on November 16, 2018.

On November 20, 2018, Petitioner returned to Dr. Sclamberg and denied improvement. Petitioner indicated he had not yet started physical therapy and was taking one half to two Norco tablets per day. The doctor took Petitioner off work and again recommended physical therapy. He indicated that Petitioner needed to be off work "due to exacerbation of shoulder injury and re-tear of the supraspinatus." PX 1. RX 7, pp. 73-77.

Petitioner returned to Dr. Sclamberg on January 4, 2019 and reported constant right shoulder pain. Petitioner also indicated he was attending therapy. The doctor recommended that Petitioner remain off work while participating in therapy. He indicated he planned to discuss surgery with Petitioner at the next visit. PX 1.

At the next visit, on February 22, 2019, Petitioner reported that he was seeing a personal trainer three times a week and that he had been "unable to schedule surgery due to legal issues." Petitioner complained of constant pain and indicated he wanted to move forward with the surgery. The doctor recommended a right shoulder arthroscopy with subacromial decompression and possible labral repair. He continued to keep Petitioner off work. PX 1.

On April 12, 2019, Petitioner returned to Dr. Sclamberg and reported that he was scheduled to undergo an IME in May. Petitioner continued to complain of right shoulder pain. The doctor again recommended surgery. He continued to keep Petitioner off work. PX 1.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Verma on June 12, 2019. Dr. Verma is affiliated with Midwest Orthopaedics at Rush. In his report (Verma Dep Exh 2), the doctor recorded a history of the 2016 surgery and the September 27, 2018 accident. He noted that Petitioner reported having "some residual soreness" after the surgery that became "acutely worse" after the 2018 accident. He also noted that Petitioner reported taking Norco after the 2016 surgery up until about six months before the accident. He noted that Petitioner denied any benefit from the injection Dr. Sclamberg injected.

Dr. Verma indicated he reviewed pre-accident 2018 records from Dr. Sclamberg and Dr. Padron. He noted that Petitioner reported ongoing right shoulder pain when he saw Dr. Patron on September 18, 2018. On examination, he noted fairly significant diffuse right shoulder pain, limited forward elevation, 4/5 strength with abduction and external rotation and no gross

evidence of instability. He described Petitioner as guarding "secondary to pain complaints." He reviewed X-rays, noting no fracture, dislocation or effusion. He diagnosed chronic right shoulder pain and opined that this condition existed prior to the alleged injury of September 27, 2018. He deferred the issues of causation and treatment until he could review the MRI images. Pending this review, he found Petitioner capable of light duty with no lifting over 5 pounds with the right arm and no repetitive lifting, pushing, pulling or overhead activity. Verma Dep Exh 2.

Petitioner returned to Dr. Sclamberg on July 26, 2019 and again complained of right shoulder pain. Dr. Sclamberg commented as follows after reviewing Dr. Verma's report: "Patient has work related injury and his described mechanism is competent for causation." He prescribed topical medication and home exercises, pending the recommended surgery. PX 1.

On July 31, 2019, Dr. Verma issued an addendum, after reviewing the October 2018 MRI. He saw "no evidence of acute or traumatic injury that would be consistent with any aggravation of the condition as a result of his September work injury." He indicated that, while a revision arthroscopy and work restrictions might be necessary, the need for these measures stemmed from Petitioner's "chronic pre-existing shoulder condition" and not the September work injury. He found Petitioner to be at maximum medical improvement from this injury. Verma Dep Exh 3.

Petitioner returned to Dr. Sclamberg on December 3, 2019 and January 7, 2020. He complained of right shoulder pain and weakness. The doctor again recommended surgery. He continued to keep Petitioner off work. PX 1.

Dr. Sclamberg testified by way of evidence deposition on February 17, 2020. PX 4. Dr. Sclamberg testified he is a board certified orthopedic surgeon with a subspecialty in sports medicine. He concentrates on shoulder and knee conditions. PX 4, p. 4. Sclamberg Dep Exh 1. He acknowledged he needed his notes to testify concerning Petitioner. He first saw Petitioner in November 2016. Petitioner had injured his right shoulder at work. He operated on the right shoulder on December 12, 2016, performing an arthroscopy, rotator cuff repair, subacromial decompression and a synovectomy with debridement. PX 4, p. 6.

Dr. Sclamberg testified that, prior to the September 27, 2018 accident, he last saw Petitioner on August 24, 2018. Petitioner was experiencing pain at night. Petitioner reported he was working, subject to restrictions of no lifting over 75 pounds and an "800 cage responsibility." PX 4, pp. 6-7. Petitioner's strength was 4/5, "near normal." He felt Petitioner was "doing well after surgery." PX 4, p. 7. Petitioner was at or near maximum medical improvement. PX 4, p. 8. He next saw Petitioner on October 16, 2018, with Petitioner reporting a new injury of September 27, 2018, while pulling a heavy rack at work. Petitioner complained of right shoulder pain radiating to his neck. Petitioner indicated he had been seen at a corporate health facility but had not undergone any imaging. PX 4, p. 8. Dr. Sclamberg testified he was concerned that Petitioner might have damaged the surgical repair so he ordered an MRI. Petitioner's symptoms were consistent with a new injury. PX 4, p. 9. The MRI,

performed on October 17, 2018, showed some changes in the rotator cuff repair. It can be difficult, following a surgery, to tell exactly how the rotator cuff looks but it appeared as if there was "small further tearing of the rotator cuff as well as some bursitis" and the suggestion of a labral tear. PX 4, p. 9. The MRI findings were consistent with a new injury. PX 4, p. 10. On October 19, 2018, he injected the right shoulder and prescribed therapy. An injection would diminish the inflammation associated with bursitis but it would not solve a labral or rotator cuff problem. PX 4, p. 10. He increased Petitioner's work restrictions. PX 4, pp. 10-11.

Dr. Sclamberg testified that, at the next visit, on November 20, 2018, Petitioner was taking narcotic pain medication and had not started therapy. He took Petitioner off work. By January 4, 2019, he was contemplating surgery because Petitioner had failed conservative care. He considered surgery because Petitioner had "an interval injury which caused his rotator cuff to tear a little and his labrum to tear" and he "wasn't getting better." PX 4, p. 11. He felt it was "appropriate to revise [the] arthroscopy." PX 4, p. 11. He kept Petitioner off work. It was his understanding there was no light duty for Petitioner. Pending the surgery, Petitioner would have been capable of performing one-armed work or work with no lifting over 5 pounds and no overhead activity. PX 4, p. 12. He continued seeing Petitioner through January 7, 2020. Petitioner did not improve and he continued to recommend surgery. PX 4, p. 13.

Dr. Sclamberg testified that, at the request of Petitioner's counsel, he reviewed Dr. Verma's report and issued a report dated October 15, 2019, addressing causation. Sclamberg Dep Exh 2. In his opinion, the accident of September 27, 2018 definitely aggravated Petitioner's condition. The last time he saw Petitioner before the accident, Petitioner was "doing pretty well." Petitioner was "happy." He has seen Petitioner often enough that he can remember him. Petitioner is a "reliable, nice guy" and he "definitely got worse after that injury." PX 4, p. 15. The September 27, 2018 accident brought about the need for more surgery. PX 4, p. 16. He and Dr. Verma agree to the extent they both believe Petitioner needs more care and has failed conservative management. Where they disagree is that Dr. Verma does not believe there was an acute injury that resulted in an aggravation. In his own opinion, the accident of September 2018 was acute and the post-accident MRI findings are acute. PX 4, p. 17. After the September 2018 accident, Petitioner did not return to the condition he was in as of August 2018. PX 4, p. 18.

Under cross-examination, Dr. Sclamberg testified that, back in 2016, Petitioner reported having injured his right shoulder while carrying bags of animal feed that weighed 200 pounds. At the first examination, in November 2016, Petitioner's strength was 4/5. Forward flexion was 140 to 160 degrees, whereas normal flexion is 180. Petitioner could externally rotate to 30 to 45 degrees. Normal external rotation is 60 degrees. Petitioner could internally rotate to "SA," meaning the sacrum. PX 4, p. 19. When he operated, in December 2016, he noted a full-thickness tear of the supraspinatus tendon. He repaired that tear. A partial thickness tear is fraying whereas full-thickness tears are "fully pulled out" and not in contact with the humeral head. Petitioner's supraspinatus tendon was not retracted. In other words, the tendon was avulsed but hovering over where it needs to be. To repair a full-thickness tear, you have to trim down the torn edge of the tendon and re-attach it, using multiple anchors. PX

4, p. 21. The anchors go into the humeral head. The tendon is not shortened during the repair. You use a resector to abrade the edges because you want fresh tissue to touch fresh tissue. Otherwise the tendon will not heal. PX 4, p. 22. He also released the coracoacromial ligament. He also debrided the labrum. PX 4, pp. 22-23. The surgical findings were related to the 2016 work accident. If, following a repair, the supraspinatus fully heals, it is not at an increased risk for re-tear. If it does not fully heal, it is at risk. PX 4, p. 23. The goals of the 2016 surgery were to relieve Petitioner's pain and restore motion and strength. PX 4, pp. 23-24. Ideally, the shoulder would be pain free and have a full range of motion after a surgery.

Dr. Sclamberg testified that, following the 2016 surgery, he released Petitioner to full duty in June 2017. He saw Petitioner again on August 15, 2017, with Petitioner reporting he was experiencing symptoms while working. Petitioner's strength was again 4/5 and he had a diminished range of motion. PX 4, p. 24. He imposed a restriction of no more than 700 cages in a day. He did not schedule a follow-up. PX 4, p. 25. He next saw Petitioner on February 23, 2018. Petitioner was working with restrictions but doing very well overall. Petitioner saw him that day to get updated restrictions. Petitioner was using a TENS unit for pain relief. He was also taking Oxycodone. Dr. Sclamberg testified he imposed more restrictions: no lifting over 75 pounds and no lifting more than 25 pounds overhead. He told Petitioner to return in six months. PX 4, p. 26. On August 24, 2018, Petitioner wanted to have his restrictions updated. When he re-examined Petitioner that day, he noted diminished active range of motion of 160 degrees forward flexion and 45 degrees external rotation. PX 4, p. 27. He also noted reduced strength. Petitioner was still taking narcotic pain medication. At the next visit, on October 16, 2018, Petitioner provided a history of the September 27, 2018 accident. When he re-examined Petitioner that day, his findings were similar to those he documented in August 2018. PX 4, p. 29. He ordered an MRI. He agrees with the radiologist's interpretation of this MRI, i.e., that it showed a re-tear of the supraspinatus tendon and was also suggestive of a labral tear. He is premising his causation opinion on the history Petitioner provided of feeling sharp pain while moving a heavy rack. He does not have additional information about the mechanism of injury. PX 4, p. 30. He believed what Petitioner told him. He assumes that Petitioner used a fair amount of force to pull the rack. A re-tear could have happened with the arm down at the side or above the head. PX 4, p. 31.

On redirect, Dr. Sclamberg testified that the pre-accident examination findings do not prompt him to change his opinion that the September 27, 2018 accident worsened Petitioner's condition. Petitioner's symptoms were worse after the accident. This was consistent with the post-accident MRI. PX 4, p. 32.

Under re-cross, Dr. Sclamberg testified that his examination findings of August 24, 2018 were consistent with a rotator cuff tear. His causation opinion is premises in large part on Petitioner's increased complaints following the accident. PX 4, p. 33.

On further redirect, Dr. Sclamberg testified his causation opinion is not based solely on Petitioner's increased complaints. Rather, it is based on everything he previously testified about. PX 4, p. 34.

Dr. Verma testified by way of evidence deposition on July 1, 2020. RX 5. Dr. Verma is a board certified orthopedic surgeon who specializes in shoulder, elbow and knee conditions. About 60% of his practice involves shoulders. RX 5, pp. 5-6. Verma Dep Exh 1. He is a professor in the department of orthopedic surgery at Rush University Medical Center. RX 5, p. 6.

Dr. Verma testified he examined Petitioner on June 12, 2019. He does not independently recall Petitioner. RX 5, pp. 7-8. His report reflects that Petitioner reported injuring his right shoulder in 2016 and later resuming restricted duty, with the restriction relating to the number of animal cages he could handle. Petitioner also reported experiencing right shoulder pain and a pop when he was pulling stacks of cages at work. He described having residual soreness in the shoulder before this event but indicated his pain increased afterward. RX 5, p. 9.

Dr. Verma testified that, in connection with the examination, he watched brief videos that confirmed Petitioner's statement that his job involved maneuvering animal cages. RX 5, p. 9. He also reviewed a risk management statement concerning the injury and various treatment records. The records included some from 2016. Those records showed that Petitioner made an "incomplete recovery" following the 2016 shoulder surgery. Petitioner had "persistent pain and function loss" and required ongoing narcotic pain medication. RX 5, p. 11. Dr. Verma testified he also reviewed the report of the MRI performed on October 17, 2018. The radiologist noted post-surgical changes, potential small bursitis, irregularity of the labrum, minimal degenerative changes of the AC joint and no acute fracture. Dr. Verma testified he later reviewed the actual MRI images. Once a patient undergoes shoulder surgery, his shoulder never looks normal. Some irregularity of the rotator cuff is to be expected after a rotator cuff surgery. RX 5, p. 13.

Dr. Verma testified that, on examination, he noted no atrophy or deformity, some deficiency in the cervical range of motion, negative Spurling's, diffuse pain over the shoulder with palpation, some limitation of elevation and weakness greater than 4/5. Petitioner was guarding. At this point in his career, he can perform a standard shoulder examination in three to five minutes. RX 5, p. 14. As an IME, he spends about 20 minutes with an examinee, in terms of the history and examination, and another 40 minutes on reviewing records and images and preparing a report. RX 5, p. 15. He took X-rays of Petitioner. The X-rays were normal. RX 5, p. 15. He concluded that Petitioner has persistent shoulder pain that is "chronic in nature." He asked to review the MRI images. He recommended light duty restrictions. RX 5, p. 15. He deferred his causation opinion to the review of the images because the real question in this case is whether the second injury changed the nature of Petitioner's shoulder in terms of his prognosis or functionality. RX 5, p. 16. After he reviewed the MRI images, he issued a second report. That report was dated July 31, 2019. He saw post-surgical changes and no evidence of a re-tear. He saw nothing that suggested an acute injury. RX 5, p. 17. After he reviewed the MRI images, he diagnosed "chronic shoulder pain with subacromial bursitis." RX 5, p. 17. He found no causal relationship between Petitioner's current condition and the accident of

September 2018. RX 5, p. 18. Petitioner "may have had a temporary symptomatic worsening of the condition" but he saw "no evidence that the injury caused an anatomic injury that resulted in any permanent worsening." He felt Petitioner could benefit from a revision arthroscopy based on his ongoing complaints but he did not link the need for this surgery to the 2018 accident. RX 5, p. 19. He also felt Petitioner needed restrictions but not due to the 2018 accident. RX 5, p. 19. It is fairly rare to have a look at a patient from a pre-injury to post-injury perspective. In his opinion, Petitioner's current right shoulder condition stems from his 2016 injury. RX 5, p. 20.

Under cross-examination, Dr. Verma testified he has no opinion as to whether Petitioner was at maximum medical improvement in July and August 2018 following his 2016 surgery because he did not have the chance to examine Petitioner at that time. RX 5, p. 21. A patient can be at maximum medical improvement and still have pain and weakness. RX 5, p. 21. Petitioner told him he felt worse after the September 27, 2018 accident. He has reviewed the records that Dr. Sclamberg generated after that accident. The last note of Dr. Sclamberg that he reviewed was dated January 4, 2019. RX 5, p. 22. In his opinion, the doctor's records show that Petitioner voiced subjective worsening after the accident but the objective findings were the same. RX 5, p. 22. Petitioner had fairly severe pain before the 2018 accident and needed narcotic pain medication. He had severe pain afterward, with no change in the objective findings, and still needed narcotic pain medication. RX 5, p. 23. Petitioner reported having "residual soreness" after the 2016 surgery but doctors do not treat residual soreness with narcotic pain medication. RX 5, p. 24. The level of pre-accident pain documented in the records and the requirement for narcotics suggest that Petitioner pre-accident pain was worse than he indicated. RX 5, p. 24. He noted Dr. Sclamberg's interpretation of the post-accident MRI. He did not see that Dr. Sclamberg and he interpreted this MRI differently. The MRI findings were consistent with Petitioner's pre- and post-accident complaints. RX 5, p. 25. They were partially consistent with Dr. Sclamberg's findings. He would disagree with the assertion that Petitioner did not return to baseline after the September 2018 accident. He sees no aggravation resulting from that accident. He would not consider Petitioner's account of the accident or his subjective description of his pain as an acute injury. RX 5, p. 26.

On redirect, Dr. Verma testified that the findings on the MRI images were chronic, not acute. RX 5, p. 26.

Petitioner testified he last saw Dr. Sclamberg on January 7, 2020. T. 28. On that date, the doctor again recommended surgery. Petitioner testified he wants to undergo this surgery. He previously had health insurance but the coverage ended in October 2019. Petitioner testified he was not able to maintain the coverage thereafter because he could not afford the COBRA payments. T. 29. Even when he had coverage, he would have had to make a co-payment of approximately $5,000 before undergoing the recommended surgery. He could not afford to make this payment. T. 31.

Petitioner testified he was initially off work from September 28, 2018 to October 21, 2018. He resumed working on October 22, 2018. The work he was assigned to perform

exceeded his restrictions. His shoulder pain was excruciating. He could not perform his job without taking pain medication. He requested lighter duty but was not accommodated. T. 32. He informed Dr. Sclamberg of this and the doctor took him off work. He then began receiving short-term disability benefits. After those benefits expired, he began receiving long-term disability benefits. T. 33. He is still receiving those benefits. The gross monthly payment is $1,544.40. After taxes and other deductions, he nets $1,389.96 per month. T. 34.

Petitioner denied injuring his right shoulder at any time other than on September 19, 2016 and September 27, 2018. T. 34. He continues to experience pain radiating from his right biceps area up to the top of his right shoulder and the right side of his neck. T. 35. The pain is constant. If he rolls onto his right side while sleeping, the pain causes him to wake up immediately. It takes him a while to get back to sleep. He has difficulty performing tasks at home such as sweeping and mopping the floor. He also has difficulty lifting, pushing or pulling items. His pain has worsened a little because he is no longer taking prescription pain medication. T. 36. He last took Oxycodone in January 2020. After he lost his health insurance he was no longer able to pay for this medication. He does not take any over the counter pain medication. He prays to try to relieve his pain. He also avoids performing activities that aggravate his shoulder. T. 37-38.

Under cross-examination, Petitioner testified his 2016 shoulder injury occurred while he was lifting a heavy bag of animal feed. T. 39. After this injury, he resumed full duty for Respondent on July 3, 2017. He settled his workers' compensation claim in August 2017. T. 39. It was that same month, August 2017, that Dr. Sclamberg first imposed work restrictions relative to the right shoulder. T. 39. The doctor imposed those restrictions because he (Petitioner) was experiencing right shoulder pain. He continued to be subject to restrictions until the accident of September 27, 2018. Dr. Sclamberg periodically adjusted his restrictions between August 2017 and September 27, 2018. T. 40. He believes the cage-related restriction remained the same but that his lifting restriction increased from 50 to 75 pounds. If the doctor's records show that the cage-related restriction changed, he would trust those records. T. 41. He was not allowed to stop working when he hit his cage maximum. In 2018, he worked with Respondent's Office of Equity to see whether Respondent could accommodate his restrictions. T. 42. The Office of Equity issued a formal accommodation plan but he does not recall when this occurred. He remembers receiving an Email indicating he was being accommodated but he cannot recall the date the Email was sent. T. 43. At some other point, he requested an accommodation so that he could avoid working on Sundays. He made this request because he is a youth minister and preacher at a church on West Warren Boulevard. He teaches youth church every Sunday and preaches at the 11 AM service every other Sunday. T. 44. Respondent granted his request. He treated with Dr. Padron through September 2018. Dr. Padron prescribed narcotic pain medication for him. T. 46. During the week of September 27, 2018, he was responsible for two rooms. He worked from 6:00 AM to 2:30 PM. He reported the accident to his supervisor, Chad Martin, on September 27, 2018. T. 47. He identified RX 2 as the report form he completed at Martin's direction. He signed this form. T. 48. When he moved the rack away from the wall, the rack rolled normally. Unless there is something obstructing a wheel, the racks typically move easily. T. 49. Nothing was obstructing

a wheel at the time of his accident. T. 49. Between September 2016 and September 2018 he was not involved in any accidents that resulted in injuries. He was involved in a car accident. He knows this accident occurred in June. He injured his back in this accident. He did not injure his right shoulder. He was off work for about a month following the car accident. He has not injured his right shoulder or any other body parts since September 27, 2018. T. 52. He played basketball in high school but no longer has time for that. T. 52.

Tamra Lynn Whittenberg testified on behalf of Respondent. Whittenberg testified she works at Respondent's Center for Comparative Medicine. She has been the manager of husbandry operations for 3 ½ years. T. 55. She oversees animal care technicians, including Petitioner. She is familiar with Petitioner's job duties. Group leaders and supervisors are also under her supervision. She manages 80 to 90 employees. T. 57. She is involved in decision-making when it comes to the question of whether Respondent can accommodate an employee's restrictions. T. 57. With respect to Petitioner, that question arose in April 2017. In was the following April that Respondent's Office of Equity became involved. Petitioner's restrictions emanated from a right shoulder injury. Originally, Petitioner was restricted to 700 cages but it is "really unclear" whether that restriction referred to 700 cages per day, per week, etc. T. 59-60. The restriction was described as "700 cage responsibility." The term "700 cages" would refer to the number of cages the worker has to take care of, in terms of checking, cleaning and changing. An animal care technician who had no restrictions would be responsible for an average of 1,000 cages per day. T. 60. Once Petitioner hit his cage limit, he would be responsible for other tasks, such as sweeping, mopping, stocking, removing trash and animal health checks for employees who were out. T. 61.

Whittenberg testified that, before the Office of Equity became involved in April 2018, Respondent was accommodating Petitioner's restrictions. The Office of Equity is responsible for implementing policies regarding harassment, discrimination and accommodating individuals with disabilities. T. 61. She had worked with this office before the issue of Petitioner's accommodations arose. She worked with the office to determine whether Petitioner's restrictions could be accommodated. T. 62. It was in September 2018 that the Office of Equity made this determination. T. 62. She believes that the Office of Equity determined that Petitioner's cage responsibility would increase to 1,000 but that he would not change out more than 250 cages per day. She cannot be certain on those numbers. T. 63. Responsibility and changing out are two different things. It could be that the Office of Equity made this determination on September 25, 2018. T. 63. The Office of Equity shared its determination with her department and with human resources. T. 63.

Whittenberg identified RX 4 as videos showing individuals moving racks and cages. She was the person who showed these individuals what to demonstrate when the videos were taken. [The Arbitrator viewed the videos.] She is involved in purchasing decisions. She was involved in the decision as to which racks Respondent should purchase. The racks Respondent uses are "high profile" and "very user friendly" in the sense that they "move easily." T. 65. In her opinion, it does not take a lot of force to move the racks. T. 65. The videos accurately

depict the process of moving racks away from a wall. An animal care technician has to move the racks to sweep, mop and check the automatic watering connections. T. 66.

Under cross-examination, Whittenberg testified she has met Petitioner. She would have to check her records to see whether she ever received complaints about Petitioner's job performance. She would describe Petitioner as an "average" employee. T. 67. There was one disciplinary action against Petitioner, maybe in 2017, but she cannot recall the subject of the action. T. 67. Following his 2016 accident, Petitioner returned to work in July 2017. T. 68. Before September 2018, Respondent was accommodating Petitioner's restrictions. In September 2018, she learned that Petitioner had complained to a supervisor about his workload. Petitioner made this complaint based on his restrictions, not because he was hurt. His restrictions were shoulder-related. Moving the racks requires some pushing and pulling. T. 69.

Petitioner was recalled in rebuttal. Petitioner testified he was written up in 2016, before his first accident, because he failed to adhere to certain procedures. He left water running overnight and failed to place a lid on a food bin. T. 71-72. In September 2018, before the accident of September 27, 2018, the Office of Equity approved his 700 cage restriction. The "700" refers to the number of cages he was responsible for on a day-to-day basis. T. 72-73. Dr. Sclamberg had restricted him to 700 cages [sic] on August 24, 2018. He cannot recall the date when the Office of Equity approved this. The approval occurred maybe a few days before the September 27, 2018 accident. However, his supervisor, Chad Martin, was requiring him to be responsible for slightly over 1,000 cages. He complained about this to Martin on Monday, September 24, 2018. He is able to pinpoint this date based on his cell phone.

Arbitrator's Credibility Assessment

Petitioner was an articulate witness. The fact that he has worked for Respondent since 2012 weighs in his favor, credibility-wise.

Respondent maintains that Petitioner lacked credibility because he purportedly changed an answer under cross-examination. Petitioner initially denied being involved in any accidents between September 2016 and September 2018. He then acknowledged being involved in a car accident but could only recall that this accident occurred during the month of June. T. 50-51. He clarified that he injured his back, and not his shoulder, in this accident. The Arbitrator does not view this exchange as undermining his credibility.

Respondent's Section 12 examiner, Dr. Verma, noted some guarding when he examined Petitioner but he described this behavior as pain-related. He did not question the legitimacy of Petitioner's complaints and acknowledged the need for revision surgery.

Respondent contends that Chad Martin's report of September 28, 2018 calls Petitioner's credibility into question. In that report (RX 3), Martin acknowledged that Petitioner reported right arm pain to him the previous day but went on to state that it was not until the following

day, September 28th, that Petitioner told him he had been injured on the job. The Arbitrator does not view Petitioner's reporting as undermining his credibility. Under cross-examination, Petitioner credibly testified he reported the accident to Martin on the day it occurred (T. 47) but, even if Petitioner reported work-related pain rather than an event, that would not automatically call his credibility into question. In Illinois, it has long been held that the word "accident," as used in the Act, is a comprehensive term almost without boundaries in meaning. Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880 (3rd Dist. 1985). An "accident" can be the experience of pain (or, in Petitioner's case, significantly increased pain) while performing a work task. Moreover, the Appellate Court has held that there is no legal authority supporting the position that not reporting an accident on the day it occurred is a reasonable basis for disputing a claim. See Oliver v. IWCC, 2015 Ill. App. LEXIS 946.

Respondent also suggests that Petitioner staged an accident because his need for accommodations was under scrutiny and/or because he realized he needed more care and had already resolved his 2016 shoulder claim. As for the former, Petitioner testified it was his supervisor, Chad Martin, who was requiring him to exceed his restrictions by taking care of 1,000+ cages. As for the latter, there is no indication that Dr. Sclamberg was contemplating active shoulder treatment when he saw Petitioner on August 24, 2018, approximately one month before the accident. In his note of that date, the doctor indicated that Petitioner was still experiencing symptoms, especially at night, and wanted his restrictions updated. He did not recommend any imaging, let alone active care in the form of an injection or surgery. He merely indicated that Petitioner should continue his regimen and return in six months. PX 1.

Overall, the Arbitrator found the opinions of Dr. Sclamberg, Petitioner's treating surgeon, more persuasive than those of Dr. Verma, Respondent's Section 12 examiner. Dr. Sclamberg saw Petitioner on numerous occasions, before and after the accident of September 27, 2018, while Dr. Verma examined him once. Dr. Sclamberg was able to recall Petitioner, having seen him over a three-year period, while Dr. Verma had no independent recollection of him. Dr. Sclamberg operated on the body part that is the subject of the instant claim. Dr. Verma reviewed the October 2018 MRI images but there is no indication he compared those images with the 2016 MRI images. His opinion that the accident of September 27, 2018 did not cause a re-tear is at odds with the radiologist's reading of the 2018 MRI. It is also at odds with his opinion that Petitioner is a candidate for the revision surgery recommended by Dr. Sclamberg. If the accident did not bring about a change in Petitioner's right shoulder anatomy, as Dr. Verma asserted, why did Petitioner become a candidate for a revision procedure after the accident?

The Arbitrator acknowledges that Dr. Sclamberg assumed it required force for Petitioner to move racks while Petitioner admitted the racks had wheels and moved fairly easily. The Arbitrator notes, however, that, at the hearing, Petitioner provided a context for his injury and did not attribute the injury solely to the act of moving one rack. On direct examination, he explained that the accident occurred during a week when he was required to "completely change out" Room 503, meaning that he had to transfer all of the animals in that room from dirty cages to clean ones. He also explained that, while Dr. Sclamberg had restricted the

number of cages he was responsible for (with the doctor's August 24, 2018 note stating "800 cage responsibility"), he was actually having to deal with slightly over 1,000 cages per his supervisor's directive. T. 18, 23. The records from Northwestern Medicine Corporate Health support this testimony. The Arbitrator also notes that the accident occurred on a Thursday, approximately six to seven hours into Petitioner's workday, with Martin's report reflecting that Petitioner worked from 6 AM to 2:30 PM, Monday through Friday. RX 3.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on September 27, 2018?

The Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on September 27, 2018. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible account of the increased work he was assigned to perform during the week of September 27, 2018; 2) Petitioner's credible account of the accident; 3) Petitioner's accident report (RX 2); 4) Chad Martin's accident report (RX 3); 5) the Northwestern Medicine Corporate Health records, which contain detailed histories of the September 2016 accident, the treatment and restrictions that followed that accident and the September 27, 2018 accident; and 6) the history that Dr. Sclamberg recorded on October 16, 2018.

There is really no dispute that Petitioner was performing assigned duties, i.e., moving racks away from a wall in preparation for cleaning, at the time of the accident. The accident occurred on Respondent's premises during Petitioner's normal workday. Petitioner satisfied both the "arising out of" and "in the course of" requirements.

Did Petitioner establish a causal connection between his accident of September 27, 2018 and his current right shoulder condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection, via an aggravation theory, between the accident of September 27, 2018 and his current right shoulder condition of ill-being. In so finding, the Arbitrator relies on the following: 1) the pre-accident records from Drs. Sclamberg and Padron, which support Petitioner's testimony that his right shoulder was stable, albeit not asymptomatic, before the accident; 2) Petitioner's credible account of the increased workload he was assigned during the week of September 27, 2018; 3) Petitioner's credible testimony that his pain level sharply increased after the accident of September 27, 2018; 4) the Northwestern Medicine Corporate Health records, which document the accident and reflect a diagnosis of "acute on chronic pain"; 5) the fact that the providers at Northwestern Medicine Corporate Health initially took Petitioner off work following the accident and then imposed very significant lifting restrictions of desk work and lifting of only 2 to 5 pounds; 6) the fact that the radiologist who compared the October 17, 2018 MRI images with the October 5, 2016 MRI images noted a re-tear of the supraspinatus tendon and a possible tear of the labrum (PX 1); and 7) Dr. Sclamberg's causation opinions.

Illinois law also supports a finding of causation in this case. In Schroeder v. IWCC, 2017 IL App (4th) 160192WC, the Appellate Court emphasized that the "chain of events" principle does not apply solely to claimants who are in pristine shape prior to their work accidents: "If we were to hold that [the principle] only applied where a claimant is in a condition of absolute good health, that holding would contradict years of Illinois precedent concerning pre-existing conditions." The Court cited International Harvester v. Industrial Commission, 93 Ill.2d 59, 63-64 (1982), noting that the health of the claimant in that case was "anything but good." The Court also cited Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003) for the proposition that an accident need only be a cause or a condition of ill-being for a claimant to recover under the Act. In the instant case, the evidence supports the conclusion that the accident of September 27, 2018 significantly increased Petitioner's pain and brought about a change in his ability to work. That other factors, including the residual disability from the 2016 work injury and the increased workload, played a role does not bar recovery. A claimant is not required to exclude all other possible contributing causes of his injury.

If anything, the facts of the instant case more clearly compel a finding of causation than those of Schroeder. The claimant in Schroeder learned that she needed a third spinal surgery while she was off work, nine months before her accident. After the accident, her surgeon again told her she needed this surgery, although he planned to perform the procedure in a somewhat different manner. Petitioner, in contrast, was on a maintenance regimen of medication prior to the September 27, 2018 accident. When Dr. Sclamberg saw him on August 24, 2018, he did not recommend any imaging or active care. It was only after the September 27, 2018 accident that the doctor recommended a revision right shoulder arthroscopy. Respondent's examiner, Dr. Verma, concurred and never suggested that Petitioner was a candidate for this surgery before the accident.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims two medical bills: 1) RX Development Associates, $1,506.36 (Nulido patches prescribed by Dr. Sclamberg on July 26, 2019, PX 2) and 2) Persistent Med, $2,924.68 (topical medication prescribed by Dr. Sclamberg on July 26, 2019, PX 3). Respondent disputes this claim based on its accident and causation defenses. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Respondent did not offer any utilization review evidence and its examiner, Dr. Verma, did not criticize any aspect of Dr. Sclamberg's care. RX 5, Verma Dep Exh 2.

The Arbitrator finds that the medication prescribed by Dr. Sclamberg was reasonable and necessary. The Arbitrator awards the claimed expenses of $1,506.36 and $2,924.68.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from September 28, 2018 through October 21, 2018 and from November 17, 2018 through the hearing of September 17, 2020. Respondent disputes this claim based on its accident and causation defenses. The parties agree

that Respondent is entitled to Section 8(j) credit for the $41,698.80 in non-occupational disability benefits it paid. Arb Exh 1.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and casuation. Based on the records from Corporate Health and Dr. Sclamberg, the Arbitrator initially finds that Petitioner was temporarily totally disabled from September 28, 2018 through October 21, 2018. Petitioner testified he resumed working on October 22, 2018 but was asked to exceed his restrictions and stopped working due to pain on November 17, 2018. The Arbitrator also finds that Petitioner was temporarily totally disabled from November 20, 2018 (the date Dr. Sclamberg took him off work) through the hearing of September 17, 2020. The Arbitrator declines to award benefits for the period of November 17, 2018 through November 19, 2018, as requested by Petitioner, because Dr. Sclamberg did not take Petitioner off work until November 20, 2018. PX 1.

Respondent is entitled to Section 8(j) credit for its payment of $41,698.80 in non-occupational disability benefits, in accordance with the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the revision right shoulder surgery recommended by Dr. Sclamberg. Respondent disputes this claim based on its accident and causation defenses. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Respondent's examiner, Dr. Verma, agreed that Petitioner is a candidate for a revision arthroscopy, although he did not link the need for this surgery to the September 27, 2018 accident. RX 5, p. 19.

The Arbitrator awards prospective care in the form of the revision right shoulder surgery recommended by Dr. Sclamberg.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC024593
Case Name	JONES, NICOLE M v. HCR MANOR CARE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0094
Number of Pages of Decision	18
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Richard Lenkov

DATE FILED: 3/15/2022

/s/Deborah Baker, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICOLE JONES,

Petitioner,

vs. NO: 14 WC 24593

HCR MANORCARE,

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 an accidental injury arising out of and occurring in the course of her employment, whether her condition of ill-being is causally related to her employment, entitlement to temporary total disability benefits, entitlement to medical expenses, and entitlement to permanent disability benefits, and being advised of the facts and law, changes the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission observes it is apparent from the record that both parties failed to redact personal identity information as such protected information appears repeatedly in multiple exhibits, including Petitioner's Exhibit 4, Respondent's Exhibit 4, Respondent's Exhibit 24, and Respondent's Exhibit 29. *See* T. 252-253. The Commission cautions counsel to adhere to Supreme Court Rule 138. *Ill. S. Ct. R. 138* (eff. Jan. 1, 2018).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 2020 as changed above is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings

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

March 15, 2022

/s/_*Deborah J. Baker*

DJB/mck

O: 2/23/22

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/s/_*Stephen J. Mathis*

/s/_*Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0094

ONES, NICOLE
Employee/Petitioner

Case# **14WC024593**

HCR MANORCARE
Employer/Respondent

On 3/9/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY GRAHAM SLEFO
161 N CLARK ST SUITE 2100
CHICAGO, IL 60601

2542 BRYCE DOWNEY & LENKOV LLC
RICH LENKOV
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nicole Jones
Employee/Petitioner
v.
HCR Manorcare
Employer/Respondent

Case # **14** WC **24593**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 17, 2019 and December 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [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] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **August 22, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**19,541.08**; the average weekly wage was $**375.79**.

On the date of accident, Petitioner was **25** years of age, ***married*** with **1** dependent child.

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**.

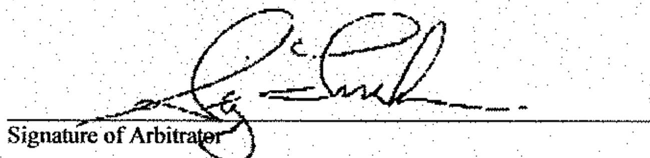
Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF HER EMPLOYMENT WITH RESPONDENT ON AUGUST 22, 2012 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL-BEING IS CAUSALLY CONNECTED TO HER EMPLOYMENT, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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



Signature of Arbitrator

March 5, 2020
Date

ICArbDec p. 2

MAR 9 - 2020

Statement of Facts

Petitioner Nicole Jones testified that on August 22, 2012, she had been employed by Respondent HCR Manorcare as a Certified Nursing Assistant for 3 months Petitioner recognized RX 5 as the Employee Handbook. She identified her signature acknowledging receipt on April 29, 2012 (RX 6). Petitioner began work for Respondent on April 29, 2012. Her application for employment notes she had less than a year of experience, having received her certification in July 2011. Her previous employment was in sales. She reported being terminated from her job at Sketchers without notice while on medical leave (RX 4). She testified that on August 22, 2012, just before 2:00 PM, she was attempting to transfer a patient from a wheelchair to a toilet when the patient lost her balance and started to fall backward. As she fell, Petitioner grabbed the patient's gait belt and used the right side of her body to push the patient onto the toilet. Petitioner explained that she had both hands on the gait belt and used all of her weight to push the patient with her right leg. The patient weighed about 170 pounds. Petitioner weighed about 145 pounds. As she prevented the patient from falling, the patient's body weight was transferred onto Petitioner's right leg. She testified she felt a pull in her right leg.

Petitioner testified that after the patient sat down, she walked out of the bathroom and into the hallway to get help from the nurse. Within a few steps into the hallway, she testified she felt a popping sensation in her right hip. She testified she was told to finish her shift. Petitioner finished her shift at 3:00 PM but stated she could barely walk. Petitioner completed an incident report on August 23, 2012. The accident is listed as 8/22/12 at 10:00 AM. The description is "As I was walking down the hallway, I heard a pop in my hip which caused immediate pain" (RX 1). Petitioner testified the nursing supervisor instructed her not to provide any other details. Petitioner had previously reported an incident on July 6, 2012 when she slipped in the shower. The report has very specific details (RX 4). Petitioner signed a Statement of Witness that says, "On Sunday 8/19, my leg was bothering me when I was walking. I rested and came to work on Wed. 8/23. During my shift, I was walking and felt a pop in my leg" (RX 2). The statement was typed by HR. Petitioner testified that she signed it, but did not read it. She testified it is inaccurate. Petitioner's time records note she did not work on August 19, 2012. She worked from 2:39 AM to 2:23 PM on August 22, 2012 (RX 3).

Debra Durham testified that she is Senior Regional HR Manager for Respondent. She identified RX 2, RX 3, RX 5, RX 7. She testified that managers are instructed to take detailed accident reports. It is important so that it does not happen to other employees.

Petitioner saw her primary care physician, Dr. Michael Rivera, at St. Charles Family Medical Center on August 23, 2012 (PX 1). Ms. Jones testified that she explained to Dr. Rivera that she was transferring a patient and felt something in her right hip. The records state: "history of hip pain, chronic and tolerable, rest usually helps recovery. For past four days pain severe, exacerbated from lifting at work, progressively harder to walk and weight bear. Works as CNA, 12 hour shift, pain increased as shift occurred." X-rays noted mild retrolisthesis in the lumbar spine. Right hip x-rays were unremarkable. Dr. Rivera assessed sacroiliitis and a strain. He ordered physical therapy. He took Petitioner off work (PX 1).

Petitioner testified she did not have chronic hip pain. She testified that she treated for hip pain in 2009 leading into 2010 during her pregnancy. She testified that she hadn't had ongoing hip pain since that time. Medical records note prior care at St. Charles Family Medicine in 2010 for cervical epidurals. Petitioner had a history of migraine headaches, epilepsy and fibromyalgia (RX 29). She was seen May 21, 2010 for back and neck pain on the right side (PX 4).

Petitioner underwent physical therapy at ATI Physical Therapy beginning August 23, 2012 (PX 3). She noted the date of injury/onset was October 22, 2012. She reported she had these symptoms previously. The August 23, 2012 note records the nature of injury as "walking at work, hip popped with sharp pain, did not fall. Reports having to pivot on right leg just before hip popped while transferring a patient from commode to chair as patient almost fell." The hand-written note on 8/31/12 states "Patient got hurt at work, but states it was not related to work" (PX 3). Petitioner underwent physical therapy at ATI through September 20, 2012 (PX 3).

Petitioner testified that Dr. Rivera referred her to Castle Orthopedic. She was seen on September 4, 2012, complaining of severe right hip pain (PX 2). The history recorded was that "the pain began approximately two weeks ago when she was walking at work and felt a snapping in the right hip." Physical examination noted she was using a crutch to help her ambulate. She demonstrated loss of motion and strength due to pain. She was sent for an MR arthrogram (PX 2). The MR arthrogram was negative for any pathology (PX 4). On September 21, 2012, it was recommended that she undergo a CT scan of her pelvis and an MRI of her lumbar spine. She was prescribed Flexeril and a Medrol Dosepak (PX 2). The September 27, 2012 MRI noted progressive degenerative changes at L3-4 and L4-5 with annular tears. The CT scan of the pelvis on September 27, 2012 was unremarkable (PX 1).

Dr. Rivera referred Petitioner to Midwest Orthopedics at Rush (PX 4). She saw Dr. Joshua Blomgren on September 27, 2012. She gave a history that "she was at work when she was walking and felt a loud pop within her hip on August 22, 2012. She reported that this was preceded by several weeks of fatigue in her hips. Dr. Blomgren notes pain out of proportion for any abnormality. He has no explanation for the etiology of her pain. He notes the possibility of a labral tear due to the history of a pop and a feeling of instability. There could be an abdominal cause which is causing referred pain. After reviewing the CT scan which showed no evidence of acute process which explains the severe pain, he referred her to Dr. Shane Nho, for a possible labral tear (PX 4).

Petitioner saw Dr. Nho on October 5, 2012 (PX 4). He recorded a history of walking to work and felt problem. D. Nho's impression was right hip myofascial pain. He stated the MRI demonstrates evidence of femoral acetabular impingement with a hip labral tear. He performed an injection in the right hip. Dr. Nho referred her to Dr. Matthew Jaycox, at Rush Pain Center, for pain management (PX 4).

Petitioner saw Dr. Jaycox on October 19, 2012 with a history of "two weeks ago while working had a popping in right hip. States always has achiness in hips." His diagnosis was persistent right hip pain secondary to trauma." (PX 8). He prescribed a right hip injection which was performed at Rush Oak Park Hospital on November 7, 2012. The history noted was "restraining a resident in a group home with assistance of other staff members" (RX 27). Dr. Jaycox also recommended she undergo a lumbar epidural steroid injection, which she underwent on November 30, 2012. On December 17, 2012, Dr. Jaycox, who refilled her medications and referred her for another injection in the right hip and another lumbar epidural steroid injection. She underwent those injections on January 11, 2013 (PX 8). Petitioner testified that she only received temporary, not permanent relief from the injections. Petitioner reported an injury on January 13, 2013 when she put her foot down getting out of her car and slid backward onto her back. She reported a contusion and bruise to her back (RX 24).

Petitioner was evaluated by Dr. Stanos at RIC on January 22, 2013. The history is: August 22 at work, walking in the hall, right leg forward, felt pop. Prior to that occasional popping/stuck. Took bath and pain reduced." Dr.

Stanos conducted an extensive examination. His assessment was severe right groin and buttock pain, status post possible internal hip derangement, impingement syndrome, SI joint disfunction, severe myofascial pain right lower abdomen. He discussed an interdisciplinary approach with a psychologist. He stated patient does not seem to be a surgical candidate given her significant guarding and diffuse myofascial pain. Nothing to suggest a focal finding in the hip joint (PX 5). Petitioner saw Dr. Nho on January 29, 2013. Petitioner was reluctant to undergo full time physical therapy as she is unable to take off work. He noted worsening of her symptoms. He stated he was concerned that any operative intervention would be unlikely to provided significant improvement (PX 4) She follow up with Dr. Jaycox who recommended additional epidural steroid injections, which she underwent on February 1, and February 19, 2013. Petitioner advanced complaints in the left hip (PX 8). On February 21, 2013, Petitioner was seen at the Emergency Department. She reported having had a recent injection with exacerbation of chronic lumbar pain (PX 11).

Dr. Nho performed right hip surgery on February 28, 2013. (PX. 4). The operative findings revealed a tear in the anterior superior labrum, a small pincer lesion and large cam lesion. Petitioner began physical therapy at Dynamic Rehabilitation on March 18, 2013. On May 1, 2013, the therapist notes Petitioner has turned the corner with improving gait, balance and strength. He recommends 6 more sessions (PX 6). Petitioner continued follow up with both Dr. Jaycox and Dr. Nho Dr. Jaycox performed trigger point injections in the right hip on June 12, 2013 (PX 8). On July 2, 2013, Dr. Nho stated she is doing really well and was released to return to full duty without restrictions (PX 4). Petitioner was seen by Dr. Dugan for a consult on July 12, 2013. She noted a history of walking normally at work and felt pop in right hip. Denied fall or trauma (PX 12). On August 6, 2013, Dr. Nho discharged her from his care for the right hip. She could work without restriction. He recommended she continue to follow up with Dr. Jaycox for pain management. On August 16, 2013, Petitioner reported that she fell down off a curb after walking several hours at the mall (PX 12). On August 21, 2013, the report is that she now has 9/10 pain and could barely walk. There was concern with a re-tear of the labrum. He noted the recent finding of a left labral tear. He requested updated imaging. Petitioner had an injection into the left hip on August 29, 2013 (PX 12).

Petitioner testified that she was in a lot pain in her left hip. She had been walking over the last year, as she had been overcompensating on the left due to the pain in the right hip. Dr. Nho recommended an MRI of her left hip. On September 10, 2013, Dr. Nho read the MRI as showing a labral tear in the left hip (PX 4). Petitioner had additional MRI studies performed. Dr. Jaycox, performed an epidural steroid injection at L3-L4 on November 21, 2013 and on the left hip on December 6, 2013 (PX 8). On December 10, 2013, Dr. Nho noted a tear of the left labrum and a disc herniation at L3-4. He noted a lumbar injection provided no relief. He did not believe that left hip surgery would benefit the Petitioner given the lack of improvement after the right hip surgery. He recommended follow up with Dr. Jaycox for pain management and Dr. Goldberg for the lumbar spine (PX 4).

Petitioner underwent additional epidural steroid injections at L3-4 on January 3, 2014 and January 31, 2014 (PX. 8). Petitioner restarted therapy on January 30, 3014 at Dynamic Rehabilitation (PX 6). On February 4, 2014, Dr. Nho recommended arthroscopic repair of the left labral tear in light of the lack of improvement. He suggested a spinal or regional pain block (PX. 4). She was seen at Northwestern for acute increase in her left hip pain on February 17, 2014 and again on February 28, 2014 (PX 12). At that admission, she underwent a psych consult for possible Suicidal Ideation. She stated she had thought of crashing her car into a truck. She noted she did not have support from parents or her husband. She stated they had a tumultuous relationship with numerous fights with threats of divorce (PX 12). She underwent the left hip surgery on March 19, 2014. The operative findings revealed a tear in the anterior superior labrum, a small pincer lesion and large cam

lesion (PX 4). On April 1, 2014, Dr. Nho recommended physical therapy and restricted her from working (PX 4). She was using a walker or crutch to ambulate at the time. Dr. Nho recommended continued follow up with Dr. Jaycox for pain management and physical therapy (PX 4). On May 9, 2014, Dr. Nho advised Petitioner she could be up as tolerated without braces or crutches and be full weigh bearing (PX 4). On July 18, 2014, Dynamic Rehabilitation included right hip therapy along with the left (PX 6). Petitioner testified that she had improvement in the left hip and was able to ambulate on it, but the right hip pain never went away.

On October 30, 2014, Ms. Jones saw Dr. Benjamin Domb at Hinsdale Orthopedics for a second opinion (PX 10, RX 26). She provided a history of transferring a patient. When the patient began to move, she put all the pressure on her right hip and felt a pop. Dr. Domb recommended a diagnostic injection on the right hip, which she underwent on November 5, 2014, and an MRI, performed November 10, 2014. On December 1, 2014, Dr. Domb read the MRI as showing no labral tear. There were some mild arthritic changes. He stated there was not anything surgical recommended. He advised Petitioner to follow up with her pain management specialist. He suggested an FCE (PX 10, RX 26).

Petitioner continued treatment with Dr. Jaycox monthly (PX 8). He noted on June 23, 2014 that Petitioner had returned to work and was tolerating it somewhat. On November 24, 2014, Petitioner was seen for follow up from work related injury while walking as CNA in 2012. She notes she is working with lawyer to develop workers' compensation case. Dr. Jaycox wrote that she is separated from her husband. Living with parents and 5 year old daughter (PX 8).

Petitioner testified she was terminated in July 2014 for inability to perform the job for medical reasons. It was about 2 weeks after she returned to work. She was disciplined for a patient falling in the shower. She could not remember any further discipline. Petitioner received a warning October 8, 2012 for leaving a high fall risk patient unattended in the dining room (RX 7). She received a written warning on October 25, 2013 for failing to listen to a patient's wishes (RX 8). On December 21, 2013, she received a second warning for a no call/no show (RX 9). She received a warning on July 15, 2014 for absenteeism. She had called in sick beyond the allowable 2 days (RX 10). On July 18, 2014, Petitioner was discharged after failing to give a patient a shower (RX 11). The notice notes she engaged in a verbal confrontation with the RN. In the report it states that she confirmed the incident and dialogue happened, stating she has difficulty working with several RNs and CNAs. She became verbally aggressive with the supervisor. She was suspended and terminated (RX 11). Petitioner testified she did not have recollection of these incidents. The Application for Adjustment of Claim was filed July 22, 2014 (RX 23).

Debra Durham testified that RX 7, RX 8, RX 9 and RX 10 are disciplinary notices from Petitioner's personnel file. Employees may not sign them if they disagree with the action being taken. There is a comment section that the employee can use if they feel something was left out or the action was not right. She testified that Petitioner was not terminated because her injury prevented her from doing her job. She was terminated pursuant to the Respondent's progressive disciplinary policy. There is an investigation conducted for the disciplinary actions. Ms. Durham denied that Unemployment was advised Petitioner was terminated because she could not fulfill her job duties due to her medical condition. She denied that the location was often short-staffed.

Theresa Fortner testified that she currently works for Amita Health. She worked for Respondent as Chief Nursing Officer from June 2014 through November 2014. She was in charge of discipline. She was a supervisor for Petitioner. She testified that she wrote RX 10 on July 15, 2014, reflecting excessive

absenteeism. She warned Petitioner that further violation could result in termination. Petitioner did not tell her she was absent due to a medical condition. There was no mention of a medical condition limiting Petitioner's activity. Petitioner did not add any comment. She signed the document. Ms. Fortner identified RX 11 as a Warning Notice she signed on July 18, 2014. This was the result of an investigation, speaking with the nurse. She testified she spoke with Petitioner. Petitioner was verbally aggressive. Petitioner was terminated for not doing her job and her confrontational aggressive demeanor when talked about it. Petitioner did not tell her she was unable to perform her duties due to a medical condition. She did not provide any employee comments. She does not recall if Petitioner was told she was discharged on July 18, 2014.

Petitioner continued under the care of Dr. Jaycox and at Northwestern Medicine. Treatment was for her complaints in the hips and back as well as extensive treatment for migraine headaches, cervical spine pain and abdominal problems. Petitioner had a history of epilepsy, seizures and migraine headaches. She was treated for left lower quadrant pain in October 2013. She gave a history of IBS since 2006 (PX 11). She had additional abdominal treatment in May 2014 and July 2014 (PX 11). Petitioner had extensive treatment for her cervical spine and headaches beginning in January 2015. She was hospitalized from January 29, 2015 through February 12, 2015. She noted she was suffering marital stress (PX 11). Petitioner saw Dr. Jaycox and Dr. Young (PX 8). Petitioner was in a motor vehicle accident in April 2015 with injury to her cervical spine. Dr. Jaycox notes the police found her at fault. She had multiple epidural steroid injections and facet blocks in the cervical spine from February 2015 through January 2016 (PX 12). Petitioner saw Dr. Lubenow for pain management on June 4, 2015. His note states the crashing of the motor vehicle is undetermined whether accidental or purposely inflicted (PX 8). On March 8, 2016, Petitioner was seen for aura which could precede a seizure. She reported stress with multiple family members and her husband away (PX 11). Petitioner had additional treatment for her neck and migraines in 2017, March 2018 December 31, 2018 (PX 11, PX 12).

Petitioner also has had additional pain management for her low back and hips from Dr. Jaycox (PX 8). She had chiropractic treatment at the Lindstrom Chiropractic Clinic from March 2016 through June 2016 for her cervical, thoracic, lumbar spine and hips and 4 additional visits from May 2017 through August 2017 (PX 9). Dr. Jaycox recommended she undergo a functional capacity evaluation, which she underwent at ATI Physical Therapy on April 13, 2016. The evaluation was noted as Valid and released her to the light physical demand level. Petitioner's duties as a CNA were considered medium (PX 3). Dr. Jaycox imposed permanent restrictions based on the FCE results (PX 8). Petitioner underwent an opioid weaning in October 2016 (PX 12). She noted she has had anxiety for 7 years since her father's motorcycle accident and death and from caring for her daughter and mother (PX 12). On October 24, 2016, Dr. Jaycox noted a recent right hip MRI showed no change. Petitioner requested a referral to a hip surgeon (PX 8). On January 13, 2017, Dr. Jaycox notes that she requires a crutch for ambulation (PX 8).

On January 19, 2017, Ms. Jones returned to Dr. Domb. Petitioner wants a total hip replacement. Dr. Domb notes she is too young and with minimal arthritis changes. He referred her to Dr. Kris Alden for recommendations (PX 10). On February 9, 2017, Dr. Alden stated she was not a candidate for a hip replacement. There are no bony abnormalities or degenerative changes. Her 24/7 pain is not typical for arthritis. The MRI shows there is maybe some type of labral etiology. Petitioner told Dr. Alden that her pain doctor was strongly in favor of a hip replacement. Dr. Alden notes Petitioner stated she typically uses a crutch to ambulate, but is not using any assistive devices today (PX 10).

Petitioner testified that she has continued to treat with Dr. Jaycox for pain management and sees him approximately every three months. On May 20, 2019, she noted a recent 1/31/19 MRI of the right hip. She said

she has seen multiple orthopedic surgeons who all refuse to proceed with a right hip replacement. On August 15, 2019, Dr. Jaycox noted that due to the persistent nature of her pain, a trial spinal cord stimulator is warranted and reasonable (PX 8).

Petitioner testified that the medical treatment she underwent first went through Blue Cross Blue Shield, which she had through Respondent. After she was terminated in July 2014, her treatment was covered by Blue Cross Blue Shield through her husband's employer.

Ryan Raymond testified that he works for Litigation Solutions. He identified RX 19 and RX 20 as Digg-it reports of Petitioner's social media and Facebook posts. PX 19 shows photos from St. Thomas on July 2, 2014. PX 20 includes Petitioner attending her daughter's dance recital 5/07/18 and photos from her ship leaving Cozumel 3/23/18. Petitioner testified that this was a cruise. She was not active and did not leave the ship. There are posts on a neighborhood message board for Montgomery, IL dated June 2, 2016, November 8, 2016 and May 19, 2017 soliciting clients for a cleaning service and January 2018 endorsements stating Nichole Smith-Jones is great (PX 20). Petitioner testified she did not do any cleaning. She posted these requests for a cleaning service run by her cousin Monica. She did not know anything about the service and would simply forward responses to her cousin.

Mr. Raymond also identified RX 14 and RX 16 as video surveillance of Petitioner taken December 2016. The video shows Petitioner walking without any crutch or apparent difficulties on December 9, 2016. She is placing and removing cleaning supplies from the back of her car. She is also seen sitting on a high stool without assistive devices and without any apparent problems moving her feet (RX 14). Petitioner is seen walking briefly without a crutch on December 16, 2016. On December 21, 2016, she is walking without a crutch and without any difficulty on a day with heavy snow cover on the ground. She is again seen removing cleaning supplies from her car. During all video she is wearing gym shoes without any braces or assistive devices (RX 16).

Petitioner testified that sitting for long periods of time was one of the hardest things to do, as she could feel the pain in her right hip starting to radiate up her back and down the side of her right leg. She no longer has left hip pain. She has difficulty standing because she is unable to put all of her weight on her right leg and she has fallen in the past due to her right leg giving out or the shooting pain that goes down her leg. She uses a crutch to ambulate on a daily basis because she is unable to comfortably stand without it. The Arbitrator notes that Petitioner was using the crutch at both hearings in this matter and needed assistance to step up onto the platform to the witness stand. She testified that she typically stays home due to the pain.

Petitioner testified that she lives with her husband and daughter. She has difficulties with activities of daily living, such as getting dressed. She has weather sensitivity. The cold exacerbates the pain in her joint, which causes stiffness. She can no longer live a regular life due to the condition of her right hip. She cannot come out and play with her nine-year-old daughter and has to rely on her spouse to help with simple tasks. Petitioner testified that she has been unable to work since being terminated by Respondent because she is unable to walk in the way that she would need to be able to for work. She did attempt to return to work at Clearbrook, during which time she was a home care worker. She testified she was not able to continue work due to pain and not being able to walk and sit for a long period of time. She testified that surgery did not fix the pain. Injections did not fix it. Therapy did not fix it. Her pain has gotten progressively worse over the past year and half or two years.

Petitioner was examined by Dr. Troy Karlsson at Respondent's request on July 27, 2015. Dr. Karlsson testified by evidence deposition taken March 11, 2019 (RX 21). He testified that Petitioner gave a history of injuring her right hip when transferring a patient from a chair to the commode and the patient began to throw herself down, so she supported the patient and one or two minutes later when walking down the hall felt a pop in her right hip. She denied problems with her hip or back prior to August 22, 2012. Physical examination noted tenderness over the soft tissues of the front of the right hip even to light touch and tenderness over the entire lateral aspect of the right hip and buttock on the right side. Dr. Karlsson opined that her subjective complaints were beyond any objective findings. He diagnosed bilateral cam and pincer lesions of the hip with labral tearing and status post-surgical treatment for both sides. Pain complaints were out of proportion to expected problems from what was found on her diagnostic testing. This is referred to as symptom magnification. Dr. Karlsson opined that her complaints were not causally related to an injury on August 22, 2012. He did not find a specific injury on that date. He noted the medical histories were of a non-traumatic event until Dr. Domb in October 2014. He opined that no work restrictions relating to the bilateral hips were necessary. Dr. Karlsson opined that the treatment Petitioner underwent was not causally related. Based on the lack of improvement, her surgery was not necessary but the choice to try it given her symptoms was reasonable. He found Petitioner at maximum medical improvement and not in need any further treatment for her hips (RX 21).

Dr. Karlsson testified that he had reviewed physical therapy records from ATI, but did not review the note from August 23, 2012 which included the nature of the injury as walking at work and her hip popped with sharp pain, and just before the hip popped she was pivoting on her right leg while transferring a patient from a commode to a chair as the patient almost fell. Dr. Karlsson testified that the mechanism of injury she reported to him could cause a labral tear, accelerate or worsen a tear that is already present with or without a pincer lesion. Dr. Karlsson noted a pincer lesion could make it more likely that the tear could occur. Dr. Karlsson further testified that twisting or catching a patient could also potentially cause the labral tear (RX 21).

Dr. Richard Noren examined Petitioner at Respondent's request on September 20, 2018. He testified by evidence deposition taken February 14, 2019 (RX 22). He testified he is an anesthesiologist with a board certification in anesthesia and pain management. Petitioner gave Dr. Noren a history of injuring her left hip on August 22, 2012 when she was transferring a patient and, as the patient stood, the patient started to fall, and she had to use her right leg to support the patient and she felt a pop in her right hip. She described it as severe pain and stated that three years prior she had hip pain throughout her pregnancy. Dr. Noren took her symptoms, performed a physical examination and reviewed medical records. He noted Petitioner denied that she and her husband were ever divorced or separated. This was inconsistent with the November 2014 office note from Dr. Jaycox. Dr. Noren diagnosed Ms. Jones with musculoskeletal pain associated with her right hip, as well as opiate-induced hyperalgesia and possibile opiate addiction. Dr. Noren also diagnosed the possibility of Munchausen Syndrome. Dr. Noren opined that the medications Ms. Jones is currently prescribed are unwarranted and should be weaned. He noted that the use of three different opiate analgesics is not consistent with current opiate prescribing guidelines. Dr. Noren reviewed the functional capacity evaluation. He testified that whether the results of the FCE are related to the alleged work injury is unclear. Based upon the records he reviewed, there is a question as to whether or not an acute injury to her right hip occurred (RX 22).

Dr. Noren opined that Petitioner's condition was pre-existing to her injury on August 22, 2012. He questioned whether there was an accident on that date. Dr. Noren noted that the radiologist reports that he reviewed of her hip MRI did not show an acute pathology to support surgical intervention. Dr. Noren opined that the injections received by Ms. Jones were unrelated to her injury of August 22, 2012 and rather due to her pre-existing condition. The basis for his opinion was his review of the radiologist's reports. Dr. Noren testified that he did

not know if he reviewed the operative report from the right hip surgery. He noted that he is not an orthopedic surgeon and the necessity of surgery is outside of his expertise. He testified it was controversial due to the records he reviewed. Dr. Noren testified that the mechanism of the injury reported by Ms. Jones in the August 23, 2012 note from ATI Physical Therapy, which stated that she was walking at work and her hip popped with sharp pain, and just before was pivoting on her right leg while transferring a patient from a commode to a chair as the patient almost fell, could have caused or aggravated a right hip labral tear (RX 22).

Conclusions of Law

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980). A claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of" employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified that on August 22, 2012, she was attempting to transfer a patient from a wheelchair to a toilet when the patient lost her balance and started to fall backward. As she fell, Petitioner grabbed the patient's gait belt and used the right side of her body to push the patient onto the toilet. Petitioner explained that she had both hands on the gait belt and used all of her weight to push the patient with her right leg. As she prevented the patient from falling, the patient's body weight was transferred on to her right leg. She testified she felt a pull in her right leg. Petitioner testified that after the patient sat down, she walked out of the bathroom and into the hallway to get help from the nurse. Within a few steps into the hallway, she testified she felt a popping sensation in her right hip. If Petitioner's testimony is credible, this incident would be an accident arising out of and in the course of her employment. Respondent contested this matter on the basis that this description of the events of August 22, 2012 is contrary to the bulk of the evidence presented. The Arbitrator notes that Petitioner's testimony is not supported by the accident report or the multiple medical histories for over a year, except for a single reference to moving a patient contained in a physical therapy note.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Having observed the Petitioner and witnesses testify and reviewed the evidence, the Arbitrator finds that Petitioner was not credible. The record shows that she has been contradicted by the greater weight of the evidence on virtually every assertion that she has made.

With respect to the claim of injury moving a patient, Petitioner's accident reporting and medical histories do not support her version of events. St. Charles Family Medical Center on August 23, 2012: "History of hip pain, chronic and tolerable, rest usually helps recovery. For past 4 days, pain severe, exacerbated from lifting at work, progressively harder to walk and weight bear. Works as CNA, 12hr shift, pain increases as shift occurred." ATI Physical Therapy on August 23, 2012: "The patient's condition has existed for over 90 days. Walking at work, hip popped with sharp pain, did not fall. Pt. limped around finishing her shift. Reports having to pivot on right leg just before hip popped while transferring a patient from commode to chair (not wheelchair to toilet) as patient almost fell." They also note she had symptoms previously. Castle Orthopedics & Sports Medicine note on September 4, 2012 "This is a 25-year-old female who presents today complaining of severe right hip pain. The pain began approximately 2 weeks ago when she was walking at work and felt a snapping in the right hip." Dr. Joshua Blomgren on September 27, 2012: "This is a 25-year-old female who presents for evaluation of right hip pain. The patient notes that she was at work when she was walking, and she heard and felt a pop within her hip. She states that this occurred on 08/22/2012. This was preceded by a few weeks of what the patient describes as a 'fatigued' feeling in her hips. The patient noted sudden onset of a sharp pain in the right hip." Dr. Shane Nho on October 5, 2012: "Nicole Jones is a 25 year-old certified nursing assistant who reports that she had a history of right hip pain and popping. She said she would get occasional achiness after overuse. She said that on August 22, 2012, the patient was walking to work. She said she felt a popping." Rush Oak Park Hospital on November 8, 2012: "This is a 25-year-old female who was working essentially as a patient care technician in an assisted living environment and, in the normal course of her duties, became injured while restraining a resident in a group home with the assistance of other staff members. She felt shearing pain radiating into her right hip and down her right leg, was evaluated by a number of practitioners..." Dr. Steven Stanos, Rehabilitation Institute of Chicago on January 22, 2013: "Aug 22 at work, walking in hall, right leg forward felt pop, severe pain 'centralized' in deep hip." Dr. Sheila Dugan, University Physical Medicine & Rehabilitation on July 12, 2013: "Nicole Jones is a 25 year old female who presents with R hip pain. Patient was walking normally at work in August 2012 and felt a pop in her R hip. Denies falls, trauma at the time." Finally on October 30, 2014, after her termination by Respondent and the filing of her claim, Dr. Domb records "Patient is a 27 y/o F, who presents with right hip pain since 8/22/12, she is a nurse aid, and she was transferring a patient when the patient starts to move and she put all the pressure on her right hip and she felt a pop." However, at trial she testified she only felt a pull and the pop occurred after walking in the hallway. Claimant's "varied and inconsistent histories of the incident undermine her claim that she suffered accidental injuries arising out of and in the course of her employment.

Petitioner's lack of consistency, undermining her credibility is exhibited in multiple other aspects of her claim. Petitioner claims that her accident reports omit any information about moving a patient and simply note the pop while walking because her supervisors told her to omit these details. There is no logical reason for them to do so. The notion is specifically denied as contrary to policy by Respondent's witnesses. Petitioner's version of her termination is also contradicted by the Respondent's witnesses and the personnel file including the disciplinary write-ups and investigation notes.

Petitioner's testimony that she had no hip problems prior her alleged accident other than during pregnancy is contradicted by the evidence. She admitted to prior hip pain during pregnancy in 2009. On August 23, 2012, Petitioner signed and dated a Statement of Witness form that stated "On Sunday 8/19, my leg was bothering me when I was walking. I rested and came to work on Wed 8/23. During my shift I was walking and felt a pop in my leg." On August 23, 2012, the St. Charles Family Medical Center history stated "History of hip pain, chronic and tolerable, rest usually helps recovery. For past 4 days, pain severe, exacerbated from lifting at work, progressively harder to walk and weight bear. Works as CNA, 12hr shift, pain increases as shift

occurred." The ATI physical therapy note indicates "had symptoms previously." On September 27, 2012, the history provided to Dr. Blomgren stated "The patient notes that she was at work when she was walking, and she heard and felt a pop within her hip. She states that this occurred on 08/22/2012. This was preceded by a few weeks of what the patient describes as a 'fatigued' feeling in her hips. Dr. Jaycox on October 19, 2012: "two weeks ago while working had a popping in right hip. States always has achiness in hips," Dr. Stanos noted on January 22, 2013: "August 22 at work, walking in the hall, right leg forward, felt pop. Prior to that occasional popping/stuck. Took bath and pain reduced." Dr. Noren opinion that Petitioner's right hip complaints pre-existed her August 22, 2012 accident is clearly established by her own medical histories.

Petitioner's statements to Dr. Noren dismissing any insinuation that she had marital problems in repeated contradicted by statements in her medical records. Dr. Jaycox has a hand-written notation that she is separated from her husband. The records repeated note separation, stress and a tumultuous relationship with threats of divorce and lack of support from her husband. She also references family stress with her parents and raising her daughter.

However, the most transparent contradiction is the presentation of her subjective complaints as compared to her social media posts and the video surveillance. Petitioner at trial presented as a severely disabled individual, utilizing a crutch and requiring help to ascend the short platform to the witness stand. She continuously reported severe, debilitating pain to her doctors. She testified to a litany of pain, symptoms, disabilities, and lifestyle losses at trial. Yet in 2016, Petitioner posted on social media looking for house cleaning clients. She posted that she was doing the cleaning, providing her personal contact information and continually referring to herself as the person performing the estimates, scheduling and services. Her testimony that she was merely assisting her cousin Monica start her business, despite virtually no knowledge of her business, would be a transparent fabrication in itself, but is even more blatant given the video evidence submitted.

The December 2016 video demonstrates that Petitioner was able to walk pain free and without a crutch. She had a car loaded with cleaning products for which the only reasonable inference is that she was performing the services. She was able to walk, bend, and carry without any apparent difficulty, even on a snow covered surface. The Arbitrator notes that this time period is when Petitioner was presenting to Dr. Jaycox with a crutch and seeking a total hip replacement. After seeing the video, Petitioner presented at the subsequent hearing in this matter in the same manner, utilizing the crutch and exhibiting extensive pain behaviors. The Arbitrator notes that she did not offer any rebuttal evidence to explain the video surveillance evidence. The record demonstrates that Petitioner was not only untruthful to the Arbitrator but also to her own treating doctors.

The lack of pathology to support her subjective complaints underlies her medical treatment. There are repeated negative diagnostic studies and notations of subjective complaints out of proportion with her objective findings. Dr. Blomgren notes pain out of proportion for any abnormality. He has no explanation for the etiology of her pain. Dr. Stanos stated patient does not seem to be a surgical candidate given her significant guarding and diffuse myofascial pain. Nothing to suggest a focal finding in the hip joint. Even Dr. Nho who ultimately performed her surgeries, did not initially believe she was a surgical candidate. He stated he was concerned that any operative intervention would be unlikely to provided significant improvement. He was correct.

The evidence, even taken in the light most favorable to Petitioner, only supports that Petitioner had chronic problem with her hips and felt a pop while merely walking. The mere fact that the claimant's duties took her to the place of injury and that, but for her employment, she would not have been there, is not sufficient, of itself, to

support a finding that her injuries arose out of her employment. *Illinois Bell Telephone Co. v. Industrial Comm'n, 131 Ill. 2d 478, 485-86, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989)*; *Caterpillar Tractor Co., 129 Ill. 2d at 63*. The claimant must show more than a mere possibility of an increased risk of injury from her employment. It is not the employer's burden of proof to disprove the existence of an increased risk of injury. Ghere v. Industrial Comm'n, 278 Ill.App.3d 840, 847, 215 Ill.Dec. 532, 663 N.E.2d 1046 (1996).

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on August 22, 2012.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The Arbitrator notes that Petitioner offered no specific medical opinion of causal connection. The treating medical records refer to the work injury on August 22, 2012, but as noted above in the Arbitrator's finding with respect to Accident, Petitioner did not provide any history of the incident she now claims for over a year. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983). Petitioner offered no persuasive medical evidence of causation.

Dr. Troy Karlsson testified that Petitioner demonstrated symptom magnification as her pain complaints were "beyond any medical explanation and that were out of proportion to expected problems from what was found on her diagnostic testing." As noted above, the symptoms were convincing contradicted by the video evidence. He opined that her pain complaints were not causally related to the August 22, 2012 accident. He did not feel that there was any specific accident of injury on August 22, 2012 accident. He opined that medical treatment was not causally related. Dr. Richard Noren testified that Petitioner's subjective complaints of pain were not supported by objective findings. Petitioner's right hip complaints preexisted her 8-22-12 accident. Petitioner's treatment was for a pre-existing condition. The Arbitrator finds the opinions that Petitioner's condition of ill-being was not causally related to the accident claimed on August 22, 2012 persuasive.

As more fully discussed in the Arbitrator's finding with respect to Accident, the Arbitrator finds that the Petitioner is not credible. The Arbitrator does not find the testimony of Dr. Karlsson and Dr. Noren that the incident as described by Petitioner could cause or aggravate a labral tear relevant given Petitioner's lack of credibility.

The Arbitrator notes that Petitioner's initial diagnostic studies did not demonstrate the labral pathology. Dr. Blomgren notes pain out of proportion for any abnormality He has no explanation for the etiology of her pain. Dr. Nho did not initially recommend surgery. Only after Petitioner continued to advance her subjective complaints did he perform the surgery. There is no medical opinion that the surgical findings were traumatic as opposed to degenerative. The Arbitrator also notes that the identical pathology was found in the opposite left hip during her subsequent surgery.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her condition of ill-being was causally connected to her employment with Respondent on or about August 22, 2012.

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

The parties placed Average Weekly Wage in dispute. Petitioner was employed by Respondent from April 27, 2012 through August 22, 2012 during the year preceding the alleged date of accident. Petitioner offered no evidence to support her claim of a $500.00 weekly wage. No wage records or testimony as to her hourly rate, hours worked or other necessary evidence to support a calculation was offered. The Arbitrator therefore adopts Respondent's stipulated wage of $375.79 per week.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident and Causal Connection, the remaining issues of Medical, Temporary Compensation, and Nature & Extent are moot.

Petitioner's claim for compensation is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC032216
Case Name	NASR, MOHAMED v. RJ TRANSPORTATION, INC. & IWBF
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0095
Number of Pages of Decision	4
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Joseph Younes
Respondent Attorney	George Tamvakis

DATE FILED: 3/15/2022

/s/Carolyn Doherty, 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

Mohamed Nasr,

Petitioner,

vs. No. 19 WC 32216

RJ Transporation, Inc. and
Rahim Javorovac,

Respondents.

DECISION AND OPINION UNDER SECTION 4(d)

This matter comes before the Commission on Petitioner's petition pursuant to section 4(d) of the Workers' Compensation Act (the Act) (820 ILCS 305/4(d) (West 2018)). Petitioner seeks findings that: Respondents were subject to the Act; Petitioner was an employee of Respondents on September 24, 2019; and Respondents knowingly failed to provide workers' compensation insurance which would have covered the injuries Petitioner sustained when a delivery package fell on his leg. For the reasons that follow, the Commission grants the petition.

Petitioner's application for adjustment of claim alleges that on September 24, 2019, Petitioner sustained injuries to his right leg when it was struck by a 400-pound pallet. Contemporaneously, Petitioner filed his petition pursuant to section 4(d) of the Act. On February 8, 2022, Commissioner Carolyn M. Doherty held a hearing, with proper notice given. Both parties were represented by counsel, and a record was made.

Petitioner testified through an Arabic interpreter that on September 24, 2019, he was employed by Respondents as a truck driver. He stated that his job duties included unloading product to deliver to customers. He added that he made deliveries for Amazon as part of his employment with Respondents. He also stated that he used a dolly which was in the truck at all times to help unload the product. Petitioner testified that Respondents told him where to go to make deliveries. Petitioner further testified that Respondent Rahim Javorovac required him to take

a course before he was able to work for Respondents as a truck driver. Petitioner submitted into evidence a certificate of attendance at the International Trucking Association's safety training for professional truck drivers. Petitioner also submitted an Illinois insurance card indicating that the truck he drove was insured by Respondent RJ Transportation, Inc. Petitioner testified that he accessed the truck at Respondents' place of business. He later testified that he was sometimes paid by check and other times in cash. Petitioner submitted several checks issued to him by Respondent RJ Transportation, Inc. He additionally testified that he was not provided with a 1099 form.

Petitioner also testified that on that on September 24, 2019, at approximately 3:00 or 4:00 p.m., he and Respondent Rahim Javorovac were unloading boxes from the truck in front of a house. He described the box as approximately the size of a desk, containing a "very heavy" chest. According to Petitioner, Mr. Javorovac was pushing the package from the top, while Petitioner was receiving it from the bottom to put it on the dolly. Petitioner testified that while Mr. Javorovac was pushing the package, it became too heavy for Petitioner to hold and it fell on Petitioner's right leg.

Petitioner further submitted into evidence a certification from the National Council of Compliance Insurance (NCCI). The NCCI certified that it is the agent designated by the Commission for the purpose of collecting proof of insurance coverage information on Illinois employers and that neither RJ Transportation, Inc. nor Mr. Javorovac filed policy information showing proof of workers' compensation insurance for September 24, 2019.

On cross-examination, Petitioner identified a photograph as depicting a truck that was in an accident. Petitioner testified that the truck was one he drove and had been driving at the time of the accident. Respondents' counsel represented that the truck was marked as "Wings & Wheels delivery," but Petitioner testified that the name on the side of the truck was not the name of the company, which was on the door of the truck. Petitioner submitted a photograph of a truck door bearing the name of RJ Transportation, Inc. Respondent did not introduce its photograph or any other exhibits or testimony into evidence.

The Commission finds that Respondents were engaged in carriage by land, and loading or unloading in connection therewith, and therefore were subject to the Act and required to provide workers' compensation insurance to their employees. See 820 ILCS 305/3(3) (West 2018). The Commission also finds that Petitioner was an employee of Respondents on September 24, 2019, as Respondents provided the truck and dolly to Petitioner, insured the truck, required Petitioner to obtain safety training, and assigned the work for Petitioner to perform—evidencing an employer-employee relationship under the *Roberson*[1] test. An employer is presumed to be aware of the laws to which it is subject. *E.g.*, *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill. App. 3d 149, 157 (2000). Respondents are thus presumed to have known of their obligations under section 4 of the Act. Petitioner submitted a certification from the NCCI that neither RJ Transportation, Inc. nor Mr. Javorovac filed policy information showing proof of workers' compensation insurance for September 24, 2019. There is no evidence in this record indicating that Respondents were operating under the mistaken belief that they were maintaining workers' compensation insurance on the accident date or any other date. Accordingly, the

[1] *Roberson v. Industrial Comm'n*, 225 Ill. 2d 159, 174-75 (2007).

Commission concludes that Respondents knowingly failed to provide workers' compensation insurance which would have covered the injuries Petitioner sustained while employed by Respondents on September 24, 2019. As such, Respondents "are no longer entitled to the benefits and protections of the Act and may be sued in civil court." See *Keating v. 68th and Paxton L.L.C.*, 401 Ill. App. 3d 456, 466 (2010).[2]

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition pursuant to section 4(d) of the Act is granted.

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.

March 15, 2022

R: 2/8/22
CMD/kcb
045

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

/s/ *Marc Parker*
Marc Parker

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

[2] The Commission notes in passing that the proposed findings submitted by both parties quoted the part of section 4(d) of the Act addressing penalties for non-compliance and requires that such non-compliance be knowing and willful, but the relevant portion of the statute here provides that "Employers who are subject to and who knowingly fail to comply with this Section shall not be entitled to the benefits of this Act during the period of noncompliance, but shall be liable in an action under any other applicable law of this State." 820 ILCS 305/4(d) (West 2018). Accordingly, Petitioner in this matter needed only to establish a knowing violation, as alleged in his petition.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC037022
Case Name	PELESKA, DORIS v. WALMART
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0096
Number of Pages of Decision	25
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Rich Hannigan
Respondent Attorney	Julie Schum

DATE FILED: 3/15/2022

/s/*Deborah Simpson, 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: medical expenses TTD PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DORIS PELESKA,

Petitioner,

vs. NO: 18 WC 37022

WALMART,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

a. Pre-accident Evidence

Prior to the present claim, Petitioner suffered other workers' compensation injuries involving her right upper extremity. In 99 WC 7649, Petitioner settled her first claim for 5.96% of the right arm for an accident that occurred on July 9, 1998. Petitioner thereafter sustained another right shoulder injury on January 4, 2010 that required right shoulder surgery and follow-up care through September 14, 2011. Petitioner settled this shoulder injury, which was addressed in 11 WC 46318, for 17.5% of the right arm.

The pre-accident treatment records show that on June 21, 2010, Dr. Robert Hall diagnosed Petitioner with right rotator cuff impingement syndrome related to the January 4, 2010 work injury. Dr. Hall performed a right subacromial injection on June 21, 2010 followed by a right shoulder arthroscopy, debridement, anterior acromioplasty, and distal claviculectomy on August 31, 2010. Petitioner's postoperative treatment through Dr. Hall included regular follow-up appointments, physical therapy, and work restrictions.

At a postoperative visit on October 22, 2010, Petitioner had tingling in the palm of her hand and a positive Tinel's sign over the ulnar nerve. Dr. Hall suspected cubital tunnel syndrome. When she then returned on November 27, 2010, Petitioner reported numbness and tingling in her index and long fingers that had bothered her for several years but abated while she used her right upper extremity less after her surgery. Dr. Hall believed Petitioner suffered from right carpal tunnel syndrome; however, on December 30, 2010, Petitioner's symptoms were improved from wearing a splint. Thereafter, on June 9, 2011, Dr. Hall diagnosed Petitioner with bilateral carpal tunnel syndrome after noting that she had numbness and tingling affecting her wrists and hands for a number of years. Nevertheless, despite possessing the symptoms characteristic of carpal tunnel syndrome, Dr. Hall indicated that Petitioner's EMG was within normal limits on July 25, 2011. At that time, Petitioner felt that she could live with her symptoms and was discharged.

On September 12, 2011, Petitioner returned to Dr. Hall and was diagnosed with right sternoclavicular osteoarthritis. A few days later, on September 14, 2011, Petitioner was diagnosed with a right radial styloid fracture after falling off her motorcycle. Dr. Hall also examined Petitioner's right shoulder and found some weakness despite being relatively asymptomatic. Dr. Hall placed Petitioner at MMI and discharged her from his care for the right shoulder. Petitioner still continued to treat with Dr. Hall for her styloid fracture through December 19, 2011, at which time Petitioner reported no symptoms and X-rays showed satisfactory healing. Dr. Hall released Petitioner to work and advised her to return as needed.

Petitioner then sustained another right shoulder injury in February 2013. On March 15, 2013, Petitioner informed Dr. Hall that she had an onset of severe right shoulder pain on February 26, 2013 after lifting shelves at work. Dr. Hall diagnosed Petitioner with a right triceps tendon strain and possible SLAP tear. Petitioner continued to treat with Dr. Hall through July 28, 2015 for her right shoulder and sternoclavicular osteoarthritis. Dr. Hall initially recommended surgical resection of the proximal clavicle, but on June 29, 2015, the recommendation was changed to a right shoulder arthroscopy after Petitioner underwent a §12 examination with Dr. Tony Romeo. Petitioner was subsequently discharged from Dr. Hall's care on July 28, 2015, because she opted to pursue further treatment with Dr. Romeo. Although the record did not contain a corresponding operative note, Petitioner testified that she underwent the right shoulder surgery on August 18, 2016 and received permanent restrictions on April 26, 2017 of no lifting over 35 pounds and frequent lifting or carrying of objects weighing up to 25 pounds. Petitioner continued to work for Respondent and eventually settled this claim for a loss of use of the person award.

b. Post-accident Evidence

On direct examination, Petitioner testified that on September 3, 2018, she asked a fellow employee to retrieve a box of bags for her since she was running out. Petitioner testified that when the coworker handed her the box, she received it with her left arm and it moved downward, causing her to reach over with her right arm. She testified that she then felt something pull in her elbow. Nevertheless, Petitioner testified that she went back to work and initially thought nothing of the incident; however, as time went on, Petitioner's right elbow became more painful and she eventually sought treatment from Condell Immediate Care on October 22, 2018.

On cross examination, Petitioner testified that it was normal for someone in her position to ask another employee to retrieve a box of the plastic bags used at the store's kiosks. Petitioner did not know how much the boxes of bags weighed but seven pounds did not sound right to her. On redirect, Petitioner testified that if the records from Adult and Pediatric Orthopedics indicated that the box involved weighed 15 to 20 pounds, then that was what she thought the box weighed. Kendra Wells, Respondent's employee of 11 years and current manager of the self-checkout kiosk area, also testified at the hearing that she was familiar with the bags involved because she ordered, stocked, and used them. Ms. Wells testified that she personally handled the boxes and each box weighed five to seven pounds. She explained that she knew how much the boxes weighed because that information was stated on the box. However, Ms. Wells testified that she did not weigh any of the boxes used on September 3, 2018.

Following Ms. Wells' testimony, the parties viewed RX 3, which Respondent presented as video surveillance footage of the accident. Petitioner was then recalled as a rebuttal witness. Petitioner testified that the video was not an accurate depiction of the accident she described on direct examination, because in the video, it was not busy and it did not show where she grabbed or was handed the box. Petitioner did not see the transfer of a box on the video.

On September 16, 2018, Petitioner filled out an incident report claiming an injury to her right elbow on September 3, 2018. Petitioner wrote that a week prior, she had asked the door host to get her a box, and when he handed her the box, her elbow popped. In between the accident date and when she reported the incident on September 16, 2018, Petitioner continued to work. She testified that she also did not seek treatment during that period, because she did not hurt badly until later on. Petitioner testified that even after the accident, she continued to work with restrictions that were accommodated by Respondent.

Petitioner also filled out a witness statement at the same time she completed the incident report. Petitioner recalled saying in the witness statement that she did not think anything of the incident at the time but now felt shooting elbow pain. Petitioner testified that she did not experience an immediate onset of pain, and instead, the pain appeared one or two weeks later. She could not recall if she had any pain between September 3, 2018 and September 17, 2018. Petitioner testified that she did not know how many days after the accident the pain started, but when it came, she related it to the incident with the box, because she had felt a "pop" and did not otherwise do anything different. Petitioner explained that she did not think anything of the "pop" sensation until a couple days later.

The treatment records show that Petitioner first presented to Advocate Condell Medical Center on October 22, 2018. A nursing triage note stated that Petitioner had felt her right elbow "pop" at work on September 1, 2018 when grabbing a box but she had no pain until three days ago when she woke up with right elbow pain after working the previous day scanning merchandise. The record also indicated that Petitioner had reported feeling the "pop" in her right elbow four days prior while pulling/lifting at work. After right elbow X-rays revealed no acute fracture, Dr. Daniel Kirschner diagnosed Petitioner with an elbow strain. Dr. Kirschner recommended Tylenol or Motrin and light duty restrictions.

On October 30, 2018, Petitioner returned to Advocate Condell Medical Center. It was then

noted that on September 3, 2018, Petitioner had injured her right elbow and heard a "pop" while grasping an object at work. This record also stated that Petitioner had reported feeling her right elbow "pop" while moving merchandise on Labor Day Weekend but had no pain until October 18, 2018. Dr. Kim Carnazzola advised Petitioner to take Aleve, wear a sling at work, and ice her right elbow. She also referred Petitioner to an orthopedist.

On November 2, 2018, Petitioner presented to Dr. David Schafer of Adult and Pediatric Orthopedics and reported persistent right elbow pain after a work injury on September 3, 2018. Dr. Schafer noted that Petitioner was acquiring a 15 to 20-pound box from an associate when she felt a popping sensation along her lateral right elbow. Petitioner told Dr. Schafer that she noticed mild pain and continued to work her shift, but in the two weeks after the incident, her elbow pain worsened. Petitioner also filled out a patient registration form at this visit, in which she wrote that her symptoms began September 3, 2018 after lifting a box. Dr. Schafer diagnosed Petitioner with lateral epicondylitis of the right elbow and administered a right elbow injection. He also gave Petitioner an arm sling and placed her on light duty restrictions of no lifting over 10 pounds and no repetitive use of the right arm.

On November 16, 2018, Petitioner presented to Dr. Schafer with complaints of tingling pain along her right hand and radiating pain from her elbow to the right trapezius. Dr. Schafer diagnosed Petitioner with cervical radiculopathy in addition to lateral epicondylitis. He further noted that cervical X-rays had revealed degenerative disease. Dr. Schafer believed that Petitioner's increased pain complaints were related to cervical pathology, and specifically, that her numbness and residual symptoms were likely related to a C6 radiculopathy. Dr. Schafer ordered a Medrol Dosepak and light duty restrictions. Petitioner testified that thereafter, on November 20, 2018, she was taken off work by Adult and Pediatric Orthopedics; however, a treatment note for this visit was not submitted into evidence.

Petitioner returned to Dr. Schafer on November 30, 2018 and stated that her pain was the worst it had been since the accident. She reported tingling in her right hand and radiating pain from her elbow to the right trapezius. Dr. Schafer opined that Petitioner's symptoms were consistent with lateral epicondylitis from the work injury, although this did not explain all of her symptoms. He suggested that Petitioner could have a secondary radial tunnel syndrome causing her neurologic complaints, cervical radiculopathy causing the worsening symptoms, or a double crush phenomenon in the elbow preventing improvement. Dr. Schafer believed that if it was cervical in nature, it was not related to the work injury since the mechanism Petitioner described was inconsistent with a cervical issue. Dr. Schafer took Petitioner off work but noted that she had been working light duty without a severe aggravation of her pain. At the hearing, Petitioner confirmed that she had been working on light duty restrictions as of her November 30, 2018 visit with Dr. Schafer.

On December 5, 2018, a right elbow MRI revealed mild humeroulnar and humeroradial joint effusion along with focal subcutaneous edema adjacent to the medial humeral epicondyle impressive of a soft tissue contusion. There were no features to suggest radial tunnel syndrome. On December 10, 2018, Dr. Schafer determined that the MRI was negative for significant abnormalities and had some focal subcutaneous edema that was not in the location of Petitioner's current complaints. Nevertheless, he believed an EMG was needed to rule out the elbow as the

source of Petitioner's pathology. Dr. Schafer expected the EMG would show cervical pathology. For the elbow condition, Dr. Schafer released Petitioner to full duty work. He noted that at the time of this visit, Petitioner had been working light duty without severe pain aggravation.

On December 28, 2018, a cervical MRI further revealed: 1) a C3-C4 disc protrusion with midline cord encroachment; 2) a C4-C5 degenerative bulging disc with spurs resulting in central canal/cord encroachment; 3) a C5-C6 degenerative bulging disc with accompanying marginal spurs and facet degeneration with central canal/cord encroachment and left foraminal encroachment; and 4) a C6-C7 left disc protrusion with accompanying disc bulge, marginal spurs, and facet degeneration resulting in central canal/cord encroachment and left foraminal encroachment. Upon reviewing the MRI, Dr. Schafer recommended a cervical injection on January 14, 2019. Dr. Schafer also rechecked Petitioner's right elbow on that day. He found that Petitioner's symptoms were consistent with lateral epicondylitis but differed from her neurologic complaints. Dr. Schafer administered a repeat right elbow injection and kept Petitioner on full duty work for her elbow.

Upon Dr. Schafer's referral, Dr. Martin Lanoff of Adult and Pediatric Orthopedics also administered a right C6-C7 injection on May 7, 2019. Dr. Lanoff's diagnosis was a right C6-C7 herniated nucleus pulposus. When Petitioner next saw Dr. Lanoff on May 28, 2019, she reported 80% relief from the injection. For her remaining cervical muscular issues, Dr. Lanoff recommended physical therapy. He noted that Petitioner's radiating symptoms had improved considerably, and as such, there was no need for a second cervical injection.

On May 9, 2019, Dr. Prasant Atluri provided a §12 report. Petitioner told Dr. Atluri that her accident occurred when she received a large box of bags from a coworker. Petitioner reported that she had initially received the box with her left arm but then reached around the box with her right arm when she realized that it was heavy. Petitioner stated that she reached out with her right hand extending her elbow when her elbow popped. Petitioner indicated that she initially felt pain in the lateral aspect of her right elbow. Dr. Atluri diagnosed Petitioner with resolved lateral epicondylitis of the right elbow. He opined that the mechanism of injury Petitioner had described, specifically that she had received the box with her right upper extremity elevated with her elbow extended and her forearm rotated with the right wrist flexed, plausibly contributed to her lateral epicondylitis. As such, Dr. Atluri determined that Petitioner's right elbow condition was causally related to the work injury that occurred on September 3, 2018. Nevertheless, he indicated that his opinion could change if the accident had not occurred as Petitioner described.

Dr. Atluri further opined that Petitioner likely reached MMI for her right elbow within five to six months of the accident. Dr. Atluri found that Petitioner's right elbow examination was normal and noted that Petitioner had no ongoing right elbow complaints. Although Dr. Atluri believed that Petitioner's treatment had been reasonable, appropriate, and work-related, he opined that no further treatment was necessary. For the resolved right elbow condition, Dr. Atluri assigned a 0% AMA impairment rating and opined that Petitioner could work without restrictions.

Additionally, Dr. Atluri noted that Petitioner had neck and hand pain at the time of his examination. However, he found that the hand pain predated and was unrelated to Petitioner's elbow injury. Likewise, Dr. Atluri determined that there were no findings suggestive of any

relationship between Petitioner's neck and the lateral epicondylitis. Dr. Atluri also noted that Petitioner had denied any prior right elbow symptoms, although she did have a pre-accident history of two right shoulder surgeries, a right wrist radial styloid fracture, bilateral carpal tunnel syndrome, and right hand pain.

Petitioner thereafter presented to Dr. Schafer on January 20, 2020 and reported a recent worsening of her right elbow symptoms with her work activities. Dr. Schafer indicated that Petitioner had been changed to a self-checkout help position that involved less lifting. Nevertheless, Petitioner felt that she could still safely continue her regular duty activities. Dr. Schafer administered a repeat right elbow injection. At that time, Petitioner testified that she was suffering from sharp right elbow pain and could not move her elbow. Petitioner testified that her pain had waxed and waned between December 10, 2018 and January 20, 2020.

On February 28, 2020, Dr. Atluri was deposed by the parties and testified consistently with his §12 report dated May 9, 2019. Dr. Atluri testified that his diagnosis of resolved right elbow lateral epicondylitis was consistent with Petitioner's reported mechanism of injury. He testified that when Petitioner demonstrated to him the maneuver she was performing at the time of the accident, her right upper extremity was elevated with the elbow extended and the forearm rotated with the right wrist flexed. Dr. Atluri testified that this position put the right elbow at risk and represented an awkward positioning of the upper extremity that made it susceptible to overloading where the extensor tendons attach at the lateral aspect of the elbow. He testified that this matched the type of abnormality documented in the clinical material he reviewed; and therefore, it was plausible that Petitioner's injury contributed to her elbow condition. Dr. Atluri testified that his opinion was based on the history Petitioner provided to him, the physical findings, the imaging studies, and the records he reviewed. He testified that if Petitioner's history was incorrect or if Petitioner's arm was positioned differently than she described, his opinion could change.

On cross examination, Dr. Atluri indicated that he was not provided with the surveillance video of the accident, an accident report, or a job description. However, on redirect, Dr. Atluri testified that Petitioner had told him about her job title and what she did. Specifically, he testified that Petitioner reported working in the self-checkout area.

At the time of the hearing, Petitioner continued to express difficulty lifting boxes, as well as lifting her granddaughter, secondary to her right elbow pain. Petitioner testified that lifting, moving furniture, and vacuuming caused her right elbow to hurt. Additionally, she woke up with the arm pain. Due to her right arm issues, Petitioner, who is right-hand dominant, testified that she compensates with her left arm and was resultantly starting to experience problems with her left arm, including difficulty pulling her shoulder behind her back. Nevertheless, Petitioner has not seen any doctors for her left arm. Petitioner also initially testified that she never had any right elbow issues prior to the accident date. However, subsequently on redirect, Petitioner stated that she did have numbness, tingling, and pain in her right elbow dating back to 2011.

II. Conclusions of Law

Following a careful review of the entire record, the Commission affirms and adopts the Arbitrator's findings as to the issues of accident and causal connection. However, for the issues

of medical expenses, temporary total disability, and permanent partial disability benefits, the Commission modifies the Decision of the Arbitrator as follows.

Regarding the awarded medical expenses, the Commission finds that the record supports the Arbitrator's award of reasonable and necessary medical expenses pursuant to PX 9; however, it modifies the award to include a credit due to Respondent for any amounts paid to Petitioner's treatment providers as documented in RX 7. The Commission further corrects a typographical error contained in the Decision of the Arbitrator as to the awarded §8(j) credit amount. There is a discrepancy where the §8(j) credit amount is listed as $661.40 in the Order of the Arbitrator's Decision but $661.46 in the findings section and body of the Decision. On the Request for Hearing, Respondent also claimed that it had paid $661.46 in medical benefits through its group plan for which credit may be allowed under §8(j). As such, the Commission believes that the Order section of the Arbitrator's Decision contained the typographical error of listing the §8(j) credit amount as $661.40 and therefore modifies it to $661.46 to conform with the rest of the Decision.

As for temporary total disability, the Commission finds that Petitioner is not entitled to any temporary total disability benefits since she continued to work under light duty accommodations. The medical records show that on November 16, 2018, Dr. Schafer maintained Petitioner's light duty restrictions. Petitioner testified that then, on November 20, 2018, she was taken off work by Adult and Pediatric Orthopedics. The treatment note for that date of service was not included in the evidence; however, there was a treatment note dated November 30, 2018 in which Dr. Schafer placed Petitioner off work. In that note, Dr. Schafer mentioned that Petitioner had been working under light duty. At the hearing, Petitioner also testified that she was working on light duty restrictions as of her November 30, 2018 visit with Dr. Schafer. When Petitioner returned to Dr. Schafer on December 10, 2018, it was noted that she continued to work with light duty restrictions without severe pain aggravation. Dr. Schafer then released Petitioner to full duty work at that time. These treatment records show that Petitioner was placed either on work restrictions or off work by her treating doctors for the claimed total temporary disability period of November 20, 2018 through December 10, 2018. However, the records also show that Petitioner continued working under light duty restrictions throughout this time. Petitioner also testified that she had continued working with restrictions that were accommodated by Respondent. Since Petitioner continued to work, an award of temporary total disability benefits is not warranted.

Lastly, in considering permanent partial disability benefits, the Commission modifies the Arbitrator's award to 5% loss of use of the right arm and gives Respondent its credit of 23.46% to the same body part. When reviewing permanent partial disability for accidents occurring after September 1, 2011, the Commission must consider the §8.1(b) enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id*. § 305/8.1b(b)(v).

Regarding criterion (i), Dr. Atluri assigned a 0% AMA impairment rating for Petitioner's resolved right elbow condition. The Commission assigns moderate weight to this factor.

Regarding criterion (ii), Petitioner was employed as a self-checkout cashier on the accident date. She was returned to full duty work by Dr. Schafer on December 10, 2018, but prior to that time, the record shows that Petitioner continued to work under accommodated light duty restrictions. The Commission assigns significant weight to this factor.

Regarding criterion (iii), Petitioner was 60 years old on the accident date. The Commission assigns some weight to this factor.

Regarding criterion (iv), Petitioner returned to her regular pre-accident job. There was no evidence to suggest that Petitioner's future earning capacity was negatively affected. The Commission assigns significant weight to this factor.

Regarding criterion (v), Petitioner treated her lateral epicondylitis with three right elbow injections, medication, and restrictions. At the hearing, Petitioner testified that she has ongoing problems lifting boxes and uses a shopping cart to do so. Petitioner also has difficulty lifting her granddaughter secondary to her elbow pain. She testified that lifting and moving furniture causes her right elbow to hurt. Petitioner also wakes up with arm pain and notices pain when vacuuming. Petitioner testified that she never had any right elbow issues before September 3, 2018. The Commission assigns significant weight to this factor.

In consideration of the above factors, given that Petitioner treated conservatively and returned back to full duty work, the record supports an award of 5% loss of use of the right arm. Respondent also has a credit of 23.46% of the right arm from prior workers' compensation settlements. The Commission finds that the Arbitrator's decision to add the 23.46% credit to the permanent partial disability amount essentially makes it so that Respondent's credit has no effect, which does not appear to be the purpose of the case cited by the Arbitrator of *Bowen v. Ill. Workers' Comp. Comm'n*, 2021 IL App (4th) 200268WC. The record does not support a finding that Petitioner's conservatively treated lateral epicondylitis resulted in a disability that exceeded the credit to which Respondent is properly entitled. As such, the Commission modifies the permanent partial disability award to 5% of the right arm and properly applies Respondent's due credit of 23.46% of the right arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 14, 2021 is modified as stated herein. For all other issues not specifically modified herein, the Commission affirms and adopts the Decision of the Arbitrator, including the Arbitrator's findings as to the issues of accident and causal connection.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner all reasonable and necessary medical expenses pursuant to PX 9 as provided in §8(a) of the Illinois Workers' Compensation Act with Respondent given a credit for all amounts paid to Petitioner's treatment providers as documented in RX 7.

IT IS FURTHER ORDERED that the typographical error contained in the Order section of the Decision of the Arbitrator that lists the §8(j) credit amount as $661.40 shall be corrected to $661.46 to conform with the rest of the Decision.

IT IS FURTHER ORDERED that all temporary total disability benefits are denied, as Petitioner continued to work under accommodated light duty restrictions during the claimed benefit period.

IT IS FURTHER ORDERED that Petitioner sustained a 5% loss of use of the right arm ($433.20 x 12.65 weeks) in permanent partial disability pursuant to §8(e) of the Act. The Commission further finds that Respondent is entitled to a credit of 23.46% of the right arm applied to the permanent partial disability amount due to its prior workers' compensation settlements.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,000.00. 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.

March 15, 2022

DLS/met
O- 1/26/22
46

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC037022
Case Name	PELESKA, DORIS v. WALMART
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	15
Decision Issued By	Paul Seal, Arbitrator

Petitioner Attorney	Rich Hannigan
Respondent Attorney	Julie Schum

DATE FILED: 7/14/2021

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

/s/ *Paul Seal, Arbitrator*

Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

- [ ] 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

Doris Peleska
Employee/Petitioner
v.
Walmart
Employer/Respondent

Case # **18** WC **37022**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Rockford, IL**, on **5/21/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/3/2018**, 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 $**37,544.00**; the average weekly wage was $**722.00**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0.00** 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 $**661.46** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $481.33/week for 3 weeks, commencing November 20, 2018, through December 10, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of pursuant to Petitioner's Exhibit 9 as provided in Section 8(a) of the Act.

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 33.46% loss of use of the right arm pursuant to Section 8(e) of the Act, with Respondent getting credit of 23.46% of the arm for the prior settlements

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

Respondent shall be given a credit of $661.40 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

JULY 14, 2021

Findings of Facts and Conclusion of Law

FINDINGS OF FACT

The parties stipulated that Petitioner was an employee of Respondent on September 3, 2018, that she reported her injury to the front-end manager on September 16, 2018, her earnings during the preceding year were $37,544.00 yielding an average weekly wage of $722.00 pursuant to section 10 of the Act. In dispute are whether Petitioner's accident arouse out of and in the course of her employment for respondent, whether Petitioner's current condition of ill-being is causally related to the September 3, 2018 injury, whether any medical bills remain unpaid and whether those bills are reasonable, necessary and causally related to the September 3, 2018 accident, whether any TTD is owed, and the nature and extent of Petitioner's injury.

On July 9, 1998, Petitioner injured her right shoulder while working for Walmart and eventually settled her claim for 5.96% of the arm. (RX 2). Petitioner testified that on January 4, 2010, while employed for Walmart, she injured her right shoulder again and required surgery. (TX 10-11). At the time she was released from treatment for the right shoulder, on September 14, 2011, she had no complaints to the right shoulder. (TX 11). She eventually settled that claim pro se for 17.5% loss of use of the right arm. (TX2, RX 2). Thereafter she had another injury to her right shoulder on February 14, 2013 which required surgery. She was eventually released with permanent restrictions of no lifting over 35 pounds with frequent lifting, carrying of objects weighing up to 25 pounds. (TX 13). She continued to work for Walmart. She testified that on September 3, 2018 while she was working at Walmart, she asked one of the employees to get her a box of bags since she was running low. The coworker handed her the box, she grabbed it with

her left hand, the box began to fall, so she used her right arm to catch it and felt something pull in her elbow. (TX14-15). She continued to work because she was so busy. As time went on, her elbow began to give her a lot of pain. (TX 15). She then presented to Condell Immediate Care on October 22, 2018. (TX 15, PX 2, p 22-34). She reported feeling a pop in her elbow when she was grabbing a box at work. (PX 2, p 29). Xrays ruled out fracture, and she was told to take Tylenol or ibuprofen, to ice the elbow, given work restrictions of no pushing/pulling, lifting or carrying with the right arm and told to follow up on October 30, 2018. (PX 2, p 28). She followed up on October 30, 2018 and reported no improvement in her condition. She was using a sling at work and now reports pain into her right hand and palm. (PX 2, p 12). She was referred to Dr. Zoellick at Adult and Pediatric Orthopedics and was released to work with restrictions of no pushing/pulling, overhead work, reaching, gripping, or use of the right hand. (PX 2, p 10). She then saw Dr. Schafer of that practice on November 2, 2018. (TX 16). She reported an accident at work where she was acquiring a 15–20-pound box from another associate when she noted a popping sensation along er right elbow after supporting the weight of the box. (PX 3, p 2). Dr. Shafer administered a cortisone injection along the lateral epicondyle to alleviate the pain and inflammation and was prescribed diclofenac for pain. (TX17, PX 3, p 3). She was put on work restrictions of no lifting over 10 pounds with the right arm and no repetitive use of the arm. She was also given a sling to be used as needed. (*Id.).* She returned to see Dr. Schafer on November 16, 2018. (TX 17, PX 3, p 5). She had mild improvement in her symptoms. She noted tingling pain along the right hand and radiating pain from the elbow to the right trapezius. (PX 3, p 5.) She was prescribed a Medrol Dosepak and continued her work restrictions. (TX17, PX 3, p 5). She followed up again on November 30, 2018. She complained of worsening pain since the last visit. (PX 3, p 7). Dr. Schafer suspected that cervical radiculopathy could be

contributing to her elbow complaints along with her lateral epicondylitis and possible secondary radial tunnel syndrome. (PX 3, p 7). MRI of the right elbow and cervical spine are ordered and she is taken off work. (TX 17, PX 3, p 8). She returned to see Dr. Schafer on December 10, 2018. She reported that the pain is the worst it has been since the accident. (PX 3, p 9). Dr. Schafer reviewed the MRI and found that it was negative for significant abnormalities. He noted some edema, but it was not in the location of her complaints. Given the negative MRI, Dr. Schafer returned her to work her normal job duties. (TX 18, PX 3, p 10, 15). Petitioner saw Dr. Schafer again on January 14, 2019, for a recheck of her right elbow. Her pain was getting worse with activities, including work. (PX 3, p 32). The doctor noted that she had a recurrence of symptoms with her return to regular work activities. He noted she had consistent signs and symptoms of lateral epicondylitis which were different than her neurologic complaints. Dr. Schafer administered a second cortisone injection to her right elbow. (PX 3, p 33). Petitioner thought she could safely continue working full duty, so no work restrictions were given. (*Id.).* On January 20, 2020, she followed up with Dr. Schafer again. She had been doing well but had a recurrence of right elbow pain. A cortisone injection was administered. (PX 3, p 40-41.) Petitioner testified that her elbow pain waxed and waned between December 10, 2018 and January 20, 2020. (TX 20).

At the request of Respondent, Petitioner saw Dr. Atluri for an examination pursuant to Section 12 of the Act. She reported to Dr. Atluri that she injured her right elbow when reaching for a box from a coworker with her left arm then using her right arm to grab the box and felt a pop in her right elbow. (RX 6). Dr. Atluri agreed that she likely had lateral epicondilytis and that the reported mechanism of injury could contribute to that condition. If the incident did not occur,

that would change his opinion on causation. He opined that Petitioner was at MMI and required no additional treatment or work restrictions. (*Id.)*.

Petitioner testified that she continues to have pain and limitations in her right elbow. She has problems lifting boxes and now uses a shopping cart because they are too heavy for her to carry. (TX 19). She has a hard time lifting her granddaughter because of her right elbow. (TX 19). Her right elbow pain wakes her at night. She feels a sharp pain in her arm when she stretches her right arm out. She notices right elbow pain when vacuuming and moving furniture to clean. She uses her left arm more now to compensate for her right elbow pain. (TX 22).

On cross-examination, Petitioner reviewed an associate incident report filled out on September 16, 2018. (TX 26). Petitioner testified that she filled the document out herself and signed it. She described that Ron handed her a box of bags and her elbow popped. (TX 27). Petitioner continued to work after her accident and Walmart accommodated her work restrictions. (TX 36). Petitioner wrote in a witness statement on September 16, 2018, that she did not think anything of the incident at the time but now she has pain in the elbow and down her hands and fingers. (TX 38). The elbow pain did not immediately onset but came on about 1-2 weeks later. She continued her usual work and daily activities after the accident. (TX 38). Petitioner does not believe the box she was handed on the date of accident to weigh only 7 pounds. (TX 42). While she did not seek treatment to her elbow until October 22, 2018, Petitioner testified that she did have issues with her right elbow prior to October 22, 2018, but did not have any issues prior to September 3, 2018. (TX 45-46).

Respondent called Kendra Wells, who is a manager at Walmart. She is familiar with the self-checkout area because she used to work as a cashier and now, she manages that area. (TX 54-55). She testified that the boxes of plastic bags weigh approximately 5-7 pounds because the

weight was marked on the box. She did not weigh the boxes herself on September 3, 2018. Walmart now uses a different box of bags. (TX 56-58).

Petitioner was recalled to review Respondent's exhibit 3, which is the surveillance video from September 3, 2018. Petitioner testified that the video she reviewed was not the video of her getting injured. When she was injured, it was very busy, and the video did not reflect the amount of customers who were in line when she was injured. Also, while the video showed her grabbing a box from another coworker, this is not where she grabbed the box when she was injured. She testified that she was near the coke machine to the left by the kiosk when she grabbed the box and was injured. (TX 64).

CONCLUSIONS OF LAW

With respect to issue C, did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

A claimant bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

The Illinois Supreme Court held in *McAllister v Illinois Workers' Compensation Comm'n,* 2020 IL 124828, that a sous-chef's knee injury "arose out" of an employment-related risk where he knelt on the ground to find a tray of carrots and injured his knee. They held that the injury was caused by a risk distinctly associated with his employment. They further held that the proper test for analyzing whether an injury "arises out of" a claimant's employment is the one set forth in *Caterpillar Tractor Co. V. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667, 133 Ill. Dec. 454 (1989). The Court in *Caterpillar* held, that as a general rule, "an injury arises out of

one's employment if, at the time of the occurrence, the employee was performing acts she 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 incidental to her 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 her duties." *Id.*

Once it is established that the injury is work related, *Caterpillar Tractor* does not require claimants to present additional evidence for work-related injuries that are caused by common bodily movements or everyday activities. *McAllister v Illinois Workers' Compensation Comm'n,* 2020 IL 124828.

Here, it is clear that Petitioner was performing acts she was instructed to perform by the employer when she was getting bags for the self-checkout kiosks. An injury to her elbow occurred while she was performing her job duties that included a risk incidental to her employment as it was directly connected to what she had to do to fulfill her job duties. No evidence or testimony was proffered to contend that Petitioner was not doing her usual job duties or that she was outside the scope of her employment when she injured her elbow.

Petitioner testified consistently that she injured her right elbow when a coworker handed her a box of plastic bags. Respondent attempted to establish that Petitioner's reporting of the accident was inconsistent. However, every report of injury to every doctor included that she felt a pop or a pull in her right elbow when she was getting a box at work. Minor distinctions such as how much the box weighed, whether she held the box with her left hand first, or how the box was handed to her can be made but have no real effect on the determination of whether the accident arose out of and in the course of Petitioner's employment, as overall, the testimony and records are consistent with the accident.

Respondent's surveillance video is of no probative value. While Ms. Wells testified that she was familiar with the area that was recorded, she was not familiar with the actual injury and did not testify as to where, when, or how it happened. Petitioner's testimony that the accident happened in a different location than what was shown on the video and that it was not crowded on the video as it was at the time of her accident is a more credible account of how the accident occurred and the video does not show the incident that Petitioner testified to and caused her injury.

Based upon the foregoing, Petitioner has established that the accident arose out of and was in the course and scope of Petitioner's employment for Respondent. Respondent failed to credibly rebut that the petitioner's injury occurred in the manner that she testified.

With respect to issue F, is Petitioner's current condition of ill-being causally related to the injury?

A prerequisite to the right to recover benefits under the Act is some causal relationship between the claimant's employment and the injury suffered. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470, 949 N.E.2d 1158, 1165 (2011). Compensation may be awarded under the Act even if the conditions of employment do not constitute the sole or principal cause of the claimant's injury. A Petitioner need only prove that some act or phase of his employment was a causative factor in the ensuing injury. *Vogel v. Industrial Comm'n*, 354 Ill.App.3d 780, 821 N.E.2d 807, (2005). A work-related injury need not be the sole or principal causative factor so long as it was "A" causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n* 207 Ill. 2d 193, 205, 797 N.E. 2d 665. (2003).

Here, there is no medical dispute as to the causation of Petitioner's lateral epicondylitis. Both Dr. Schafer and Respondent's Section 12 examiner, Dr. Atluri agree that Petitioner suffered lateral epicondylitis and that the accident of September 3, 2018 was a cause of that condition. Having already found that Petitioner's accident arose out of and was in the course of her employment, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident of September 3, 2018.

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

No issue exists as to whether the medical treatment Petitioner received was reasonable and necessary. An issue exists as to whether all appropriate charges for the treatment has been paid. Respondent offered into evidence as Exhibit 7, a medical bill payment leger. Petitioner offered into evidence PX 9, a group exhibit of medical bills. Petitioner's exhibit shows the following providers with outstanding balances:

Medical Provider	Date of Service	Charges	Balance
1. Advocate Condell Immediate	10/22/2018	$ 184.00	$184.00
2. Advocate Condell Medical	10/22/2018-10/30/2018	$ 740.00	$740.00
			$924.00

Respondent's exhibit 7 shows payments made by Respondent. It does not show a payment made to Advocate Condell Immediate Care for the date of service of October 22, 2018. The exhibit does reflect 2 payments made to Advocate Condell Medical Center. One payment of $103.74 for the October 30, 2018 date of service and one payment for $277.44 for the October 22, 2018 date of service. However the payment screens do not show how much was billed, what the payments were for or if they were payments in full. Respondent shall pay to Petitioner all medical charges as outlined in Petitioner Exhibit 9 pursuant to Section 8(a) of the Act and pursuant to the Illinois

Fee Schedule. Respondent shall be given a credit of $661.46 for medical benefits that have been paid and Respondent shall hold Petitioner harmless for 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 listed on Arbitrator Exhibit 1 that it paid $1,892.05 in "other benefits, for which credit may be allowed under Section 8(j) of the Act." Respondent's counsel indicated that this was "medical that pas paid directly by work comp as opposed through a group health plan." While Respondent certainly can claim a credit for medical bills paid by its workers' comp carrier pursuant to 8(a), there is no such credit available under Section 8(j) of the Act.

With respect to issue K, what temporary benefits are in dispute, the Arbitrator finds as follows:

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n*, 372 Ill.App.3d 527, 542, 310 Ill.Dec. 18, 865 N.E.2d 342 (2007)

The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Flynn*, 211 Ill.2d at 556, 286 Ill.Dec. 62, 813 N.E.2d 119. Therefore, when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury and whether the employee is capable of returning to the work force.

Having already found that the Petitioner's accident arose out of and in the course of her employment for respondent and that the accident was a cause of her injury and need for treatment, and no dispute as to the reasonableness of her medical treatment, the Arbitrator finds

that Petitioner was temporarily and totally disabled for 3 weeks from November 20, 2018, through December 10, 2018.

With respect to issue L, what is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner had two previous injuries to her right arm. One in 1998 resulting in 5.96% loss of use of her arm as a result of a shoulder injury and one in 2010 again to her right shoulder, resulting in 17.5% loss of use of the right arm. Respondent is entitled to a credit for those injuries.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Respondent offered the AMA impairment rating of Dr. Atluri of 0% impairment. The Arbitrator therefore gives some 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 cashier at the time of the accident and that she has able to return to work in her prior capacity as a result of said injury. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident and has less time left in the workforce the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was offered that indicates the injury had any impact on Petitioner's future earnings capacity. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner has ongoing disability that is permanent. The Arbitrator notes that she has waxing and waning complaints of pain to her right elbow and

her activities of daily living are impacted by her ongoing complaints. The Arbitrator therefore gives *greater* weight to this factor.

In *Bowen v The Illinois Workers' Compensation Comm'n*, 2021 ILApp (4th) 200268WC, the Appellate Court reiterated that a lower court must be clear in awarding additional PPD to a scheduled body part with a previous PPD award or settlement for which Respondent may claim a credit. Given the foregoing factors and the record taken as a whole, the Arbitrator finds that as a result of the September 3, 2018 injury, Petitioner sustained permanent partial disability to the extent of 10% loss of use of the right arm pursuant to Section 8(e) of the Act. Accordingly, in addition to the permanent partial disability of 5.96% of an arm from the July 9, 1998 accident and the 17.5% of an arm from the January 4, 2010 injury, the Arbitrator awards a total PPD award of 33.46% loss of use of the right arm pursuant to Section 8(e) of the Act, with Respondent getting credit of 23.46% of the arm for the prior settlements. Representing $433.20 per week for 75 weeks, or $32.490.00.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC042418
Case Name	HUGHES, MALCOLM v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0097
Number of Pages of Decision	17
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Carl Salvato
Respondent Attorney	Devin Mapes

DATE FILED: 3/16/2022

/s/Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MALCOLM HUGHES,

Petitioner,

vs. NO: 13 WC 42418

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 the accrual date of the permanent partial disability benefits and being advised of the facts and law, provides additional discussion as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

This matter was heard by the Arbitrator on May 30, 2019 and August 21, 2019. The Request for Hearing indicates that the issues in dispute included causal connection, whether Petitioner was entitled to maintenance benefits beyond the stipulated period of November 1, 2014 through February 15, 2019, Respondent's credit for maintenance benefits paid, and the nature and extent of Petitioner's injury. Arb.'s Ex. 1. In his April 21, 2020 Decision, the Arbitrator found Petitioner's current right knee condition of ill-being remains causally related to the undisputed August 7, 2013 work accident; however, the Arbitrator denied Petitioner's request for maintenance benefits beyond the stipulated period, concluding Petitioner had ceased making good-faith efforts at vocational rehabilitation in early 2019. The Arbitrator found Respondent entitled to a credit of $199,243.20 for maintenance benefits previously paid, and concluded Petitioner's injuries resulted in 45% loss of use of the person as a whole, with the permanent partial disability benefits beginning to accrue on February 16, 2019.

On Review, Petitioner filed a Statement of Exceptions and Supporting Brief arguing that, as a matter of law, the permanent partial disability award began to accrue on the date of maximum medical improvement ("MMI"), a date which Petitioner identified as August 1, 2014.[1] Respondent did not file a Statement of Exceptions or a brief on review. The Commission disagrees with Petitioner's position.

Initially, the Commission notes that Petitioner's reliance on *Iannoni v. City of Chicago*, 2019 IL App (1st) 182526, is misplaced as *Iannoni* only addresses the issue of when an injured employee is entitled to lump sum payments of a workers' compensation award. In *Iannoni*, the injured employee filed a petition pursuant to section 19(g) of the Workers' Compensation Act ("Act") claiming that all permanent partial disability benefits awarded by an arbitrator should be paid in a lump sum, whether they had accrued or not. The Circuit Court ordered that the entire amount of the arbitrator's award was due to be paid when the Commission adopted the arbitrator's decision and award, making it the final decision and award of the Commission. However, the City of Chicago only paid the part of the award for benefits that was due as of the time of the payment and represented that it would pay the remainder of the award monthly, as it accrued. The Appellate Court reversed the Circuit Court's order and held that the City correctly paid the award as it accrued over time, reasoning that lump sum awards are limited to exceptional circumstances and the claimant had not requested that the award be a lump sum pursuant to section 9 of the Act. *Iannoni*, 2019 IL App (1st) 182526 at ¶¶ 14-15, 19. The Appellate Court did not address the issue of when permanent partial disability benefits begin to accrue, which is the issue to be decided in the instant case.

The Commission emphasizes that the MMI date is not an automatic trigger for permanent disability benefits; rather, permanent disability commences only after the temporary phase of the disability concludes. *See Wright v. Bd. of Trustees, State Universities Ret. Sys. of Illinois*, 2014 IL App (4th) 130719, ¶ 22 (holding that any permanent partial disability is present the day after a claimant is no longer temporarily totally disabled – either a claimant is permanently partially disabled or is not permanently partially disabled). The courts have held that the temporary phase includes both periods of temporary total incapacity under section 8(b) as well as periods of vocational rehabilitation under section 8(a). *See Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 121-123 (1990) (finding that a claimant was still entitled to temporary total disability benefits even after undergoing a vocational rehabilitation program); *see* also *Freeman United Coal Min. Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 180 (2000) (holding there may indeed be instances when temporary total disability benefits cease but maintenance benefits for vocational rehabilitation continue). In cases where the claimant undergoes vocational rehabilitation, as in the present matter, it is not until the rehabilitation program ends that the employee may be entitled to permanent disability compensation. *See Freeman United Coal Mining Co.*, 318 Ill. App. 3d at 178 (noting that rehabilitation efforts may be undertaken even though the extent of the permanent disability cannot yet be determined). Accordingly, the Commission affirms the finding that Petitioner's permanent partial disability award began to accrue as of February 16, 2019, the day after Petitioner was no longer entitled to maintenance benefits as found by the Arbitrator.

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[1] In a separate motion filed on review, the parties also appeared to agree that Petitioner reached MMI on December 19, 2014 and that as a matter of law, benefits should begin to accrue on December 19, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 21, 2020, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $967.20 per week for a period of 224 weeks, representing November 1, 2014 through February 15, 2019, as provided in §8(a) of the Act. Respondent shall have a credit in the amount of $199,243.20 for maintenance benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 225 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 45% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay those benefits that have accrued from February 16, 2019 through April 17, 2020, and shall pay the remainder, if any, in weekly payments.

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

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

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

March 16, 2022

/s/ *Deborah J. Baker*

DJB/mck

D: 1/26/22

/s/ *Stephen J. Mathis*

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/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0097

HUGHES, MALCOLM
Employee/Petitioner

Case# **13WC042418**

CITY OF CHICAGO
Employer/Respondent

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2731 SALVATO O'TOOLE & FROYLAN
CARL S SALVATO
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

0010 CITY OF CHICAGO
MATTHEW A LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MALCOLM HUGHES
Employee/Petitioner
v.
CITY OF CHICAGO
Employer/Respondent

Case # **13** WC **42418**

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MAY 30, 2019** and **AUGUST 21, 2019**. After reviewing all the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **AUGUST 7, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**75,437.44**; the average weekly wage was $**1,450.72**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**67,427.66** for TTD, $**0.00** for TPD, $**199,243.20** for maintenance, and $**0.00** for other benefits, for a total credit of $**266,670.86**. (*See* RX 1).

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

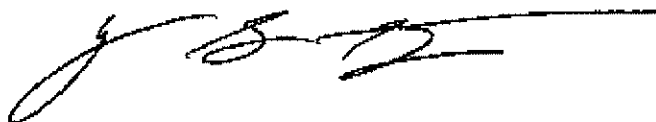
ORDER

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

- The Arbitrator finds Petitioner entitled to **$967.20/week** for maintenance benefits from **November 1, 2014 through February 15, 2019**.; and,
- Respondent shall pay Petitioner the sum of **$721.66**/week for a further period of **225** weeks, as provided in Section **8(d)2** and Section **8.1b** of the Act, because the injuries sustained caused **a 45% loss of use of the person-as-a-whole**. and;
- Respondent is entitled to a credit for paid benefits. (*See above* and RX 1).; and,
- The Respondent shall pay those benefits that have accrued from **February 16, 2019 through April 17, 2020** in a lump sum, and shall pay the remainder, if any, in weekly payments.

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

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



Signature of Arbitrator

APRIL 17, 2020
Date

APR 21 2020

MALCOLM HUGHES v. CITY OF CHICAGO

13 WC 42418

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on May 3, 2019 and August 21, 2019. The issues in dispute were causal connection, maintenance, Respondent's credit, and the nature and extent of the injury, if any. (Arbitrator's Exhibit 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1) and Transcript at 8-9).

FINDINGS OF FACT

The Petitioner testified that he worked for the Respondent as a laborer for over thirty-five years. (Transcript (*hereinafter*, T.) at 15). The Petitioner testified that his job duties as a laborer consisted of forming, grading and finishing cement, curbs, sidewalks, bridges, retaining walls and foundation walls. Petitioner testified that there is a lifting requirement of over 100 pounds. (T. at 16). Petitioner performed these duties from 1984 until 2013, when Petitioner sustained an injury to his right knee that required reconstructive surgery while in the employ of the Respondent. (T. at 17).

Prior to the accident of August 7, 2013, Petitioner previously injured his shoulder requiring surgery in 2009 and sustained a bi-lateral carpal tunnel injury requiring surgery in 2011. (T. at 17). Petitioner returned to full-duty employment from his prior injuries and was in a full-duty capacity on the date of the incident in question, August 7, 2013. (T. at 17-18).

On that date, Petitioner was operating a chute on the back of the cement truck. Petitioner was backing the truck up during a sidewalk replacement project when he slipped on a railroad tie, a four-inch by four-inch piece of lumber, they were "using to block the grass and sidewalk from the curb, like, a fencing ...." (T. at 19). Petitioner testified he slipped and fell and hit his right knee on the railroad tie. He felt immediate pain in his right knee after striking the railroad tie. (T. at 19-20).

Petitioner did not work the balance of the day. (T. at 21). On the same day of the incident, Petitioner reported this incident to his supervisor, Chris Aviano. (T. at 20-21). He was required to fill out a "blue card", which is required by the Respondent, to open a claim and begin with treatment with the Respondent's designated clinic, Mercy Works. (T. at 21).

After the incident, Petitioner reported to Mercy Works with complaints of right leg pain and stiffness. (T. at 22). Petitioner had no history of right leg pain before this incident. (T. at 25). The Mercy Works' doctor prescribed medication and therapy which did not alleviate Petitioner's right leg pain. (T. at 22-23). Petitioner also was taken off work by the Mercy Work's physician and has not returned to work since that date, August 7, 2013. (T. at 23). Petitioner continued to see and treat with the doctors at Mercy Works, as per Respondent's protocol, while recovering from his injuries. (T. at 24).

The Petitioner then sought medical treatment, of his own choice, at Midwest Orthopedics at Rush, with Dr. Charles Bush-Joseph. (T. at 24 and Petitioner's Exhibit 1). Dr. Bush-Joseph is an orthopedic surgeon who specializes in conditions of the knee. Petitioner complained of right knee pain and stiffness. Dr. Bush-Joseph ordered an MRI which revealed the existence of torn meniscus of the right knee. (T. at 25 and Petitioner's Exhibit (*hereinafter*, PX) 1). After arriving at this diagnosis, Dr. Bush-Joseph recommended physical therapy. (T. at 25 and PX 1). After the MRI and a lack of progress with the physical therapy program, Dr. Bush-Joseph then prescribed an arthroscopic surgery to Petitioner's right leg/knee. (T. at 25 and PX 1). Surgery was eventually performed by Dr. Bush-Joseph on January 20, 2014. (*Id.*). The surgery consisted of a right medical meniscectomy and debridement. (*Id.*). Prior to said surgery, Petitioner never had surgery to his right knee or sustained any prior injury to his right leg and/or knee. (T. at 25).

Petitioner began a course of post-surgical physical therapy at Athletico and continued to follow-up periodically with Dr. Bush-Joseph. (T. at 26 and PX 1). Dr. Bush-Joseph eventually prescribed a Functional Capacity Evaluation (FCE) after all post-surgical therapy had been completed and Petitioner plateaued during physical therapy and work conditioning.

On October 14, 2014, Petitioner underwent the FCE at NovaCare Rehabilitation. (T. at 27, PX 1, and PX 3). The FCE report revealed: "(Petitioner) does not demonstrate the ability to meet the physical demand requirements of a Laborer based upon the job description provided by the employer. Although (he) demonstrated the ability to function in the heavy category with his maximum lifting, he was only able to function in the light to medium category with frequent lifting, walking and carrying as well as his positional tolerance according to the U.S. Department of Labor." (PX 3). The report also noted Petitioner demonstrated consistent performance

throughout testing, resulting in an "accurate representation" of his functional abilities. (PX 3). Consequently, Petitioner was placed at a medium physical demand level. (T. at 27-28 and PX 3).

Following the FCE, Petitioner returned to Dr. Bush-Joseph on December 19, 2014. (T. at 28 and PX 1). Dr. Bush-Joseph observed the FCE revealed Petitioner "had difficulty with squatting, and kneeling activities that should be performed no more than occasional(ly)." (PX 1). He reported Petitioner could "work at a medium physical demand level, which include(s) a 50-pound lifting restriction on an occasional basis and frequent lifting of 25 pounds on a regular basis" and "I felt these restrictions are permanent in nature." (T. at 28 and PX 1). Petitioner also confirmed those work restrictions. (T. at 28). Dr. Bush-Joseph then placed Petitioner at maximum medical improvement (MMI). (T. at 28-29 and PX 1). Petitioner has continued to follow-up with Dr. Bush-Joseph since being place at MMI and Dr. Bush-Joseph continues to endorse these permanent restrictions. (T. at 29).

Respondent began vocational rehabilitation and training for Petitioner in July of 2015 through TRIUNE. (T. at 30 and PX 4). TRIUNE determined that Petitioner was not a good candidate for employment, due to his restrictions, age and educational background. (T. at 31 and Respondent's Exhibit 4)

Thereafter, Respondent contacted Petitioner and requested Petitioner start conducting at least ten (10) job searches per week and hand deliver these job searches on a weekly basis to Respondent. (T. at 32). Petitioner asserted he remained in full compliance with the weekly job log requirement all the way through his testimony on May 30, 2019. (T. at 32). Subsequently, Respondent elected to change Petitioner's vocational program from TRIUNE to a new provider, MedVoc. (T. at 33 and PX 5).

Petitioner testified he complied with his requirements under the MedVoc vocational program. (T. at 32, PX 5, and Respondent's Exhibit (*hereinafter*, RX) 2). He also asserted that, during that program, his required weekly job searches increased from 10 to 18 per week and were to be conducted via computer, telephone, and in-person interviews. (T. at 34). Petitioner met on Fridays with his MedVoc counselors through March 15, 2019. (T. at 35 and PX 5).

While participating in the MedVoc vocational rehabilitation program, on December 24, 2018, Respondent's Department of Water Management (DWM) sent Petitioner correspondence explaining they had identified a position of Watchman, which was within his physical capabilities. (RX 4). The letter further indicated that Respondent was making the job available to Petitioner, requested he make an appointment to begin the process, and set forth the steps needed to move that job offer forward. (RX 4). It also stated: "If you believe your restrictions

would prevent you from performing theses (sic) duties, you MUST bring the relevant documentation to the appointment." (*Id.*) (emphasis in original).

Petitioner took issue with a questionnaire from Respondent's DWM dated January 8, 2019 that allegedly was included with the written job offer. (T. at 54-58 and RX 4). Although Petitioner acknowledged his signature, he asserted he filled out the questionnaire in October of 2018 instead of on January 8, 2019. (T. at 56). The questionnaire sought to determine via ten (10) queries Petitioner's ability and willingness to perform the job duties of a DWM Watchman. The response "I am willing to do this" is marked for each of the listed ten questions. (RX 4). However, a "No" response is marked for the response "I am physically able to do this" to Questions 1-3 and Question 5. (RX 4). Petitioner asserted he would not be able to wear the required steel toed work boots and walk patrols as specified by these job duty questions. (T. at 39-40).

Petitioner also admitted to a return-to-work conversation with Mr. Paul Plantz of Respondent's Department of Fleet and Facility Management (DFFM). (T. at 62). He reported the discussion centered on a position of Watchman for DFFM but insisted the telephone call took place in December of 2018 and not in March of 2019. (T. at 62). Petitioner acknowledged he informed Mr. Plantz during that call he could not meet the physical requirements of the Watchman position for DFFM. (*Id.*). However, introductory correspondence from Mr. Plantz to Petitioner dated March 20, 2019 requested contact with the Petitioner by March 27, 2019 and contradicts Petitioner's testimony at trial. (*Compare* T. at 62 and RX 6).

Petitioner testified his maintenance benefits were stopped in February of 2019 and Respondent's payment log confirms payment through February 15, 2019. (T. at 41-42 and RX 1). On March 13, 2019, due to Respondent's direct job offers to Petitioner, Respondent directed MedVoc to "place (Petitioner's) vocational rehabilitation services on hold." (T. at 35 and RX 2). Petitioner testified he would continue under a MedVoc program if it were offered. (T. at 36). He also reported his right knee symptoms have progressively worsened to the point where he and Dr. Bush-Joseph have discussed the option of a total right knee replacement procedure. (T. 46-47).

Petitioner also sought out and met with Ed Steffan, a certified vocational and rehabilitation counselor, on April 29, 2019. (PX 6). Mr. Steffan has conducted an initial vocational assessment and labor market survey that concluded Petitioner is not employable in the current labor market. (PX 6). Mr. Steffan opined: "given Mr. Hughes' diminished physical capacities, extensive non-successful vocational placement services, limited education and lack of transferable skills, we do not recommend Mr. Hughes be referred to E.P.S. Rehabilitation,

Inc. or any other company for vocational placement assistance given the failed vocational assistance to date." (PX 6). In more than one section of his May 28, 2019 report[1], Mr. Steffan cited Dr. Bush-Joseph's December 19, 2014 work restrictions of *"No prolonged standing/walking. No kneeling, squatting, climbing"* to apply a sedentary work level to Petitioner's "diminished physical capacities." (PX 6) (emphasis in original).

CONCLUSIONS OF LAW

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

Issue F: *Causal connection*

Petitioner immediately reported a right knee injury to his immediate supervisor on the date of the accident in question, which was August 7, 2013. Following that, the Petitioner sought medical care at Mercy Works. Thereafter, Petitioner came under the care of an orthopedic surgeon of his own choice, Dr. Charles Bush-Joseph of Midwest Orthopedics at Rush. (PX 1). Dr. Bush-Joseph ordered an MRI which revealed the existence of a right medical meniscus tear of the right knee. (PX 1). After an unsuccessful course of physical therapy, Petitioner underwent a medical meniscectomy and debridement of the right knee (*Id.*). After surgery, Petitioner continued to experience pain, numbness, and stiffness in his right leg. Dr. Bush-Joseph, after post-surgical therapy, ordered an FCE for Petitioner that placed Petitioner at a medium level of functionality. (PX 3). He also declared Petitioner to be at MMI and his medium level work restrictions to be permanent. (PX 1).

Accordingly, the Arbitrator finds Petitioner's current state of ill-being is causally related to his work injury with the Respondent on August 7, 2013.

[1] Issued two (2) days prior to the start of trial on May 30, 2019. (*Compare* PX 6 and T. at 1).

Issue K: *Maintenance benefits*

The record reveals Respondent paid Petitioner maintenance benefits from November 1, 2014 through February 15, 2019. (RX 1).[2] Petitioner seeks additional maintenance benefits beyond February 15, and Respondent disputes any liability for further maintenance benefits.

An employee's entitlement to maintenance begins when his medical condition has stabilized, he has reached MMI, 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 claimant must make a good faith effort in his job search and vocational rehabilitation program. If such a good faith effort is not made or ceases, entitlement to maintenance ends and permanency benefits, if any (i.e.: permanent partial disability (PPD), wage loss differential, and permanent total disability (PTD)), commence.

Here, Petitioner commenced his formal vocational rehabilitation program on October 6, 2017 with MedVoc. Although Petitioner had previously interviewed with TRIUNE vocational rehabilitation, it was determined he would not be a good fit for their program. (PX 4). Instead, Petitioner participated in the vocational program administered by MedVoc from October 6, 2017 through March 13, 2019. During this vocational effort, Petitioner abided by MedVoc's application instructions, but many potential employers were not hiring. (RX 2). The MedVoc counselors reported on their repeated requests to Petitioner to contact prospective employers by telephone to determine if they are hiring before prior to appearing in-person to fill out an application. (RX 2). Communication difficulties and disagreements between Petitioner and MedVoc were documented in these status reports and call into question the diligent or good faith nature of Petitioner's job search efforts and his credibility on the same.

Petitioner had further difficulties and disagreements directly with Respondent during its efforts to offer him work within his medium level restrictions. Petitioner repeatedly asserted Dr. Bush-Joseph had imposed upon him walking restrictions. (T. 40-41 and 50-51). However, Dr. Bush-Joseph's December 19, 2014 MMI report discussed Petitioner's October 14, 2014 FCE findings and only cited "a 50-pound lifting restriction on an occasional basis and frequent lifting of 25 pounds on a regular basis." (PX 1). He went on to find Petitioner "had difficulty with squatting and kneeling activities that should be performed no more than occasional(ly). I felt these restrictions are permanent in nature." (PX 1). Accordingly, any

[2] Certain payments during this period were listed under Respondent's "TTD" section and were for the identical maintenance amount of $1,934.40. (RX 1 at 4).

walking restrictions from Dr. Bush-Joseph that were cited by Petitioner during his testimony or to Respondent during the Watchman job offers cannot be verified by the medical report contained within the record and are given little, if any, credence. (*Id.*).

Similarly, Mr. Steffan's vocational assessment quoted Dr. Bush-Joseph's December 19, 2014 report as instructing Petitioner to avoid "prolonged standing/walking", despite such a restriction not being found in that Dr. Bush-Joseph report. (*Compare* PX 6 and PX 1). Mr. Steffan also read Dr. Bush-Joseph's report to prohibit ("No kneeling, squatting, climbing") certain work activities the doctor only had limited Petitioner to performing "... no more than occasional(ly)." (*Compare* PX 6 and PX 1). These misstatements of highly relevant medical facts by a vocational counselor in his eve-of-trial report undermines Mr. Steffan's credibility and the credibility of his report before the Arbitrator and they are given little, if any, credence, as well.

Furthermore, Petitioner asserted he could not perform the duties of a Watchman for DWM as offered by the Respondent because of the need for steel-toed shoes. (T. at 39-40). However, he subsequently acknowledged Dr. Bush-Joseph had not restricted him from wearing steel-toed shoes while at work. (*See* T. at 66 and PX 1). Additionally, Petitioner's assertion his discussions with Mr. Plantz at Respondent's DFFM took place in October of 2018 is not supported by the March 20, 2019 correspondence from Mr. Plantz meant to initiate those discussions. (*Compare* T. at 62-63 and RX 6).

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 plaintiff'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).

In the case at hand, Petitioner has failed to prove that he diligently participated in a bona fide search for employment when Respondent offered two (2) Watchman positions within his work restrictions. He was obligated under the Act to make a "good-faith" effort to cooperate in his rehabilitation effort. The record and Petitioner's and Mr. Steffan's lack of credibility establish that, as the calendar turned to 2019, he did not make such an effort.

As such Petitioner only is entitled to maintenance from November 1, 2014 through February 15, 2019. Additionally, Respondent shall have a credit for all benefits paid during this period. (RX 1).

Issue L: *Nature and extent of injury*

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

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

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

(i) The reported level of impairment from (a) above;

(ii) The occupation of the injured employee;

(iii) The age of the employee at the time of injury;

(iv) The employee's future earning capacity; and

(v) Evidence of disability corroborated by medical records.

(See 820 ILCS 305/8.1b)

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

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence by either party. As such, the Arbitrator gives ***no weight*** to this factor.

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

ii. The Arbitrator finds the Petitioner was employed by the Respondent as laborer at the time of the injury and he was

not able to return to work in his prior capacity at a full duty status after said injury. The Arbitrator therefore gives ***moderate weight*** to this factor.

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

iii. The Arbitrator notes the Petitioner was 51 years old at the time of the accident. (AX 1). The Arbitrator therefore gives ***some weight*** to this factor.

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

iv. The Arbitrator notes the Petitioner was released to restricted duty and his treating physician and FCE found him to be capable of medium-duty work. Petitioner was unable to return to his heavy-duty work level as a laborer for Respondent and has, as of trial, been unable to locate new employment within his current work restrictions. As such, the Arbitrator therefore gives ***moderate weight*** to this factor.

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

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner suffered injuries to his right leg for which he received medical care, including surgical intervention, that resulted in Dr. Bush-Joseph imposing permanent work restrictions that limit Petitioner to medium-duty work. Petitioner continues to have residual pain and discomfort in his right leg and asserts his movement with his right lower extremity is impaired. Due to the Petitioner's medically documented injuries and all the testimony within the record, the Arbitrator therefore gives ***significant 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 a **45% loss of use of the person-as-a-whole** pursuant to Section 8(d)2 and Section 8.1b of the Act.

Issue N: *Respondent's credit*

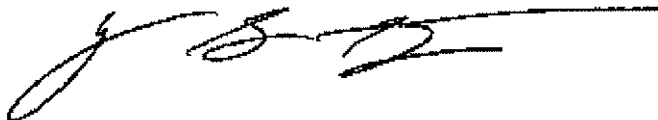
Based upon the findings in **Issue K:** above, Respondent shall have credit for past benefits (TTD and maintenance) paid to Petitioner. (*See* RX 1).

Issue O: *Other issues*

The parties were afforded an opportunity to submit their own proposed arbitration decisions for the Arbitrator's consideration. 50 Il. Admin. Code 9030.80(a).[3] Petitioner's proposed decision, delivered to the Arbitrator via e-mail, included a section claiming entitlement to penalties and attorney's fees under Sections 19(k), 19(l), and 16, respectively, due to the Respondent's failure to pay certain benefits.

However, Petitioner failed to claim entitlement to penalties and/or attorney's fees on the May 30, 2019 Request for Hearing (RFH) form. (AX 1). Also, Petitioner failed to indicate on the RFH whether he "**had or had not**" filed a penalty petition in support of this claim for penalties and attorney's fees. (AX 1) (emphasis added). Additionally, Petitioner's counsel, when queried, acknowledged: "that the petitioner is not seeking penalties nor attorneys' fees ...". (T. at 7-8). Furthermore, a review of the actual IWCC file for 13 WC 42418 failed to find any **filed** penalty/attorney's fees petition and no such petition was admitted into evidence prior to the close of proofs on August 21, 2019. Finally, the parties sought and were granted permission to amend the RFH relative to (1) the medical bills issue, (2) the paid benefits issue, and (3) receipt of the Arbitration Decision via e-mail, but took no action to amend the penalty/attorney's fees issue of the RFH prior to its admission into evidence. (Tr. at 5-10).

As the IWCC file and the record of these proceedings lack a penalty/attorney's fees petition setting forth any allegations entitling Petitioner to penalties under Sections 19(k) and 19(l), as well as attorney's fees under Section 16, and multiple opportunities to advance such a claim were afforded the Petitioner, the Arbitrator declines to award the same.



Signature of Arbitrator

APRIL 17, 2020
Date

[3] The parties are reminded Section 9030.80(a) mandates that such proposed decisions "shall not be made part of the record." (*See* 50 Il. Admin. Code 9030.80(a)).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC033773
Case Name	PEARCE, DENNIS v. THE AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0098
Number of Pages of Decision	23
Decision Issued By	Marc Parker, Commissioner, Marc Parker, Commissioner

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Julie Webb

DATE FILED: 3/17/2022

/s/*Marc Parker, Commissioner*

Signature

DISSENT

/s/*Marc Parker, Commissioner*

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Pearce,

Petitioner,

vs. No. 17 WC 33773

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 the issues of occupational disease, causal connection, nature and extent, and §1(e) - §1(f)/disablement, and being advised of the facts and law, reverses the Amended Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 61-year-old coal miner, alleged he developed occupational diseases including pneumoconiosis, COPD and chronic bronchitis as a result of working as a coal miner for 36 years. He lost no time from work as a result of his claimed conditions, and worked for Respondent until the day the mine shut down on September 23, 2017.

At the March 11, 2021 arbitration hearing, Petitioner testified that he began experiencing shortness of breath and breathing difficulties five years earlier, while he was still working in the mine. He claimed his symptoms progressed and testified that he now becomes short of breath after walking one-half a mile. Petitioner admitted that but for the mine shutting down, he would have continued working. Petitioner is now retired.

Petitioner presented the opinions of two retained medical experts. Dr. Smith, a certified B-reader, interpreted Petitioner's October 4, 2017 chest x-ray as showing the presence of simple coal workers' pneumoconiosis ("CWP"). Dr. Istanbouly, a board certified pulmonologist but not

a B-reader, examined Petitioner on June 18, 2018 and diagnosed him with CWP, chronic bronchitis and COPD, mainly from mine exposures. Dr. Istanbouly opined Petitioner could no longer regularly work as a coal miner for over 40 hours/week.

Respondent presented the opinions of two retained experts, Dr. Meyer, a board certified radiologist and certified B-reader; and Dr. Rosenberg, a board certified pulmonologist and certified B-reader. Both read Petitioner's October 4, 2017 chest x-ray and opined it did not show CWP. Dr. Rosenberg also reviewed Petitioner's medical records but did not examine him. In addition to concluding Petitioner did not have CWP, Dr. Rosenberg opined that: Petitioner's records did not reveal the presence of chronic bronchitis or respiratory problems, Petitioner was not disabled from a pulmonary perspective, and he was capable of performing heavy manual labor. Dr. Rosenberg attributed Petitioner's cough to the Lisinopril medication he was taking for hypertension.

The Arbitrator found that Petitioner proved he suffered from the following occupational diseases which arose out of and in the course of his employment: CWP, chronic bronchitis and COPD. The Arbitrator found Petitioner's experts more persuasive than Respondent's, and awarded Petitioner 6% loss of body as a whole under §8(d)2. In so finding, the Arbitrator relied upon Dr. Istanbouly's opinions that Petitioner suffered from simple, early stage CWP and COPD, and Dr. Smith's opinion that Petitioner had simple coal worker's pneumoconiosis. The Arbitrator gave greater weight to Dr. Istanbouly's opinions because he alone examined Petitioner and took a history from him. The Arbitrator also found Petitioner credible, believing there was no reason to doubt his testimony at arbitration, or what he reported to Dr. Istanbouly.

The Commission views the evidence differently than the Arbitrator. Petitioner testified at the March 2021 arbitration hearing that his breathing problems – shortness of breath and difficulty filling his lungs with air – began approximately 5 years earlier, while he was still working at the mine. However, that testimony is contradicted by the contemporaneous medical records of Petitioner's primary physician, Dr. Rider, who examined him multiple times in 2015 and 2016. At those visits, Dr. Rider reported Petitioner had no chronic cough, decreased exercise tolerance, or shortness of breath. Petitioner's arbitration testimony is also contradicted by Dr. Istanbouly's June 18, 2018 report, in which Dr. Istanbouly documented Petitioner's admission of having no respiratory problem upon leaving the coal mine.

Petitioner also told Dr. Istanbouly in June 2018 that he had been, "coughing almost on a daily basis for the past few years." That history, however, is inconsistent with Dr. Rider's subsequent note dated February 27, 2020 in which she reported, after examining Petitioner's respiratory system, "Negative for cough, chest tightness, shortness of breath and wheezing."[1]

[1] While Dr. Rider did note on November 1, 2018 that Petitioner was experiencing, "Congestion, cough and wheezing (occasional), no shortness of breath," she diagnosed him with acute sinusitis, environmental allergies and panlobular emphysema. Dr. Rider did not offer any opinion as to the cause of those conditions, none of which were documented as being present on Petitioner's subsequent visit to Dr. Rider in February 2020.

CWP:

A diagnosis of CWP is usually made upon the reading of a chest x-ray by a B-reader. The opinions of B-readers are usually considered more reliable than those of non-B-readers. Dr. Istanbouly is not a B-reader, and the Commission does not find his opinion that Petitioner developed CWP from coal dust inhalation, as persuasive as did the Arbitrator. Dr. Istanbouly admitted he did not know the difference between a 1/0 profusion and a 0/1 profusion on chest x-ray films, and could not state whether Petitioner's showed a 1/0 or a 0/1 profusion. Dr. Istanbouly acknowledged he relied on Dr. Smith's interpretation of Petitioner's chest imaging.

Dr. Smith was the only B-reader who opined Petitioner suffered simple coal worker's pneumoconiosis. Dr. Smith was not presented for a deposition. He found no opacities in Petitioner's upper lung zones; only small ones in his middle and lower lung zones. He did not find any chest wall plaques, classifications or large opacities.

The Commission finds the opinions of Respondent's two B-reader experts – that Petitioner did not develop CWP – more persuasive. Both gave depositions in which they explained the bases of their opinions. Dr. Rosenberg is well qualified, having been certified as a B-reader in 2000, and recertified four times since. He also worked as a medical advisor for the Social Security Administration and the Industrial Commission of the State of Ohio. Dr. Rosenberg reviewed Petitioner's chest x-ray and opined that it showed no opacities.

Dr. Meyer testified regarding the training and examination required to become a B-reader. He served as a board examiner for the American Board of Radiology, and is on the American College of Radiology Pneumoconiosis Task force. He was engaged in redesigning the course, the exam, and submitting cases for the B-reading training module and exam. He currently reads an average of 200 to 250 x-rays per week. Dr. Meyer read Petitioner's chest x-ray and opined that it was normal, with no small opacities, large opacities, or findings of CWP. Dr. Meyer testified that CWP is typically an upper lung zone predominant process. He opined that the small opacities which Dr. Smith reportedly saw in the middle and lower lung zones of Petitioner's chest x-ray were not consistent with the general progression of CWP.

Chronic Bronchitis/COPD:

The Commission also finds more persuasive Dr. Rosenberg's opinions that Petitioner did not develop work-related chronic bronchitis or COPD. Dr. Rosenberg has been board certified in pulmonary disease since 1980, and holds additional board certifications in internal medicine and occupational medicine. He has taught pulmonary physiology, pulmonary medicine, respiratory physiology and pulmonary disease.

Although Dr. Rosenberg did not examine Petitioner, he did review his prior medical records going back to 2008, something which Dr. Istanbouly did not do. Dr. Rosenberg testified

that in 2008, Petitioner was diagnosed with cardiomyopathy, a condition which can lead to shortness of breath. No doctor opined that Petitioner developed that condition from mine exposures. Dr. Rosenberg did not believe Petitioner had chronic bronchitis, which is defined by the World Health Organization and the American Thoracic Society as having, "a chronic cough and sputum production for three months out of a given year, for two consecutive years." Dr. Rosenberg testified that the history Petitioner provided to Dr. Istanbouly – that his cough was mostly dry and occasionally productive – was not consistent with that definition. Dr. Rosenberg noted that a diagnosis of chronic bronchitis was not found in any of Petitioner's treatment records which he reviewed.

Dr. Istanbouly diagnosed Petitioner with chronic bronchitis, a component of COPD; and believed Petitioner had a mild obstructive defect "consistent with" COPD. However, Dr. Istanbouly acknowledged that shortness of breath can be caused by deconditioning and heart disease, the latter of which Petitioner was shown to have. Dr. Istanbouly also admitted Petitioner's cough was not triggered by dust, smoke, fumes or vapors; but rather, by lying down and strenuous activity.

Dr. Istanbouly testified Petitioner had a "7.5 pack-year history of smoking," yet he did not consider that a significant cause of his condition. Dr. Istanbouly did not believe Petitioner could regularly perform the work of a coal miner for over 40 hours/week, but he acknowledged Petitioner's "mild cough, mild sputum production," was not the reason Petitioner quit working at the mine, and would not preclude him from working full time. The Commission finds Dr. Istanbouly's opinions somewhat inconsistent.

Dr. Rosenberg did acknowledge that coal mine dust can cause chronic bronchitis or COPD in some workers. He also found that Petitioner's 2018 pulmonary function tests, "at worst, reveal a minimal degree of airflow obstruction." However, Petitioner's 2019 pulmonary function tests showed a normal FEV_1/FVC ratio. Dr. Rosenberg opined that an obstruction which is not permanent is not likely related to past coal mine dust exposure.

Considering the record as a whole, the Commission finds Petitioner did not meet his burden of proving he developed CWP, chronic bronchitis or COPD as a result of any exposures while working for Respondent. The Commission reverses the Arbitrator's finding that Petitioner proved a work-related accident/exposures on September 23, 2017, or that any current condition of ill-being is causally connected to such accident/exposures.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Amended Decision of the Arbitrator filed June 8, 2021, is hereby reversed, and all benefits are denied.

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

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

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.

March 17, 2022

MP/mcp
o-2/17/22
068

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

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

DISSENT

I respectfully dissent from the majority's decision and would affirm and adopt the well-reasoned decision of the Arbitrator in which she found that Petitioner proved he sustained an occupational disease which arose out of and in the course of his employment. In reversing the Arbitrator's decision, the majority concluded that the opinions of Dr. Meyers and Dr. Rosenberg were more persuasive than those of Dr. Smith and Dr. Istanbouly. I disagree with that conclusion.

Petitioner testified he worked in Respondent's coal mine for 36 years. There is no dispute that during that time, he was exposed to coal dust, silica dust, roof bolting glue fumes, and diesel fumes. Petitioner testified he first noticed shortness of breath while he was still working in the mine, and that his condition has been worsening since then. Currently, he becomes short of breath after walking one-half of a mile, and he can no longer hunt. No evidence was offered to contradict that testimony.

Although Dr. Rider reported, at some of Petitioner's exams, that Petitioner did not have a chronic cough or shortness of breath, that does not make his testimony uncredible. Symptoms in patients diagnosed with reactive airway disease can wax and wane, as Dr. Rosenberg testified.

That Petitioner may have had fewer symptoms at some of his examinations is not proof he did not have an occupational disease.

I find, as did the Arbitrator, Dr. Istanbouly's opinions to be the most persuasive. Chronic bronchitis is a diagnosis based on the patient's history, and only Dr. Istanbouly examined and took a history from Petitioner. Petitioner's complaints of having a "mostly dry," and, "occasionally productive," cough are not outside the WHO and ATS definitions of chronic bronchitis, which require only that a chronic cough and sputum production be present 25% of the time for two consecutive years.

Dr. Istanbouly testified that having hyperexpanded lungs is a manifestation of emphysema, which is included in COPD, both diagnoses which can be used interchangeably. Dr. Rosenberg also agreed that Petitioner's chest x-ray showed hyperexpansion of his lungs. He also agreed that such a finding would be consistent with a diagnosis of COPD.

Dr. Istanbouly opined that Petitioner's pulmonary function tests revealed a mild obstructive defect. Dr. Rosenberg also agreed with that finding, though he quantified Petitioner's airflow obstruction to be at worst, minimal. For an occupational disease to be compensable, however, exposure to an occupational hazard need only be *a* cause, not the sole cause or main cause of the condition of ill-being.

I also find Dr. Rosenberg's opinions to be less persuasive than does the majority. He never examined Petitioner, and his opinions were based entirely upon a review of Petitioner's records. Although Dr. Rosenberg reported that Petitioner had not been diagnosed with chronic bronchitis *in the records he reviewed,* he is not able to state Petitioner currently does not suffer from chronic bronchitis or COPD.

Dr. Rosenberg also made several concessions in his testimony. He acknowledged that coal mine dust *can* result in chronic bronchitis and shortness of breath. He admitted Petitioner's pulmonary function tests *did* reveal a degree of airflow obstruction, and that an obstruction can be caused by scar tissue in the lungs. He conceded that Petitioner's x-ray showed hyperexpansion of the lungs, which, he acknowledged, could be consistent with COPD. Dr. Rosenberg agreed that a patient can have CWP – despite having a normal pulmonary function test, a normal clinical exam, and no symptoms. Even though Dr. Rosenberg did not believe Petitioner's chest x-ray showed CWP, he acknowledged Petitioner could nonetheless have that condition. Respondent's other expert, Dr. Meyer, agreed with that opinion, testifying that a chest x-ray read as negative for CWP would not rule out a coal miner having pathological CWP.

Finally, I find that Dr. Rider's records would also support affirming the Arbitrator's decision. On November 1, 2018, Dr. Rider documented Petitioner's diagnoses as, "COPD," and, "first stage black lung." In addition, Dr. Rider reported Petitioner had, "Associated COPD symptoms," including, "Congestion, cough and occasional wheezing." Dr. Rider's assessment of Petitioner was acute non-recurrent maxillary sinusitis, environmental allergies and *panlobular*

emphysema. Dr. Rider's diagnoses support Dr. Istanbouly's opinions that Petitioner, in fact, suffered from COPD and emphysema.

I agree with the Arbitrator's findings, and would have affirmed her decision. Therefore, I respectfully dissent.

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC033773
Case Name	PEARCE, DENNIS v. THE AMERICAN COAL CO
Consolidated Cases	
Proceeding Type	
Decision Type	Amended Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	15
Decision Issued By	Jeanne AuBuchon, Arbitrator

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Kenneth Werts

DATE FILED: 6/8/2021

INTEREST RATE FOR THE WEEK OF JUNE 8, 2021 0.04%

/s/ *Jeanne AuBuchon, Arbitrator*

Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMEMDED ARBITRATION DECISION 19(F)

DENNIS PEARCE
Employee/Petitioner
v.
THE AMERICAN COAL CO.
Employer/Respondent

Case # **17** WC **33773**

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 Jeanne L, AuBuchon, Arbitrator of the Commission, in the city of **Collinsville**, on **March 11, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Disease/exposure, causation, Sections 1(d)-(f), 19(d).**

FINDINGS

On **09/23/17**, 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 **$63,600.06;** the average weekly wage was $**1,223.08.**

On the date of accident, Petitioner was **61** years of age**, married** with **0** dependent children.

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

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

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

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

ORDER

- The Respondent shall pay the Petitioner the sum of $733.84/week for a further period of 30 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused a permanent and partial disablement to the extent of 6% MAW.

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

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

Jeanne L. AuBuchon
Signature of Arbitrator

JUNE 8, 2021

PROCEDURAL HISTORY

This matter proceeded to trial on March 11, 2021, pursuant to Section 7 of the Illinois Workers' Occupational Diseases Act (820 ILCS 310) (hereinafter "the Act"). The issues in dispute are: 1) whether the Petitioner sustained an occupational disease arising out of and in the course of his employment, including whether the requirements of Sections 1(d)-(f) were met; 2) the causal connection between exposure to the occupational disease and the Petitioner's current condition of ill being; and 3) the nature and extent of the Petitioner's injury.

FINDINGS OF FACT

An Application for Adjustment of Claim was filed on November 16, 2017, wherein the Petitioner alleged he sustained an occupational disease of his lungs, heart, pulmonary system and respiratory tracts. (AX2) The Petitioner alleged he sustained an occupational disease as a result of inhalation of coal mine dust, including but not limited to coal dust, rock dust, fumes and vapors for a period in excess of 36 years, with the date of last exposure being September 23, 2017. (Id.)

The Petitioner was 64 years old at the time of Arbitration and lives in Eldorado, Illinois. (T. 12) He graduated from high school and took one year of junior college at Southeastern Illinois College (T. 12-13)

The Petitioner worked 36 years in the mining industry, half of which was above ground and the other half below ground. (T. 13) In addition to coal dust, he was regularly exposed to and breathed roof bolting glue fumes, silica dust and diesel fumes. (Id.) On the last date of exposure, the Petitioner was working for American Coal Company at the New Future mine as a hoist man. (T. 14) He said he was exposed to coal dust on his last day of employment, which was when the mine shut down. (T. 15)

On October 9, 1981, the Petitioner began his mining career at Kerr-McGee, which later was bought out by American Coal. (T. 16) The Petitioner spent his entire mining career at the same mine. (T. 15) He was hired in as a general laborer which he described as doing general construction work underground, work on the conveyor systems and any other grunt work that needed to be done. (T. 16-17) About a year later, he moved on to being a roof bolter, using a machine that drills holes into the roof of the mine -- anywhere from 6 to 8 feet deep -- and installing bolts that support the roof. (T. 17) Glue pins approximately 3-feet long were used to secure the bolts into the roof. (T. 18) The Petitioner described a strong odor that came from these glue pins -- strong enough to take your breath away. (Id.) The Petitioner also described silica rock dust exposure performing this job from drilling hundreds of holes per shift. (T. 18-19).

After five years as a roof bolter, the Petitioner became a mine examiner, in which capacity he traveled the entire mine looking for hazards, unsafe conditions or anything that was not up to standards (T. 19) He described being in all parts of the mine and being exposed to high doses of coal dust especially at the working face of the mine, where coal was being cut, and on the conveyor system, where the return air system picked up the methane and coal dust and carried it out of the mine. (T. 19-20) He was a mine examiner for approximately 12 years. (T. 21)

The Petitioner then moved up to the surface and took the job of hoist man for the last 17 years of his career. (Id.) As a hoist man, the Petitioner was in charge of the main elevator that runs up and down the mine shaft, transporting miners, supplies and equipment to and from the mine. (T. 21-22, 30-31) Every shift he would inspect and sign off on papers certifying that the elevator was safe. (T. 22) The hoist itself was located in a separate building. (T. 29-30) Because that job only took an hour out of each shift each day, the Petitioner also ran equipment on the surface of the mine. (Id.) The Petitioner testified that the dust exposure on the surface was almost

as bad as it was below the mines because everything that came up from the mine – equipment and material cars -- was covered in coal that fell off and was run over and ground into powder. (T. 23) In some places, the fine coal dust powder built up to 6-8 inches deep. (Id.)

When the Petitioner was laid off from the mine, he received unemployment, Social Security benefits and his pension. (T. 32)

The Petitioner first started noticing breathing problems in the last five years of working in the mine. (Id.) He noticed shortness of breath -- that it was hard for him to feel like his lungs were getting filled up with air. (T. 24) From the time he first started noticing breathing problems until he left the mine, his condition worsened and has continued to worsen since. (Id.). The Petitioner described his breathing difficulties affecting his daily living -- getting short of breath going upstairs to the second story of his house and after walking a half mile. (T. 25) He used to deer hunt but partially because of his breathing problems he could not climb up into a deer stand. (Id.) The Petitioner enjoyed bicycling but was limited to riding on level ground because of breathing difficulties. (Id.) He fishes occasionally and uses a riding mower to mow his lawn. (T. 36, 38) He spends most of his time caring for his wife, who has severe heart disease. (Id.) The Petitioner was a smoker for about 10 years, smoking an average of three-fourths of a pack per day. (T. 27)

In addition to having breathing problems, the Petitioner had a stent placed "in his heart" about 12 years ago but has not needed to return to a cardiologist since then. (Id.) He has a primary care doctor but has not seen him for breathing problems because after being laid off from the mine, he has not had health insurance. (T. 26) The Petitioner takes medications for high blood pressure and cholesterol. (T. 28)

While working at the mine, the Petitioner underwent periodic chest X-ray screenings by the National Institute for Occupational Safety and Health. (T. 34) He received letters regarding

the results of those screenings but, at the time of Arbitration, did not have copies. (T. 35) None of the prior screenings were submitted as evidence.

On June 18, 2018, at the request of his attorney, the Petitioner saw Dr. Suhail Istanbouly, a board-certified practitioner in internal medicine, pulmonary medicine, critical care medicine and sleep medicine. (T. 32, PX1) In his report, Dr. Istanbouly noted that the Petitioner had been experiencing mild coughing almost daily, triggered mainly by lying down and strenuous activities. (PX1, Deposition Exhibit 2) The cough was mostly dry and occasionally productive of slight yellowish sputum. (Id.)

A spirometry test revealed mild obstructive defect with FEV1 (forced expiratory volume) of 3.17 liters, 83% predicted; FVC (forced vital capacity) of 4.8 liters, 95% predicted and FEV1/FVC of 66%, which Dr. Istanbouly said was consistent with chronic obstructive pulmonary disease (COPD) GOLD stage 1. (Id.) Dr. Istanbouly diagnosed the Petitioner as having simple, early stage coal workers' pneumoconiosis (CWP) related to long-term coal dust inhalation and COPD, mainly related to long-term coal dust inhalation and smoking as a secondary factor. (Id.) He reported that it was obvious that long-term coal dust inhalation was a significant contributor to the Petitioner's chronic respiratory symptoms of chronic daily cough, sputum production and exertional dyspnea. (Id.)

Dr. Henry K. Smith, a "B-reader" radiologist, examined a chest X-ray performed October 4, 2017, and found interstitial fibrosis of classification p/p, mid to lower zones involved bilaterally of a profusion 1/0. (PX2) He found no chest wall placques, classifications or large opacities. (Id.) The Petitioner's heart size was normal, and the great vessels within the structure were unremarkable. (Id.)

In a deposition on November 16, 2020, Dr. Istanbouly testified that the Petitioner's chronic respiratory symptoms described above equated to a diagnosis of chronic bronchitis -- a form of (COPD). (PX1) He stated that based on the level and duration of exposure to coal dust, the Petitioner's inhalation of coal dust was the main culprit for the Petitioner's condition, and that his cigarette smoking was a secondary contributing factor. (Id.) He noted that according to textbooks, significant lung damage from smoking would require a 20 pack-year history, as opposed to the Petitioner's 7.5 pack-year history. (Id.)

On cross-examination, Dr. Istanbouly stated that the Petitioner had a normal oxygen saturation at rest and no wheeze, crackles or rales. (Id.) The Petitioner did have decreased breath sounds. (Id.) When confronted with the Petitioner's normal spirometry results for FVC, Dr. Istanbouly stated that he could not rule out the possibility of restrictive defect just based on normal FVC. (Id.) He also stated that he did not rely solely on Dr. Smith's reading of the chest X-ray, but read them himself and developed his own impression. (Id.)

According to Dr. Istanbouly, the Petitioner's condition could improve now that he is no longer working in the mine, but it may not go away completely. (Id) Dr. Istanbouly opined that because of the diagnosis of COPD, the Petitioner was not capable of performing the work of a coal miner for more than 40 hours per week on a regular basis. (Id.)

Dr. Istanbuly also pointed to several limitations to pulmonary function tests. (PX1) He stated that in the early stage of lung injury or disease, it is possible for a person to have normal pulmonary function tests – even when a lobe of a lung has been removed. (Id.) In addition, he said pulmonary function tests only reflect lung function on the day of the test. (Id.) Dr. Istanbuly testified that it is possible for a person to begin work in a coal mine at the top of the "normal" range and leave mining at the bottom of the "normal" range and having a significant loss of lung

function. (Id.) He said such tests do not specify etiology of pulmonary abnormalities – just the type and severity. (Id.) He also testified that chest X-ray did not necessarily rule out the existence of CWP. (Id.)

At the request of the Respondent, Dr. Cristopher Meyer, also a "B-reader" radiologist, reviewed the same chest X-ray and found no CWP. (RX1, Deposition Exhibit B) He noted that the Petitioner's lungs were clear, and there were no small rounded, small irregular or large opacities. (Id.) He reported that the mediastinum, cardiac silhouette, bones and soft tissues were unremarkable. (Id.) In his report, Dr. Meyer disagreed with Dr. Smith's findings, stating that the examination was normal. (Id.)

At his deposition on September 17, 2019, Dr. Meyer testified consistently with his report. (RX1) He acknowledged that two equally qualified "B readers" of chest X-rays can disagree as to whether they think they are seeing small opacities. (Id.) He added that it is important to recognize that reading X-rays is an interpretative skill, and that is why there are divergences of opinion. (Id.) He also acknowledged that studies exist that show as much as 50% of autopsies of coal miners showed abnormalities of CWP that were not apparent on X-rays. (Id.) Dr. Meyer further admitted that CWP could develop at any time during a miner's career and show up on an X-ray after a miner has ceased working in the mine. (RX1)

A review of the Petitioner's medical records was conducted on June 10, 2020, by Dr. David Rosenberg, a board-certified physician in internal medicine, pulmonary disease and occupational medicine hired by the Respondent. (RX2, Deposition Exhibit B) He concluded that, at worst, the Petitioner's pulmonary function tests revealed a minimal degree of airflow obstruction and that the Petitioner was not disabled from a pulmonary perspective and does not have a coal-mine-related form of obstruction. (Id.)

Dr. Rosenberg reviewed the following: records from Harrisburg Medical Center, including pulmonary function tests from June 18, 2018; predicted value calculations from the pulmonary function tests from June 18, 2018; records from The Heart Group; records from Primary Care Group; the B-readings of the October 4, 2017, chest X-ray conducted by Dr. Smith and Dr. Meyer; Dr. Istanbouly's report; pulmonary function tests from Stat-Care conducted April 15, 2019; predicted value calculations for the April 15, 2019, pulmonary function tests; and the October 4, 2017, chest X-ray. (Id.) These records – except the X-ray films – were admitted as exhibits at Arbitration.

The Harrisburg Medical Center pulmonary function tests from June 18, 2018, showed FCV and FEV1 values as stated above that were lower than predicted levels and a FEV1/FVC ratio as stated above that was less than 1 percentage point over lower limits. (Id.) The Stat-Care pulmonary function tests from April 15, 2019, showed the Petitioner's FVC was 4.36 liters (86% predicted), and his FEV1 was 3.15 liters (82% predicted) – lower than the levels a year prior and still lower than levels for someone of his age, height and weight. (Id.) However, the Petitioner's FEV1/FVC ratio was higher than the year prior at 72%. (Id.)

Dr. Rosenberg testified consistently with his report. (PX2) He said that under the American Medical Association Guides to the Evaluation of Permanent Impairment, the Petitioner would fall in a Class 0. (Id.) He noted that the Petitioner's medical records of prior doctor and hospital visits failed to show evidence of serious breathing complaints. (Id.) He opined that the Petitioner was capable of heavy manual labor and that it was unlikely the Petitioner would ever develop complicated pneumoconiosis, cor pulmonale, asthma or reactive airway disease. (Id.) He disagreed with Dr. Istanbouly's diagnosis of chronic bronchitis and stated that at worst, the pulmonary function tests revealed mild obstruction. (Id.)

In his review of the October 4, 2017, chest X-ray, Dr. Rosenberg noted hyperexpansion, which he testified during cross-examination could be consistent with COPD. (Id.) He also conceded that patients could have radiologically significant CWP yet have normal pulmonary function tests, normal blood gases, a normal physical exam of the chest and no symptoms, which would generally be expected of a patient with simple CWP. (Id.) He said the Petitioner could have CWP even with a negative X-ray reading. (Id.)

All of the doctors testified that that a miner with CWP, COPD, emphysema, and/or chronic bronchitis should avoid further exposure to the environment of a coal mine. (PX2, RX1, RX2)

CONCLUSIONS OF LAW

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

Issue C: Did the Petitioner suffer an occupational disease which arose out of and in the course of his employment by the Respondent?

Section 1(d) of the Act provides that the term "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendering disabling as a result of the exposure of the employment. Further, such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public.

The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that he has an occupational disease as defined by the Act. Dr. Istanbouly's examination and conclusions that the Petitioner was suffering from simple, early stage CWP and COPD, as well as Dr. Smith's reading of the X-ray, are consistent with the Petitioner's complaints. There was no reason to doubt the Petitioner's testimony nor what he reported to Dr. Istanbouly.

Further, the Respondent's doctors could not state that Dr. Istanbouly and Dr. Smith's conclusions were clearly erroneous – they admitted that qualified doctors could have a difference of opinion. Considering the Respondent's doctors' concessions on the points outlined in the Findings of Facts above and the fact that Dr. Istanbouly examined the Petitioner himself, rather than simply reviewing records, the Arbitrator gives greater weight to Dr. Istanbouly's opinion.

Regarding the element of disablement, Section 1(e) of the Act provides defines the term as an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment. Evidence of the Petitioner's disablement was shown in the Petitioner's testimony of his physical limitations from his breathing problems and in Dr. Istanbouly's opinion that the Petitioner was not capable of performing the work of a coal miner for more than 40 hours per week on a regular basis.

Evidence of significant, long-term exposure of the Petitioner to agents that cause CWP and COPD was unrebutted. The Act provides that an employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists. This is true of the Petitioner's work in the coal mine, where the risks of inhalation of coal dust and other agents is not common to the general public.

Lastly, Section 1(f) of the Act provides that no compensation shall be payable for or on account of any occupational disease unless disablement occurs within two years after the last day of the last exposure to the hazards of the disease. The Petitioner testified that he first noticed

trouble breathing in the last five years of his work in the mine and that this continued to worsen thereafter.

Based on all of the above, the Arbitrator finds that the Petitioner has proved by a preponderance that he suffers from a compensable occupational disease, as defined by the Act, that arose out of and in the course of his employment with the Respondent.

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

In light of the findings above that the Petitioner suffers from an occupational disease which arose out of and in the course of his employment, the Arbitrator similarly finds that the Petitioner's exposure to coal dust and other lung irritants was a significant factor to his development of CWP and COPD.

Therefore, the Arbitrator finds that the Petitioner's condition was causally related to the exposure to coal dust and other agents that last occurred on September 23, 2017.

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

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

(i) **Level of Impairment.** As described above, the record contains two sets of pulmonary function tests that revealed an obstructive impairment; however, the relevant measures in Table 5-4 of the

AMA Guides, the FVC, FEV1, ratio, and DLCO, are above the lower limit of normal. Dr. Rosenberg rated the Petitioner as a Class 0. The Arbitrator gives little weight to this factor.

(ii) **Occupation.** The Petitioner's occupation of that coal mining involved daily exposure to coal dust and other lung irritants. The doctors agreed that a miner with CWP, COPD, emphysema, and/or chronic bronchitis should avoid further exposure to the environment of a coal mine. Inasmuch as coal mining comprised practically the entirety of Petitioner's working life, the hazards of this occupation are given significant weight.

(iii) **Age.** Petitioner was 61 when he ended his coal mine employment with Respondent and could have worked several more years. The Arbitrator places significant weight on the fact that Petitioner was not precluded from further remunerative work because of his age.

(iv) **Earning Capacity.** Because the Petitioner spent his entire working career in the mines and because he is ill-trained for any other work that would pay as well as coal mining, his earning capacity was diminished. Therefore, the Arbitrator places some weight on this factor.

(v) **Disability.** The Petitioner's testimony and corroboration by the medical records showed that he continues to experience breathing problems with exertion – walking long distances, climbing stairs and bicycling on anything but even surfaces. To his credit, the Petitioner has tried to maintain his health by continuing his walking and cycling. However, the coal dust he inhaled for more than 36 years will continue to irritate his lungs in the future. While the Petitioner's pulmonary function tests were within the range of normal, his FVC has dropped over 9 percentage points in the year between Dr. Istanbouly's testing and that of Stat-Care. The Arbitrator places significant weight on this factor.

Therefore, the Arbitrator finds the Petitioner's temporary total disability to be 6 percent of the person as a whole.

<u>Issue O</u>: Other issues: Disease, causation and Sections 1(d)-(f) of the Occupational Diseases Act.

These issues were addressed above under Issues C and F.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC033090
Case Name	EMMONS, RODNEY v. STATE OF ILLINOIS DEPT OF NATURAL RESOURCES/ JAKE WOLF FISH HATCHERY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0099
Number of Pages of Decision	7
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	William Trimble
Respondent Attorney	Bradley Defreitas

DATE FILED: 3/18/2022

/s/Deborah Baker, Commissioner
Signature

STATE OF ILLINOIS)		
) SS.	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MCLEAN)	☐ 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

RODNEY EMMONS,

Petitioner,

vs. NO: 16 WC 33090

STATE OF ILLINOIS/DEPT. OF NATURAL RESOURCES,
JAKE WOLF FISH HATCHERY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the disputed issue of the nature and extent of Petitioner's 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 September 13, 2021 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $718.36 per week for a period of 22.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 4.5% loss of use of the person as a whole.

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

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

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

March 18, 2022

/s/ *Deborah J. Baker*

DJB/mck

/s/ *Stephen J. Mathis*

O: 3/16/22

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/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC033090
Case Name	EMMONS, RODNEY v. ST OF IL/DEPT OF NATURAL RESOURCES/JACK WOLF FISH HATCHERY
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	4
Decision Issued By	Adam Hinrichs, Arbitrator

Petitioner Attorney	William Trimble
Respondent Attorney	Bradley Defreitas

DATE FILED: 9/13/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 8, 2021 0.05%

/s/*Adam Hinrichs, Arbitrator*
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

September 13, 2021

/s/ *Brendan O'Rourke*

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Rodney Emmons
Employee/Petitioner

Case # **16** WC **033090**

v.

Consolidated cases: ______

State of Illinois/Dept. of Natural Resources/Jake Wolf Fish Hatchery
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Adam Hinrichs**, Arbitrator of the Commission, in the city of **Bloomington**, on **8/26/2021**. By stipulation, the parties agree:

On the date of accident, **9/20/2016**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**62,257.47**, and the average weekly wage was $**1,197.26**.

At the time of injury, Petitioner was **60** years of age, ***married*** with **1** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury:

Petitioner testified that he was employed by Respondent on September 20, 2016 and that on that date he was cleaning silt or muck build up from a pond used by Respondent. This required him to scoop organic material and rocks with a scoop shovel into the back of a John Deere Gator. Petitioner testified that while he was doing this, he developed pain in his lower back, radiating down both legs.

Petitioner was seen by Dr. Lee Ho at Pekin Pro Health. Dr. Lee Ho ordered an X-ray which was performed at Pekin Hospital on 9/20/2016. (PX 3).

On 10/06/2016, Petitioner followed up with Dr. Lawrence Li, an orthopedic surgeon. Dr. Li performed physical examination and found that Petitioner's straight leg raise was positive on the left, and negative on the right. Dr. Li diagnosed Petitioner with lumbar strain versus herniated disc and ordered an MRI. (PX 5).

On 10/11/2016, Petitioner followed up with Dr. Li post- MRI. Dr. Li determined that Petitioner had lumbar spine acute boney injury to the pedicles/laminae of L4 and L5, more involved on the left than right. Dr. Li noted that "this is super imposed on pre-existing spinal stenosis." Dr. Li ordered Petitioner off work, prescribed Mobic, Prilosec, Ultram, and Cyclobenzaprine, and ordered physical therapy ("PT"). (PX 5)

Petitioner underwent PT and found it helpful. On 11/09/2016, the Athletico therapist, Michael Derry, indicated that Petitioner was appropriate for discharge from PT, as his job demands were 92.86% met. (PX 6)

On 11/10/2016, Dr. Li released Petitioner to return to work full duty. (PX 5)

Petitioner testified that he returned to work and continued there for another year, but that he was unable to perform the heavier aspects of his job with the Respondent due to his back pain. In October of 2017, Petitioner retired from Respondent's employ.

Petitioner is an outdoorsman. Petitioner testified that he is a fisherman but cannot stand up as long to fish in a boat. Likewise, although he loves to duck hunt, he cannot stand in a duck blind for a very long time. He always loved to walk in the outdoors, but he is no longer able to comfortably walk as far. Petitioner described mowing his lawn, and indicated that although his lawn is not large, he can no longer mow it all at once.

Consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria:

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

With regard to subsection (i) of Section 8.1(b), the Arbitrator notes that neither party submitted an AMA impairment. The Arbitrator has considered and gives no weight to this factor.

With regard to subsection (ii) of Section 8.1(b), the Arbitrator notes that Petitioner was employed at the Jake Wolf Fish Hatchery, and his job included heavy manual tasks. The Arbitrator has considered and gives greater weight on this factor.

With regard to subsection (iii) of Section 8.1(b), the Petitioner was 60 years of age on the date of the accident at issue. The Arbitrator has considered and gives some weight to this factor.

With regard to subsection (iv) of Section 8.1(b). the Arbitrator notes that no evidence was presented regarding Petitioner's future earning capacity. The Arbitrator has considered and gives no weight to this factor.

With regard to subsection (v) of Section 8.1(b), the Arbitrator notes that Petitioner testified that he has continued to have pain in his low back, and that it has limited his ability to engage in many of the outdoor activities he has enjoyed throughout his life. The Arbitrator notes that the treating records of Dr. Lawrence Li related a lumbar spine acute boney injury to the pedicles/laminae of L4 and L5, necessitating physical therapy and medication continuing two months after Petitioner's last office visit. The medical records corroborate Petitioner's testimony.

Based on the above factors and the record taken as a whole, the Arbitrator concludes that the injury sustained caused a 4.5% loss of use to Petitioner's person a whole, as provided in Section 8(d)2 of the Act.

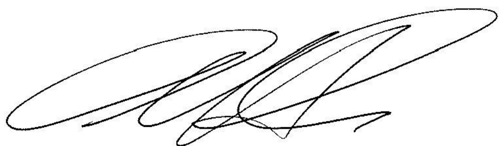
ORDER

Respondent shall pay all outstanding reasonable and necessary medical bills related to Petitioner's low back, as outlined in Petitioner's Exhibit 7, pursuant to the fee schedule.

Respondent shall pay Petitioner the sum of $**718.36**/week for a further period of **22.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **a 4.5% loss of use to Petitioner's person as a whole**.

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

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



Signature of Arbitrator

SEPTEMBER 13, 2021

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC028614
Case Name	MAGERS, JEFFREY v. CHICAGO METRO FIRE PREVENTION
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0100
Number of Pages of Decision	17
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Tracy Jones
Respondent Attorney	Timothy Furman

DATE FILED: 3/18/2022

/s/Thomas Tyrrell, 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 KANE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Magers,

Petitioner,

vs. NO: 19 WC 28614

Chicago Metro Fire Prevention,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering accident, causal connection, notice, earnings, medical expenses, prospective medical treatment, and temporary total disability ("TTD") benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator and corrects two scrivener's errors. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission solely seeks to correct two clerical errors on the Arbitrator Decision Form. The Decision Form correctly states that Respondent shall receive a credit of $4,977.81 for TTD it paid; however, the Arbitrator mistakenly wrote that Respondent shall receive a total credit of $0. The Arbitrator also wrote that Respondent shall receive a credit of $4,977.81 pursuant to Section 8(j) of the Act. The Commission thus modifies the above-referenced sentences to read as follows:

> Respondent shall be given a credit of $4,977.81 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of **$4,977.81**.
>
> Respondent is entitled to a credit **for all medical bills paid** pursuant to Section 8(j) of the Act.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 9, 2021, is modified as stated herein.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,780.00. 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.

March 18, 2022

o: 1/25/22
TJT/jds
51

_/s/ *Thomas J. Tyrrell*_____
Thomas J. Tyrrell

_/s/ *Maria E. Portela*_____
Maria E. Portela

_/s/ *Kathryn A. Doerries*___
Kathryn A. Doerries

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

22IWCC0100

MAGERS, JEFFREY
Employee/Petitioner

Case# **19WC028614**

CHICAGO METRO FIRE PREVENTION
Employer/Respondent

On 2/9/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2489 BLACK & JONES ATTY AT LAW
TRACEY L JONES
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2542 BRYCE DOWNEY & LENKOV LLC
TIM ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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)

Jeffrey Magers
Employee/Petitioner
v.
Chicago Metro Fire Prevention
Employer/Respondent

Case # **19** WC **028614**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Wheaton**, on **10/30/20**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **1/22/19**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11527.45**; the average weekly wage was $**1047.95**.

On the date of accident, Petitioner was **58** 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 $**4977.81** 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 $4,977.81 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $698.63/week for 42 2/7 weeks, commencing 1/8/2020 through 10/30/2020, as provided in Section 8(b) of the Act.

Petitioner is entitled to reasonable and necessary medical expenses associated with pre-operative testing and evaluation in addition to the ACL repair surgery recommended by Dr Milos, pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services of $1,115.75, pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act. Respondent shall be given a credit for medical benefits paid by Respondent's group health provider. Respondent shall hold Petitioner harmless for any paid medical benefits for which Respondent claims a credit pursuant to 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.

Signature of Arbitrator

2/2/2021
Date

ICArbDec19(b)

FEB 9 - 2021

Procedural History

This matter was tried, on October 30, 2020, pursuant to Sections 19(b) and 8(a) of the Act. Respondent disputed accident, causation, TTD benefits, liability for unpaid medical bills and TTD benefits. Petitioner sought prospective medical care consisting of a revision of a prior ACL repair surgery. (Arb. Ex. #1).

Findings of Fact

Jeffery Magers (hereinafter referred to as "Petitioner") testified that he worked for Chicago Metro Fire Prevention (hereafter referred to as "Respondent"), as a fire alarm technician, since November 5, 2018. (TR. 9).

Petitioner testified on January 22, 2019 he was performing a service call in a pump room of a manufacturing plant. Petitioner was replacing a faulty fire alarm sprinkler switch. Petitioner testified the switch was in the back of the pump room with no clear walkway to access the switch. Petitioner testified he had to crawl, on his hands and knees, through pipes to reach the switch. Petitioner testified he had to crawl over and under pipes to reach the switch, which was a distance of approximately 4 feet. Petitioner testified as he was crawling through the pipes, he felt a pop in his left knee. (TR. 14). Petitioner testified he has to set for a couple of seconds to let the pain reside before moving. Petitioner testified he noticed swelling in his knee which was getting worse. (TR. 15). Petitioner testified he completed the job, filled out a service ticket, returned to his truck and reported the injury to his supervisor, Joel Kagel. (TR. 15, 16). Petitioner testified he called his supervisor on his work phone and reported injuring his knee at work. (TR. 16).

Petitioner testified after reporting the incident to his supervisor he performed one more service call before returning home. Petitioner testified at home his knee was painful and swollen. Petitioner testified he iced his knee and his knee gave out the next morning. Petitioner testified, after his knee gave out, he called Joel Kagel and told him that his knee was worse. Petitioner said Joel Kagel told him to come to the shop and fill out an accident report before seeing a doctor. (TR. 18, 19). Petitioner testified he went to the shop and filled out the paperwork before going to the Elmhurst Occupational Health Clinic. (TR. 19).

Mr. Kagel, testified for Respondent. Mr. Kagel testified he had been employed by Respondent for 14 years and on January 22, 2019 he was the manager of field operations. (TR. 69). Mr. Kagel testified, on January 22, 2019, he received a phone call from Petitioner reporting an injury. Mr. Kagel testified that Petitioner said he injured his knee crawling on some sprinkler pipes to access an area of a sprinkler room. (TR. 70). Mr. Kagel testified that he remembered filling out the injury report with Petitioner and submitting the report to human resources. Mr. Kagel also remembered sending Petitioner to Elmhurst Hospital to have his knee evaluated. (TR. 71). On cross examination, Mr. Kagel testified Petitioner originally worked for Respondent on a contract basis before being hired. Mr. Kagel testified Petitioner was a good employee who never had any issues. (TR. 74). Mr. Kagel testified since being hired Petitioner he was unaware of Petitioner ever reporting left knee pain or complaints prior to January 22, 2019. (TR. 79). Mr. Kagel testified Petitioner

was able to perform his full work duties from November of 2018 through January 22, 2019 without any complaints or problems. (TR. 80).

Medical Treatment

Petitioner presented to the Elmhurst Occupational Health Clinic on January 23, 2019. The history contained in the medical records state that Petitioner heard a "pop" to the left medical knee yesterday while crawling over pipe at work and, since the incident, experiencing tightness, swelling and weakness in the left knee. X-rays were taken which showed no fracture, dislocation or large joint effusion. Petitioner was diagnosed with a left knee sprain, prescribed Ibuprofen and placed on light duty. (PX1). He followed up at Elmhurst Occupational Health on February 1, 2019 reporting his symptoms were not better and that he was experiencing popping and giving way while on stairs. Petitioner reported pain levels of 5/10. Petitioner was referred to an orthopedic. (PX1).

On February 5, 2019, Petitioner was evaluated by G&T Orthopedics and, at that time, an MRI was ordered. The history in that record indicates "*He had an injury at work on December 22. He was looking on somebikes he got into a squatting position and felt a pop in his knee.*" (RX 3).[1] Petitioner testified the history contained in the G&T Orthopedics was not accurate. Petitioner testified he was crawling through pipes not looking at bikes. (TR. 59).

The February 9, 2019 MRI showed extensive edema suggesting osseous contusions given the reported injury, medial meniscal posterior horn nondisplaced radial tear, and suspicion of a near complete ACL tear with patellofemoral compartment predominant osteoarthritis. (PX 1, RX 3). On February 12, 2019, Dr. Giannoulias diagnosed an ACL tear and recommended surgery. (RX 3).

On February 21, 2019. Petitioner presented to Dr. Stephen Milos. The history provided by Petitioner states "patient [complained of] painful left knee after twisting on 1/22/19" and "twisted knee getting out of a pipe at work with immediate pain and swelling in the knee.". (PX 2). Dr. Milos opined Petitioner sustained a "traumatic ACL rupture and medial meniscus tear secondary to his work injury." (PX2. Pg. 139). Dr. Milos recommended surgery which was performed on April 4, 2019. The surgery consisted of an ACL reconstruction using patellar tendon allograft, partial medial meniscectomy, and chondroplasty of the patellofemoral joint. (PX 6, pgs. 794-6).

Postoperatively Petitioner attended physical therapy at ATI. Petitioner transitioned to work hardening in June of 2019. (PX 4). On July 24, 2019, Petitioner returned to Dr. Milos reporting that he was doing well until a couple weeks ago when he developed sharp pain in his knee and was unable to progress further in work

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[1] The Arbitrator does not find the medical history contained in the G&T Orthopedics' medical records to be accurate. The Arbitrator also notes a discrepancy with the date of accident. The records list the date of accident as the 22nd of December. However, the Patient Information Form for Workers' Compensation Cases and the Elmhurst Occupational Health Referral state the date of accident as January 22, 2019, not December 22nd as contained in the G&T Orthopedics medical record dated February 8, 2020.

conditioning. He was told to hold on therapy and begin a course of steroids. Dr. Milos noted that if there was no improvement, then he would need to undergo another MRI. (PX 2).

Petitioner testified that on August 9, 2019 he went to get out of his recliner and his left knee gave out and he fell. (TR 28, 62-63). Petitioner testified he landed on his backside and had pain in his buttocks and back. Petitioner testified he was evaluated by Dr. Stiles on August 27, 2019 and diagnosed with a sacral fracture. A history was taken of a fall at home when his "knee gave out." (PX 3, pg. 168). Petitioner was ordered to follow up with Dr. Milos.

Petitioner retuned to Dr. Milos on August 30, 2019 who noted that Petitioner had patellofemoral arthritis which was likely causing crepitus and giving out of the knee. He recommended a trial of Orthovisc injections and an MRI. (PX 2, pg. 97). The series of 3 injections were performed in September of 2019 without improvement. On September 30, 2019, Petitioner followed up with Dr. Milos who noted the MRI showed a possible tiny tear of the anterior horn of the lateral meniscus. (PX 2, pg. 65). Dr. Milos noted the MRI also showed increased T2 weighted signal at the site of the graft placement in the ACL suspicious for a partial tear. Based on the ongoing complaints, swelling, and instability, Dr. Milos diagnosed a functionally torn ACL and recommended a revision ACL surgery. Dr. Milos also indicated Petitioner was unable to return to work. (RX 2).

On December 4, 2019, Petitioner was examined by Dr. Bryan Neal, pursuant to Section 12 of the Act. Bryan Neal. (RX 1). In his report dated December 20. 2019, Dr. Neal stated Petitioner reported many years of significant left knee arthritis, which he sought treatment with his primary care provider. Dr. Bruce Stiles. Dr. Neal noted that he was not provided medical records prior to the date of accident including the records from Dr. Stiles. Dr. Neal stated if those records were made available for review, they would most likely aid in understanding how long, why and to what degree left knee pain and instability existed prior to January 22, 2019. In his report Dr. Neal stated the examinee may believe he injured his left knee on January 22, 2019 but with many years of significant left knee symptomatology prior to this date, it would be critical to delineate whether anything on January 22, 2019, caused a new condition not present prior to this date or permanently worsened what was an unequivocally symptomatic left knee prior to this date as opposed to a simple expression and experience of pain while working on that date from a condition that was pre-existing and symptomatic prior to this date. (RX 1).

Dr. Neal opined Petitioner had a pre-existing knee symptomatology before January 22, 2019 and that he felt some pain and symptomatology in this day, but, he did not suffer any acute knee injury on January 22, 2019. Dr. Neal further opined Petitioner's symptoms on and after January 22, 2019, including the surgery and current knee condition were not related to the work activities and work events on January 22, 2019, but rather to knee conditions which developed for reasons other than what occurred on January 22, 2019. Dr. Neal also opined Petitioner's complaints were consistent with his known osteoarthritis which was pre-existing to January

22, 2019. Dr. Neal found Petitioner to be at maximum medical improvement and could return to work with no restrictions. (RX 1).

Testimony of Dr. Milos, the treating physician

Dr. Milos testified he saw Petitioner on February 21, 2019 and, at that time, Petitioner reported a work injury occurring on January 23, 2019 when he twisted his knee getting out of—working on a pipe at work.[2] The MRI showed an ACL tear as well as a radial tear of the medical meniscus and some patella arthritis. The exam showed tenderness on the medial side of the left knee consistent with a tear, positive McMurray, which was a finding for a meniscus tear. Petitioner had swelling in the knee and an unstable Lachman, a test for the ACL. Dr. Milos opined Petitioner's injury caused the ACL tear which was consistent with the mechanism of injury and he testified that performed surgery on April 4, 2019. (PX 6, pgs. 6,7).

During the surgery, Dr. Milos noted a tear of the ACL and medical meniscus. The ACL was reconstructed and a partial meniscectomy was performed. After surgery Petitioner underwent therapy and in late July of 2019, Petitioner developed instability and increased pain. Dr. Milos testified he ordered an MRI which showed a possible tiny anterior horn meniscus tear and an increased signal intensity on the ACL greater than what he would expect, which could be a partial tear. At that time, Dr. Milos ordered a series of orthyovisc injections. (PX6, pgs. 7-9).

Dr. Milos testified the main issue with Petitioner's left knee involves instability which cases pain. Dr. Milos diagnosed recurrent ACL tear. Dr. Milos testified Petitioner's knee is unstable and requires another ACL surgery. Dr. Milos testified Petitioner's main issue involves instability caused by the ACL which was related to Petitioner's work injury. Dr. Milos also testified Petitioner has work restrictions consisting of sit-down work with limited walking. (PX 6, pgs. 8-12).

Testimony of Dr. Neal, the Section 12 Examiner

Dr. Neal testified he examined Petitioner on December 4, 2019 and Petitioner reported he last worked on January 22, 2019 and had undergone knee surgery on April 4, 2019. Dr. Neal testified the history obtained from Petitioner showed a long-standing problem with the left knee including arthritis for 10 years, which he had been treating for with Dr. Bruce Stiles. Dr. Neal also testified Petitioner reported on January 22, 2019 he was in a fire pump room when he had to crawl through some pipes when he got stuck and when he tried to back up his knee popped. (RX 2, pgs. 10,11).

Dr. Neal testified he diagnosed left knee pain with some residual left knee osteoarthritis symptomatology and a healed and asymptomatic sacrococcygeal fracture. Dr. Neal found no causal connection. In support of his opinion, Dr. Neal testified Dr. Milos was someone who had seen Petitioner prior to January 22, 2019 but those records were not made available to him for review. Dr. Neal testified Petitioner reported significant

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[2] The Arbitrator finds the date of January 23, 2019 to be a scrivener's error based upon the testimony of Petitioner and Mr. Kegel and various medical records.

symptomatology which, in his opinion, was consistent with knee arthritis and existed for a number of years in multiple areas including the left knee. Dr. Neal also testified Petitioner took Ibuprofen on a daily basis prior to January 22, 2019 for his left knee. Dr. Neal further testified Petitioner was under the care of his primary care provider, Dr. Stiles, specifically for his knee. (RX 2, pgs. 18, 19).[3] Regarding Petitioner's past medical records, Dr. Neal testified "*However it's obvious from his history and I suspect if the other records were reviewed, that he had significant arthritic symptomology for years.*". Dr. Neal further testified "*Certainly, someone who had the arthritic pain as he described before January 22, 2019, you would expect some symptoms while you were crawling in a tight space on arthritic knees when you're morbidly obese…*". (RX 2, pgs. 19-20).

Dr. Neal noted that Petitioner reported to Dr. Milos, on February 21, 2019, he twisted his knee and had no previous knee issues which contradicted other records and what Petitioner told him. Dr. Neal testified he doesn't know whether Petitioner told Dr. Milos was consistent with Petitioner's medical records because he did not have Petitioner's prior medical records to review. Dr. Neal further testified he is going to assume the history Petitioner provided during his examination was forthcoming. (RX 2, pgs. 24, 25).

Dr. Neal opined Petitioner's mechanism of injury would not acutely tear or damage an ACL. Dr. Neal further opined Petitioner was at maximum medical improvement and he could work full duty without any restrictions. Dr. Neal also opined the medical treatment Petitioner received was reasonable and necessary but not related to a work accident. Dr. Neal opined he did not find an aggravation or permanent worsening of Petitioner's condition. (RX 2, pgs. 31, 32).

On cross examination, Dr. Neal testified that he had not reviewed any of Petitioner's medical records prior to January 22, 2019 including the medical any primary care physician or orthopedic physician. (RX 2, pgs.36, 37).

Additional Testimony

At trial, Petitioner testified he was not working due to his restrictions and he has been unable to undergo the surgery recommended by Dr. Milos. (TR 34). Petitioner testified he was not receiving TTD benefits which terminated on January 7, 2020. Petitioner testified he has ongoing symptoms in his knee including pain, swelling, and instability. (TR 31). He has problems with activities of daily living such as stairs. (TR 31). Petitioner testified he wants the surgery recommended by Dr. Milos. (TR 35).

The Arbitrator found the testimony of Petitioner and Mr. Kagel to be credible.

Conclusions of Law

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

In support of the Arbitrator's decision relating to issues "C" whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

[3] Dr. Neal testified he never reviewed Dr. Stiles' medical records because those records were not provided to him.

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

The Arbitrator finds that Petitioner proved by the preponderance of the evidence he sustained an accidental injury that arose out of an in the course of his employment with Respondent on January 22, 2019. "Courts generally regard employees whose duties require them to travel away from their employer's premises [traveling employees] differently from other employees when considering whether an injury arose out of and in the course of employment." *Wright v. Industrial Comm'n.*, 62 Ill. 2d 65, 68 (1985). In *Venture-Newberg-Perini v. IWCC*, the Illinois Supreme Court, quoting *Wright v Indust. Comm'n*, stated employees "whose duties require them to travel away from their employer's premises" are traveling employees and regarded differently. 1 N.E.3d 535, 540 (2013). A traveling employee is an employee "whose performance of duty required travel away from the employer's premises." *Wexler & Co. v Indust. Comm'n*, 288 N.E.2d (1972). If a traveling employee is injured, that injury is compensable if: 1) he is performing an act the employer instructs him to, 2) he is performing an act that he has a common law or statutory duty to perform while performing duties for the employer, or 3) he is performing acts which might be reasonably expected incident to his assigned duties. *Venture-Newberg-Perini v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728; 1 N.E.3d 535, 540 (2013).

The Arbitrator finds the evidence establishes that Petitioner was a traveling employee. His job required him to drive to job sites and perform work for customers at locations away from Respondent's premises. When injured, he was at a customer's location away from his employer's premises.

Given that he was a traveling employee, the second issue to be analyzed in determining whether the accident arose out of and in the course of the employment is whether the activity the employee was engaged in at the time of the injury was reasonable and foreseeable. *Wright* at 62 Ill. 2d 65 at 69. Only those which arise out of acts which the employee is instructed to perform, acts which he has a common law or statutory duty to perform, or acts which the employee might be reasonably expected to perform incident to his duties are compensable. *Id.* In the instant case, Petitioner was required to replace a faulty fire alarm device. In order to perform the work, he had to get access to the device. In order to do so, Petitioner had to climb through pipes that lined the room for a 4-foot distance. The only way to traverse through it was to climb on his hands and knees. Petitioner testified he was in a position where his chest was horizontal to the ground with his leg stretched out and planted on the ground when his torso got stuck between two pipes. (TR 64-65). He had to grab ahold of another pipe and pull himself through. (TR 65). As he was pulling himself through the pipes on his hands and knees, Petitioner testified that his left knee popped, and pain went all the way up to his back. (TR 14, 65). This activity was not only reasonable and foreseeable, but it was necessary for him to carry out the job duty of replacing the faulty device.

The Arbitrator further notes Petitioner immediately reported the injury to his supervisor, Joel Kagel, completed an accident report and was treated at the occupational health clinic, the following day. The history contained in occupational health clinic are consistent with Petitioner's testimony.

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

Accidental injuries need not be the sole cause of the Petitioner's current condition of ill-being as long as the accidental injuries are a causative factor resulting in the current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003). Causal connection between accidental work injuries and an injured worker's current condition of ill-being may be established by a chain of events, including Petitioner's ability to perform work duties before the date of accidental injuries and inability to perform those same duties following that date. *Darling v. Industrial Commission*, 176 Ill.App.3d 186 (1988). Petitioner's condition of health prior to the accidental injuries need not be perfect, if after an accident occurs and following the accident, the Petitioner's condition has deteriorated, and it is plainly inferable that the intervening injury caused the deterioration; the salient factor is not the precise previous condition, it is the deterioration from whatever the previous condition had been. *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC.

The Arbitrator finds, after reviewing all the evidence, that Petitioner has proven by the preponderance of the evidence, his left knee condition is causally related to his January 22, 2019 work accident.

Respondent disputed causal connection based on the testimony of Dr. Neal. Dr. Neal who testified that Petitioner's left knee condition was preexisting and not related to the work injury of January 22, 2019. In support of that opinion, Dr. Neal testified he relied on his belief Petitioner: (1) had diagnostic evidence of osteoarthritis prior to January 23, 2019 which was not acute, (2) had left knee pain that was present prior to January 22, 2019, (3) had been seen his primary care physician for his left knee prior to January 22, 2019, (4) took ibuprofen every 4 hours prior to January 22, 2019 for left knee pain, and (5) the mechanism of injury was not likely to cause an ACL tear.

The Arbitrator finds the opinions of Dr. Milos more reliable and persuasive than the opinions of Dr. Neal. The Arbitrator further finds Dr. Neal's opinion were not consistent with the evidence and were based upon guess, surmise or conjecture. At trial, no evidence was admitted supporting Dr. Neal's opinions that Petitioner had been previously diagnosed with left knee osteoarthritis, was undergoing medical treatment with Dr. Stiles for a left knee condition for ten years or that Petitioner was taking ibuprofen for left knee pain. Dr. Neal testified he never received or reviewed any of Petitioner's prior medical records including those of Petitioner's primary care physician, Dr. Stiles. No medical records were offered into evidence showing that Petitioner had undergone left knee treatment with Dr. Stiles prior to January 22, 2019. Petitioner testified he never had symptoms in his left knee prior to January 22, 2019. Petitioner specifically denied any symptoms or

problems in his left knee prior to the work injury. The medical records from Petitioner's treating physician's fail to indicate any prior left knee complaints, symptoms or treatment which is consistent with Petitioner's trial testimony. The Arbitrator also notes that Mr. Kagel, Petitioner's supervisor, testified Petitioner never complained of left knee pain or was unable to perform his work duties due to left knee issues.

There was no evidence introduced at trial showing that Petitioner used medication for left knee pain January 22, 2019. Petitioner denied the use of ibuprofen for his knee prior to January 22, 2019. Petitioner admitted using ibuprofen for his knee after January 22, 2019 and ibuprofen was provided to Petitioner after his work accident from Elmhurst Occupational Health. (PX 1 p 30).

The Arbitrator finds Dr. Neal's causation opinions were based, in part, on the assumption Petitioner was diagnosed with osteoarthritis prior to January 22, 2019, was receiving treatment for left knee symptoms prior to January 22, 2019 and was taking ibuprofen every 4 hours for left knee pain. Dr. Neal testified he did not review any of Petitioner's medical records prior to January 22, 2019 nor was any medical records introduced into evidence supporting the foundation of which Dr. Neal's opinions were based upon. As such, the Arbitrator finds Dr. Neal's opinions were based upon guess, surmise or conjecture. It is axiomatic that the weigh accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3rd 507, 514-15 (First Dist. 2000).

The Arbitrator finds the opinions of Dr. Milos to be persuasive. Dr. Milos testified the examination, diagnostic testing and history supported that Petitioner sustained an ACL tear and meniscus tear as the result of Petitioner's work injury on January 22, 2019. The examination showed tenderness on the medial side of the left knee consistent with a tear, positive McMurray test, which is also consistent with a meniscus tear and a unstable Lachman test which is consistent with an ACL tear. Dr. Milos testified the exam findings were consistent with the MRI which showed tears in the ACL and medial meniscus. Petitioner testified he had no prior symptoms in his left knee which is consistent with the history Petitioner provided to Dr. Milos. Dr. Milos opined Petitioner's injury caused the ACL tear and the mechanism was consistent with injury. (PX 8, pg. 1058). Dr. Milos also noted bone bruising on the MRI which, he testified, was consistent with an acute ACL tear.

The Arbitrator finds that Petitioner proved by the preponderance of the evidence that his left knee condition was causally related to his work accident of January 22, 2019 also under a chain-of-events theory. In pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of a pre-existing condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill.2d 30, 36-37. When a worker's physical structures, diseased or not, give way under the stress of their usual

tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n,* 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). When an employee with a preexisting condition is injured in the course and of his employment the Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. *Sisbro, Inc. Industrial Comm'n,* 207 Ill.2d 193, 278 Ill.Dec. 70,797 N.E.2d 665, (2003). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). When a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Shafer v. Illinois Worker's Compensation Comm'n,* 2011 IL App. (4th) 100505 WC. The chain-of-events principles have been applied where an accident is claimed to have aggravated a preexisting condition. See *Schroeder v. Illinois Worker's compensation Comm'n,* 2017 IL App. (4th) 160192 WC.

Prior to the January 22, 2019 work accident, Petitioner was working full duty and was not experiencing any left knee symptoms. After his January 22, 2019 work accident, Petitioner was unable to return to work due to his left knee symptoms. Petitioner's preexisting asymptomatic condition was aggravated or made symptomatic due to his January 22, 2019 accident and resulting in his current disability.

The Arbitrator also finds that Petitioner has proven by the preponderance of the evidence, the sacral facture is causally related to his January 22, 2019 work accident. Petitioner testified his left knee has given out 4 times after his work injury. Petitioner testified on August 9, 2019 he fell when trying to stand from his recliner because his knee gave out. Petitioner sought treatment with Dr. Stiles who recorded a history of the fall from Petitioner's left knee giving out. (PX 3, pgs. 168). Dr. Milos performed ACL reconstruction surgery. After the surgery, in late July of 2019, Petitioner developed instability in his left knee. Dr. Milos testified he ordered an MRI which showed a possible tiny anterior horn meniscus tear and an increased signal intensity on the ACL greater than what he would expect, which could be a partial tear. Dr. Milos testified Petitioner continues to suffer from left knee instability and diagnosed a recurrent ACL tear. Dr. Milos testified Petitioner's knee is unstable and requires another ACL surgery.

With respect to issue "J" were the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

As stated above, the Arbitrator found Petitioner sustained an accidental injury that arouse out of and in the course of his employment and that his current condition of ill-being is casually related to his injury. The Arbitrator further finds that Petitioner has proven by the preponderance of the evidence the medical services

provided to were reasonable, necessary and causally related to the accident. Dr. Neal, who performed the Section 12 Examination, testified all of Petitioner's medical treatment had been reasonable and necessary. As such, Respondent is ordered to pay for all related medical treatment outlined in Petitioner's exhibit 9 including the office visit with Dr. Milos on 1/22/20 and the visit with Dr. Stiles of 8/27/19, pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

With respect to issue "K" whether Petitioner is entitled to prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds Petitioner has proven by the preponderance of the credible evidence that he is entitled to an award of prospective medical treatment. Specific medical procedures or treatments that have been prescribed by a medical service provider have been incurred within the meaning of the statute, even if they have not yet been paid for. *See Plantation Manufacturing Company v. Industrial Commission,* 691 N.E.2d 13, 17 (Ill. App. 1997).

During physical therapy Petitioner developed pain and instability in his left knee. Petitioner's complaints were noted in the therapy and Dr. Milos records. The July 16, 2019 therapy notes indicate Petitioner developed increasing pain "doing increased activity throughout [therapy] session." (PX 4, pg. 485). Dr. Milos testified that Petitioner gave him a history that the increasing pain occurred while performing therapy for his left knee. (PX 8 pg. 1063). Dr. Milos felt a repeat MRI would be necessary but first tried steroids. When those failed to resolve the symptoms, a repeat MRI was carried out and interpreted as showing a tear of the anterior horn of the lateral meniscus and a possible re-tear of the ACL. Given the testimony of the Petitioner, the histories in the records, and the lack of intervening injury, the Arbitrator finds Petitioner's recurrent tears and need for revision surgery are causally related to the work injury of 1/22/19.

Based on the above, the Arbitrator finds that Petitioner's left knee condition is related to the work injury and further finds the proposed revision ACL repair procedure recommended by Dr. Milos is reasonable, necessary medical expenses and related to his work injury. As such, Respondent shall pay for prospective medical recommended by Dr. Stephen Milos consisting of the revision ACL surgery, pre-operative testing and evaluation, pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

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

To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work. *City of Granite v. Industrial Commission,* 279 Ill. App. 3d 1087, 1090 (1996). The dispositive question is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. *Freeman United Coal v. Industrial Commission,* 318 Ill.App.3d 170, 175-76 (2000). The factors to be considered in determining whether a claimant has reached maximum, medical improvement include: (1) a release to return to work; (2) the medical testimony concerning

the claimant's injury; (3) the extent of the injury; and (4) "most importantly," whether the injury has stabilized. *See Mechanical Devices v. Industrial Commission,* 800 N.E.2d 819, 826 (Ill. App. 2003).

The Arbitrator finds that Petitioner's condition has not stabilized and has not reached maximum medical improvement. Dr. Milos has recommended surgery and issued work restrictions, which Respondent has not accommodated. As such, Arbitrator finds that Petitioner has proved by the preponderance of the evidence that he is entitled to temporary total disability benefits from January 8, 2020 through October 30, 2020 less a credit of $4,977.81 for TTD benefits previously paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	10WC033570
Case Name	STIMELING, STEVEN v. PEORIA PUBLIC SCHOOLS
Consolidated Cases	10WC033571
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0101
Number of Pages of Decision	65
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	TODD STRONG
Respondent Attorney	Stephen Kelly

DATE FILED: 3/18/2022

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Stimeling,

Petitioner,

vs. NO. 10WC 33570

Peoria Public Schools, District 150,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2021, is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 18, 2022

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

SJM/sj

o-2/23/22
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 22IWCC0101
NOTICE OF ARBITRATOR DECISION

STIMELING, STEVEN
Employee/Petitioner

Case# **10WC033570**
10WC033571

PEORIA PUBLIC SCHOOLS DISTRICT 150
Employer/Respondent

On 1/8/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Stimeling
Employee/Petitioner

v.

Peoria Public Schools, District 150
Employer/Respondent

Case # **10** WC **33570**

Consolidated cases: **10** WC **33571**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **November 12, 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] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Evidentiary Rulings as to Petitioner's Exhibits 65 & 68**

FINDINGS

On **November 17, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$35,880.00**; the average weekly wage was **$690.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **rendered during the timeframe of November 17, 2009 through June 24, 2010** as contained in Petitioner's Exhibit 67 as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered during the timeframe of November 17, 2009 through June 24, 2010** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of November 17, 2009 through June 24, 2010** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of **$414.00/week** for **50 weeks**, because the injuries sustained caused **10% loss of the person-as-a-whole,** as provided in Section 8(d)2 of the Act.

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** 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. Rowe-Sullivan
Signature of Arbitrator

1/4/21
Date

JAN - 8 2021

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Stimeling Case # **10** WC **33570**
Employee/Petitioner

v. Consolidated cases: **10** WC **33571**

Peoria Public Schools, District 150
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 53 years of age and is a lifelong Peoria area resident. He testified that he graduated from East Peoria High School and had two years of law enforcement training at ICC, among other law enforcement continuing education courses. He testified that he worked for other police departments in a part-time capacity when he was not working his full-time position for Respondent. He further testified that he worked 19 years for Respondent and that he was certified through the Police Training Institute.

Petitioner testified that, subsequent to the accident of November 17, 2009, he had been asked to work in the Chief of Security's office while working light duty as a result of the accident. He testified that, as to his termination from employment with Respondent, on August 16, 2011, after working in an accommodated light duty position for approximately two years, Respondent indicated to him that they were no longer willing or able to accommodate his light duty restrictions.

Petitioner testified that, as to his neck and back condition prior to the date of November 17, 2009, he considered himself to be in excellent health. Petitioner denied that he was under medical treatment for neck or back ailments in the years prior to this accident. Petitioner further denied that he underwent an MRI of the cervical spine on or about September 9, 2008.

As to the incident of November 17, 2009, Petitioner testified that he was involved in an altercation with a student who became combative. He testified that the student was transferred to the school from the Department of Corrections. He testified that he was making his rounds when the confrontation took place. He testified that he was able to get the combative student to the floor and into handcuffs, but sustained injuries to the right eye after having been hit by the student's elbow. He testified that the injury to his right eye caused him to be blinded and was very tender to the touch, as well as having been black and blue. He testified that he was concerned about a fracture to the outer area of his eye.

Petitioner testified that he went to IWIRC and was seen by Dr. Hauter. He testified that he was referred for an MRI by his primary care physician, Dr. Popp. He further testified that he was eventually referred to Dr. Klopfenstein. He testified that Dr. Klopfenstein ultimately performed a three-level cervical fusion in June 2011.

Petitioner testified that while undergoing therapy at IWIRC on June 24, 2010, he had to do a return to work assessment and that he was moving 80 pounds from waist to floor to above his head approximately

10 times. He testified that on the tenth time of performing this activity, he felt several pops in his back, that he fell to his knees, and that he could not move. He testified that he had an appointment with Dr. Hauter right after the session, and that they had to wheel him into the examination room. He testified that he was in work conditioning at the direction of Dr. Hauter as a result of the neck injury sustained as a result of the first accident (*i.e.*, November 17, 2009).

Petitioner testified that he underwent treatment to neck as well as having sought ongoing treatment for his lower back. He testified that he eventually underwent treatment with Dr. Kube, and that he ultimately underwent a surgery with Dr. Kube in August 2013. He testified that he is still having ongoing issues with pain in his neck and lower back, as well as in his right eye.

Petitioner testified that he eventually continued his treatment with Dr. McCall, and that he had a dorsal column stimulator implanted in November 2015. He testified that as to his eye, he was referred to Heyde Eye Center and that they referred him to the University of Iowa. He testified that, as to his right eye, he is not able to see and that it continues to be blurry. He testified that he is not able to read or watch TV with his right eye. As to his neck and back, Petitioner testified that he does not feel that he is able to safely perform work as a police officer. As to his hobbies or activities of daily living, Petitioner testified that he is unable to play the drums, that he is unable to perform scouting responsibilities with his kids , that he has a motor home for which he is unable to do the maintenance or sleep on the bed, and that his wife has to do household chores.

Petitioner testified that he currently takes Dilantin for his neck and back pain. He testified that he has a new primary care physician in Morton as Dr. Popp had retired, and that he is currently treating with Millenium Pain Center in Bloomington.

Petitioner testified that he never saw Dr. Lanoff, but did acknowledge that he saw Dr. Soriano at the request of Respondent.

On cross examination, Petitioner agreed that he told the truth on direct examination. Petitioner agreed that he had told the truth to Dr. Fletcher and Dr. Kube. Petitioner agreed that he testified that he had not sustained injury to either his neck or back before November 17, 2009.

On cross examination, Petitioner agreed that his attorney sent him to Dr. Kube. Petitioner agreed that he did not tell either Dr. Fletcher or Dr. Soriano about the misstepping off a ladder in September 2012. He agreed that he felt well enough in September 2012 to go on top of his RV. He agreed that after the RV ladder incident, he had surgery to his low back with Dr. Kube.

On cross examination, Petitioner agreed that he had a seizure in April 2014. He testified that he did not know that it was a grand mal seizure. Petitioner agreed that as a result of the seizure, he was rushed to the emergency room.

On cross examination when asked whether, subsequent to the surgery performed by Dr. Kube, he was ordered to undergo an FCE, Petitioner responded that he did not recall that. Petitioner denied remembering going to the facility and being told to do a two-day test. Petitioner denied being aware that in the records there was an FCE that indicated that he failed to give full effort. Petitioner testified that he did not recall his primary care physician having cleared him for this exam. Petitioner further testified that he was not aware that the study said it did not reflect his actual abilities or that he could likely to do higher functioning than what was reflected on the study.

On cross examination, Petitioner agreed that he was aware that Dr. Fletcher testified, but testified that he was not aware that Dr. Fletcher testified that he was able to work but just not as a security officer. Petitioner testified that he has not looked for work since he started collecting SSDI in December 2012.

Petitioner agreed that he has an Associate's degree in criminal justice, and that he has certifications related to being a police officer.

At the outset, the Arbitrator notes that any handwritten notes that appear on Arbitrator's Exhibit 3 (*i.e.*, Petitioner's Exhibit List) were not made by the Arbitrator.

The Application for Adjustment of Claim for 10 WC 33570 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Application for Adjustment of Claim for 10 WC 33571 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of OSF St. Francis Medical Center dated January 15, 1990 were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent excision of pilonidal cyst and sinus tract on that date by Dr. Jalovec for a pre- and post-operative diagnosis of recurrent pilonidal cyst and sinus tract. The Arbitrator notes that many of the records were illegible. (PX3).

The medical records of OSF St. Francis Medical Center dated February 2, 2008 were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen in the emergency room on that date with complaints of fever, dizziness, sore throat, and nausea. (PX4).

The medical records of OSF St. Francis Medical Center for the dates of July 26, 2008 and March 28, 2008 were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 26, 2008 for his right elbow which he reported was red and swollen, and that he stated that he may have an infection from being sprayed with a paint gun. The clinical impression was noted to be that of right elbow cellulitis. (PX5). The records further reflect that Petitioner was also seen on March 28, 2008, at which time he was seen for sinus complaints. It was noted that Petitioner was complaining of left facial pain and bloody sinus drainage. The clinical impression was noted to be that of acute sinusitis. (PX5).

The medical records of IWIRC for the dates of September 16, 2009 and September 23, 2009 were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on September 16, 2009 for his left knee, that he stated that the injury occurred on September 15, 2009, that he took a student down to the floor, and that he hit his left knee on the hard, concrete tile floor. It was noted that Petitioner's past work injuries were that of the left knee and right shoulder in 2008. The assessment was noted to be that of a left knee strain with history of left knee injury with Baker's cyst. The records further reflect that Petitioner was seen on September 23, 2009, at which time it was noted that he was seen for his left knee, and that he stated that his symptoms had improved 80% since his last office visit. The assessment was noted to be that of left knee strain, resolved. (PX6).

The medical records of IWIRC were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.[1] The records reflect that Petitioner was seen on November 17, 2009, at which time it was noted that he was a 42-year-old male who presented for initial evaluation of a right eye injury. It was noted that Petitioner stated that the injury occurred on November 17, 2009 at 0830 hours, that he stated that he was arresting a student, that he stated that the student was fighting with him, and that he put cuffs on the student. It was noted that Petitioner stated that while the student was cuffed he took his left elbow and hit him in the right eye, that the student had to be double-jointed, that the pain was rated at 10/10 at initial onset and was now a 6/10, and that he described his symptoms as a constant headache, sharp, and blurred vision. It was noted that Petitioner had not been taking any medication for symptom relief, that he had no prior care, and that no x-rays were performed. It was further noted that Petitioner was letting a student out of a padded area and attacked him, that he was placed in handcuffs and elbowed on the lateral side of the right eye, that

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

he stated it started swelling immediately and had lost vision in his eye, and that he could see light but could only see gray and black colors. It was noted that Petitioner complained of pain around the eye. The assessment was noted to be that of (1) right eye contusion; (2) questionable right orbit fracture; (3) right eye hemorrhage. Petitioner was recommended to consult with Heyde Eye Center, was unable to work until cleared by Opthalmology, and was to follow-up on November 19, 2009. (PX7).

The records of IWIRC reflect that Petitioner was seen on November 19, 2009, at which time it was noted that he stated that he still could not see out of his right eye, that he lost about 50% of his vision and still has some tenderness around the right eye with discoloring, that he stated that he still saw a blanket over the right eye but that it had been "lighting up," and that he rated his current pain level at 3/10 without medication and 1/10 with medications. It was noted that Petitioner was currently taking Vicodin as needed and used eye drops twice a day, that he was currently unable to work until cleared by an ophthalmologist, that he reported that he was seen at Heyde Eye Center the day before and was told that there was no damage to the right eye, and that he was given eye drops and was able to return back to work. It was further noted that Petitioner was still with discomfort on the outer portion of the orbit, that he was told there was no orbit fracture and that there was no hemorrhage, and that he was given eye drops and had a follow-up appointment in two weeks. It was also noted that Petitioner had been taking Naprosyn for pain relief. The assessment was noted to be that of (1) right eye contusion – slow improvement; (2) questionable right orbit fracture – x-rays were read as no fracture by ophthalmology; (3) right eye hemorrhage – improved. Petitioner was instructed to continue medicines and/or comfort measures as directed, was to return to work without restrictions November 19, 2009, and was to follow-up with the clinic in 10 days. (PX7).

The records of IWIRC reflect that Petitioner was seen on November 30, 2009, at which time it was noted that he rated his current pain level at 2/10, that if his eye was touched then there was a stabbing pain that was constant, that he stated that his right eye still hurt and had a bump on it, and that he also stated that he could still only see about 50% out of his eye. It was noted that Petitioner was using eye drops for his right eye but had run out, and that he had no work restrictions. It was further noted that Petitioner stated that he was elbowed in the right eye by a cuffed student, that he still had orbital pain and decreased vision and was followed by ophthalmology, that he denied nose bleeds but did have some neck stiffness, and that he denied numbness or tingling in the face. The assessment was noted to be that of (1) right eye contusion – slow improvement; (2) questionable right orbit fracture – MRI to rule out; (3) right eye hemorrhage – improved; continue to follow-up with ophthalmology; (4) neck sprain – mild with full range of motion. Petitioner was recommended to undergo an MRI of the orbit, was to re-check in 48 hours, and was given restrictions of no altercation or combat risk activity. (PX7).

The records of IWIRC reflect that Petitioner was seen on December 2, 2009, at which time it was noted that he stated that his symptoms included headaches with a pain level of 2/10, sharp orbital pain with a pain level of 2/10 and sharp, stabbing neck pain with a pain level of 5/10. It was noted that Petitioner was currently taking no medication and was to start eye drops from Dr. Heyde that day, that he was waiting for a doctor to do an EOG per Dr. Heyde, and that he was following work restrictions. It was further noted that Petitioner stated that his vision had not improved, that he was seen by Dr. Heyde and that his vision had gone from 20/30 to 20/50 in his right eye, that he stated that he saw a "white wash," that he was having headaches and thought maybe his neck strain was causing this, and that he was taking Naproxen and Vicodin per his primary care physician for non-work related issues. The assessment was noted to be that of (1) right eye contusion – improving; (2) questionable right orbit fracture – MRI negative for fracture; (3) right eye hemorrhage – improved; continues to follow-up with ophthalmology; awaiting referral to specialist per Dr. Heyde; (4) neck sprain – maybe cause of headaches; should improve with physical therapy. Petitioner was instructed to continue medicines and/or comfort measures as directed, was to continue follow-up with his specialist, was to be referred for physical therapy, and was to return to work with restrictions of no combat or risk of altercations. Petitioner was further recommended to return in one week. (PX7).

The records of IWIRC reflect that Petitioner was seen on December 7, 2009, at which time it was noted that he stated that his symptoms had not showed any improvement since his last office visit, that he stated that his neck and back were hurting that day, that he stated that the back was not work-related, that he rated his current pain level at 5/10 but increased with movement of the neck, and that he stated that his vision in the right eye was still blurry. It was noted that Petitioner was currently using an antibiotic eye drop four times a day, that he stated that he had not used the eye drops for the past two weeks because the pharmacy was unable to fill his prescription and would call him when they had the medication in stock, and that he was following work restrictions. It was further noted that Petitioner stated that he was having increased pain in the neck with performing his exercises, that this increased his headache and his blurred vision, that he felt that his vision was not improved from the last visit, and that he noted that when he bent over to wash his daughter's hands he had sudden onset of his left lower back pain. It was noted that Petitioner noted that the neck pain radiated into both arms, and that he stated that this was associated with numbness and tingling. The assessment was noted to be that of (1) right eye contusion – no change; awaiting special testing; (2) neck sprain – this is suspicious for a C6-C7 radiculopathy. Petitioner was recommended to undergo an MRI of the cervical spine, was to follow-up with ophthalmology, was to take Vicodin, was to return on December 10th, and was recommended to work sedentary duty (lifting 10# occasionally, sitting mostly). (PX7).

The records of IWIRC reflect that Petitioner was seen on December 9, 2009, at which time it was noted that he stated that he had a constant headache at 2/10, that the headache was more prominent on the right, that he stated that the posterior skull had a constant irritation that included his posterior shoulder, and that he rated the pain at 5/10. It was noted that Petitioner had an MRI of his cervical spine on December 7, 2009 and was there for the results. It was noted that Petitioner was taking Vicodin for this injury, that he took one that morning for pain, that he was scheduled for an OEG in Iowa City but was unsure of the date, and that he was to follow-up with Dr. Heyde on December 29, 2009. It was further noted that Petitioner stated that he had had no change in vision, and that he stated his neck pain was the same and still down both arms. The assessment was noted to be that of (1) cervical sprain with disc bulge and C6-7 spinal stenosis; this correlates with the pain outline and with the loss of his triceps reflex; (2) right ocular hemorrhage. Petitioner was recommended to take Vicodin, to take a Medrol dose pack, to see Dr. Klopfenstein, and to return in two weeks for a recheck. (PX7).

The records of IWIRC reflect that Petitioner was issued a Work Status form on June 11, 2010, noting that he was to continue work conditioning. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of cervical neck strain. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to have no altercation risk and no safety sensitive work. Petitioner was issued a Work Status form on December 24, 2009, which noted that he was given a prescription for Vicodin, was recommended to follow-up with the neurosurgeon, was to follow-up with the neuro-ophthalmologist, and was to return in two weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of right ocular hemorrhage and cervical strain with C6-7 disc bulge. It was noted that Petitioner was issued work restrictions of Sedentary Duty and was instructed to have no combative or altercation risk. Petitioner was issued a Work Status form on January 6, 2010, which noted that he was to return in four weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of cervical strain and ocular hemorrhage. It was noted that Petitioner was issued work restrictions of Sedentary Duty and was instructed to do no commercial driving, no safety-sensitive duties, and no combat or altercations. Petitioner was also issued a Work Status form on February 10, 2010, which noted that he was to follow-up with the pain clinic, was to follow-up with the neurosurgeon, was to follow-up with the eye doctor, and was to return in four weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of right ocular hemorrhage and cervical strain. It was noted that Petitioner was issued work restrictions of Sedentary Duty and was instructed to do no commercial driving, no safety-sensitive duties, and no combat or altercation risks. (PX7).

The records of IWIRC reflect that Petitioner was issued a Work Status form on March 10, 2010, which noted that he was to follow-up with the specialist and was to return on March 31, 2020. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of left ocular hemorrhage and cervical neck strain. It was noted that Petitioner was issued work restrictions of Sedentary Duty and was instructed to do no commercial driving, no safety-sensitive duties, and no combat or altercation risks. Petitioner was issued a Work Status form on March 30, 2010, which noted that he was to follow-up with the eye specialist, was to follow-up with the neurosurgeon, and was to return in three weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of ocular hemorrhage and c-spine strain. It was noted that Petitioner was issued work restrictions of Sedentary Duty and was instructed to do no safety-sensitive duties, and no combat or altercation risks. Petitioner issued a Work Status form on May 14, 2010, which noted that he was to follow-up with the work conditioning program and was to return in one month. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of ocular hemorrhage and cervical neck strain. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to do no combat or altercation risks. (PX7).

The records of IWIRC reflect that Petitioner was issued a Work Status form on April 20, 2010, which noted that he was to follow-up with the physical therapy evaluation and was to return in three weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of right ocular hemorrhage and cervical neck strain. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to do no combat or altercation risks. Petitioner was issued a Work Status form on June 24, 2010, which noted that he was to continue Naprosyn, was given a prescription for Skelaxin, and was to return in two weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of right eye ocular hemorrhage and cervical radiculopathy. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to do no combat or altercation risks. Petitioner was issued a Work Status form on July 8, 2010, which noted that he was to undergo a physical therapy consult, was to undergo an MRI, was given a Medrol dose pack, and was to return in three weeks. The date of injury was noted to be that of November 9, 2009, and the diagnosis was noted to be that of low back strain, ocular hemorrhage, and cervical radiculopathy. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to do no combat or altercation risk positions. Petitioner was issued a Work Status form on August 2, 2010, which noted that he was to resume physical therapy, was to continue his medications per his primary care physician, and was return in three weeks. The date of injury was noted to be that of November 19, 2009, and the diagnosis was noted to be that of lumbar back sprain and cervical radiculopathy. It was noted that Petitioner was issued work restrictions of Medium Duty and was instructed to do no safety-sensitive duties and no combat or altercation risks. (PX7).

The records of IWIRC reflect that Petitioner was seen on March 15, 2012 for a fitness for duty evaluation after a cervical fusion. It was noted that Petitioner stated that he had near full range of motion, that he had been released by his neurosurgeon to return to work without restrictions, that he stated that he continued with three back injections every six months through the pain clinic, that he used some Vicodin when the back flared, and that he stated that the Vicodin usage increased to about two a day just prior to the next back injection. It was further noted that Petitioner stated that he still had decreased vision in the right eye, that he stated that he was currently not taking any medications, and that he was being evaluated to return as a District 150 police officer. The assessment was noted to be that of cervical spinal stenosis, lumbar disc disease, and right decreased vision. It was noted that Petitioner was post three-level cervical fusion with plates and screws, that he had minimal discomfort, and that he had near full range of motion. It was noted that the MRI of the lumbar spine from July 8, 2010 had a L4-5 left disc herniation with foraminal narrowing, that it compressed the L4 disc, that an L5-S1 disc herniation was noted compressing the right S1 nerve, and that Petitioner had chronic pain that was being controlled by frequent back injections and narcotic use. It was noted that Petitioner's vision was 20/70 on that date. It was noted that given the

chronic spinal changes in the cervical and lumbar regions, Petitioner was at an increased risk of injury to himself or others, that this risk would be most evidence in effecting an arrest, and that he had devicicets [*sic*] that could be exploited by a combatant and was not safe to return to the job of a District 150 police officer without restrictions to minimize the risk of injury to himself or others. It was noted that Petitioner may be able to perform some of the job activities if the job could be modified to include restrictions of Medium Duty (lifting 50# occasionally, 25# frequently) and no combat or altercation risks. (PX7).

The interpretive report for a CT of the right eye orbit dated November 30, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that the films were interpreted as revealing normal orbits. (PX8).

The interpretive report for an MRI of the cervical spine dated December 7, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that the films were interpreted as revealing diffuse degenerative disk disease throughout the cervical spine; at the C3-C4 level, there is bilateral uncovertebral joint hypertrophic change resulting in mild left neural foraminal stenosis; at the C4-C5 level there is bilateral uncovertebral joint hypertrophic change and facet arthropathy resulting in moderate right and mild to moderate left neural foraminal stenosis; there is a broad-based disc osteophyte complex effacing the anterior thecal sac resulting in an AP dimension of 8-9 mm; at the C5-C6 level, there is bilateral uncovertebral joint hypertrophic change, greater on the left with a large osteophyte compressing the left C6 nerve root, the combination of findings results in moderate to severe bilateral neural foraminal stenosis, as well as mild to moderate central canal stenosis; at the C6-C7 level, there is a broad-based disc osteophyte complex effacing the anterior thecal sac and flattening the cord resulting in an AP dimension of 8-9 mm; bilateral uncovertebral joint hypertrophic change, greater on the left, results in severe left and moderate right neural foraminal stenosis; at the C7-T1 level, there is moderate facet arthropathy resulting in moderate bilateral neural foraminal stenosis; the cervical spine is in anatomic alignment. It was noted that no focal acute disc herniation was present. (PX9).

The IWIRC Referral to Dr. Klopfenstein dated December 11, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that the "Issues to Address" was that of a cervical sprain with disc bulge and C6-7 spinal stenosis. (PX10).

The medical records of OSF St. Francis Medical Center dated March 26, 2010 were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen in the emergency room on March 26, 2010, at which time it was noted that his "Problem List" included chronic back pain, low back pain with lower extremity pain, cervical degenerative disk disease status post anterior cervical fusion, left L4/L5 and right L5/S1 disc herniations, post-laminectomy syndrome, lumbar region, status post L5/S1 laminectomy, and low back pain, among other issues. It was noted that Petitioner also had numbness and tingling in the bilateral buttocks and bilateral feet in dorsal and plantar surfaces in all toes. It was further noted that Petitioner presented with arm edema, that he arrived with two days of rapidly advancing huge axillary abscess with extension to the skin on his flank and anterior abdominal wall, that he had one additional non-abscessed pustule near his right breast but that it had spontaneously healed, and that he had no known prior history of MRSA. It was noted that due to the large size surgery was consulted to consider a more formal procedure, and that it was planned to admit Petitioner for further treatment. The admitting diagnosis was noted to be that of methicillin-resistant *Staphylococcus aureus* right axillary abscess; the procedure performed was that of an incision and drainage of right axillary abscess. It was noted that Petitioner took six Vicodin per day for chronic neck pain from an injury, so he was given Ultram, Norco, and Morphine as needed for pain. Petitioner was discharged home on the same date. (PX11).

The interpretive report for an MRI of the lumbar spine dated July 8, 2010 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12.[2] The records reflect that the films were interpreted as revealing left foraminal disc herniation L4-5; right paramedian disc herniation L5-S1. The "Clinical" information made reference to back pain and lower extremity numbness and tingling. (PX12).

The interpretive report for an MRI of the cervical spine dated February 8, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that the films were interpreted as revealing multilevel degenerative changes as described; at C4-C5, there is mild-to-moderate central canal and mild left/moderate right foraminal stenosis; at C5-C6, there is moderate central canal and mild right/moderate to severe left foraminal stenosis; at C6-C7, there is mild central canal and mild bilateral foraminal stenosis. (PX13).

The interpretive report for a bone scan dated February 25, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that the imaging was interpreted as revealing minimal uptake in the left acromioclavicular joint consistent with arthritic change; in the SPECT images, there does appear to be uptake in the spinous process at what appears to be C3; this may only be due to arthritic change; recommend comparison with prior outside radiographs of the cervical spine; alternatively, magnetic resonance imaging could be obtained. The Ordering Diagnosis was noted to be that of cervicalgia. (PX14).

The interpretive report for an EMG performed on March 16, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 15.[3] The records reflect that the testing was interpreted as revealing (1) right median nerve entrapment at the flexor retinaculum (carpal tunnel); (2) right ulnar nerve entrapment at the elbow; (3) right lower cervical radiculopathy. It was noted that there was no electric evidence of right brachial plexopathy or right musculocutaneous/axillary neuropathy, and that clinical correlation was suggested. The Patient History noted that Petitioner was a police officer, that he stated that he was attacked by a boy in the 150 school district, and that since then had had neck pain and numbness in the right hand, as well as shoulder pain. (PX15).

The interpretive reports for a CT of the cervical spine, injection for CT cervical myelography, cervical myelography, and x-rays of the cervical spine dated April 18, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The records reflect that the post-myelographic CT of the cervical spine was interpreted as revealing moderate circumferential spinal stenosis at C4-C5 and C5-C6; left-sided neural foraminal narrowing at C5-C6 and C6-C7. The records reflect that the cervical myelography performed on the same date was interpreted as revealing spinal stenosis at C4-C5 and C5-C6; please correlate with post-myelographic CT of the cervical spine. The records reflect that x-rays of the cervical spine performed on the same date were interpreted as revealing degenerative changes present with narrowing at C4-C5, C5-C6, and C6-C7; there is bone encroachment upon the neuroforamen on the left at C5-C6 and C6-C7; no fractures are seen; no destructive lesion is seen. (PX16).

The Operative Report of Dr. Jeffrey Klopfenstein dated June 8, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The records reflect that Petitioner underwent (1) C4-C5, C5-C6, and C6-C7 anterior cervical discectomies; (2) bilateral C5, C6, and C7 decompressive foraminotomies; (3) C4-C5, C5-C6, and C6-C7 anterior cervical arthrodesis using allograft augmented with autograft; (4) harvest of local autograft; (5) C4-C7 anterior cervical plating using Atlantis Vision system; (6) microdissection – use of operating microscope; (7) use of intraoperative fluoroscopy for a pre- and post-operative diagnosis of C4-C5, C5-C6, C6-C7 spondylosis. (PX17).

[2] Any handwriting that appears on the exhibit was not made by the Arbitrator.

[3] Any highlighting that appears in the exhibit was not made by the Arbitrator.

The Methodist Medical Center discharge instructions dated June 8, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The records reflect that Petitioner was recommended to wear the collar as instructed per his surgeon, and that he was to follow-up with Dr. Klopfenstein as scheduled. (PX18).

The interpretive report for x-rays of the cervical spine dated July 19, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The records reflect that the films were interpreted as revealing fairly good mobility present status post interbody fusion from C4 through C7. (PX19).

The INI Work Status Letter dated October 17, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 20. The letter reflects that Jan Boerke, ACNP, noted that Petitioner had undergone C4 through C7 anterior cervical discectomy, decompressive foraminotomies, and anterior cervical arthrodesis and plating by Dr. Klopfenstein on June 8, 2011, that he had recovered quite well from his surgery, that she received a copy of Petitioner's job description, and that he would be able to perform all duties listed on his job description with the exception of numbers 10 and 13. It was noted that Petitioner could perform with modifications, that he should avoid aggressive physical contact for a duration of 12 months, and that all other duties not requiring physical restraint or aggressive contact he was able to perform as listed on his performance responsibilities. (PX20).

The interpretive report for x-rays of the cervical spine dated November 29, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 21.[4] The records reflect that the films were interpreted as revealing post-operative changes in the cervical spine similar to July 19, 2011. The History noted neck pain status post C5 to C7 fusion. (PX21).

The IWIRC Fitness for Duty Evaluation dated February 15, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 22.[5] The records were duplicative of those as contained in Petitioner's Exhibit 7. The Arbitrator notes that the fitness for duty evaluation-related documentation contains dates of service of both February 15, 2012 and March 15, 2012. (PX22; PX7).

The interpretive report for an MRI of the lumbar spine dated December 14, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 23.[6] The records reflect that the films were interpreted as revealing small, probable superiorly extruded free disc fragment on the left at L1-2, mildly impinging upon the left L2 nerve root; clinical correlation regarding a possible left L2 radiculopathy is seen; small left foraminal disc protrusion at L4-5, displacing the left L4 nerve root; very small right paracentral disc protrusion at L5-S1, contacting but not displacing the right S1 nerve root. The History was noted to be that of back pain for months; no surgery. (PX23).

The interpretive report for a bone scan dated February 1, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 24. The records reflect that the testing was interpreted as revealing (1) bilateral L4-L5 facet arthropathy; no acute abnormality in the lumbar spine; (2) post-traumatic activity in the anterior right first rib and anterior left second and 3rd ribs; (3) other arthritic activity as described. The History was noted to be that of 45-year-old male with lower back pain; history of fall from a ladder with chest pain in August 2012; history of c-spine fusion in 2011. (PX24).

The medical records of OSF St. Francis Medical Center dated June 18, 2013 were entered into evidence at the time of arbitration as Petitioner's Exhibit 25. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that he was a 45-year-old male with a past medical history of chronic back pain that was brought to the emergency department by EMS for

[4] Any highlighting that appears in the exhibit was not made by the Arbitrator.
[5] Any highlighting that appears in the exhibit was not made by the Arbitrator.
[6] Any highlighting that appears in the exhibit was not made by the Arbitrator.

exacerbation of back pain. It was noted that Petitioner reported that he had been nauseous over the past few days and vomited several times on Sunday, that he was able to keep liquids and fluids down on that date, that the symptoms were similar to his chronic symptoms but that the pain was more severe, and that he reported that he always has numbness down the back of his legs and pain radiating down his right leg. It was noted that Petitioner's Past Medical History Positives included chronic back pain, arthritis, and bronchospasm, among other issues. It was also noted that Petitioner had chronic back pain from three bulging lumbar discs, that he presented to the emergency department with exacerbation of chronic pain, and that he denied any new symptoms. It was noted that Petitioner was treated with Toradol and Norflex, that he was able to stand and walk with a steady gait, and that he reported that he recently signed a pain contract. Petitioner was advised to continue to take his prescribed medications as directed, to follow-up with his primary care physician within the next week if his symptoms did not improve or worsened, and that he was discharged home. It was also noted that Petitioner's wife stated that he could not get off the couch, that he vomited yesterday and was nauseated, that his wife stated that he seemed "out of it," that he took two Vicodin earlier last night, and that he reported numbness in his back for 2-3 years from three ruptured discs in his back L3-4-5. (PX25).

The interpretive report for a CT of the head dated September 27, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 26. The records reflect that the films were interpreted as revealing no acute intracranial process. The History was noted to be that of seizures. (PX26).

The interpretive report for an MRI of the brain dated November 15, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 27. The records reflect that the films were interpreted as revealing essentially normal MRI of the brain; no acute findings; no temporal lobe abnormalities. The History was noted to be that of seizure two months ago; history of altercation; facial injury; dizziness. (PX27).

The medical record of OSF Center for Health dated January 20, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 28.[7] The record appears to relate to a procedure performed at Central Illinois Pain Management. (PX28).

The medical records of OSF St. Francis Medical Center dated January 20, 2014 were entered into evidence at the time of arbitration as Petitioner's Exhibit 29. The records reflect that Petitioner was seen in the emergency room on January 20, 2014, at which time it was noted that he presented with complaints of nausea and coffee ground-like emesis onset four days PTA, and that he reported three episodes of emesis for the first two days since onset, four episodes of emesis yesterday, and no emesis on that date. It was noted that Petitioner stated that used Vicodin, Tramadol, and Mobic, that he had been using Mobic for 3-4 years but did not remember the dosage, and that he reported that he had been taking his medications regularly. It was further noted that there was a suspicion for ulcer or stomach inflammation from prolonged Mobic use. It was noted that Petitioner was informed that it was in their best medical opinion that he would benefit from admission/observation to the hospital for further evaluation and treatment. The clinical impression was noted to be that of (1) chronic back pain; (2) depression; (3) essential hypertension, benign. It was noted that the ED impression was that of acute upper GI bleed secondary to PUD vs. gastritis vs. other. It was noted that Petitioner underwent an EGD and that gastroenterology was consulted. The OSF Gastroenterology Consult dated January 20, 2014 noted that Petitioner was a 46-year-old male with increasing anorexia over the last few months, that he had lost 80# because of poor appetite in the last six months, and that he had noticed one melenic stool earlier that morning. It was noted that Petitioner noted that he had started Tramadol last week, that he had been on chronic NSAID therapy, and that he underwent

[7] Any highlighting that appears in the exhibit was not made by the Arbitrator.

regular lumbosacral injections for control of his chronic low back pain. The records reflect that Petitioner was discharged on January 22, 2014. (PX29).

The medical records of OSF St. Francis Medical Center dated February 17, 2014 were entered into evidence at the time of arbitration as Petitioner's Exhibit 30. The records reflect that Petitioner was seen in the GI lab on that date for follow-up of GI bleeding for which he was admitted to the hospital. It was noted that at that time Petitioner reported having chronic back pain, and that he was taking non-steroidal anti-inflammatory medications, muscle relaxants, and narcotic analgesics. It was noted that Petitioner underwent EGD with small ulcerations seen in the stomach. The records further reflect that Petitioner underwent a colonoscopy on February 17, 2014. (PX30).

The medical records of OSF St. Francis Medical Center dated April 24, 2014 were entered into evidence at the time of arbitration as Petitioner's Exhibit 31. The records reflect that Petitioner was a 46-year-old male who presented to the emergency department via EMS with wife and 10-year-old son for evaluation of syncopal event. It was noted that Petitioner stated that he did not remember the incident, that prior to the incident he was sitting on his desk looking at his computer, that his son stated Petitioner was standing when he started to shake, and that Petitioner then fell on his head and continued to shake. It was noted that Petitioner's son reported that Petitioner stopped shaking and shortly began to shake again, that his son did not talk to him while he was shaking, and that the son also reported difficulty breathing and coughing during this episode. It was noted that Petitioner suddenly stopped shaking and got up to sit on a chair, that he was speaking but that his son was unable to understand him, that his son asked him what his name was and that Petitioner did not know. It was noted that Petitioner did not recall these events, that about six months ago he had a similar episode, that his wife stated that Petitioner had a seizure "but there was no damage to the brain" and that he was not placed on seizure medications. It was further noted that Petitioner's wife stated that "pain caused the seizure." It was noted that Petitioner had a history of "bulging disc" and discectomy, and that he reported tingling and numbness of the legs and feet at baseline. It was noted that Petitioner was admitted for overnight observation, that he was requesting his Oxycodone for chronic back pain, and that the plan was for an EEG and neurology recommendations. It was noted that a CT of the head performed on April 24, 2014 was interpreted as revealing (1) no acute intracranial hemorrhage, mass, or infarct by CT criteria; (2) mild bifrontal cerebral atrophy. It was noted that Petitioner would benefit from admission/observation for further evaluation and EEG in the morning. The ED Notes noted that Petitioner stated that he took Oxycodone/Acetaminophen and Tramadol for chronic low back pain, that he stated that he took his pain medications that day and took them daily, that he denied overdose, that when asked about Oxcarbazepine he stated that he had a seizure at work six months ago and had been on that medication since then after seeing neurology, that he was taking Lorazepam because he lost his job and was waiting on disability, that he had been taking that for a couple of months, that his wife thought he had some seizure-like episode a year ago then six months ago again which neurology thought might be due to his "severe and extreme pain," and that he was trying to go back to work despite his extreme pain. The CDU Discharge Summary noted an admitting and discharge diagnosis of seizure. (PX31).

The medical record of OSF Center for Health dated June 12, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 32.[8] The record appears to relate to a procedure performed at Central Illinois Pain Management. (PX32).

The interpretive report for an MRI of the lumbar spine dated May 29, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 33. The records reflect that the films were interpreted as revealing (1) there is no disc herniation; (2) degenerative changes described more fully above, with mild central canal stenosis L1-L2, mild proximal left L4-L5 neuroforaminal stenosis, minimal grade 1 L4 and grade 1 L5 spondylolisthesis; (3) normal appearance of the lower thoracic cord and conus

[8] Any highlighting that appears in the exhibit was not made by the Arbitrator.

medullaris. The History was noted to be that of 250-pound 47-year-old male reportedly assaulted November 2009, with chronic neck and back pain ever since that time; pain in the lower back radiates down the left leg; the patient also has bowel and bladder incontinence; lumbar surgery in 2013. (PX33).

The medical records of Illinois Neurological Institute/Dr. Jeffrey Klopfenstein were entered into evidence at the time of arbitration as Petitioner's Exhibit 34.[9] The records reflect that Dr. Klopfenstein authored a letter to Dr. Hauter dated December 31, 2009, in which it was noted that he had seen Petitioner in neurosurgical consultation on that date and that he was a 42-year-old police officer who was struck in the head with an elbow and thereafter developed paraspinal neck pain radiating to the occipital region as well as into the shoulders and upper extremities bilaterally in a non-dermatomal fashion, that the symptoms were bilateral in nature and did not involve paresthesias, weakness, or bowel or bladder change, and that an MRI of the cervical spine demonstrated diffuse subtle spondylosis with some foraminal stenosis, particularly at C6-C7, for which he was referred. It was noted that Petitioner had undergone physical therapy that was aborted due to the fact that he had some non-specific visual complaints following physical therapy. It was noted that Dr. Klopfenstein suspected that Petitioner's symptoms were primarily myofascial in origin given the bilateral symptoms and the lack of clear cut substantial acute pathology on the cervical spine MRI, that it was conceivable that there was a component of radicular pain involved, that in either case he did not believe that surgical intervention was warranted at that time, and that he had taken the liberty of referring him for epidural steroid injections and possible trigger point injections in efforts to manage his pain conservatively. It was noted that Petitioner was also asked to resume physical therapy with traction, and that he was to return in six weeks for reassessment. It was noted that if Petitioner's symptoms persisted at that time, they would consider EMG and nerve conduction studies to assess for clear cut radicular pathology, and that he was asked to continue with light duty at work. (PX34).

The records of Illinois Neurological Institute reflect that Dr. Klopfenstein issued a letter to Dr. Hauter dated March 31, 2010, at which time it was noted that Petitioner was seen in follow-up on that date and that he had undergone conservative measures in the form of injections and now graded his pain at 1/10 and had made significant progress. It was noted that given Petitioner's response to conservative measures Dr. Klopfenstein did not believe that surgical intervention was required, that he was asked to continue following with the pain clinic for his injections, and that he was cleared to commence physical therapy. It was noted that Dr. Klopfenstein would be happy to see Petitioner in follow-up should his pain return. The records reflect that Jan Boerke, APN, issued a letter to Dr. Hauter dated July 23, 2010, at which time it was noted that Petitioner was seen in the neurosurgery clinic on that date, that he presented with complaints of low back pain and right lower extremity pain, that he stated he was doing conditioning in physical therapy in anticipation of return to work a few weeks ago, that he was lifting approximately 85 pounds when he felt something pop in his back, and that he now complained of right low back pain which he stated was his number one complaint. It was noted that the pain radiated to Petitioner's right buttock and posterolateral right thigh and posterior calf, that the pain stopped at his heel, and that he stated that he had numbness and tingling in his right leg in the same distribution. It was noted that Petitioner stated with pain medications his pain was managed at a 5/10 level, and that he did not complain of left leg pain. It was noted that Petitioner stated that he had had urinary retention, that he had trouble initiating his urinary stream and did not feel he emptied his bladder completely, that he had one episode at which time he stepped wrong and had a severe bout of pain and had a small amount of urinary leakage, and that he denied any frank urinary incontinence. It was noted that Petitioner also stated that he had some difficulty with constipation, that he was on a Fentanyl patch and Vicodin, and that he had not had any epidural steroid injections or physical therapy for his low back complaints. It was noted that a referral was made for epidural steroid injections, possible right sacroiliac injections, and conservative pain management. Petitioner was recommended to return in eight weeks. It was noted that Petitioner was not able to return to work at that time. (PX34).

[9] Any highlighting and/or markings that appear in the exhibit was not made by the Arbitrator.

The records of Illinois Neurological Institute reflect that a Spine History Form was completed with a Review Date of July 21, 2010 by Dr. Klopfenstein, that the impression was noted to be that of back and leg pain, that the MRI showed a small right foraminal disc at 4/5 and nothing to explain incontinence, and that Petitioner was given an appointment with "Jan" to assess bladder function and to arrange for conservative care. As to the chief complaint, it was noted that the complaints included low back pain, pain in both legs mainly in the right leg, and numbness in the right leg and buttock. It was noted that the referring diagnosis was that of lumbar disc herniation L4-L5. It was noted that Petitioner hurt himself in a physical therapy appointment to return back to work from his neck injury. At the time of the February 3, 2011 visit with Jan Boerke, APN, it was noted that Petitioner was a 43-year-old male who was initially injured on November 19, 2009 at which time he was struck in the head by a student while working as a police officer, that he subsequently developed neck discomfort, that he was seen by Dr. Klopfenstein in December of 2009 and again in March of 2010, that his pain was felt to be mainly myofascial in origin, and that he was sent for conservative measures with good improvements. It was noted that Petitioner again presented to the office in July of 2010, that at that time he had complaints of low back and right lower extremity pain, that he had alternating lumbar and cervical epidural steroid injections routinely for pain management, and that he reported on that date for an evaluation of his neck and upper extremity pain. It was noted that Petitioner complained of neck pain which he rated as 6/10, that the pain radiated interscapularly and to the back of his upper arm ending at the elbow, that the neck pain was rated 6/10 and the left upper extremity pain was 3/10, that he had occasional radiation to his left forearm and occasional pain down his right arm, and that he stated that he had numbness in the entire aspect of his bilateral arms. It was noted that Petitioner had tingling bilaterally in fingers 1, 2, and 3, left greater than right, and that he reported some urinary urgency with difficulty initiating his stream. It was noted that Petitioner also reported stool incontinence approximately 10 times over the last 4-5 months. It was also noted that Petitioner was on a Fentanyl patch as well as Vicodin, Flexeril, and Amitriptyline. It was further noted that Petitioner also complained of low back pain which he rated as 6/10, that the pain radiated to his left buttock and down the "center" of his left thigh, that he had infrequent right leg pain, and that he complained of right leg numbness along the entire right leg and left leg numbness in the lower leg. It was noted that a repeat MRI of the cervical spine was ordered to evaluate the source of Petitioner's neck and upper extremity complaints, that he was to return to the clinic following his MRI, that he was to continue his regime of alternating lumbar and cervical epidural steroid injections in the meantime, and that they would consider repeating the MRI of the lumbar spine once the cervical spine had been fully evaluated. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen by Dr. Klopfenstein on February 23, 2011, at which time it was noted that the repeat MRI of the cervical spine demonstrated multi-level cervical spondylosis from C3-C4 through C6-C7 with disk osteophyte complexes at all of these levels but interestingly paracentric to the left whereas Petitioner's complaints were located on the right, and that the foramen at C3-C4 on the right was largely patent. It was noted that Petitioner's complaints were that of axial neck pain with radiation into both shoulders and down the right upper extremity and the right hand with numbness of the entire right arm, that his sensory complaints were in a non-dermatomal fashion, that on examination he had 5/5 strength throughout the upper extremities although he demonstrated poor effort secondary to pain and sensation in both his low back and neck with efforts, that he had loss of sensory sensation to pinprick examination in all dermatomes of the right upper extremity whereas he had no loss of sensation in the left upper extremity, and that deep tendon reflexes were 2+ throughout the upper extremities without asymmetry. It was noted that Dr. Klopfenstein did not believe that surgical intervention was warranted at that time without further evaluation. It was further noted that the plan was to send Petitioner for a bone scan and EMG nerve conduction study of the right upper extremity, after which he was to return to the clinic and decisions would be made regarding surgical intervention. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen by Dr. Klopfenstein on April 6, 2011, at which time it was noted that he was seen in follow-up for his axial neck pain and radiating bilateral upper extremity pain and paresthesias that did not seem to follow a radicular pattern. It

was noted that Petitioner's MRI of the cervical spine demonstrated multi-level degenerative changes most pronounced at C6-C7 where there was a sizable left paracentric disk osteophyte complex and arguably foraminal stenosis C5-C6 and C6-C7 on the right side, and that the EMG demonstrated right carpal tunnel syndrome as well as right ulnar nerve entrapment at the elbow and, finally, right lower cervical radiculopathy although the nerve root was not identified. It was noted that a bone scan was also reviewed and that it demonstrated minimal uptake in the cervical spine with exception of the SPECT images; where there was possible uptake in the C3 spinous process. It was noted that based on Petitioner's bone scan, Dr. Klopfenstein did not believe that degenerative disk disease or facet arthropathy was the source for his axial neck pain, and that alternatively his pain may be arising from the disk osteophyte complex on the left and the foraminal stenosis on the right, although his initial suspicion for these was not terribly high given his non-specific pain complaints. It was noted that a long discussion was had with Petitioner as to whether he would consider surgical intervention if the likelihood of success were lower than normal to which Petitioner replied in the affirmative, and therefore he was sent for CT myelography of the cervical spine to better assess the foramina of the lower cervical spine. It was noted that if there was significant stenosis superimposed upon the disk osteophyte complex at C6-C7, they would consider anterior cervical discectomy, fusion and plating, although it was made clear to Petitioner that the likelihood of success was less than usual. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen by Dr. Klopfenstein on May 18, 2011, at which time it was noted that he had been following him for quite some time with complaints of axial neck pain and non-dermatomal bilateral upper extremity pain and paresthesias, that he had been sent for a CT myelogram to better assess the foramina and central canal, that this had been completed and demonstrated multi-level degenerative changes, less pronounced at C4-5, C5-6, and C6-7, that there appeared to be foraminal stenosis bilaterally at C4-5 and to the left at C5-6, and that there was evidence of degenerative disk disease at all three levels, most pronounced at C6-7 where there was evidence of gas between the disk space. It was noted that a long discussion was had with Petitioner regarding his options, that he had been offered surgical intervention in the form of C4-5 and C5-6 anterior cervical discectomy, fusion, and plating for neural decompression, that given the significant degenerative disk disease at C6-7 and his complaints of axial neck pain Dr. Klopfenstein believed that incorporation of C6-7 was warranted, and that Petitioner voiced understanding and wished to proceed. It was noted that Petitioner was quoted a 50-60% chance of improvement of his symptoms. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen on July 22, 2011, at which time it was noted that he was six weeks out from surgery, that he stated that he was doing very well, that he had minimal neck pain, that he denied arm pain or numbness and tingling compared to prior to surgery, and that he stated his neck pain was 85% better and that his arm pain, numbness, and tingling were 100% better. It was noted that Petitioner took Vicodin approximately one time per day for low back pain as well as Elavil, and that he continued to have epidural steroid injections, the last being one month ago, for low back pain. It was noted that Petitioner was to slowly increase his activities back to his usual routine, that he did not wish to pursue physical therapy but would do his own conditioning at home, and that he had requested return to work with the beginning of the school year which was August 22, 2011. It was noted that Petitioner was to return at six months post-op for one final appointment and cervical flexion and extension x-rays prior to the appointment. The records reflect that a letter was issued to Chief of Security for Peoria Public Schools District 150 on October 17, 2011, noting that Petitioner had undergone C4 through C7 anterior cervical discectomy, decompressive foraminotomies, and anterior cervical arthrodesis and plating by Dr. Klopfenstein on June 8, 2011, that he had recovered quite well from his surgery, that Ms. Boerke had received a copy of Petitioner's job description, and that he would be able to perform all duties listed on the job description with the exception of numbers 10 and 13, which he could perform with modifications. It was noted that Petitioner should avoid aggressive physical contact for a duration of 12 months, and that all other duties not requiring physical restraint or aggressive contact Petitioner was able to perform as listed on his performance responsibilities. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen on December 7, 2011 by Ms. Boerke, at which time it was noted that he stated that he was doing very well, that he had only mild bilateral, lateral myofascial neck discomfort which he rated generally at 2/10, that he felt that this was improving, that compared to prior to surgery his neck pain was 90% better, that his arm pain was 100% better and that numbness and tingling was 100% better, and that he was taking no pain medications. It was noted that Petitioner was also being treated for low back pain and had serial epidural steroid injections, which he felt provided excellent relief. It was noted that from a neurosurgical standpoint Petitioner was cleared to return to work with the exception of no heavy physical contact for one year, and that following one year he would be able to return to physical contact as well. At the time of the May 21, 2012 visit with Ms. Boerke, it was noted that Petitioner presented with complaints of low back pain, that he had presented to the office at intervals with alternating complaints of back pain and neck pain, and that he stated that he was doing very well following his cervical surgery, but that he complained of low back pain which he rated 4-7/10. It was noted that Petitioner had bilateral buttock pain, left greater than right, and pain in bilateral thighs in the "center of his thigh" which he rated as 3/10, that he stated his number one complaint was low back pain, and that he also complained of numbness and tingling in his bilateral buttocks and bilateral feet in the dorsal and plantar surface in all toes. It was noted that Petitioner had been taking Vicodin, that he managed his back pain with epidural steroid injections approximately every two months, that his last injection was one week ago and that he stated he had had good relief, and that his last physical therapy was two years ago. It was noted that Petitioner stated that he would not consider lumbar surgery at that time so therefore no imaging studies would be obtained. Petitioner was ordered to undergo physical therapy, both land and aquatic, to help address his low back pain. It was noted that Petitioner was to continue to follow-up with Dr. Estep regarding ongoing pain management, and that he was to return to the clinic if further neurosurgical issues developed. (PX34).

The records of Illinois Neurological Institute reflect that Petitioner was seen on March 27, 2013, at which time it was noted that he was with a couple years of lower back and bilateral leg pain, that his pain was 6/10 at rest but 10/10 with bending, standing, and sitting too long, that it was described as a tingling at times that traversed into the buttocks and down the legs in a "spotty" distribution, and that he had failed physical therapy and mesial [*sic*] branch block. It was noted that Petitioner had chronic back and leg pain without spine surgical pathology, and that it was felt he was a reasonable candidate for DCS trial. Petitioner was referred for a neuropsychogical evaluation. Included within the records of Illinois Neurological Institute was a Medical Absence form dated August 18, 2011, which noted that Petitioner could return to work on August 22, 2011 as a school police officer. A Medical Absence form dated May 5, 2011 noted that Petitioner could return to work with no restrictions. A Medical Absence form dated July 22, 2011 noted that Petitioner could return to work on July 22, 2011. A return to work slip issued by Dr. Popp dated July 21, 2011 noted that Petitioner was to continue off work and could go back to work August 18th if cleared by his neurosurgeon. (PX34).

The medical records of Heyde Eye Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 35.[10] The records reflect that Petitioner was seen on September 11, 2012, at which time it was noted that his attorney needed an update on his right eye. The diagnosis was noted to be that of optic neuropathy, status post ocular trauma, among other issues. It was noted that a discussion was held regarding cataracts. At the time of the September 18, 2012 visit, it was noted that reading was difficult. At the time of the June 8, 2010 visit, it was noted that Petitioner was scheduled for a cataract exam. At the time of the February 16, 2010 visit, it was noted that Petitioner was there for a scheduled re-check. It was noted that they reviewed the Iowa City report with Petitioner at length. At the time of the December 1, 2009 visit, it was noted that Petitioner was still unable to see in the right eye and that he had had no improvement. The diagnosis was noted to be that of orbital contusion, among other issues. It was noted that a discussion was held regarding the need for an EOG. At the time of the December 29, 2009 visit, it was noted that it was

[10] Any highlighting that appears in the exhibit was not made by the Arbitrator.

expected that Petitioner's visual acuity would return to normal, that the injury was an elbow and not a weapon or bullet, and that there was no socket fracture. It was noted that Petitioner's decreased visual acuity was not consistent with the findings. It was noted that the EOG in Iowa City would show if the optic nerve was transmitting. (PX35).

The records of Heyde Eye Center reflect that Petitioner was seen on November 17, 2009, at which time it was noted that his injury had occurred at 8:30 that morning, that it was painful, and that he had a headache. The diagnosis was noted to be that of ocular trauma to the right eye and ecchymosis of the right eye, among other issues. It was noted that it was explained to Petitioner that there was bruising, but no fracture or damage to the eye. (PX35).

The medical records of Central Illinois Pain Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 36. The records reflect that Petitioner was seen on October 19, 2010, at which time it was noted that he was complaining of low back pain with lower extremity pain more on the left side with right leg numbness. It was noted that Petitioner's pain started in July 2010, that he described his pain more sharp and burning pain and aching pain with more numbness on the right leg but the pain is more on the left side, and that he described his pain in the whole leg and could not specify any specific part of the leg. It was noted that Petitioner's pain got worse with activity, standing for a long time, sitting for a long time, and bending and other physical activity, that his pain got better in a sitting position and having his legs up, and that his pain medication was helping. It was noted that Petitioner did not have any physical therapy for this pain or other treatments, and that he had been evaluated by Dr. Klopfenstein and had been referred to the facility. The impression was noted to be that of 43-year-old male with low back pain and lower extremity pain more on the left side with right leg numbness. It was noted that the MRI of the lumbar spine showed left neural foramen disc herniation at the L4-L5 level and right paramedian L5-S1 disc herniation, that the pain was more on the left side, that it could be originating from the L4-L5 foraminal disc herniation, and that Dr. Baha thought that Petitioner would benefit from a lumbar epidural steroid injection. It was noted that they would try to limit Petitioner's steroid exposure, but that he had had several cervical epidural steroid injections. It was noted that most likely they would start with lumbar epidural steroid injection at the L4-L5 interspace slightly to the left of midline, and that it was difficult to explain Petitioner's numbness on the right leg. (PX36).

The records of Central Illinois Pain Center reflect that Petitioner was seen on February 18, 2010, at which time he had been referred by Dr. Klopfenstein with a chief complaint of bilateral posterolateral upper back and neck pain with bilateral arm pain, being of greater intensity within his left arm than right, and that he described the pain as a burning sensation across his upper back and neck and more of a numbness and tingling within his bilateral upper extremities. It was noted that Petitioner identified these symptoms occurred on November 18, 2009, indicating that he was a police officer at a school, indicating that he was making an arrest on a student, that he indicated that he was elbowed in the area of the right eye, and that he had had pain as he was describing since that time. It was noted that when asked what helped, Petitioner indicated ice to the area of the posterior neck gave some relief and that when asked what worsened his pain, he indicated most all activities. It was noted that Petitioner indicated that he had not incorporated any physical therapy or steroid injection therapies to date, and that he indicated that he had taken some Vicodin and Naproxen for pain management but saw minimal relief. It was noted that Petitioner indicated that he had seen a chiropractor in the past for his low back, but not for his neck. The impression/diagnoses were noted to be that of (1) bilateral upper back and neck pain, described as a burning sensation, as well as bilateral upper extremity numbness and tingling, status-post November 18, 2009 injury; (2) C6-C7 broad-based disc bulging with osteophyte formations and flattening of the cord with 8.0 mm diameter, and severe left to moderate right neural foraminal narrowing; (3) C5-C6 left-sided C6 nerve root compression, secondary to large osteophyte formations; (4) obesity class II per the National Institute of Health. It was noted that it was felt that a trial of left-sided C6-C7 cervical epidural steroid injection with C-arm could be of additional benefit in the management of Petitioner's pain, and that he wished to proceed. It was noted

that it was felt incorporation of physical therapy in the future could be of some additional benefit as well as in the management of Petitioner's symptoms. (PX36).

The records of Central Illinois Pain Center reflect that Petitioner underwent (1) attempted C6-C7 epidural steroid injection; (2) C5-C6 epidural steroid injection, number one, with fluoroscopic guidance on February 22, 2010 by Dr. Bell for a pre- and post-procedure diagnosis of bilateral neck pain, left greater than right, with bilateral upper extremity pain, left greater than right. The records reflect that Petitioner was seen by Dr. Baha on March 8, 2010, at which time noted that he had had cervical epidural steroid injection which helped him, that he desired to undergo another injection, that he stated following the injection he experienced headache for about two days and then the headache subsided, and that overall his pain was improved. It was noted that Petitioner desired to proceed with another injection. The records reflect that Petitioner underwent cervical epidural steroid injection at C5-6 interspace by Dr. Baha on March 8, 2010 for diagnoses of (1) neck pain with bilateral shoulder and upper extremity pain more on the left side; (2) cervical degenerative disk disease with facet joint hypertrophy and osteophyte formation and neural foraminal stenosis. (PX36).

The records of Central Illinois Pain Center reflect that Petitioner underwent cervical epidural steroid injection at the C5-6 interspace by Dr. Baha on April 20, 2010 for diagnoses of (1) neck pain with bilateral shoulder and upper extremity pain more on the left side; (2) cervical degenerative disk disease with facet joint hypertrophy and osteophyte formation and neural foraminal stenosis. At the time of the August 16, 2010 visit with Dr. Bell, it was noted that Petitioner was well-known to the clinic and had undergone cervical epidural steroid injections in the past, that the last was in April 2010, that he felt that the injections had given him some benefit but that he had gotten recurrence of his pain at that time, and that before he was getting pain more in both shoulders but now was getting more in his left shoulder. It was noted that overall Petitioner felt the pain benefit had continued but wished to proceed with another set of injections to see if he could gain further benefit, and that he was there for the first injection. It was noted that Petitioner underwent C6-C7 epidural steroid injection number one, series number two, on that date for a pre- and post-procedure diagnosis of C5-C6 and C6-C7 degenerative disk disease with osteophytic formation and resultant left upper extremity and left shoulder pain. The records reflect that Petitioner underwent C6-C7 epidural steroid injection, number two, series two, by Dr. Marshall on August 31, 2010 for a diagnosis of C5-C6 and C6-C7 degenerative disk disease with osteophytic formation and resultant left upper extremity and left shoulder pain. It was noted that Petitioner tolerated the injection well and was discharged in good condition and that, of note, while he was receiving physical therapy for his neck he developed disc herniations in his low back, had been seen by the neurosurgeon and referred for conservative pain management for his low back disc herniations, and that they would see him back for a consult and treat regarding his low back pain in the near future. (PX36).

The records of Central Illinois Pain Center reflect that Petitioner underwent C6-7 cervical epidural steroid injection number three, series two, by Dr. Marshall on October 11, 2010 for a diagnosis of C5-6 and C6-7 degenerative disk disease with osteophytic formation and resultant left upper extremity and left shoulder pain. At the time of the January 3, 2011 visit with Dr. Marshall, Petitioner underwent L4-L5 epidural steroid injection, number one, under fluoroscopy, for diagnoses of (1) C5-C6 and C6-C7 degenerative disk disease; (2) left L4-L5 disc herniation; (3) right L5-S1 disc herniation. At the time of the May 16, 2011 visit with Dr. Marshall, it was noted that Petitioner received his last epidural in January, that it was a lumbar epidural, that it helped his low back and lower extremity discomfort for at least four weeks maybe longer, and that his worst pain again was located bilaterally in his low back and bilaterally in his lower extremities. It was noted that the pain was about equal bilaterally in the legs but that Petitioner had numbness in the right leg in addition to pain, and that Dr. Marshall had recommended a repeat L4-L5 midline epidural. Petitioner underwent L4-L5 epidural steroid injection under fluoroscopy on May 16, 2011 for diagnoses of (1) C5-C6 and C6-C7 degenerative disk disease; (2) left L4-L5 disc herniation; (3) right L5-S1 disc herniation. (PX36).

The records of Central Illinois Pain Center reflect that Petitioner underwent a lumbar epidural steroid injection at the L4-L5 interspace by Dr. Baha on July 7, 2011 for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease status post anterior cervical fusion. The records reflect that Petitioner underwent lumbar epidural steroid injection L4-5 on August 16, 2011 by Dr. Marshall for diagnoses of (1) left L4-5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion. The records reflect that Petitioner also underwent an L4-5 interlaminar epidural steroid injection under fluoroscopy by Dr. Cory on January 18, 2012 for diagnoses of (1) multi-level lumbar disc protrusions on the left at L4-5 and on the right at L5-S1; (2) history of cervical degenerative disk disease, now status post anterior cervical fusion. (PX36).

The medical records of Associated Family Practice were entered into evidence at the time of arbitration as Petitioner's Exhibit 37. The records reflect that Petitioner was seen on April 24, 2012 for evaluation for medication refills. It was noted that Petitioner presented for three-month follow-up evaluation of hypertension, GERD, depression, anemia, allergic rhinitis, and erectile dysfunction. It was noted that Petitioner had a history of chronic low back pain for which he was being seen at the pain clinic, and that he indicated that the next injection was due in three weeks. It was noted that Petitioner was asking for additional Vicodin, stating that Dr. Popp used to allow him to take 1-2 qid PRN as well as having prescribed the Fentanyl patch. It was noted that Petitioner stated that of his depression "If I'm not in any pain, I'm O.K." It was further noted that Petitioner reported that some days he could hardly get out of bed due to back pain, and that he denied cervical pain. The assessment was noted to be that of essential hypertension, allergic rhinitis, GERD, and chronic low back pain. It was noted that Ms. Estep, nurse practitioner, would change the dosing on his Vicodin prescription, and that Petitioner was told that a prescription for #120 must last 30 days. It was further noted that Petitioner was also referred to Dr. Klopfenstein for chronic low back pain, and that he again brought in another disability form which he had completed and asked her to sign. It was noted that Ms. Estep again explained that she could not complete a disability form to reflect treatment by other healthcare providers, but that she could provide Petitioner with medical records of any treatments/recommendations per Dr. Popp. (PX37).

The records of Associated Family Practice reflect that Petitioner was seen on March 26, 2012, at which time he was seen for a chief complaint of cough, shortness of breath, and wheezing with activity when outside. It was noted that Petitioner related that he used to purchase over-the-counter bronchial medication, but that the medication was no longer available over-the-counter as of 2012. It was noted that Petitioner related that he was recently discharged by his employer and was presently on unemployment. It was noted that Petitioner requested a disability form be completed, relating that he had asked Dr. Garrels to complete the disability form but that he was afraid that he would not do it. It was noted that Petitioner related increased low back pain when he worked outside in the yard, that his pain also increased about two weeks before his next spinal injection was due, and that he related occasionally taking Vicodin and asked if she would change the "sig" on his script. The assessment was noted to be that of GERD, allergic rhinitis, and chronic low back pain. It was noted that it was explained to Petitioner that Vicodin was to be used as written, and that she would not change the script or increase the quantity for the month. It was further noted that Ms. Estep explained to Petitioner that she could not complete a disability form to reflect treatment by other physicians, but that she could provide him with medical records of any treatments/recommendations of Dr. Popp. (PX37).

The records of Associated Family Practice reflect that Petitioner was seen on January 24, 2012, at which time it was noted that he came in for follow-up evaluation of hypertension, GERD, depression, anemia, allergic rhinitis, and erectile dysfunction with chronic back and neck pain. It was noted that Petitioner reported that he continued to feel depressed because he was not working, and that he wondered if an increased dose of medication might be helpful. The assessment was noted to be that of essential hypertension, allergic rhinitis, anemia, depression, and GERD. It was noted that for persistent feelings of

depression they would increase the Zoloft to 100mg daily. A return to work slip was issued on August 17, 2011 allowing Petitioner to return to work with no restrictions on August 18, 2011. (PX37).

The medical records of Methodist Outpatient Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 38. The records reflect that Petitioner underwent a Physical Therapy Evaluation on August 3, 2012, at which time it was noted that he had two ruptured discs, had undergone epidurals every two months, that he was status post cervical fusion and was working towards return to work, and that he was lifting an 80# crate from floor to shelf and heard a pop in his low back. The Discharge Summary dated October 4, 2012 noted that Petitioner still felt no low back pain or lower extremity pain following his epidural injection last week, that he was sleeping about eight hours per night without pain, and that he was able to stand/ambulate without needing a seated rest break. (PX38).

The medical records of INI Neurosurgery/Dr. Todd McCall were entered into evidence at the time of arbitration as Petitioner's Exhibit 39.[11] The records reflect that Petitioner was seen on February 13, 2013, at which time it was noted that he was a 45-year-old male with back pain since starting physical therapy. It was noted that the sharp pain was 8/10 in severity in the office with Petitioner in no acute distress, that the pain was worse with activity, and that it occasionally traversed into the thigh. It was noted that Petitioner's back pain was possibly due to facet arthropathy or it was potentially myofascial in nature. It was noted that they would attempt a facet block and if that did not work, then Petitioner would return and they would discuss a dorsal column stimulator. At the time of the October 15, 2015 visit, it was noted that Petitioner was a 48-year-old male status post left L5/S1 decompression in 2013 by Dr. Kube, that he had continued left leg pain and back pain, that the pain shot down his leg to the foot, and that the pain was 7/10 at baseline but 10/10 with bending/twisting. It was noted that Petitioner had failed physical therapy and injections, and that the dorsal column stimulator trial provided 95% pain relief. The assessment was noted to be that of failed back syndrome. It was noted that Dr. McCall appreciated no further surgical pathology of the spine, and that as an alternative he felt a spinal cord stimulator would be a very reasonable treatment option. It was noted that Petitioner wished to proceed, and that the procedure was scheduled for November 3rd. (PX39).

The records of Dr. McCall reflect that a Telephone Encounter note was generated dated March 14, 2016, at which time it was noted that Petitioner called to state that he was told Dr. McCall would send a letter for him to get disability. It was noted that Petitioner was notified that she did not see this noted in Dr. McCall's office note and that his policy was that he did not support long-term disability except in severe cases. It was noted that Petitioner requested an appointment with Dr. McCall and stated that he would also like to discuss further surgery. Another Telephone Encounter note was generated dated May 17, 2016 noted that Petitioner requested a letter be sent to his lawyer indicating that he had been under Dr. McCall's care for failed back syndrome in the setting of diffuse spondylosis, that he appreciated no further surgical pathology, and that from his perspective as a spine surgeon Petitioner had reached maximal recovery of his back and lumbar spine issues. (PX39).

The operative report dated November 3, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 40. The records reflect that Petitioner underwent surgery on November 3, 2015 by Dr. McCall which consisted of (1) T8-T9 partial laminectomy for placement of dorsal column stimulator paddle lead with Medtronic; (2) placement of dorsal column stimulator generator in right flank; (3) use of intraoperative fluoroscopy for localization and confirmation midline placement of paddle lead for a pre- and post-operative diagnosis of failed back syndrome. (PX40).

[11] Any highlighting that appears in the exhibit was not made by the Arbitrator.

The transcript of the deposition of Dr. Todd McCall dated July 27, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 41. Dr. McCall testified that he is a board-certified in neurosurgery. (PX41).

Dr. McCall testified that he first saw Petitioner on February 13, 2013 and that he had had a previous surgery by Dr. Kube. He testified that he saw Petitioner again in 2015, that at that point he was having back and continued left leg pain, and that he had had a previous L5-S1 decompression by Dr. Kube. He testified that his medical records demonstrated that when he saw Petitioner on October 15, 2015, he had left leg pain and back pain. He testified that the physical examination performed was not really a remarkable neurologic examination, and that his left leg was difficult to examine because of the pain limitation. He testified that based on Petitioner's percutaneous trial by Dr. Feather, he offered an implantation. He testified that the medical records demonstrated that he performed the procedure on November 3, 2015. He testified that the diagnosis was that of failed back syndrome, which meant anyone who had had previous back surgery and continued to have symptomatology. He testified that he was attempting to treat both pain in the back and leg with this type of procedure. (PX41).

Dr. McCall testified that when he saw Petitioner on December 3rd he was doing very well, that the incisions were well-healed, that he was doing great, and that he had no pain. He testified that he thought it was a successful procedure at that point. He testified that he thought that he saw Petitioner one more time after this visit for some recurrence of back pain, and that the visit occurred on May 11, 2016. He testified that at that time Petitioner stated that he was having some continued back pain, and that he told him that there was nothing more he could do with regard to the stimulator. (PX41).

Dr. McCall testified that when Petitioner came to see him, he had leg pain for which he did not have a good explanation. He testified that Petitioner's imaging studies were unremarkable, and that they showed the surgical decompression without any further nerve compression. He testified that back pain was a very complicated issue, that a lot of people had back pain for no good explanation, and that a lot of times it was myofascial. He testified that the pain may be due to some of Petitioner's degenerative spondylotic changes which were very common, but that it was hard to pin down exactly why he was having his pain. (PX41).

Dr. McCall testified that Petitioner's need for the dorsal column stimulator was not related in any way to the neck surgery. He testified that he would never use the word "need" for a dorsal column stimulator because it was always an elective procedure to control pain, and that the procedure that he performed for this had nothing to do with the cervical surgery and neck pain. He testified that it was for low back and leg pain specifically. He testified that as of the last time that he saw Petitioner in May of 2016 he had been released from his care, and that he did not have any treatment suggestions at that time. He testified that he did not specifically refer Petitioner back to his previous doctors, but that he may have verbally recommended him to follow-up with Dr. Feather again. (PX41).

On cross examination, Dr. McCall agreed that he had no knowledge regarding any work injuries in this case. He agreed that he had no opinions in this case as it related to any relationship to those work injuries. He agreed that he had no knowledge of Petitioner's activities leading up to the time that he saw him on October 15, 2015. He agreed that at Petitioner's initial post-op follow-up, he did not report any pain issues. He agreed that he did not know what Petitioner was doing physically from December 2015 to May 2016. (PX41).

On cross examination when asked if at the time of trial it was shown that Petitioner was doing activities such as frequent bending and stooping that that was the type of activity that could aggravate the procedure that he did, Dr. McCall responded that those types of activities could aggravate chronic back pain in general. When asked if someone fell from a ladder and fell on their bottom and whether that was the type of event that could aggravate the degenerative condition that Petitioner had in his back, Dr. McCall

responded that he had seen people fall and had traumatic injuries that did not develop chronic pain in the setting of spondylosis, and that whether there was an interaction between the trauma and the spondylosis causing pain was difficult to determine. (PX41).

On cross examination when asked if at the time of trial it was shown that Petitioner fell from a ladder, went to the emergency room and reported that and had an increase in low back pain, and whether that was the type of injury that could have aggravated his condition of ill-being in his back, Dr. McCall responded that it was possible. When asked whether he agreed that, as it related to his first visit in this case, it appeared that Petitioner's objective findings were outweighed by his subjective complaints, Dr. McCall responded that he would agree with that statement. (PX41).

The interpretive report for an EMG performed on March 27, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 42. The records reflect that Petitioner was seen by Dr. Trudeau on March 27, 2013, at which time it was noted that he had the chief complaint of severe lower back and bilateral lower extremity discomfort for several years. It was noted that Petitioner was not felt able to do his work duties as a law enforcement officer and was considered disabled in that regard. It was noted that on the pain diagram Petitioner showed regions of tightness and discomfort in the upper back region but especially pressure in the low back, burning pain which radiated up and down the lower extremities, and shocking-type of numbness and tingling sensations in both lower extremities. It was noted that the study was interpreted as revealing (1) bilateral S1 radiculopathies right essentially equal to left in electroneurophysiologic testing terms; moderately severe on either side, consistent with the clinical assessment of Dr. Kube; (2) no current evidence of L2, L3, L4, or L5 radiculopathy on either side; (3) no current evidence of entrapment neuropathy; (4) no current evidence of lumbar plexopathy; (5) no current evidence of mononeuritis multiplex. (PX42).

The medical records of Prairie Spine & Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 43. The records reflect that Petitioner was seen on May 14, 2013, at which time it was noted that he was there for evaluation as a self-referral. It was noted that Petitioner had been having pain in his back since injuring it during a therapy program related to a previous work injury, that he was at work and was in an altercation with another individual who was ultimately arrested, that he lost partial vision in his right eye with this altercation, and that he also needed neck reconstruction which Dr. Klopfenstein performed. It was noted that Petitioner felt like he had been getting the "runaround" with Illinois Neurologic Institute since the time of his latest injury, that he stated he was doing physical therapy, that they had him lifting boxes with weights, and that in one such incident he was doing this and his back popped a couple of times and he went to his knees. It was noted that Petitioner had been having back pain and leg pain ever since, that he was basically sent for an MRI by the IWIRC doctor, and that it sounded like he was working within the employer's chain of physicians until now. It was noted that Petitioner wanted to know what else Dr. Kube might recommend for him because he was not getting adequate relief with the current suggestions being provided to him. The assessment was noted to be that of patient with radicular pain, aggravated degenerative disk disease, disc herniation, and severe back pain, now chronic secondary to the trauma from an injury while at IWIRC during his work conditioning program from a previous work injury. It was noted that Petitioner was recommended to undergo an EMG as they were likely looking at surgical intervention for him as he had been refractory to therapy and injections to date. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen by Dr. Alexander Cummings on April 23, 2013, at which time it was noted that he was referred for a spinal cord stimulator trial. It was noted that Petitioner had been having pain since approximately June 2012, that he had failed multiple therapies and procedures including physical therapy, medication, and epidural steroid injection, and that he also had a negative discogram. At the time of the April 23, 2013 visit with Dr. Kube, it was noted that Petitioner continued to have pain, that they went through his discogram results, that the discogram was essentially negative, and that he had facet arthropathy, although Petitioner stated he had had

previous facet injections which were unhelpful. It was noted that Petitioner had had occasional relief from an epidural injection, and that Dr. Kube did not see anything that he could reliably decompress that was really going to change him. It was noted that Dr. Kube thought that they were looking at a spinal cord stimulator trial, and that they were going to get him in to see Dr. Cummings to try to move this forward. At the time of the April 9, 2013 visit, it was noted that they had Petitioner's EMG that demonstrated bilateral S1 radiculopathy, that it was fairly significant, and that this was constant [*sic*] with Petitioner's examination. It was noted that given the large propensity to back pain that Petitioner had, Dr. Kube's recommendation was for a provocative discogram to see if they could pinpoint the back pain to the bottom disc and, if so, then decompression and fusion would be the likely treatment plan. Petitioner was issued a Work Status Form on April 9, 2013, allowing him to return to light activity. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner underwent x-rays of the lumbar spine on March 21, 2013, which were interpreted as revealing loss of disc height at L4-5 and L5-S1, otherwise a minimal amount of spondylolisthesis at these levels is noted. At the time of the March 21, 2013 visit with Dr. Kube, it was noted that they had the results of the FCE and that it demonstrated a few inconsistencies. It was noted that Dr. Kube thought that Petitioner should safely be able to do a 50-pound permanent restriction, which would place him at a permanent Medium duty. It was noted that Petitioner was to return to talk about a stimulator trial, and that they were getting him set up with a psychological profile in the interim. Petitioner was issued a Work Status Form dated February 11, 2014, indicating that Dr. Kube agreed with the findings of the FCE and that Petitioner should be placed at the activity level outlined in the evaluation with the added provisions in his dictated office note. At the time of the work conditioning session on January 16, 2014, it was noted that Petitioner did not participate in work conditioning the day before due to waking up and not being able to walk due to pain. It was noted that Petitioner did go to his previously scheduled appointment with his family practice physician and was given pain medications which he said seemed to help, and that even with the pain medications, his pain levels remained 6/10. It was noted that Petitioner was able to fully participate in two hours of work conditioning, and that he continued to take several opportunities to lay down between exercises due to the fact that he said it was unbearable for him to stand extended amounts of time. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner presented for his second day of work conditioning on January 14, 2014, that he stated that he was "feeling sick from the pain" and that his current pain level was 5/10 in his low back with pain medication. It was noted that Petitioner demonstrated range of motion deficits and to all planes with pain in all planes, and that most of the pain was located at the left side of the low back. At the time of the January 13, 2014 work conditioning session, it was noted that Petitioner voiced some concerns about whether he would be able to successfully complete the program. It was noted that several times Petitioner was witnessed wincing as if in discomfort, and that other times he stopped to stretch his back or lay down in between activities. The records reflect that Petitioner was issued a Work Status Form dated January 7, 2014, noting that he was to be off work during work conditioning. At the time of the January 7, 2014 visit, it was noted that Petitioner was really not making a whole lot of progress at that point, that he still had a lot of the same pain, that the decompression would not have been intended to do a substantial amount with respect to the back pain, that he continued to have this, that the discogram was negative, and that he was also having continued radicular complaints. It was noted that Dr. Kube's plan was to try to move Petitioner forward into a work conditioning program and also a functional capacity evaluation, and then to re-evaluate him. It was noted that they discussed a dorsal column stimulator trial and that Dr. Kube thought he was a candidate for this. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on December 16, 2013, at which time it was noted that he stated that his pain was slightly increased after slipping as he was getting in his car that morning at his home. It was noted that Petitioner continued to demonstrate progress toward his therapy goals, that in spite of his reports of increased symptoms that morning he was still able to fully participate in his therapy session, and that he paced himself appropriately

and was demonstrating improved form. It was noted that Petitioner appeared to be responding well to electrical stimulation for pain management, and that he reported that he had relief for an extended amount of time after receiving that treatment. At the time of the December 13, 2013 physical therapy session, it was noted that Petitioner stated that he was sore but was having less pain than his last session, and that he felt that the electrical stimulation made a significant difference in his pain and activity levels. It was noted that Petitioner appeared to be making progress and was benefiting from therapy services, and that his pain was more manageable on that date which he attributed to the use of electrical stimulation. It was noted that Petitioner denied any episodes of his back "locking up" that week. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on December 11, 2013, at which time it was noted that he stated that he took his children to their Christmas party last night and that after standing an extended amount of time, his back "locked up." It was noted that Petitioner stated that he had to go out to his car and sit with the seat warmers on, and that that had never happened to him before. It was noted that Petitioner continued to have fluctuations in his symptoms, that symptom exacerbations continued to be unpredictable, and that in spite of increased pain he was able to fully participate in his therapy session. It was also noted that Petitioner had not been requiring the use of his cane for ambulation that week. At the time of the December 9, 2013 therapy session, it was noted that Petitioner had only had one episode since his appointment with Dr. Kube last week where his back "locked up." It was noted that Petitioner stated that the doctor wanted him to continue physical therapy for one more month prior to his next doctor's visit, and that he felt that the electrical stimulation was the key in him doing better since his last therapy session. It was noted that Petitioner was able to ambulate into the clinic without use of any assistive device on that date, and that upon observation there was no noticeable gait deficit. The records reflect that Petitioner was issued a Work Status Form on December 3, 2013, taking him off work. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on December 2, 2013, at which time it was noted that he stated that he was not able to attend therapy the week before due to illness, that he stated that his back pain "hit" and he was in bed for the first three days of last week, and that his current pain level was 6/10 with pain medications. It was noted that Petitioner appeared to be struggling throughout his exercise session that day, that he came to therapy ambulating with a straight cane in his right hand, that upon observation he was bearing maximum weight through his right upper extremity in order to unload the weight on the left, and that during his initial evaluation he was ambulating without any assistive device. It was noted that Petitioner stated that he believed that when he got sick last week "the infection went to my back," and that he also reported that this was the second time since his evaluation that his back had forced him to be in bed for several days and that this occurrence was random. At the time of the November 21, 2013 therapy session, it was noted that Petitioner returned with a new onset of low back pain. It was noted that Petitioner had a L5-S1 microdiscectomy in the summer of 2013, that he participated in post-operative physical therapy for about six weeks and was doing rather well, that during his six week follow-up with Dr. Kube they released him to go back to a desk job but unfortunately Petitioner had a significant increase in pain after sitting for longer than 60 minutes, and that Dr. Kube also recommended that he consider a second round of physical therapy but was unable to attend due to his work-related duties. It was noted that Petitioner eventually noticed significant difficulty getting out of bed and was essentially bedridden for a couple of days, that a follow-up recently occurred for his 12 week post-operative follow-up, and that Petitioner could not really identify any diagnosis that he was given, but felt that Dr. Kube mentioned something about a muscle strain. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen on November 4,2013, at which time it was noted that he went back to work and could not handle it. It was noted that Petitioner's pain scores were actually increased again quite a bit especially in his back, and that they talked about maybe trying to get an epidural injection but that as Dr. Kube talked to him, without having identified the absolute pain generator for his back, he thought Petitioner probably just overdid it a little too much, too early with

respect to his back and that this was why the pain was coming back. It was noted that Dr. Kube wanted to "shut him back down from work" and get Petitioner back into therapy to see if they could move him forward, and that they would give him a refill on his Tramadol and muscle relaxants. Petitioner was recommended to return in four weeks. At the time of the September 23, 2013 visit with Dr. Kube, it was noted that Petitioner was six weeks out from his decompression, substantially better, and feeling pretty good, that he wanted to know whether he could do a little bit of work, and that he was trying to get a light duty job. It was noted that Petitioner was to return to work light duty and was to return in six weeks. Petitioner was issued a Work Status Form dated September 17, 2013, allowing him to do light activity. At the time of the September 13, 2013 physical therapy session, it was noted that Petitioner continued to report that he was not having any pain in the region of his surgery, that he had 4/10 pain at the levels above his surgical site which he stated was there he had other disc issues, and that he was reporting some increased discomfort that day secondary to having to sit for an extended amount of time at a job interview earlier. It was noted that Petitioner continued to respond well to therapy and was making good progress toward his goals, that at times he could be overly enthusiastic with his activities, that he was wanting to try a fast walk/light jog earlier in the week since he was feeling so good, and that a significant amount of time was spent educating him on his body's recovery process and the proper time for those types of activities. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on September 11, 2013, at which time he stated that he was not having any pain along his incision site, that he reported tenderness but that this did not feel the same as pain, and that he also noted that there was some increased swelling in the region of his incision. It was noted that Petitioner's primary concern was at the disc level above his surgical site. It was noted that Petitioner continued to do quite well and fully participated in his therapy session, that he tended to be rather aggressive in his exercise and required some cues in order to decrease the rate of his activity, and that education continued to be provided for monitoring his body mechanics with activity. At the time of the September 9, 2013 physical therapy session, it was noted that Petitioner stated that he was having 3/10 pain which he described as a sore in his low back, that he stated that it began three days ago, that it was his opinion that the pain was extending from his "other disks that are out," and that he did not believe that it was in the area of his surgical site. It was noted that Petitioner reported that he could stand only about ¾ of the time that it took to wash dishes before the pain increased. It was noted that Petitioner continued to demonstrate good progress and was progressing toward his goals, that his strength appeared to be improving and he was doing better setting his abdominal muscles during exercise, and that they continued to provide cues in order for him to decrease the rate at which he exercised in order to ensure proper form and muscle recruitment. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on September 6, 2013, at which time it was noted that he stated that he was feeling much better than he did at his last therapy session and that he currently denied pain. It was noted that Petitioner continued to respond quite well to therapy, that his pain was well managed, that his functional levels continued to improve, and that he was performing a good basic core stabilization and lumbar stabilization program. At the time of the September 4, 2013 physical therapy session, it was noted that Petitioner stated that he was not having any pain currently, that he noted that over the weekend his right sacroiliac joint became "irritated," and that he described it as annoying. It was noted that Petitioner stated that he felt the sacroiliac pain mostly if he was sitting or standing for greater than 30-45 minutes, that his pain was not constant, and that he noted that his core strength seemed to be improving. It was noted that Petitioner denied back pain and reported that the tenderness in his back was gone. At the time of the August 26, 2013 physical therapy session, it was noted that Petitioner stated that he was having no problems, that there had been no pain over the weekend, and that he currently had no pain. It was noted that Petitioner was sleeping well. It was further noted that Petitioner continued to do quite well in recovering from his surgery, that his pain was well managed, and that he presented to therapy without any pain. It was also noted that Petitioner did have some increased

symptoms after exercise, but responded well to electrical stimulation with cold pack in order to keep this manageable. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen for physical therapy on August 23, 2013, at which time it was noted that he denied pain and that he felt he continued to respond well since the surgery and was tolerating therapy sessions well. It was noted that Petitioner continued to do quite well and was demonstrating good progress that week, that he had tolerated the advances in his program without any pain increase, and that it appeared that his pain was well managed and he demonstrated good self-management skills. At the time of the August 22, 2013 physical therapy session, it was noted that Petitioner stated that he was not currently having any pain, that he was experiencing some tenderness around his incision site, and that he did not consider that pain. It was noted that Petitioner responded well to therapy that day and was able to fully participate in his therapy session. It was further noted that Petitioner did have some irritation in his low back as his muscles fatigued, and that he responded well to electrical stimulation and ice in order to keep the symptoms manageable after therapy. The records reflect that Petitioner underwent a Physical Therapy Evaluation on August 20, 2013, at which time it was noted that he complained of improving surgical discomfort throughout the low back, that he had intermittent right lower extremity symptoms, that the symptoms seemed to radiate through the right groin, anterior lateral thigh, and the right knee, and that he denied any symptoms into the foot or ankle. It was noted that they were to proceed with a very basic core stabilization program. (PX43).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen by Dr. Kube on July 8, 2013, at which time it was noted that the discogram was negative, that he still had the radiculopathy, that he had a protrusion, right-sided more than left, which was that Dr. Kube saw and what he was aiming at treating, and that his symptoms tended to be slightly more left-sided in their location. It was noted that Dr. Kube recommended against a fusion given the results of the discogram, that he would concentrate on decompression alone and try to get Petitioner's radiculopathy under control, and that hopefully this would help affect the remainder of the issue when he went through rehab. (PX43).

The operative report dated April 22, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 44. The records reflect that Petitioner underwent provocative discograms at L3-4, L4-5, and L5-S1 on April 22, 2013 by Dr. Kube for a pre- and post-operative diagnosis of degenerative change with low back pain, L4-5, L5-S1. (PX44).

The operative report dated August 5, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 45. The records reflect that Petitioner underwent (1) bilateral hemilaminotomy with microdiscectomy, L5-S1; (2) use of operative microscope for dissection; (3) use of C-arm imagery for confirmation of level and placement of incision on August 5, 2013 by Dr. Kube for a pre- and post-operative diagnosis of disk protrusion with stenosis and radiculopathy, bilateral, S1, with pathology at the L5-S1 level. (PX45).

The FCE performed at Champion Fitness dated January 28, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 46. The records reflect that the preponderance of the evidence indicated less than full participation, that the Performance Criteria Profile was consistent with overguarding (fearful subject), that though Petitioner may possess true dysfunction the data may not represent his true status at that time, and that the demonstrated physical functions data should not be used to project current work capacity since he could likely have functioned higher than willing. It was noted that Petitioner reported significant increases in pain and presented with significantly altered gait pattern with increased activity and upon completion of testing, in which he did not complete/refused to attempt to participate in the activity circuit portion of the testing secondary to reports of severe pain. It was noted that it was the therapist's opinion that Petitioner could function at least at the following levels: (1) Material Handling: Occasional: floor to waist 35#, waist to shoulder 40#, shoulder to overhead 35#, carry 35#, pushing 37#,

pulling 40#; Frequent: floor to waist 30#, waist to shoulder 25#, shoulder to overhead 20#, carry 17.5#, pushing 18.5#, pulling 20#; Constant: floor to waist 15#, waist to shoulder 12.5#, shoulder to overhead 10#, carry 8.75#; (2) Non-Material Handling: Occasional: sitting, standing, walking, bending, squatting, climbing, kneeling/crawling; Constant: reaching, grip/fine motor. It was noted that on January 28, 2014 Petitioner ambulated with an antalgic gait and an assistive device (straight cane) which he stated he bought himself at a local drug store. It was noted that a normal gait pattern was noted upon arrival on February 6, 2014, but that a severe antalgic gait was noted upon departure. It was noted that upon completion of testing, Petitioner laid on the treatment table stating his pain was so intense he could not do any more activity, that he proceeded to lie on the table while completing his post pain drawing, and that upon leaving the facility Petitioner walked with a severe antalgic gait, alternating which leg was being favored, and that he also "staggered" to his vehicle as if he was going to fall. It was noted that Petitioner made it safely into his vehicle. In the Present Activity/Job Goal portion of the test results, it was noted that Petitioner was trying to get Dr. Kube to do more surgery on his back on L3-L4 and on L4-L5, and that he planned to get full social security disability and did not plan on returning to work. (PX46).

The transcript of the deposition of Dr. Richard Kube dated June 29, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 47. Dr. Kube testified that he is board-certified by the American Board of Orthopedic Surgery, the American Board of Spine Surgery, and the American Board of Independent Medical Examiners. (PX47).

Dr. Kube testified that Petitioner first presented to Prairie Spine and Pain Institute on or about March 21, 2013 with a history of a work-related injury. He testified that Petitioner gave a history that he was having pain in his back since a therapy program that he was performing related to a previous injury that he had, that he had been lifting boxes with weights up to 85 pounds, and that during one of those incidents doing that his back popped a couple of times and he went to his knees. He testified that Petitioner reported that he had been having back and leg pain ever since then. He testified that Petitioner was seen for a second opinion. (PX47).

Dr. Kube testified that on physical examination Petitioner had specific point tenderness in areas of his back, that he also had some dermatomal sensory deficits that they picked up on at bilateral L4 and 5 and possibly S1, which was basically areas over the dorsal and lateral aspect of the foot, as well as a little bit of the proximal shin area. He testified that on the MRI of the lumbar spine dated December 14, 2012, he noted that Petitioner had maybe some mild loss of disk height at multiple disks, that there was a little bit of disk dessication at L3-4, moreso at L4-5, L5-S1, and that there was a disk protrusion at L5-S1. He testified that there was also "maybe the smallest amount of spondylolisthesis," but that he was not really impressed with it. He testified that his working diagnosis was that Petitioner had a radicular-type pain and symptoms with the sensory deficit, that he felt that he had a disk herniation with severe back pain, that he possibly aggravated the degenerative condition that he had, and that this would fit the type of mechanism that he described having occurred during what sounded like a work conditioning program. He testified that he wanted to get an EMG, which was performed by Dr. Trudeau on March 27, 2013. (PX47).

Dr. Kube testified that the finding of the EMG study was that of bilateral S1 radiculopathy. He testified that a bilateral S1 radiculopathy would account for pain radiating into both lower extremities. He testified that he recommended a provocative discogram which was performed on April 22, 2013, and that it revealed annular tears at L4-5, L3-4, and L5-S1. He testified that he discussed with Petitioner on April 23rd that he was a possible candidate for a dorsal column stimulator trial. He testified that when he saw Petitioner on July 2, 2013, he indicated that he would not be a candidate for multi-level lumbar fusion but that they discussed the possibility of performing a decompression. He testified that with Petitioner's leg scores being the predominant problem, that would be a reason to discuss perhaps doing a decompression alone for him. He testified that the decompression would not necessarily be curative of the lumbar pain.

He further testified that lumbar pain was in and of itself a different diagnosis than the lumbar radiculopathy. (PX47).

Dr. Kube testified that on August 5, 2013, Petitioner underwent a bilateral hemilaminotomy with microdiscectomy at L5-S1. He testified that at the September 17, 2013 post-operative visit, Petitioner's leg pain score at that point had improved by about 75% and that his back scores had improved by 30%. He testified that that was an indication that the surgery was effective in assisting treatment for the symptomatology of radiculopathy. He testified that when he saw Petitioner on October 29, 2013, he reported a history of making an effort to return back to work at that point in time. He testified that Petitioner indicated that he had noticed an increase in pain subsequent to his return to work effort, and that they discussed possibly proceeding with an epidural injection and/or reinitiating physical therapy. He testified that when he saw Petitioner on January 7, 2014, he was not really making much progress and had the same kind of pain. He testified that at that point he suggested attempting a work conditioning program and an FCE. He testified that he also discussed the possibility of proceeding with a dorsal column stimulator to treat the lower lumbar pain, and that he recommended a trial to see whether Petitioner would be a candidate for permanent implantation. He agreed that one of the purposes for the dorsal column stimulator was to decrease the need for chronic pain management through medications. (PX47).

Dr. Kube testified that Petitioner proceeded with the work conditioning program on January 13, 2014 and that he returned on February 11, 2014, at which time he placed him at maximum medical improvement absent a dorsal column stimulator trial, placing him at a 50-pound permanent lifting restriction and/or Medium duty. He testified that he next saw Petitioner on January 15, 2015, and that he was just about what he looked like before his initial surgery. He testified that he discussed with Petitioner whether he was still a candidate for a dorsal column stimulator trial. He testified that his restrictions of no lifting greater than 50 pounds was greater than what Dr. Hauter, Dr. Klopfenstein, and Genesis Healthcare felt that Petitioner was functionally capable of doing. (PX47).

Dr. Kube testified that Dr. Feather's note dated February 17, 2015 indicated that Petitioner had undergone the dorsal column stimulator trial and that it appeared that he had a successful trial attempt. He testified that it was Dr. Feather's plan to move Petitioner forward with a permanent implant. Dr. Kube testified that it appeared it would be medically necessary or medically indicated for Petitioner for a dorsal column stimulator permanent implantation. He testified that Petitioner had been at maximum medical improvement short of the stimulator, and that there was really no reason for him to believe that that would change. (PX47).

When asked to assume that the history Petitioner provided to him was correct and having been asked whether the condition that he diagnosed him with as to the lumbar spine and the bilateral lumbar radiculopathy was causally connected to the mechanism of injury that he described, Dr. Kube responded that lifting weights such as those described by him could certainly cause a rupture or at least an aggravation of a lumbar condition. He testified that assuming an accurate history, Petitioner could have aggravated a preexisting condition so as to make his lower back condition symptomatic. He testified that the incident as described in Petitioner's history could have aggravated a preexisting condition so as to necessitate the medical care and treatment that he had testified to. (PX47).

On cross examination, Dr. Kube agreed that he concentrated on Petitioner's low back and that it appeared that the surgery performed by Dr. Klopfenstein was successful as it related to his cervical area. He agreed that, as it related to the cervical area, he had no opinion on causation. He agreed that as far as Petitioner's work capabilities for the cervical area, he never got into it so he had no opinion. He testified that he did not have any recollection as to having seen the neck-related records pre-dating Petitioner's visit with him. (PX47).

On cross examination, Dr. Kube agreed that he could not say whether Petitioner, outside of his history to him, had had preexisting low back pain or radiculopathy pre-dating the physical therapy event that occurred. He testified that Petitioner did not talk about any intervening incidents that did not occur at the school district. He testified that Petitioner indicated that he had no back issues prior to the physical therapy for the neck and the other recovery. He testified that if Petitioner had prior low back complaints pre-dating the physical therapy event, it was possible that his opinion might change. He agreed that he had testified in many cases in the past before the IWCC and that he had testified that falls to the bottom/buttocks from a certain height could cause an aggravation of a preexisting condition in the low back. He agreed that falls onto the bottom or buttocks area could cause the type of condition that he saw on MRIs in this case, and that they could cause a condition that he had seen in surgery. He agreed that if it was shown that Petitioner sustained a fall prior to seeing him and went to the emergency room, that he fell off a ladder and gave complaints of low back pain and pain going down his legs away from school district activity, it could be an aggravating factor to his low back. He further agreed that it could have resulted in the findings that he saw on the MRIs and surgery. (PX47).

On cross examination, Dr. Kube agreed that if it was shown that Petitioner was doing yard work and sustained a twisting injury to his back while performing yard work such as raking, it was the type of twisting that could aggravate someone's low back complaints and degenerative condition in the low back. He testified that for the timeframe after he first saw him in 2013 but prior to surgery, Petitioner had not told him of any accidents that occurred to him away from the school district. He testified that while they were treating Petitioner, he did not talk about any intervening injuries that he was aware of. He agreed that violently twisting the back or sustaining a jerking motion to the back could be an aggravating factor to one's back, depending on the severity. When asked if he had seen anyone who had been sick and vomited and whether that was the type of event that could herniate a disk, Dr. Kube responded that it was uncommon but that he had seen it happen. (PX47).

On cross examination, Dr. Kube testified that he did not know that Petitioner went to the emergency room in the five months prior to surgery. He testified that he did not know whether Petitioner sustained any seizures that resulted in him going to the hospital. He testified that he was not aware of any falls to the ground that Petitioner may have had in that intervening incident that may have involved his low back. He agreed that Petitioner's BMI was high. When asked whether a high BMI could be an aggravating factor for an individual with a back like Petitioner's, Dr. Kube responded that it was more of a "stretch." He testified that it was theorized that smoking could accelerate degenerative changes but that he did not know that it had necessarily been linked to specific symptoms, but that it certainly slowed healing. He testified that his "big thing" for smoking was if he was going to fuse a patient, as nicotine could slow down fusion. (PX47).

On cross examination, Dr. Kube agreed that the surgery was for radiculopathy and that it seemed to have improved right after surgery. He testified that it was more or less a success. He testified that they were dealing with continued back pain and that Petitioner still had some radiculopathy, which was not uncommon. When asked whether he agreed that the radiculopathy was not limiting Petitioner in any way, Dr. Kube responded that it probably had some contribution to where he was but that the back was the larger contribution. He testified that Petitioner's history to him was that he did not have any significant low back problems pre-dating the work incident. He agreed that credibility was a "big thing" with his patients, and that he had to rely on them to tell the truth. He agreed that being motivated was important to get a patient back to work, as was trying their best to receive care and move forward. (PX47).

On cross examination, Dr. Kube agreed that he ordered the FCE. He agreed that he saw what Petitioner did in the FCE. He testified that there were some inconsistencies, but that he could not remember what they were. He agreed that the FCE indicated less than full participation, that there was an indication of overguarding, and that demonstrated physical data should not be used to project current work capacity

since Petitioner could likely have functioned at higher than willing. He testified that he would ideally want Petitioner to fully cooperate as much as he could, but that that did not happen in this case. He testified that that was why he bumped him up to 50 pounds from 35. He agreed that there were a lot of things that Petitioner could do with a 50-pound weight restriction for work capability. (PX47).

On cross examination, Dr. Kube agreed that the IWIRC and Genesis notes were dated in the 2011-2012 timeframe. He agreed that his restrictions were placed in 2014. He agreed that he relied on his restrictions more than what was seen in those exhibits. He testified that he did not know what Petitioner was doing for activity currently. He agreed that if Petitioner were exceeding the 50-pound weight restriction, that could be aggravating his back condition. (PX47).

On cross examination, Dr. Kube testified that he did not recall if he saw any medical records from Dr. Popp or Dr. Gilbert. He testified that he did not recall seeing any family medical records. He testified that he did not know that there were some records that indicated that Petitioner was choosing physicians for a particular reason of getting disability. He testified that he did not know that Petitioner told one of the physicians that he would pick that physician because he was afraid other physicians would not give him a disability slip. (PX47).

On cross examination, Dr. Kube agreed that he did not have a specific date for an injury in November 2009. He testified that he did not know how long after surgery in June 2011 the physical therapy occurred. He testified that Petitioner never told him that he fell off a ladder. (PX47).

On redirect, Dr. Kube agreed that he was not provided by medical records by defense counsel for any history about falling off a ladder, using a yard rake and violently twisting the back, vomiting in the emergency room, or having a seizure in the emergency room. He agreed that any answers to those questions were based off a hypothetical scenario. He testified that seeing the medical records would be helpful in order to render those opinions. He agreed that he was more or less speculating without having the facts. (PX47).

The medical records of University of Iowa Hospitals & Clinics/Dr. Thomas Oetting were entered into evidence at the time of arbitration as Petitioner's Exhibit 48.[12] The records reflect that Petitioner was seen on January 15, 2010, at which time it was noted that he was a referral for decreased vision after a contusion to the right eye, no improvement per Dr. Heyde. It was noted that Petitioner worked at a special school for severely disturbed children, that on November 17, 2009 he was involved in an altercation with a student and that, after handcuffing him and while escorting him to a room, the student forcefully resisted entering a room and swinging his elbow, hitting him in the right eye. It was noted that Petitioner thought that he was told that his vision in his right eye was 20/30 prior to the incident, and that his vision was blurry immediately afterwards. It was noted that Petitioner thought his vision had not changed much since the incident. It was noted that Petitioner also had headaches, that they were daily, waxed and waned in intensity, were better with Vicodin, and hurt in a band-like fashion. The assessment was noted to be that of a 42-year-old man with right amblyopia elbowed in the right fronto-orbital area restraining a disabled student at work. It was noted that Petitioner was reassured that there was no evidence of permanent damage to his visual system and that they expected him to improve over the next two months. It was noted that if Petitioner's vision had not returned to baseline, they would like to see him again. (PX48).

The records of University of Iowa Hospitals & Clinics reflect that Petitioner was seen on April 16, 2010 visit, at which time it was noted that he was last evaluated in January and had a constricted field in the right eye but no relative afferent pupillary defect, that he reported improvement in his vision but his Goldmann perimetry showed more constriction, that there was no hint of a relative afferent pupillary defect, and that his funduscopic exam was again normal. It was noted that Petitioner could return to full

[12] Any highlighting that appears in the exhibit was not made by the Arbitrator.

employment. It was noted that Petitioner was to return in six months, sooner if his vision worsened. (PX48).

Two discs related to Unity Point Proctor and Methodist Medical Centers were entered into evidence at the time of arbitration as Petitioner's Exhibit 49. The Arbitrator notes that notes attached to the subpoena issued for Unity Point – Proctor noted that 225 pages were not printed, and that 833 pages were not printed for Unity Point – Methodist Medical Center. (PX49).

The medical records of Illinois Regional Pain Institute/Dr. Glen Feather were entered into evidence at the time of arbitration as Petitioner's Exhibit 50. The records reflect that Petitioner was seen on July 29, 2014, at which time it was noted that he was presenting with pain in the low back region. It was noted that Petitioner had an on-the-job related injury to his cervical region back in 2009, that he then went to physical therapy and while in physical therapy he related that he was lifting 90 pound weights when he felt a pop in the low back region, that he stated that this caused him to "bulge disc in my low back," that he then saw a local orthospine surgeon who performed surgery at the L5-S1 level and that this relieved the pain into the right lower extremity, that he then saw a local neuro-spine surgeon who felt that further surgery was not indicated and recommended a spinal cord stimulator, and that the orthospine surgeon also recommended a spinal cord stimulator and would never return calls when it came time to implant a spinal cord stimulator. It was noted that Petitioner had been seen at a local pain clinic to get epidural steroid injections approximately every two months, that they had not been providing any pain medications, that he had been getting refills of Hydrocodone and/or Oxycodone from other pain physicians, and that he typically got Hydrocodone approximately 120 tablets per month, but on occasion would get Oxycodone approximately 120 tablets per month. It was noted that Petitioner described pain that was constant, a 7/10 on that date, that there was sharpness, aching, and burning, and that it radiated down the left lower extremity. It was noted that Petitioner would occasionally get pain into the right side, but that it was typically left-sided. It was also noted that Petitioner still had some neck pain. It was noted that Petitioner had a history of seizures and was currently under the care of a neurologist, that he had depression, that he suffered insomnia, and that he took Lorazepam for anxiety. It was noted that Petitioner wanted to consider a spinal cord stimulator implant but that no one would give him any help in that regard, and that he had tried to get a psych eval but had been unable to get that as well. It was noted that Petitioner was able to ambulate without assistance, and that he ambulated with a limp. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, radiculopathy, myalgia and myositis, and degeneration of lumbar or lumbosacral intervertebral disc, among other issues. Petitioner was given a prescription for Gabapentin. It was noted that Dr. Feather was going to have Petitioner see Dr. Lisa Rogers for a psych eval. Petitioner was also recommended to use Robaxin and Percocet. It was noted that a random urine screen was to be performed and that Petitioner was to be monitored. It was further noted that getting steroid injections every two months was typically above what was considered an appropriate regimen. It was noted that Petitioner had seen another pain clinic that gave some injections but did not provide any other therapeutic treatment modality, and that he was given the choice to either go back to them for his full therapy or see Dr. Feather. It was noted that if Dr. Feather found that Petitioner was going back to them for injections but coming to him for narcotics, he was to be discharged. It was noted that a TENS unit was ordered to replace the over-the-counter unit Petitioner had. (PX50).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on August 29, 2014, at which time it was noted that he was able to see the pain psychologist. It was noted that Petitioner was a candidate to get a spinal cord stimulator trial, but that the issue was that he had a sleep disorder. It was noted that Petitioner continued to have severe pain for the back radiating to the legs, that the characteristics were unchanged, and that the pain level remained unchanged. It was noted that Petitioner's medications still fell short in providing adequate pain relief. It was noted that they would try to get workman's compensation to approve the spinal cord stimulator trial. Petitioner was allowed to use the Percocet and was recommended to try Ambien for sleep. At the time of the September 29, 2014 visit, it was noted that

Petitioner was there for a medication refill. It was noted that they were still waiting on approval for Petitioner's spinal cord stimulator trial. The assessment was noted to be that of chronic pain, post-laminectomy pain syndrome, lumbar, radiculopathy, and myalgia and myositis, among other issues. Petitioner was recommended to continue with current medications and it was noted that a discussion was held regarding the narcotic agreement. It was noted that Dr. Feather was going to give Petitioner a second chance, that he would stop all Norco, and that Dr. Feather would control the Percocet. (PX50).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on November 24, 2014, at which time it was noted that he was there for a medication refill. It was noted that Petitioner's low back was still a problem, that work comp was still denying, that his pain was still 7/10, and that he remained on Oxycodone. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, and radiculopathy, among other issues. Petitioner was given a prescription for Percocet and was recommended to return in one month. It was noted that Petitioner underwent random urine testing on that date. At the time of the October 28, 2014 visit, it was noted that Petitioner stated that his pain was worse in the afternoon through the night, that standing and sitting increased his pain, and that he was seen for a medication refill. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, and radiculopathy, among other issues. Petitioner was recommended to continue his current medications, and his Percocet and Methocarbamol were refilled. Petitioner was recommended to return in one month. At the time of the December 23, 2014 visit, it was noted that Petitioner was seen for a medication refill. It was noted that Petitioner was still awaiting approval for a spinal cord stimulator trial, and that he wished to get a script for Viagra. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, and radiculopathy. Petitioner's Percocet was refilled and he was given Viagra. Petitioner was recommended to return in one month. (PX50).

Included within the records of Illinois Regional Pain Institute was a letter authored by Dr. Feather dated September 15, 2014, in which it was noted that he recommended a spinal cord stimulator trial to reduce Petitioner's pain and improve function and quality of life. It was noted that they were requesting predetermination of coverage/prior authorization for the implantation. (PX50).

Additional medical records of Illinois Regional Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 51.[13] The records reflect that Petitioner was seen on January 20, 2015, at which time it was noted that he was there for a medication refill. It was noted that Petitioner had had no change in dose, range of motion, or function, that he denied side effects or complications, and that his pain remained 8/10. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, and radiculopathy, among other issues. Petitioner was given refills and was recommended to return in one month. It was noted that Petitioner was scheduled for a spinal cord stimulator trial in three days. At the time of the January 30, 2015 visit, it was noted that Petitioner was seen for a spinal cord stimulator trial lead pull. It was noted that Petitioner had 99% pain relief with 100% coverage, that there were no side effects or complications, that he had improved range of motion and function, and that he felt he would be able to come off pain medications. The assessment was noted to be that of other chronic pain and radiculopathy, among other issues. Petitioner was recommended to return after the scheduled procedure. It was noted that a permanent spinal cord stimulator was to be scheduled. At the time of the February 17, 2015 visit, it was noted that Petitioner was there for a medication refill, that he had a spinal cord stimulator trial that was successful, and that they would be going for a permanent implant to be approved. (PX51).

The medical records of Genesis Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 52. The records reflect that Petitioner was seen for a fitness for duty evaluation on August 5, 2011, that he was not able to return to work in his full duty capacity, and that his

[13] Any highlighting that appears in the exhibit was not made by the Arbitrator.

restrictions/limitations included no patrol work as of the Physician's Statement - Disability Claim form dated August 22, 2012. The records reflect that Dr. Garrels noted that, as of the visit date of August 5, 2011, Petitioner had had an excellent outcome from the surgical procedure he had, that in the fitness for duty assessment he was concerned about the nature of Petitioner's work and the threat of incapacitation and the impact it would have on his ability to perform and safety of the public he served, and that from his experience of seeing patients with single and multi-level fusions, the common thing was the inability of the patient to sustain moderate to heavy levels of physical exertion without significant aggravations in the spinal condition, especially radicular symptoms resulting in loss of feeling and strength in an extremity. It was noted that Dr. Garrels' recommendation was that Petitioner may not return to patrol activities due to the high risk of incapacitation associated with uncontrolled situations similar to the injuries he had sustained in the past. (PX52).

The Security Agent Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 54.

The transcript of the deposition of Dr. David Fletcher dated May 8, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 55. Dr. Fletcher testified that he is board-certified in Occupational Medicine as well as Preventive Medicine. (PX55).

Dr. Fletcher testified that he saw Petitioner for an IME and that he authored a report dated March 13, 2017. He testified that when he saw Petitioner he had a 7/10 pain rating, that he complained of numbness in his right leg and foot, that he complained of monocular vision, and that he complained of what he described were seizures. He testified that Petitioner described the radiation of pain in his entire left leg, front and back of his leg, and that he had no upper extremity complaints at all. He testified that Petitioner's rating on the Pain Disability Questionnaire was a score of 127, which was a severe self-reported disability. When asked whether, upon his examination of Petitioner he was concerned about symptom magnification, Dr. Fletcher responded that he thought that there was overreporting in his situation. He testified that he indicated in his report that he felt that Petitioner's pain drawing was not consistent with an anatomical problem, and that he was also concerned that he thought he was overmedicated. He testified that he also had concerns that Petitioner had received a dorsal column stimulator and was still receiving controlled substances. (PX55).

Dr. Fletcher testified that a dorsal column stimulator does not relieve the pain 100% of the time in most circumstances, but that it certainly made a major impact. He testified that the majority of the patients that he had recommended to have a dorsal column nerve stimulator who had gone through the protocol he recommended did not need to take controlled substances. He testified that it was a concern when he saw a patient that had the device and was still taking controlled substances. When asked what it indicated to him if a patient was taking narcotics after the stimulator was implanted, Dr. Fletcher responded that it indicated to him that he was concerned about overreporting of subjective complaints and that they may have dependency on the narcotics. (PX55).

Dr. Fletcher testified that, as to the x-rays performed in his office on the date of the examination, he was a little bit concerned about the fact that there was some haloing around the screws, and that he was concerned about some instability in the fusion. He testified that he would be very leery to do anything further especially since Petitioner was on a dorsal column nerve stimulator, and that it would probably be prone to failure. When asked whether he had an opinion as to whether Petitioner should undergo any type of treatment due to the condition of the fusion in the neck, Dr. Fletcher responded that he would not recommend that because of his high pain levels. He testified that to him Petitioner's major complaint was his leg pain, that if one looked at the pain drawing he did not really describe any radicular pain in his arm, and that if he had described arm and had neurological complaints in the upper extremity he would be more apt to recommend that, but he did not in this case. (PX55).

When asked of his opinion as to whether Petitioner's neck and low back complaints were causally related to the accident, Dr. Fletcher responded that based on the work history he thought there was a causal relationship, assuming that the history was correct. When asked of his opinion as to whether Petitioner's medical care for the neck and low back was causally related to the accident, Dr. Fletcher responded that, based on the subjective complaints and the various objective testing, he thought that the treatment that was rendered was reasonable and necessary. He further testified that he believed that the medical care and treatment, including the surgical intervention, the cervical fusion, the lumbar fusion, and the dorsal column stimulator implantation, was reasonable and necessary. (PX55).

When ask if he was familiar with the type of physical activities required of someone engaged in the type of occupation that Petitioner held, Dr. Fletcher responded in the affirmative. When asked whether he held an opinion whether Petitioner was able to return to the previous occupation, Dr. Fletcher responded that he did not believe that he could do that job because of the physical nature of the job to be combative and to be engaged in potentially combative episodes with students. When asked whether he was able to form an opinion whether Petitioner was permanently and totally disabled from all types of work based on the work injuries, Dr. Fletcher responded that he thought Petitioner's employability would be very diminished because of his injuries. He testified that he was aware that Petitioner was getting SSDI, and that he had not seen in the materials any kind of vocational search. He testified that Petitioner certainly would have the need for permanent restrictions, that his narcotics were going to further impact his employability, and that unless he saw a labor market survey with all of those variables, he could not say absolutely that Petitioner would be unemployable, but that he would think "virtually he would be." (PX55).

When asked whether in his review of the medical records and discussing the case with Petitioner there was any indication that he was addicted to narcotics prior to his accident, Dr. Fletcher responded that he did not see any indication, that he had records going back prior to the injury, and that he did not see anything that indicated that. When asked of his diagnosis for Petitioner, Dr. Fletcher responded that he had a chronic pain syndrome or failed back syndrome, that he was status post anterior cervical fusion, that he was status post lumbar fusion, and that he had some blunt eye trauma. He testified that Petitioner had grossly monocular vision when he tested him, that his gross eye exam showed some evidence of trauma, and that he needed to see an ophthalmologist or an optometrist to really define that. He testified that he would not defer on Petitioner's employability to an eye specialist, but that he would defer as far as the management and diagnosis of the condition. (PX55).

When asked of his opinion as to whether Petitioner was at maximum medical improvement, Dr. Fletcher responded that if he were the treating physician he would use the term "less is more" in that he would encourage him to be as active as possible, that he would try to wean him off narcotic pain medication and work with his dorsal column nerve stimulator, that he would not encourage testing, and that he did not believe that he would benefit with physical therapy. He testified that Petitioner filled out a written questionnaire and indicated that he could not do household chores, that he had problems walking up stairs, that he needed help showering, that he said that he could do limited driving, that he could not prepare meals, that he could not mow the lawn, and that he could not do any recreational activities. He testified that the responses were pretty consistent with the responses on the Pain Disability Questionnaire. He testified that Petitioner indicated to him that because of his pain, he was not able to do those activities. He further testified that Petitioner also reported that he did not get much benefit from the dorsal column nerve stimulator. (PX55).

Dr. Fletcher testified that he indicated in his report that Petitioner's pain drawing was not consistent with an anatomical pattern, that what he was trying to say was that this was not consistent with a known medical condition, and that that would be a "red flag" for someone doing a dorsal column stimulator not to have a distinct nerve root dermatomal problem. He testified that the fact that Petitioner had global anterior and posterior leg pain was a major inconsistency. He agreed that in order for the doctor to do the dorsal

column stimulator Petitioner would have to pass some type of psychological testing, but that he had never seen the psych testing that was done. (PX55).

On cross examination, Dr. Fletcher agreed that he had testified to two distinct work accidents. He agreed that his opinions were based off those two distinct work accidents. He agreed that his understanding was that Petitioner had two work accidents while working for Respondent on November 17, 2009 and then another occurring on June 24, 2010 that happened in therapy. He testified that, as to the June 24, 2010 alleged work accident, he had no accident report or any indication that Petitioner told Respondent about this work accident. He agreed that he had an accident report as it related to the November 17, 2009 incident. He testified that the sources of information that he had in this case were from Petitioner's attorney, the medical records, and Petitioner's history. He agreed that the more information that he had and the more complete the information he had, the better his opinions were. He agreed that he stood behind the proposition that if there were pieces of the puzzle missing, it could affect his opinions in the case. (PX55).

On cross examination, Dr. Fletcher testified that he did not contact the treating physicians in this case. He testified that he felt that if he started talking to treating physicians, he felt it took away from his independence. He testified that he did not have a labor market survey. He testified that he did not have any psychological testing that was required by Dr. McCall. He testified that he had some medical records from OSF St. Francis Medical Center, but that he did not know if it was complete. When asked whether he had the complete records of UnityPoint Proctor or Methodist Hospitals showing treatment to Petitioner over his lifetime, Dr. Fletcher responded that he did not have it over the lifetime because the earliest records that he had were from 2008. He agreed that it was fair to say that he had no medical records pre-dating 2008 for Petitioner. (PX55).

On cross examination, Dr. Fletcher agreed that he had no evidence of any complaints of Petitioner's neck pre-dating 2008, and that he had no evidence or any kind of information regarding his having any low back complaints pre-dating 2008. He testified that Petitioner did, however, deny that history. When asked if Petitioner did - and at the time of trial it was shown - that he had prior neck or low back complaints pre-dating 2008 and whether that could change his opinions in the case, Dr. Fletcher responded that it possibly could and that he would have to see what the evidence was. He testified that he did not see any medical records of Dr. Soriano. When asked whether he was aware of any lawsuits that Petitioner may have had that involved his neck or low back, Dr. Fletcher responded that Petitioner denied that. He further testified that he was relying on the accuracy of Petitioner's history. (PX55).

On cross examination, Dr. Fletcher denied that he was aware of any motor vehicle accidents pre-dating 2008. He testified that he was not aware of any prior lawsuits Petitioner may have had involving his body as a whole prior to 2008, and that it sounded like there was a lot of information that he did not know. He further denied having seen any interrogatories or discovery evidence that may have been involved in lawsuits pre-dating 2008 involving Petitioner. He testified that he was not aware of any prior worker's compensation claims that Petitioner filed. (PX55).

On cross examination, Dr. Fletcher agreed that Dr. Hauter diagnosed Petitioner as only suffering from a cervical strain when he first treated him. He agreed that Dr. Hauter indicated that Petitioner may not have a work-related condition. He agreed that he saw in the medical records of Dr. Klopfenstein that Petitioner was not a surgical candidate when he first began his treatment. He agreed that he saw that Dr. McCall and Dr. Kube testified. He agreed that both physicians talked about an injury in September 2012. He testified that Petitioner did not tell him about an accident in September 2012. He agreed that he was aware that the records showed him that Petitioner did have an injury to his low back in September 2012. He agreed that it was the type of injury that could cause a herniated disk to the low back. He agreed that both Dr. McCall and Dr. Kube testified that the fall off a ladder in September 2012 could have been

responsible for the surgery performed by Dr. Kube. He testified that he did not disagree with that, but that he did not get that history. (PX55).

On cross examination, Dr. Fletcher testified that he agreed with Dr. Kube and Dr. McCall that the fall in September 2012 could be responsible for the surgery performed by Dr. Kube assuming Petitioner was on a ladder, that he fell off the ladder and landed on his buttocks, that he went to the emergency room that day, that they did diagnostic testing, and that it showed a herniated disk. He agreed that he was somewhat "guided" by the sources of information that he had from Petitioner and his attorney. He testified that if it was true that Petitioner had an intervening injury as described, it could be the cause. He further agreed that it would be the cause of Petitioner's need to have restrictions to his low back. (PX55).

On cross examination, Dr. Fletcher agreed that he reviewed Dr. Kube's testimony and that he had a different work accident date. He agreed that Dr. Kube testified that there was a work accident occurring on or about November 19, 2009. He testified that the date that he was given was November 17th. When asked whether he was aware of any other intervening accidents after June 24, 2010 that Petitioner suffered to his low back that may have aggravated his condition of ill-being, Dr. Fletcher responded that he did not tell him of any other accidents. He testified that he was not aware of any intervening accidents to Petitioner's cervical spine subsequent to November 17, 2009. (PX55).

On cross examination, Dr. Fletcher agreed that he had seen individuals who suffered from seizures and that they could be very violent. When asked whether he knew that Petitioner suffered from a seizure condition, Dr. Fletcher responded that that was what Petitioner said but that he did not really see good documentation about it. He testified that the records dated April 24, 2014 from St. Francis Medical Center were not furnished to him. He agreed that he was unaware that Petitioner had a surgery [*sic*] and went into the facility, woke up, and told them that he had injured his cervical spine as he had never seen the record. He agreed that a seizure could aggravate Petitioner's cervical condition, especially in someone who had had the fusion that he did. He testified that he had not seen any statements from Petitioner's wife or son who accompanied him to the hospital at that time. (PX55).

On cross examination, Dr. Fletcher agreed that he had not seen any complaints to Petitioner's neck or low back area pre-dating November 17, 2009. He testified that he did not have the records of May 18, 2009. He agreed that he was unaware that Petitioner provided complaints to a medical provider of neck and low back pain in the timeframe of May 2009, and further testified that it was a complete surprise to him. He agreed that Petitioner had several diagnostic studies immediately following November 17, 2009, and that those studies showed a degenerative condition in his cervical spine. (PX55).

On cross examination, Dr. Fletcher testified that Petitioner's response to the pain drawing was non-dermatomal. He agreed that this was a "red flag" in the medical field, and that he would be concerned about Petitioner's complaints compared to what he saw on physical examination. He testified that the FCE showed less than valid effort and agreed that it was another "red flag" to a physician of his expertise in determining someone's ability to return to work and their truthfulness. Dr. Fletcher testified that he asked Petitioner whether he had any prior cervical complaints and that he denied having had any. He testified that Petitioner denied having had any prior low back complaints, and that he also denied having any prior accidents. He agreed that if that was not true, it was a red flag to him as an occupational specialist. (PX55).

On cross examination, Dr. Fletcher agreed that Petitioner stated that he could not mow the yard. He agreed that Petitioner told him that he had difficulty climbing stairs, and that he indicated that he was unable to do normal daily activity without pain. He testified that he saw comments in Dr. Kube's deposition regarding yard work and increased complaints. He agreed that he did not state that Petitioner was unable to do anything and that he was physically permanently and totally disabled. He agreed that Petitioner physically could do something, but that he did not get any information from him as to whether he had attempted to look for any type of job. He agreed that if he were the treating physician, he would want

Petitioner to be as active as possible and would encourage him to look for a job. He agreed that the FCE had Petitioner at a Medium level. He testified that he did not think that Petitioner could do more than Medium, but that medium was still quite employable. (PX55).

On cross examination, Dr. Fletcher testified that he was not provided any diagnostic studies from 2008 to November 2009 of Petitioner's cervical spine or lower spine. He agreed that his opinion was that Petitioner was at maximum medical improvement. (PX55).

On redirect when asked whether his opinions were based solely on the specific date that the altercation occurred, Dr. Fletcher responded that it was his experience that occasionally there may be a little variance in date by a couple of days, but that he relied on that incident. He testified that it was possible that if Petitioner was asymptomatic with his preexisting condition and the altercation incident occurred, the incident could have aggravated the preexisting condition. He testified that he had no idea whether there were any medical records regarding any treatment pre-accident and that he had not been furnished those. (PX55).

On redirect, Dr. Fletcher agreed that Petitioner indicated that he could not do certain activities because of pain. He agreed that he expected Petitioner to be in increased pain if he performed those activities that he stated that he could not do, including cutting the grass. (PX55).

On further cross examination, Dr. Fletcher agreed that when he was an independent medical examiner, he was provided more information than he would be as a treating physician. When asked whether he would expect in the independent medical examiner process that he would have the right accident date when looking at all the records and getting information from opposing counsel, Dr. Fletcher responded that he would hope so. He agreed that there were two different accident dates between what he had testified to and what Dr. Kube had testified to. (PX55).

On further cross examination, Dr. Fletcher testified that trimming hedges in the last couple of years would be inconsistent with what Petitioner told him that he could and could not do. He further testified that shoveling show would be inconsistent with what Petitioner told him. He testified that Petitioner said that he could drive, but had to stop with breaks. When asked whether he asked Petitioner about any hobbies he may be engaged in physically, Dr. Fletcher responded that his response was that he had no recreational activities and that he was in too much pain. (PX55).

The Illinois Form 45 was entered into evidence at the time of arbitration as Petitioner's Exhibit 56.[14] The record reflects that the form was completed on November 17, 2009, that the incident was reported on November 17, 2009, and that Petitioner was elbowed in the right eye. (PX56).

The IWIRC records dated February 10, 2010 were entered into evidence at the time of arbitration as Petitioner's Exhibit 57. The records reflect that Pw was seen on that date for evaluation of his cervical spine strain and ocular hemorrhage. It was noted that Petitioner stated that his symptoms had remained the same in the neck with intense pain radiating to both shoulders, and that in the right eye his vision was still 20/20. It was noted that Petitioner stated that he was no longer having any pain in the eye but that it was tender to the touch, that he was seen by Dr. Wall for his eye injury and was told there was no permanent damage, and that he was going back on March 19, 2010. It was noted that Petitioner was currently taking Vicodin given by his primary care physician Dr. Popp. It was further noted that Petitioner was seen in Iowa City by an eye specialist who felt that this was not permanent, that he was told he should regain his vision in the next two months and would have follow-up at that time, that he was evaluated by Dr. Klopfenstein who wanted to try epidural steroid injections, and that he was awaiting the scheduling of this. It was noted that Petitioner was still having neck pain which he described in the center of his spine, that he

[14] Any highlighting that appears in the exhibit was not made by the Arbitrator.

stated that since he had the flu last week with persistent vomiting that the numbness and tingling in his upper extremities was worse and was now constant. The assessment was noted to be that of (1) cervical strain – awaiting pain management evaluation; (2) ocular hemorrhage. Petitioner was recommended to continue medications, to return to work with restrictions, and to continue follow-up with specialists. Petitioner was recommended to return in four weeks. (PX57).

The IWIRC records dated January 6, 2010 were entered into evidence at the time of arbitration as Petitioner's Exhibit 58. The records reflect that Petitioner stated that his symptoms had remained the same, that he stated that he had been having more constant neck pain than before, that he stated the neck pain kept him up last night, and that he rated his current pain level at 6/10 and constant. It was noted that Petitioner was currently taking Vicodin at bedtime as needed, that he was following work restrictions, that he reported that he saw Dr. Klopfenstein on December 30, 2009 and that he was sending him to the pain clinic for injections, and that he also wanted him to start physical therapy. It was noted that Petitioner stated that he had had no improvement in his vision, that he saw Dr. Klopfenstein for his cervical strain, and that Dr. Klopfenstein was recommending injections with the pain clinic. The assessment was noted to be that of (1) cervical strain; (2) ocular hemorrhage. Petitioner was issued restrictions and was recommended to return in four weeks. (PX58).

The Letter from Dr. Klopfenstein to IWIRC dated December 31, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 59. The letter was duplicative of that as contained in Petitioner's Exhibit 34. (PX59; PX34).

The IWIRC records dated December 24, 2009 were entered into evidence at the time of arbitration as Petitioner's Exhibit 60. The records reflect that Petitioner stated that he still could not see out of the right eye, that he stated that prolonged sitting more than three hours caused an increase in pain levels in the neck, that he rated his current pain at 5/10, and that he reported that he would have an EOG done on January 15, 2010 and was to follow-up with Dr. Klopfenstein on December 30, 2009. It was noted that Petitioner was currently taking Vicodin as needed. It was noted that Petitioner's neck pain was present and that his arm tingling increased with prolonged sitting, that turning his neck too far caused pain, and that he denied headaches. The assessment was noted to be that of (1) cervical sprain with disc bulge and C6-7 spinal stenosis; (2) right ocular hemorrhage. Petitioner was dispensed Vicodin, was recommended to follow-up with specialists, was given work restrictions, and was recommended to return in two weeks. (PX60).

The IWIRC records dated September 16, 2009 were entered into evidence at the time of arbitration as Petitioner's Exhibit 61. The records reflect that Petitioner was seen for an initial evaluation of his left knee, that he stated the injury occurred on September 15th, that he stated that a student walked up onto him and that as he took the student down to the floor, he hit his left knee on the hard concrete tile floor. The assessment was noted to be that of left knee strain, history of left knee injury with Baker's cyst. Petitioner was given Vicodin, was given instructions regarding stretching exercises and applying ice, and was recommended to wear his knee brace. Petitioner was further recommended to return to work without restrictions and was to follow-up in one week. (PX61).

The IWIRC records dated September 23, 2009 were entered into evidence at the time of arbitration as Petitioner's Exhibit 62. The records reflect that Petitioner was seen for evaluation of his left knee injury, that he stated that his symptoms had improved 80% since his last office visit, that he rated his pain level at 2/10 by the end of the day, and that he stated that he was trying to go without the knee brace that day to see how he did without it. It was noted that Petitioner was currently taking Vicodin only as needed at bedtime and had not needed it for the past few days, and that he was working full duty self-modified. The assessment was noted to be that of (1) left knee strain – resolved. Petitioner was instructed to continue medications and/or comfort measures as directed, was to return to work without restrictions, and was released from care. (PX62).

The Psychological Pain Evaluation dated August 19, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 63. The records reflect that Petitioner was seen by Dr. Rogers to provide a psychological recommendation for a spinal cord stimulator. It was noted that overall Petitioner appeared to be quite capable of handling the psychological and physical discomfort that accompanied various medical procedures, that he was open to receiving information and discussing matters pertaining to his health, and that there were no indications that he would overutilize medical services. It was noted that Petitioner's somatization score was close to the average of a pain patient, that his score suggested that he was concerned about and attentive to his health-related problems and symptoms but that somatic issues did not appear to occupy an undue amount of attention, and that he may be experiencing mounting frustration and periodic somatic distraction. It was noted that Petitioner was cognitively and emotionally distressed by his physical symptoms, and that his score suggested that he had the ability to actively participate in a treatment plan for pain relief without major interference from excessive somatic thought. It was noted that Petitioner's depression score suggested that he was more depressed than the average community subject, but that he had fewer symptoms of depression than the average pain patient. It was further noted that Petitioner's anxiety score was above average for the community sample but below average for the pain patient sample, and that he was experiencing an appropriate level of concern about his pain. It was noted that it was believed that Petitioner could proceed with a trial of the spinal cord stimulator. (PX63).

The medical records of Memorial Medical Center dated September 29, 1998 were entered into evidence at the time of arbitration as Petitioner's Exhibit 64. The records reflect that Petitioner was seen in the emergency department on that date, at which time it was noted that he stated that he was attacked by a student, pushing him backwards, that he stated that he landed on the floor on his low back and struck the back of his head on a desk and a locker, and that he complained of some low back pain, headache, and some mild neck pain. The assessment was noted to be that of closed head injury with neck and low back pain. Petitioner was recommended to undergo CTs of the cervical spine, lumbosacral spine, and the head. Also included in the exhibit were two pages from OSF St. Francis Medical Center dated July 26, 2008 referring to Petitioner's right elbow. (PX64).

The medical records of Illinois Regional Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 66. The records reflect that Petitioner was seen on March 17, 2015, at which time it was noted that he was there for a Percocet refill, that he was still awaiting approval for spinal cord stimulator permanent implant, and that there were no side effects or complications with the medications. The assessment was noted to be that of other chronic pain, post-laminectomy pain syndrome, lumbar, and radiculopathy, among other issues. It was noted that Petitioner was given a prescription for Percocet. It was noted that they would continue to pursue spinal cord stimulator approval, and that Petitioner was to return in one month. At the time of the December 12, 2016 visit, it was noted that Petitioner was there to be weaned from his opiates, that he had had his spinal cord stimulator implanted by Dr. McCall in January 2015, that he had not been able to wean from the opiates, and that he was currently on Fentanyl. It was noted that Petitioner stated that his pain was still 7/10 but felt much better with pain control, and that he had not experienced withdrawal. The assessment was noted to be that of other chronic pain and other intervertebral disc displacement, lumbar region, among other issues. It was noted that the withdrawal protocol would be available. Petitioner was recommended to return in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on January 10, 2017, at which time it was noted that he was there for a Fentanyl refill, that he had had increased pain that month, and that he wanted to go up on his dose. It was noted that Petitioner stated that his spinal cord stimulator was working and that he had had no overall improvement in range of motion or function. The assessment was noted to be that of other chronic pain and postlaminectomy syndrome, among other issues. It was noted that Petitioner's Fentanyl was refilled, that his dose was not increased, and that it would be lowered again the next month. Petitioner was recommended to return in one month. At the time of the February 7, 2017 visit, it was noted that Petitioner was there for a medication refill, that he had no side effects or

complications, and that his pain was 5-7/10, stabbing, shooting, and sharp. The assessment was noted to be that of other chronic pain and other intervertebral disc displacement, lumbar region, among other issues. Petitioner was recommended to continue at the current dose and to return in one month. At the time of the March 7, 2017 visit, it was noted that Petitioner stated that the Fentanyl patch was effective for pain relief and better mobility. The assessment was noted to be that of other chronic pain and long term (current) use of Methadone for pain management, among other issues. It was noted that Petitioner was educated on CDC guidelines and the possible need to start tapering down on Fentanyl, and that Dr. Feather would be consulted. Petitioner was recommended to follow-up in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on April 4, 2017, at which time it was noted that he stated that he was having some increased low back pain since the last office visit, that he stated that his pain was worse when standing for long periods of time, and that he stated that the Fentanyl helped with pain and provided good relief of symptoms. The assessment was noted to be that of other chronic pain and other intervertebral disc degeneration, lumbar region, among other issues. It was noted that there was to be no change in current therapy and that they would need to taper the Fentanyl at the next visit. Petitioner was recommended to return in one month. At the time of the May 4, 2017 visit, it was noted that Petitioner was there for a medication refill, and that he stated that the Fentanyl patch was effective for pain relief and better mobility but that he had experienced increased pain related to a decrease in Fentanyl pain. The assessment was noted to be that of other chronic pain and postlaminectomy syndrome, among other issues. Petitioner was recommended to continue his medications and to follow-up in one month. At the time of the June 2, 2017 visit, it was noted that Petitioner was requesting a refill for Fentanyl patches. The assessment was noted to be that of other intervertebral disc displacement, lumbar region, and postlaminectomy syndrome, among other issues. Petitioner was recommended to continue with his current medications and to return in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on June 29, 2017, at which time it was noted that he was there for a medication refill. It was noted that Petitioner stated that movement in general worsened the pain, that he stated that he had had his spinal cord stimulator on at all times and that it provided some relief, and that he stated that the Fentanyl taper was not going as well as expected and he was having increased pain. The assessment was noted to be that of other chronic pain and postlaminectomy syndrome. Petitioner was given a prescription for Percocet and was recommended to return in three weeks. At the time of the July 20, 2017 visit, it was noted that Petitioner stated that he was having increased low back and leg pain, that he stated that the pain had gotten worse since tapering down on the Methadone, that he stated that the Oxycodone made him throw up, and that he stated that the pain went to the knee on the right and down the entire leg on the left. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and other chronic pain, among other issues. It was noted that Petitioner's Percocet as to be discontinued due to the side effect of intermittent vomiting, that he was given a prescription for Morphine, that diagnostic imaging was ordered for the spinal cord stimulator, and that he was to follow-up in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on August 17, 2017, at which time it was noted that he was there for evaluation and medication change. It was noted that Petitioner did not like the Morphine because it gave him the hiccups, that he wanted to go back to Oxycontin and stated that he could deal with the side effects of this medication, and that he was still waiting on MRI scheduling. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and postlaminectomy syndrome, among other issues. Petitioner was given a prescription for Oxycontin and was recommended to return in one month. At the time of the September 13, 2017 visit, it was noted that Petitioner was there for a medication refill. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and other chronic pain, among other issues. It was noted that Petitioner was given a prescription for Oxycontin, was to return in one month, and was to bring in his MRI denial letter to the next office visit. At the time of the October 11, 2017 visit, it was noted that Petitioner presented

for a medication refill. It was noted that Petitioner was waiting to begin physical therapy and that he reported that his MRI had been denied by both WC and insurance. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and postlaminectomy syndrome, among other issues. It was noted that Petitioner was given a prescription for Oxycontin and was recommended to begin physical therapy when it was approved. Petitioner was also recommended to return in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on November 11, 2017, at which time it was noted that he was there for a medication refill. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and other chronic pain, among other issues. Petitioner was given a prescription for Oxycontin, was recommended to begin physical therapy as scheduled, and was to follow-up with the lumbar MRI results when performed. At the time of the December 8, 2017 visit, it was noted that Petitioner reported a pain level of 9/10. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and other chronic pain, among other issues. Petitioner's Oxycontin was refilled and he was recommended to begin physical therapy when scheduled. At the time of the January 8, 2018 visit, it was noted that Petitioner stated that he did not take the Lyrica due to side effects, that he stated that he was having "weird thoughts" and could not drive, and that he stated that he had also tried Gabapentin but that this made him very tired. It was noted that Petitioner stated that he had his spinal cord stimulator adjusted in the summer, that it helped 10%, that he stated that the battery was not lasting as long, and that he stated it was only lasting 24 hours. The assessment was noted to be that of other intervertebral disc degeneration, lumbar region, and postlaminectomy syndrome, among other issues. Petitioner's Oxycontin was refilled, he was prescribed Oxycodone for severe breakthrough pain only, and he was to follow-up on a referral to Senora regarding his physical therapy. Petitioner was recommended to return in one month and was to get ahold of the Medtronic rep to assess battery life and programming. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on February 8, 2018, at which time it was noted that he was there for medication refill. It was noted that Petitioner stated that the additional Oxycodone made a huge difference in pain relief and that he was able to go shopping, walk further, and get around much easier, and that he stated that he had GI upset at first but now was not having any side effects. The assessment was noted to be that of other chronic pain and long term (current) use of Methadone for pain management, among other issues. Petitioner was recommended to schedule an MRI of the lumbar spine and was given prescriptions for Oxycontin and Oxycodone. Petitioner was recommended to return in one month. At the time of the March 8, 2018 visit, it was noted that Petitioner was seen for a medication refill. It was noted that Petitioner had had no changes in the timing, severity, or quality of pain, that he stated that the Oxycontin and Oxycodone provided good effectiveness in pain relief, that he stated that he had not been contacted for a lumbar MRI yet, and that he was waiting to hear back from Medtronic. The assessment was noted to be that of other chronic pain, among other issues. Petitioner was given refills of Oxycontin and Oxycodone, was recommended to follow-up on the MRI, and was to call Medtronic. Petitioner was recommended to return in one month. (PX66).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on April 5, 2018, at which time it was noted that he was seen for a medication refill. It was noted that Petitioner stated that he had a little decrease in pain when he was cooking and doing dishes since the increase in Oxycodone, that he still had the low back pain with radiation down both legs, that he stated the MRI needed to be put through insurance and not WC because it would get denied, and that he stated that he had left messages for Medtronic but would follow-up again. It was noted that Petitioner stated that he was getting 20% coverage from his spinal cord stimulator and that it was reducing his pain 25% on average, and that he stated that this was better than what it had been in the past. The assessment was noted to be that of other chronic pain, among other issues. It was noted that Petitioner was to follow-up with "Jamie" from Medronic, that he was to return in one month, and that his parking placard was filled out. At the time of the May 3, 2018 visit, it was noted that Petitioner reported needing a new battery for his spinal cord stimulator and was going to

contact Medtronics to proceed. The assessment was noted to be that of other chronic pain, among other issues. Petitioner was given medication refills and was recommended to return in one month. (PX66).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 67.

The IWIRC records dated June 24, 2010 were entered into evidence at the time of arbitration as Petitioner's Exhibit 71. The records reflect that Petitioner returned for evaluation of his cervical strain and ocular hemorrhage, that he stated that his symptoms included cervical aching to sharp neck pain, that he rated his current pain level 5-8/10, and that he had developed sciatic nerve pain. It was noted that Petitioner was currently taking Vicodin and had had three epidurals at INI, that he had follow-ups with Dr. Wahl and Dr. Heyde, and that he had finished physical therapy on that date. It was noted that Petitioner stated that he injured his lower back in therapy, that he noted pain with twisting and had a hard time finding a comfortable position, that he still had pain in his neck but that it had improved, and that he stated his vision was unchanged and still had difficulty seeing clearly. The assessment was noted to be that of (1) lumbar back sprain with right sacroiliac pain – muscular; this is acute from physical therapy today; (2) cervical radiculopathy – post epidural injections with improvement; (3) right eye ocular hemorrhage – still with loss of sight. Petitioner was issued work restrictions, was recommended to continue Naprosyn, was given Skelaxin, and was recommended to return in two weeks. (PX71).

The records review report of Dr. Martin Lanoff dated May 18, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Dr. Lanoff opined that he did not think that Petitioner had any preexisting condition, that he thought he had no medical malady whatsoever, that he thought that Petitioner was obviously involved in an altercation and had significant trauma to the right eye, that he may have had some mild soft tissue issues in the cervical spine, and even on the lifting date of June 20, 2010, and that mild soft tissue issues should have improved with or without treatment in 6-8 weeks with no permanence whatsoever. It was noted that Dr. Lanoff's diagnosis was that of subjective complaints out of proportion to the objective findings with no medical malady whatsoever, and it was noted that one could simply look at all of the medical records to see that Petitioner's doctors could not find a medical malady. It was noted that Dr. Lanoff felt that it was pointless for him to see Petitioner for an IME and that for him to perform another examination, in addition to all of the prior examinations he had already had that had never found any lasting objective pathological entity, would simply be a waste of time and resources involving this case. (RX1).

The report reflects that Dr. Lanoff opined that Petitioner could return to full, unrestricted duty immediately, that he expected his pain behaviors would not allow him to do so but that was his choice, and that he found it a "travesty" that Petitioner was on Social Security Disability in the first place. It was noted that Dr. Lanoff opined that Petitioner had no current problems except for his complaints which did not relate to the incident at work since he had no medical malady, and that he further opined that he had, or in the future would, suffer any permanent impairment from this incident "none whatsoever." It was noted that Dr. Lanoff opined that Petitioner had reached maximum medical improvement 6-8 weeks after the original injury, and that there was not even a need for him to have been lifting in June of 2010 because he should have been back to work by then. It was noted that Dr. Lanoff further opined that he had no treatment recommendations and that to continue to treat Petitioner, including a spinal cord stimulator, was simply validating his continued pain behaviors. The report further reflects that Dr. Lanoff opined that Petitioner could perform full, unrestricted duty, and that no restrictions were related to a work accident. (RX1).

The various IME reports of Dr. Soriano dated were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Dr. Soriano authored an IME report dated June 30, 2015, which noted that Petitioner was previously seen in 2010 for an IME. It was noted that after that Petitioner returned to work for a period of time but was then referred to Dr. Klopfenstein, that in 2010 he

underwent a three-level anterior cervical discectomy and fusion, and that he had therapy post-operatively, but that he alleged this caused a herniated disc in his lumbosacral spine and total body pain. It was noted that as to his neck, Petitioner stated that it still hurt, that he had been placed on permanent disability by the school district physician, and that after his lumbar surgery he had no physical therapy and was still having left leg, thigh, and calf pain, as well as pain in the entire left foot. It was noted that Petitioner's pain then radiated up his spine to the top of his head, left shoulder, down both arms, and stopped at his wrists. It was noted that Petitioner was on Social Security Disability and was not receiving worker's compensation checks. It was further noted that Petitioner had been treating with a pain management physician, Dr. Marshall, since 2014 whose treatments had provided temporary relief, that he rated his pain at 7/10 on the medications, that he had a spinal stimulation trial which provided 95% relief of his low back pain, head pain, and pain in his arms and legs, and that he still had numbness and tingling in the midline of his low back at L5-S1 which radiated through his entire left leg. It was noted that Petitioner stated that he was weak in the leg and had fallen four times because his legs had given out, that that had caused him to go to the emergency room, and that he now also had seizures and had been told by the neurologist that it was related to an eye injury. It was further noted that during the day Petitioner sat around most of the day and that he drove a car, but that he did not exercise because of his "blown discs" from L2 to L5. (RX2).

The report dated June 30, 2015 noted that Dr. Soriano indicated that the opinions rendered in his two prior reports remained unchanged, and that he found no reason to change any opinions offered in the prior two reports based on Petitioner's normal objective examination. It was noted that Dr. Soriano believed that there was significant exaggeration in Petitioner's symptoms with the three positive Waddell's signs, and that the exaggerated symptomatology involving pain through his entire body from head to toe and the lack of any objective findings on physical examination or radiological studies was consistent with symptom magnification. It was further noted that Dr. Soriano found nothing objectively on exam, and that Petitioner's current complaints were exaggerated and consistent with symptom exaggeration. It was noted that Dr. Soriano's diagnosis was symptom exaggeration and subjective complaints which had no correlation with any physical exam finding, the injury in question, or any medical disease of which he was aware. It was further noted that Dr. Soriano opined that there was no medical data to support Petitioner's subjective complaints. (RX2).

The report dated June 30, 2015 noted that Dr. Soriano's prognosis was excellent, that Petitioner's psychological status was the overriding factor in preventing any further progression in his status, and that he believed that there was a significant volitional attempt to continue to portray himself in a condition of ill-being that did not exist on an objective basis. It was noted that Dr. Soriano's opinion was supported by the lack of any objective traumatic findings on Petitioner's radiological studies, the three positive Waddell's signs on this exam, the positive Waddell's signs on the prior exam, and the lack of any known medical disease that would cause the symptom complex he had. It was noted that Dr. Soriano opined that Petitioner was capable of a full return to work without restriction, and that the current problems with his neck and back were not caused by the alleged incident at work. It was noted that Dr. Soriano further opined that he believed that Petitioner had not, nor would he in the future, suffer any permanent impairment from this injury, that regardless of cause he believed that he had reached maximum medical improvement from his low back and neck surgeries, that he recommended no further treatment, that in his opinion he was capable of performing any and all work activities, and that no work restrictions were necessary. (RX2).

The report dated June 30, 2015 noted that Dr. Soriano also authored a "Comment" that, as to Dr. Garreis [*sic*], it was not clear what data he was relying upon, but that his statement that there was a high risk of further problems was unsupported in any medical literature of which he was aware, that Dr. Garreis [*sic*] was not basing this upon any scientific Class 1 or 2 papers of which he was aware, and that certainly no papers that had ever been published had indicated that this was the case for a successful fusion. It was noted that it was somewhat of a paradoxical and outlier opinion since he stated from his exam Petitioner had had an excellent outcome from his surgical procedure, and that it appeared that Dr. Garreis [*sic*] was

basing his inability to return to work upon what might happen in the future and on his personal experience, which was not scientific and certainly not based upon evidence-based medicine. It was noted that Dr. Soriano strongly disagreed with these opinions. It was further noted that Dr. Soriano opined that it was his opinion that the surgery performed by Dr. Kube for protruding discs bilaterally was consistent with preexisting degeneration and not acute trauma-related disc herniations, and that the surgery performed had no relationship to exertion during physical therapy or the injury associated with physical therapy. It was further noted that in Dr. Soriano's opinion Petitioner's subjective complaints had no foundation in any physical examination findings or radiological studies, that his subjective complaints were dramatically exaggerated and that, despite the Psy.D.'s report, there was no indication for placement of an epidural stimulator. It was further noted that the delayed onset of upper extremity symptoms had no relationship to the injury, that this occurred weeks after the original injury, that the delayed onset of low back and right sciatic pain also had no relationship to the injury, and that any treatment associated with upper extremity symptomatology and lower extremity symptomatology had no relationship to the injury in question. (RX2).

The records reflect that Dr. Soriano issued an IME report dated August 30, 2010, in which it was noted that Petitioner reported that he was injured on or about November 19, 2009, that at that time he was working as a police officer in a school hallway when a student who was severely emotionally disturbed attacked him from the side, that the student began swinging at him so he maced him three times, that he then struggled with him on the floor and another officer cuffed the student's hands in front, and that as he lifted the student off the floor, the student hit him in the right eye with his elbow. It was noted that Petitioner's head went back and he lost his eyesight for a few minutes, that his eye then swelled up, that he did not drop to the ground, that he did not lose consciousness, and that he sustained no initial cuts, bruises, or bleeding. It was noted that Petitioner reported the injury and was sent to IWIRC where he saw Dr. Hauter, that he was then referred to an eye center, that an MRI of the cervical spine was performed for complaints of neck pain in the midline of his neck radiating to both shoulders, that he was taken off work and placed on light duty, and that he was then transferred to a different school on light duty and did not miss any work days. It was noted that Petitioner ultimately saw Dr. Klopfenstein, who recommended and performed three epidurals which were helpful. (RX2).

The report dated August 3, 2010 noted that three weeks ago, Petitioner was lifting an 85-pound crate on the last day of therapy and felt a pop in his right lower back, that he could not move or lift after that, that he returned to the office of Dr. Klopfenstein because of his low back pain, that an MRI was ordered on July 8th and he was diagnosed with a herniated disc, and that an epidural was recommended. It was noted that Petitioner had never had prior symptoms such as this, that he treated with chiropractor three years ago for maintenance therapy, and that he had never had spine surgery. It was noted that Petitioner currently had pain in his neck radiating to both shoulders and, a week after that, had pain radiating into his arms, that his hands felt like they were on fire and that this woke him at night, that his low back pain was such that he could not sit, stand, or walk for any length of time, that he had numbness and tingling in the right buttock, thigh, and down to his ankle, that he had a shooting pain in the left thigh, that he could not see out of his right eye due to blurriness, that he had trouble urinating, and that he had had a few episodes of incontinence. It was noted that Petitioner currently took four Vicodin per day and took a muscle relaxer even though he did not complain of spasms, and that he rated his pain levels between 6-8/10. (RX2).

The report dated August 3, 2010 notes that Dr. Soriano opined that the diagnosis was that of status post orbital contusion of the soft tissues of the eye; cervical soft tissue strain; soft tissue strain of the lumbar spine. It was noted that based on his objectively normal exam, Dr. Soriano opined that no further treatment was required to cure the injuries or conditions caused by the work injury, that Petitioner's subjective complaints of visual loss had no foundation in physical exam findings or ophthalmological testing, and that, based upon his objectively normal exam, he would not render any assessment of permanent partial impairment. It was noted that Dr. Soriano indicated that Petitioner had extensive lumbar preexisting conditions which he did not believe had any relationship to the complaints of lumbar pain, that he required

no permanent restrictions, and that he believed that the medical treatment to date had been reasonable, necessary, and related to the injury. (RX2).

The records reflect that Dr. Soriano issued an addendum report dated July 5, 2017, in which it was noted that he had been provided additional materials including the depositions of Dr. Fletcher, Dr. McCall, and Dr. Kube, as well as various additional medical records. It was noted that after his review of the additional materials Dr. Soriano found no cause to change the opinions rendered in his prior reports, that it now appeared that there was a September 2012 preceding incident or injury that, in his opinion, was more likely than not the cause of his original and ongoing back pain, and that the new fall off a ladder and not the November 17, 2009 work incident was the direct cause for any lumbar surgery or treatment performed. (RX2).

The records reflect that Dr. Soriano issued an addendum report dated June 28, 2017, in which it was noted that he had been provided additional materials including he depositions of Dr. Fletcher, Dr. McCall, and Dr. Kube, as well as various additional medical records. It was noted that after his review of the additional materials, Dr. Soriano found no cause to change the opinions rendered in his prior reports, that it appeared that there was a preceding incident to Petitioner's alleged work injury which, in his opinion, was more likely than not the cause of his ongoing and pre-work injury back pain, and that the newly-discovered incident and not the work incident was the direct cause for any lumbar surgery or treatment performed. (RX2).

The records reflect that Dr. Soriano issued an addendum report dated September 27, 2013, in which it was noted that he had reviewed the operative report dated August 5, 2013 of the surgery performed by Dr. Kube and that, after review of the report, he found no cause to change the opinions rendered in his August 3, 2010 report. It was noted that Dr. Soriano indicated that it was of interest that the surgery was performed four years after the original injury, that it was also of significance that Dr. Kube himself did not label this a herniated disc but rather a protrusion, that review of the operative report clearly indicated no tear in the posterior longitudinal ligament or annulus and no extruded fragments, and that there were also no findings indicative of a traumatic event or a free disc fragment. It was noted that Dr. Soriano opined that this was clearly a surgery performed for degenerative changes and had no relationship to the injuries of November 7, 2009 or June 24, 2010, and that the proof of his opinion was in the operative report which clearly showed that surgery was performed for degenerative purposes and had no relationship to the accident from four years prior to that time. (RX2).

The records reflect that Dr. Soriano issued an addendum report dated June 19, 2017, in which it was noted that he had reviewed the depositions of Dr. Fletcher, Dr. McCall, and Dr. Kube. It was noted that after review of the additional materials, he found no cause to change the opinions rendered in his prior reports, that it now appeared that there was a preceding incident to Petitioner's alleged work injury which, in his opinion, was more likely than not the cause of his ongoing and pre-work injury back pain, and that the newly discovered incident and not the work incident was the direct cause for any lumbar surgery or treatment performed. (RX2).

The medical records of IWIRC were entered into evidence at the time of arbitration as Respondent's Exhibit 3. Included within the records of IWIRC was an interpretive report for an MRI of the right shoulder performed on October 13, 2008 for a clinical history of right shoulder pain. The records reflect that Petitioner was seen on August 2, 2010, at which time it was noted that he had constant aching and sharp neck and low sharp and aching back pain. It was noted that the low back pain extended to his right buttock and down his right leg, that Dr. Klince had recommended an epidural injection, and that he also had pelvic pressure. It was noted that Petitioner was now experiencing bladder problems, that he had left hand numbness, and that he had seen his primary care physician for multiple medications. It was noted that Petitioner was not working due to summer break and that he was scheduled to start work on August 31,

2010. It was noted that Petitioner stated that his primary care physician sent him to see Dr. Klopfenstein and that he was seen by his nurse practitioner who recommended that he continue with physical therapy and start epidural steroid injections, that he had not started either, that he started with numbness to his left hand since his last visit and with Dr. Klopfenstein's office, that he had an IME in Rockford, that he stated he had had no improvement with the Medrol dose pack, that he was currently taking Vicodin (which he left in Rockford), Fentanyl Patch and a muscle relaxer that were given to him by Dr. Popp, and that he was requesting a refill of Vicodin since he "left his prescription in Rockford." The assessment was noted to be that of (1) lumbar back sprain with right sacroiliac pain – physical therapy consult; (2) cervical radiculopathy – some improvement; (3) right eye ocular hemorrhage – still with loss of sight; cannot relate this to his cervical disc disease. Petitioner was referred for physical therapy, and it was noted that his primary care physician only was to prescribe narcotic pain medications. Petitioner was also issued work restrictions and was recommended to return in three weeks. (RX3).

The records of IWIRC reflect that Petitioner was seen on July 8, 2010, at which time it was noted that he stated that his symptoms were constant low back pressure and sharp neck pain, that he rated his current pain level at 6/10, that he was currently taking Vicodin from his primary care physician and stated that he finished the Skelaxin (which did not help), that he was not working, and that he was off for the summer. It was noted that Petitioner stated that he was still having his pain in his lower back and that it radiated to both legs, that he denied bowel or bladder trouble, that he denied numbness and tingling, that the pain radiated to the mid-calf with the right more than the left, and that he noted no improvement in his vision and stated that the nerve in his neck was causing his vision decrease. It was noted that Petitioner stated that the neck pain still radiated to both shoulders, that his lower back pain was the worst, and that he noticed an increase in symptoms with walking or with certain positions. The assessment was noted to be that of (1) lumbar back sprain with right sacroiliac pain – now having radiation of the pain to both legs, rule out a central disc; (2) cervical radiculopathy – some improvement; (3) right eye ocular hemorrhage – still with loss of sight, cannot relate this to his cervical disc disease. Petitioner was issued work restrictions, was given a Medrol dose pack, was recommended to stop taking Naprosyn, was recommended to return in three weeks, and was referred for physical therapy. (RX3).

The records of IWIRC reflect that Petitioner was seen for work conditioning on June 24, 2010, at which time it was noted that he reported that he felt strong, was ready for discharge from work conditioning and return to full duty, and that he stated that he planned to continue strengthening at the health club. It was noted that Petitioner was to return to the doctor with discharge to full duty recommended. At the time of the June 11, 2010 visit, it was noted that Petitioner stated that his symptoms had worsened since his last visit, that he complained of intense pain in the middle of his neck which radiated between both shoulder blades and all the way down his back, that he stated that the vision in his right eye was the same and blurry, and that he stated that he was currently on two Vicodin and the pain was still there. It was noted that Petitioner was currently taking Vicodin from his primary care physician but nothing from IWIRC, and that he was currently off work for the summer. It was noted that Petitioner reported that his neck pain had improved significantly after the injections but that the pain had returned, with tingling over his shoulders with certain movements. It was further noted that Petitioner was doing work conditioning and that he was off for the summer. The assessment was noted to be that of (1) cervical strain – with recurrent pain; (2) ocular hemorrhage – vision continues to improve. Petitioner was recommended to continue work conditioning and was issued work restrictions. Petitioner was also recommended to return in two weeks. (RX3).

The records of IWIRC reflect that Petitioner was seen for work conditioning on June 10, 2010, at which time it was noted that he stated that he had marked improved tolerance of work conditioning activity compared to the initial session, that he noted feeling better with less fatigue overall, and that his neck pain persisted. At the time of the June 14, 2010 visit, it was noted that Petitioner stated that his symptoms had not changed since his last visit, that he continued to have neck pain in the middle of his neck which was

intermittent, that he rated his current pain level at 4-5/10, and that he stated his vision in the right eye remained the same as the last visit. It was noted that Petitioner was currently not taking any Vicodin any longer, but did take Naprosyn as needed. It was noted that Petitioner stated that he was doing better, that he had been doing physical therapy three times per week, and that he denied numbness or tingling in his arms or hands. It was further noted that Petitioner had minimal neck discomfort. The assessment was noted to be that of (1) cervical strain – improved with steroid injection; (2) ocular hemorrhage – vision continues to improve. Petitioner was recommended to continue work conditioning and was issued work restrictions. Petitioner was recommended to return in one month. (RX3).

The records of IWIRC reflect that Petitioner was seen on April 20, 2010, at which time it was noted that he stated that his symptoms had improved, that he rated his current pain level at 0/10 for the neck strain, that he was given a third injection that morning, and that he stated that he had been released by Dr. Klopfenstein. It was noted that Petitioner saw the eye specialist on April 16th and was released back to regular duty and to physical therapy. It was noted that Petitioner was currently taking Vicodin. It was noted that Petitioner started having increasing pain on April 15th with numbness and tingling in his shoulders and arms, that he stated that he had to take Vicodin because of the pain, and that he had improved after the injection. It was noted that Petitioner's vision had improved and that he had been cleared to resume physical therapy by Dr. Klopfenstein. The assessment was noted to be that of (1) cervical strain – improved with steroid injection; (2) ocular hemorrhage – slowly improving. Petitioner was recommended to resume physical therapy, was issued work restrictions, and was recommended to return in three weeks. At the time of the March 30, 2010 visit, it was noted that Petitioner stated that his symptoms had improved as far as his neck was concerned, but that he still could not see out of his right eye. It was noted that Petitioner rated his current pain level at constant 1/10 for the neck, that he was currently taking Vicodin as needed, that he stated that the last time he took the Vicodin was on March 25th, and that he was following work restrictions. It was noted that Petitioner had not been seen by the pain clinic since his last visit at IWIRC. It was further noted that Petitioner reported no pain to his neck or numbness and tingling down his arms into his hands/fingers, that he canceled his last pain clinic visit as he was pain-free, and that he was using pain medication on a daily basis. The assessment was noted to be that of (1) cervical strain – improved with steroid injection; (2) ocular hemorrhage – basically has monocular vision. Petitioner was recommended to continue with follow-up with the neurosurgeon, eye specialist, and pain physicians as scheduled, was issued work restrictions, and was to return in three weeks. (RX3).

The records of IWIRC reflect that Petitioner was seen on March 10, 2010, at which time it was noted that he stated that his symptoms had improved as far as his neck was concerned but that he still could not see out of his right eye, that he rated his current pain level at constant 2/10, that he was currently taking Vicodin up to six tablets a day as needed, that he reported that he had received injections while at the pain clinic on March 8th, and that he was to follow-up with the pain clinic on March 22nd. It was noted that Petitioner stated that he was seen by the pain clinic and had had two injections with good pain relief in his neck, that he denied numbness and tingling in his fingers and hands, that he denied headache, and that he still could not see out of his right eye. The assessment was noted to be that of (1) cervical strain – improved with steroid injection; (2) ocular hemorrhage – basically has monocular vision. Petitioner was recommended to continue with pain clinic appointments, was to continue to follow-up with the neurosurgeon, eye specialist, and pain physicians, was given work restrictions, and was to return in one month. At the time of the May 14, 2010 visit, it was noted that Petitioner stated that his symptoms had not changed since his last visit, that he continued to have neck pain in the middle of his neck which was intermittent, that he rated his current pain level 4-5/10, that he stated his vision in the right eye remained the same as the last visit, and that he was currently not taking Vicodin any longer but did take Naprosyn as needed. It was noted that Petitioner stated that he was doing better, that he had been doing physical therapy three times a week, that he denied numbness or tingling in his arms or hands, and that he had minimal neck discomfort. The assessment was noted to be that of (1) cervical strain – improved with steroid injection;

(2) ocular hemorrhage – vision continues to improve. Petitioner was recommended to do work conditioning, was issued work restrictions, and was to return in one month. (RX3).

The records of IWIRC reflect that Petitioner was seen on December 3, 2009 for physical therapy, at which time it was noted that he presented with a history of cervical, shoulder, and upper arm pain, that he reported original onset of November 17, 2009 due to an altercation with a student, that he sustained injuries to his eye as well that had resulted in a loss of visual acuity and was being watched closely by Heyde Eye Center, that his symptoms were constant in the neck, shoulders, and upper arms, and that he reported no previous episodes of symptoms. At the time of the December 7, 2009 physical therapy visit, it was noted that Petitioner noted non-work-related low back pain that day that developed over the weekend. At the time of the April 22, 2010 physical therapy visit, it was noted that Petitioner's right eye symptoms were stable and that he had been cleared to return to therapy. It was noted that Petitioner reported no symptoms for the past three days, following his injection. At the time of the April 26, 2010 physical therapy visit, it was noted that Petitioner reported no symptoms on that date and that he had a temporary increase of his symptoms following home exercise program performance. At the time of the April 30, 2020 physical therapy visit, it was noted that Petitioner was tolerating treatments well and had mild neck soreness. At the time of the May 3, 2010 physical therapy visit, it was noted that Petitioner stated that he had generalized soreness from his sessions and increased activity at home over the weekend. It was noted that Petitioner was tolerating treatments well and had mild neck soreness. At the time of the May 7, 2010 physical therapy visit, it was noted that Petitioner stated that his neck soreness persisted but overall felt good that day, and that he reported tolerating the session activity well. (RX3).

The records of IWIRC reflect that Petitioner was seen on May 10, 2010 for physical therapy, at which time it was noted that he stated that his neck soreness persisted but overall felt good, and that he reported knee discomfort with the treadmill. At the time of the May 14, 2010 physical therapy visit, it was noted that Petitioner had no new complaints. At the time of the May 27, 2010 physical therapy visit, it was noted that Petitioner stated that he was pleased with the findings of his recent heart diagnostic testing and that he stated that he felt good and was ready to resume work conditioning sessions. At the time of the June 1, 2010 work conditioning visit, it was noted that Petitioner could already tell that he had had too many days off since his last visit. At the time of the June 3, 2010 work conditioning visit, it was noted that Petitioner continued to improve. At the time of the June 8, 2010 work conditioning visit, it was noted that Petitioner had a limited workout that day due to A/C failure at his house. At the time of the June 11, 2010 work conditioning visit, it was noted that Petitioner understood that he was not quite yet fit to return to duty. At the time of the June 16, 2010 work conditioning visit, it was noted that Petitioner stated that he had overall fatigue. At the time of the June 21, 2010 work conditioning visit, it was noted that Petitioner stated that he felt better that day and that he noted recent missed session and illness was due to overexposure to hot weather. (RX3).

The records of IWIRC reflect that Petitioner was seen on June 23, 2010 for work conditioning, at which time it was noted that he had no change in his cervical symptoms. At the time of the June 24, 2010 work conditioning visit, it was noted that Petitioner stated that he felt strong and that his cervical symptoms were unchanged. It was noted that the Plan of Care was to that Petitioner was to return to the doctor with a recommendation for discharge from work conditioning and a return to full duty. At the time of the July 13, 2010 physical therapy visit, it was noted that Petitioner reported production of low back pain and bilateral thigh, unilateral right leg symptoms during material handling activities on the final day of work conditioning, that he stated that his symptoms had been severe enough to inhibit standing/walking, that the symptoms were constant in the low back and intermittent in the lower extremities, that he reported one previous episode of symptoms five years ago, that *cauda equina* signs were negative, and that he reported that his sleep was disturbed by his current symptoms. At the time of the August 3, 2010 physical therapy visit, it was noted that Petitioner reported that his *cauda equina* signs had abated but that he continued with the numbness symptoms in the right leg and pain to the left knee. It was noted that Petitioner had also

developed bilateral lower extremity edema issues and was seeing his personal physician about those. It was further noted that Petitioner had had an IME and was worse due to the car ride. (RX3).

The Prior Claims Memo was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The medical records of UnityPoint Health - Methodist Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records reflect that Petitioner was seen on January 3, 2012, at which time it was noted that he stated that his left anterior thigh hurt. It was noted that Petitioner had a history of ecchymosis over the left anterior thigh, that there was no history to suggest any head injury, and that it was not a job-related problem. The primary diagnosis was noted to be that of contusion of thigh. At the time of the September 27, 2013 emergency room visit, it was noted that Petitioner arrived by Advanced Medical Transport after having a seizure at a work class, that AMT stated that he became combative after the seizure, and that he was given Ativan en route. It was noted that at about 9:30 that morning, Petitioner had tonic-clonic generalized seizure while seated in a training class at work, that there was no seizure history, and that no witnesses had come with him to the emergency department. It was noted that Petitioner had no prior history of seizures, that this was the first one, that he had no history of head injury or back pain, and that he had a baseline normal neurologic status. The primary diagnosis was noted to be that of grand mal seizure. The Advanced Medical Transport patient care report noted that they had been called to the scene of a 42-year-old male who had had a seizure, that on arrival Petitioner was standing fighting with fire and staff at the facility, that he was alert to person only trying to get away from everyone, and that fire and EMS grabbed him and placed him on the ground in the prone position. It was noted that dispatch was contacted, and that police assistance was requested. The Toxicology report dated September 27, 2013 noted that the sample was positive for opiates. (RX5).

The records of UnityPoint Health - Methodist Medical Center reflect that Petitioner underwent an EEG on November 15, 2013, which was interpreted as revealing a normal awake and stage II sleep EEG; clinical correlation is suggested. It was noted that Petitioner was a 46-year-old male who came with a history of seizure about six months ago, that he had some "entire body shook," and that the doctor told him "this is a pain seizure." It was noted that Petitioner had "another seizure" about two months ago, that apparently this event "he was very somnolent and sleeping throughout the day," and that he had a background history of a head injury, right eye blindness, hypertension, and back surgery. The records reflect that Petitioner underwent an MRI of the left knee and an MRI of the right shoulder on October 30, 2008. The records reflect that Petitioner underwent outpatient labs on February 3, 2015, February 20, 2015, February 27, 2015, and March 11, 2015. The records further reflect that Petitioner underwent surgery by Dr. Below on December 2, 2008, which was that of right shoulder arthroscopy, subacromial decompression with acromioplasty, distal clavicle excision, debridement of paralabral cyst, and arthroscopic repair of SLAP tear for pre- and post-operative diagnoses of right shoulder labral tear, paralabral cyst, impingement with subacromial bursitis, and acromioclavicular joint degenerative joint disease. The records reflect that Petitioner underwent pre-operative testing on May 24, 2011. The records reflect that Petitioner underwent an ultrasound of the neck and neck soft tissue on June 24, 2015 for an indication of abnormal thyroid function tests, tiredness. Petitioner underwent outpatient labs on June 26, 2015. (RX5).

The records of UnityPoint Health - Methodist Medical Center reflect that Petitioner underwent a bone scan on July 6, 2015. The records reflect that Petitioner underwent outpatient labs on August 21, 2015. The records reflect that Petitioner was seen in the emergency room on September 19, 2015, at which time it was noted that a DUI evaluation was performed. The records further reflect that Petitioner underwent outpatient labs on October 28, 2015, May 11, 2016, and June 6, 2016. (RX5).

The medical records of Dr. Popp were entered into evidence at the time of arbitration as Respondent's Exhibit 6.[15] The records reflect that Petitioner was seen on August 25, 2010, at which time it was noted that he was sent to Rockford and that it was okay to return to work, and that he wished to discuss this with Dr. Popp. At the time of the August 3, 2010 visit, it was noted that Petitioner had left his medications in Rockford and needed a refill. At the time of the July 16, 2010 visit, it was noted that Petitioner was complaining of sciatic nerve problems including numbness and tingling as well as pain and pressure in his lower back radiating to his belly button, and that he was taking 6-8 Vicodin per day. It was noted that Petitioner was referred to Dr. Tracy for evaluation. At the time of the May 20, 2010 visit, it was noted that Petitioner wanted to be released to go back to work. At the time of the May 18, 2010 visit, it was noted that Petitioner stated that he was at IPMR the day before, that he broke out in a sweat that morning, that he could not swallow, that he had chest pain, that he felt weak, and that he had a headache. At the time of the April 29, 2010, April 5, 2010, and April 2, 2010 visits, Petitioner was seen for a right axillary abscess. (RX6).

The records of Dr. Popp reflect that Petitioner was seen on March 31, 2010 for hospital follow-up for an abscess. At the time of the January 7, 2010 visit, Petitioner was seen to discuss his pain medications. The Progress Note dated January 6, 2010 noted that Petitioner called and said that his work comp doctor told him to call Dr. Popp to have his Vicodin increased from 4 to 6 a day, and that it was a potentially addictive drug and if he was having more pain, he was to be seen in the office. The Progress Note dated November 3, 2009 noted that Petitioner requested a refill of Vicodin. The Progress Note dated September 15, 2009 noted that Petitioner requested more Vicodin. At the time of the August 19, 2009 visit, it was noted that Petitioner was seen for a pain medication refill. It was noted that Petitioner had twisted his left knee on August 9th. The Progress Note dated August 17, 2009 noted that Petitioner called for a refill of Vicodin. The Progress Note dated March 23, 2009 noted that Petitioner called for a refill of Vicodin. Petitioner was seen on November 24, 2008 for pre-operative clearance for a right rotator cuff repair. At the time of the July 29, 2008 visit, Petitioner was seen in follow-up for his right elbow. At the time of the May 16, 2008 and May 9, 2008 visits, Petitioner was seen for a spot on his leg. At the time of the May 1, 2008 visit, it was noted that Petitioner had possible MRSA. (RX6).

The records of Dr. Popp reflect that a Progress Note dated March 19, 2008 was issued, which noted that Petitioner wanted a refill of Vicodin given to him by Dr. Popp on March 5th for neck and back pain. The Progress Note dated March 31, 2008 noted that Petitioner requested a refill of Vicodin. At the time of the April 16, 2008 visit, it was noted that Petitioner was seen for evaluation of his hypertension and GERD. It was noted that Petitioner had pain in his neck, back, legs, and feet. The Progress Note dated March 5, 2008 noted that Petitioner just had a vasectomy, did too much work over the weekend and that his neck and back were sore, and that he also wanted Vicodin. The Progress Note dated October 22, 2007 noted that Petitioner was requesting another antibiotic for a spider bite. At the time of the December 20, 2006 visit, Petitioner was seen for hypertension, cholesterol, and GERD. At the time of the March 3, 2006 visit, Petitioner was seen for stress. The Progress Note dated March 16, 2004 noted that clarification was needed for a prescription for Wellbutrin. At the time of the November 24, 2003 visit, it was noted that Petitioner was complaining of back pain. The diagnosis was noted to be that of a lumbosacral strain. Petitioner was given a prescription for Vicodin. (RX6).

The records of Dr. Popp reflect that Petitioner was seen on September 27, 2011, at which time it was noted that he needed a note or letter stating that he was able to perform the requirements of his job description. It was noted that Petitioner was complaining of low back pain. At the time of the August 17, 2011 visit, it was noted that Petitioner was to return to work with no restrictions on August 18th. At the time of the May 5, 2011 visit, it was noted that Petitioner stated that his employer was forcing him to go to full-time work from light duty. It was noted that Petitioner still had a lot of neck and back pain. The

[15] The Arbitrator notes that many of handwritten entries contained throughout the exhibit were illegible.

Progress Note dated March 24, 2011 noted that Petitioner called for a refill of Fentanyl patch and Vicodin. At the time of the October 27, 2010 visit, it was noted that Petitioner was seen for evaluation after having trouble holding his bowels for four days. The letter from Illinois Municipal Retirement Fund dated March 15, 2012 noted that Petitioner had advised IMRF that he wished to apply for disability benefits. (RX6).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Payments Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

The transcript of the deposition of Dr. Soriano dated October 9, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. Dr. Soriano testified that he is board-certified in neurosurgery. (RX9).

Dr. Soriano testified that he authored a report dated August 3, 2010 concerning the IME that he performed of Petitioner on July 27, 2010. He testified that he did not limit or control the information given to him by Petitioner during that examination. He testified that he also authored a letter dated September 27, 2013, which was generated after he received and reviewed the operative report of Dr. Kube. He testified that as to the report dated June 30, 2015, he generated the report for the examination performed on June 17, 2015. He testified that he further authored a report dated June 19, 2017 after he had opportunity to review the depositions of Dr. Fletcher, Dr. McCall, and Dr. Kube. He testified that the document dated June 28, 2017 was very similar to the report of June 19th, but that he believed it was simply additional materials that he reviewed including records from aquatic therapy, Heyde Eye Center, OSF Center for Pain Management, Dr. Klopfenstein, and St. Francis Medical Center, among others. He testified that the report dated July 5, 2017 was also authored by him as well. (RX9).

On cross examination, Dr. Soriano testified that in the July 5, 2017 report he indicated that he had received records where Petitioner fell off a ladder which preceded the alleged work-related accident, and that it was his opinion that the fall off the ladder was likely responsible for the pain rather than the work injury of November 17, 2009. When asked what medical records he was referencing as to the fall off the ladder, Dr. Soriano responded that he thought it was information contained in the depositions that he reviewed. He agreed that he reviewed no medical records to substantiate a history of a fall off a ladder, and that those portions of the depositions were found in cross examination by Respondent's counsel. He agreed that the sole basis of his conclusion and opinion in the July 5, 2017 report was the questions posed by Respondent's counsel in cross examinations of Dr. McCall and Dr. Kube. (RX9).

On cross examination, Dr. Soriano agreed that in his initial report he referenced reviewing records dating all the way back to 1998. He agreed that he was given a lot of records from IWIRC. He testified that he did not know if he was aware that IWIRC was the "company doctor" for Peoria Public School District 150. When asked if there existed September 16, 2009 and September 23, 2009 records from IWIRC where it detailed that the examination did not demonstrate any cervical or lumbar complaints and whether that could affect his opinions, Dr. Soriano responded that it would not because of the fact that review of the operative reports and review of the x-rays did not show anything that was acute or injury-related. (RX9).

On cross examination, Dr. Soriano agreed that he was not provided any series of medical records or any medical records that demonstrated that Petitioner had any ongoing medical treatment for neck or back complaints that would have pre-dated the November 17, 2009 work accident. He agreed that he summarized in the IWIRC records that Petitioner was treating for a left knee injury and a right shoulder injury. He agreed that he was not given records that Petitioner was given a full duty return to work clearance in September 2009. (RX9).

On cross examination, Dr. Soriano testified that he did not have any quarrel with the treatment or evaluation for Petitioner's eye and some initial treatment for some stiffness in his neck, and that he did not have any problem with a few weeks of therapy for a soft tissue strain in the low back that Petitioner says

occurred during therapy. He testified that he was not asked the question of whether Petitioner underwent medical care or treatment for the lumbar or cervical conditions that was not reasonable and necessary, setting aside the issue of causation. (RX9).

On cross examination, Dr. Soriano agreed that in his initial report dated August 3, 2010 he gave the opinion that he felt that Petitioner had a cervical soft tissue strain and a soft tissue strain of the lumbar spine. He testified that his understanding of the original mechanism of injury that occurred on November 17, 2009 was that Petitioner was wrestling with a student who attacked him from the side, that he took a swing at him, and that he struggled with him. He testified that once Petitioner got him to the floor after being maced, he had to wrestle with him and cuff his hands in from to him, that he lifted the student off the floor and then he was struck in the right eye with the student's elbow, his head went back, and he lost eyesight. He agreed that the November 17, 2009 IWIRC record was concerned about a right orbit fracture around the eye. When asked whether that could be a "distracting injury" in that they were concerned about a right eye contusion that they suspected could be severe enough to cause a fracture in the orbit of the eye and whether that was something that appeared in the note to be their main concern at that point in time, Dr. Soriano responded that that was their main concern. He testified that if he was being asked if it would mask neck pain or low back pain, then the answer would be in the negative. He testified that if Petitioner had significant neck pain at that time before he suffered the injury and physical therapy, he would have noted the neck pain. (RX9).

On cross examination, Dr. Soriano agreed that there was swelling noted in the eye and facial area. When asked whether swelling could mask neck pain, Dr. Soriano responded that it could not in and of itself. When asked whether, given the nature of this incident, he felt that the cervical and lumbar strain could be causally connected to the "skirmish" that Petitioner had with the student that he was encountering in his capacity as a police officer, Dr. Soriano responded that he believed that the cervical strain was directly related and that he believed that if Petitioner's history that he reported was true that he felt a pop during physical therapy, then he would accept that history that he felt a pop in the right lower back and could not lift after that. He testified that if the history was accurate, then he accepted that as part of the injury since Petitioner was in therapy because of the original injury. (RX9).

On redirect, Dr. Soriano agreed that, accepting those histories and that Petitioner had some type of strain-type injury to the cervical/low back, it would not be responsible for the procedures that were performed by Dr. Kube or any INR [*sic*] physician in this case to the cervical/low back. He agreed that his opinions did not change that Petitioner's condition of ill-being was not related to the work injury described. (RX9).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The records reflect that Petitioner underwent a transforaminal lumbar epidural steroid injection on December 30, 2014 by Dr. Marshall for diagnoses of (1) postlaminectomy syndrome, lumbar region, S/P L5/S1 laminectomy; (2) left L4/L5 and right L5/S1 disc herniations. The records reflect that Petitioner underwent a transforaminal epidural steroid injection left L3-L4 under fluoroscopy by Dr. Baha on April 9, 2014 for diagnoses of (1) lumbosacral spondylosis facet joint arthropathy; (2) left L4/L5 and right L5/S1 disc herniations; (3) low back pain with lower extremity pain; (4) cervical degenerative disk disease status post anterior cervical fusion. It was noted that Petitioner had had a procedure on November 13, 2013 which helped him for two weeks and recently the pain started to worsen, that he desired to proceed with another injection, and that he fell on ice after two weeks that exacerbated the pain. The records reflect that Petitioner underwent a transforaminal epidural steroid injection left L3-L4 under fluoroscopy on November 13, 2013 by Dr. Baha for diagnoses of (1) postlaminectomy syndrome, lumbar region, status post L5/S1 laminectomy; (2) lumbosacral spondylosis facet joint arthropathy; (3) left L3/L4 and right L5/S1 disc herniations; (4) low back pain with lower extremity pain; (5) cervical degenerative disk disease status post anterior cervical fusion. It was noted that

Petitioner was complaining of low back pain with lower extremity pain more on the left side, that he had had a lumber epidural steroid injection on May 24, 2013 at L5-S1 interspace on the right side which helped his pain, that he had lumbar laminectomy by Dr. Kube in July 2013 which helped his pain, that at that time his pain was more on the right side, and that currently Petitioner was complaining of low back pain with left lower extremity pain. It was noted that Petitioner had been evaluated by Dr. Kube and had been told that he was not a candidate for further surgery at this time, and that he had been referred by his primary care physician for treatment. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent chest x-rays on September 12, 2012, which were interpreted as revealing no acute cardiopulmonary process; rib fracture could be better evaluated with dedicated rib radiographs if clinically indicated. It was noted that the Reason for Exam was that of fell from ladder, left chest pain, former smoker. The records reflect that Petitioner underwent lumbar epidural steroid injection at right in the L4-L5 interspace under fluoroscopy by Dr. Baha on January 25, 2013 for diagnoses of (1) left L4/L5 and right L5/S1 disc herniations; (2) cervical degenerative disk disease status post anterior cervical fusion; (3) low back pain with lower extremity pain. It was noted that Petitioner had had LESI on November 28, 2012 which helped him but lasted shorter than the previous injection from September 26, 2012, and that they decided to proceed with another injection. The records reflect that Petitioner underwent medial branch blocks for facet joints left L4-L5 and L5-S1 levels with local anesthetic and steroid on March 4, 2013 by Dr. Baha for diagnoses of (1) lumbosacral spondylosis facet joint arthropathy; (2) left L4/L5 and right L5/S1 disc herniations; (3) low back pain with lower extremity pain; (4) cervical degenerative disk disease status post anterior cervical fusion. It was noted that Petitioner had LESI on November 28, 2012 and September 26, 2012 which helped, that he was currently complaining of low back pain and occasional lower extremity pain, that he had been evaluated by Dr. McCall and had been referred for facet nerve block, and that they decided to proceed with medial branch blocks on the left side. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent lumber epidural steroid injection at the L4-L5 interspace on November 28, 2012 by Dr. Baha for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation;; (3) history of cervical degenerative disk disease, status post anterior cervical fusion; (4) low back pain with lower extremity pain. It was noted that Petitioner had had a lumbar epidural steroid injection which helped, that his last injection was on September 26, 2012, and that he desired to undergo another injection. The records reflect that Petitioner underwent lumbar epidural steroid injection at the L4-L5 interspace on September 26, 2012 by Dr. Baha for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion; (4) low back pain with lower extremity pain. It was noted that Petitioner had had a lumbar epidural steroid injection which helped him, and that he desired to undergo another injection. The records reflect that Petitioner underwent a lumbar epidural steroid injection at the L4-L5 interspace on July 19, 2012 by Dr. Baha for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion; (4) low back pain with lower extremity pain. It was noted that Petitioner had had a lumbar epidural steroid injection on May 15, 2012 which helped him, and that he desired to undergo another injection. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent a lumbar epidural steroid injection at the L4-L5 interspace on May 15, 2012 by Dr. Baha for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion. It was noted that Petitioner had had a lumbar epidural steroid injection on March 16, 2012, that he stated that the injection helped for four weeks and then the pain started to return, and that he desired to undergo another injection. The records reflect that Petitioner underwent L5-4 epidural steroid injection under fluoroscopy by Dr. Marshall on March 16, 2012 for diagnoses of (1) left L4-5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion. It was noted that Petitioner received periodic epidural steroid injections for his

chronic low back and bilateral posterior lower extremity radicular pain, that his last injection was in January, that he had done well but that his pain was returning, and that he wished to undergo repeat injection. The records reflect that Petitioner underwent an additional injection on January 15, 2012 as well. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent a lumbar epidural steroid injection at the L4-L5 interspace by Dr. Baha on November 8, 2011 for diagnoses of (1) left L4-L5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion. It was noted that Petitioner had had lumbar epidural steroid injections which helped him, that he desired to undergo another injection, and that his last injection was on August 16, 2011. The records reflect that Petitioner underwent lumbar epidural steroid injection L4-5 by Dr. Marshall on August 16, 2011 for diagnoses of (1) left L4-5 disc herniation; (2) right L5-S1 disc herniation; (3) history of cervical degenerative disk disease, status post anterior cervical fusion. The records reflect that Petitioner was seen in the emergency room on March 22, 2009, at which time it was noted that he was complaining of a sore throat, body aches, and vomiting for 2-3 days. The records reflect that Petitioner underwent nuclear medicine bone spect on October 6, 2015, which was interpreted as revealing (1) mild bilateral L4-L5 facet joint arthropathy, unchanged; (2) resolution of focal rib uptake since the prior exam; (3) no new abnormality. It was noted that the comparison was that of a bone scan from February 1, 2013. The history was noted to be that of 48-year-old male with history of spinal stenosis and lumbar herniations; surgery history of L5/S1 laminectomy with resultant post laminectomy syndrome; cervical discectomy. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent x-rays of the lumbar spine on September 26, 2017, which were interpreted as revealing (1) minimal grade 1 spondylolisthesis of L4 on L5 of 4 mm associated with facet arthropathy at the L4-5 and L5-S1 levels; (2) previous left-sided hemilaminectomy changes L4-5 L5-S1; (3) generator box for dorsal column stimulator electrodes over the right flank with wires extending above the level of the visualized field-of-view at least the T10 level; there is mild developmental hypoplasia dorsal aspect to the L4 vertebra with pseudoretrolisthesis of L3 on L4 of 3 mm; pseudospondylolisthesis of L4 on L5 of 4 mm; this is unchanged from previous MRI lumbar spine of July 8, 2010. The clinical history as that of a 50-year-old disabled male with back pain and lower extremity pain; patient had a work-related injury in 2009 and now with pain radiating down the left leg; previous L5-S1 surgery and placement of dorsal column stimulator electrodes; patient with chronic back pain; hypertension; left L4-5 and L5-S1 disc herniations in 2013; cervical disc fusion in 2013; pain management agreement in 2013; postlaminectomy syndrome L5-S1; mixed hyperlipidemia; asthma; long-term use of opiates; opiate-related disorder. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent transforaminal lumbar epidural steroid injection under fluoroscopy, left L4 and L5 on June 25, 2015 by Dr. Cory for diagnoses of (1) left L4/L5 and right L5/S1 disc herniations; (2) postlaminectomy syndrome, lumbar region, status post L5/S1 laminectomy. It was noted that in addition to the right L4 radicular pain Petitioner was reporting increasing weakness in the right thigh, that his knee was giving out, that he thought his primary care physician had ordered an EMG and nerve conduction studies, and that a repeat MRI from earlier that month was unchanged from 2/12, again demonstrating L4-5 and L5-S1 protrusions. It was noted that Dr. Cory was going to move down a level on the left and do L4 and L5 injections. The records reflect that Petitioner underwent transforaminal lumbar epidural steroid injection under fluoroscopy, left L4 and L5 on August 11, 2015 by Dr. Baha for diagnoses of (1) left L4/L5 and right L5/S1 disc herniations; (2) cervical degenerative disk disease status post anterior cervical fusion; (3) lumbosacral spondylosis facet joint arthropathy. It was noted that Petitioner had a LESI procedure on June 25, 2015 which helped him for six weeks and that recently the pain started to worsen, and that he desired to proceed with another injection. (RX10).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent transforaminal lumbar epidural steroid injection under fluoroscopy on October 5, 2015 by Dr. Marshall for diagnoses of

(1) left L4/L5 and right L5/S1 disc herniations; (2) postlaminectomy syndrome, lumbar region, status post L5/S1 laminectomy. It was noted that Petitioner returned with continued left low back pain and left lateral lower extremity pain, that he had had one previous epidural injection in the past six months, that his pain had worsened since the last visit, and that he wished to undergo a lumbar transforaminal epidural steroid injection. The records reflect that Petitioner underwent transforaminal epidural steroid injection left L4 and L5 under fluoroscopy on August 2, 2016 by Dr. Baha for diagnoses of (1) left L4/L5 and right L5/S1 disc herniations; (2) cervical degenerative disk disease status post anterior cervical fusion; (3) lumbosacral spondylosis facet joint arthropathy; (4) postlaminectomy syndrome, lumbar region, status post L5/S1 laminectomy; (5) intervertebral disc disorder with radiculopathy of lumbosacral region. It was noted that Petitioner had had LESI procedure on October 5, 2015 which helped him for three weeks and that recently the pain started to worsen, that he desired to proceed with another injection, that he had had two injections at Methodist Hospital which did not help, and that his last injection was three months ago. (RX10).

The Job Description was entered into evidence at the time of arbitration as Respondent's Exhibit 11.

The transcript of the deposition of Dr. McCall dated July 27, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The record was duplicative of that as contained in Petitioner's Exhibit 41.[16] (RX12; PX41).

CONCLUSIONS OF LAW

As it pertains to 10 WC 33570 for the alleged date of accident of November 17, 2009:

The parties stipulated at the time of hearing that on November 10, 2009, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of November 10, 2009.

At the outset, the Arbitrator is admittedly gravely concerned by the number of physicians in these cases that have suggested that Petitioner's complaints were not supported by the objective findings or were considered to be non-dermatomal and/or non-anatomical in nature. For example, the Arbitrator notes that Dr. Klopfenstein at the time of the visit on February 23, 2011 noted that Petitioner's complaints were that of axial neck pain with radiation into both shoulders and down the right upper extremity and the right hand with numbness of the entire right arm, that his sensory complaints were in a non-dermatomal fashion, that on examination he had 5/5 strength throughout the upper extremities although he demonstrated poor effort secondary to pain and sensation in both his low back and neck with efforts, that he had loss of sensory sensation to pinprick examination in all dermatomes of the right upper extremity whereas he had no loss of sensation in the left upper extremity, and that deep tendon reflexes were 2+ throughout the upper extremities without asymmetry. (PX34). Similarly, at the time of the December 29, 2009 visit at Heyde Eye Center, it was noted that it was expected that Petitioner's visual acuity would return to normal, that the injury was an elbow and not a weapon or bullet, and that there was no socket fracture. It was noted that Petitioner's decreased visual acuity was not consistent with the findings. (PX35). Furthermore, the medical records of

[16] Please refer to Petitioner's Exhibit 41 for the Arbitrator's rulings related to all objections raised during the course of Dr. McCall's deposition testimony.

Central Illinois Pain Center records reflect that when he was seen on October 19, 2010, it was noted that Petitioner's pain started in July 2010, that he described his pain more sharp and burning pain and aching pain with more numbness on the right leg but the pain is more on the left side, and that he described his pain in the whole leg and could not specify any specific part of the leg. The medical records noted that it was difficult to explain Petitioner's numbness on the right leg. (PX36). Similarly, Dr. McCall testified that when Petitioner came to see him, he had leg pain for which he did not have a good explanation. (PX41).

The Arbitrator additionally notes that at the time of the December 9, 2013 therapy session at Prairie Spine & Pain Institute, it was noted that Petitioner was able to ambulate into the clinic without use of any assistive device on that date, and that upon observation there was no noticeable gait deficit. (PX43). Furthermore, the FCE performed at Champion Fitness dated January 28, 2014 noted that on January 28, 2014 Petitioner ambulated with an antalgic gait and an assistive device (straight cane) which he stated he bought himself at a local drug store. It was noted that a normal gait pattern was noted upon arrival on February 6, 2014, but that a severe antalgic gait was noted upon departure. It was noted that upon completion of testing, Petitioner laid on the treatment table stating his pain was so intense he could not do any more activity, that he proceeded to lie on the table while completing his post pain drawing, and that upon leaving the facility Petitioner walked with a severe antalgic gait, alternating which leg was being favored, and that he also "staggered" to his vehicle as if he was going to fall. (PX46).

Perhaps most significantly to the Arbitrator, however, was the fact that even Petitioner's own IME physician, Dr. David Fletcher, when asked whether, upon his examination of Petitioner he was concerned about symptom magnification, Dr. Fletcher responded that he thought that there was overreporting in his situation. (PX55). Dr. Fletcher also testified that he indicated in his report that Petitioner's pain drawing was not consistent with an anatomical pattern, that what he was trying to say was that this was not consistent with a known medical condition, and that that would be a "red flag" for someone doing a dorsal column stimulator not to have a distinct nerve root dermatomal problem. Dr. Fletcher also testified that the fact that Petitioner had global anterior and posterior leg pain was a major inconsistency. (PX55). As a result of the number of such notations contained throughout the medical records in this matter, the Arbitrator admittedly questions the credibility of Petitioner in this case.

The Arbitrator finds that the initial post-accident medical treatment indicated that Petitioner was actually improving while undergoing conservative care with Dr. Klopfenstein. In fact, the medical records of Dr. Klopfenstein indicated that at the time of the March 31, 2010 visit, Petitioner graded his pain at 1/10 and had made significant progress. It was noted that given Petitioner's response to conservative measures Dr. Klopfenstein did not believe that surgical intervention was required, that he was asked to continue following with the pain clinic for his injections, and that he was cleared to commence physical therapy. (PX34). Similarly, at the time of the April 20, 2010 visit at IWIRC, it was noted that Petitioner stated that his symptoms had improved, that he rated his current pain level at 0/10 for the neck strain, that he was given a third injection that morning, and that he stated that he had been released by Dr. Klopfenstein. It was noted that Petitioner saw the eye specialist on April 16th and was released back to regular duty and to physical therapy. (RX3).

Furthermore, at the time of the March 30, 2010 visit at IWIRC, it was noted that Petitioner stated that his symptoms had improved as far as his neck was concerned, but that he still could not see out of his right eye. It was noted that Petitioner rated his current pain level at constant 1/10 for the neck, that he was currently taking Vicodin as needed, that he stated that the last time he took the Vicodin was on March 25th, and that he was following work restrictions. It was noted that Petitioner had not been seen by the pain clinic since his last visit at IWIRC. It was further noted that Petitioner reported no pain to his neck or numbness and tingling down his arms into his hands/fingers, that he canceled his last pain clinic visit as he was pain-free, and that he was using pain medication on a daily basis. (RX3). Finally, the records of IWIRC reflect that Petitioner was seen for work conditioning on June 24, 2010, at which time it was noted

that he reported that he felt strong, was ready for discharge from work conditioning and return to full duty, and that he stated that he planned to continue strengthening at the health club. It was noted that Petitioner was to return to the doctor with discharge to full duty recommended. It was further noted that Petitioner's work conditioning goals had been achieved, that he had improved general conditioning and balance abilities, and that he had also achieved heavy/extra heavy physical demand range for material handling. (PX71; RX3).

Having considered the entirety of the extensive medical evidence in this matter, the Arbitrator finds that the injuries sustained by Petitioner that were causally related to the underlying accident at issue had reached maximum medical improvement as of June 24, 2010, and that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of November 10, 2009.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment rendered during the timeframe of November 17, 2009 through June 24, 2010 was reasonable, necessary, and causally related to his work accident of November 17, 2009. As a result thereof, Respondent shall pay all reasonable and necessary medical services for treatment rendered during the timeframe of November 17, 2009 through June 24, 2010 as contained in Petitioner's Exhibit 67, 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 (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks the recovery of temporary total disability benefits for the timeframe of August 16, 2011 through March 13, 2017. (AX1). In light of the Arbitrator's aforementioned conclusions as to the issue of causation and the Arbitrator's finding that Petitioner had achieved maximum medical improvement from his injuries as of June 24, 2010, the Arbitrator denies Petitioner's request for temporary total disability benefits.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, the Arbitrator notes that the injuries occurred before September 1, 2011 as it pertains to Section 8.1b of the Act. Based on the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

With respect to disputed issue (O) pertaining to the admissibility of Petitioner's Exhibits 65 and 68, the Arbitrator admits Petitioner's Exhibits 65 and 68 over the objections raised by Respondent. The Arbitrator further states, however, that no weight was given to either of these particular exhibits during the course of rendering the opinions contained herein.

As it pertains to 10 WC 33571 for the alleged date of accident of June 24, 2010:

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on June 24, 2010 that arose out of and in the course of his employment with Respondent.

At the outset, the Arbitrator is admittedly gravely concerned by the number of physicians in these cases that have suggested that Petitioner's complaints were not supported by the objective findings or were considered to be non-dermatomal and/or non-anatomical in nature. For example, the Arbitrator notes that Dr. Klopfenstein at the time of the visit on February 23, 2011 noted that Petitioner's complaints were that of axial neck pain with radiation into both shoulders and down the right upper extremity and the right hand with numbness of the entire right arm, that his sensory complaints were in a non-dermatomal fashion, that

on examination he had 5/5 strength throughout the upper extremities although he demonstrated poor effort secondary to pain and sensation in both his low back and neck with efforts, that he had loss of sensory sensation to pinprick examination in all dermatomes of the right upper extremity whereas he had no loss of sensation in the left upper extremity, and that deep tendon reflexes were 2+ throughout the upper extremities without asymmetry. (PX34). Similarly, at the time of the December 29, 2009 visit at Heyde Eye Center, it was noted that it was expected that Petitioner's visual acuity would return to normal, that the injury was an elbow and not a weapon or bullet, and that there was no socket fracture. It was noted that Petitioner's decreased visual acuity was not consistent with the findings. (PX35). Furthermore, the medical records of Central Illinois Pain Center records reflect that when Petitioner was seen on October 19, 2010, it was noted that Petitioner's pain started in July 2010, that he described his pain more sharp and burning pain and aching pain with more numbness on the right leg but the pain is more on the left side, and that he described his pain in the whole leg and could not specify any specific part of the leg. The medical records noted that it was difficult to explain Petitioner's numbness on the right leg. (PX36). Similarly, Dr. McCall testified that when Petitioner came to see him, he had leg pain for which he did not have a good explanation. (PX41).

The Arbitrator additionally notes that at the time of the December 9, 2013 therapy session at Prairie Spine & Pain Institute, it was noted that Petitioner was able to ambulate into the clinic without use of any assistive device on that date, and that upon observation there was no noticeable gait deficit. (PX43). Furthermore, the FCE performed at Champion Fitness dated January 28, 2014 noted that on January 28, 2014 Petitioner ambulated with an antalgic gait and an assistive device (straight cane) which he stated he bought himself at a local drug store. It was noted that a normal gait pattern was noted upon arrival on February 6, 2014, but that a severe antalgic gait was noted upon departure. It was noted that upon completion of testing, Petitioner laid on the treatment table stating his pain was so intense he could not do any more activity, that he proceeded to lie on the table while completing his post pain drawing, and that upon leaving the facility Petitioner walked with a severe antalgic gait, alternating which leg was being favored, and that he also "staggered" to his vehicle as if he was going to fall. (PX46).

Perhaps most significantly to the Arbitrator, however, was the fact that even Petitioner's own IME physician, Dr. David Fletcher, when asked whether, upon his examination of Petitioner he was concerned about symptom magnification, Dr. Fletcher responded that he thought that there was overreporting in his situation. (PX55). Dr. Fletcher also testified that he indicated in his report that Petitioner's pain drawing was not consistent with an anatomical pattern, that what he was trying to say was that this was not consistent with a known medical condition, and that that would be a "red flag" for someone doing a dorsal column stimulator not to have a distinct nerve root dermatomal problem. Dr. Fletcher also testified that the fact that Petitioner had global anterior and posterior leg pain was a major inconsistency. (PX55). As a result of the number of such notations contained throughout the medical records in this matter, the Arbitrator admittedly questions the credibility of Petitioner in this case.

Of great significance to the Arbitrator is the fact that the medical records for the work conditioning note of June 24, 2010 are completely void of any notation whatsoever as to any injury having occurred during the course of lifting, let alone any suggestion that Petitioner was brought to his knees due to pain, that he was unable to move, or that he had to be wheeled to the exam room of Dr. Hauter on that date as testified to by Petitioner at the time of arbitration. (PX71; RX3). Instead, the records of IWIRC reflect that Petitioner was seen for work conditioning on June 24, 2010, at which time it was noted that he reported that he felt strong, was ready for discharge from work conditioning and return to full duty, and that he stated that he planned to continue strengthening at the health club. It was noted that Petitioner was to return to the doctor with discharge to full duty recommended. It was further noted that Petitioner's work conditioning goals had been achieved, that he had improved general conditioning and balance abilities, and that he had also achieved heavy/extra heavy physical demand range for material handling. (PX71; RX3).

Having considered and reviewed the entirety of the evidence in this matter, the Arbitrator finds that Petitioner failed to prove by a preponderance of evidence that he sustained an accident on June 24, 2010 that arose out of and in the course of his employment. In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (E), (F), (J), (K), and (L), as those issues are rendered moot. The claim is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	10WC033571
Case Name	STIMELING, STEVEN v. PEORIA PUBLIC SCHOOLS
Consolidated Cases	10WC033570
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0102
Number of Pages of Decision	6
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	TODD STRONG
Respondent Attorney	Stephen Kelly

DATE FILED: 3/18/2022

/s/*Stephen Mathis, 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 PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Stimeling,

Petitioner,

vs. NO. 10WC 33571

Peoria Public Schools, District 150,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2021, is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 18, 2022

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

SJM/sj
o-2/23/22
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STIMELING, STEVEN
Employee/Petitioner

Case# **10WC033571**
10WC033570

PEORIA PUBLIC SCHOOLS DISTRICT 150
Employer/Respondent

On 1/8/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Stimeling
Employee/Petitioner
v.

Case # **10** WC **33571**

Consolidated cases: **10** WC **33570**

Peoria Public Schools, District 150
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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **November 12, 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. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Evidentiary Rulings as to Petitioner's Exhibits 65 & 68**

FINDINGS

On **June 24, 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 not*** sustain an accident that arose out of and in the course of employment.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

Respondent shall be given a credit of **$0** 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 **$0.**

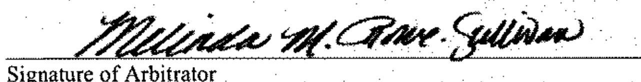
Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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.

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

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



Signature of Arbitrator

1/4/21
Date

JAN - 8 2021

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC003890
Case Name	TAMAYO, VICTOR v. COOK COUNTY SHERIFF'S DEPARTMENT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0103
Number of Pages of Decision	17
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Al Koritsaris
Respondent Attorney	Michael Bantz

DATE FILED: 3/18/2022

/s/Stephen Mathis, 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

Victor Tamayo,

Petitioner,

vs. NO. 20WC 03890

Cook County,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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

No bond is required for the removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 18, 2022

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

SJM/sj
o-2/23/22
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC003890
Case Name	TAMAYO, VICTOR v. COOK COUNTY
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b)/8(A) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	Al Koritsaris
Respondent Attorney	Jason Stetz

DATE FILED: 9/21/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 21, 2021 0.04%

/s/Molly Mason, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)/8(A)

Victor Tamayo
Employee/Petitioner

v.

Cook County
Employer/Respondent

Case # **20** WC **3890**

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 **August 24, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☒ Other **Prospective Medical Treatment**

FINDINGS

On the date of accident, **February 1, 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 $**72,134.40**; the average weekly wage was $**1,387.20**.

On the date of accident, Petitioner was **39** 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 $**59,187.20** 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 $**13,299.09** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,928.49 to Premier Pain (PX 6); $405.58 to Hinsdale Orthopaedics (PX 4) (the Arbitrator declines to award the additional $205.00 claimed by Petitioner because that charge relates to an April 2021 visit to Dr. Chudik and no records concerning this visit are in evidence); and $19,810.44 to Athletico (PX 8) as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent stipulated that Petitioner was temporarily totally disabled from February 27, 2020 through May 19, 2021. Arb Exh 1. Respondent shall pay Petitioner temporary total disability benefits of $924.80 /week from February 27, 2020 through July 12, 2021 and on July 19, 2021 (the date Dr. Said administered an epidural steroid injection). This period is equal to 71 6/7 weeks. For the reasons set forth in the attached decision, the Arbitrator declines to find that Petitioner was temporarily totally disabled from July 13, 2021 through July 18, 2021 and from July 20, 2021 through the hearing of August 24, 2021. Respondent shall receive credit for its stipulated payment of $59,187.20.

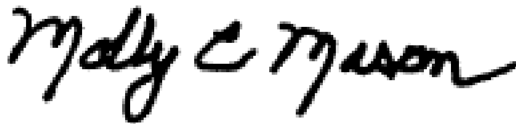
Prospective Care

The Arbitrator awards prospective care in the form of return visits to Drs. Said and Lorenz along with any additional lumbar spine treatment they recommend. See the attached decision for details.

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

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

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



Signature of Arbitrator

SEPTEMBER 21, 2021

Victor Tamayo v. Cook County Sheriff's Department
20 WC 3890

Summary of Disputed Issues

The parties agree that Petitioner, a longtime correctional officer, sustained an accident on February 1, 2020. Petitioner testified he stepped forward with his right foot and slipped on a plastic pad that paramedics had left on the floor after they tended to an inmate. Petitioner testified his right leg went forward while his left leg went back. He managed to bring his legs back underneath him, using his strength. He felt pain in his right leg, hip and buttock. He underwent Emergency Room care later that day. On February 14, 2020, he began a course of treatment with Dr. Chudik at Hinsdale Orthopaedics. On that date, a physician's assistant described Petitioner's right hip and waist as "hyper flexing" when his right foot slipped forward on the plastic pad. Petitioner was initially diagnosed with a right hamstring injury. Respondent does not dispute this injury. Some of Petitioner's subsequent "visits" at Hinsdale Orthopaedics were virtual, due to the pandemic. In September 2020, Dr. Chudik examined Petitioner's back, for the first time, and concluded that Petitioner's persistent symptoms could also be consistent with a back injury. He ordered a lumbar spine MRI, which demonstrated mild to moderate central stenosis at L2-L3 and L4-L5. PX 2 p. 72. He referred Petitioner to his partner, Dr. Lorenz, for a spinal evaluation. Dr. Lorenz interpreted the MRI as showing a protrusion at L4-L5 with moderate narrowing which corresponded to Petitioner's right leg pain. PX 2, p. 75. He referred Petitioner to a pain physician for the purpose of epidural steroid injections. Petitioner underwent an injection on July 19, 2021. At the hearing, he testified he had recently undergone a second injection and had an upcoming appointment to return to Dr. Said, the pain physician. The last treatment record in evidence is dated July 19, 2021. PX 5.

Respondent's first examiner, Dr. Forsythe, found a causal relationship between the work accident and the right hamstring strain. RX 1. In an addendum, he recommended two weeks of work conditioning and indicated that a spine surgeon would have to address the issue of whether the accident also resulted in a back injury. RX 2. Respondent's second examiner, Dr. Singh, agreed that the accident caused a back injury but he characterized that injury as a resolved strain. RX 3.

The disputed issues include causal connection, medical expenses, temporary total disability benefits and prospective care.

Arbitrator's Findings of Fact

Petitioner testified he began working as a correctional officer for Respondent in 2004. His duties include counting tiers, distributing food, subduing inmates and monitoring checkpoints.

Petitioner denied injuring or having pain in his right hip or lower back before the accident of February 1, 2020. He was not subject to any restrictions as of that date. On that

date, he worked his regular overnight shift. Paramedics came to the facility to tend to an inmate who was fatally injured. They left a plastic pad behind, on the floor. Petitioner testified he did not see this pad. He stepped on the pad with his right foot and slipped. His right leg went forward and his left leg went back. He managed to regain his footing by bringing his legs back underneath him, using his strength. He felt pain in his right leg and right hip/buttock area. He reported the incident. He only had a couple of hours left to work and managed to finish his shift. Later that morning he went to the Emergency Room at Franciscan Health Olympia Fields where he saw a resident, Dr. Sasaki. The doctor noted his right heel had slid on a slippery AED pad with his "right leg flexed at the hip and his knee extended forward" while his "left knee flexed down." She also noted that Petitioner had managed to catch himself and reported significant pain in his right posterior upper leg, near the hamstring. PX 1, p. 9. On examination, she noted tenderness in that area as well as by the right ischium. She obtained right femur and pelvic X-rays which showed mild degenerative changes of both hip joints and no evidence of an ischial tuberosity avulsion fracture. PX 1, p. 12. She prescribed Norco, provided Petitioner with crutches and recommended that Petitioner follow up with an orthopedic surgeon. PX 1, pp. 13-14.

Petitioner testified he followed up at Hinsdale Orthopaedics. He saw a physician's assistant, Brian Amundson, PAC, at that facility on February 14, 2020. He provided a history of the work accident and Emergency Room care. Amundson noted that, when Petitioner's right foot slipped forward on an AED pad, this "caused a sudden hyper flexion of [Petitioner's] right hip and waist." He also noted an immediate onset of right posterior leg pain associated with swelling and bruising. He described Petitioner's right hamstring as tender and apparently attached but "different in consistency versus the left proximal hamstring." PX 2, p. 2. He diagnosed a right hamstring strain. He ordered an MRI and took Petitioner off work. PX 2, p. 3.

Petitioner testified he began receiving temporary total disability benefits at this point.

The right hamstring MRI, performed without contrast on February 24, 2020, showed unremarkable, intact hamstring tendons and edema at the biceps femoris and semitendinosis myotendinous junction in the mid calf, "compatible with myotendinous junction strain." The radiologist indicated that the full extent of the strain was "not in view." PX 2, p. 4.

Petitioner returned to Hinsdale Orthopaedics on February 26, 2020 and saw Dr. Chudik. The doctor reviewed the X-rays and MRI. He recommended that Petitioner participate in physical therapy and avoid aggravating activities. PX 2, pp. 5-7.

Petitioner underwent an initial physical therapy evaluation at Athletico on April 8, 2020. The therapist described Petitioner's gait as abnormal. PX 2.

Petitioner had a telemedicine visit with Jessica Price, another physician's assistant at Hinsdale Orthopaedics, on April 9, 2020. Petitioner reported that therapy was helpful but that he felt knots and soreness in his medial distal hamstring. He complained of pain with bending

and fast walking. Price recommended that he continue therapy, noting he might require a knee MRI. PX 2, pp. 16-18.

Petitioner continued attending therapy thereafter, with the therapists typically describing Petitioner's gait as antalgic. PX 7.

Respondent offered into evidence a utilization review report dated April 15, 2020, non-certifying the prescribed therapy but certifying additional therapy once a week for four weeks. The reviewer, an orthopedic surgeon, certified this reduced schedule after noting that Petitioner remained symptomatic after attending seventeen out of eighteen approved therapy sessions. RX 4, pp. 1-7.

Petitioner had a telemedicine visit with Dr. Chudik on May 22, 2020. The doctor noted improvement with therapy but indicated Petitioner was still experiencing pain in the anterior knee with flexion and pain with sitting and bending over. PX 2, p. 23. The doctor recommended that Petitioner continue therapy and transition to work conditioning. PX 2, p. 24.

Petitioner testified he participated in one session of work conditioning and then began experiencing more pain as well as tingling down his leg.

Petitioner returned to Hinsdale Orthopaedics on June 10, 2020 and saw Dr. Chudik. Petitioner reported that he had started work conditioning two days earlier, that the session was "very difficult" and that it exacerbated his hamstring pain and caused pain in his abdomen and low groin area, where he had undergone a hernia repair in 2017. The doctor concluded that Petitioner's hamstring strain was "not completely healed" and that Petitioner was "not ready for the intensity of work conditioning." He recommended that Petitioner stay off work, build up more strength with therapy and avoid aggravating activities. PX 2, pp. 25-27.

Respondent offered into evidence a utilization review report non-certifying work conditioning. The reviewer, an orthopedic surgeon, noted that Petitioner was experiencing depression and anxiety and had already participated in twenty-nine therapy sessions. He advocated a modified duty return-to-work program. RX 4, pp. 12-19.

Petitioner cancelled a therapy session on June 24, 2020, indicating that he might have been exposed to COVID. PX 2, p. 28.

On July 8, 2020, Petitioner had a telemedicine visit with Dr. Chudik. Petitioner reported that he had been potentially exposed to COVID and had a cough. Petitioner also reported doing home exercises because his therapy facility had shut down due to a COVID exposure. The doctor noted that Petitioner was "actively coughing during the entire telemedicine visit." He recommended that Petitioner remain off work, continue formal therapy via virtual visits and return in six weeks. PX 2, pp. 29-30.

At Respondent's request, Dr. Forsythe conducted a Section 12 examination of Petitioner on August 10, 2020. In his report of that date, Dr. Forsythe described Petitioner as "congenial" throughout the examination. He indicated he reviewed an accident report and job description as well as the Emergency Room records, MRI and Hinsdale Orthopaedics notes. Dr. Forsythe recorded a consistent history of the accident and subsequent care. He noted that, following the Emergency Room visit, Petitioner had seen his primary care physician, who referred him to Dr. Chudik. {No records from the primary care physician are in evidence.] He also noted that therapy had been interrupted due to COVID and that Petitioner had experienced increased pain after one work conditioning session. He indicated that Petitioner was experiencing pain in the proximal and distal hamstring and rated his pain at 3-4/10. He described Petitioner's gait as mildly antalgic and exaggerated. On right hamstring examination, he noted 1+ tenderness of the proximal hamstring at the origin on the ischial tuberosity. He described Petitioner as demonstrating "exaggerated difficulty transitioning from a seated to a supine position" yet "easily hopping onto the examination table."

Dr. Forsythe obtained three X-rays of the right femur. He noted no fracture. He agreed with the radiologist's interpretation of the MRI. He diagnosed a right hamstring strain and causally linked this injury and subsequent treatment to the work accident. He recommended a repeat right femur MRI. He indicated that, if this study showed no tear, Petitioner should attend two more weeks of therapy followed by two weeks of work conditioning and a release to full duty. He saw no clear pre-existing condition relating to Petitioner's right leg. He found Petitioner capable of desk duty and did not anticipate any permanency. RX 1.

On August 19, 2020, Petitioner saw Dr. Chudik at the office and indicated he was performing home exercises and had been unable to participate in formal therapy for two months due to insurance issues. He reported pain when sitting and bending down. Dr. Chudik indicated that Petitioner was "not improving" with conservative care. He recommended a repeat MRI. He continued to keep Petitioner off work. PX 2, pp. 31-33.

A pelvic MRI, performed without contrast on August 28, 2020, showed that the hamstring origin was "intact bilaterally." The radiologist noted no evidence of tearing, tendon retraction or significant tendinopathy. PX 2, p. 34.

On September 2, 2020, Petitioner returned to Dr. Chudik and reported pain with bending and sitting. Petitioner also complained of waking frequently at night and tingling down his leg with extended sitting. On examination, Dr. Chudik noted positive straight leg raising. The doctor indicated he informed Petitioner that "some of the symptoms could be due to lumbar radiculopathy from the original injury" based on the MRI and clinical examination. He diagnosed both a right proximal hamstring strain and lumbar radiculopathy. He prescribed a Medrol DosePak and formal therapy to address both the radicular symptoms and the hamstring strain. PX 2, pp. 35-37.

Petitioner underwent an initial therapy evaluation at Athletico on October 1, 2020. The therapist noted that Petitioner reported constant low back and right hamstring pain. PX 2, pp. 38-41.

Petitioner returned to Dr. Chudik on October 14, 2020 and reported that his low back stiffened up and his right hip locked up the day he started the Medrol DosePak. Petitioner reported improvement with therapy but indicated he was still experiencing tingling and pain down his right leg. The doctor recommended that he continue therapy for six more weeks and then attempt light duty. He continued to keep Petitioner off work. PX 2, pp. 45-47.

After additional therapy, Petitioner had a telemedicine visit with Vincent Walsh, PAC, of Hinsdale Orthopaedics on December 2, 2020. Petitioner reported that he was still experiencing low back pain and radiating leg pain. He also reported he had not attended therapy for the last several days while awaiting the results of COVID testing. Walsh recommended that Petitioner take Ibuprofen 600 mg three times per day for the next three weeks and resume therapy once he felt better. He kept Petitioner off work. PX 2, pp. 55-56.

Petitioner returned to Hinsdale Orthopaedics on January 5, 2021 and saw Vincent Walsh, PAC, again. Petitioner complained of sharp pain in his posterior buttock radiating to his foot, leading to some numbness and tingling. Petitioner also indicated that therapy was providing little relief. On examination, Walsh noted tenderness about the medial hamstring belly and over the ischial tuberosity, no swelling or ecchymosis, mildly diminished sensation over the lateral right lower leg, exquisite tenderness over the L5 and S1 region and positive straight leg raising on the right. Walsh expressed concern that Petitioner's symptoms were emanating from the lower back. He referred Petitioner to Dr. Lorenz, a spine surgeon. He recommended that Petitioner increase his Ibuprofen intake and remain off work. He also noted that Petitioner complained of tightness in his chest and reported a history of anxiety, depression and panic attacks. He recommended that Petitioner relay these symptoms to his primary care physician. PX 2, pp. 57-59.

Petitioner reported to therapy on January 6, 2021 but the therapist found it inappropriate to conduct the session, noting that Petitioner had undergone an EKG per his primary care physician after his visit the previous day. The therapist described Petitioner as "visibly disturbed" and experiencing increased anxiety and chest pain after seeing the words "spinal surgeon" on a card. Petitioner complained of pain in his mid back and neck as well as his lower back and leg. PX 2, pp. 64-66.

Petitioner was discharged from therapy on January 10, 2021, with a therapist informing Petitioner he should follow up with Dr. Lorenz and that Dr. Chudik felt additional hamstring therapy was not medically necessary. PX 7, p. 1.

Respondent's first Section 12 examiner, Dr. Forsythe, issued an addendum on February 5, 2021, after reviewing the pelvic MRI of August 28, 2020 and Walsh's note of January 5, 2021. Dr. Forsythe again diagnosed a right hamstring strain. He causally linked this condition to the

work accident. He recommended that Petitioner attend work conditioning for two weeks "to facilitate a return to full duty." He noted that Dr. Chudik felt Petitioner's radicular symptoms were consistent with lumbar radiculopathy. He deferred this issue to a board certified spine physician. RX 2.

Petitioner first saw Dr. Lorenz on February 11, 2021. Dr. Lorenz recorded a history of the work accident and subsequent care. He described Petitioner's symptoms as "somewhat vague," noting that Petitioner complained of hamstring pain as well as mid back and radiating leg pain. He described straight leg raising as negative bilaterally. He obtained lumbar spine X-rays which showed degenerative disc disease, most pronounced at L2-L3. He prescribed a lumbar spine MRI. PX 2, pp. 67-69.

On February 17, 2021, Dr. Chudik noted that Dr. Lorenz had ordered a lumbar spine MRI. He put treatment on hold pending the results of this study. He indicated he "agreed that the lumbar spine MRI and resulting treatment are related to the original work-related injury on February 1, 2020." He kept Petitioner off work and recommended home exercises. PX 2, pp. 70-71.

The lumbar spine MRI, performed without contrast on February 22, 2021, showed multilevel degenerative disc disease resulting in neural foraminal narrowing at L2-L3, L3-L4 and L4-L5. The interpreting radiologist also noted mild to moderate central canal stenosis at L2-L3 and L4-L5. PX 2, pp. 72-73.

On March 1, 2021, Dr. Lorenz discussed the MRI results with Petitioner. The doctor interpreted the MRI as showing a protrusion at L4-L5 and moderate narrowing. He opined that the protrusion and narrowing "corresponds to [Petitioner's] leg pain on the right side." He recommended an epidural steroid injection on the right at L4-L5. PX 2, pp. 74-75.

According to the itemized bill from Hinsdale Orthopaedics (PX 4), Petitioner returned to Dr. Chudik on April 12, 2021. No records concerning this visit are in evidence.

At Respondent's request, Petitioner underwent a Section 12 examination by a spine surgeon, Dr. Singh, on May 5, 2021. In his report of that date, Dr. Singh indicated he reviewed the Emergency Room records along with an incident report and records from Hinsdale Orthopaedics. He noted complaints of 4-5/10 low back pain and "entire right lower extremity dyesthesias into the foot." On examination, he noted 5/5 lower extremity strength and 5/5 negative Waddell's. He interpreted the February 22, 2021 lumbar spine MRI as showing a central disc protrusion without stenosis at L4-L5. He opined that the work accident caused a lumbar strain "which has resolved." He viewed the disc protrusion as an "incidental finding." He described Petitioner's leg complaints as non-anatomic. He found the treatment to be excessive, indicating that the strain required four weeks of conservative management. He concluded that Petitioner would have reached maximum medical improvement within four weeks of the accident. He found Petitioner capable of full duty. RX 3.

Petitioner testified that he continued undergoing medical care, using his group health coverage, after Dr. Singh's examination.

On July 12, 2021, Petitioner saw Dr. Said of Premier Pain at Dr. Lorenz's referral. Dr. Said recorded a consistent history of the work accident and noted that Petitioner denied any prior spinal, hip or knee surgeries. He noted that Petitioner reported having used cocaine two days earlier and that Petitioner described this as a one time occurrence and a lapse of judgment on his part. He described Petitioner's affect as appropriate. He attributed Petitioner's pain to lumbar degenerative disc disease and spondylosis causing a right lower extremity radiculopathy. He recommended an L4-L5 epidural steroid injection but recommended that this be delayed one or two weeks due to Petitioner's cocaine usage. PX 5, pp. 5-8.

Dr. Said administered the L4-L5 epidural steroid injection on July 19, 2021. PX 5, pp. 1-4.

Petitioner testified he experienced slight relief of his leg and hip symptoms for a couple of days following the injection. He testified he underwent a second injection the week before the hearing and experienced more relief of longer duration. He is still experiencing slight numbness down his leg with walking and sitting. He is scheduled to return to Dr. Said on September 9, 2021.

Under cross-examination, Petitioner denied being convicted of a felony or crime of dishonesty at any point during the preceding ten years. He testified he provided a complete and honest description of his accident and symptoms to the treating and examining physicians he saw. He experienced some improvement after the first injection. He denied experiencing improvement before that injection.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise, as does his status as a correctional officer.

Respondent's first examiner, Dr. Forsythe, noted some symptom magnification but nevertheless recommended treatment. RX 1. The second examiner, Dr. Singh, noted no positive Waddell's signs but described Petitioner's complaint of pain in his entire right leg as "non-anatomic." RX 3.

Overall, the Arbitrator finds the causation opinions of Drs. Chudik and Lorenz more persuasive than those of Dr. Singh. Dr. Singh saw Petitioner on one occasion while providers at Hinsdale Orthopaedics saw him over an extended period. Dr. Singh acknowledged that the lumbar spine MRI showed a disc protrusion and some degree of stenosis yet concluded that Petitioner merely sustained a strain.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between the undisputed work accident of February 1, 2020 and his current conditions of ill-being?

As noted previously, there is no dispute that Petitioner injured his right hamstring as a result of the February 1, 2020 work accident. Additionally, Respondent's second examiner, Dr. Singh, concedes that Petitioner established causation as to a lumbar spine condition, albeit one he viewed as a minor strain that had resolved. The question before the Arbitrator is whether Petitioner established causation as to a more significant lumbar spine condition requiring care beyond the four-week period advocated by Dr. Singh.

The Arbitrator finds in Petitioner's favor on this issue. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident back problems; 2) the fact that none of the records in evidence refer to any such problems; 3) Petitioner's credible description of the mechanics of the accident; 4) the fact that, two weeks after the accident, a physician's assistant at Hinsdale Orthopaedics described Petitioner as "hyper flexing" both his right hip and his waist when his right foot slid forward on the piece of plastic; 5) the fact that therapists at Athletico documented buttock pain and gait issues in 2020; 6) the lumbar spine MRI, which showed a disc protrusion at L4-L5 and associated narrowing, according to Dr. Lorenz; 7) Dr. Chudik's opinion that the need for the lumbar spine MRI and back treatment stemmed from the work accident; 8) Dr. Lorenz's opinion that the lumbar spine MRI findings are consistent with Petitioner's ongoing symptoms; and 9) Dr. Singh's concession that the accident caused a back injury, albeit one he viewed as minor and requiring little care.

The Arbitrator concludes that the accident caused both right hamstring and lumbar spine injuries. It was natural for Dr. Chudik and his assistants to initially focus on the hamstring, given that Petitioner was predominantly complaining of posterior leg pain. The back condition might have been diagnosed earlier but for the initial focus on the hamstring injury and the fact that several visits in 2020 were conducted virtually due to COVID concerns. When Dr. Chudik first examined Petitioner's back, on September 2, 2020, following a negative pelvic MRI, he noted positive straight leg raising. He concluded that some of Petitioner's symptoms were lumbar in origin. He ordered a lumbar spine MRI, which demonstrated a protrusion and mild to moderate stenosis, according to his partner, Dr. Lorenz. Dr. Singh, Respondent's second examiner, agreed that the lumbar spine MRI showed a protrusion but concluded that this finding was "incidental." He initially indicated he saw no stenosis. Later in his report, he conceded there was "minimal" stenosis. [See RX 3, p. 4]. This inconsistency undermined the doctor's credibility.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the following unpaid medical expenses: 1) Premier Pain & Spine (Dr. Said), balance of $1,928.49 (7/12/19 and 7/19/19, PX 6); 2) Hinsdale Orthopaedics, $610.58 (PX 4); and 3) Athletico, $19,810.44 (physical therapy and work conditioning from March 3, 2020

through January 6, 2021, PX 8). Respondent disputes this claim based on Dr. Singh's opinions and the utilization review evidence.

The Arbitrator has previously found that Petitioner established causation as to a lumbar spine condition as well as a right hamstring strain. The Arbitrator finds it reasonable for Dr. Chudik to have referred Petitioner to Dr. Lorenz, a spine surgeon, for an evaluation. The Arbitrator also finds it reasonable for Dr. Lorenz to have referred Petitioner to Dr. Said, a pain physician, for lumbar epidural steroid injections. The available records reflect that Dr. Said evaluated Petitioner on July 12, 2021 and administered the first such injection on July 19, 2021. Petitioner testified the injection helped, albeit temporarily. The Arbitrator awards the $1,928.49 in charges relating to Dr. Said's care, subject to the fee schedule.

The $610.58 balance from Hinsdale Orthopaedics (PX 4) includes a $205.00 charge for Petitioner's visit to Dr. Chudik on April 12, 2021. As noted earlier, no records concerning this visit are in evidence. The Arbitrator awards Hinsdale Orthopaedic charges in the amount of $405.58 ($610.58 minus $205.00), subject to the fee schedule. The Arbitrator declines to award the claimed $205.00 because these charges are not supported by medical records.

The Arbitrator also awards the claimed $19,810.44 balance from Athletico relating to the therapy and work conditioning prescribed by Dr. Chudik, to the extent this amount does not represent improper balance billing. In 2020, Respondent's utilization reviewers questioned the duration of the prescribed therapy as well as the need for work conditioning but, in February 2021, Respondent's first examiner, Dr. Forsythe, recommended two weeks of work conditioning to facilitate a return to work. The Arbitrator does not view the therapy or work conditioning as excessive. The sessions extended over a significant period but some of that was due to COVID and the delayed lumbar diagnosis. It was not until September 2, 2020 that Dr. Chudik added the lumbar spine to Petitioner's therapy regimen.

<u>Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to prospective care?</u>

Petitioner claims he was temporarily totally disabled from February 27, 2020 through the hearing of August 24, 2021. In reliance on Dr. Singh, Respondent maintains Petitioner was temporarily totally disabled from February 27, 2020 through May 19, 2021. The parties agree that Respondent paid $59,187.20 in temporary total disability benefits. Arb Exh 1.

The Arbitrator has previously found that Petitioner established causation as to a lumbar spine condition as well as a right hamstring sprain. The Arbitrator has elected to rely on Petitioner's treating physicians rather than Dr. Singh in making this finding.

The Arbitrator finds that Petitioner was temporarily totally disabled from February 27, 2020 through July 12, 2021 (the date he first saw Dr. Said) and on July 19, 2021 (the date of the first epidural steroid injection). PX 5. Respondent shall receive credit for its stipulated payment of $59,187.20. The Arbitrator declines to find that Petitioner was temporarily totally disabled

from July 13, 2021 through July 18, 2021 because, according to Dr. Said, the first lumbar injection had to be delayed due to Petitioner's recreational drug usage. The Arbitrator also declines to find that Petitioner was temporarily totally disabled from July 20, 2021 through the hearing. Dr. Said did not make any treatment recommendations or address work status when he administered the first injection on July 19, 2021. PX 5, pp. 1-4. Petitioner testified he went on to have a second injection shortly before the August 24, 2021 hearing but he did not offer into evidence any "off work" note or other records concerning this second injection. He further testified he was scheduled to return to Dr. Said on September 9, 2021. The Arbitrator awards prospective care in the form of this return visit, along with any additional lumbar spine treatment recommended by Dr. Said and/or Dr. Lorenz.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC020975
Case Name	ROBINSON, STAR v. FORD MOTOR COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0104
Number of Pages of Decision	11
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Steven Seidman
Respondent Attorney	Jason Stellmach

DATE FILED: 3/18/2022

/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

STAR ROBINSON,

Petitioner,

vs. NO: 17 WC 20975

FORD MOTOR COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision with respect to the credit due Respondent. On Review, the parties stipulated to the Arbitrator's award of TTD benefits in the amount of $42,668.60 covering the period of October 12, 2017 through January 10, 2019, the date Petitioner reached maximum medical improvement (MMI) for her work-related injury.

The Arbitrator also awarded Respondent a credit of $25,320.20 for TTD previously paid to Petitioner, and $23,058.75 for short term/long term disability benefits also paid to Petitioner from July 30, 2018 through May 31, 2019. The Commission finds that the credit awarded to Respondent extended beyond the TTD period. Accordingly, the Commission modifies the amount of credit down from $23,058.75 to $12,333.75. By the parties' stipulation, $12,333.75 represents the short term/long term disability benefits paid from July 30, 2018 through January 10, 2019.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 18, 2020 is hereby modified as stated above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $656.44 per week for 65 weeks, commencing October 12, 2017 through January 10, 2019, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $25,320.20 for temporary benefits previously paid to Petitioner for the relevant TTD period.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall also receive a credit of $12,333.75 for short term/long term disability benefits paid from July 30, 2018 through January 10, 2019 pursuant to Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any and all claims for reimbursement by reason of having received such payment of benefits only to the extent of such credit and not for any benefits paid after January 10, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for reasonable and necessary medical services, pursuant to the medical fee schedule, through January 10, 2019, as provided in Sections 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 $590.80 per week for 38.7 weeks, because the injuries sustained caused the 18% loss of use of the left leg, as provided in Section 8(e)(12) 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 consistent with this Decision.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,000.00. 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.

March 18, 2022

CAH/pm
D: 3/17/2022
052

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

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 22IWCC0104
NOTICE OF ARBITRATOR DECISION
CORRECTED

ROBINSON, STAR
Employee/Petitioner

Case# **17WC020975**
17WC033698

FORD MOTOR COMPANY
Employer/Respondent

On 9/18/2020, 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:

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

0560 WIEDNER & McAULIFFE LTD
JASON T STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

CORRECTED
ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Star Robinson
Employee/Petitioner

v.

Ford Motor Company
Employer/Respondent

Case # **17** WC **20975**

Consolidated cases: **17WC33698**

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 **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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

Star Robinson v. Ford Motor Company, 17WC20975 consol. 17WC33698

FINDINGS

On **January 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 $**51,202.84**; the average weekly wage was $**984.67**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**25,320.20** for TTD, $**0** for TPD, $**0** for maintenance, and $**23,058.75** for other benefits, for a total credit of $**48,378.95**.

Respondent is entitled to a credit of $**23,058.75** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner sustained an accidental injury to the left knee which reached maximum medical improvement on January 10, 2019.

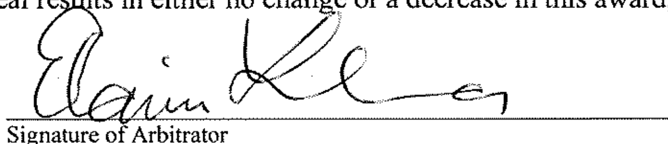
Respondent shall pay Petitioner temporary total disability benefits of $656.44 per week for 65 weeks, commencing October 12, 2017 through January 10, 2019, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $25,320.20 for temporary total disability benefits that have been paid.

Respondent shall pay for reasonable and necessary medical services, pursuant to the medical fee schedule, through January 10, 2019, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $590.80 per week for 38.7 weeks, because the injuries sustained caused the 18% loss of use of the left leg, as provided in Section 8(e)(12) of the Act.

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

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



Signature of Arbitrator

September 11, 2020

Date

ICArbDec p. 2

SEP 18 2020

STATEMENT OF FACTS

Petitioner worked for Respondent Ford Motor Company as an Assembly Worker in its stamping plant. Petitioner testified that she had worked for Respondent since September of 2012.

Petitioner testified that on July 29, 2016, she suffered an injury to her low back while working on Line 13. She testified that she was closing a rack by lifting it up and out towards her and then up and closed. When she was lifting the rack up and out, it fell on one side and she felt pulling pain in her right lower back. Petitioner testified that she notified her team leader of the accident that same day.

Petitioner testified that she had experienced lower back pain in the past in the form of sciatica, which she described as pain from her right low back and hip down her right leg. Petitioner testified that this was where she experienced pain on July 29, 2016 and that the accident aggravated her pre-existing pain. Petitioner testified on cross-examination that she did not recall if she had seen a doctor or been to a medical facility in July of 2016 prior to the accident on July 29, 2016, but that she would not dispute the medical records if they say she did. The medical records indicate that Petitioner went to Ingalls Memorial Hospital on July 13, 2016, with complaints of low back pain after playing with her son and right leg pain at work. (PX3) Petitioner described her pain as sharp and throbbing when weightbearing. *Id.* Petitioner further reported she could barely stand up straight. *Id.* Petitioner revealed that she had been diagnosed with sciatica about a year earlier. *Id.*

Following the accident on July 29, 2016, Petitioner sought treatment at Respondent's on-site medical department that same day. (PX2) The history of accident that was documented indicated that Petitioner went to close a rack and when she lifted the bar up off the rack, it fell on her. *Id.* Petitioner reported an injury to her lower back and complained of constant throbbing and sharp pain when the bar initially fell on her. *Id.* Petitioner was given restrictions of no lifting more than 5 lbs., bending or twisting and referred for physical therapy. *Id.*

Petitioner testified on cross-examination that she did not attend physical therapy because she did not have a car. She explained that she used Uber to get to work and could not afford to take Uber to therapy, as well. Petitioner testified that she was able to work from the date of the accident through January 24, 2017.

It is agreed and stipulated by the parties that on January 24, 2017, Petitioner suffered an injury to her left knee while working for Respondent. Petitioner testified that she as loading a door on a rack when she twisted and tripped on the mat on the floor. Petitioner indicated that she felt a popping and pain in her left knee following the accident.

Petitioner testified that she had suffered a left knee injury in approximately 2012 or 2013 and had some stiffness and swelling at that time. She also testified that she had only treated at Respondent's on-site medical department for that injury. Petitioner denied having any stiffness or swelling in her left knee at the time of the January 24, 2017 accident.

Petitioner went to Respondent's on-site medical department following the injury on January 24, 2017. *Id.* Petitioner complained of consistent throbbing in the knee. *Id.* Petitioner was restricted to limited kneeling, knee bending and was to avoid twisting of the left knee. *Id.*

Petitioner continued to follow up at Respondent's on-site medical department and was referred for left knee x-rays. *Id.* Petitioner underwent the x-rays at Ingalls Memorial Hospital, the results of which showed no acute osseous finding. (PX3) On February 6, 2017, Petitioner was referred to physical therapy for her left knee. (PX2) Petitioner was subsequently referred to an orthopedic surgeon. *Id.*

Petitioner saw Dr. Srinivasu Kusama at Bone and Joint Physicians on June 22, 2017. *Id.* Dr. Kusama recommended an MRI of the left knee and released Petitioner to light duty. *Id.* Petitioner underwent the MRI on June 28, 2017, the results of which revealed degenerative signal in the anterior horn of the lateral meniscus and a possible synovial cyst and blunting at the lateral meniscus which raised the concern of a vertically oriented tear. *Id.* Petitioner continued to follow up at Respondent's on-site medical department complaining of pain in her left knee. *Id.*

On July 31, 2017, Petitioner went to Ingalls Memorial Hospital's Emergency Room complaining of sciatica that started five days before and had not resolved. (PX3) Petitioner was treated and released. *Id.* On August 1, 2017, Petitioner followed up with Dr. Nanette Fabi at Primary Healthcare Associates, who noted that Petitioner reported putting weight on her right knee at work and had right leg and back pain. (PX7) Dr. Fabi further noted that Dr. Kusuma had obtained an MRI in the past and was told she had a meniscus tear since 2014, "this one is work related injury." *Id.* Dr. Fabi ordered physical therapy. *Id.*

Petitioner followed up with Dr. Kusuma on August 2, 2017 for her left knee pain. (PX2) Petitioner continued to complain of swelling in her left knee, some limping and intermittent achy and severe pain. *Id.* Dr. Kusuma also noted that Petitioner had lower back pain with radiculopathy down her right leg from a work-related accident about a year earlier which caused her low back pain and radiculopathy to flare up. *Id.* Dr. Kusuma diagnosed Petitioner as having a left knee lateral meniscus tear and right lumbar radiculopathy. *Id.* Dr. Kusuma referred Petitioner to Dr. Joseph Thometz regarding her left knee and kept Petitioner on light duty. *Id.*

On August 14, 2017, Petitioner reported a right shoulder accident at work. *Id.* Petitioner reported that she was loading a panel onto a rack when the panels slid into the rack too fast and her glove got caught under the panels. *Id.* Petitioner felt a pull on her right arm and then pain. *Id.* Petitioner went to Respondent's on-site medical department and was restricted from any work above shoulder level and limited reaching or pushing with her arm and shoulder. *Id.*

Petitioner saw Dr. Thometz on August 21, 2017. *Id.* Dr. Thometz examined Petitioner, reviewed the left knee MRI and diagnosed Petitioner as having persistent knee pain. *Id.* Dr. Thometz recommended arthroscopic surgery with possible partial meniscectomy. *Id.*

On September 27, 2017, Petitioner followed up with Dr. Fabi regarding pain in her right shoulder. (PX7) Dr. Fabi prescribed pain medication, continued Petitioner's restrictions and advised Petitioner to return if symptoms persisted. *Id.*

On October 12, 2017, Dr. Thometz performed a left knee arthroscopy, partial lateral meniscectomy and debridement of the patella. (PX6) Petitioner was taken off work post-operatively by Dr. Thometz, during which time Petitioner received temporary total disability (TTD) benefits. (PX2, RX3) Petitioner continued to follow up post-operatively with Dr. Thometz and underwent physical therapy. (PX2, PX5)

On February 1, 2018, Petitioner underwent an MRI of her lumbar spine, ordered by Dr. Thometz, the results of which showed mild degenerative disease at L3-L4 and L4-L5 levels. (PX4) On April 12, 2018, Dr. Thometz ordered an MRI of the left knee. *Id.* On April 27, 2018, Petitioner underwent the left knee MRI, the results of which showed signal in the superior aspect of the anterior and posterior horn lateral meniscus, probably postsurgical, and no evidence for ligamentous injury. *Id.* On May 3, 2018, Dr. Thometz noted Petitioner complained of ongoing pain in her left knee and pain in her low back. *Id.* Dr. Thometz administered a cortisone injection to Petitioner's left knee and recommended physical therapy for Petitioner's back. *Id.* Dr. Thometz also kept Petitioner off work indicating that she could not work. *Id.*

On May 30, 2018, Dr. Thometz noted Petitioner reported some temporary relief from the knee injection and that physical therapy for Petitioner's back had not been authorized. *Id.* Dr. Thometz recommended Visco supplementation to Petitioner's left knee and kept her off work. *Id.*

On June 28, 2018, Petitioner underwent an independent medical examination (IME), at the request of Respondent, with Dr. Brian Forsythe regarding her left knee. (RX2) Dr. Forsythe diagnosed Petitioner with status post left knee lateral meniscus debridement and chondroplasty and found that Petitioner had residual soft tissue pain following the surgery. *Id.* Dr. Forsythe noted that the surgery revealed patellar chondrosis intraoperatively, which was a preexisting condition, and that Petitioner's subjective complaints were not supported by objective findings. *Id.* Dr. Forsythe found the surgery reasonable and related to the January 24, 2017 accident. *Id.* Additionally, Dr. Forsythe determined that Petitioner required no additional treatment and released her to full duty work without restrictions. *Id.* Dr. Forsythe opined that if Petitioner refused to return to work full duty, it would be reasonable to obtain a functional capacity evaluation (FCE). *Id.* Dr. Forsythe opined that Petitioner reached maximum medical improvement (MMI) for her left knee on April 27, 2018. *Id.*

Additionally, on June 28, 2018, Petitioner underwent an IME, at the request of Respondent, with Dr. Frank Phillips regarding her low back. (RX1) Dr. Phillips opined that Petitioner did not sustain any work-related lumbar injury. *Id.* Dr. Phillips admitted that he was not provided the lumbar MRI and did not review it, but explained that, based on the information provided, he did not believe Petitioner's back condition was related to any work-related injury. *Id.* Dr. Phillips noted that Petitioner had some back pain and some possible radicular symptoms, but the physical exam was not conclusive for radiculopathy. *Id.* Dr. Phillips opined that Petitioner could return to work, regular duty. *Id.*

On July 25, 2018, Dr. Thometz reviewed the IMEs and, regarding the left knee, released Petitioner to return to work on July 30, 2018 with the following permanent restrictions: no repetitive bending/twisting, squatting, kneeling or lifting greater than 5 lbs. (PX2) Dr. Thometz explained that he would have Petitioner start back at work with the restrictions and gradually increase her activity as tolerated. *Id.* On August 1, 2018, Dr. Thometz reiterated his work release and restrictions for Petitioner regarding her left knee, as well as took Petitioner off work due to treatment for her lumbar strain. *Id.*

Petitioner continued to follow up with Dr. Thometz, who continued to recommend physical therapy for her low back and Visco supplementation for her left knee. *Id.* On November 21, 2018, Dr. Thometz noted that Petitioner was attending yoga and that, according to Petitioner, it was helping with her pain. *Id.* On January 10, 2019, Petitioner reported that while she was having some problems with her left knee, she was managing with turmeric, yoga, essential oils and using a knee sleeve. *Id.* Dr. Thometz found Petitioner to be at MMI and discharged Petitioner from care regarding her left knee. *Id.* Petitioner testified that she did not follow up with Dr. Thometz regarding either her low back or her left knee after January 10, 2019. Petitioner further testified that she had not seen any other medical provider regarding her back or her left knee after January 10, 2019.

Petitioner testified that she started working as a Registered Nurse in January 2019 and was laid off due to the COVID-19 pandemic in 2020. Petitioner indicated that she was capable of performing her job as a Registered Nurse, but that her low back will get stiff if she sits for long periods of time, such as over two hours. Petitioner testified that her left knee is sensitive to cold, rainy weather and will get stiff and painful under those conditions. Petitioner indicated that she does not take over the counter medication, instead using turmeric to help with inflammation. Petitioner also testified that she continues to attend yoga to help with her pain.

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 Dr. Forsythe found during the IME that Petitioner's subjective complaints were not supported by the objective findings. Dr. Forsythe also cited the April 27, 2018 MRI, which revealed no evidence for a ligamentous injury. However, the Arbitrator notes that the April 27, 2018 MRI showed signal in the superior aspect of the anterior and posterior horn lateral meniscus, probably postsurgical, as well as no evidence for ligamentous injury. Further, the Arbitrator notes that Petitioner continued to remain on restrictions and continued treating for her left knee condition through 2017 and 2018. The Arbitrator notes that on January 10, 2019, Dr. Thometz indicated that Petitioner reported that while she was still having some problems with her left knee, she was managing with turmeric, yoga, essential oils and using a knee sleeve. Additionally, Dr. Thometz found Petitioner to be at MMI and discharged Petitioner from care, with the previously placed permanent restrictions, regarding her left knee on January 10, 2019. Finally, Petitioner testified that she did not follow up with Dr. Thometz or any other medical provider regarding her left knee after January 10, 2019.

Based upon the above, the Arbitrator finds that Respondent is liable for medical expenses incurred through January 10, 2019, the date Dr. Thometz found Petitioner had reached MMI regarding her left knee injury.

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 on July 25, 2018, Petitioner followed up with Dr. Thometz regarding her left knee pain and to review the June 28, 2018 IMEs. The Arbitrator further notes that, regarding Petitioner's left knee, Dr. Thometz released Petitioner to return to work with restrictions beginning July 30, 2018 and imposed permanent restrictions of no repetitive bending/twisting, no squatting/kneeling, and no lifting greater than 5 lbs. Dr. Thometz explained that he would have Petitioner start back at work with restrictions and gradually increase her activity as tolerated. Additionally, the Arbitrator notes that Dr. Thometz reiterated the work release and restrictions regarding Petitioner's left knee on August 1, 2018. Furthermore, the Arbitrator notes that Dr. Thometz did not declare Petitioner to be at MMI regarding his left knee condition until January 10, 2019, noting that Petitioner was managing with turmeric, yoga, essential oils and a knee sleeve. Finally, the Arbitrator notes that Respondent issued TTD benefits through July 8, 2018.

Based on the above, the Arbitrator finds that Petitioner is entitled to TTD benefits through January 10, 2019. The Arbitrator notes that Petitioner received benefits from Unicare in the amount of $23,058.75, for which Respondent is entitled to a credit under Section 8(j) of the Act.

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

Pursuant to 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. As such, the Arbitrator gives no weight to 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 an Assembly Worker at the time of the accident and that she did not return to work in her prior capacity. Once released from care in January 10, 2019, Petitioner began working as a Registered Nurse. The Arbitrator gives great weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 31 years old at the time of the accident. The Arbitrator gives this factor some weight.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was submitted at trial by either party as to Petitioner's earning capacity. Based on Petitioner's testimony that she was able to work without issue as a Registered Nurse until laid off due to the COVID-19 pandemic, the Arbitrator finds that Petitioner is capable of working. The Arbitrator gives this factor significant weight.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent a left knee arthroscopy, partial lateral meniscectomy, and debridement patella on October 12, 2017. The April 27, 2018 left knee MRI revealed signal in the superior aspect of the anterior and posterior horn lateral meniscus, probably postsurgical, and no evidence for ligamentous injury. On January 10, 2019, Dr. Thometz, placed Petitioner at MMI regarding her left knee while noting that Petitioner had permanent restrictions regarding her left knee and continued to have left knee issues which she was managing with turmeric, essential oils, yoga and a knee sleeve. Finally, Petitioner testified that she has not sought any medical treatment since January 10, 2019. The Arbitrator gives this factor great weight.

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 18% loss of use of the left leg pursuant to Section 8(e)12 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC012007
Case Name	TUTOKY, STEVEN v. STATE OF ILLINOIS - PONTIAC CORRECTIONAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review Under 19b
Decision Type	Commission Decision
Commission Decision Number	22IWCC0105
Number of Pages of Decision	10
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Alexis Ferracuti
Respondent Attorney	Bradley Defreitas

DATE FILED: 3/21/2022

/s/Marc Parker, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Totoky,

Petitioner,

vs. NO: 19 WC 12007

State of Illinois/Pontiac Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2021, is hereby affirmed and adopted.

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

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

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

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.

March 21, 2022

/s/ *Marc Parker*
Marc Parker

MP:yl
o 3/17/22
68

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC012007
Case Name	TUTOKY,STEVEN v. PONTIAC CORRECTIONAL CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Adam Hinrichs, Arbitrator

Petitioner Attorney	Alexis Ferracuti
Respondent Attorney	Bradley Defreitas,

DATE FILED: 5/24/2021

INTEREST RATE FOR THE WEEK OF MAY 18, 2021 0.03%

/s/ *Adam Hinrichs, Arbitrator*
Signature

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

MAY 24, 2021

/s/ *Brendon O'Rourke*
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEVE TUTOKY Case # **19WC 12007**
Employee/Petitioner
v.

PONTIAC CORRECTIONAL CENTER
Employer/Respondent(s)

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 **ADAM HINRICHS**, Arbitrator of the Commission, in the city of **PEORIA**, on March 30, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES:

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

Findings:

On **12/20/2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of, and in the course of, his 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 $**1,040.00**; the average weekly wage was $**54,080.00.**

On the date of the accident, Petitioner was **29** years of age, and ***married*** with **2** dependent children.

Petitioner ***has NOT*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0.00.**

ORDER:

Petitioner is hereby awarded payment of his reasonable and necessary unpaid medical bills totaling $2,100.00, as well as $60.00 in out-of-pocket costs. Respondent shall pay these amounts directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act, and subject to reductions under the medical fee schedule. The Respondent is entitled to a credit for payments made by the group health insurance carrier under Section 8(j).

Petitioner is hereby awarded six weeks of supervised physical therapy per the recommendation of Respondent's Section 12 examiner, Dr. Bernie Bach.

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.

MAY 24, 2021

Signature of Arbitrator

FINDINGS OF FACT

Steven Tutoky, Petitioner, has worked for the IDOC Pontiac Correctional Center, Respondent, since January 7, 2013 as a correctional officer. Petitioner's primary job responsibility is providing for the safety and security of the institution, which includes transporting inmates and working in the towers to guard the prison from escape and intrusion.

The Petitioner testified that on December 20, 2018 at approximately 2:00 p.m. he was working in Tower 27 at the Pontiac Correctional Center. He was closing Tower 27 for the day. The Petitioner testified it was part of his job duties at that time to pack away a mini .223 rifle into a hard plastic case that is approximately 2 feet by 5 feet, and transport that rifle and case from Tower 27 to Tower 23. The towers are approximately one-eighth of a mile apart and connected by a wide sidewalk. Petitioner testified that the sidewalk from Tower 27 to Tower 23 is not well maintained, that there are multiple cracks and breaks, and there is a slight incline where the sidewalk splits off where gravel, grass and sidewalk meet.

The Petitioner testified at hearing that while carrying the rifle case, he must maintain awareness while transporting this rifle through the yard, not only for his own safety but also for the safety of others. At the time of the incident, while carrying the gun and case, and paying attention for inmates who are regularly loose in the yard, his attention was not focused on the sidewalk below. The Petitioner testified that there are multiple areas on the sidewalk that have more than a two-inch crack or break, and those are filled with gravel in order to maintain the sidewalk's level height. While walking from Tower 27 to Tower 23, Petitioner stutter stepped when he hit a gravel portion in the sidewalk, feeling a pop in his left knee with the immediate onset of pain and stiffness. At the spot where the Petitioner stutter stepped, there is also an incline in the sidewalk.

The Petitioner testified that he stutter stepped on the sidewalk because of the break in the sidewalk with gravel filling, the incline, and his need to keep his eyes on the activities in the yard while transporting the rifle. The sidewalk is not a public sidewalk, and is owned, maintained and controlled by the Respondent. The Petitioner testified that he had never injured his left knee before either outside of work or working as a correctional officer at the Pontiac Correctional Center.

The Petitioner reported the incident promptly to his shift commander, Major John Wheat. The Petitioner testified that he completed an incident report with Major Wheat, and testified that the report is expected to be a summary which gives basic information, not specific detail.

In the Tristar accident report, Petitioner wrote that he was "carrying a rifle and a case closing down a tower" and "walking and I felt a large pop in my left knee." (Rx. 1). The Petitioner testified that he gave a more detailed verbal description to Major Wheat which matched the one the Petitioner gave at trial, as well as to his treating doctor, Dr. Brian Sipe, and to Respondent's Section 12 examiner, Dr. Bernie Bach.

Major Wheat instructed Petitioner to go to occupational health at OSF St. James. Petitioner presented to OSF St. James, and reported that his left knee had been "feeling funny for the last few days and today he was walking at work and experienced severe pain in his left knee [and] a popping sound." (Px. 2, p. 28). Petitioner testified that his left knee had only been feeling funny in the front of his knee, and the pop was in the back of his knee. Petitioner reported pain, swelling, and difficulty ambulating or bearing weight. Petitioner reported no prior problems with his knee. Petitioner

further reported that it "felt like a zit inside my knee that popped," and that his knee has been "sore" for the past week. (Px. 2. p. 31). The Petitioner was given a knee immobilizer, analgesic, and was diagnosed with an acute left knee strain. The Petitioner was taken off of work and given a referral to an orthopedist.

On December 21, 2018, Petitioner presented to Brian Sipe, D.O. The Petitioner reported that he was walking at work, twisted or slipped, and felt a pop on the lateral side of his knee. The Petitioner had lost motion in the knee and could not bend it all the way at that time. The Petitioner's exam showed general joint line tenderness and positive MacMurray's. The Petitioner was found to have a large effusion both on the posterior and anterior side of the knee along with internal derangement of the left knee as a whole. Dr. Sipe ordered an MRI and a lower extremity veins (LEV) test to rule out tears.

On December 24, 2018, the Petitioner underwent the LEV test. On the LEV, a baker's cyst was discovered. On December 28, 2018 the Petitioner underwent an MRI which revealed that his ligaments were intact and confirmed he had a baker's cyst which measured 4.3 x .7 x .5 centimeters.

On January 2, 2019, the Petitioner then followed up with Dr. Sipe and Richard Saylor PAC at OSF St. James orthopedic. Dr. Sipe prescribed a corticosteroid injection for the left knee. Petitioner underwent his first injection, and was released to full duty work.

One year later, on January 13, 2020, Petitioner returned to Dr. Sipe with complaints of left knee pain and swelling. The Petitioner reported that he had been doing well but that there was an increase with pain and swelling recently due to regular job training as well as continuing training for state trooper physical exam. Dr. Sipe performed another injection to Petitioner's left knee. Dr. Sipe advised Petitioner to return PRN, and to continue compression, ice, and anti-inflammatories.

On May 13, 2020, Petitioner presented at Rush Orthopedics for a Section 12 exam with Dr. Bernie Bach. Dr. Bach found the Petitioner to be cooperative, friendly and respectful throughout the exam. The Petitioner testified that he gave a complete history of accident and subsequent medical care to Dr. Bach. Dr. Bach noted that Petitioner was carrying a rifle case, and had a stutter step injury on the sidewalk in an area of the cement sidewalk that was not covered by cement. Dr. Bach diagnosed a "component of hypertrophic fat pad based on the anterior localization of [Petitioner's] pain, adjacent to the patellar tendon." Dr. Bach found Petitioner's current condition of ill-being to be related to the accident of December 20, 2018. Dr. Bach noted that the Baker's cyst was a non-contributing factor to Petitioner's current condition. Dr. Bach found that the Petitioner's ongoing complaints of physical disability and his medical treatment to date were reasonable, necessary and related to the accident of December 20, 2018. Dr. Bach recommended six weeks of physical therapy at which point Petitioner could be placed at MMI. (Rx. 3) Physical therapy was not authorized by the Respondent.

On March 8, 2021, Petitioner returned to Dr. Sipe. Petitioner reported his left knee pain as 6/10 with mild swelling. Petitioner requested another steroid injection in his knee, and Dr. Sipe accommodated Petitioner's request. The Petitioner testified at hearing that he is requesting the ability to seek annual injections in his left knee with Dr. Sipe. Dr. Sipe has not prescribed an annual injection, instead he relates in his notes that he will see Petitioner on an as needed basis. (Px 3, p. 31)

The Petitioner testified that prior to receiving his most recent knee injection, the his left knee hurt regularly. Certain activities make the Petitioner's pain worse such as running, stairs, bending, and squatting down as Petitioner is required to do in the regular course of his job duties. The Petitioner testified that he continues to wear his knee brace and he takes ice and Motrin over the counter to deal with the ongoing swelling and pain. The Petitioner testified that for two to three months after he receives an injection, his left knee feels very good. After that initial period ends, however, Petitioner testified that the swelling starts to come back and he begins to have a lot of pain in the top of his knee and the back of his knee. The Petitioner testified that the photo submitted as Petitioner's Exhibit 4 was an accurate depiction of the swelling of his left knee.

The Petitioner testified that prior to this incident he did significant physical activity, including previously "squatting three or four hundred pounds," and had no prior knee treatment. The Petitioner testified that he has difficulty sitting and keeps his legs straightened at a forward angle because he starts to feel pressure and pain in the left knee if he sits for longer periods of time. Petitioner further testified that this knee injury has inhibited his ability to do activities with his children like sitting on the floor cross-legged. The Petitioner also testified that he can no longer snowboard or squat heavy weight as a result of this injury because he begins to feel a soreness in the top of the left knee when performing those activities.

CONCLUSIONS OF LAW

In Regard to Issue C: Did an accident occur that arose out of, and in the course of, Petitioner's employment by the Respondent? The Arbitrator finds as follows:

Incorporating the findings above, the Arbitrator finds that the Petitioner has proven by a preponderance of the evidence that on December 20, 2018, an accident occurred which arose out of, and in the course of, Petitioner's employment by the Respondent. The Petitioner testified to a defect in the concrete sidewalk that was filled with gravel. This defect was also near an incline in the sidewalk. While he was walking on the sidewalk between Towers in the Respondent's prison yard to transport a rifle, the Petitioner stutter stepped when he hit the gravel defect in the sidewalk, feeling a pop in his left knee with the immediate onset of pain and stiffness. As required by his job duties, Petitioner was primarily focused on the activities in the prison yard while he was transporting the rifle between towers. Petitioner's field of vision was also limited due to the large rifle case he was carrying. Petitioner's testimony was unrebutted. The Arbitrator observed the Petitioner and found him to be credible.

While the initial OSF occupational health medical record indicates that Petitioner's knee had been feeling funny for a few days, Petitioner testified that he had never sought treatment prior to the accident date for his left knee. The record supports the Petitioner's testimony. Moreover, when Petitioner's knee popped after the stutter step, it was followed by the immediate onset of pain and stiffness. There was a material change in Petitioner's left knee on December 20, 2018. Moreover, the Respondent's examiner, Dr. Bernie Bach, confirmed that Petitioner's current condition in his left knee was the consequence of the stutter step incident on December 20, 2018, not a prior accident or pre-existing condition.

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that on December 20, 2018, he sustained an accident to his left knee that arose out of and in the course of his employment for Respondent.

In Regard to Issue J: Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator finds as follows:

Incorporating the findings above, the Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary. The Petitioner is hereby awarded payments of the outstanding medical bills, totaling $2,100.00, and out of pocket expenses, totaling $60.00. (Px. 1). Respondent shall pay these amounts directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act, and subject to reductions under the medical fee schedule. The Respondent is entitled to a credit for payments made by the group health insurance carrier under Section 8(j).

In Regard to Issue L: What is the nature and extent of the injury? The Arbitrator finds as follows:

Relying on the opinions of Respondent's Section 12 examiner, Dr. Bernie Bach, the Arbitrator finds that the Petitioner has not yet reached MMI. Therefore, a finding on the nature and extent of the injury is premature.

In regard to Issue O: Prospective Medical: The Arbitrator finds as follows:

Incorporating the findings above, the Arbitrator awards six weeks of supervised physical therapy, as prescribed by Respondent's Section 12 examiner, Dr. Bernie Bach, in order to treat the work-related injury to Petitioner's left knee.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC012392
Case Name	FRENCH, TERRI v. STATE OF ILLINOIS - VIENNA CORRECTIONAL CENTER
Consolidated Cases	
Proceeding Type	Petition for Review Under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0106
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 3/21/2022

/s/Marc Parker, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terri French,

Petitioner,

vs. NO: 18 WC 12392

State of Illinois/Vienna Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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

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.

March 21, 2022

/s/ *Marc Parker*
Marc Parker

MP:yl
o 3/17/22
68

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC012392
Case Name	FRENCH, TERRI v. STATE OF IL/VIENNA CC
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	8
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 8/2/2021

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

/s/*William Gallagher, Arbitrator*
Signature

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

August 2, 2021

/s/ *Brendon O'Rourke*
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Terri French
Employee/Petitioner

Case # 18 WC 12392

v.

Consolidated cases: n/a

State of IL/Vienna C.C.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on June 8, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, March 1, 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 $74,856.00; the average weekly wage was $1,439.54.

On the date of accident, Petitioner was 50 years of age, single with 1 dependent child(ren).

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

Respondent shall be given a credit of $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. The parties stipulated TTD benefits had been paid in full through the date of trial.

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

ORDER

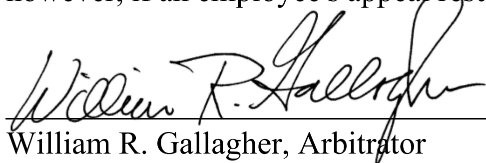
Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right elbow surgery recommended by Dr. George Paletta.

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.



AUGUST 2, 2021

William R. Gallagher, Arbitrator
ICArbDec19(b)

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on March 1, 2018. According to the Application, Petitioner was "Getting milk from cooler, slipped and fell on wet floor" and sustained an injury to her "Right shoulder, elbow, body as a whole" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. The prospective medical treatment sought by Petitioner was right elbow surgery, as recommended by Dr. George Paletta, an orthopedic surgeon. Petitioner and Respondent stipulated temporary total disability benefits had been paid in full (Arbitrator's Exhibit 1).

This case was previously tried in a 19(b) proceeding on June 7, 2018. At that time, Petitioner sought payment of medical bills and temporary total disability benefits as well as prospective medical treatment. The prospective medical treatment sought by Petitioner in the prior proceeding was right shoulder surgery, as recommended by Dr. Paletta. Respondent disputed liability on the basis of accident and causal relationship. The Arbitrator ruled in favor of Petitioner and awarded payment of medical bills and temporary total disability benefits as well as the prospective medical treatment sought by Petitioner. The Arbitrator's Decision was filed with the Commission on July 11, 2018. Respondent filed a Review of the Arbitrator's Decision to the Commission. In its Decision and Opinion on Review, the Commission affirmed the Arbitrator's Decision, but with a minor modification in the amount of temporary total disability benefits awarded (Petitioner's Exhibit 9).

Subsequent to the Arbitrator's Decision, Petitioner was treated by Dr. Paletta for her right shoulder condition. On August 28, 2018, Dr. Paletta performed arthroscopic surgery on Petitioner's right shoulder. The procedure consisted of a rotator cuff repair, subacromial decompression, bursectomy and acromioplasty (Petitioner's Exhibit 4).

Following surgery, Petitioner continued to be treated by Dr. Paletta who ordered physical therapy. Petitioner experienced some difficulties obtaining the physical therapy, but was able to find a therapist to treat her, at least for a while. When Dr. Paletta saw Petitioner on December 10, 2018, he noted Petitioner continued to complain of significant right elbow pain and some biceps pain, but Dr. Paletta noted he had been treating her for her shoulder condition and wanted her to recover from that injury before he did any further evaluation of the elbow (Petitioner's Exhibit 3).

When Dr. Paletta saw Petitioner on February 6, 2019, he noted Petitioner continued to have right shoulder symptoms. He attributed this to the fact Petitioner was unable to complete physical therapy because insurance did not want to pay for it. Dr. Paletta ordered additional physical therapy. Petitioner again informed Dr. Paletta she was continuing to have right elbow symptoms, but Dr. Paletta again indicated Petitioner needed to fully recover from the shoulder injury before he did any further evaluation of the elbow (Petitioner's Exhibit 3).

Dr. Paletta again saw Petitioner on April 1, 2019, and Petitioner continued to experience difficulty obtaining physical therapy. Petitioner continued to have both the right shoulder and right elbow

pain. Dr. Paletta again indicated he would defer any evaluation of Petitioner's right elbow until she recovered from her right shoulder injury.

Dr. Paletta subsequently saw Petitioner on May 20, 2019. Petitioner had been able to receive physical therapy in regard to her right shoulder and he noted improvement in that condition. Dr. Paletta examined Petitioner's right elbow and noted tenderness at the common extensor origin. He opined Petitioner had chronic lateral elbow pain likely consistent with lateral epicondylitis. He ordered an MRI scan of Petitioner's right elbow (Petitioner's Exhibit 3).

The MRI was performed on May 30, 2019. According to the radiologist, the MRI revealed mild proximal common extensor insertional tendinitis without tendon tear and trace fluid in the olecranon bursa (Petitioner's Exhibit 7).

Dr. Paletta reviewed the MRI on June 3, 2019. He opined it revealed evidence of mild chronic lateral epicondylitis which corresponded to Petitioner's clinical symptoms. He recommended Petitioner undergo an injection into the common extensor tendon followed by a course of physical therapy (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Helen Blake, a pain management specialist, on June 10, 2019. At that time, Dr. Blake diagnosed Petitioner with right lateral epicondylitis. She administered an injection to the common extensor tendon origin (Petitioner's Exhibit 8).

Dr. Paletta subsequently saw Petitioner on July 24, 2019. At that time, Petitioner advised the injection helped her dramatically for about two weeks, but its effect wore off and Petitioner's symptoms were essentially the same as they were prior. Dr. Paletta reaffirmed his diagnosis of chronic lateral epicondylitis of the right elbow. He discussed treatment options with Petitioner which included symptomatic treatment/observation, more injections or surgery. The surgery Dr. Paletta suggested was an open fasciotomy, debridement and partial lateral epicondylectomy. Petitioner made the decision to proceed with the surgery (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. James Emanuel, an orthopedic surgeon, on October 14, 2019. In connection with his examination of Petitioner, Dr. Emanuel reviewed medical records and the MRI which were provided to him by Respondent. Dr. Emanuel's examination of Petitioner's right elbow was benign and he described a full range of motion and good strength. He opined Petitioner's pain response to palpation was out of proportion to his findings. Dr. Emanuel also reviewed the MRI and opined it was within normal limits (Respondent's Exhibit 2).

Dr. Emanuel opined Petitioner's right elbow symptoms had resolved by April 18, 2018, and there was no evidence of right elbow complaints until sometime thereafter. He opined Petitioner had sustained a contusion to her right elbow and the MRI findings did not support a diagnosis of lateral epicondylitis. He also opined elbow surgery was not indicated, Petitioner was at MMI and could work without restrictions (Respondent's Exhibit 2).

Dr. Paletta was deposed on July 15, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Paletta's testimony was consistent with his medical records and

he reaffirmed the opinions contained therein. Dr. Paletta testified he performed surgery on Petitioner's right shoulder and continued to treat her afterward. When he saw Petitioner on April 1, 2019, he noted Petitioner was making good progress with her shoulder, but had complaints of ongoing elbow pain. He testified that when he initially saw Petitioner, she informed him she had some elbow pain, but it had resolved, but on April 1, 2019, Petitioner experienced recurrent right elbow pain. Dr. Paletta said he ordered an MRI scan which he personally reviewed and he opined it was consistent with his diagnosis of right lateral epicondylitis (Petitioner's Exhibit 10; pp 7-9).

In regard to the injection performed by Dr. Blake on June 10, 2019, Dr. Paletta testified that when he saw Petitioner afterward, the effects of the injection had worn off and Petitioner was back to the same level of elbow symptoms she had prior to the injection. He said the fact Petitioner had a recurrence of her symptoms confirmed that lateral epicondylitis was the source of her pain. He reaffirmed his opinion Petitioner's elbow condition was work-related and that Petitioner should undergo elbow surgery (Petitioner’s Exhibit 10; pp 10-13).

On cross-examination, Dr. Paletta was questioned about the treatment Petitioner received immediately after the accident. Respondent's counsel reference to record of Convenient Care Clinic of March 1, 2018, which noted Petitioner had tenderness of the medial epicondyle, but no tenderness of the lateral epicondyle. Dr. Paletta agreed that if Petitioner did not have immediate pain or evidence of trauma at the lateral at the epicondyle, this could cause him to alter his opinion (Petitioner's Exhibit 10; pp 23-24).

On redirect examination, Dr. Paletta testified Petitioner had chronic lateral epicondylitis. Further, he had no other explanation as to Petitioner having this condition other than the work accident (Petitioner's Exhibit 10; pp 31-32).

Respondent tendered into evidence the record of Convenient Care Clinic of March 1, 2018. It did indicate Petitioner had tenderness of the medial epicondyle, but no tenderness of the lateral epicondyle (Respondent's Exhibit 4).

Dr. Emanuel was deposed on November 2, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Emanuel's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Emanuel testified Petitioner's elbow symptoms were not consistent with epicondylitis. He based this on his findings on examination and the mechanism of injury. Dr. Emanuel stated Petitioner's pain symptoms were consistent with olecranon bursitis. He also said surgery was not appropriate (Respondent's Exhibit 3; pp 17-19).

On cross-examination, Dr. Emanuel stated Petitioner had sustained a contusion to her elbow as a result of the accident and probably has olecranon bursitis. While he restated his opinion surgery was not indicated, Dr. Emanuel testified he would recommend stretching exercises, massage and the use of a brace, but not injections and surgery (Respondent's Exhibit 3; pp 27- 28).
At trial, Petitioner testified she continues to experience right elbow symptoms. She wants to proceed with the surgery recommended by Dr. Paletta.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's condition of ill-being in regard to her right elbow is related to the accident of March 1, 2018.

In support of this conclusion the Arbitrator notes the following:

There was no evidence Petitioner had any right elbow symptoms/conditions prior to the accident of March 1, 2018.

Petitioner had elbow complaints at the time of the accident which resolved, but only temporarily.

When Petitioner informed Dr. Paletta she had recurrent elbow complaints, he focused on the treatment for Petitioner's right shoulder which, as noted herein, required surgery and an extensive amount of physical therapy.

Dr. Paletta's findings on examination and the MRI supported his diagnosis of right lateral epicondylitis.

Even though Dr. Paletta agreed on cross-examination that the lack of lateral epicondyle complaints at the time of treatment provided shortly after the accident could cause him to alter his opinion, he also testified there was no explanation for Petitioner's right elbow complaints other than the accident.

Respondent's Section 12 examiner, Dr. Emanuel, disagreed with Dr. Paletta's diagnosis of lateral epicondylitis; however, he concluded Petitioner had olecranon bursitis which was related to the accident.

Based on the preceding, the Arbitrator finds the opinion of Dr. Paletta be more persuasive than that of Dr. Emanuel in regard to causality.

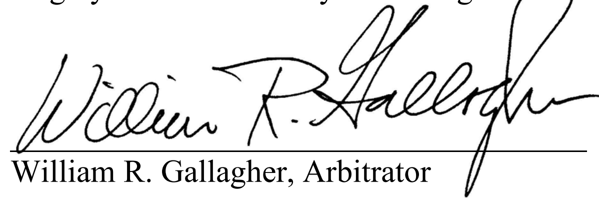
In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes the medical services provided to Petitioner were reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the right elbow surgery recommended by Dr. George Paletta.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC014627
Case Name	WIN, ZAW v. KEURIG/DR. PEPPER
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0107
Number of Pages of Decision	9
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Scott Shapiro
Respondent Attorney	Matthew Novak

DATE FILED: 3/21/2022

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Zaw Win,

Petitioner,

vs. NO: 20 WC 14627

Keurig/Dr. Pepper,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent 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 October 5, 2021, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

March 21, 2022

/s/ *Marc Parker*
Marc Parker

MP:yl
o 3/17/22
68

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC014627
Case Name	WIN, ZAW v. KEURIG/DR. PEPPER
Consolidated Cases	No Consolidated Cases
Proceeding Type	Request for Hearing-**Nature and Extent Only**
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	Scott Shapiro
Respondent Attorney	Joseph Garofalo

DATE FILED: 10/5/2021

/s/*Molly Mason, Arbitrator*

Signature

INTEREST RATE FOR THE WEEK OF OCTOBER 5, 2021 0.05%

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

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)

X None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION – NATURE AND EXTENT

ZAW WIN
Employee/Petitioner

Case # **20** WC **014627**

v.

Consolidated cases: **D/N/A**

KEURIG DR. PEPPER
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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/20/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/8/2018**, 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 $**38,697.36**; the average weekly wage was $**744.18**.

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

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

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

Respondent shall be given a credit of $**0.00** 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 stipulated credit under Section 8(j) of the Act. Arb Exh 1.

ORDER

Respondent shall pay the medical bill of Northlake Fire Department (PX 2), subject to any credit it is due under Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $446.41/week for 30 weeks, because the injuries sustained caused the disfigurement of the forehead, as provided in Section 8(c) of the Act.

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

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

Signature of Arbitrator

October 5, 2021

Zaw Win v. Keurig/Dr. Pepper
20 WC 14627

Summary of Disputed Issues

The parties agree that Petitioner, a quality control technician, sustained a work accident on March 8, 2018. Petitioner testified he struck the left side of his forehead on the sharp edge of a conveyor on that date. Paramedics took him to the Emergency Room at Gottlieb Memorial Hospital, where he was diagnosed with a 4.75 centimeter vertical laceration. A nurse practitioner placed ten sutures in the laceration. PX 1, p. 15. A head CT scan showed no acute intracranial abnormality. Petitioner was discharged with directions to return to work the next day with "minimal bending over." PX 1, p. 43. Petitioner lost no time from work.

The sole disputed issue is nature and extent, with Petitioner seeking disfigurement benefits under Section 8(c) of the Act.

Arbitrator's Findings of Fact

Petitioner testified he worked as a quality technician for Respondent as of March 8, 2018. He inspected cans, checking their weight and sealing.

Petitioner testified he was injured at approximately 7:00 or 8:00 PM on March 8, 2018. He went under a conveyor belt to retrieve some cans. As he came back up, he struck the left side of his forehead against the sharp edge of another conveyor. He began to bleed. His supervisor and other individuals arrived at the scene. Someone called 911. Paramedics came to the scene and transported Petitioner to the Emergency Room at Gottlieb Memorial Hospital. Petitioner recalled receiving fifteen sutures and Tylenol at the Emergency Room.

The Emergency Room records set forth a consistent history of the accident. Petitioner denied losing consciousness but indicated he had a mild headache. PX 1, pp. 8-9. A nurse practitioner described the left forehead laceration as "straight" and 4.75 centimeters long. She ordered a head CT scan, which showed no acute intracranial abnormality. PX 1, pp. 17-18. The nurse practitioner placed ten sutures in the laceration. PX 1, p. 15. She released Petitioner to work with "minimal bending over." PX 1, pp. 31, 43.

Petitioner testified he returned to work the following day at his supervisor's direction. He was in pain but he went to work. He is not claiming any lost time. Arb Exh 1.

In addition to the hospital records, Petitioner offered into evidence an ambulance bill, which reflects a $0 balance (PX 2), and two photographs of his face. Petitioner testified he took these photographs the Friday before the hearing.

The Arbitrator conducted a viewing of the scar. It is approximately 2 inches long, narrow, straight, very slightly indented and white. It extends upward from the left side of Petitioner's forehead up into the hairline.

Under cross-examination, Petitioner testified he only underwent treatment at Gottlieb Memorial Hospital's Emergency Room. If the hospital records reflect he received ten rather than fifteen sutures, that might be correct. He cannot say whether the recorded measurement of 4.75 centimeters is correct because he did not measure the scar.

No other witnesses testified at the hearing.

Arbitrator's Conclusions of Law

What is the nature and extent of the injury?

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in determining the nature and extent of Petitioner's injury. That section sets forth five factors to be considered in assessing permanency. The Arbitrator assigns no weight to the first enumerated factor, i.e., any AMA Guides impairment rating, noting that Petitioner is alleging disfigurement rather than disability and that neither party offered a rating into evidence. The Arbitrator assigns weight to the second and third factors, Petitioner's age at the time of the hearing and occupation. Petitioner was a 63-year-old quality control technician as of the March 8, 2018 accident. The Arbitrator views him as an older individual who will have to live with his forehead scarring for less time than a young individual. The Arbitrator assigns no weight to the fourth factor, future earning capacity, since Petitioner resumed his regular job and claims no diminution of earnings. The Arbitrator gives no consideration to the fifth factor, evidence of disability corroborated by the treatment records, since Petitioner is seeking benefits for disfigurement rather than disability.

The Arbitrator, having considered the foregoing, along with the scar viewing and the location of the scar, finds that Petitioner is entitled to 30 weeks of disfigurement under Section 8(c) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC008310
Case Name	PALACIOS, WILLIAM v. EMPIRE TODAY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0108
Number of Pages of Decision	25
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Richard Lenkov

DATE FILED: 3/21/2022

/s/Carolyn Doherty, 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

WILLIAM PALACIOS,

Petitioner,

vs. NO: 20 WC 8310

EMPIRE TODAY,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2021, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,900.00. 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.

March 21, 2022

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

d: 3/17/2022
CMD/ma
045

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC008310
Case Name	PALACIOS, WILLIAM v. EMPIRE TODAY
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	22
Decision Issued By	William McLaughlin, Arbitrator

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Richard Lenkov

DATE FILED: 9/7/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 31, 2021 0.05%

/s/*William McLaughlin, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

William Palacios
Employee/Petitioner

v.

Empire Today
Employer/Respondent

Case # **20** WC **8310**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **William McLaughlin**, Arbitrator of the Commission, in the city of **Chicago**, on **June 29, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

E. x☐ Was timely notice of the accident given to Respondent?

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **3/6/2020**, 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 $**37,376.04**; the average weekly wage was $**718.77**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of $**813.34** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **813.34** .

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to Concentra - Occupational Health Centers of Illinois , to Suburban Orthopedics , and to Persistent Rx , as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $479.18/week for 65 4/7 weeks, commencing 3/27/20 through date of hearing, 6/29/2021, as provided in Section 8(b) of the Act.

The Arbitrator awards prospective medical in the form of right shoulder arthroscopic surgery as recommended by Dr. Chhadia and a medial branch block as recommended by Dr. Novoseletsky.

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

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

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

Signature of Arbitrator

SEPTEMBER 7, 2021

20 WC 8310

STATEMENT OF FACTS

On March 6, 2020, Mr. William Palacios, Petitioner, was employed by Empire Today, Respondent, as a Warehouse Associate. (T. 9-10). Petitioner had been employed as such for a little over a year. As a Warehouse Associate, he was responsible for receiving at the dock door, picking orders, and providing inventory to go with the order. (T. 10-11). Petitioner testified that he worked from approximately 5:00 am to 1-2:00 pm Monday through Friday and then 5:00 am to 10-11:00 am on Saturdays. (T. 11).

Petitioner testified that on March 6, 2020, he was assigned to work in “the cage,” which is a specific place in the warehouse and was “a relatively new place for him to be assigned.” (T. 15). He testified that he had been working in this capacity for approximately six days. (T. 15-16). His job duties in the cage were to receive a “request form and then look for the parts that were on the request form.” He would then hand them to the contractor. (T. 16). He testified that the parts in the cage were different parts than what he previously worked with. (T. 16-17).

Petitioner testified that on Friday, March 6, 2020, he was working with “material he had never handled before.” He testified that the box he was handling weighed approximately twenty to thirty-five pounds. There were three pallets with approximately sixty boxes per pallet for a total of 180 boxes. (T. 17-18).

Petitioner testified that to move these boxes he would have to pick them up and throw them over his right shoulder and hand the box to the contractor over the half-sized door that separated them. (T. 18-19). He testified that the contractors would pull the box off his shoulder after he spun around. He advised that he had to do this with all three pallets. (T. 19). Petitioner testified that as he was doing this he was “getting pretty beat up,” which he thought was just a part of work. He was able to continue working and completed his shift on that day. (T. 20). Petitioner testified that following his shift on Friday, March 6, 2020, he did not think he needed medical attention. (T. 22).

Petitioner testified that following his shift at work he went home, showered, ate dinner, and watched TV. (T. 24-25). He testified that he had some back pain, shoulder pain and "just everything on the right side." (T. 26). Petitioner testified that he did work the next day on Saturday, March 7, 2020, and was stationed in the cage. He testified that he was having back spasms and "couldn't sit down for long." (T. 27). He told Dave K., the warehouse manager, and Tyrone Baity, his immediate supervisor, that he was having pain. (T. 27, 30). He did not request medical care at that time because he "figured I just need[ed] to rest and it [would] be fine by Monday." (T. 27-28). He was able to complete his shift on Saturday. He was off Sunday, March 8, 2020. Petitioner testified that after completing his shift on Saturday, he did not do anything the rest of the day and through Sunday. He was trying to take it easy and relax due to the back spasms. (T. 28). He testified that he was experiencing pain in the middle of his back and higher by his right shoulder. His neck was tight. (T. 29).

Petitioner testified that he attempted to come into work on Monday, March 9, 2020 but was still having pain. He was not able to complete his shift on Monday and did request medical treatment at that time. (T. 29). He advised that he spoke to Tyrone Baity and David K. Petitioner testified that he completed an accident report. (T. 30). The accident report indicates that the accident occurred when "Bill (sic) lifting and pulling boxes over right shoulder/not normal job duty – first time doing it." (Rx. 1). The date of accident indicated "6/6/20" but was signed and dated March 9, 2020. Petitioner testified that 6/6/20 was a mistake and it should have been March 6, 2020. (T. 31).

Petitioner testified that he was aware he needed to report accidents to his supervisor but that he did not know that it had to be the "very same day it happened." (T. 57). He confirmed, however, that he did tell his supervisor the next day. (T.59).

Petitioner testified that following completion of the accident report he was sent by the company to Concentra, which he saw that same day, March 9, 2020. (T. 32). At Concentra, a history of accident of "picking up boxes in new department and had to flip them up on his shoulder three days ago" with pain to

mid back. (Px. 2, pg 6). It further advised that "Pt reports that on 3/6/2020 he was repetitively lifting boxes over his shoulder at work and then the next day when he woke up, he was experiencing pain in his mid-back." (Px. 2, pg 6). He was diagnosed with thoracic myofascial strain and prescribed cyclobenzaprine, ibuprofen, a hot and cold compress and was referred to physical therapy. He was also given work restrictions. (Px. 2, pg 8-9).

Petitioner began physical therapy with Concentra on that same day and continued treatment through March 25, 2020. (Px. 2). Physical therapy took an initial history of "lifting boxes at work that were awkward to handle … states he was throwing the boxes over his shoulder to deliver them." (Px. 2, pg 11). He testified that throughout his treatment with Concentra, Respondent was accommodating his restrictions and he was working light duty. (T. 33-34). On March 25, 2020, Respondent stopped accommodating his restrictions because they laid him off. (T. 34-35). Petitioner testified that this layoff became permanent, and he no longer works for Respondent. (T. 35). Petitioner testified that following the layoff he received workers' compensation benefits for approximately two weeks through April 8, 2020. (T. 36; Rx. 7).

Petitioner testified that on April 14, 2020, he sought treatment with Dr. Thomas McNally at Suburban Orthopedics. Petitioner testified that his symptoms continued in the same place as before, the middle of his back, his neck and right shoulder. (T. 36-37). Dr. McNally noted a history of injury from working in a new department and that Petitioner was forced to lift boxes repetitively by placing the box on his right shoulder and passing it overhead. (Px. 3, pg 11). He repeated this activity one hundred times that day and advised Dr. McNally that "the following day he began to experience gradual onset of pain to the shoulder, neck and mid back." (Px. 3, pg 11). Dr. McNally noted on physical exam decreased range of motion of the right shoulder and tenderness. He diagnosed Petitioner with a strain of the neck, a strain of the lower back, a strain of the wall of thorax, a strain of the shoulder, as well as neck pain and degenerative disc disease at the thoracic and cervical levels. He prescribed meloxicam and

recommended that Petitioner stop physical therapy until after MRIs were completed. He recommended MRIs of the cervical spine and right shoulder. (Px. 3, pg 16). Dr. McNally took Petitioner off work at that time. (Px. 3, pg 18).

Petitioner underwent the MRI of the cervical spine on April 15, 2020. The MRI demonstrated "cervical spondylosis notable for disc osteophyte complex at C3/4 with 3 mm central disc protrusion component indenting the ventral thecal sac effacing the ventral CSF space and contacting the central cervical cord itself, which is mildly effaced, moderate bilateral foraminal stenosis at C6/7 and moderate disc desiccation from C4/5 through C7/T1." (Px. 3, pg 54-55).

Petitioner underwent the MRI of his right shoulder on April 17, 2020. The MRI demonstrated "low grade partial tearing of the infraspinatus tendon, superimposed upon moderate tendinopathy. Moderate grade interstitial partial tearing of subscapularis tendon. No full thickness rotator cuff tear or muscle atrophy, severe acromioclavicular degenerative changes, with anterior downsloping acromion, narrowing the subacromial outlet, suspected focal nondisplaced SLAP tear … mild glenohumeral degenerative changes." (Px. 3, pg 61-62).

Following the MRIs, Petitioner returned to Dr. McNally in follow up. Dr. McNally noted ongoing complaints without much change. (Px. 3, pg 65). He noted the findings on the MRIs and maintained the same diagnoses. He recommended an MRI of the thoracic spine and referred him to Dr. Dmitry Novoseletsky for interventional pain management and to Dr. Ankur Chhadia for evaluation and treatment of his right shoulder. He was kept off work. (Px. 3, pg 68).

Petitioner underwent the MRI of his thoracic spine on May 2, 2020. The MRI demonstrated "moderate disc desiccation from T4, T5 through T10 and T11. Thoracic spondylosis is notable for a 2 mm annular disc bulge at T5/6 effacing the ventral thecal sac and bilateral lateral recesses." (Px. 3, pg 81).

Petitioner saw Dr. Dmitry Novoseletsky at Suburban Orthopedics on May 4, 2020. Dr. Novoseletsky documented a similar history of injury. He noted symptoms of mid back pain on the right

side as well as stiffness in his neck with an increase in headaches. (Px. 3, pg 84.) Petitioner described his pain as six to seven out of ten. (Px. 3, pg 84.). Dr. Novoseletsky reviewed the MRIs of the thoracic and cervical spine and diagnosed him with thoracic facet joint syndrome and thoracic internal disc disruption (IDD). He recommended continued use of meloxicam and Tylenol. He recommended a right thoracic medial branch block . He felt Petitioner's pain could be from IDD or facets. If the medial branch block did not provide relief, he would recommend an epidural steroid injection just below T12 level. He took Petitioner off work. (Px. 3, pg 87). Petitioner testified that he has not undergone the recommended medial branch block. (T. 40).

Petitioner saw Dr. Ankur Chhadia at Suburban Orthopedics on May 8, 2020. Dr. Chhadia noted a similar history of injury. He documented Petitioner's symptoms as achiness in the right shoulder and pain that would increase with activity and certain range of motion. (Px. 3, pg 96). On examination, Petitioner had positive impingement tests. (Px. 3, pg 97). Dr. Chhadia reviewed the MRI of the right shoulder. He diagnosed Petitioner with a partial thickness rotator cuff tear, AC joint degenerative joint aggravation and biceps tendonitis. He recommended medication and an injection into the right subacromial space. This injection was performed that day by Dr. Chhadia. Dr. Chhadia kept Petitioner off work as well. (Px. 3, pg 99). Petitioner testified that the injection provided only temporary relief. (T. 42).

Petitioner followed up with Dr. Chhadia on June 5, 2020. Dr. Chhadia documented that the cortisone injection did not give him much relief and he kept Petitioner off work. (Px. 3, pg 107, 110). Petitioner followed up with Dr. Novoseletsky on June 15, 2020. Dr. Novoseletsky noted ongoing pain with the same symptoms. Petitioner had pain ranging from a six to an eight out of ten. (Px. 3, pg 112). Dr. Novoseletsky continued to recommend the medial branch block and kept Petitioner off work. (Px. 3, pg 115).

Petitioner has continued to follow up with Dr. Novoseletsky since that time with his last visit being February 10, 2021. (Px. 3, pg 207) Dr. Novoseletsky continued to recommend the medial branch block

procedure and kept Petitioner off of work. (Px. 3, pg 129, 154, 177, 190). Petitioner has testified that he has not been able to have the procedure and does wish to have to have the procedure. (T. 51)

Petitioner continued to follow up with Dr. Chhadia seeing him on July 7, 2020. At that time, Dr. Chhadia noted that Petitioner's shoulder symptoms were getting worse and he recommended a second steroid injection, which he performed at that visit. (Px. 3, 120, 123). Petitioner testified that this injection also only provided temporary relief. (T. 43).

Petitioner saw Dr. Chhadia on August 18, 2020. Dr. Chhadia noted continued symptoms and recommended surgery in the form of "arthroscopic rotator cuff debridement vs repair, subacromial decompression, distal clavicle excision, biceps tenodesis, possible open." (Px. 3, pg 145). He continued Petitioner off work. Petitioner has continued to follow up with Dr. Chhadia through June 1, 2021. Dr. Chhadia continued to recommend surgery and keep Petitioner off work. (Px. 3). Petitioner testified that he has not had the surgery as recommended by Dr. Chhadia and does wish to undergo the surgery recommended. (T. 51)

Petitioner testified that currently he continues to have symptoms and pain. He has pain in his back from "the middle of my back all the way up to my neck, constant headaches, … and then my shoulder." (T. 49). He testified that his pain in his right shoulder is eight to ten out of ten and in his neck it is a ten out of ten. He testified that he has to move slowly when performing everyday activities. He has spasming and it will lock up if he sits too long. He testified that he does take Tylenol and anti-inflammatory medication as prescribed by Dr. Novoseletsky. (T. 51). Petitioner testified that he had not any injury to his right shoulder or midback/neck prior to the incident on March 6, 2020 and has not had any injury to his right shoulder or midback/neck since the incident on March 6, 2020. (T. 52).

Petitioner testified that following his move to the cage he did have a meeting with Samantha [Morris} in HR, regarding the move to the cage. He could not remember the exact date the meeting took place but acknowledged the meeting was at his request. (T. 23). He testified that if Samantha Morris

testified that it occurred on March 6, he could not dispute that but did not remember the exact date of the meeting. (T. 62). He felt he was being harassed by his supervisor and was concerned with that as he did not know why he was being moved. (T. 23). He acknowledged that he did not like working in the cage (T. 61). Petitioner testified he did not discuss that he had injured himself outside of work or on a project on his own house. (T. 63-64). He advised that the meeting lasted approximately 20 minutes. Petitioner testified that on March 6, 2020, he did not think he had suffered an injury severe enough to report nor did he think he needed medical treatment. (T. 67). He expected to feel better after resting at home. (T. 68). He testified that he reported the injury as soon as he believed he would need medical care on Monday March 9, 2020 to David K. and Tyrone Baity. (T. 68).

Dr. Ankur Chhadia testified via evidence deposition on December 29, 2020. (Px. 5). Dr. Chhadia is a practicing board certified orthopedic surgeon with a focus on knee and shoulder. (Px. 5, pg 6). Dr. Chhadia testified that he treated Petitioner for right shoulder pain. (Px. 5, pg 7). Petitioner was referred to him by Dr. McNally. (Px. 5, pg 7). Dr. Chhadia testified that his understanding of how Petitioner was injured was that he was "working in a different department … lifting boxes that weighed between 30-60 pounds … repetitively passing the boxes overhead. (Px. 5, pg 8). Dr. Chhadia testified that he had the opportunity to review the records from Occupational Health Centers (Concentra) related to Petitioner's treatment prior to coming to see him. (Px. 5, pg 9-10).

Dr. Chhadia testified that to his knowledge Petitioner had not had right shoulder problems prior to the event on March 6, 2020. (Px. 5, pg 10). He had numerous pertinent findings on exam at his first visit with Petitioner including limited active and passive range of motion, tenderness to palpation at the acromioclavicular joint, positive impingement testing, and biceps and labrum positive testing. (Px. 5, pg 11-12). Dr. Chhadia testified that his diagnosis was "right rotator cuff tear, partial thickness, acromioclavicular joint, degenerative disease, aggravation and biceps tendinitis. " (Px. 5, pg 13). He testified that the injections provided were both diagnostic and therapeutic in nature. (Px. 5, pg 14). Dr.

Chhadia testified that he recommended surgery on August 18, 2020. He was recommending the surgery because Petitioner had been having five months of symptoms with persisting moderate to severe symptoms even though he had been treated conservatively with time, rest, medicine, physical therapy and several injections. (Px. 5, pg. 17). Dr. Chhadia testified that the severe acromioclavicular degenerative changes as well as the mild glenohumeral degenerative changes contributed to Petitioner's condition and the need for surgery. (Px. 5, pg 20-21). He testified that these degenerative conditions could be aggravated by activities such as the ones performed by Petitioner. (Px. 5, pg 22).

Dr. Chhadia testified that in his opinion, to a reasonable degree of medical and surgical certainty, Petitioner's right shoulder condition is causally related to the work activities on March 6, 2020 as described to him. (Px. 5, pg 19). He testified that the basis for his opinion is the history provided to him of the activities, the time course of the events and the clinical course of events, his physical examination and diagnostic studies. (Px. 5, pg 19). He felt that the need for surgery was related to those activities and his current shoulder condition. (Px. 5, pg 20). Dr. Chhadia testified that he kept Petitioner off work through this treatment of him because he has significant shoulder, neck and back conditions and very limited to no use of his right shoulder at this point. (Px. 5, pg 14,15,16, 21).

Dr. Dmitry Novoseletsky testified via evidence deposition on December 30, 2020. Dr. Novoseletsky is a practicing physician, who is board certified in physical medicine, rehabilitation and pain medicine. (Px. 6, pg 7). Dr. Novoseletsky testified that he is currently treating Petitioner. Petitioner was referred to him by Dr. McNally. (Px. 6, pg 8). Dr. Novoseletsky testified that Petitioner came to see him because he was experiencing pain in the neck and back area with a focus on the mid back. Dr. Novoseletsky testified that his understanding was that this pain developed when Petitioner was lifting boxes repetitively throughout the day. (Px. 6, pg 10). Dr. Novoseletsky testified that at Petitioner's first visit he conducted an examination with findings of focal pain and tenderness in the thoracic area predominately at T8/9. He also examined and reviewed both the MRI of his thoracic spine and the MRI of

his cervical spine. (Px. 6, pg 12-14). Dr. Novoseletsky diagnosed Petitioner with thoracic facet and joint syndrome and thoracic IDD, which stands for internal disc disruption. (Px. 6, pg 14). He recommended a diagnostic right sided thoracic medial branch block. The purpose of this procedure is to "pinpoint tension rate and narrow down the area of concern." (Px. 6, pg 14). Dr. Novoseletsky testified that this procedure has not been performed to his knowledge and throughout the time he has seen Petitioner, his symptoms have not changed. Dr. Novoseletsky testified that he continues to recommend the procedure. (Px. 6, pg 14-15). He explained that this a diagnostic procedure and future treatment depends on the outcome of the procedure. (Px 6, pg 20)

Dr. Novoseletsky testified that in his opinion to a reasonable degree of medical and surgical certainty that Petitioner's currently condition as it relates to his spine is related to the activities as described to him as occurring on March 6, 2020. (Px. 6, pg 15). He testified that the basis for that opinion is that Petitioner did not have complaints similar to this in the past and that the repetitive injury with the movement as discussed very likely caused this type of injury. (Px. 6, pg 15-16). Dr. Novoseletsky testified that he reviewed the IME report of Dr. Kern Singh and disagreed with the findings and conclusions of Dr. Singh. He did not feel that Petitioner only suffered a strain/sprain. He felt that Dr. Singh did not take into consideration the MRI findings and that a sprain/strain is a "short acting" type of injury. It would have resolved but Petitioner's condition did not and, therefore, he feels Petitioner's condition is more likely the perpetual injury and disc injuries as he opined. (Px. 6, pg 18-19). Dr. Novoseletsky felt that the disc injuries were causally related to Petitioner's work activities on March 6, 2020. (Px. 6, pg 22). He testified that he has kept Petitioner off of work through his treatment (Px. 6, pg 20).

Petitioner underwent two Section 12 examinations at the request of Respondent. The first was with Dr. Kern Singh on June 15, 2020. The exam was initially scheduled for May 18, 2020, but Petitioner testified he was unable to attend due to his house taking in water. (T. 42). Petitioner attended the rescheduled appointment. Dr. Singh testified via evidence deposition. (Rx. 15). He also authored a

report (Rx. 4). Dr. Singh testified that Petitioner developed back and mid back pain after lifting boxes weighing approximately thirty pounds from ground to above shoulder. He reviewed medical records from Occupational Health Centers but no treatment records after March 25, 2020 were provided to him prior to his deposition. (Rx. 15, pg 9, 19). Dr. Singh did not review any imaging related to Petitioner. (Rx. 15, pg 20). Dr. Singh testified that Petitioner had ongoing pain in his neck, mid back and low back at the time of his examination. (Rx. 15, pg 10). Dr. Singh testified that on physical examination he found full range of motion and full strength with negative Waddell findings. (Rx. 15, pg 13). He testified that negative Waddell findings indicated to him that there was no symptom magnification on his exam. (Rx. 15, pg 14).

Dr. Singh testified that he diagnosed Petitioner with cervical and lumbar strain. He opined that the cervical strain was related to the original injury based on the fact that the symptoms began around the time of injury. (Rx. 15, pg 15). Dr. Singh did not testify to the causal relationship of the lumbar strain he diagnosed but did address that in his report. His report indicated that the lumbar strain he diagnosed was related to the accident. (Rx. 4, Rx 15). Dr. Singh testified that at the time of his examination he felt Petitioner could work full duty without restrictions and that Petitioner did not need any further treatment. (Rx. 15, pg 16). Dr. Singh did not have a job description from the employer. (Rx. 15, pg 22). He testified that the sprain of both the lumbar spine and cervical spine would have resolved in "approximately four to six weeks." (Rx. 15, pg 22). Dr. Singh also testified that he calculated an impairment rating based on the AMA guides. He found an impairment rating of 0%. (Rx. 15, pg 18).

Petitioner's second Section 12 examination was with Dr. Craig Phillips on February 19, 2021. Dr. Phillips did not testify in this matter. Dr. Craig Phillips is a hand and upper-extremity surgeon for the Illinois Bone & Joint Institute. (R. Ex. 6 at 14). Dr. Phillips is the fellowship director of hand & upper-extremity surgery at the NorthShore University Medical Center. *Id.* Dr. Phillips is also a clinical assistant professor of surgery in the orthopaedic section of the University of Chicago's department of surgery. *Id.*

On 2/19/21, Dr. Phillips performed an independent medical evaluation of Petitioner. *Id.* at Dr. Phillips' physical examination was limited due to Petitioner's self-imposed guarding and Petitioner's statements of being "scared." *Id.* Petitioner exhibited symptom magnification. *Id.* at 13. Dr. Phillips diagnosed diffuse myofascial pain of the right shoulder. *Id.* at 12. Dr. Phillips further opined that Petitioner's current right shoulder condition is not causally connected to the alleged 3/6/20 incident. *Id.* Dr. Phillips recommended no further treatment for Petitioner's right shoulder pain, found that Petitioner had reached maximum medical improvement and was able to return to full duty work. *Id.* at 13-14.

Dr. Phillips opined that Petitioner has a 1% upper extremity impairment rating using AMA guidelines. *Id* at 14. Dr. Phillips documents a history of Petitioner lifting boxes for the first time and would lift them from a pallet and then put them on his right shoulder. Petitioner indicated to Dr. Phillips that he had pain in his mid thoracic spine and mild pain in the right shoulder that started gradually. (Rx. 6, pg 2). Dr. Phillips noted ongoing symptoms of pain over the anterior shoulder that is zero out of ten at rest but with any motion will increase to four to six out of ten and that it will wake him up at night. He also documented Petitioner had complaints of pressure and weakness in his right shoulder. (Rx. 6, pg 3). Dr. Phillips reviewed medical records from Concentra, Suburban Orthopedics, and the Section 12 exam report from Dr. Singh. (Rx. 6). Dr. Phillips conducted a physical examination. He also reviewed the MRI of the right shoulder, which he felt showed "moderate [to] severe AC joint arthrosis, degenerative labrum superiorly and diffuse supraspinatus and infraspinatus tendinopathy." Dr. Phillips felt that while his MRI did show chronic degenerative changes Petitioner's "physical examination is significant for nonstructural pain in his shoulder with obvious symptom magnification." (Rx. 6, pg 12). He indicated he could not determine whether Petitioner was malingering but he did have evidence of symptom magnification. (Rx. 6, pg 12). He felt that there was no causal connection between Petitioner's current right shoulder condition and the alleged accident because his current findings are not structural. (Rx. 6, pg 13). He felt that the right shoulder treatment Petitioner had received was reasonable and necessary because he does

have pain in his shoulder and while Dr. Phillips did not believe he sustained any injury or developed any infrastructure changes, Dr. Chhadia was attempting to treat the shoulder with injections and that was reasonable in an attempt to minimize Petitioner's symptoms. (Rx. 6, pg 13). Dr. Phillips felt Petitioner did not need any further treatment but required reassurance "that he can move his shoulder and he needs behavior modification, possibly a psychological evaluation." (Rx. 6, pg 13). Dr. Phillips felt that Petitioner could return to work full duty. (Rx. 6, pg 13). Dr. Phillips rendered an AMA impairment rating of 1% upper extremity impairment, which correlates to a 1% whole body impairment. (Rx. 6, pg 14).

Respondent called two witnesses who testified via evidence deposition and were not present at hearing: Samantha Morris and Tyrone Baity.

On 3/6/20, Samantha Morris was Respondent's employee relations manager. (R. Ex. 14 at 5). Ms. Morris is responsible for employee matters, including corrective actions and investigations. *Id.* Ms. Morris also aids in workers' compensation investigations. *Id.* Ms. Morris can be pulled into investigating workers' compensation claims in instances where the accident is reported to human resources, or require investigation. *Id.* at 14.

On 3/5/20, Petitioner left a post-it note on Ms. Morris's desk requesting a meeting. (R. Ex. 14 at 18). The meeting took place on 3/6/20 and involved a conversation about Petitioner's unhappiness with his reassignment to the cage. *Id.* at 15.

Ms. Morris first became aware of Petitioner's alleged workplace injury after receiving the accident report on 3/9/20. *Id.* at 21, 25.

She testified that she is aware of workers' compensation injuries but the "workers' compensation umbrella does not fall underneath me." (Rx. 14, pg 5-6). She elaborated that Anthony LaManna is the person that would deal with a workers' compensation claim. (Rx. 14, pg 6). Mr. LaManna did not testify in this matter. Ms. Morris testified that if Petitioner suffered an injury "there could have been several individuals he could have reported it to" naming Tyrone Baity or Joe Sutten, as two of such people. (Rx14, Pg 6).

Ms. Morris testified that employee discipline is something she is responsible for and she was involved in two corrective actions for Petitioner. She advised that the first one was dated April 25, 2019 and regarding attendance. He was given a "first written warning." (Rx. 14, pg 7-9, Res. Dep Ex 1). She also testified there was a second corrective action dated July 5, 2019 that involved accepting and returning

materials back to from the installers. He had put a product back incorrectly into the system. (Rx. 14, pg 10-11, dep ex. 2). Neither of these infractions led to his termination or any further action. (Rx. 14, pg 11).

Ms. Morris testified that she was aware of Petitioner's workers' compensation claim because she is included in the emailed report of injury for "any accident reports that happen within her facilities." (Rx 14, pg 15). She testified she became aware that Petitioner was "alleging that he injured himself" on "the next morning [March 7, 2020] when I was copied on the accident email." (Rx. 14, pg 21). She testified that the email came from Tyrone Baity. A copy of this email was not presented or placed into evidence. She clarified on cross that she "misspoke" and the email would have come on March 9, 2020. (Rx. 14, pg 25).

Ms. Morris testified that when she received the report that she "reached out to the workers' comp team right away and …advised that I wasn't sure that was the case because I had talked to [Petitioner] on 3/6." (Rx. 14, pg 15.). She testified that the meeting was at Petitioner's request because he was upset he was 'moved to the supply cage" (Rx. 14, pg 20). She testified that he did not mention that he was in pain that day. (Rx 14, pg 22).

Ms. Morris testified on cross that she takes notes during every meeting with any employee and that she writes as them as the employee talks. (Rx. 14, pg 26.) She testified that this meeting took place for an hour and half. (Rx. 14, pg 26). Tyrone Baity also testified by evidence deposition on June 1, 2021 for Respondent.

Tyrone Baity also testified by evidence deposition on June 1, 2021 for Respondent. On 3/6/20, Tyrone Baity was Respondent's warehouse manager. (R. Ex. 13 at 5). Mr. Baity was responsible for managing warehouse personnel, participating in disciplinary actions and handled on-site workers' compensation accidents. *Id.* at 6.

Mr. Baity testified that the company policy, which is outlined in the company manual, is to report workplace injuries to one's supervisor. *Id.* at 10. On 3/6/20, Mr. Baity was Petitioner's direct supervisor. *Id.* at 11. Petitioner did not report an accident on 3/6/20. *Id.* at 12, 14-15.

Petitioner did not report his accident when he returned to work on 3/7/20. (R. Ex. 13 at 15). According to Mr. Baity, due to Petitioner's failure to immediately report his accident, Petitioner did not adhere to Respondent's company policy. *Id.* at 12.

Mr. Baity testified that Petitioner worked the next day, Sunday, March 8, 2020, and also on Monday, March 9, 2020. He testified that Petitioner did not advise him of any injuries on either of those

dates. (Rx. 13, pg 20). He testified that Petitioner had a normal workday on both of those days and did not complete any accident reports. (Rx. 13, pg 21). In fact, he testified that Petitioner "did not complete an accident report at any point." (Rx 13, pg 21). He testified that the first time he became aware of Petitioner "was alleging he got hurt at work" was when Petitioner was working inside the cage and he said his "back was actually hurting" but Mr. Baity did not know the exact date that occurred. (Rx. 13, pg 22). He testified that David Kraco, operations manager, actually handled the injury. (Rx, 13 pg 23). Mr. Kraco was not brought in to testify.

Mr. Baity was shown the accident report completed by Petitioner dated March 9, 2020 marked as Respondent's exhibit 1. He testified that this was the first time he had seen this form. (Rx. 13, pg 25). He testified that if Petitioner was following procedures, he could have turned it in to himself, David Kraco or Petitioner could have faxed or mailed it himself. (Rx. 13, pg 26). Mr. Baity testified that after this Petitioner continued to work his regular job with no restrictions. (Rx. 13, pg 29.) He testified that Petitioner no longer works for Respondent because after the furlough for COVID he was not asked to return. (Rx. 13, pg 29). Mr. Baity testified to being present for Petitioner's two disciplinary actions regarding attendance and inventory in 2019. (Rx., 13, pg 31-36). Petitioner was not terminated as part of any disciplinary action. (Rx. 13, pg 40).

CONCLUSIONS OF LAW

The aforementioned Statement of Facts is hereby incorporated into each section of these Conclusions of Law.

Section l(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 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).

In regards to (C), Whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent:

The Arbitrator finds that Petitioner has proved and shown by a preponderance of the evidence that he did suffer an accident that arose out of and in the course of the Petitioner's employment. The Arbitrator finds that Petitioner's testimony credible regarding his work injury, his treatment, and ongoing symptoms. Petitioner testified that he was lifting a box weighing between twenty and thirty-five pounds. He testified that to lift this box he would lift it from the pallet to above his right shoulder, placing it on his shoulder while he would bring it to the contractor, who would remove the box from Petitioner's shoulder over the half door that separated them. The basis of his injury was revealed to the doctors the Petitioner saw including the two Section 12 examiners. The injury was documented in the accident report that was completed three days after the event.

Despite Respondent's attempt to question the credibility of the respondent by raising certain allegations including that he met with the HR director also on March 6, 2020 for an hour and half from 12:00 to 1:30 pm at his request to discuss working in the new position. (Rx. 14, Dep Ex. 1).

1. Discussed injuring his back working for another employer when he had been working for Respondent for a year and half at that point. (Rx. 14, Pg 22)
2. Discussed disciplinary actions that occurred a year earlier with no further disciplinary actions at that same meeting. (Rx. 14, Dep Ex. 1)
3. Was requested to throw out leveler into the dumpster also on March 6, 2020, by his supervisor, Tyrone Baity, because Mr. Baity was trying to get Petitioner overtime. (Rx. 13, pg 12-13)
4. Was caught on video, that was not presented at trial, taking the leveler out of the dumpster on March 6, 2020, which was investigated by the company's internal attorney, Hillary Victor, who also was not presented at trial. (Rx. 13, pg 12-13, 18).
5. Used that leveler when he returned home after full day of work also on March 6, 2020. (Rx. 14, pg 12-13)
6. Injured himself at home using the leveler on March 6, 2020. (Rx. 14, pg 12-13).
7. Told his supervisor that he injured himself using the leveler at home on Saturday, March 7. (Rx. 14, pg 12-13).
8. Worked Sunday March 8, 2020 with no issues or problems even though his scheduled does not include working on Sunday. (Rx. 14, pg 20).
9. Changed his story and completed an accident report on Monday, March 9, 2020. (Rx. 1).
10. Either turned the accident report into Tyrone Baity who then emailed the safety team or turned it into someone else and never told Tyrone Baity about the injury at work. (Rx. 13, pg 21; Rx 14, pg 25; Rx 1)

11. Continued to work full duty until he was laid off with no problems or concerns, even though Petitioner was on light duty per the Company's clinic and was paid TTD for two weeks following the layoff (Rx. 13, pg 29, Px. 2, Rx. 7).

The Arbitrator gives little credibility to these attempts. Further, there is no evidence of prior back or shoulder problems other than Ms. Morris's note. Arbitrator gives little credibility that Petitioner told Samantha Morris that he injured himself at his prior employer (from at least over a year and half ago) on Friday and conversely would have told Tyrone Baity that he injured himself using leveler at home on Saturday and then filed an accident report on Monday alleging a different history of injury.

Based upon all the above, the Arbitrator finds the Petitioner more credible than the Respondent's witnesses and concludes that he did suffer an accident that arose out of an in the course of his employment with Respondent.

(E), Whether there was timely notice of the accident given to Respondent?: the Arbitrator finds:

The Arbitrator finds that timely notice was provided to Respondent. The Arbitrator find it disingenuous that Respondent would dispute notice when it put the accident reported dated three days after the alleged accident into evidence and saw the company clinic that same day. (Rx. 1, Px. 2) Petitioner gave notice well within the forty-five days required by the Act.

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

The Arbitrator finds that Petitioner's current condition of ill-being of both his right shoulder and his back is causally related to the injury that occurred on March 6, 2020. The Arbitrator notes that Dr. Singh agreed that Petitioner had suffered a work-related condition and that Petitioner's current condition at the time of his evaluation was causally related to the injury of March 6, 2020. Dr. Novoseletsky also testified that Petitioner's condition was causally related to the incident of March 6, 2020.

The Arbitrator finds the opinion of Dr. Chhadia as it related to causation more persuasive than that of Dr. Phillips. Petitioner has credibly related right shoulder pain and problems since the time of the injury. He has treated conservatively without relief. Dr. Phillips's position was that there was no injury because there is no structural damage, despite the findings he acknowledged on the MRI. Dr. Phillips further stated that Petitioner had symptom magnification but that all the treatment was reasonable, which is in contradiction that if Petitioner had no injury, he would have suffered a 1% impairment rating to the whole body as a result.

Therefore, based on the above, the Arbitrator finds that Petitioner's current condition of ill-being related to his right shoulder and back is causally related to the injury that occurred on March 6, 2020.

(J), Whether the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary treatment?", the Arbitrator finds:

Because the Arbitrator has ruled in favor of the Petitioner in the above mentioned paragraphs, the Arbitrator the treatment Petitioner has had is reasonable, necessary, and related to the work injury of March 6, 2020. There was no evidence presented that the treatment provided is not reasonable as Dr. Singh did not review or address any medical treatment after March 25, 2020 and Dr. Phillips actually found that all the treatment was reasonable. Therefore, all the bills related to treatment at Concentra, Suburban Orthopedics, and Persistent Rx are awarded and Respondent is liable for payment of these bills pursuant to the Illinois Workers' Compensation Fee Schedule.

(O), Whether Petitioner is entitled to future medical treatment:

In addition, the Arbitrator finds that the treatment as recommended by Dr. Novoseletsky and Dr. Chhadia to be reasonable, necessary, and related to the accident of March 6, 2020. Regarding the medial branch block, this treatment was not specifically addressed by Dr. Singh and Dr. Novoseletsky testified as to the reasons for the treatment. There is nothing to refute that.

Regarding the shoulder surgery, the Arbitrator finds that Dr. Chhadia's opinion and rational for the surgery is more persuasive than the opinion of Dr. Phillips. Dr. Chhadia based his opinion for the need for surgery on the complaints of Petitioner, the ongoing nature of complaints and his findings on examination including the MRI findings. Dr. Phillips declared that even though there were MRI findings Petitioner was magnifying his symptoms and there were no structural injury. His opinion is simply not credible in light of the overwhelming evidence.

Therefore, the Arbitrator awards the treatment recommended by Dr. Novoseletsky and Dr. Chhadia and Respondent will authorize and pay for said treatment.

(K), What temporary benefits are in dispute and what TTD is owed:

The Arbitrator finds that Petitioner was temporarily and totally disabled from working as a result of this injury for the time period as alleged by Petitioner, March 27, 2020 through the date of hearing June 29, 2021, a period of 65 4/7 weeks. Petitioner's doctors have him off work for both the shoulder and the back and the Arbitrator has already discussed why Drs. Novoseletsky and Dr. Chhadia are more credible than Respondent's doctors. Respondent will receive a credit for TTD paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC021628
Case Name	BALTHAZOR, JAMES v. QUALITY SAW & SEAL
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0109
Number of Pages of Decision	11
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Randall Sladek
Respondent Attorney	Michael Scully

DATE FILED: 3/21/2022

/s/Carolyn Doherty, 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

JAMES BALTHAZOR,

Petitioner,

vs. NO: 17 WC 21628

QUALITY SAW & SEAL,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 4, 2021, is hereby affirmed and adopted.

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

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

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

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

March 21, 2022

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

d: 3/17/2022
CMD/ma
045

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC021628
Case Name	BALTHAZOR, JAMES v. QUALITY SAW & SEAL
Consolidated Cases	
Proceeding Type	19(b)/8(A) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	8
Decision Issued By	Michael Glaub, Arbitrator

Petitioner Attorney	Randall Sladek
Respondent Attorney	Julie Schum

DATE FILED: 5/4/2021

INTEREST RATE FOR THE WEEK OF MAY 4, 2021 0.03%

/s/*Michael Glaub, Arbitrator*
Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

James Balthazor
Employee/Petitioner

Case # **17** WC **21628**

v.

Consolidated cases: ______

Quality Saw & Seal
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 **3/17/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

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

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

N. [x] Is Respondent due any credit?

O. [x] Other **vocational rehabilitation**

FINDINGS

On the date of accident, **9/9/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**95,462.12**; the average weekly wage was $**1,835.81**.

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

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

Respondent shall be given a credit of $**86,195.62** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**86,195.62**.

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 $9,775.84, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,223.87/week for 97 weeks, commencing 3/14/18 through 1/22/20, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,223.87/week for 60 1/7 weeks, commencing 1/23/20 through 3/17/21, as provided in Section 8(a) of the Act.

Respondent shall pay to Petitioner penalties of $**1,502.96**, as provided in Section 16 of the Act; $**5,594.83**, as provided in Section 19(k) of the Act; and $**1,920.00**, 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.

Michael Glaub **MAY 4, 2021**

Signature of Arbitrator

ICArbDec19(b)

Procedural History

This matter was tried on March 13, 2018 pursuant to Sections 19(b) and 8(a) of the Act. At that time, the Arbitrator found that petitioner did sustain an accident that arose out of and in the course of his employment. Within the Decision, the Arbitrator noted that in addition to the left elbow injury, petitioner suffered cardiac arrest and was intubated during elbow surgery. The Arbitrator found that the conditions related to the cardiac arrest were causally related as were the left arm condition(s) to the September 9, 2016 injury. TTD and medical benefits were awarded accordingly.

Findings of Fact

After the Hearing on Mach 13, 2018, petitioner was next evaluated at Midwest Orthopedics at Rush on April 6, 2018. Dr. Bush-Joseph examined petitioner's left shoulder following cortisone injections administered on February 23, 2018. Petitioner, in terms of the left shoulder, was doing well at that time and was released with home exercise instructions and no restrictions. (Px. 2)

Petitioner's left elbow, as examined by Dr. Cohen on the same day, was progressing but lacking formal therapy. Dr. Cohen recommended same and restricted lifting. Petitioner followed-up with Dr. Cohen on May 16, 2018 and the status was generally unchanged. Petitioner noted that he was trying to perform home exercises but only felt slightly better. Dr. Cohen reiterated that petitioner would benefit from a course of therapy focused on strengthening and endurance. By June 27, 2018, it appears that petitioner was cleared for further treatment. Dr. Cohen believed that three months of therapy were indicated and was hopeful petitioner could reach full duty status on the elbow. (Px. 2)

In the interim, petitioner continued treatment for intubation and cardiac arrest conditions. These conditions were treated at Rush University Medical by Dr. Husain (otolaryngology), Dr. Fitzgerald (physical medicine), Dr. Balk (pulmonology) and Dr. Boll (cardiology). (Px. 7-9)

As of August 22, 2018, Dr. Cohen noted that petitioner's left elbow and shoulder symptoms were improving, and therapy was going well. Dr. Cohen recommended 6-8 weeks of additional strengthening with concentration on high repetition and low resistance exercises to build strength and endurance. (Px. 2)

Petitioner returned to Dr. Cohen on October 17, 2018 for left elbow examination. Dr. Cohen expressed frustration that little had changed with petitioner's condition as a result of a lack of the specific therapy he had prescribed. He restated his request that petitioner undergo a final course of therapy focused on strengthening and endurance. (Px. 2)

On November 6, 2018, Dr. Kress performed a Section 12 evaluation of petitioner's pulmonary issues. He diagnosed cough and dyspnea which he suspected was related to larynx irritation. He believed that petitioner's symptoms were likely related to his intubation and CPR following cardiac arrest after his first elbow surgery. Dr. Kress also suspected that petitioner's substernal chest pain was a manifestation of CRPS which may require pain management. He further noted that petitioner's chest pain, as well as his physical and neurocognitive dysfunction, may hinder his ability to work. (Px. 6)

On referral from Dr. Fitzgerald, Dr. Rothke performed a neurologic evaluation on December 5, 2018. He opined that test results indicated deficits in information processing speed and manual dexterity and variability in attention/concentration as well as new learning capacity and memory for both visual and verbal information. He remarked that these types of deficits demonstrated likely had multifactorial etiology including anoxic brain injury, untreated obstructive sleep apnea and ongoing depressed mood and anxiety. Dr. Rothke also noted that delays in treatment due to multiple insurance denials also contributed to the symptoms. Dr. Rothke recommended cognitive behavioral therapy and psychiatry interventions. (Px. 4)

Petitioner continued treatment with Dr. Cohen. On December 8, 2018, Dr. Cohen again remarked about requested therapy that had not been approved. He noted that petitioner's elbow was essentially the same and would benefit from 6-8 weeks of therapy including strengthening. (Px. 2)

Petitioner next saw Dr. Cohen on February 6, 2019 and his condition and treatment status were generally unchanged. By April 3, 2019, petitioner had been able to begin therapy and felt as though he was making progress. Dr. Cohen noted that soreness in the elbow was no longer constant and that likely petitioner was simply deconditioned. He prescribed an additional 4-6 weeks of therapy to build strength and endurance. He also changed increased petitioner's lifting ability to 20 lbs. (Px. 2)

As of May 29, 2019, according to Dr. Cohen, the additional therapy had not been approved. As far as the elbow, petitioner continued to have soreness. Dr. Cohen stated that petitioner had yet to receive the vigorous therapy recommended and requested the adjuster's assistance in obtaining the "appropriate therapy." (Px. 2)

On the same day, petitioner underwent a chest CT at Rush. It showed persistent enlarged mediastinal lymph nodes and bilateral hilar fullness which had mildly improved. There was also persistent segmental atelectasis involving the right upper lobe anterior segment likely related to more central airway narrowing. (Px. 8)

Petitioner saw Dr. Cohen for the last time on July 24, 2019. At that time, Dr. Cohen noted that petitioner was two years post-surgery and unable to obtain formal therapy for rehabilitation. With petitioner's elbow essentially unchanged and therapy stunted, he placed petitioner at MMI and maintained the 20 lbs. lifting restriction. (Px. 2)

Dr. Cohen later testified as follows during his deposition:

"I had been trying and writing and lobbying for this gentleman to get what I felts was the appropriate therapy to give him the best clinical outcome. For reasons that are not entirely clear to me, having been an orthopedic surgeon for 25 years, he never got what I felt was the appropriate level of rehabilitation and therapy. As such, reluctantly, I said he was at maximum medical improvement." (Px. 12, p. 20)

Dr. Cohen when on to state:

"The gentleman had an elbow injury. I saw him after one failed surgery. He had tendon and joint pathology. He had a complication that led to a whole slew of other issues. All I can say is that his elbow itself most likely will never be back to normal, and as I stated more than once, I believe that the inability to receive the appropriate therapy and rehabilitation compromise his ultimate outcome." (Px. 12, p. 20)

Dr. Neal was retained by the respondent for a Section 12 examination on September 9, 2019. In his subsequent report, he diagnosed residual subjective static left elbow pain. He maintained his opinion that petitioner's condition was not causally related to the work accident. In terms of restrictions, Dr. Neal stated as follows:

"It is my professional opinion, within a reasonable degree of medical and surgical certainty, after reflecting upon the elbow symptoms, conditions, and diagnostic studies he had in the past, after reflecting upon the two surgical procedures he had in the past, after reflecting upon how the medical records indicate he did following surgery, and how he reported to me he did following the surgery and how he is now, appreciating the degree of his elbow mobility, his lack of any instability, and the relative mild nature of work activities and job duties and considering the question of the ability to work from the standpoint of his current left elbow, it is my professional opinion he may work his regular job on a full-time basis without restrictions." (Rx. 3, p. 47) Dr. Neal issued a 7% upper extremity impairment rating. (Rx. 3, p. 50).

Following his release from orthopedic treatment, petitioner continued his treatment stemming from his first surgery complications. To wit, he was seen by Dr. Boll in cardiology on August 17, 2020 and had an echocardiogram denied by workers' compensation on September 21, 2020.

On January 23, 2020, petitioner underwent a vocational interview with Kari Stafseth at Vocamotive. In Ms. Stafseth's March 5, 2020 report she indicated that petitioner would be a candidate for vocational testing and counseling as well as computer and job seeking skills training. (Px. 13) Petitioner tendered his high school transcript which indicates that he ranked 413 out of 492 in his class at Fond du Lac High School. (Px. 14)

Petitioner testified that he began looking for work in early 2020. He looked for work in landscaping and snow plowing. (T. 20) He also applied at stores and car dealerships. (T. 20) He testified that he did find sporadic work delivering pizza and working off a loan for a local farmer. (T. 21) Otherwise, he had not found any consistent employment.

In terms of his daily activity, he testified that he cuts his own grass and maintains his pool with help from others. (T. 24-25) He also goes shopping at the store. (T. 28) Respondent submitted surveillance footage from February, March, April, May and July 2019, as well as footage from May 2020. The footage generally shows petitioner going about his regular daily activities but does not show him working or performing any apparent lifting exceeding the restrictions as imposed by Dr. Cohen. (Rx. 5-13)

Conclusions of Law

Is Petitioner's current condition causally related to the accidental injuries of September 9, 2016?

The Arbitrator notes that this issue was previously addressed in the 2018 trial. At that time, the Arbitrator adopted the opinions of Dr. Cohen over those of Dr. Neal to find that the left elbow condition was causally related to the work accident of September 9, 2016. Additionally, the Arbitrator found that the cardiac arrest and intubation were medical conditions causally related to the accident.

The Arbitrator finds that no evidence has been submitted that would break the chain of causation overall. However, the current dispute involves the petitioner's work restrictions upon completion of his left elbow treatment. Dr. Cohen, with petitioner's treatment and therapy essentially stagnated, released petitioner from his care with a left upper extremity 20 lbs. lifting restriction on July 24, 2019. As Dr. Cohen testified, he had hoped that petitioner could return to full duty, in terms of the left elbow, but petitioner was unable to obtain consistent therapy as prescribed and had reached maximum medical improvement.

Respondent again presented the Section 12 opinion of Dr. Neal. In his lengthy updated report of September 9, 2019, Dr. Neal opines that petitioner may work his regular job on a full-time basis without restrictions. Though the report is verbose, in terms of the issue of causation Dr. Neal provides generalities and non-specifics leading into his statement on work ability. Dr. Neal does not reference any of the surveillance footage in his report.

The Arbitrator adopts the medical opinions of Dr. Cohen over those of Dr. Neal and finds the 20 lbs. left upper extremity restriction credible. The Arbitrator also finds that petitioner's otolaryngology, cardiology, pulmonology and physical medicine treatment at Rush University remain causally related to the accident.

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

Based on the Arbitrator's finding on causal relation listed above, the Arbitrator finds the petitioner's treatment to be reasonable and necessary. The payment of the following medical bills shall be paid (pursuant to the Illinois Medical Fee Schedule) by respondent to petitioner:

- Px. 3 Midwest Orthopedics at Rush $1,194.69
- Px. 4 Dr. Steven Rothke Neuropsychological Evaluation $4,850.00
- Px. 9 Rush University Medical $1,385.90
- Px. 15 Vocamotive – vocational services $2,345.25

What temporary benefits are in dispute?

Petitioner claims entitlement of temporary benefits from March 14, 2018 through January 22, 2020 and maintenance benefits form January 23, 2020 through March 17, 2021. Respondent disputes all temporary benefits claimed. It would appear however that any real controversy regarding temporary benefit entitlement begins with Dr. Neal Section 12 report of September 19, 2019.

The Arbitrator has adopted Dr. Cohen's opinion as stated above. Accordingly, the Arbitrator finds that petitioner, with a 20 lbs. lifting restriction for the left upper extremity, was temporarily and totally disabled from March 14, 2018 through January 22, 2020. Petitioner met with Kari Stafseth, vocational counselor, on January 23, 2020 and thereafter conducted a self-directed job search. Formal vocational services were denied by respondent pursuant to Dr. Neal's opinion. The Arbitrator finds that petitioner shall be entitled to maintenance benefits from January 23, 2020 through the date of trial, March 17, 2021.

Is Respondent due any credit?

Respondent has tendered an Rx. 1 indicating medical payments made in this case. Respondent shall receive a credit for said payments. Respondent also tendered Rx. 2 indicating payments of indemnity benefits. This exhibit indicates $86,195.42 in indemnity benefits from March 14, 2018 through September 7, 2019. Respondent shall receive a credit for $86,195.42 for this trial.

Vocational Rehabilitation

Petitioner presented Kari Stafseth, CRC. (Px. 13) Stafseth testified that petitioner was a candidate for vocational rehabilitation which would provide him with comprehensive job-seeking skills. (Px. 13, p. 13) Further, she recommended vocational testing, development of keyboarding and computer proficiency. (Px. 13, p. 13) Finally, she would also provide comprehensive vocational counseling and evaluation of cost-effective retraining that would mitigate wage loss exposure. (Px. 13, p. 13) She identified job targets of sales representative, inventory control clerk, customer service representative, telephone operator, dispatcher, security guard, procurement clerk and front desk clerk, all of which were in the semi-skilled employment filed. (Px. 13, p. 14) She projected potential earnings of $12-18 per hour. (Px. 13, p. 15)

Having adopted the 20 lbs. lifting restriction above, the Arbitrator concordantly adopts the unrebutted vocational rehabilitation opinion of Kari Stafseth, CRC and awards petitioner vocational training as recommended by Stafseth.

Penalties

Petitioner has filed a penalties petition for prematurely terminated TTD benefits. (Px. 11) Respondent first terminated benefits on or about July 5, 2019 with a TTD payment at that time through July 6, 2019. (Rx. 2) At that time, petitioner remained under the care of Dr. Cohen. Respondent then did not administered benefits for another two months with issuance on September 16, 2019. (Rx. 2) It would appear that termination of benefits occurred without written explanation and before a Section 12 opinion existed to support such termination. As of the date of trial, petitioner still has not been brought current through the Dr. Neal exam or report.

Under Section 19(k), where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, the Commission may award compensational additional to the otherwise payable under the Act equal to 50% of the amount payable at the time of such award. The Arbitrator finds that payment of TTD from

July 7, 2019 through September 9, 2019 (9 1/7 weeks) -- $11,189.66 -- were vexatiously delayed. Accordingly, the Arbitrator awards $5,594.83 in Section 19(k) penalties.

Under Section 19(l), in case the employer or the carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of Section 8(a) or 8(b) benefits, the employee may be entitled to additional compensation in the sum of $30 per day for each day benefits were withheld, not to exceed $10,000. In this case, benefits were held for 64 days. Accordingly, the Arbitrator awards $1,920 in 19(l) penalties.

Under Section 16, the Arbitrator may award penalties in conjunction with 19(k) penalties. The Arbitrator hereby awards 20% of the amount of total penalties-- $1,502.96 (20% of ($7,514.83)).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC017863
Case Name	WESTER, CHRISTOPHER v. INSPERITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0110
Number of Pages of Decision	21
Decision Issued By	Christopher Harris, Commisioner

Petitioner Attorney	Matthew Kennedy
Respondent Attorney	Stephen Klyczek

DATE FILED: 3/21/2022

/s/Christopher Harris, 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	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTOPHER WESTER,

Petitioner,

vs. NO: 20 WC 17863

INSPERITY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, 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. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 14, 2021 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,100.00. 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.

March 21, 2022

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

CAH/tdm
O: 3/17/22
052

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC017863
Case Name	WESTER, CHRISTOPHER v. INSPERITY
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Maureen Pulia, Arbitrator

Petitioner Attorney	Matthew Kennedy
Respondent Attorney	Stephen Klyczek

DATE FILED: 9/14/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 14, 2021 0.05%

/s/Maureen Pulia, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTOPHER WESTER,
Employee/Petitioner

Case # **20** WC **17863**

v.

Consolidated cases: _____

INSPERITY,
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 **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **8/30/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **4/18/20**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,819.09**; the average weekly wage was $**612.25**.

On the date of accident, Petitioner was **46** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services for petitioner's right shoulder treatment from 4/18/20 through 8/30/21, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay all reasonable and necessary medical expenses pursuant to Section 8(a) and 8.2 of the Act for the right shoulder arthroscopy with evaluation of his superior labrum, possible biceps tenodesis and labral debridement versus repair, evaluation of his rotator cuff and treatment if it is found to be pathologic, and subacromial decompression.

Respondent shall pay Petitioner temporary total disability benefits of $408.17/week for 38-5/7 weeks, commencing 11/4/20 through 8/1/21, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 11/4/20 through 8/30/21, and shall pay the remainder of the award, if any, in weekly payments.
In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

SEPTEMBER 14, 2021

ICArbDec19(b)

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 46 year old maintenance technician, alleges he sustained an accidental injury to his right shoulder and neck, that arose out of and in the course of his employment be respondent on 4/18/20. Petitioner began working for respondent on 11/11/19. He reported that his duties differed from day to day and included painting, light remodeling, pulling out carpets, outside work, moving large appliances, and repurposing apartments for someone else to move in. He stated that he was essentially a handyman for a property management company. Petitioner denied any problems with his right shoulder prior to the injury on 4/18/20.

On an average day petitioner testified that they would complete the emergency orders first, and then do all the other work orders related to the building maintenance or repurposing of the apartments. Petitioner was given orders each day for what he would do.

Vicki Chamblin, testified that she was hired as Property Manager by respondent on 4/8/20. She testified that her duties were to oversee both properties. She testified that she met petitioner that day when she met the entire staff.

Petitioner testified that on and about 4/18/20 respondent had a blitz to get a bunch of apartments rented. During that period the maintenance staff was painting like crazy, and respondent even had to hire out for painters to get the apartments painted. On 4/18/20 after completing the emergency orders, petitioner continued working on getting the apartments done. He stated that they all had been working real hard to get the apartments painted and ready to be rented, on top of all the on-call maintenance. He was tired. After lunch he was painting overhead and lifted a bucket of paint and felt a pop in his right arm. He also felt shooting pain down his right arm. He testified that he turned to Ron Beggs, the maintenance supervisor, and asked him if he heard a pop, and Beggs said he did.

Petitioner testified he and Beggs went down and reported the accident to Tara Hickman that afternoon. Petitioner testified that Hickman was the Acting Manager at Serenity Springfield at that time. Petitioner testified that respondent was in the process of a company change with new management. Petitioner testified that he was unaware that a new Property Manager had been hired at that time.

Beggs testified that he was working with respondent when petitioner hurt himself carrying a 5 gallons container of paint. He did not recall hearing a pop. He also did not recall the date it happened. He testified that he was a coworker of petitioner. He stated that after the injury he told petitioner to go down to the office and report it. He did not know if petitioner did it or not.

Petitioner testified that he never heard anything back for a while after he reported the accident. During this period, he continued to try and work through his pain. He testified that he had mobility of the right shoulder, but it was very painful. When petitioner did not hear back, he reached out to a lot of people, but was not sure who was in charge because all the players were changing with the new management coming in. He then sent an email to the new Regional Manager, Seanne Spangenburg.

Tara Hickman, Assistant Property Manager for respondent at Serenity Spring Creek, was called as a witness on behalf of respondent. She testified that on 4/18/20 she was Acting Manager for respondent. She testified that as Acting Manager, she had to do the same Assistant Property Manager duties she did at Serenity Spring Creek at the Serenity Springfield location. Hickman testified that she had been out on leave due to COVID exposure, but believed she was in the Springfield location on 4/18/20. She testified that petitioner reported his accident to her on 4/18/20. She testified that Ron Beggs was with petitioner. She testified that after petitioner reported it to her she sent an email to Spangenburg, the Regional Manager. Hickman testified that she was on leave due to an exposure of COVID sometime around the 20th of April 2020, and then for 14 days. She believed she went on leave a day or two after petitioner reported his injury to her. She also testified that she was taken off work around 3/16/20 for another exposure to COVID 19, and would have returned 14 days later.

Chamblin testified that on 4/27/20 petitioner came to her with a sling and stated that his right shoulder hurt. She stated that she was the only one in the office when petitioner arrived. She testified that petitioner told her it was old age and hereditary. She stated that he said more that she could not remember, and then stated that he lifted a 5 pound bucket. She testified that he told her it happened one day last week. She testified that when she asked why he did not report it at the time, petitioner stated that he did not realize it at the time, and thought about it after the fact. She stated that he told her he remembered hearing it pop when he picked up the bucket. She testified that petitioner did not ask to make a workers' compensation claim. She testified that he asked to take a ½ day off because he was going to the doctor. She stated that she told petitioner to bring any letters regarding restrictions to her. Chamblin testified that there was no furniture being assembled on 4/18/20, and that all that was done prior to her hire date of 4/8/20. Chamblin testified she sent an email to Spangenburg after petitioner reported the injury. She denied knowing that petitioner had a workers' compensation claim.

Chamblin denied getting any email from Tara Hickman regarding a workers' compensation claim for petitioner, or talking to her about that. Chamblin testified that when she was hired she was Hickman's supervisor. She testified that Hickman was off work on 4/18/20 due to a COVID 19 exposure and did not

return to work until 4/22/20. She stated Hickman worked primarily at Serenity Spring Creek and came to Serenity Springfield location to drop off papers.

Spangenburg testified that she works in Indianapolis at the home base. She testified that she was in this position on 4/18/20. She testified that her duties were overseeing the management teams that were on the individual properties in the portfolio, that included respondent's Serenity Spring Creek and Springfield Serenity locations. She testified that she worked with both Chamblin and Hickman. She testified that she hired Chamblin in April of 2020, but did not remember the date. She then testified that she hired her late March or early April 2020. Then on cross-examination she testified that she has no reason to disagree that Chamblin was hired on 4/3/20.

Spangenburg testified that on 4/18/20 Hickman was the Assistant Property Manager, primarily at Serenity Spring Creek. She also testified that Hickman would help with office/admin work at the Serenity Springfield location. Spangenburg testified that sometimes her job duties included intake of workers' compensation claims. She testified that if it is reported to her she reports it to Human Resources, and sometimes fills out the First Report of Injury. She testified that on 4/18/20 Hickman was off on leave, and was supposed to be working at home, but was not working at home at that time.

Spangenburg testified that she was first made aware of petitioner's injury when Chamblin sent her an email on 4/27/20. She stated that she and Chamblin talked, and that Chamblin told her petitioner said he was injured. She stated that she told Chamblin to get more information. She testified that she reported the injury to Human Resources and then created the report on 4/28/20. Spangenburg testified that she never talked to petitioner or ever got any emails from petitioner or Hickman regarding an on the job injury.

Petitioner testified that on 4/28/20 he talked to Chamblin and Spangenburg. On 4/28/20 Spangenburg completed a First Report of Injury. It was noted that the injury was reported on 4/28/20 at 8:00 am to Vicki Chamblin, Property Manager. It noted that petitioner's physician was Dr. Saxsma. The description of the Accident on the report was illegible. This report was electronically signed at 10:30 am that day. Neither Spangenburg nor Chamblin could explain the "Questionable?" designation in the lower left hand corner of the document.

Petitioner testified that on 4/28/20 he begged Dr. Saxsma, his primary care physician, to squeeze him in so he could get some pain medication. He testified that when he saw Dr. Saxsma that day Dr. Saxsma did not have his laptop with him and the doctor was in a hurry. Petitioner testified that he told Dr. Sasma

that they were moving a lot of furniture, and that it was a 5 pound gallon pail of paint that caused his problems. Dr. Saxsma's records show that petitioner reported that he had been working very hard at his job. He reported lifting and constructing many pieces of apartment furniture, and several days ago lifted a piece of furniture and felt a pop in his right shoulder and had pain and limited range of motion since that time. Dr. Saxsma examined petitioner and assessed a suspected rotator cuff/labrum injury. He recommended an MRI. Petitioner wanted to pursue conservative treatment. He prescribed diclofenac sodium and prednisone.

Chamblin testified that Hickman was let go on 5/4/20.

On 5/7/20 petitioner underwent an MRI of the right shoulder. He gave a history of pain and discomfort in his right shoulder after lifting at work over 2 weeks ago. The results of the MRI were 1) supraspinatus & subscapularis signal abnormality from non-specific tendinopathy; 2) superior labral tear with configuration SLAP lesion type 2; and 3) glenohumeral; joint arthritis from minimal-mild DJD/OA.

On 5/13/20 the Illinois Form 45: Employer's First Report of Injury was completed by Seanne Spangenburg, respondent's Regional Manager, with respect to petitioner's alleged injury. She identified the date of accident as 5/13/20 at 12:00 pm, while lifting a 5 gallon bucket of paint. With respect to how the accident occurred Spangenburg wrote "Chris came to work with a brace on. Property Manager asked what was wrong. Chris stated that he hurt his shoulder the day before but stated it was just part of getting old and that it was likely hereditary but that he double (sic) be fine. Chris then reported that he thought it was possibly from lifting a 5 gallon bucket of paint. Chris then stated on a later date that he was seen by his and need to watch it for 5".

On 6/1/20 petitioner presented to Dr. Maender, on the referral of Dr. Saxsma, for his right shoulder pain. Petitioner gave a history of an injury at work, near the end of April, while he was lifting a 5 gallon bucket of paint and felt a pop in the shoulder. He reported that he had a little pain in the shoulder at the time of the injury, but in the days following the injury, the pain became worse, and deeper in the shoulder. Petitioner also reported some popping in the shoulder with certain movements. His worst pain was with internal rotation and repetitive overhead movement, such as when he was painting. Dr. Maender examined petitioner and reviewed the MRI of the right shoulder. He was of the opinion that the MRI showed a superior labral tear extending down anteriorly; mild glenohumeral arthritis; moderate AC joint arthritis, minimal rotator cuff tendinopathy; and minimal fluid along the biceps. He assessed a right slap tear. Dr Maender recommended a course of physical therapy for his rotator cuff and stabilizing exercises

for his scapular. He also prescribed Mobic. Dr. Maender gave petitioner work restrictions including no overhead work, and no lift, push, or pull greater than 10 pounds.

On 7/13/20 Dr. Maender noted that physical therapy had not yet been approved by respondent. Petitioner reported that his condition remained unchanged, but in the last couple weeks had several episodes of numbness coming down to his hand. Dr. Maender's recommendation remained the same. He stated it was the best chance petitioner had of avoiding surgery.

On 8/7/20 petitioner began a course of physical therapy at Midwest Rehab for his right shoulder.

When petitioner followed-up with Dr. Maender on 8/24/20 he reported that workers' comp had approved the physical therapy. He noted some improvement, but still had popping with pain with some motions of his shoulders. He also complained of numbness in the left arm, sometimes involving some or all fingers. Petitioner stopped the Mobic because he was not getting any benefit from it, and has used Tylenol on a few occasions. They discussed surgery that involved a right shoulder arthroscopy, a probable biceps tenodesis versus superior labral repair, and subacromial decompression. Petitioner indicated that he wanted to proceed with the surgery. With respect to the numbness in the arm, Dr. Maender did not think the surgery would improve it, because he thought it could be secondary to cervical radiculopathy. He told petitioner he would refer him to a neck specialist for this condition.

On 8/27/20 Genex performed a Utilization Review on the recommended prospective request for 1 right shoulder arthroscopy to include subacromial decompression, evaluation of the rotator cuff, biceps tenodesis, and superior labral repair. It was noted that the mechanism of injury was undisclosed in the submitted documentation. Genex found that the requested services did not meet the established criteria for medical necessity.

On 9/17/20 Genex performed a Utilization Review on 12 physical therapy sessions for the right shoulder between 9/14/20 and 11/14/20. Genex certified 12 physical therapy sessions for the right shoulder between 9/14/20 and 11/14/20.

On 9/30/20 petitioner followed-up with Dr. Maender. He continued to report pain down the lateral side of his shoulder, with a pop with certain rotations. He also reported pain along his medial scapula and up along his paracervical musculature. He reported that therapy made a difference with his mobility, as well as strength. He noted that he continued to have occasional numbness and tingling coming down his left arm, that had not improved. He reported that respondent had not been accommodating his restrictions, and at times he was lifting over 200 pounds. He stated that he over compensates when he

tries to do this and he thought that was part of his increasing pain. Dr. Maender instructed petitioner to continue with therapy since he was making improvement. He restricted petitioner from lifting, pushing, and pulling greater than 20 pounds. He indicated that petitioner should be evaluated by a spine specialist given his persistent numbness and tingling.

On 10/21/20, after 19 visits, petitioner was discharged from physical therapy. His final assessment was improved active range of motion, and pain with MMT into abduction. It was noted that overall petitioner had made progress with his strength and range of motion, but was still reporting pain with work related activities. He subjectively stated that he "pushes through the pain" at work. It was noted that his functional assessment score appeared to have regressed. It was also noted that he had no more sessions currently scheduled.

On 10/21/20 Genex performed a Utilization Review for unknown physical therapy sessions for the right shoulder between 9/30/20 and 12/14/20. Genex did not certify these sessions. It was that the submitted documentation did not disclose the petitioner's mechanism of injury.

Petitioner testified that on 10/23/20 he was placed on leave. He testified that he met with the Property Manager and was told to give his keys back. He testified that he was off until he got a new job on 8/2/21.

On 10/30/20 petitioner reported to Dr. Maender that he continued to have pain across his lateral shoulder and along his trapezius, with numbness and tingling in all his fingers. He also reported popping with some therapy exercises. He stated that physical therapy was stopped so he continued with his therapy exercises at home. He also stated that he was sent home from work last Friday. Dr. Maender's diagnoses remained the same. He noted that petitioner saw minimal improvement with therapy. Petitioner reported better strength, but no less pain. Dr. Maender believed petitioner's pain was likely twofold- cervical radiculopathy and superior labral tear. Dr. Maender was of the opinion that petitioner's numbness and tingling was not coming from the shoulder. With respect to his shoulder, Dr. Maender was of the opinion that since petitioner failed conservative treatment, he was recommending a right shoulder arthroscopy with evaluation of his superior labrum, possible biceps tenodesis and labral debridement versus repair, evaluation of his rotator cuff and treatment if it is found to be pathologic, and a subacromial decompression. He continued petitioner's restrictions. Petitioner indicate that he wanted the surgery recommended by Dr. Maender. Dr. Maender restricted petitioner from lifting, pushing or pulling greater than 20 pounds.

Petitioner testified that his last check was received on 11/3/20. He testified that it was a workers' compensation check.

On 11/13/20 petitioner presented to Dr. Saxsma for his right shoulder and right sided neck pain. He reported that his pain had been significantly worse over the last few weeks, and he was having trouble sleeping, and a lot of difficulty moving. Dr. Saxsma prescribed Prednisone and Gabapentin. He suspected petitioner's discomfort was pain radiation from a right cervical radiculopathy.

Dr. Saxsma had a note in his office records dated 11/20/20 reflecting a phone call from petitioner. Petitioner called to give him updated information as to the cause of his injury resulting in the first office visit. Petitioner reported that the injury resulted from lifting a heavy 5 gallon bucket with his right arm/shoulder. Dr. Saxsma noted that he did not recall this information in the office visit of 4/28/20, which was the reason for its absence from his documentation. Dr. Saxsma further noted that petitioner was in a great deal of pain at that time and it could have been overlooked.

Petitioner's job description of Maintenance Supervisor for respondent was offered into evidence. His essential job functions were detailed. The position summary was "performs technical and mechanical work that ensures the inside and external buildings, grounds, amenities, and common areas of the property meet the Company's standards for cleanliness, appearance, safety, and overall functionality by performing maintenance-related tasks." His physical demands were:

1) Incumbents need to be able to bend, stoop, climb ladders, reach, carry objects, and crawl in confined areas;
2) Incumbents must be able to work inside and outside in all weather conditions;
3) Incumbents must be able to push, pull, lift, carry, or maneuver weights of up to 25 pounds independently and 50 pounds as assistance;
4) Rare or regular travel may be required for the accomplishment of some or all of the daily responsibilities of this position;
5) Incumbents must be able to "take call" during evenings and weekends.

On 8/2/21 petitioner began working for Finn Window Cleaning. He testified that he had to get a job because he was starving to death, had no income, and was kicked off unemployment. His job title is Operations Manager, who sells window cleaning jobs to clients, and also does some training on window cleaning. He testified that his duties are within the restrictions he was given by Dr. Maender. He testified that he makes $18.25/hour plus commission. He stated that since he only started on 8/2/21 he has not made much commission. He testified that he works 40 hours a week.

Petitioner testified that he still does the exercises Dr. Maender told him to do since he did not have insurance to get further treatment. He testified that he currently experiences numbness, uncomfortableness, and trouble sleeping, but the degree varies. He testified that his right arm gets fatigued quicker, and painful after a long time. He reported pain and discomfort with or without use of the right arm. Petitioner testified that he wants the surgery recommended by Dr. Maender.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Accident appears to be the threshold issue in this case. Petitioner, Beggs, and Hickman testified on behalf of petitioner, and Chamblin and Spangenburg testified for respondent. A lot of conflicting testimony was offered with no credible evidence to support or rebut it, even when such evidence would have been readily available and may have been able to prove certain testimony true or false. Such evidence includes date of hire for Chamblin; payroll and time sheets for Hickman; and emails that were referenced by many witnesses. Absent this evidence, the arbitrator is left to determine whether or not petitioner sustained an accident injury to his right shoulder and neck on 4/18/20 based on the credibility of the witnesses, as well as the credible medical evidence.

Based on the testimony of Spangenburg, Chamblin, and petitioner, on or around the date of the alleged accident, there was new ownership of respondent's business and the management team was changing, and Hickman had been in an Acting Property Manager role.

Petitioner testified that he injured his right shoulder lifting a 5 pound bucket of paint on 4/18/20 while working on a lot of apartments getting them ready to rent. Beggs, petitioner's co-worker, testified that he was working with petitioner when he hurt himself carrying a 5 pound bucket of pain. Beggs also told petitioner to go down to the office and report it. Petitioner testified that Begg's went down to the office with him to report the injury to Hickman, who was the Acting Property Manager at that time.

Hickman testified that in fact petitioner did report the injury to her on 4/18/20. She also testified that Begg's was with petitioner. Begg's testified that he did not go down with petitioner to report the injury. Nonetheless, Hickman testified that petitioner reported the injury to her on 4/18/20, after which she sent an email to Spangenburg about petitioner's injury. This email was not offered into evidence.

Although Chamblin and Spangenburg testified that Hickman was not working on 4/18/20, Spangenburg testified that Hickman was the Assistant Property Manager on 4/18/20, primarily at the Serenity Spring Creek location, but would help out with office and administrative work at Serenity

Springfield. Although both Chamblin and Spangenburg testified that on 4/18/20 Hickman was on leave, no records such as leave, payroll, or sick time documents were offered into evidence to support this claim.

Petitioner continued working with pain. When he did not hear back from management he started reaching out to other people, because he was not sure who was in charge due to all the new management personnel changes. He sent an email to Spangenburg, however this email was also not offered into evidence.

On 4/27/20 petitioner went to Chamblin's office. She testified that petitioner had a sling on his right shoulder and stated that it hurt. She stated that petitioner told her it was old age or hereditary. She then testified that he reported more that she could not remember, but also testified that he reported lifting a 5 pound bucket one day last week and hearing a pop in his right shoulder. She testified that he told her he did think about it at the time. She also testified that petitioner did not ask to report a worker's compensation injury, rather, he only asked for ½ day off to go to the doctor. The arbitrator notes that this testimony contradicts the testimony of petitioner and Hickman who both testified that he reported the injury on 4/18/20. Chamblin claimed that after this conversation she sent an email to Spangenburg "reporting the injury". She also denied getting an email from Hickman regarding petitioner's alleged injury. She claims Hickman was off work on 4/18/20 due to a COVID exposure, but again no payroll, sick, or other records were offered into evidence to support this claim. Also, the email from Chamlin to Spartenburg was not offered into evidence.

Spartenburg testified that she worked with both Hickman and Chamblin. She stated that she hired Chamblin in April of 2020, but could not remember the date. Then she stated that she hired Chamblin in late March, or early April 2020. Then she testified that she had no reason to disagree that Chamblin was hired on 4/3/20. The arbitrator finds it significant that the date Chamblin was actually hired could have been resolved by simply offering into evidence Chamblin's payroll records, but no payroll, or other records to prove the actual hire date for Chamblin were offered into evidence.

Spangenburg stated that her first knowledge of petitioner's alleged injury was on 4/28/20 when Chamblin sent her an email dated 4/27/20. Again, this email was not offered into evidence. She stated that she and Chamblin talked and Chamblin told her that petitioner said he was injured. Spangenburg told Chamblin to get more information and then reported the injury to Human Resources. That same day, Spangenburg completed a First Report of Injury.

Petitioner testified that on 4/28/20 he reached out to Saxsma, trying to get him to squeeze him in for any appointment due to his right shoulder complaints. When petitioner presented to Dr. Saxsma that day he reported that he had been working very hard at his job. He reported lifting and constructing many pieces of apartment furniture, and several days ago he lifted a piece of furniture and felt a pop in his right shoulder and had pain and limited range of motion since that time. Petitioner testified that Dr. Saxsma was very rushed that day and did not have his computer with him. Petitioner testified that he told Saxsma he was moving a lot of furniture, and when he lifted the 5 gallon bucket of paint he felt pain in his shoulder. With respect to this claim, Dr. Saxsma had a note in his office records dated 11/20/20 reflecting a phone call from petitioner. Petitioner called to give him updated information as to the cause of his injury resulting in the first office visit. Petitioner reported that the injury resulted from lifting a heavy 5 gallon bucket with his right arm/shoulder. Dr. Saxsma noted that he did not recall this information in the office visit of 4/28/20, which was the reason for its absence from his documentation. Dr. Saxsma further noted that petitioner was in a great deal of pain at that time and it could have been overlooked.

On 5/13/20 Spangenburg completed the Illinois Form 45: Employer's First Report of Injury with respect to petitioner's alleged injury. She identified the date of accident as 5/13/20 at 12:00 pm, while lifting a 5 gallon bucket of paint. With respect to how the accident occurred Spangenburg wrote "Chris came to work with a brace on. Property Manager asked what was wrong. Chris stated that he hurt his shoulder the day before but stated it was just part of getting old and that it was likely hereditary but that he double (sic) be fine. Chris then reported that he thought it was possibly from lifting a 5 gallon bucket of paint.".

On 6/1/20 when petitioner presented to Dr. Maender, he gave a history of an injury at work, near the end of April, while he was lifting a 5 gallon bucket of paint and felt a pop in the shoulder. He reported that he had a little pain in the shoulder at the time of the injury, but in the days following the injury, the pain became worse, and deep in the shoulder.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 4/18/20. The arbitrator found the testimony of petitioner, Beggs and Hickman more persuasive than the testimony of Chamblin and Spangenburg.

Petitioner, Beggs and Hickman all testified to petitioner injuring his right shoulder while lifting a 5 gallon bucket of paint on 4/18/20. Although Chamblin testified that Hickman was not working that day, she offered no credible evidence, that was easily available, such as payroll, leave or sick records, to support her claim. For this reason the arbitrator finds the testimony of petitioner, Beggs, and Hickman that petitioner injured his right shoulder at work on 4/18/20, and reported it the same day, credible.

The arbitrator found the testimony of Chamblin to be the least persuasive. The arbitrator found Chamblin argumentative at times, and found it most interesting that the emails Chamblin kept wanting to refer to on her cross-examination were never addressed on her redirect testimony, nor were they ever offered into evidence. In fact, none the emails between Spangenburg and Chamblin regarding petitioner's injury to his shoulder at work on 4/18/20 were offered into evidence by respondent to support Chamblin and Spangenburg's testimony.

The arbitrator also finds it significant that Chamblin testified that when petitioner came to her office on 4/27/20 he told her his sore shoulder was from old age and hereditary and needed to take ½ day off to see the doctor. Although she claims petitioner did not report any work injury to her, she testified that petitioner told her that he heard a pop in his right shoulder last week lifting a 5 pound bucket, and after this conversation with petitioner she drafted an email to Spangenburg "reporting the injury". If Chamlin truly believed petitioner was not reporting a work injury, the arbitrator finds there would be no reason for Chamblin to "report the injury" to Spangenburg, and then for Spangenburg to report the injury it to Human Resources and then fill out a First Report of Injury on 4/28/20, and an Illinois Form 45: Employer's First Report of Injury on 5/13/20 identifying petitioner's injury as an injury to his right shoulder after lifting a 5 gallon bucket of paint.

Although the arbitrator notes Dr. Saxsma did not note on 4/28/20 that petitioner specifically stated that he was lifting a 5 gallon bucket of paint when he injured his right shoulder, but was working very hard at his job lifting and constructing many pieces of apartment furniture, and felt a pop in his right shoulder while lifting a piece of furniture, Dr. Saxsma did note in a future office visit report that although he did not recall petitioner stating that he injured his right shoulder lifting a 5 gallon bucket of paint when he saw him on 4/28/20, that petitioner was in a great deal of pain at the time and it could have been overlooked.

The arbitrator finds it significant that even though Chamblin testified that petitioner never reported an injury to his right shoulder at work, her own testimony, as well as Spangenburg's testimony, and the accident reports, support a finding that petitioner did in fact allege an injury to his right shoulder at work

while lifting a 5 gallon bucket of paint. The arbitrator finds the many inconsistencies in the witnesses' testimony could have easily been proven or disproved if the respondent had offered into evidence certain records or emails, easily accessible to them, to support its witnesses' testimony. For these reasons, the arbitrator finds the petitioner, Beggs and Hickman were more persuasive witnesses than Chamblin and Spangenburg.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder, and possibly his neck, that arose out of and in the course of his employment by respondent on 4/18/20.

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

Having found the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder, and possibly his neck, that arose out of and in the course of his employment by respondent on 4/18/20, the arbitrator finds petitioner's current condition of ill-being as it relates to his right shoulder causally related to the injury he sustained on 4/18/20. With respect to petitioner's neck it has not yet been determined whether or not some of his complaints in his right arm are causally related to his neck. For this reason, the arbitrator will refrain at this point from finding a causal connection between any possible neck issues and the injury petitioner sustained on 4/18/20.

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 has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder, and possibly his neck, that arose out of and in the course of his employment by respondent on 4/18/20, the arbitrator finds all the medical services provided to petitioner from 4/18/20 through 8/30/21 for his right shoulder were reasonable and necessary to cure or relieve petitioner from the effects of the injury he sustained on 4/18/20.

Respondent shall pay reasonable and necessary medical services for petitioner's right shoulder treatment from 4/18/20 through 8/30/21, as provided in Sections 8(a) and 8.2 of the Act.

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

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder, and possibly his neck, that arose out of and in the course of his employment by respondent on 4/18/20, and that all the medical services provided to petitioner from 4/18/20 through 8/30/21 for his right shoulder were reasonable and necessary to cure or relieve petitioner from the effects of the injury he sustained on 4/18/20, the arbitrator finds the arbitrator finds the medical treatment recommended by Dr. Maender with respect to petitioner's right shoulder and neck to be reasonable and necessary to cure or relieve petitioner from the effects of his injury on 4/18/20.

On 10/30/20 Dr. Maender believed petitioner's pain was likely twofold-cervical radiculopathy and a superior labral tear. Dr. Maender was of the opinion that petitioner's numbness and tingling was not coming from the shoulder. With respect to his shoulder, Dr. Maender was of the opinion that since petitioner failed conservative treatment, he was recommending a right shoulder arthroscopy with evaluation of his superior labrum, possible biceps tenodesis and labral debridement versus repair, evaluation of his rotator cuff and treatment if it is found to be pathologic, and subacromial decompression.

Based on Dr. Maender's treatment recommendations on 10/30/20 the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses pursuant to Section 8(a) and 8.2 of the Act for the right shoulder arthroscopy with evaluation of his superior labrum, possible biceps tenodesis and labral debridement versus repair, evaluation of his rotator cuff and treatment if it is found to be pathologic, and subacromial decompression. Since no treatment has yet been recommended for the cervical spine, the arbitrator is ordering any prospective medical treatment for the cervical spine at this time.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner alleges he is entitled to temporary total disability benefits for the period 11/4/20 through 8/1/21, a period of 38-5/7 weeks. Respondent claim no TTD is owed.

On 10/30/20 petitioner reported to Dr. Maender he was sent home from work last Friday. Following his examination Dr. Maender's diagnoses remained the same, and he restricted petitioner from lifting, pushing or pulling greater than 20 pounds. Petitioner testified that his last check was received on 11/3/20. He testified that it was a workers' compensation check.

Respondent offered no evidence with respect to this issue.

Having found the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/18/20; that petitioner was left go by respondent on or about 10/23/20; that Dr. Maender placed

petitioner on restrictions that prevented him from performing his full duty job; that respondent last paid petitioner workers' compensation benefits on 11/3/20; that respondent did not offer petitioner any maintenance benefits or vocational rehabilitation; and, that petitioner did not find alternate employment until 8/2/21, the arbitrator finds the petitioner was temporarily totally disabled from 11/4/20 through 8/1/21, a period of 38-5/7 weeks, for which respondent owes petitioner temporary total disability benefits.

Respondent shall pay Petitioner temporary total disability benefits of $408.17/week for 38-5/7 weeks, commencing 11/4/20 through 8/1/21, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 11/4/20 through 8/30/21, and shall pay the remainder of the award, if any, in weekly payments.

Respondent is entitled to any temporary total disability benefits that were paid for the period 11/4/20 through 8/1/21.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC021896
Case Name	PITTMAN, JANINE v. BEVERLY FARM
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0111
Number of Pages of Decision	19
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	John Winterscheidt
Respondent Attorney	Timothy Furman

DATE FILED: 3/21/2022

/s/Christopher Harris, 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

JANINE PITTMAN,

Petitioner,

vs. NO: 19 WC 21896

BEVERLY FARM,

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 treatment, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2021 is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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.

March 21, 2022

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

CAH/tdm
O: 3/17/22
052

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC021896
Case Name	PITTMAN, JANINE v. BEVERLY FARM
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	John Winterscheidt
Respondent Attorney	Timothy Furman

DATE FILED: 9/7/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 31, 2021 0.05%

/s/*Linda Cantrell, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Janine Pittman
Employee/Petitioner

v.

Beverly Farm
Employer/Respondent

Case # **19** WC **021896**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 24, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 20, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,795.36**; the average weekly wage was $**380.68**.

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 $**2,392.88** for TTD, $**0.00** for TPD, $**9,970.32** for maintenance, and $**0.00** for other benefits, for a total credit of $**12,363.20**.

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

ORDER

Respondent shall pay Petitioner's medical expenses contained in Petitioner's Group Exhibit 14, as provided in Sections 8(a) and 8.2 of the Act, as the Arbitrator finds said bills to be reasonable, necessary, and causally related to the work accident. Respondent shall be given credit for any amounts previously paid under Section 8(a) of the Act for medical benefits. The parties stipulate that Respondent shall receive a credit for medical bills paid through its group medical plan pursuant to Section 8(j) of the Act. Respondent shall further hold Petitioner harmless from all claims or liabilities made by the group medical plan to the extent of such 8(j) credit.

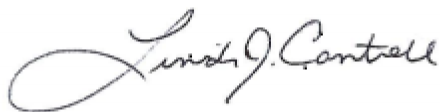
Respondent shall reimburse Petitioner directly for out-of-pocket expenses in the amount of $114.00 she paid to Innovare Health Advocates/Dr. Becky Dr. Ganz. Respondent shall further pay for the services provided by England & Company Rehabilitation Services, Inc. in the amount of $2,090.20.

Respondent shall pay Petitioner permanent and total disability of $565.06 (Min. rate)/week for life commencing on June 24, 2021, pursuant to Section 8(f) of the Act.

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

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

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



SEPTEMBER 7, 2021

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JANINE PITTMAN,)
)
Employee/Petitioner,)
)
v.) Case No.: 19-WC-021896
)
BEVERLY FARM,)
)
Employer/Respondent.)

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 24, 2021 on all issues. Petitioner filed an Application for Adjustment of Claim alleging injuries to her left arm, wrist, hand, middle finger, and body as a whole as a result of her hand getting caught between the brake and wheel of a patient's wheelchair on June 20, 2019. The parties stipulated that Petitioner is entitled to TTD benefits from 2/14/20 through 4/19/20 (9-2/7 weeks), and maintenance benefits from 9/17/20 through the date of arbitration, 6/24/21 (40 weeks). The parties further stipulated that Respondent is entitled to a credit of $2,392.88 in TTD benefits paid and $9,970.32 in maintenance benefits paid. The issues in dispute are accident, causal connection, medical bills, and the nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner was 55 years old, single, with no dependent children at the time of accident. She graduated high school in 1981 and over 25 years later she attended basic community college classes. Petitioner attended a vocational technical school where she studied medical billing and coding but was never certified or worked in that field. After high school, Petitioner worked as a preschool teacher and teacher's assistant through 2017, although she was never certified to do so. That job required her to lift students weighing about 30 pounds with both hands daily. The next and last job Petitioner held was with Respondent where she was employed as a Direct Care Services Attendant. Petitioner's job duties involved helping clients with their daily life activities, including using the restroom, feeding, assisting them in and out of wheelchairs and beds, and clothing them. Her job required heavy lifting and the use of both hands daily.

Prior to June 20, 2019, Petitioner never experienced medical conditions that prevented her from working. She testified that on 6/20/19 she was preparing a client to board a wheelchair van when her left middle finger became caught between the brake and wheel of the client's

wheelchair. Petitioner testified she felt excruciating pain and reported the accident to her supervisor that day. She stated she was seen by Respondent's on-site medical personnel and X-rays of her left hand were taken. She was allowed to continue working, but her hand condition did not improve, and she sought treatment with her primary care physician, Dr. Becky Ganz. On 6/25/19, Dr. Ganz took x-rays and allowed her to continue working. Respondent referred her to Gateway Occupational Health (GOH) on 6/26/19 where she was prescribed medication, a hand brace, and work restrictions of no use of her left hand. Respondent provided Petitioner with light duty work as a switchboard operator where she answered phone calls, interviewed new clients, and performed data entry for new clients. She testified she used one finger to type with her nondominant right hand. Petitioner testified she was told by Respondent's Human Resource Manager, Toi Williams, that the switchboard operator job was not permanent and was created to accommodate her temporary restrictions.

Petitioner underwent an MRI and was referred to Dr. Randall Rogalsky on 7/15/19. Dr. Rogalsky placed her hand in a cast, prescribed medication, ordered physical therapy, and restricted her work duties to no use of the left hand. Petitioner's condition did not improve with therapy and she was referred to Dr. Corey Solman. On 12/18/19, Dr. Solman recommended she see a hand specialist. On 1/7/20, Petitioner treated with Dr. Richard Howard who recommended surgery and continued her restrictions. She underwent surgery on 2/20/20. She returned to light duty work at the switchboard on 4/20/20 and was released at MMI on 7/23/20 with permanent restrictions of limited use of the left hand, limited pushing, pulling, and grasping and no lifting greater than three pounds. She continued to work as a switchboard operator with those restrictions. She testified that Respondent told her they no longer have work available within her restrictions and she was terminated on 9/17/20.

Petitioner testified she performed a job search within her restrictions, and she has not been offered an interview or employment. She does not own a computer and she applies for jobs using her cell phone. While Petitioner lives in Alton, Illinois, she testified she sought employment not only in Alton, but also in Wood River, Godfrey, and Edwardsville, Illinois, as well as St. Louis and Hazelwood, Missouri and in the states of Arizona and Texas. She testified she contacted the employers listed by Respondent's vocational rehabilitation expert, Karen Kane-Thaler, and recorded those contacts on her job search logs. Those contacts did not result in employment. Petitioner testified she was evaluated by vocational rehabilitation counselor, Tim Kaver, on 12/15/20, and underwent testing providing her best effort.

Petitioner testified that throughout her treatment various physicians advised her to discontinue wearing her brace. She stated she continued to do so because it helps alleviate her pain. She stated that Respondent has paid all of her medical bills, with the exception of Dr. Ganz' bill in the amount of $114.00, which she personally paid.

Petitioner testified that her left hand is in constant pain and swells every day. The pain keeps her from sleeping more than four hours per night. She stated she experiences a constant burning sensation and redness in her hand, as well as a "zapping" sensation that shoots from her palm to her fingers. Petitioner's injuries have adversely affected her daily activities and she cannot use her left hand to wash her hair, wash dishes, or button clothing. She is left-hand dominant and writes by gripping a pen between her left thumb and index finger. She cannot tie

her shoes without assistance, and she lives alone. Petitioner testified she does not feel she is capable of working any job in any capacity.

Petitioner takes Tylenol daily and wears a fingerless glove prescribed by her physical therapist to alleviate pain. Petitioner removed the glove at arbitration and the Arbitrator visualized discoloration and swelling of Petitioner's left hand. Petitioner's left hand was lighter in color and swollen compared to her right hand. She attempted to make a fist and her fingertips were barely curled to the mid-part of her palm.

On cross-examination, Petitioner testified she sought employment every day for eight hours a day since Respondent terminated her employment. She testified that she prepared the hand-written job logs admitted into evidence. She utilized Indeed and LinkedIn and recorded whether she submitted an application to a potential employer. Petitioner stated she prepared a resume herself and followed up with potential employers by email. She did not contact potential employers in person due to the COVID-19 pandemic. She has not received treatment since being released by Dr. Howard.

Respondent called Human Resource Director and Safety Coordinator, Toi Williams, to testify as a witness. Ms. Williams testified she has held this position for two years and three months. Her job duties include receiving reports of injury and assigning light duty work. She testified she accommodated Petitioner's temporary restrictions by initially having her work in the gift shop. Petitioner was offered the job as switchboard operator due to the COVID pandemic. She stated Petitioner timely provided work slips and arranged doctor's visits through her. Ms. Williams testified that Petitioner held the switchboard operator position on 7/23/20 when her permanent restrictions were prescribed.

Ms. Williams identified a document that described the duties of a switchboard operator that was in effect in July 2020. Ms. Williams described the job duties to include, but not limited to, the operation of a single switchboard, receptionist duties, secretarial duties, and duties as assigned by the administrative assistant. Operating a switchboard included answering and transferring calls to various buildings and personnel and routing outgoing 911 calls. The switchboard operator also called various buildings on Respondent's campus to determine whether employees had reported to work and documented the findings in binders. The operator also documented information from potential clients who contacted the facility. She testified that the operator position required a pleasant disposition.

Ms. Williams testified she supervised Petitioner in the switchboard operator position from 4/20/20 through 9/17/20. Ms. Williams stated she had issues with Petitioner's job performance in talking on the phone and transferring calls. She stated Petitioner never reported being unable to perform the switchboard operator job, never told her she experienced left hand pain while performing her job, and never reported extreme fatigue due to working the position. She stated that if Petitioner were to report any of these issues it would be directly to her or the HR Manager.

Ms. Williams identified four Disciplinary Action Forms dated 1/9/20, 2/13/20, 8/21/20, and 9/17/20 related to Petitioner's job performance. She prepared three of the reports herself and

assisted the HR Manager in preparing the fourth report. On 1/9/20, Petitioner was performing her switchboard duties and received a verbal warning for missing calls and taking too long to answer calls. On 2/13/20, Petitioner received a written warning for failure to transfer calls to the supervisor and administrator. On 8/21/20, Petitioner received a written warning for being rude to some residents that called to speak to residents of another building. Specifically, Petitioner asked the residents why they called so often. On 9/17/20, Petitioner received a written warning for questioning a scheduler why he/she was calling in to take off work. Ms. Williams testified that the event that lead to Petitioner's termination was when Petitioner failed to contact maintenance when requested to do so. Ms. Williams testified that Petitioner's termination did not have anything to do with her inability to physically perform her job.

Ms. Williams testified that the switchboard operator job was only temporary due to Petitioner's restrictions, and that if her workers' compensation case was closed she would return to her previous direct support position. Ms. Williams explained that if the switchboard operator position became available full-time, Petitioner could have applied for it and Respondent could have accommodated Petitioner's permanent restrictions. However, Ms. Williams testified the switchboard operator position was a part-time position.

On cross-examination, Ms. Williams testified she has been a HR Safety Manager for 25 years. She believes Petitioner to be an honest person. Ms. Williams stated Petitioner was not instructed to perform secretarial or receptionist duties that is included in the job description of a switchboard operator, but all of the other duties were expected of Petitioner. She agreed that the switchboard operator duties included frequent use of both hands and lifting up to ten pounds frequently. Ms. Williams agreed that Petitioner's permanent restrictions included limited use of her left hand, limited pushing, pulling, and grasping, and no lifting greater than 3 pounds with her left hand. She denied that the essential job function of lifting up to 10 pounds was beyond Petitioner's permanent restrictions because the employee can use one hand to lift.

Ms. Williams testified that Petitioner received one disciplinary action from the date of her hire in February 2018 until the date of her accident in June 2019, and four disciplinary actions after her accident. She testified that no one filled the switchboard operator position prior to Petitioner although the position existed. The job description for switchboard operator was created in 2017. She stated that no one is presently working the switchboard operator job which is presently a part-time position. Since Petitioner's termination, the person answering the phones is called a switchboard/scheduler. Ms. Williams stated Respondent does not presently have a full-time job available within Petitioner's permanent work restrictions, but a part-time job is available that Respondent has not yet advertised.

MEDICAL HISTORY

On 6/25/19, Petitioner presented to her primary care physician, Dr. Becky Ganz, and provided a history of accident. Dr. Ganz diagnosed worsening left wrist and left finger pain. X-rays of the left hand revealed slight ossific density projecting over the dorsal margin of the third proximal phalanx, which the interpreting radiologist opined may reflect a subtle avulsion injury or degenerative change. X-rays of the left wrist were essentially negative.

At the direction of Respondent, Petitioner was seen at Gateway Occupational Health (GOH) the following day where a history of accident was recorded. Petitioner was diagnosis with a left wrist sprain and left third proximal phalanx avulsion injury. Petitioner was prescribed pain medication, a wrist brace, and restrictions of no use of the left hand. Petitioner continued to treat with GOH and an MRI was ordered due to ongoing symptoms. She was advised to discontinue the use of the brace to avoid developing adhesive capsulitis.

On 7/15/19, Petitioner was examined by Dr. Randall Rogalsky who took a history of accident and diagnosed a fractured left proximal phalanx of the middle finger. Dr. Rogalsky casted Petitioner's hand and continued her work restrictions of no use of the left hand. Dr. Rogalsky referred Petitioner to physical therapy that did not improve her condition. On 10/21/19, Dr. Rogalsky noted Petitioner could not bend her PIP or DIP joints and had decreased range of motion in her ring and fifth fingers. He referred Petitioner to Dr. Strenge for further treatment.

Dr. Strenge was not accepting new patients and Petitioner saw Dr. Corey Solman on 12/18/19. Dr. Solman took a history of accident and diagnosed chronic regional pain syndrome in the left long, right, and small fingers. He opined that the injury of 6/20/19 was the prevailing factor in the development of Petitioner's acute injury, that being a proximal phalanx fracture and/or sprain of the left long finger, and the immobilization period required for her injury incited chronic regional pain syndrome. Dr. Solman prescribed pain medication, imposed restrictions of no use of the left hand, and referred Petitioner to a hand specialist.

On 1/7/20, Petitioner was examined by Dr. Richard Howard who recorded her accident history and diagnosed stiffness of the finger joints of the left hand. He recommended surgery and limited use of the left hand, no pushing, pulling, grasping, and no lifting greater than 1-2 pounds. On 2/20/20, Dr. Howard performed an extensor tenolysis and PIP joint capsulotomies of the left middle, ring, and small fingers. Petitioner was taken off work and underwent physical therapy. Dr. Howard indicated in every office note that Petitioner's accident was work-related. He released Petitioner to light duty work effective 3/3/20 with restrictions of limited use of the left hand, no lifting, pushing, pulling or repetitive movement. Dr. Howard advised Petitioner to discontinue use of her splint in order to increase her range of motion. He reported that Petitioner did not appear motivated to push herself to gain a full fist. On 7/23/20, Dr. Howard released Petitioner at MMI with permanent restrictions of limited use of the left hand, limited pushing, pulling, grasping, and lifting, with a three-pound lifting limit.

Petitioner's job search logs contain over 300 job contacts from 2/12/21 through 6/17/21. A majority of the contacts reflect Petitioner submitted a job application. The job search logs do not contain information as to whether Petitioner was contacted in response to her applications or whether Petitioner followed up with the contacts.

Timothy Kaver testified via deposition on 5/13/21. Mr. Kaver is a certified vocational rehabilitation counselor who was retained jointly by Petitioner and Respondent's counsel to determine if Petitioner was employable, and if so, to develop a vocational rehabilitation plan. Mr. Kaver was provided with records, including Petitioner's job search logs to date, and Dr. Howard's permanent restrictions. Following his records review, interview of Petitioner, and vocational testing, Mr. Kaver opined Petitioner is unemployable in the open labor market.

Mr. Kaver based his opinion on Petitioner's age, permanent restrictions, limited educational background, scholastic aptitude, and limited work history lacking transferrable skills.

Regarding Petitioner's scholastic aptitude, Mr. Kaver administered the Adult Basic Learning Examination (ABLE) which determines a subject's reading ability, ability to understand what is read, and reading retention. Petitioner tested at a 6.6 grade level. Mr. Kaver also administered the Wide Range Achievement Test (WRAT) which revealed Petitioner's word recognition to be at the 7th grade level, arithmetic at the 3rd grade level, and spelling at the high school level. Mr. Kaver opined that Petitioner possesses very basic reading skills and very low math skills. He noted Petitioner is left-hand dominant and used her left hand to write during testing. She had to stop frequently and shake her and out. She reported her hand was fatigued after testing. Mr. Kaver testified he had no reason to doubt Petitioner's test-taking effort. He stated Petitioner had previous computer experience, including data-input and e-mail usage, though she has no Microsoft Word abilities. Mr. Kaver opined that if Petitioner had no restrictions on her left hand she would be employable at entry level service jobs that have on-the-job-training. Petitioner told him her left hand pain affects her sleep and makes her fatigued during the day, forcing her to recline periodically during the day. She reported that in a typical eight-hour day, she has to recline for up to six hours. This limitation is not reflected in Petitioner's medical records. Mr. Kaver's review of Karen Kane-Thaler's report of 2/26/21 did not change his opinion.

Karen Kane-Thaler testified by way of deposition on 6/1/21. Mrs. Kane-Thaler is a certified rehabilitation consultant who drafted two reports dated 2/26/21 and 5/25/21 with respect to Petitioner. She reviewed Mr. Kaver's report, Petitioner's permanent restrictions, and Petitioner's job search logs through the respective dates of her reports. Mrs. Kane-Thaler described her initial report as an "employability assessment labor market survey". She performed an aptitude profile and transferable skill analysis which defined Petitioner's baseline reasoning, mathematic, and language skills based on her job history obtained from Mr. Kaver's report.

Mrs. Kane-Thaler testified that based on Petitioner's educational background, participation in positions that require communication with individuals and documentation of that communication, and previous interest in the subject, Petitioner's skillset provided her with two options: 1) take vocational courses in billing and medical coding; or 2) apply to the numerous jobs for which Petitioner was immediately qualified, examples of which were provided. Mrs. Kane-Thaler further looked at accessible options in the St. Louis/Alton area, as well as applicable wage rates, to make this recommendation. Mrs. Kane-Thaler determined that given Petitioner's physical limitations, she would be able to work with a one-handed keyboard. She opined that based on research done in the open labor market of Alton, Illinois and the greater metro-east and St. Louis Metropolitan service area, Petitioner would be able to obtain employment.

In Mrs. Kane-Thaler's report dated 5/25/21, she evaluated Petitioner's job search logs from 2/1/21 through 4/18/21. Mrs. Kane-Thaler identified positions that Petitioner applied for that were not appropriate given her education level and physical limitations. She opined that Petitioner self-limited her job search by not expanding her search to jobs within 50 miles from

her home. She opined that Petitioner needed to refocus her job search on positions consistent with her physical and educational abilities.

On cross-examination, Mrs. Kane-Thaler admitted she has never met Petitioner or reviewed her resume. She admitted that Petitioner has no experience as a sales clerk, order taker, telephone sales representative, medical coder, accounts receivable specialist, cashier, garment inspector, sorter or hanger, ambassador, customer service loan specialist, customer service representative, receptionist or greeter, or account representative, all of which she listed in her report as jobs Petitioner was qualified to perform.

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. She was performing a task distinctly related to her employment which required her to assist clients with daily living activities, including maneuvering in a wheelchair. Petitioner felt "excruciating" pain when her left middle finger became caught between the brake and wheel of a client's wheelchair. Petitioner immediately reported her injury to her supervisor and provided a consistent history of accident to her treating physicians. Petitioner's testimony was consistent with the medical records. No evidence was introduced that contradicted Petitioner's history of accident.

Further, Respondent stipulated Petitioner is entitled to TTD benefits from 2/14/20 through 4/19/20 (9-2/7 weeks), and maintenance benefits from 9/17/20 through the date of arbitration, 6/24/21 (40 weeks). Based on the credible testimony of Petitioner and treating records, the Arbitrator finds Petitioner sustained her burden of proof in establishing she suffered an accident that arose out of and in the course of her employment with Respondent on June 20, 2019.

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

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 197 Ill.Dec. 502, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 66 Ill.Dec. 347, 442 N.E.2d 908 (1982).

The Arbitrator finds Petitioner's testimony credible that she had an immediate onset of pain and swelling in her left hand when her left middle finger got caught between the brake and wheel of her client's wheelchair. Petitioner was able to perform her job duties without incident prior to her accidental work injury on 6/20/19, which Petitioner described required her to lift and use both hands frequently. There was no evidence offered other than the work accident that could reasonably explain Petitioner's sudden onset of pain, redness, and swelling in her left hand and her inability to work. There is no history of prior injuries or treatment with respect to Petitioner's left hand. Drs. Solman and Howard unequivocally relate Petitioner's condition to her work accident of 6/20/19. Respondent did not submit a causation opinion pursuant to Section 12 of the Act and there is no evidence in the record to suggest that Petitioner's injuries were caused by anything other than her accident on 6/20/19.

Based upon the foregoing, the Arbitrator finds that Petitioner met her burden of proof and established that her current condition of ill-being in her left hand is casually related to her accidental injury of June 20, 2019.

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

Based upon the above findings as to accident and causal connection, the Arbitrator finds that Petitioner is entitled to the reasonable and necessary medical benefits. Respondent shall therefore pay Petitioner's medical expenses contained in Petitioner's Group Exhibit 14, as provided in Sections 8(a) and 8.2 of the Act, as the Arbitrator finds said bills to be reasonable, necessary, and causally related to the work accident. Respondent shall be given credit for any amounts previously paid under Section 8(a) of the Act for medical benefits. The parties stipulate that Respondent shall receive a credit for medical bills paid through its group medical plan pursuant to Section 8(j) of the Act. Respondent shall further hold Petitioner harmless from all claims or liabilities made by the group medical plan to the extent of such 8(j) credit.

Respondent shall reimburse Petitioner directly for out-of-pocket expenses in the amount of $114.00 she paid to Innovare Health Advocates/Dr. Becky Dr. Ganz.

Respondent shall further pay for the services provided by England & Company Rehabilitation Services, Inc. in the amount of $2,090.20. Mr. Kaver testified he met with Petitioner to determine employment and wage-earning potential of Petitioner at the request of

both counsel for Petitioner and Respondent. The joint agreement to retain Mr. Kaver's services was outlined in a letter dated 11/30/20 which was not attached to Mr. Kaver's deposition transcript or offered as an exhibit at arbitration. However, Respondent's counsel did not object in Mr. Kaver's deposition or at arbitration that it jointly retained Mr. Kaver's services. There is no evidence that Mr. Kaver's services or charges were unreasonable or unnecessary.

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

With respect to the nature and extent of Petitioner's injuries, the Arbitrator concludes that Petitioner is entitled to a permanent total disability award under the "odd-lot" theory.

The Illinois Supreme Court has frequently held that 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." *Ceco Corp. v. Industrial Comm'n,* 447 N.E.2d 842, 845 (Ill. 1985) (citing e.g*, Gates Division, Harris-Intertype Corp. v. Industrial Comm'n,* 399 N.E.2d, 1308 (Ill. 1980); *Arcole Midwest Corp. vs. Industrial Comm'n*, 405 N.E.2d 1306 (Ill. 1980)). However, an employee need not be reduced to total physical incapacity to be entitled to PTD benefits. *Id*. Rather, a person is totally disabled when he or she is incapable of performing services except those for which there is no reasonably stable market. *Id*. If an employee's disability is limited and it is not obvious that the employee is unemployable, the employee may nevertheless demonstrate an entitlement to PTD by proving that he or she fits within the "odd lot" category. *Id*. The odd lot category consists of employees who, "though not altogether incapacitated for work, [are] so handicapped that he will not be employed regularly in any well-known branch of the labor market." *Valley Mould & Iron Co. v. Industrial Comm'n*, 419 N.E.2d 1159 (Ill. 1981 (citing (2 A. Larson, Workmen's Compensation sec. 57.51, at 10-164.24 (1980)).

An employee meets the burden of proving that he or she falls into the odd-lot category in one of two ways: (1) by showing a diligent but unsuccessful job search; **or** (2) by demonstrating that the disability coupled with the employee's age, training, education, and experience does not permit the employee to find gainful employment. *ABB C-E Servs. v. Industrial Comm'n*, 737 N.E.2d 682 (5th Dist. 2000). Once the employee makes this showing, the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant. *Ceco Corp*, 447 N.E.2d at 845-846. *See also Westin Hotel v. Industrial Comm'n*, 865 N.E.2d 342, (2007). Absent evidence of available employment, the Commission can rightfully award PTD benefits to the employee. *Waldorf Corp. v. Industrial Comm'n*, 708 N.E.2d 476 (3d Dist. 1994).

To meet its burden, the employer must show more than a theoretical possibility of an available job and cannot rely on speculative testimony that the employee has the potential for employment. *See, e.g, Walliser v. Waste Management East*, 12 ILWC 2451, 2017 WL 4769231 (September 29, 2017). In *Walliser*, the Commission reversed a decision awarding a wage differential instead of PTD benefits to a garbage truck driver who performed a job search with vocational counselors provided by the employer that included approximately 2,000 job contacts. The counselor testified that she did not currently know of a job that was available for the worker but stated "it is not impossible in my eyes" and that just because she had not found him a job does not mean that one does not exist. The counselor further testified that the worker was

employable due to his “potential.” Yet, the counselor admitted that the job search was a “pretty good sample” and, out of those, he was not employable. The Commission found the counselor’s opinion “completely speculative and contradicted by the actual evidence.” The Commission explained that the worker was only required to show a diligent but unsuccessful job search, which he did. “He is not required to engage in a universally exhaustive job search that excludes every possible employer that might, possibly, offer employment to him at some undetermined point in the future.” Since the counselor acknowledged that it was a valid job search and the worker was unable to secure employment within his restrictions, the Commission awarded PTD benefits.

In this case, Petitioner proved that she falls into the “odd lot” category by both methods. Petitioner was released at MMI on 7/23/20 with permanent restrictions of limited use of the left hand, limited pushing, pulling, grasping, and lifting, with a three-pound lifting limit. Petitioner’s restrictions prevent her from returning to her pre-accident employment. She continued to work for Respondent as a switchboard operator within her permanent restrictions until she was terminated on 9/17/20. While Respondent allowed Petitioner to continue working as a switchboard operator, this fact does not render Petitioner employable in a reasonably stable labor market. Respondent’s Human Resources Director and Safety Coordinator, Toi Williams, testified that the switchboard operator position was only temporary due to Petitioner being on worker’s compensation. She testified that if Petitioner’s worker’s compensation case was closed, she would go back to her regular job as a direct care services attendant. Ms. Williams testified that no one held the switchboard before Petitioner was assigned the light duty position and the position was created for her. Ms. Williams testified that no one is presently working the switchboard operator job. Finally, Ms. Williams testified that Respondent does not presently have any full-time jobs within Petitioner’s permanent work restrictions.

Counsel for Petitioner and Respondent jointly retained the services of Tim Kaver of England & Company for a vocational evaluation. The joint agreement to retain Mr. Kaver’s services was outlined in a letter dated 11/30/20 which was not attached to Mr. Kaver’s deposition transcript or offered as an exhibit at arbitration. However, Respondent’s counsel did not object in Mr. Kaver’s deposition or at arbitration that it jointly retained Mr. Kaver’s services.

Mr. Tim Kaver testified he has been employed in the field of vocational rehabilitation since 1985 and certified since 1992. Mr. Kaver performs a variety of services for people who have disabilities, including developing vocational training plans, helping people become retrained for new careers, and providing job placement services for people coming out of school. He has a contract with the federal government under the United States Department of Labor for federal injured worker rehabilitation, and he also works for the State of Missouri Division of Workers’ Compensation.

Mr. Kaver interviewed Petitioner on 12/15/20 after reviewing her medical treatment along with her permanent sedentary restrictions. He noted that Petitioner had been employed at Beverly Farm as a Direct Care Services Attendant for one year earning $11.25 per hour. She was employed as a part-time preschool teacher and teacher assistant from 1982 to 2017 earning $7.25 per hour. Petitioner reported to Mr. Kaver she began looking for employment in November 2020 but was unable to identify any specific job goal as she did not know what job she was qualified

to perform or a job she could perform as a one-handed worker. Petitioner reported she primarily applied for office clerical jobs, although she did not believe to be qualified or physically able to be a competitive job applicant. Mr. Kaver felt vocational testing was appropriate given the time lapse since Petitioner's school enrollment. Petitioner tested at a 6.6 grade level on the Adult Basic Learning Examination (ABLE) which determines a subject's reading ability, ability to understand what is read, and reading retention. Mr. Kaver also administered the Wide Range Achievement Test (WRAT) which revealed Petitioner's word recognition to be at the 7th grade level, arithmetic at the 3rd grade level, and spelling at the high school level. Based on this testing, Mr. Kaver opined that Petitioner is not a good candidate for college course enrollment. He stated Petitioner would need to obtain new vocational skills through on-the-job training and not through written instruction.

Mr. Kaver noted Petitioner obtained a high school diploma in 1981. She completed basic studies courses as a part-time college student in 2007, 2008, and 2010. He noted Petitioner did not do well in college and she dropped out. He noted Petitioner was enrolled in a voc tech school for medical billing and coding but she did not complete the program and was never employed as a coder. He stated Petitioner possesses very basic computer skills and can input data only as she does not know how to type/keyboard. She is not familiar with Microsoft Word. Mr. Kaver reported that medical records verify Petitioner's inability to use her left hand for any sustained activities. He observed Petitioner using her left dominant, injured hand during testing for one hour. She had to periodically stop throughout testing and shake her hand. She reported that after testing her hand was fatigued and swollen. Mr. Kaver noted that Petitioner wrote rather shaky and very slow. He opined that such an injury does not allow Petitioner to perform manual labor activities, including caring for disabled patients or performing classroom work as a school teacher. Mr. Kaver testified that Petitioner has no professional clerical skills, and as a one-handed worker, she lacks the ability to train for any occupations. He opined that Petitioner lacks transferable skills which would allow her to function as a non-dominant, one-handed worker.

Mr. Kaver concluded that Petitioner is not employable in the open labor market. His opinion is based on Petitioner's permanent restrictions, her difficulty with daily living activities, limited educational background, scholastic aptitude, and limited work history lacking transferrable skills.

Petitioner began a self-directed job search on 2/12/21. She submitted job search logs containing over 300 job contacts from 2/12/21 through 6/17/21. A majority of the job contacts reflect Petitioner submitted an on-line job application. Understandably, Petitioner testified she did not contact potential employers in person due to the COVID-19 pandemic. Petitioner testified she does not own a computer and applied for the jobs using her cell phone, including filling out applications on her phone. She testified, and the job search logs reflect, that she applied for jobs located in Alton, Illinois where she lives, as well as Wood River, Godfrey, and Edwardsville, Illinois, St. Louis and Hazelwood, Missouri, and in the states of Arizona and Texas. She testified she contacted the employers listed by Respondent's vocational rehabilitation expert, Karen Kane-Thaler, and recorded those contacts on her job search logs. Those contacts did not result in a single job interview or employment.

Mr. Kaver reviewed Petitioner's job search logs through the date he testified on 5/13/21. He stated that Petitioner applied for clerical-based jobs because she did not know what type of jobs to apply for and was looking for sedentary, one-handed positions, which is typical of his clients that are not able to return to manual labor. He testified that Petitioner is not qualified for any office-based employment.

Despite Petitioner and Respondent's joint decision to retain the services of Mr. Kaver to perform a vocational assessment of Petitioner, and after Mr. Kaver opined Petitioner was not employable in the open labor market, Respondent retained Mrs. Kane-Thaler to perform a Employability Assessment/Labor Market Survey. Mrs. Kane-Thaler reviewed Petitioner's medical records, Mr. Kaver's report, a switchboard operator job description, and job search logs dated October 2020. The Arbitrator notes that no job search logs prior to 2/12/21 were offered into evidence at arbitration.

Mrs. Kaver obtained Petitioner's medical status, self-described physical limitations, current daily activities, educational background, academic training, and vocational background from Mr. Kaver's report. She testified that she does not have any information other than that contained in Mr. Kaver's report regarding Petitioner's educational background and scholastic aptitude. She testified she is not aware of any documentation that contradicts Mr. Kaver's findings. She stated that vocational rehabilitation counselors meet with individuals who need assistance finding work in order to "learn about their own personal impression of their physical ability, get a better understanding of their work history and job duties, and their impression of their educational abilities. However, she acknowledged she has never met Petitioner or had any discussions with her prior to issuing her reports.

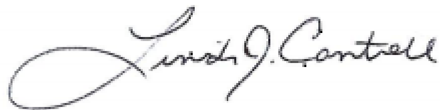
Mrs. Kane-Thaler testified she never reviewed any resume concerning Petitioner. She is aware that Petitioner has no employment experience as a sales clerk, order taker, telephone sales representative, medical coder, accounts receivable, cashier, garment inspector/sorter, ambassador or greeter, customer service loan specialist or representative, receptionist, or account representative. These are the positions that Mrs. Kane-Thaler identified in her report dated 2/26/21 that Petitioner may qualify for if she returned to school and obtained medical billing and coding training and enhancement of her computer knowledge and used a one-hand keyboard. Mrs. Kane-Thaler agreed that Petitioner does not qualify for some of the positions identified in her report without going to school and obtaining training. She further testified there are no jobs she would expect Petitioner to obtain without that education. She testified that the switchboard operator position would require Petitioner to operate a computer.

Mrs. Kane-Thaler testified she issued a second report after reviewing Petitioner's job search logs dated February 2021 through April 2021. She stated that Petitioner is employable because she is clear and concise, she worked as a switchboard operator for six to eight months, and she has the ability to use computers. Mrs. Kane-Thaler opined that Petitioner has at least basic level computer skills, if not more, utilized for basic communication, customer service skills, and maintaining records. Her opinion is based on Petitioner's job search logs that reflect Petitioner used email and performed job searches using the computer. Mrs. Kane-Thaler opined that Petitioner applied for jobs that were explicitly inappropriate given her educational background and physical restrictions.

After reviewing all the evidence, hearing Petitioner's credible testimony and personally viewing Petitioner's noticeably injured hand, while she may not be "obviously unemployable" as outlined by the *Ameritech Servs.* Court, the Arbitrator finds she is permanently and totally disabled as a result of the injury she sustained to her dominant hand on June 20, 2019. 389 Ill. App. 3d 191, 203-04, 904 N.E.2d 1122, 1133 (2009). In conjunction with Petitioner's diligent job search in her good-faith effort to find work within Dr. Howard's permanent restrictions, the Arbitrator finds the testimony of certified vocational rehabilitation counselor, Tim Kaver, more persuasive than that of certified rehabilitation consultant, Karen Kane Thaler. Respondent has failed to meet its burden of proving there is a reasonably stable labor market for Petitioner.

The Arbitrator finds Petitioner demonstrated that her disability, coupled with her age, training, education, and experience, does not permit her to find gainful employment in a regular and stable segment of the job market and finds Petitioner to be in the "odd lot" category of permanent total disability.

Accordingly, Respondent shall pay Petitioner permanent and total disability of $565.06 (Min. rate)/week for life commencing on June 24, 2021, pursuant to Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.



______________________________________ __________________

Arbitrator Linda J. Cantrell Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC029109
Case Name	BRYANT, ERIC v. STATE OF ILLINOIS/ CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	22IWCC0112
Number of Pages of Decision	12
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 3/21/2022

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIC BRYANT,

Petitioner,

vs. NO: 19 WC 29109

CHESTER MENTAL HEALTH CENTER,
STATE OF ILLINOIS.

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

March 21, 2022

o-3/8/22
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC029109
Case Name	BRYANT,ERIC v. CHESTER MENTAL HEALTH
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 8/09/2021

INTEREST RATE FOR THE WEEK OF AUGUST 10, 2021 0.05%

/s/ *Linda Cantrell, Arbitrator*

Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

AUGUST 9, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ERIC BRYANT
Employee/Petitioner

Case # **19** WC **029109**

v.

Consolidated cases:

STATE OF ILLINOIS/CHESTER MENTAL HEALTH 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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville,** on **June 23, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 15, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,236.00**; the average weekly wage was $**946.85**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **4** dependent children.

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

Respondent shall be given a credit of $**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 $**any benefits paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical expenses outlined in Petitioner's group exhibit 1 pursuant to the medical fee schedule or a PPO agreement (whichever is less) as provided in §8(a) and §8.2 of the Act. Respondent 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 be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits.

Respondent shall authorize and pay for the care and treatment recommended by Dr. Gornet, including but not limited to, a two-level disc replacement surgery at C5-6 and C6-7.

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

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

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

Arbitrator Linda J. Cantrell

ICArbDec19(b)

Date: August 9, 2021

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 23, 2021 pursuant to Section 19(b) of the Act. The parties stipulated that on September 15, 2019 Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. The issues in dispute are causal connection, medical bills, and prospective medical care with regard to Petitioner's cervical spine only. The parties stipulated that Petitioner's current condition of ill-being in his left shoulder is causally connected to his injury on 9/15/19, that the medical expenses with regard to his left shoulder were reasonable and necessary, and that Petitioner has reached maximum medical improvement with regard to his left shoulder. The only disputed injury subject to this Section 19(b) hearing is Petitioner's cervical spine. All other issues have been stipulated.

TESTIMONY

Petitioner was 37 years old, married, with four dependent children at the time of accident. Petitioner has been employed as a Security Therapy Aide I at Respondent's Chester Mental Health Center for seven and a half years. Petitioner testified that on 9/15/19 he broke up a fight between two patients and felt a pop in his left shoulder and had lower neck pain. Petitioner filled out an accident report and did not mention injury to his neck because he had more pain in his shoulder.

Petitioner denied any injuries or treatment to his left shoulder or neck prior to 9/15/19. He testified that two or three years ago he was punched in the head and a cervical MRI was performed because he had headaches. He stated the MRI results "came back clear" and he did not seek any treatment. Following the 9/15/19 accident Petitioner treated with Dr. Paletta for his left shoulder injury. He underwent an MRI, injections, physical therapy, and surgery to repair his rotator cuff. He stated that from the date of accident through his shoulder surgery he experienced neck pain but attributed the pain to his shoulder injury. He testified that his neck pain increased while undergoing physical therapy for his shoulder which he reported to his therapist. Dr. Paletta ordered a cervical MRI and referred Petitioner to Dr. Gornet.

Dr. Gornet ordered cervical injections that helped for a short time. He was examined by Dr. Bernardi pursuant to Section 12 of the Act. Dr. Bernardi released him to return to full-duty work without restrictions. Petitioner testified he returned to full-duty work. Petitioner testified he continues to have severe pain in his lower neck radiating into both shoulders and midway down his back that causes severe headaches. He desires to undergo surgery recommended by Dr. Gornet. He has not had any other injuries, trauma, or accidents since September 15, 2019.

On cross-examination, Petitioner agreed he did not indicate neck pain on the health questionnaire filled out at his initial visit with Dr. Paletta. He denied telling his physical therapist in February 2020 that he ran into a wall and had an increase in pain. He stated he went into a wall when he was trying to restrain the patient on 9/15/19.

MEDICAL HISTORY

Petitioner was evaluated at the emergency department at Chester Memorial Hospital following the accident. The note states decreased range of motion and pain and swelling over the left AC joint. X-rays were obtained and negative for fractures. Petitioner was diagnosed with an

acromioclavicular sprain and prescribed pain medication. He was to follow up with his primary care physician, whom he saw on 9/17/19 and was kept off work for persistent left shoulder pain.

On 9/23/19, Petitioner was evaluated by Dr. George Paletta for left shoulder pain. Dr. Paletta noted a consistent history of Petitioner's accident and complaints of significant left shoulder pain. Dr. Paletta noted Petitioner's pain radiated up to the base of his neck and into his shoulder blade. A physical examination was performed and suggestive of a rotator cuff tear. Dr. Paletta ordered an MRI of the shoulder and opinioned Petitioner's left shoulder condition was causally related to his work accident. He restricted Petitioner to no use of the left arm.

Petitioner underwent the shoulder MRI on 9/30/19 that demonstrated a moderate to high grade partial thickness rotator cuff tear involving the anterior supraspinatus. Dr. Paletta recommended an injection and physical therapy per the impingement protocol. He also recommended Medrol dose pack and Naprosyn. Petitioner returned to Dr. Paletta on 12/4/19 and reported temporary relief of his symptoms from the injection but his pain returned. Respondent did not approve therapy and the window for its efficacy had closed after the effects of the injection wore off. Dr. Paletta recommended surgery and continued Petitioner's light duty restrictions.

On 1/7/20, Petitioner underwent arthroscopic subacromial decompression, bursectomy, and acromioplasty, with distal clavicle excision, and rotator cuff repair. On 1/20/20, Petitioner reported improvement in his condition and his postoperative pain was reasonably well controlled with medication. He was to continue wearing his sling and begin physical therapy. He was given light duty restrictions. Petitioner began physical therapy on 1/27/20. He returned to Dr. Paletta on 2/26/20 and reported that everything had been progressing well until about a week prior when he experienced increasing pain, particularly with forward elevation. He also noted increased soreness in his shoulder. There was no precipitating trauma or injury. Because of the increased symptoms, Dr. Paletta held Petitioner off physical therapy for ten days and recommended a home exercise program. He remained on light duty.

Petitioner returned to Dr. Paletta on 4/14/20 and was progressing with physical therapy. He was progressed to therapy emphasizing functional rehabilitation, overhead strengthening, and work specific strengthening. He remained on light duty. On 5/27/20, Petitioner followed up with Dr. Paletta who noted he had been doing well until approximately three weeks prior when he noted increasing pain in the left shoulder, upper arm, and neck. There was no intervening trauma or injury. Upon physical examination of the cervical spine, Dr. Paletta noted mild limitation of extension and left lateral bend. Spurling's test provoked neck pain and pain into the periscapular region. He still demonstrated mild residual weakness of the left shoulder. Dr. Paletta believed that Petitioner's lingering complaints were cervical in nature and ordered a cervical MRI. He held physical therapy and prescribed a 12-day Prednisone taper. Petitioner was given work restrictions of no lifting more than 10 pounds overhead and no repetitive overhead activities. The cervical MRI was performed on 7/14/20 and the radiologist noted central protrusions at both C5-6 and C6-7 resulting in dural displacement. There was a right foraminal protrusion at C5-6 resulting in right foraminal stenosis, and bilateral foraminal protrusions at C4-5 resulting in mild bilateral foraminal stenosis.

On 8/19/20, Dr. Paletta noted a phone call from Petitioner stating physical therapy for his left shoulder caused a significant increase in neck pain. Dr. Paletta recommended Petitioner cease physical therapy and perform an at-home exercise program until he could be evaluated by

a spine specialist. Dr. Paletta believed Petitioner's cervical symptoms were contributing to his residual rotator cuff pain. Petitioner was evaluated by Dr. Matthew Gornet on 8/27/20 who noted Petitioner complained of bilateral shoulder pain, significant neck pain, frequent headaches, pain into both shoulders, left greater than right, and tingling into his arms to his forearms, and pain between his shoulder blades. Dr. Gornet noted Petitioner's accident and treatment history. That following rotator cuff surgery a portion of his symptoms remained and he experienced increased neck pain and headaches as he engaged in rehabilitation. Dr. Gornet noted Petitioner did not have any pre-accident neck pain or symptoms and his current symptoms were constant and worse with reaching, pulling, lifting, or fixed head positions. He also had bilateral arm parasthesias. Physical examination revealed restricted range of motion. Dr. Gornet reviewed the cervical MRI and noted central disc protrusions as C5-6, C6-7 and an annular tear at C6-7. Dr. Gornet assessed axial neck pain causing referred symptoms and parasthesias into Petitioner's bilateral shoulders and arms. Petitioner was given light duty restrictions of no lifting greater than 5 pounds and no overhead work. He was prescribed Meloxicam and Cyclobenzaprine and referred to Dr. Helen Blake for a steroid injection at C6-7.

On 9/17/20, Dr. Blake performed a steroid injection at C6-7. Petitioner returned to Dr. Gornet on 11/19/20 and reported the injection did not provide significant relief. Dr. Gornet recommended a CT scan to further evaluate Petitioner's facet joints. Dr. Gornet believed that Petitioner had exhausted conservative measures for his cervical condition and recommended surgical intervention in the form of a two-level disc replacement at C5-6 and C6-7. Petitioner's restrictions remained the same.

On 1/19/21, Petitioner was evaluated by Dr. Robert Bernardi pursuant to Section 12 of the Act. Dr. Bernardi testified by way of evidence deposition on 4/23/21. Dr. Bernardi testified consistently with the opinions expressed in his report. He noted that on 9/15/19 Petitioner was trying to break up a fight between two patients when he developed pain over the anterior aspect of his left shoulder. Petitioner reported it all happened so fast he was not exactly sure how he was hurt. His pain extended over the top of his left shoulder blade into the left side of his neck. Initially, he felt confident that everything was stemming from his shoulder. Now, the localized pain in his shoulder is 80 to 85% better since his surgery but his neck continues to bother him.

Dr. Bernardi noted Petitioner's pain began in the midline and extended to the left, radiating over the top of the left shoulder blade, and occasionally extending over the lateral aspect of the left deltoid. Dr. Bernardi reviewed Petitioner's medical records and noted them in his report. He noted Petitioner was pleasant, very cooperative, and showed no signs of symptom magnification. Dr. Bernardi reviewed the cervical MRI from 7/14/20 and noted disc protrusions at C5-6 and C6-7 but classified them as "minute" in appearance. Dr. Bernardi diagnosed very small and noncompressive disc protrusions at C5-6 and C6-7 and neck pain of uncertain etiology. He did not believe Petitioner's complaints were related to his work accident on 9/15/19 because his symptoms, physical exam findings, and neurological exam were not consistent with a symptomatic disc protrusion. He also believed that the records did not support a history that Petitioner's current neck symptoms were related to the work accident. He did not recommend further treatment and believed Petitioner was at maximum medical improvement. He did not believe Petitioner was a candidate for a two-level disc replacement even though he does not perform the recommended surgery.

On cross-examination, Dr. Bernardi testified that Petitioner did not have any prior history of significant neck pain before the work accident on 9/15/19. He stated there can be an overlap

between shoulder and neck pathology and that following left shoulder surgery, Petitioner's symptoms did not resolve. He agreed with Dr. Gornet that Petitioner did not have any neurological deficits and was suffering from axial neck pain. He also agreed that cervical disc protrusions could cause axial neck pain and headaches. Dr. Bernardi acknowledged that the findings on Petitioner's MRI could be asymptomatic and caused to be made symptomatic. Nevertheless, Dr. Bernardi did not believe that Petitioner's symptoms and pain were emanating from his disc protrusions at C5-6 and C6-7. He did not dispute that Petitioner suffered from the symptoms and pathology that he described, he merely could not explain them. However, he agreed that the mechanism of injury described by Petitioner is the type of mechanism of injury that could cause or aggravate an underlying condition of the cervical spine.

Dr. Bernardi acknowledged that Petitioner's cervical spine complaints were initially recorded in the records in May 2020 while undergoing physical therapy for his left shoulder. He further stated that Petitioner did not have a history of any intervening accidents or injuries to his neck. Dr. Bernardi agreed that when he examined Petitioner, he still had persistent neck complaints and had not returned to his pre-injury status or baseline. Moreover, he agreed that a patient's symptoms and complaints are the driving force behind treatment, including surgery, rather than findings on an MRI.

Dr. Matthew Gornet testified by way of evidence deposition on 3/11/21. He is a board-certified fellowship trained orthopedic surgeon whose practice is devoted to spine surgery. He actively participates in research and clinical trials concerning neck and low back pain, has performed countless cervical disc replacement surgeries, and authored papers on the topic. Dr. Gornet first saw Petitioner on 8/27/20 upon the referral of Dr. Paletta. He noted a consistent history of the accident and that prior to the accident Petitioner did not have any history of significant neck pain. He stated that following the accident Petitioner's symptoms were localized in the left shoulder and radiated into the base of his neck, but his neck pain came to the forefront after shoulder surgery and during the course of physical therapy. He stated there is often an overlap between cervical pathology and shoulder pain particularly when there is a mechanical load to the arm, which can cause a neck injury and/or shoulder injury. Dr. Gornet performed a physical examination and reviewed Petitioner's imaging studies which revealed central disc protrusions at C5-6 and C6-7. Dr. Gornet gave Petitioner work restrictions, ordered a steroid injection, and prescribed anti-inflammatories and muscle relaxants. Those conservative measures did not give Petitioner any lasting relief and Dr. Gornet recommends disc replacement surgery at C5-6 and C6-7.

Dr. Gornet testified he does not agree with Dr. Bernardi's assessment that Petitioner's neck pain was due to an uncertain etiology. He stated Petitioner has structural disc pathology at C5-6 and C6-7 which is the source of his symptoms. Classifying an injury as "minimal" depends on how much pain or symptoms it produces. In this situation, Petitioner has significant symptoms that are referable to that area. As far as "uncertain etiology", Dr. Gornet testified that Petitioner's neck pain is most certainly associated with his accident. Dr. Paletta clearly documents pain referred to the base of the neck on his first exam. Physical therapy made it dramatically worse which was documented by Dr. Paletta. Dr. Gornet testified there is no dispute that Petitioner's neck symptoms, which he did not have prior to his accident, are referable to his work-related injury and subsequent physical therapy. Dr. Gornet testified that he did not expect Petitioner's symptoms to resolve without surgery and that following the recommended surgery, he expects Petitioner would likely return to full-duty work and his symptoms will considerably improve.

Petitioner returned to Dr. Gornet on 3/29/21 and continued to report significant axial neck pain, frequent headaches, and pain between his shoulder blades. Dr. Gornet reviewed Dr. Bernardi's report with Petitioner. Dr. Gornet noted that his treatment recommendations remained the same and he believed Petitioner would benefit from the proposed surgery. Non-steroidal anti-inflammatories and muscle relaxers were dispensed and Petitioner's restrictions remained the same.

CONCLUSIONS OF LAW

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

The parties stipulated that Petitioner accident on 9/15/19 arose out of and in the course of his employment. Petitioner testified credibly and without rebuttal that prior to 9/15/19 he was working full duty with no restrictions. Following the accident, Petitioner developed immediate severe shoulder pain and pain in the base of his neck. He initially believed the neck pain was coming from his shoulder, but following surgery, he still had lingering neck pain that became more severe during the course of physical therapy. Petitioner's neck pain became so severe an MRI was ordered and he was referred to Dr. Gornet. Both the radiologist, Dr. Ruyle, and Dr. Gornet observed the same pathology at C5-6 and C6-7.

The Arbitrator finds Petitioner's testimony to be credible and consistent with the medical evidence. Drs. Gornet and Bernardi testified Petitioner's accident would be a sufficient mechanism of injury to cause disc protrusions at C5-6 and C6-7. There is no history in the record that evidences any pre-existing neck condition. The Arbitrator also relies on the credible opinions of Dr. Gornet in finding a causal connection between Petitioner's cervical condition and the 9/15/19 work accident. The Arbitrator finds the opinion of Dr. Gornet to be persuasive given the objective findings on Petitioner's MRI, his interpretation of the MRI consistent with both Dr. Ruyle and Dr. Paletta, the lack of cervical symptoms prior to the work accident, and Petitioner's persistent complaints of neck pain since the accident.

The Arbitrator is not persuaded by Dr. Bernardi's opinions that Petitioner's work accident did not contribute to his cervical condition in any way, that the etiology of his pain could not be explained, and that treatment is not necessary. Dr. Bernardi agreed there is an overlap between shoulder and cervical spine symptoms, that Petitioner's records initially noted pain in the base of his neck and later severe pain into both shoulders following post-operative physical therapy, and that the only history of accident or injury was the 9/15/19 incident. Moreover, Dr. Bernardi testified he did not doubt Petitioner's report of axial neck pain and he agreed that Petitioner had not returned to his pre-injury baseline over a year after the accident.

Based upon the foregoing, the Arbitrator finds that Petitioner met his burden of proof regarding causal connection and finds Petitioner's current condition of ill-being in his cervical spine is causally connected to his work injury of 9/15/19.

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

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

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 383, 902 N.E.2d 1269, 1273 (2009). Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings as to causal connection and the objective medical evidence showing pathology accountable for his symptoms, the Arbitrator finds Petitioner is entitled to the reasonable and necessary medical care administered and recommended. Petitioner attempted to resolve his condition conservatively with a steroid injection, work restrictions, nonsteroidal anti-inflammatories, and muscle relaxants. He has continued to work at the direction of Dr. Bernardi. Despite conservative treatment and the passage of time, Petitioner's condition of ill-being continues to persist.

Respondent shall pay the reasonable and necessary medical expenses outlined in Petitioner's group exhibit 1 pursuant to the medical fee schedule or a PPO agreement (whichever is less) as provided in §8(a) and §8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits.

Respondent shall authorize and pay for the care and treatment recommended by Dr. Gornet, including but not limited to, a two-level disc replacement surgery at C5-6 and C6-7.

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

Arbitrator Linda J. Cantrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC032205
Case Name	DZIEDZIC, CHRISTINE v. WOODLAWN MEMORIAL PARK
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0113
Number of Pages of Decision	23
Decision Issued By	Christopher Harris, Commissioner

Pro Se	Christine Dziedzic
Respondent Attorney	Padraig McCoid

DATE FILED: 3/22/2022

/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

CHRISTINE DZIEDZIC,

Petitioner,

vs. NO: 18 WC 32205

WOODLAWN MEMORIAL PARK,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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.

March 22, 2022

CAH/tdm
O: 3/17/22
052

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

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC032205
Case Name	DZIEDZIC, CHRISTINE v. WOODLAWN MEMORIAL PARK
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	Peter Lekas
Respondent Attorney	Padraig McCoid

DATE FILED: 7/21/2021

THE INTEREST RATE FOR THE WEEK OF JULY 20, 2021 0.05%

/s/ *Joseph Amarilio, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRISTINE DZIEDZIC, Case # **18 WC 032205**
Employee/Petitioner

v.

WOODLAWN MEMORIAL PARK,
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 **JOSEPH D. AMARILIO**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MAY 20, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/19/2018**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**69,766.84**; the average weekly wage was $**1,341.67**.

On the date of accident, Petitioner was **48** 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.

ORDER

DENIAL OF BENEFITS:

Because Petitioner's conditions of ill-being are not causally related to the accident of May 19, 2018, benefits are denied.

Respondent shall be given a credit of $**0.00** for temporary total disability benefits that have been paid, if any.

Respondent shall be given a credit of $**0.00** for medical benefits that have been paid, 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.

Joseph D. Amarilio

Signature of Arbitrator JOSEPH D. AMARILIO

JULY 21, 2021

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Christine Dziedzic,)
)
Petitioner,)
vs.) No. 18 WC 032205
)
Woodlawn Memorial Park,)
)
Respondent.)

ATTACHMENT TO DECISION OF ARBITATOR

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Finding of Facts

Petitioner testified she was a Family Service Manager, a sales manager, for Woodlawn Memorial Park ("Woodlawn') at the time of the accident (Tr. 16). She started working for the Respondent in January of 2018. (Tr pp. 64-65) Respondent Woodlawn does not dispute the accident of May 19, 2018. (Arb.X1) On May 19, 2018, Petitioner testified she was walking outside her office to get to her car and saw a frequent visitor sitting in his car. The visitor came daily, sometime times 2-3 times a day, to visit his wife's grave. (Tr. pp. 18 -22). Petitioner had prior incidents with the visitor that required a police report (Tr. 21). She testified the individual was not allowed in the office. *Id*. On May 19, 2018, as this individual looked at her, he accelerated his vehicle in such a way that it made a screeching sound. He was speeding towards her. (Tr. 22-25) Petitioner testified she turned and ran about 200 yards away from the individual to the office. *Id.* At trial, she testified she twisted her ankle or foot (Tr. 88). She noticed her left foot swell immediately after the incident and later it became black and blue. *Id*. She testified the incident resulted in conditions of ill-being to her left foot, lumbar spine condition, and dental.

Petitioner's job duties included overseeing the sales operations at the cemetery and funeral home (Tr. 11). She testified her job duties included preparing a budget, hiring and training employees, and sales (Tr. 12, 90-91). She attended funeral services and inspected grave sites (Tr. 12-13). Her duties included telemarking and campaigning to generate sales (Tr. 14). She attended burials and

stayed during the service. (Tr. 111). She was able to leave the service if a family service counselor was available. *Id*. She testified she worked from 7:45 a.m. to the same time in the evening (Tr. 13). She testified her job was never a sit-down job (Tr. 15). A job description showed requirements of meeting sales quotas, managing sales counselors, developing marketing programs, participating in events to raise awareness for the business, reviewing contracts and discounts, and preparing reports (RX 3). The job description does not include physical requirements. *Id*. Petitioner testified there were sales counselors available to assist if she was unable to perform a task (Tr. 93).

Petitioner testified that her job was pretty rigorous and that she was in and out of the building all day long and in the evening. She testified that she spent very little time in her office. Petitioner testified that her job was not a sit-down job. (Tr. pp. 13, 15, 16)

Petitioner worked for Woodlawn approximately four months before the accident. (Tr. 98). She testified she was not wearing a boot at any time during the four-month period. *Id*.

Following the accident, Petitioner returned to Woodlawn and resumed her job duties (Tr. 33; Tr. 99). She testified she was working within her work restrictions (Tr. 98). Petitioner testified she had to crawl on her hands and knees to return to her car after a funeral service (Tr. 99-100).

Petitioner was terminated from Woodlawn for an unrelated cause on October 2, 2018 (Tr. 98-99). Following her departure, Petitioner testified she did not seek new employment because she had surgery scheduled on November 20, 2018 and expected to be off work post-operation (Tr. 97). Petitioner did not undergo surgery until May 2019 (Tr. 104). She testified she has not sought any employment since leaving Woodlawn, because she was not released to work. *Id*. Also, she did not seek employment because she was "creating a job." *Id*.

Petitioner testified that she misses being an active person and uses cannabis to reduce her pain. Petitioner testified that she is losing her feet from inflammation and pain and this causes a spike in her blood pressure. She further testified that she has trouble sleeping and that she lost teeth from clenching her teeth due to pain. Petitioner testified that she uses Tylenol on occasion. (Tr. pp. 67-68)

Petitioner testified that she took business classes at Morton College but did not complete a four-year degree. Petitioner testified that she has worked at cemeteries, funeral homes and crematories for the last 32 years. Petitioner testified that she has experience in sales. (Tr. Pg. 69-70)

Petitioner testified on cross-examination that Dr. Rozanski released her to return to work as a custodian in January 2017. Petitioner testified that her life was getting back to normal form her surgeries in January of 2017. Petitioner testified on cross-examination that she was truthful answering Dr. Rozanski's questions when he examined her on May 23, 2018. Petitioner further testified that Dr. Rozanski's records were not correct on May 23, 2018. (Tr. pp. 75-82)

Petitioner testified on cross-examination that she did not see Dr. Mahr for her left foot on June 18, 2018. Petitioner testified on cross-examination that she saw Dr. Rozanski one time after

September 17, 2020. She testified that Dr. Rozanski wrote her a handicapped placard note to renew it for her car. (Tr. pp. 82- 85*)*

Petitioner testified on cross-examination that sales counselors at work would help her if she needed assistance. She further testified that she was a cemetery and funeral general manager multiple times in the 1990's. Petitioner testified on cross-examination that she was the founder of a business called Gone But Not Forgotten, a pre-standing bereavement gift shop. Petitioner testified on cross-examination that she has no employees for her new company and is looking to sell her new business concept to funeral directors or cemetery managers. (Tr. pp. 93-97)

Petitioner testified on redirect examination that running was not her thing and that she did not do a lot of running prior to May 19, 2018. Petitioner testified that she is a walker not a runner. (Tr. pp. 112-113)

Testimony of Elizabeth Del Real

Ms. Elizabeth Del Real was the office manager for Woodlawn on the date of the accident (Tr. 116). She worked for Woodlawn's parent company for ten years. *Id*. Ms. Del Real testified the employee parking lot was "right next to" the office. (Tr. 118). She recalled Petitioner complained of her left foot before the accident (Tr. 118). Ms. Del Real testified Petitioner wore a boot on her left foot "on and off" before the accident (Tr. 119). She recalled Petitioner complaining of her left foot prior to the accident. *Id*.

Ms. Del Real testified Petitioner was working within her restrictions after the accident (Tr. 120, 123). She testified the funeral services employees attended lasted between 10 and 20 to 30 minutes (Tr. 125). Ms. Del Real stated there were other employees available to assist with job duties, including the general manger, family service manager, and others (Tr. 127). She heard no issues related to Petitioner's ability to perform her job duties after the accident. *Id*.

Elizabeth Del Real testified on cross – examination that the individual was not allowed to come into the office anymore. She further testified that she was aware of the Petitioner's incident on May 19, 2018. Ms. Del Real testified that the Petitioner came through the back door on May 19, 2018 and stated that the individual was trying to run her down in the parking lot in the back. Ms. Del Real testified that she called the police after this incident. Apparently, a police report was not made regarding the May 19, 2018 incident. (TR. pp. 121-122)

Pre-Accident Medical Summary

Petitioner underwent three surgeries to the left foot in 2016. In March 2016, Dr. Brian Rozanski removed a ganglion cyst formed at the dorsal aspect of her left foot, as well as a bunion (RX2, p. 10). In September 2016, Dr. Rozanski performed a removal of a recurrent ganglion cyst (RX5). In December 2016, Dr. Rozanski performed a bone fusion with bunionectomy with excision of an additional portion of the ganglion cyst (RX6).

On January 19, 2017, Petitioner complained of pain under the arch of her left foot (Tr. 73). Dr. Rozanski instructed Petitioner not to do any extensive weight bearing. (Tr. 74). He prescribed a boot (Tr. 75). He authorized Petitioner to work in a sedentary position (RX, pp. 30-31).

Post-Accident Medical Summary

On May 23, 2018**,** four days after the work accident, Petitioner returned to Dr. Rozanski. She complained of pain in her left foot for several months (PX1, p. 1). Petitioner told Dr. Rozanski she believed the pain may have been due to walking on the foot too soon after surgery (PX1, p. 1). Petitioner testified Dr. Rozanski made a mistake by not mentioning the work accident (Tr. 77). Petitioner testified her foot was "swollen and black and blue when I came in, so there was something that happened that day." (Tr. 65). Dr. Rozanski's office notes do not mention the left foot appearing black and blue nor being swollen (PX1, p. 1; Tr. 82). An X-ray of the left foot was negative for fractures or dislocations (PX1, p.1). The study demonstrated a broken screw at the Lapidus site, but not where the pain palpated. *Id*. Dr. Rozanski diagnosed plantar fasciitis/myositis and possible avascular necrosis, or AVN. *Id*.

On May 30, 2018, Dr. Rozanski wrote notes after a telephone call with Petitioner (PX1, p. 2). His notes indicate Petitioner mentioned an "incident" at work. *Id*. He opined the work incident fractured the arthrodesis site and screw. *Id*. He based his decision on the lack of improvement after an injection. *Id*.

On June 12, 2018, an MRI of the left foot demonstrated post-surgical changes, no evidence of fracture, hallux valgus deformity, and arthropathy at first metatarsophalangeal ("MTP") joint (PX1, pp. 4-5).

Petitioner was examined by her primary physician, Dr. David Mahr on June 18, 2018 and June 25, 2018. Dr. Mahr noted on June 18, 2018 that Petitioner was noticeably trying to avoid putting weight on her left foot while walking. On June 25, 2018, Dr. Mahr noted that the Petitioner had finally gotten a hold of Dr. Rozanski to look at her foot. (PX. 4, pp. 3-4, 12)

On June 17, 2018, Petitioner presented to Adventist Medical Center LaGrange's emergency room. The Adventist records were admitted as Respondent's Exhibit 10. Petitioner presented with low back pain (RX10, p. 7). She testified she went to the emergency room after losing control of her bladder (Tr. 31). She told Dr. Jessica Sinnott she was moving furniture the day before when she began experiencing pain. *Id*. Petitioner testified the office notes are inaccurate (Tr. 101). The pain was non-radiating and like the pain she experienced with kidney stones in the past (RX10, p. 7; Tr. 101). An MRI of the lumbar spine demonstrated mild degenerative spondylosis (RX10, p. 10). Dr. Sinnott diagnosed back pain and instructed Petitioner to follow up with her primary care

physician. *Id*.

On July 2, 2018, Petitioner returned to Dr. Rozanski for the left foot (PX1, p. 9). She reported an incident at work that triggered her left foot condition. *Id*. Dr. Rozanski diagnosed plantar fasciitis/myositis and possible AVN. *Id*. He administered a second injection to the left foot and recommended a bone stimulator to avoid surgery. *Id*.

On October 17, 2018, Petitioner presented to Dr. George Holmes pursuant to Section 12 of the Act. The Arbitrator admitted Dr. Holmes' reports as Respondent's Exhibit 2 and an intake form as Petitioner's Exhibit 7. On the intake form, Petitioner wrote a history of "threw out my back while on boot for foot injury from balance, limping." (PX7, p. 4; Tr. 99-100). Relative to the foot, she reported running from an aggressive customer, turning a corner, and having an immediate onset of pain (RX 2, p. 9). The left foot pain radiated to the lateral side of her foot and up her leg. *Id*. Dr. Holmes found Petitioner had a nonunion from a previous Lapidus surgery with single screw fixation (RX2, pp. 10-11). He diagnosed a long-standing nonunion from the pre-accident surgery (RX2, p. 11). He found her current complaints were not related to the accident. *Id*. Dr. Holmes based his opinion on the May 23, 2018 office note showing there was pain present in the left foot for several months, as well as Petitioner's history that she walked on the foot too soon after surgery. *Id*. He also based his opinion on his review of the diagnostic films, which "clearly show a longstanding nonunion." *Id*. Dr. Holmes recommended operative treatment, including removing the screw and possibly putting a bone graft in the area. *Id*. He found any future treatment unrelated to the work accident. *Id*. Regarding work restrictions, he recommended steel shank rocker-bottom soled shoes. *Id*. Dr. Holmes found any restrictions were not related to the work accident. *Id*.

On October 29, 2018, Petitioner returned to Dr. Rozanski and reported minimal relief from injections (PX1, p. 11). Dr. Rozanski diagnosed a nonunion of the left foot at the Lapidus with a broken screw. *Id*. He recommended excision of the nonunion with arthrodesis using a graft. *Id*.

Petitioner testified that surgery was scheduled for November 20, 2018. Petitioner further testified that the Respondent cancelled the surgery on November 19, 2018. Petitioner testified that she remained under the care of Dr. Rozanski and that the pain in her left foot continued to worsen. (TR. pp. 35-37)

On March 29, 2019, Dr. Rozanski drafted a narrative opinion addressed to Petitioner's attorney. Dr. Rozanski noted he failed to take a history of the incident due to modifications of a template that he frequently used (PX1, p. 55). He noted the mechanism of injury may not have been traumatic, but it could cause injury. *Id*. Dr. Rozanski agreed with Dr. Holmes that the pain Petitioner was experiencing was from a nonunion at the arthrodesis site. *Id*. Also, he agreed that the nonunion was not caused by the incident, as nonunions occur over time. *Id*.

However, he disagreed that the incident could not aggravate a nonunion. *Id*. He opined not all nonunions are painful. *Id*. Dr. Rozanski opined because Petitioner was asymptomatic working at a full-time job prior to the incident proved that the nonunion already was present. *Id*. He believed

it was reasonable to believe the incident aggravated her existing but asymptomatic nonunion. *Id*. He recommended a resection of the nonunion and arthrodesis with use of a graft. *Id*. He recommended sedentary work (PX1, p. 56).

On May 6, 2019, Petitioner presented to Adventist's emergency room (PX3). She had a medical history of hypertension, anxiety, cancer, and chronic left foot pain (PX3, p. 9). She reported a history of feeling great and kneeling to clean a bathtub when she felt a stabbing pain between her toes. *Id*. She could not walk up her steps. *Id*. She rated her pain at 10/10 near the left hip. *Id*. She reported being an everyday smoker. *Id*. The physician diagnosed chronic left foot pain with concern for an ischemic limb and history of hypertension (PX3, p. 13). The physician noted Petitioner had broken hardware in foot and prescribed Norco. *Id*. She had no deep vein thrombosis (PX3, p. 77). He admitted Petitioner to the hospital (PX3, p. 14)

On May 9, 2019, Dr. Rozanski performed an excision of the nonunion with arthrodesis using allograft material (PX1, pp. 12-13). Petitioner testified she noticed no improvement after the surgery (Tr. 43).

On July 24, 2019, Petitioner returned to Dr. Rozanski with left foot pain (PX1, p. 47). Dr. Rozanski recommended continued physical therapy and authorized Petitioner off work. *Id*.

Petitioner testified that she had no physical therapy after her left foot surgery. Petitioner further testified that she did not notice any improvement after her surgery. (Tr. pp. 42-43)

On August 7, 2019, Dr. Holmes reviewed updated medical records and drafted a Section 12 addendum report. Dr. Holmes diagnosed a nonunion from a failed Lapidus surgery that was unrelated to the work accident (RX2, pp. 7-8). He found if patients have a nonunion, they are unable to "make a nonunion a greater nonunion." (RX2, p. 7). Dr. Holmes noted one of the most common complications of a Lapidus procedure is a nonunion. *Id*. He found the surgery to repair the nonunion was unrelated to the work accident. *Id*. Dr. Holmes found any work restrictions were unrelated to the accident. (RX2, p. 8). He found Petitioner at maximum medical improvement. *Id*.

On October 10, 2019, Petitioner returned to Dr. Rozanski and reported numbness in her left toes with pain towards the ankle (PX1, p. 48) The examination revealed no pain with passive range of motion. *Id*. There was some pain to palpation at the antero-medial region to the left ankle. *Id*. Dr. Rozanski performed a left foot injection and authorized Petitioner off work. *Id*.

On December 9, 2019**,** Petitioner related numbness in her toes and pain toward her ankles. (PX1, p. 49) She reported the injection did not provide much relief. *Id*. In addition, she now claimed her right foot was painful due to overcompensation of the left foot. *Id*. The exam revealed no pain with passive range of motion, but some pain with palpation to the antero-medial ankle. *Id*. The right foot had a bunion that was without pain and no crepitus. *Id*. Dr. Rozanski recommended Petitioner continue weight bearing as tolerated. *Id*. He recommended multi-lock system ("MLS") laser treatment, which was administered on December 12, 2019. *Id*.

On February 3, 2020, Petitioner reported weight bearing periodically. *Id*. She continued with numbness in the toes and pain toward the ankle. *Id*. Also, she related right foot pain from overcompensating. *Id*. Dr. Rozanski recommended she continue weight bearing as tolerated. *Id*. Dr. Rozanski noted the laser treatment was unsuccessful and stopped after three treatments. *Id*.

An MRI of the lumbar spine on February 6, 2020 demonstrated right paracentral disc protrusion with annular disc fissure and mild facet arthropathy at L1-L2, and disc bulges at L4-L5 and L5-S1 (PX1, p. 52).

On June 17, 2020, Dr. Holmes examined Petitioner for a second time in accordance with Section 12 of the Act. Petitioner complained of bilateral foot and back pain (RX2, p. 1). The examination revealed increased pain in the left foot more than the right (RX2, p. 2). She had pain with palpation across the medial aspect of the tarsometatarsal joints. *Id*. Dr. Holmes diagnosed a nonunion from the Lapidus surgery (RX2, p. 3). He opined the accident did not aggravate Petitioner's pre-existing condition. *Id*. Dr. Holmes found the MLS laser treatment, ongoing office visits, physical therapy, and the injection unrelated to the accident. *Id*. He found any further treatment unrelated to the work accident. *Id*. Dr. Holmes opined Petitioner could return to work in a sedentary or semi-sedentary capacity. *Id*. He found she could walk with shoe inserts for at least 15 minutes per hour. *Id*. He recommended an additional CT scan to determine if the Lapidus has healed. *Id*. If healed, she would be at maximum medical improvement. *Id*.

On July 16, 2020, Petitioner presented to Dr. Joseph Rabi at Chicago Pain and Orthopedic Institute. The Arbitrator admitted the records from Chicago Pain and Orthopedic Institute as Petitioner's Exhibit 5. She presented for the left foot, low back, upper extremity, lower extremity, and facial numbness and tingling (PX5, 1). She reported a history of running from a customer, pivoting, and noticing immediate pain in her left foot. *Id*. The examination revealed no swelling, positive lumbar facet loading, a positive straight leg raise, and diminished sensation in the upper and lower extremities. *Id*. Dr. Rabi assessed left foot injury and low back exacerbated from wearing a boot (PX5, p. 2). He noted he was not sure that her back injury was related to the work. *Id*. He authorized Petitioner off work and recommended physical therapy and an EMG (PX5, pp. 2, 9). The office note does not mention moving furniture (Tr. 103).

On July 20, 2020, Petitioner presented to Dr. Steven Sclamberg at Chicago Pain and Orthopedic Institute. She reported back pain after wearing a Cam boot (PX5, p. 3). The exam revealed a mildly antalgic gait, tenderness over the medial malleolus over the midfoot diffusely, and swelling over the left foot and ankle. *Id*. Dr. Sclamberg diagnosed left foot pain. *Id*. He authorized Petitioner off work and ordered a CT and X-rays of the left foot (PX5, p. 3, 11).

On July 21, 2020, a Nerve Conduction Study/Electromyography test was performed at Chicago Neurodiagnostics by Dr. Olga Kozlova upon referral form Dr. Rabi. Dr. Kozlova opined that there

is electrodiagnostic evidence of bilateral lower lumbar radiculopathies primarily affecting L5 roots, chronic with no evidence of acute denervation and left peroneal mononeuropathy, chronic, sensorimotor, moderate in severity (PX5, pp. 12-19).

On July 27, 2020, Petitioner returned to Dr. Sclamberg and reported left foot, left leg, and whole-body pain (PX5, 5). She reported being unable to perform her daily activities. *Id*. She managed her pain with marijuana and was not taking other medications. *Id*. The exam revealed a mildly antalgic gait, decreased plantar flexion and dorsiflexion secondary to pain, tenderness over the medial malleolus over the midfoot diffusely, and mild swelling over the left foot and ankle. *Id*. A CT scan of the left foot demonstrated postoperative and degenerative changes. *Id*. An X-ray of the left foot demonstrated no acute fractures and degenerative changes. *Id*. Dr. Sclamberg diagnosed left foot pain and recommended a functional capacity evaluation. *Id*. He authorized Petitioner off work (PX5, p. 10). He concluded the whole-body pain was not likely related to the foot (PX5, p. 5). He recommended the whole-body pain and suicidal ideations be addressed prior to further treatment. *Id*.

On August 6, 2020, Dr. Sclamberg interpreted an EMG as demonstrating bilateral lumbar radiculopathy at L5, chronic (PX5, p. 7). He also found left peroneal mononeuropathy. *Id*. Petitioner's back pain was "doing okay," with most of the pain in the foot and leg. *Id*. The exam revealed positive lumbar facet loading, a negative straight leg raise, and intact sensation in the upper and lower extremities. *Id*. Dr. Sclamberg diagnosed left foot injury, low back pain exacerbated from wearing a boot, likely muscle and chronic pain, and possible lumbar radiculopathy. *Id*. Dr. Sclamberg found Petitioner had no back pain, so there was nothing he could do for her from an interventional pain perspective (PX5, p. 8). He concluded the back injury or pain did not come from the work injury. *Id*. He opined the back pain came from the common peroneal neuropathy from the left foot. *Id*.

On September 17, 2020, Petitioner returned to Dr. Rozanski with pain at the left ankle radiating up her bilateral legs and lower back (PX1, p. 57). She noted occasional swelling to her left foot. *Id*. The exam revealed strength within normal limits with guarding in the left foot and ankle. *Id*. There was no tenderness to palpation at the arthrodesis site on left foot. *Id*. Dr. Rozanski diagnosed status post arthrodesis of the first met-cuneonavicular joint of the left foot due to the nonunion of the Lapidus. *Id*. He found Petitioner at maximum medical improvement. *Id*. He released Petitioner to work with restrictions of avoiding standing or walking for extended periods. He instructed her to follow-up with him as needed. (Px 1, p. 54)

Petitioner testified she continues with left foot pain (Tr. 58). She is no longer wearing a boot (Tr. 104-105). She can weight bear and drive (Tr. 104-105, 112). She testified she can barely get out of bed in the morning. *Id*. She stated it was hard to sit, stand, and lie down (Tr. 59). She uses marijuana to handle pain (Tr. 67). She is not taking pain medication (Tr. 86). Petitioner testified the accident also resulted in issues with her teeth (Tr. 68). At trial, she indicated she was missing a tooth. *Id*. There are no medical records related to her dental condition.

Evidence Deposition of Dr. Rozanski

On November 18, 2019, Dr. Rozanski testified through an evidence deposition. The Arbitrator admitted Dr. Rozanski's deposition transcript as Petitioner's Exhibit 2. Dr. Rozanski was licensed in 2002 after attending podiatry school and three years of residency (PX2, pp. 5-6). He was board-certified as a Doctor of Podiatric Medicine in 2007 (PX2, pp. 6-7). He has not published any medical articles (PX2, p. 8). Dr. Rozanski sees an average of 300 patients a month (PX2, p. 29). Not many of the patients involve trauma requiring surgery. *Id*.

Dr. Rozanski testified he asks each patient why they came in for a visit (PX2, p. 10). When Petitioner presented on May 23, 2018, he had not examined her in over a year (PX2, pp. 29-30). He noted the pain was present for several months in the left foot, and Petitioner thought it was because she walked too soon after surgery (PX2, p. 31). The office note does not contain a history of the accident (PX2, p. 32). He testified he documents histories provided by patients (PX2, p. 43). Dr. Rozanski testified a work incident involving running would be important in determining causal connection, and he would want to include such information in his office notes (PX2, p. 40).

Rozanski testified Petitioner informed him the May 23, 2018 office note was inaccurate (PX2, p. 42). It was possible he was in a rush when he saw her that day (PX2, p. 47). He said it was possible Petitioner had told him about the incident at work (PX2, p. 47). The possibility of her telling him about the work accident was based on an assumption (PX, p. 52). Also, he testified that it made no sense for Petitioner to have pain for several months and not present for care (PX2, p. 48). This was also based on an assumption (PX, p. 52).

He testified he had a telephone call with Petitioner on May 30, 2018 (PX2, p. 12). Petitioner conveyed an injury at work during the call (PX2, pp. 13). He said it was at that point he determined Petitioner's condition involved a nonunion (PX2, p. 14).

He testified the incident at work could have aggravated the nonunion (PX, p. 51). He testified the accident was a contributing factor to the surgery (PX, p. 51) He based his opinion on Petitioner being asymptomatic and having no pain before the accident (PX2, p. 25). Dr. Rozanski agreed walking on a nonunion too soon after surgery can displace a screw (PX2, p. 45). He testified his office note stating Petitioner had pain for several months would mean she was symptomatic (PX2, p. 45). Dr. Rozanski testified smoking and being overweight could cause issues with healing (PX2, p. 34). A common complication from a Lapidus procedure is a nonunion (PX2, p. 35). He testified the first time he recommended surgery was after Dr. Holmes' first exam (PX2, p. 37).

Regarding work restrictions, Dr. Rozanski testified he released Petitioner to sedentary work (PX2, pp. 22-23). He testified his understanding of a sedentary job is to sit behind a desk (PX2, p. 23). He had no knowledge of Petitioner's job title (PX2, p. 46). He did not read a job description (PX2, p. 46). He did not recall her job duties (PX2, p. 46).

Evidence Deposition of Dr. Holmes

On December 2, 2019, Dr. Holmes testified through an evidence deposition. Dr. Holmes' Section 12 reports were summarized above. The Arbitrator admitted Dr. Rozanski's deposition transcript

as Respondent's Exhibit 8. Dr. Holmes is a board-certified orthopedic surgeon (RX8, p. 5). He completed medical school in 1976, two years of residency, and orthopedic training in 1985. *Id*. Dr. Holmes specializes in foot and ankle surgery (RX8, p. 6). He performs an estimated 200 surgeries related to the foot and ankle every year (RX8, p. 7). Dr. Holmes practices at Midwest Orthopedics at Rush, where they treat more non-unions than the average community orthopedic surgeon (RX8, p. 8). He authored medical articles related to delayed unions and/or nonunions in 1994, 2006, and 2013 (RX8, pp. 9-10).

Dr. Holmes examined Petitioner at Respondent's request on October 17, 2018. (RX8, p. 12). Dr. Holmes obtained X-rays which confirmed a "straightforward nonunion" of her prior Lapidus procedure with single screw fixation, and sclerotic margins consistent with a longstanding nonunion (RX8, p. 15). Dr. Holmes explained how the sclerotic margins are similar to the "rings on a tree," which can reveal the history of nonunion, and the lack of soft bony bridging was indicative of a longstanding nonunion (RX8, pp. 17-18). Finally, he noted her history of cigarette smoking in relation to healing (RX8, pp. 17).

Dr. Holmes confirmed the opinions in his October 2018 report that the alleged work injury did not cause or contribute to the nonunion, the nonunion predated the incident, and no medical treatment or work restrictions would be related to any work injury (RX8, p. 16). Dr. Holmes reviewed his summary of the medical records, and noted the history Petitioner gave to Dr. Rozanski on May 23, 2018 was pain for several months in the left foot, and that she thought she walked on it too soon after surgery, was experiencing significant pain in the mornings and while transferring from a seated to standing position, and did not give any history of trauma or injury (RX8, pp. 16-17). Dr. Holmes noted the phone note on May 30, 2018 contradicted the history in May 23, 2018 note, and this did not change his opinion that the nonunion and broken screw predated the work incident (RX8, pp. 31-32; 35).

Dr. Holmes testified his opinion may have changed if a patient had no symptoms prior to an incident (RX8, pp. 33-34). He testified a gap in treatment could mean a patient was asymptomatic, in general (RX8, p. 32). He explained it would not be unusual for a patient to not present for treatment (RX8, p. 38). Dr. Holmes compared it to patients who fail to treat tumors or broken bones, patients with bad outcomes after surgery, and patients with "surgeon fatigue." *Id*.

Also, the radiographs demonstrated a longstanding nonunion with sclerosis; therefore, it was unlikely one instance would cause a screw to fail (RX8, p. 37). He opined the surgery on May 9, 2019 was unrelated to the work accident (RX8, pp. 24).

Dr. Holmes testified he was aware Petitioner was a sales manager (RX8, p. 18). He confirmed his recommendation that she wear steel shanked shoes at work. *Id*. Any work restrictions were unrelated to the accident (RX8, p. 19).

Independent Rehabilitation Services' Report

On April 9, 2019, David Patsavas, a Certified Rehabilitation Consultant, prepared a Labor Research Report. The Arbitrator admitted the report as Respondent's Exhibit 1. As part of her job, Petitioner was responsible for developing sales staff and meeting sales quotas, increasing market share and customer base, and maintaining ethical standards (RX1, p. 4). She was expected to have a working knowledge of Windows-based computer applications and customer relationship management systems (RX1, p. 4).

Mr. Patsavas reviewed Petitioner's education, work history, and skills described in her professional online profile and business website (RX1, p. 3). Her online profile states she "has experience in Sales, with a demonstrated history of working in the Death Care Services industry." *Id*. The profile states Petitioner is skilled in "sales leadership training, new store development, telemarketing, in-home sales, and notes that she is a successful business owner and a strong sales professional." *Id*. Petitioner stated she had 32 years in the Death Care Services industry (RX1, p. 3; Tr. 69).

Also, Mr. Patsavas reviewed her business website. Petitioner testified her new business is an outdoor venue for memorial services (Tr. 56). The website states Petitioner is the Founder and Creator of MissUMuch.com, the world's first memorial drive-in custom movie theater. (RX1, p. 4). In addition, she is the "Founder of the patented and trademarked Gone But Not Forgotten which was the very first free-standing bereavement gift shop and grief resource center in that area." *Id*. She first testified she started the website on April 13, 2020. *Id*. She later testified she started the website in 2019 (Tr. 97). She testified she has not made money from the website. *Id*.

Regarding her education, Mr. Patsavas notes Petitioner took Business Administration and Management courses at Morton College. *Id*. She does not have a four-year degree (Tr. 69). She is a Minister of Consolation and Bereavement through the Archdiocese of Chicago. *Id*.

Mr. Patsavas concluded from Petitioner's education and work history, she had "a notable career in sales and sales management, as well as a documented history of entrepreneurship and business ownership. (RX1, p. 11). The job descriptions and online profiles reviewed by this Consultant infer an advanced level of computer skills, including use of Microsoft Office programs and sales specific platforms." *Id*.

Mr. Patsavas found a viable and stable labor market existed for Petitioner in her geographic area, within her overall transferable skills, physical capabilities, work history, and educational background (RX1, p. 12). He identified 18 positions to be potentially viable for Petitioner with her education, work history, and work restrictions (RX1, pp. 5-10). Mr. Patsavas found Petitioner could earn wages in between $40,000.00 and $70,000.00 per year (RX1, p. 12).

II. Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his or her 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). It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable. *Shell Oil v. Industrial Comm'n,* 2 Ill.2nd 590, 603 (1954). Decisions of an Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Petitioner testified in open hearing before the Arbitrator who had opportunity to view Petitioner's demeanor under direct examination, and under cross-examination. The Arbitrator finds the Petitioner demeanor appeared to be sincere in her beliefs. The Arbitrator notes Petitioner's testimony during the trial was at times argumentative and frequently non-responsive. Which is understandable in part due her desire to be believed. However, the Arbitrator finds Petitioner's testimony was inconsistent with the medical records and contained exaggerations. Her testimony was contradicted by the facts, the medical records and the record as a whole.

The Arbitrator finds Ms. Elizabeth Del Real testimony to be credible. Her testimony was candid and straight forward.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator makes the following findings and conclusions:

The Arbitrator finds Petitioner failed to meet her burden of proof that the accident caused the condition of ill-being related to the left foot, lumbar spine, and dental conditions. Petitioner failed to provide a consistent or credible history regarding the onset and extent of her symptoms.

Petitioner's testimony alone may not be sufficient to carry her burden of proof, especially in light of the long-standing principle expressed in *Shell Oil v. Industrial Commission*, 2 Ill.2d 590 (1954), where the Illinois Supreme Court held that contemporaneous medical records are more reliable than later testimony because "[i]t is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission,* 98 Ill. 2d 20 (1983).

To argue the contrary would require 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. *U.S Steel v. Industrial Commission,* 8 Ill. 2d 407 (1956).

The Arbitrator finds Petitioner failed to prove her current condition of ill-being related to the left foot is causally related to the accident of May 19, 2018. In reaching the conclusion, the Arbitrator notes the inconsistencies in the record and in Petitioner's testimony. The original treating record calls to question the onset of symptoms. On May 23, 2018, Petitioner reported several months of pain in the left foot (PX1, p. 1). She told Dr. Rozanski she thought the pain started from walking on the left foot too soon after the pre-accident surgery. *Id*. In the initial office note, Dr. Rozanski makes no mention of the onset of pain beginning after running at work or any incident at work. He testified such a history would be important to establish causation it relates to Petitioner's left foot condition (PX2, p. 40, 43).

The Arbitrator finds it significant Dr. Rozanski noted the history of walking on the left foot too soon after surgery, but he failed to document running several days prior. Moreover, Petitioner testified with certainty that her left foot was swollen, black and blue, when she was initially seen by Dr. Rozanski, and, thus, she argued something occurred "that day." Her testimony was not corroborated in the office note. To the contrary. The initial office notes specifically state that the physical examination revealed no ecchymosis and no edema. (Tr. p. 65, PX1, p. 1)).

The Arbitrator finds it significant that Dr. Rozanski upon performing a physical examination did not find evidence of ecchymosis and swelling. The Arbitrator is mindful that a bruising and swelling is consistent acute trauma. Moreover, Dr Rozanski initial assessment was as follows: 1. Planter fasciitis/myositis. 2. Pain in limb. 3. Difficulty walking. 4. Possible AVN. (PX1, p. 1) None of which was indicated by Dr. Rozanski as an acute traumatic condition.

Even if Dr. Rozanski failed to document the history during the initial visit and failed to observe ecchymosis and swelling, he noted left foot pain for several months prior to the visit. The Arbitrator finds the history of several months of left foot pain consistent with Elizabeth Del Real's testimony, who stated Petitioner was wearing a boot "on and off" in the four months prior to the accident (Tr. p. 119). She also testified Petitioner complained of the left foot prior the accident. Also, the history of several months of pain is consistent with Dr. Holmes' review of the diagnostic films that demonstrated a longstanding nonunion.

The Arbitrator acknowledges Dr. Rozanski mentions a work incident in his notes after a telephone call on May 30, 2018 with Petitioner. Although he mentions the incident, Dr. Rozanski based his causation opinion on the assumption Petitioner was asymptomatic prior the work accident. Ms. Del Real's testimony and Dr. Rozanski's own office note on May 23, 2018 contradict this assumption. Further, the Arbitrator finds it significant Dr. Rozanski did not provide a detailed history of the accident until July 2, 2018, almost two months after the accident.

The Arbitrator finds that the opinions of Dr. Holmes are more consistent with the facts and gives minimal weight to the opinions of Dr. Rozanski. The Arbitrator notes he is not required to give more weight to a treating physician's opinion over another examining physician's opinion. *Prairie Farms Dairy v. The Industrial Commission*, 279 Ill.App.3d 546 (5th Dist. Ind. Comm. Div. 1996).

Dr. Rozanski based his causation opinion on the assumption that Petitioner worked a full-time job without issue prior to the accident; without pain or discomfort. His opinion, however, does not mention Petitioner's use of a boot on the left foot while working for Woodlawn prior to the accident. Further, his opinion contradicts his own office note from May 23, 2018 that stated Petitioner had several months of left foot pain and that no swelling or bruising was noted upon physical examination.

The Arbitrator notes that Dr. Rozanski agreed with Dr. Holmes that Petitioner's diagnosis was a nonunion in her left foot. They both agreed that the nonunion was not caused by the work incident. However, Dr. Rozanski disagreed with Dr. Holmes that if the work incident did in fact occur, it could not have caused an aggravation of the nonunion. (Px 2, pp. 20-21) Dr. Rozanski opinion that a nonunion "absolutely" could be aggravated by trauma and become symptomatic is more persuasive in theory but not based on the credible facts and circumstances of this matter.

Also, Dr. Rozanski's testimony calls to question his credibility as it relates to causation. Dr. Rozanski testified as to the importance of taking detailed office notes related to the onset of symptoms. He claimed his office notes might be "porous." (PX1, p. 55). Dr. Rozanski clearly wanted to give the Petitioner the benefit of the doubt and state that his office notes maybe porous. However, the Arbitrator does not believe that he would have overlooked to record the significant bruising and swelling as testified by Petitioner. Dr. Rozanski failed to explain his own negative findings for bruising and swelling. Findings one would expect to see with an acute twisting injury.

Dr. Rozanski testified that he based his opinions on assumptions, instead of the facts contained in his own office notes. Further, Dr. Rozanski was unaware of Petitioner's job duties and never reviewed a job description for a family service manager (Tr. 46). He testified he was unaware of Petitioner's job title. At trial, Petitioner testified Dr. Rozanski's notes were inaccurate (Tr. p. 77).

Dr. Holmes' findings were generally consistent with the evidence. His findings were based on a review of the records and diagnostic films. He based his opinions on the pre-accident medical records, lack of history provided in the initial treating records, and diagnostic reports and films. He referenced the MRI of the left foot that showed a longstanding non-union. Dr. Holmes provided an explanation regarding how his review of the records and examination led him to conclude there was no causal connection. In contrast, Dr. Rozanski testified his opinions were based, in part, on assumptions. Assumptions which proved to be not supported by the evidence. Therefore, the Arbitrator finds Dr. Holmes' findings more consistent the facts and finds Petitioner's current condition of ill-being unrelated to the work accident.

As the issue of causation relates to the lumbar spine, the Arbitrator finds Petitioner's condition unrelated to the accident. The Arbitrator finds it significant Petitioner provided an alternative history related to the lumbar spine on June 17, 2018. She provided a history of injuring her back while lifting furniture the day before the visit. When asked about the inconsistencies, Petitioner testified the provider's notes were also inaccurate. The Arbitrator finds it significant Petitioner claims a second provider had incorrect or wrong notes. The Arbitrator finds it unlikely two independent providers produced inaccurate notes related to the onset of injuries. Moreover, the first time Petitioner reported low back pain related to using the boot was when she presented to Dr. Holmes on October 17, 2018, four months after the onset of complaints. Given the alternative history and lack of any concurrent history related to use of the boot for fourth months, the Arbitrator finds Petitioner failed to prove by a preponderance of the credible evidence that her lumbar spine condition is causally connected to the work accident.

Even if the records included a consistent history related to the lumbar spine, her own treaters failed to provide a causal connection to the work accident. On July 16, 2020, Dr. Rabi noted he was not sure the back condition was related to the work injury (PX5, p. 2). On July 27, 2020, Dr. Sclamberg concluded Petitioner's whole-body pain was not likely related to the left foot and suggested a psychological evaluation (PX5, p. 5).

Based on the totality of the evidence, the Arbitrator finds that Petitioner failed to prove that her lumbar spine condition is causally connected to the work accident.

As it relates to the dental condition, Petitioner testified the left foot condition caused her teeth to fall out. Petitioner did not produce any causation opinion stating the dental condition was related to the work accident. Moreover, Petitioner's dental condition is mentioned nowhere in the factual or medical records. The first mention of the dental condition was revealed at trial. Therefore, the Arbitrator finds the dental condition is unrelated to the work accident.

Petitioner testified for the first time she twisted her ankle or foot on the accident date. This history is found nowhere in the medical records. Also, Petitioner testified she was crawling on her hands and knees while working after the accident. This history was never described to any provider and appears nowhere in the records. Petitioner's testimony was contradicted by Ms. Del Real, who testified Petitioner had no issues performing her job duties after the accident date. Petitioner also testified she had to run 200 yards, or two football fields, on the date of the accident. Although Petitioner claimed that was walker, not a runner, she testified that she outran a speeding car over the distance of a speeding car.

Ms. Del Real's testimony that the employee parking lot was next to the office makes this testimony not credible and is an additional example of Petitioner's exaggerations. In addition, Petitioner testified she experienced no improvement after the surgery in May 2019. However, she testified she was no longer wearing a boot and could now weight bear on her foot. In addition, Petitioner's

testimony related to when she started her business was contradicted during cross examination. She testified on direct that she started her business in April 2020, but later admitted on cross that she started the site in 2019.

The Arbitrator gives more weight to the medical records containing contemporaneous notes than Petitioner's testimony years after treatment. Petitioner testified at least two of her providers - Dr. Rozanski and Dr. Sinnott - had inaccurate office notes as it relates to the mechanism of injury. The Arbitrator finds it questionable for two independent providers to have inaccurate histories of the onset of symptoms. Based on her multiple exaggerations and contradictions, the Arbitrator gives more weight to the contemporaneous medical records related to the onset of Petitioner's left foot and lumbar conditions.

In addition, Petitioner claimed she never had issues with her left foot during the fourth months prior to the work accident. Her testimony was contradicted by the initial office note stating she had several months of left foot pain prior to the accident. This history is consistent with Ms. Del Real's testimony that Petitioner wore a boot on her left foot "on and off" before the accident. The Arbitrator finds the testimony of Ms. Deal Real credible, and finds her testimony provided additional proof Petitioner had issues with the left foot several months before the accident.

Based on the totality of the evidence, the Arbitrator finds Petitioner not credible and discounts her testimony. The Petitioner's argument that Dr. Rozanski simply wrote the incorrect history in the initial treatment records is contradicted by the facts in the record. Further, the Arbitrator finds Ms. Del Real's testimony regarding Petitioner's pre-accident complaints and use of a boot more credible given Petitioner's demeanor and lack of credibility at trial.

Based on the record as a whole, including the testimony, medical records and exhibits, and the expert deposition testimony, the Arbitrator finds Petitioner failed to prove by a preponderance of the credible evidence that her left foot condition, lumbar spine condition, and dental condition were causally connected to the work accident.. The Arbitrator bases his decision on the lack of credibility of Petitioner's testimony. The Arbitrator gives more weight to the findings and opinions of Dr. Holmes since they are supported by the evidence. Moreover, the medical records and Ms. Del Real's testimony suggest Petitioner's left foot condition was preexisting and caused by Petitioner walking on the left foot prior to the surgery.

In support of the Arbitrator's decision with respect to (J) Medical Expenses, the Arbitrator makes the following findings and conclusions:

Based on the Arbitrator's findings of a lack of causal connection between Petitioner's current condition of ill-being and the work accident, the Arbitrator finds Respondent is not liable for medical expenses related to Petitioner's treatment.

In support of the Arbitrator's decision with respect to (K) Temporary Total Disability, the Arbitrator makes the following findings and conclusions:

Based on the Arbitrator's findings of a lack of causal connection between Petitioner's current conditions of ill-being and the work accident, the Arbitrator finds Respondent is not liable for temporary total disability benefits.

In support of the Arbitrator's decision with respect to (O) Nature and Extent of Injury, the Arbitrator makes the following findings and conclusions:

Based on the Arbitrator's findings of a lack of causal connection between Petitioner's current conditions of ill-being and the work accident, the Arbitrator finds no permanency is warranted, and, thus, none is awarded.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC009251
Case Name	RICHARDS, MARY v. US STEEL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0114
Number of Pages of Decision	17
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Mary Massa, Nathan Becker
Respondent Attorney	James Keefe, Jr.

DATE FILED: 3/22/2022

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)) SS. COUNTY OF MADISON)	☒ Affirm and adopt (no changes) ☐ Affirm with changes ☐ Reverse ☐ 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

MARY RICHARDS,

Petitioner,

vs. NO: 17 WC 9251

U.S. STEEL,

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 (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2021 is hereby affirmed and adopted.

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

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

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.

March 22, 2022

CAH/pm

O: 3/17/2022

052

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC009251
Case Name	RICHARDS, MARY v. U S STEEL
Consolidated Cases	
Proceeding Type	
Decision Type	Corrected Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Nathan Becker
Respondent Attorney	James Keefe, Jr.

DATE FILED: 9/15/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 14, 2021 0.05%

/s/*Linda Cantrell, Arbitrator*

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Mary Richards
Employee/Petitioner

v.

U.S. Steel
Employer/Respondent

Case # **17** WC **009251**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **6/23/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/2/17**, 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 with respect to her left shoulder and cervical spine are causally related to the accident.

In the year preceding the injury, Petitioner earned $**76,334.96**; the average weekly wage was $**1,467.98**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**19,573.06** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**19,573.06**.

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

ORDER

The parties stipulated that Petitioner's left shoulder and cervical spine injuries are causally connected to her work injury on 2/2/17. The Arbitrator finds that Petitioner's right shoulder condition is not causally connected to her work injury of 2/2/17.

The parties stipulated that the medical treatment related to Petitioner's left shoulder and cervical spine is reasonable, necessary, and related, except for chiropractic treatment she received. Based on the Arbitrator's finding that Petitioner's right shoulder condition is not causally connected to her work injury on 2/2/17, Respondent is not liable for any medical expenses related to Petitioner's right shoulder.

Respondent shall pay reasonable, necessary, and causally related medical expenses related to Petitioner's left shoulder and cervical spine, including chiropractic expenses, contained in Petitioner's Group Exhibit 18, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given 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.

The parties stipulated that Petitioner is entitled to and Respondent paid 20 weeks of TTD benefits from 3/21/17 through 3/26/17 and 7/31/18 through 12/11/18. The claim for TTD benefits for the period 3/12/20 through 10/19/20 relates to Petitioner's right shoulder and said benefits are denied based on the Arbitrator's finding that Petitioner's right shoulder condition is not causally connected to her work injury of 2/2/17.

Respondent shall pay Petitioner permanent partial disability benefits of $**775.18 (Max Rate)** per week for **200** weeks, because the injuries sustained caused 15% loss of person as a whole related to Petitioner's left shoulder injury and 25% loss of person as a whole related to Petitioner's cervical spine injury.

Respondent shall pay compensation that has accrued from July 22, 2019 through June 23, 2021, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Arbitrator Linda J. Cantrell

SEPTEMBER 15, 2021

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARY RICHARDS,)
)
Employee/Petitioner,)
)
v.) Case No.: 17-WC-009251
)
U.S. STEEL,)
)
Employer/Respondent.)

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 23, 2021 on all issues. Petitioner made an oral motion to amend the Application for Adjustment of Claim to reflect the correct date of accident of February 2, 2017 and include Petitioner's right shoulder and neck as body parts affected. The Arbitrator granted Petitioner's motion to amend without objection. The parties stipulated that on February 2, 2017 Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. The issues in dispute are causal connection with regard to Petitioner's right shoulder only, medical bills related to Petitioner's right shoulder and chiropractic bills related to Petitioner's cervical spine and left shoulder, temporary total disability benefits related to Petitioner's right shoulder only, and the nature and extent of Petitioner's injuries. The parties stipulated that Petitioner's current conditions of ill-being in her cervical spine and left shoulder are causally connected to her injury on 2/2/17, and that the medical expenses with regard to her cervical spine and left shoulder, with the exception of chiropractic bills, were reasonable and necessary. All other issues have been stipulated.

TESTIMONY

Petitioner was 63 years old, married, with no dependent children at the time of arbitration. She testified she worked for Respondent for 25 years and retired on 3/29/21. The last ten years of her career she was designated as an electrician. Petitioner testified she was injured on February 2, 2017 when she was walking through a doorway and a tool belt, which was hanging from her right shoulder, got caught on the door causing her to fall to the ground. Petitioner reported to the emergency room and followed up with Respondent's doctor, Dr. Kent Parker, who referred her to Dr. George Paletta. Dr. Paletta ordered an MRI of her left shoulder and on 3/21/17 he surgically repaired a torn rotator cuff, SLAP tear, and a long head biceps tear. Prior to undergoing left shoulder surgery, Petitioner experienced headaches and neck pain that radiated into both shoulders that made it difficult to lift. She had stiffness, weakness, and loss of

range of motion in her shoulder. Dr. Paletta released Petitioner to full duty work on 11/15/17. She testified her left shoulder has improved, but she still has weakness and decreased range of motion. She did not have any problems with her left shoulder prior to 2/2/17.

Petitioner testified that Dr. Paletta ordered an MRI of her cervical spine and referred her to Dr. Matthew Gornet. She underwent two injections by Dr. Helen Blake and a two-level disc replacement at C5-6 and C6-7 on 7/31/18 by Dr. Gornet. Petitioner stated that prior to cervical surgery she had headaches, neck pain, and a lot of pressure. She stated her neck symptoms significantly improved following surgery. She still has some radiating pain into her shoulders and very few headaches. Looking up for more than 4 to 5 minutes increases her symptoms and she has to rest. Petitioner testified she did not have any of these symptoms prior to 2/2/17.

Dr. Gornet ordered an MRI of Petitioner's right shoulder and referred her back to Dr. Paletta. Dr. Paletta thought she required a reverse total shoulder replacement and referred her to Dr. Jay Keener. Petitioner agreed that her medical records do not indicate right shoulder symptoms until March 2019, two years after her accident. She testified she told the emergency room personnel she had right shoulder pain. She admitted she injured her right shoulder 20 years ago but she has been pain free since and was able to swing 10-pound sledgehammers at work. She has not received treatment for her right shoulder in the last 20 years. She testified she also told Dr. Parker and Dr. Paletta she had right shoulder pain, but those symptoms are not mentioned in their records. She stated the doctors only addressed one injury at a time and did not treat her right shoulder until her left shoulder and neck were repaired. She testified she told Dr. Gornet on 2/8/18 she had right shoulder symptoms. Dr. Gornet told her the pain in her right shoulder could be radiating from her neck injury.

Petitioner agreed that the pain diagrams she filled out shortly following her accident do not indicate right shoulder symptoms. She stated she only indicated on the diagrams what was hurting her the most at the time. The first time right shoulder symptoms are mentioned in the medical records is on 3/11/19 when Dr. Gornet noted Petitioner had an increase in right shoulder pain after working with a railroad gate for Respondent in February 2019. She testified she did have right shoulder pain immediately following the 2/2/17 accident. She stated her shoulder hurt the same following the work duties she performed in February 2019 as it did after her accident on 2/2/17.

Petitioner began treating with Dr. Keener on 10/1/19 and underwent a right reverse total shoulder replacement on 3/12/20. He placed her off work while she underwent post-operative care. She stated that after her accident on 2/2/17 until she had the right shoulder replacement, she experienced weakness, pain, and decreased range of motion in her shoulder. She continues to have weakness and pain in her shoulder. She supports her right arm with a towel when she sleeps and she has difficulty performing activities such as raking leaves.

Petitioner testified she was able to return to work after Dr. Keener released her at MMI on 10/13/20. She stated she was assigned lighter work duties which she described were not "light" as she had to carry a ladder to the job sites. She was never able to perform her job duties without right shoulder pain following the accident. Her left shoulder did not bother her as much but she had numbness in both hands. She continued to have neck pain while performing her job

duties, many of which required her to look overhead for long periods of time. She used a wagon to haul her tools and equipment to job sites. She often performed overhead jobs that required the use of both hands.

On cross-examination, Petitioner testified she is right-hand dominant. She signed the Application for Adjustment of Claim on 3/24/17 and agreed it indicated a left shoulder/arm and man as a whole injury and did not indicate a right shoulder injury. She testified she signed the Application in her attorney's office three days following her left shoulder surgery and she was wearing a sling and taking medication at that time. She stated she could not use either arm when she fell on 2/2/17 and her co-worker helped her up. When she reported to the emergency room her primary pain was located in her left shoulder. When she first saw Dr. Paletta she thought her right shoulder pain was from her neck injury.

She denied that she told the emergency room personnel that she fell on her left shoulder. She identified her signatures on pain diagrams dated 2/7/17 and 5/4/17. Petitioner testified she was released without restrictions by all of her doctors. Her pay rate was higher when she retired than at the time of her accident on 2/2/17.

MEDICAL HISTORY

On 2/2/17, Petitioner reported to Gateway Regional Medical Center emergency department and reported a history of falling onto her left shoulder when she was carrying a tool bag. She reported pain in the anterior and posterior region of the left shoulder and trapezius. X-rays of the left shoulder/arm were taken. There were no complaints of right shoulder pain. Petitioner was ordered to follow up with Dr. Kent Parker, Respondent's on-site company doctor.

Petitioner completed an injury report the same day. She was examined at Respondent's medical facility, Granite City Works, and reported she fell on her left shoulder. She described pain in the neck, left shoulder, and headaches. There are no markings on the pain diagram that indicate injury or symptoms in her right shoulder. She reported aching and burning in the left shoulder and rated her pain a 7 out of 10. She was diagnosed with a left shoulder contusion. She was instructed to apply ice and take over-the-counter Tylenol and return to work without restrictions. On 2/10/17, Petitioner followed up at Granite City Works and again filled out a pain diagram indicating aching and burning symptoms in her left shoulder. She rated her pain 7 out of 10. She was placed on light duty restrictions.

On 2/10/17, Petitioner was examined by Dr. Paletta with a chief complaint of left bicep and parascapular pain related to her work accident. Dr. Paletta noted Petitioner's toolbelt got caught when she was coming through a doorway causing her to fall forward mainly to the left side. He noted she fell directly on her left shoulder. Pertinent physical examination revealed normal cervical spine and right shoulder and a history of a previous rotator cuff repair on the right shoulder in 2001. X-rays of the left shoulder revealed type II acromion and mild arthritic changes in the AC joint between the collarbone and the tip of the shoulder blade, otherwise normal. Dr. Paletta diagnosed a possible rotator cuff tear versus strain of the left shoulder. He recommended an MRI and placed Petitioner on light duty restrictions.

On 2/10/17, an MRI arthrogram of the left shoulder revealed supraspinatus and subscapularis rotator cuff tendon tears and Dr. Paletta recommended surgery. Petitioner returned to Granite City Works on 2/10/17 and prepared a pain diagram indicating left shoulder symptoms, with no symptoms reported in the right shoulder.

On 3/21/17, Dr. Paletta performed arthroscopic left shoulder surgery consisting of labral debridement, debridement of subscapularis rotator cuff tendon tear, supraspinatus rotator cuff tear repair, subacromial decompression, bursectomy and acromioplasty. On 3/24/17, Petitioner followed up at Granite City Works and advised she could return to light duty work on 3/27/17. She was in a shoulder immobilizer and taking pain medication. The pain diagram that day indicated pins and needles, burning, and aching, with symptoms in her left shoulder, the left side of her neck, and head. Petitioner also reported headaches.

On 4/3/17, Petitioner followed up with Dr. Paletta and reported difficulty with certain activities of daily living, such as putting on her bra and pulling up her pants. She stated she felt like she was being forced to drive to work on narcotics. Dr. Paletta ordered physical therapy, refilled her Norco prescription, and restricted her to desk/sedentary duty only and instructed her not to drive. On 4/19/17, Petitioner returned to Dr. Paletta's office because she fell at Sam's Club on or about 4/5/17 which increased her left shoulder pain and decreased her range of motion. She reported she fell forward and scraped both knees and turned to the right to avoid striking her left shoulder. Dr. Paletta noted an abrasion on Petitioner's elbow but did not indicate which elbow, though he noted Petitioner was wearing a sling on her left arm when she fell. She reported she was continuing to have significant neck pain which she had since her accident on 2/2/17 and complained that nothing had been done to address her neck symptoms. An ultrasound was performed that revealed the repair was intact. Dr. Paletta ordered Petitioner to resume physical therapy, including modalities to her cervical spine due to ongoing issues.

On 5/4/17, Petitioner presented to Granite City Works and prepared a pain diagram indicating burning and stabbing in her left shoulder and the left side of her neck.

On 6/23/17, Dr. Paletta noted Petitioner was making progress and she stopped taking narcotic medication. On 8/16/17, Petitioner reported achiness and discomfort in the left trapezius. Dr. Paletta recommended continued physical therapy and light duty. On 10/4/17, Petitioner reported continued posterior left shoulder pain with intermittent neck pain and headaches. She denied radicular symptoms. She reported difficulty with overhead activities. Dr. Paletta's impression was mild residual rotator cuff weakness and lack of endurance status post-rotator cuff repair. Petitioner was to transition out of supervised physical therapy and into a home exercise program. Dr. Paletta noted Petitioner's neck was bothering her but it was not interfering with physical therapy for the left shoulder. He recommended a cervical MRI if her symptoms interfered with therapy. Petitioner was released to work with no overhead lifting greater than 15 pounds and was expected to resume full duty work in four weeks.

On 11/15/17, Dr. Paletta released Petitioner at MMI without restrictions for her left shoulder. He noted she had a few episodes of pain going down the posterior lateral aspect of her left arm but had overall improved. Dr. Paletta ordered a cervical MRI due to Petitioner's ongoing neck pain. The MRI revealed a left-sided protrusion at C6-7, right-sided protrusion at C5-6, and

left-sided protrusion at C3-4. Dr. Paletta referred Petitioner to Dr. Matthew Gornet for further valuation.

On 2/8/18, Petitioner reported to Dr. Gornet she experienced neck pain, headaches to both sides, left shoulder and arm pain radiating into her forearm and hand, with tingling in both hands into her thumb, index, and ring fingers. Dr. Gornet noted Petitioner's symptoms began on 2/2/17 when she fell at work. Dr. Gornet diagnosed disc herniations at C5-6 and C6-7 and recommended left-sided epidural steroid injections at both levels that were performed by Dr. Helen Blake on 2/27/18 and 3/13/18. He referred Petitioner to Dr. Phillips for nerve conduction studies to evaluate for potential carpal tunnel syndrome.

On 4/9/18, Petitioner reported to Dr. Gornet that the injections provided substantial relief for three days. On 7/31/18, Dr. Gornet performed a disc replacement at C5-6 and C6-7. He noted on 9/13/18, Petitioner continued to have left-sided pain as well as numbness and tingling in her hands. Dr. Gornet felt this could be related to carpal tunnel syndrome or facet fusion at C4-5 and foraminal narrowing at C3-4. Further observation was warranted and he kept Petitioner off work.

On 3/11/19, Petitioner reported to Dr. Gornet that about a month ago she was pulling on a railroad gate and had increased right shoulder pain. Dr. Gornet noted Petitioner could have some permanent symptoms secondary to arthritic changes in her neck. He released her to full duty work at that time. On 6/17/19, Petitioner returned to Dr. Gornet with continued complaints of right shoulder pain with intermittent numbness and tingling and a heavy sensation. Dr. Gornet recommended an MRI arthrogram that revealed massive rotator cuff tears of the supraspinatus, infraspinatus, and subscapularis tendons with retraction and atrophy, as well as glenohumeral joint osteoarthritis. On 7/22/19, Petitioner told Dr. Gornet she had right shoulder pain with intermittent numbness and tingling. Nerve studies were not approved. He released her at MMI with no restrictions related to her neck and referred her back to Dr. Paletta for right shoulder complaints.

On 8/9/19, Petitioner returned to Dr. Paletta's office with a primary complaint of right shoulder pain and limited range of motion. Physical examination revealed significant motion defects with regard to rotation of the right shoulder. He noted the 7/22/19 MRI arthrogram revealed a massive retracted rotator cuff tear. He referred Petitioner to Dr. Jay Keener for a reverse total shoulder arthroplasty. On 10/1/19, Dr. Keener noted Petitioner's prior left shoulder and cervical spine surgeries. He noted Petitioner had a previous right shoulder rotator cuff surgery in 2001 and made a good recovery with no issues until her fall in 2017. Petitioner stated she noticed immediate irritation in her right shoulder when she fell on 2/2/17 but did not focus on it as the left arm injury was more concerning. X-rays of the right shoulder showed significant glenohumeral joint osteoarthritis and subtle proximal humeral migration with decreased acromial humeral space. Dr. Keener recommended a reverse total shoulder arthroplasty and causally related her condition to the 2/2/17 incident. He stated Petitioner may have had pre-existing arthritis, but she had no pain and close to normal function in her right arm before the accident which caused her current symptoms and at a minimum aggravated her condition. Dr. Keener administered an injection to the glenohumeral joint and allowed Petitioner to continue working full duty.

On 3/12/20, Petitioner underwent a right reverse total shoulder arthroplasty. On 7/20/20, Petitioner was released to light duty work with a 20-pound lifting/push/pulling-below waist restriction, and a 5-pound overhead restriction. On 10/13/20, Petitioner reported improved range of motion and her strength was slowing improving. Dr. Keener recommended a return to full duty work and advised she may have to modify her work duties but he did not prescribe specific restrictions.

On 12/1/20, Petitioner reported to Dr. Keener's office with increased right shoulder complaints. She had been working full duty for approximately seven weeks and had increased pain in her shoulder while using a drill in a slightly abducted overhead position and fell forward against a wall. She stated she has modifying her activities slightly to prevent injury. She continued to report pain and weakness particularly with overhead activities. Dr. Keener advised Petitioner to continue to work with self-modifications but indicated she may need to file for disability if she continued to struggle with work. Petitioner last saw Dr. Keener on 4/21/21 and advised she had retired because she was unable to do her job with her right shoulder. Petitioner continued to voice frustration with the lack of overhead strength. She stated she irritated her right shoulder raking leaves and had pain in her right anterior chest radiating to the scapular posteriorly, which were new symptoms. She had pain with range of motion, mild external rotation weakness, and mild abduction weakness. Dr. Keener noted slight scapulothoracic crepitus and mild tenderness along the medial scapula. Dr. Keener opined that Petitioner's increased pain was related to overuse and scapulothoracic bursitis which is a relatively new finding. He recommended a Medrol Dosepak, muscle relaxants, and therapy to stretch her peck minor and work on scapular strengthening. He released her to follow up as needed.

Dr. Jay Keener testified by way of evidence deposition on 7/17/20. Dr. Keener is a board-certified orthopedic surgeon. He reviewed the medical records of Drs. Paletta and Gornet and was asked to assume there was no medical documentation of Petitioner complaining of right shoulder pain for 25 months after the 2/2/17 incident. Dr. Keener testified he believed the work accident aggravated Petitioner's right shoulder condition causing the need for the reverse total shoulder arthroplasty based on Petitioner's subjective complaints. He could not state whether the accident caused the recurrent rotator cuff tear, but at a minimum the work accident aggravated her condition.

On cross-examination, Dr. Keener testified that a person with a prior shoulder condition might experience weakness as opposed to pain with a traumatic rotator cuff tear. He stated sometimes there are distracting injuries that result in a patient not reporting one injury over another. He stated the arthritis in Petitioner's shoulder could have developed after the 2/2/17 incident as he did not examine her until 2 ½ years after the accident. He did not review any medical records predating 2/2/17. He testified that if Petitioner had a recurrent rotator cuff tear prior to 2/2/17 it could have accelerated the arthritis in her shoulder. He stated it would be atypical for a patient to not experience shoulder symptoms until two years after a rotator cuff tear. Dr. Keener agreed if Petitioner did not have right shoulder symptoms until two years after the accident the shoulder replacement would not be work related.

Dr. Christopher Lenarz performed a record review at Respondent's request on 7/10/20. Dr. Lenarz reviewed all of Petitioner's medical records associated with the care and treatment to the cervical spine, bilateral shoulders, and the right shoulder MRI scan. Dr. Lenarz opined the 2/2/17 accident did not cause or aggravate her right shoulder condition necessitating the reverse total shoulder replacement. He based his opinion upon the absence of right shoulder complaints for two years since the work injury. On 10/7/20, Dr. Lenarz testified by way of evidence deposition. His testimony was consistent with his records review report. Dr. Lenarz is board certified and fellowship trained in treatment of the elbow and shoulder. He opined that the 2/2/17 accident in no way contributed to Petitioner's right shoulder condition. He explained Petitioner had a prior rotator cuff tear and the MRI scan showed arthropathy, advanced degenerative changes and significant atrophy that would take years to develop. Dr. Lenarz added if the accident played a role the symptoms would manifest earlier than two years post-accident. Dr. Lenarz agreed a trauma can make asymptomatic findings that were shown on Petitioner's right shoulder MRI scan become symptomatic.

CONCLUSIONS OF LAW

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

The parties stipulated that Petitioner's left shoulder and cervical conditions were causally related to her work accident on February 2, 2017. Respondent disputes that Petitioner's right shoulder condition is causally connected to the work accident.

The initial primary focus of Petitioner's treatment related to her left shoulder injury, which required surgery and post-operative treatment until she was released at MMI with no restrictions on 11/15/17. However, the medical records of Gateway Regional ER, Dr. Paletta, and Gateway Regional Medical Center from the date of accident through the date Petitioner reached MMI for her left shoulder injury do not contain any history of injury or symptoms related to her right shoulder. The emergency room records and Dr. Paletta's initial office note dated 2/10/17 state Petitioner fell and landed directly on her left shoulder. Dr. Paletta's examination that date revealed a normal right shoulder. The numerous pain diagrams Petitioner filled out through 5/4/17 do not indicate any injury or symptoms in her right shoulder.

Petitioner began treating with Dr. Gornet in February 2018 for ongoing neck pain. Dr. Gornet noted Petitioner tripped and fell on 2/2/17 and landed hard on her left shoulder. She reported numbness and tingling in her hands at several visits with Dr. Gornet through April 2018. Dr. Gornet suspected carpal tunnel syndrome and recommended nerve studies. He noted on 2/8/18 that Petitioner complained of neck pain with headaches to both sides, particularly the left shoulder and arm with burning in her left upper extremity into her forearm and hand, with tingling in both hands. At this point she has left arm pain. Petitioner's complaints and examination do not involve her right shoulder. On 7/31/18, Petitioner underwent a two-level cervical disc replacement. At her follow up visit on 9/13/18, Petitioner complained of left-sided pain and numbness in her hands that Dr. Gornet again attributed to possible carpel tunnel syndrome. There is no mention of right shoulder symptoms on this date.

On 3/11/19, Petitioner reported increased right shoulder pain after pulling on a railroad gate. Physical examination revealed strength of 5/5. This is the first mention of right shoulder symptoms in Petitioner's medical records since the date of accident over two years earlier. On 6/17/19, it was noted Petitioner had difficulty with right arm abduction and an MRI was ordered.

Petitioner filed an Application for Adjustment of Claim on 3/28/17 and did not indicate a right shoulder injury. The Application was amended to include her right shoulder the day of arbitration. The Arbitrator appreciates that the Commission has acknowledged there is overlap between shoulder injuries and cervical spine conditions. *See Tiffany Molton v. Red Bud Reg'l Care*, 18 I.W.C.C. 0381; however, the mechanism of injury and the absence of any right shoulder complaints in Petitioner's medical records for over two years following the accident is atypical as Dr. Keener opined. Although Petitioner testified she told all of her treating physicians she experienced right shoulder pain following the accident, not one physician noted these symptoms until March 2019, nor did Petitioner report any right shoulder symptoms on the pain diagrams she prepared during the three months following the accident. The Arbitrator notes that Dr. Paletta and Dr. Gornet are thorough in their examinations and accident history and both doctors reported normal examination of Petitioner's right shoulder upon initial examination.

Based on the medical evidence, the Arbitrator finds that Petitioner's right shoulder condition, including the reverse total shoulder replacement performed by Dr. Keener, is not causally connected to the February 2, 2017 work injury.

<u>Issue (J)</u>: Were the medical services that were provided to Petitioner reasonable and necessary?

The parties stipulated that the medical treatment related to Petitioner's left shoulder and cervical spine is reasonable, necessary, and related, except for chiropractic treatment she received. Based on the Arbitrator's finding that Petitioner's right shoulder condition is not causally connected to her work injury on 2/2/17, Respondent is not liable for any medical expenses related to Petitioner's right shoulder.

With respect to the chiropractic expense incurred, Respondent offered no evidence that this treatment was unreasonable or unnecessary. The records show Petitioner received physiotherapy treatment, not chiropractic adjustments, to her effected body parts for which she received some benefit. Respondent did not dispute the reasonableness or necessity of Petitioner's physical therapy and the Arbitrator sees no reason to deny medical expenses related to physiotherapy.

Therefore, Respondent shall pay reasonable, necessary, and causally related medical expenses related to Petitioner's left shoulder and cervical spine, including chiropractic expenses, contained in Petitioner's Group Exhibit 18, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent is not liable for medical expenses related to Petitioner's right shoulder. 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.

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

The parties stipulated that Petitioner is entitled to and Respondent paid 20 weeks of TTD benefits from 3/21/17 through 3/26/17 and 7/31/18 through 12/11/18. The claim for TTD benefits for the period 3/12/20 through 10/19/20 relates to Petitioner's right shoulder and said benefits are denied based on the Arbitrator's finding that Petitioner's right shoulder condition is not causally connected to her work injury of 2/2/17.

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

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

(i) **Level of Impairment**: Neither party submitted an AMA rating. Therefore, the Arbitrator places no weight on this factor.

(ii) **Occupation**: Petitioner returned to full duty work for Respondent as an electrician. The Arbitrator notes that Petitioner's job duties caused symptoms when performing heavy lifting and overhead work. Petitioner testified she retired because she could not perform her job duties; however, the Arbitrator notes that Petitioner was released to return to full duty work without restrictions for her causally connected left shoulder and cervical spine injuries. Petitioner retired on 3/29/21. The Arbitrator places some weight on this factor.

(iii) **Age**: Petitioner was 58 years old at the time of accident. She has since retired. The Arbitrator places less weight on this factor.

(iv) **Earning Capacity**: There was no evidence of diminished earning capacity in the record. Petitioner testified she was earning a higher rate of pay at the time she retired than at the time of her accident. The Arbitrator places less weight on this factor.

(v) **Disability**: As a result of her injuries, Petitioner underwent a left shoulder arthroscopic labral debridement, debridement of subscapularis rotator cuff tendon tear, supraspinatus rotator cuff tear repair, subacromial decompression, bursectomy and acromioplasty. Petitioner underwent a two-level disc replacement at C5-6 and C6-7. She was released to full duty work without restrictions for both of her injuries. She testified her left shoulder has improved, but she still has weakness and decreased range of motion. Petitioner testified her neck symptoms

significantly improved following surgery, but she still has some radiating pain into her shoulders. Looking up for more than 4 to 5 minutes increases her symptoms and she has to rest. Prior to retiring she had difficulty performing her job duties, particularly with overhead activity, and modified how she carried her equipment to job sites. The Arbitrator places greater weight on this factor.

Based on the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained permanent injuries that resulted in 15% loss of her body as a whole related to her left shoulder injury and 25% body as a whole related to her cervical spine injury.

Respondent shall pay compensation that has accrued from July 22, 2019 through June 23, 2021, and shall pay the remainder of the award, if any, in weekly payments.

Arbitrator Linda J. Cantrell DATED:

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005618
Case Name	STURGIS, LAKISA v. MIDWEST PHYSICIAN ADMINISTRATIVE SERVICES, LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0115
Number of Pages of Decision	12
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	RAYMOND M. SIMARD
Respondent Attorney	James Jannisch

DATE FILED: 3/22/2022

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAKISA STURGIS,

Petitioner,

vs. NO: 19 WC 5618

MIDWEST PHYSICIAN ADMINISTRATIVE
SERVICES, LLC,

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, causation, notice, temporary total disability, medical expenses, nature and extent and §16 attorney fees, and being advised of the facts and law, modifies the Arbitrator's legal analysis but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner slipped on ice while walking to her car after leaving work for the day. The Arbitrator denied accident by citing *Dukich v. IWCC*, 2017 IL App (2d) 160351, and found:

> This is not a case where Petitioner was exposed to [a] risk distinctly associated with her employment as a certified medical assistant, nor a risk personal to her. This is a neutral risk that has no particular employment or personal characteristics such as those to which the general public is commonly exposed.
>
> Here[,] Petitioner was crossing a common semi-circular driveway which was used by patients entering the facility as well as staff, vendors and whomever else had business in the building. Respondent's Exhibit 1; Respondent's Exhibit 2; Petitioner's Exhibit 1. Respondent did not own or have responsibility for the area where Petitioner fell. Petitioner's Exhibit 3. Respondent exercised no control over the route Petitioner took in

or out of its facilities [nor] required Petitioner to park in any particular location. No work duties contributed to the fall.

The testimony and evidence in this matter support the conclusion Petitioner was not exposed to a risk greater than that of the general public. Dangers created by freezing ice, rain or snow in a common parking area are conditions to which all members of the public are exposed to every winter in this part of the state, day or night. Petitioner was simply injured going from work and that is not compensable. *Dec. 4*.

Petitioner argues that the Arbitrator erred by relying on *Dukich*. We agree that *Dukich* focused on whether wet pavement from rain is a hazardous condition and found that it is not. However, we find that *Dukich* can be properly cited for the following:

> We acknowledge that both our supreme court and our appellate court have repeatedly held that accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the hazardous condition of the employer's premises.

Dukich v. IWCC, 2017 IL App (2d) 160351WC, ¶ 40, 86 N.E.3d 1161. To the extent the Arbitrator's decision is not clear, we find that this case must be analyzed under the "parking lot" exception to the "general premises rule." As explained by the appellate court:

> In sum, *DeHoyos* stands for the proposition, that if an employer provides a lot to its employees, and an employee is injured on that lot, the employee is entitled to recover under the Act. *Id.* However, this parking lot exception has been narrowed since its inception. Just four years after *DeHoyos*, our supreme court stated, "[t]he decisive issue in parking lot cases usually is whether or not the lot is owned by the employer, or controlled by the employer, or is a route required by the employer." *Maxim's of Illinois, Inc. v. Industrial Comm'n*, 35 Ill. 2d 601, 604, 221 N.E.2d 281 (1966). The employer's control or dominion over the parking lot is a significant factor in the analysis. *Joiner*, 337 Ill. App. 3d at 816. Our supreme court has also recognized that "[r]ecovery has been permitted for injuries sustained by an employee in a parking lot provided by *and* under the control of an employer. (Emphasis added.) *Illinois Bell*, 131 Ill. 2d at 484.
>
> In determining whether the parking lot exception applies, it is clear that we must determine whether the employer "provided" the parking lot in question to its employees. We make this determination by considering: (1) whether the parking lot was owned by the employer, (2) whether the employer exercised control or dominion over the parking lot, and (3) whether the parking lot was a route required by the employer.

Walker Brothers v. IWCC, 2019 IL App (1st) 181519WC, ¶¶ 22-23, 2019 IL App (1st) 181519W, ¶¶ 22-23, 149 N.E.3d 560. Considering those three factors, we find the following:

1) Was the parking lot owned by the employer? We find that Respondent is a tenant in the building so the parking lot is clearly not "owned" by Respondent.

2) Did the employer exercise control or dominion over the parking lot? Petitioner argues that, by virtue of merely paying rent, Respondent was contributing to the maintenance of the parking lot. Unlike some cases which specifically mention that the employer/tenant was obligated to pay a pro-rata share of common expenses (or some other indication of control), the lease in this case has no such provision. In fact, the lease specifically states:

> Section 5.03 - Operation and Maintenance. **Lessor agrees to maintain** the interior hallways, lavatories (if any), **all parking areas, driveways, sidewalks**, drainage, lighting facilities, traffic directional signs and markers, landscaping and plantings within the Common Areas **and keep the same in a clean and sightly condition, clearly striped, and reasonably free of rubbish, refuse, snow, ice** and dirt.
>
> …
> Exhibit C
> …
> 13. **Lessor shall have the right to control and operate the public and common use portions and facilities of the building and parcel III such manner as it deems**. … *Px3 (Emphases added)*.

Based on these lease terms, we find that Respondent did not have any control or dominion over the parking lot or common areas.

3) Was the parking lot a route required by the employer? There is no evidence that Respondent required, suggested or in any other way influenced where Petitioner parked. Petitioner testified there is a sign that *requests* employees park in "remote" areas as a courtesy to patients. This was posted on a window of the building (put there presumably by the landlord). Nobody from Respondent actually indicated to Petitioner where she should park. Furthermore, Petitioner testified that she was told by the building's "security" (not anyone directly affiliated with Respondent) to park in the "perimeter" of the lot. Again, pursuant to the lease terms, control of the parking lot was the right of the Lessor/Landlord and not Respondent/tenant.

We point out a few other considerations in terms of whether Respondent "required" the route Petitioner took:

- Petitioner was not required to park in the South lot. She could have also parked in the North lot. She also did not establish that there were no other options for her such as street parking, etc.

- Petitioner slipped and fell in the circular driveway outside of the building before she even got to the parking lot. Therefore, even if Petitioner was *requested* (by the landlord and not Respondent) to park in the "perimeter," this was not a factor in her injury. She fell long before she reached the parking lot.

- Petitioner testified that the entire lot was full except for that spot in which she parked. *T.57-59*. We find that a little incredulous but, if that's the case, then the request that she park in the perimeter was irrelevant, since her choice was not due to any instruction, direction or requirement. Again, she could have parked in the North lot or, perhaps, on the street.

Based on the above, we affirm the Decision of the Arbitrator with the clarification regarding the legal analysis.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2020, is hereby affirmed and adopted with the clarification noted above.

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

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

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

March 22, 2022

/s/ *Maria E. Portela*

SE/
O: 1/25/22
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STURGIS, LAKISA Case# **19WC005618**
Employee/Petitioner

MIDWEST PHYSICIAN ADMINISTRATIVE SERVICES LLC
Employer/Respondent

On 1/6/2020, 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 1.56% 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:

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

1596 MEACHUM STARCK BOYLE ET AL
JAMES JANNISCH
225 W WASHINGTON ST SUITE 500
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lakisa Sturgis
Employee/Petitioner
v.
Midwest Physician Administrative Services, LLC
Employer/Respondent

Case # **19** WC **005618**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the City of **Chicago**, on **October 28, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 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.

In the year preceding the injury, Petitioner earned $**38,385.36**; the average weekly wage was $**738.18**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**4,758.91** for other benefits, for a total credit of $**4,758.91**.

Respondent is entitled to a credit of $**22,321.62** under Section 8(j) of the Act.

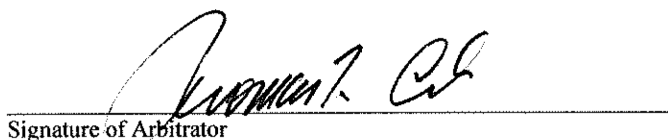
ORDER

Denial of Benefits

Because Petitioner's injury did not arise out of and in the course of her employment with Respondent, 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

1-6-2020

Date

JAN 6 - 2020

Lakisa Sturgis v. Midwest Physician Administrative Services, LLC, No. 19 WC 05618

Preface

The parties proceeded to hearing October 28, 2019, on a Request for Hearing indicating the following disputed issues: whether Petitioner sustained accidental injuries that arose out of and in the course of employment; whether Respondent was given notice of the accident within the time limits stated in the Act; whether Petitioner's current condition of ill-being is causally connected to the injury; whether Respondent is liable for unpaid medical bills; whether Petitioner is entitled to a period of temporary total disability; what is the nature and extent of the injury; and whether Petitioner is entitled to penalties/attorney's fees. Lakisa Sturgis v. Midwest Physician Administrative Services, No. 19 WC 005618 Transcript of Proceedings on Arbitration at 4-5; Arbitrator's Exhibit 1.

Findings of Fact

The facts of this matter are straight forward and essentially not in dispute.

Lakisa Sturgis (Petitioner), a 49 year old female, testified she had been employed by Midwest Physician Administrative Services (Respondent) for three years as a certified medical assistant on February 11, 2019. The location of the office where she works is in a building at 3700 203rd Street in Olympia Fields. Petitioner drove to work on February 11, 2019, and parked in the lot of the building. She initially testified that she was directed by security to park in the perimeter and that she did so on February 11, 2019. However, she later said under cross examination that there is no section designated with signs or paint markings as employee only. She also testified to parking in the third row from the building, when the sign posted suggests employees use remote spaces. Sturgis at 14-15, 16, 17,37.

Petitioner left work on February 11, 2019, at 6:30 pm and noticed freezing ice, rain and snow when she got outside of the building. She was with her co-worker, Tabitha Irwin-Edwards, as she exited the building. Petitioner said she slipped and fell on ice while she was walking to her car. She fell on her right knee. Petitioner noticed pain in her right knee after she fell. She had never injured her right knee before that day. Petitioner marked on Petitioner's Exhibit # 1 her path from the door and the location where she fell. She also marked on Petitioner's Exhibit # 1 a letter P indicating the location her vehicle was parked on February 11, 2019. Petitioner testified Petitioner's Exhibit # 2 accurately reflects a sign posted by the entrance to the building which states "Physicians, Staff and Vendor Reps, In respect for our patients parking needs, thank you for using the most remote parking spaces. St. James Public Safety." Petitioner testified that St. James Osteopathic Hospital later became Franciscan Health Olympia Fields. Sturgis at 18, 19, 20, 21, 22, 23.

After her fall, Petitioner was taken to the emergency room at Franciscan Health. She underwent x-rays and then engaged in text messages with her manager, Mary Jager. While in the emergency room, Petitioner was examined and given a soft brace and prescribed an MRI of the right knee. She was also given sedentary work restrictions which could not be accommodated.

On February 13, 2019, Petitioner underwent an MRI of the right knee. She was treated by Dr. Payne on February 19, 2019, at which time he recommended a right knee surgery. Petitioner was examined again by Dr. Payne on March 5, 2019, and underwent surgery, a partial medial meniscectomy and partial lateral meniscectomy on her right knee on March 22, 2019. On April 2, 2019, Petitioner was re-evaluated by Dr. Payne and sent to physical therapy for four weeks. Petitioner received a knee injection on April 30, 2019, when she was next evaluated by Dr. Payne. Payne released her to return to work without restrictions as of May 6, 2019. She received a second injection on May 7, 2019. Dr. Payne gave Petitioner a third injection on May 16, 2019. Petitioner drives an hour to work and notices pain, stiffness, swelling and soreness in her knee after five to ten minutes of driving. She takes Extra Strength Tylenol. Sturgis at 24, 25, 26, 28, 29, 30, 31; Petitioner's Exhibit 4.

Respondent is not the only tenant in the medical office building where Respondent is located. Patients regularly come to Respondent's location. The building is three stories high with a lobby on the ground floor. There are two entrances to the building, one on the north side and one on the south side. There is also a parking lot on the north side. Petitioner testified she is not restricted from parking in the north side lot. Petitioner said the north side lot is farther from the entrance to the building and she prefers parking in the south lot because it is closer. Petitioner testified under cross examination her understanding of parking in the perimeter was within the parking lot surroundings that wouldn't affect patients. Petitioner said that she did not have a parking sticker, did not have to enter the parking lot through a gate, or register her vehicle with either Respondent or Franciscan Health. She also confirmed there is no section designated with signs or paint markings as employee only. Petitioner tried to park in the same spot every time she worked. But she acknowledged under cross examination that she did not have to park in the same spot. Petitioner also confirmed that she was never reprimanded or punished by Franciscan Health or Respondent if she did not park in the same spot. Petitioner said the sign posted by the entrance did not say employees shall or must park in a certain location of the parking lot. Petitioner confirmed that Petitioner's Exhibit # 1 shows she was parked in the third row from the building on February 11, 2019. Additionally, the row closest to the building is handicap parking so Petitioner was parked in the second row from the building after the handicap row. Petitioner also confirmed that Petitioner's Exhibit # 1 shows there are five more rows farther south from the building in the south parking lot. Petitioner confirmed her text message to her manager, Mary Jager, after she fell, stated "We didn't even make it to the main parking lot. I fell in the round circle in front of the building." Petitioner confirmed there are no restrictions about who can use the entrance or the half circle drive where she fell. She explicitly testified that the employees of other tenants and the general public use the entrance and the half circle drive. Petitioner also said that there are no restrictions on which vehicles can use the half circle drive. Sturgis at 33, 34, 35, 36, 37, 38, 40-41, 42.

Petitioner's Exhibit # 3 is a lease between Franciscan Health Olympia Fields and DuPage Medical Group. The terms of the lease indicated the parking area and driveway where Petitioner fell is a common area maintained by the landlord and not part of Respondent's premises.

Tabitha Irwin-Edwards testified she has worked for Respondent for five years at the 3700 203rd Street location. She has known Petitioner for five years. Irwin-Edwards said that there is a

lobby on the ground floor of the building with multiple entrances. She said that employees of Respondent can park in either the north or south parking lot and there are no restrictions for employees of Respondent. Irwin-Edwards said that she did not have a parking sticker or parking pass. She said that she did not have to register her vehicle with either Respondent or Franciscan Health. Irwin-Edwards testified that there were no marked parking spots for employees. She said that the sign posted by the entrance did not say employees shall or must park in the most remote spaces. Irwin-Edwards said that she had never been reprimanded or ticketed by Franciscan Health for not using the most remote spots. She further testified that no one from Respondent ever asked her to use the more remote areas. Sturgis at 84, 86, 89-92, 94, 98.

Morgan Militzer testified that she has been the manager for safety and employee health with Respondent for two years. She investigates employee injuries for Respondent. Militzer is familiar with Respondent's location where Petitioner worked. She is familiar with Franciscan's rules that were in effect on February 11, 2019. Militzer is familiar with the parking lots that were available for Petitioner to use as an employee of Respondent at the Olympia Fields location. She testified there are multiple parking lots Respondent's employees can use at that location and the employees are not required to park in any designated area. Militzer said Respondent does not track where the employees park and that the employees to do not have a parking sticker or pass which allows them to use certain areas of the parking lots. She also said that the property owner does not ask for information about Respondent's employees' vehicles nor do the employees have to register their vehicles with the property owner. Militzer said Respondent's employees can park anywhere at that site. She testified that Respondent's employees are not given incentives for parking remotely nor are they punished by Respondent for parking too close to the building. Militzer also said that the property owner would not ticket Respondent's employees for parking in certain areas of the south parking lot. Sturgis at 101-106.

Conclusions of Law

The decision in this case begins and ends with disputed issue **C**, did an accident occur that arose out of and in the course of Petitioner's employment with Respondent.

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she suffered a disabling injury which arose out of and in the course of her employment. The phrase "in the course of employment" refers to the time, place and circumstances of the injury. If the injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties and while she is performing those duties or doing something incidental thereto, the injury is deemed to have occurred in the course of employment. An injury "arises out of" employment when the injury had its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. The focus is on the type of risk to which a claimant is exposed. There are three: one distinctly associated with one's employment, one that is personal to the employee, and one that is neutral having no particular employment or personal characteristic such as those to which the general public is commonly exposed. Injuries resulting from a neutral risk generally do not arise out of employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree

than the general public. Dukich v. Illinois Workers' Compensation Commission, 2017 I App (2d) 160351 WC Paragraphs 30-31 (citations omitted).

This is not a case where Petitioner was exposed to risk distinctly associated with her employment as a certified medical assistant, nor a risk personal to her. This is a neutral risk that has no particular employment or personal characteristics such as those to which the general public is commonly exposed.

Here Petitioner was crossing a common semi-circular driveway which was used by patients entering the facility as well as staff, vendors and whomever else had business in the building. Respondent's Exhibit 1; Respondent's Exhibit 2; Petitioner's Exhibit 1. Respondent did not own or have responsibility for the area where Petitioner fell. Petitioner's Exhibit 3. Respondent exercised no control over the route Petitioner took in or out of its facilities, or required Petitioner to park in any particular location. No work duties contributed to the fall.

The testimony and evidence in this matter support the conclusion Petitioner was not exposed to a risk greater than that of the general public. Dangers created by freezing ice, rain or snow in a common parking area are conditions to which all members of the public are exposed to every winter in this part of the state, day or night. Petitioner was simply injured going from work and that is not compensable.

I find as a conclusion of law Petitioner's injury did not arise out of and in the course of her employment as a certified medical assistant. Therefore, she is not entitled to compensation for medical benefits, temporary total disability, or permanent partial disability. Any notice issue is moot. Petitioner is not entitled to penalties or fees because she is not entitled to benefits under the Act.

Arbitrator

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC034042
Case Name	EVANS, TYRON v. STATE OF ILLINOIS/ ILLINOIS DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0116
Number of Pages of Decision	7
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Damon Young
Respondent Attorney	Joseph L. Moore

DATE FILED: 3/22/2022

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tyrone Evans,
Petitioner,

vs. NO: 17 WC 34042

State of Illinois-IDOT,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 30, 2021, is hereby affirmed and adopted.

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

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

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.

March 22, 2022
o3/16/22
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC034042
Case Name	EVANS, TYRON v. STATE OF ILLINOIS-IDOT
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	5
Decision Issued By	Adam Hinrichs, Arbitrator

Petitioner Attorney	Damon Young
Respondent Attorney	Joseph L. Moore

DATE FILED: 9/30/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 30, 2021 0.05%

/s/ *Adam Hinrichs, Arbitrator*
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

September 30, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

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

TYRONE EVANS
Employee/Petitioner

Case # **17** WC **034042**

v.

STATE OF ILLINOIS - IDOT
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 **ADAM HINRICHS**, Arbitrator of the Commission, in the city of **PEORIA**, on **August 19, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **04/23/2017**, 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 $**43,956.00**; the average weekly wage was $**845.30**.

On the date of accident, Petitioner was **61** 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 $**7,626.48** under Section 8(j) of the Act.

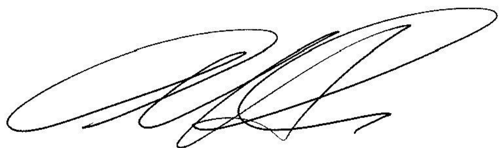
ORDER

Respondent shall pay all medical bills outlined in Petitioner's Exhibit 8, totaling 19,779.07, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall make this payment directly to Petitioner's attorney in accordance with Section 9080.20 of the Rules Governing Practice before the IWCC. The Respondent shall be given a full credit for payments made by its group health insurance carrier pursuant to Section 8(j).

Respondent shall pay Petitioner the sum of $507.18/week for a period of 35 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a 7% permanent partial disability to the Petitioner's person as a whole.

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

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



Signature of Arbitrator

SEPTEMBER 30, 2021

FINDINGS OF FACT

Petitioner testified that on April 23, 2017, he was moving a box that partially tore, and as he tried to hold onto the box, he hurt his low back. (T10). Petitioner stated at the time of his injury he worked as a Communications Specialist for Illinois Department of Transportation. (T10). Petitioner estimated that the box weighed between 30 to 40 pounds. (RX1). Petitioner stated that on the day of his injury he presented to Unity Point Hospital's emergency room. (T11). Petitioner complained of low back pain and was diagnosed with a low back injury (PX2).

Petitioner was released to return to work with light duty restrictions on May 23, 2017, by Dr. James D. Ausfahl, at Unity Point. (RX3). Dr. Ausfahl released Petitioner to return to work with no restrictions on June 6, 2017. (RX3).

Petitioner had ongoing complaints of pain due to the accident and continued his medical treatment at the Center for Pain Management with Dr. Yibling Li who prescribed physical therapy. (T11, PX 7). Petitioner participated in physical therapy from May 2017 through September 2017. (PX3). Petitioner received two epidural steroid injections from Dr. Li, on March 14, 2018, and July 13, 2018. (PX7).

Petitioner's pain did not resolve, and he presented to Dr. O'Leary at Midwest Orthopedic Center on March 5, 2019, and was prescribed an MRI and more conservative care. (T13). Petitioner had an MRI taken on April 23, 2019, that showed L4 foraminal narrowing and thecal sac constriction, and a constricted disc bulge at L4-5. (PX5). Dr. O'Leary recommended a diagnostic epidural steroid injection that was performed on July 29, 2019. Another steroid injection was performed on September 18, 2019. Dr. O'Leary felt Petitioner had lifestyle limiting pain from this injury and recommended ongoing use of Tramadol. On March 19, 2020, Dr. O'Leary noted that Petitioner was doing ok, was not a surgical candidate, and released him PRN.

Petitioner testified that he was released full duty with no restrictions to return to work on June 6, 2017. (T19, RX3). Petitioner testified that he essentially worked light duty following this full duty release as he had ongoing pain complaints that required treatment. Petitioner stated he reported a pain level of 8 out of 10 only two days after being released from Dr. Ausfahl full duty. (T20-21, RX1).

Petitioner testified that his doctor recommended he wear a back brace, but did not prescribe one. (T22). Petitioner testified that he worked for about two years after his injury before retiring. (T24). Petitioner testified he was able to satisfactorily perform his job duties up until his retirement date.

Petitioner stated he still has mid-back pain, and pain into his legs and down to his toes, and that it is hard to sit for long periods of time. (T14). Petitioner stated he is able to use a leaf blower as he was seen doing during the Respondent's surveillance. Petitioner testified he takes Tramadol twice daily and wears a back brace to control his pain. (T17).

The Arbitrator observed the Petitioner and found him to be a sincere, consistent, and credible witness. Petitioner's account of his undisputed work accident, medical care that followed, and his current pain complaints is supported by the record.

CONCLUSIONS OF LAW

The parties stipulated that on April 23, 2017, Petitioner sustained an accident arising out of and in the course of his employment with the Respondent, that Respondent has or will pay all reasonable and causally related medical bills, pursuant to the fee schedule, as outlined in Petitioner's Exhibit 8, Petitioner's temporary total disability

benefits have been paid and there is no further dispute as to said benefits, and Respondent is entitled to a full 8(j) credit. Therefore, the only issue that remains to be addressed is:

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

The Arbitrator shall consider the following factors to determine the level of permanent partial disability for Petitioner: (i) the reported level of impairment; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. The analysis of the aforementioned factors is as follows:

(i) Neither party provided an AMA impairment rating for consideration. No weight is given to this factor.

(ii) Petitioner was employed as a Communications Specialist with the Illinois Department of Transportation. Petitioner returned to work full duty without restrictions following his accident. Petitioner testified that while he returned to work full duty, his job duties were light. The Arbitrator has considered and gives some weight to this factor.

(iii) Petitioner was sixty-one years old at the time of his injury. The Arbitrator has considered and gives some weight to this factor as Petitioner has few remaining potential years in the labor force.

(iv) There was no evidence of diminished future earning capacity introduced into the record. Petitioner returned to work with the Respondent post-accident in the same job as prior to the accident. The Arbitrator gives no weight to this factor.

(v) Petitioner testified that he continues to experience pain in his mid-back, and pain that goes down his legs and into his toes. Petitioner has discomfort driving and sitting for periods of time, which was evident to the Arbitrator when observing the Petitioner at hearing. Petitioner underwent physical therapy and four steroid injections. Petitioner continues to wear a back brace and is prescribed and takes Tramadol to control his pain. The Arbitrator has considered and gives significant weight to this factor.

After consideration of the foregoing factors, the Arbitrator concludes that Petitioner is now permanently partially disabled to the extent of 7% of his person of a whole as provided in Section 8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC006295
Case Name	FONCK, FRANCINE v. STATE OF ILLINOIS - DORS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0117
Number of Pages of Decision	8
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Aaron Wright

DATE FILED: 3/23/2022

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF WILLIAMSON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francine Fonck,
Petitioner,

vs. NO: 12 WC 6295

State of Illinois-DORS,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2021, is hereby affirmed and adopted.

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

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

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.

March 23, 2022
o3/16/22
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC006295
Case Name	FONCK, FRANCINE v. DORS
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Aaron Wright

DATE FILED: 9/8/2021

THE INTEREST RATE FOR WEEK OF SEPTEMBER 8, 2021 0.05%

/s/*William Gallagher, Arbitrator*
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

September 8, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Francine Fonck
Employee/Petitioner
v.
DORS
Employer/Respondent

Case # 12 WC 06295

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 Herrin, on August 16, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 4, 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 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 $10,873.42; the average weekly wage was $209.29.

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

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

SEPTEMBER 8, 2021

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on August 14, 2010. According to the Application, Petitioner was "Lifting Wheelchair" and sustained an injury to her "Low Back" (Respondent's Exhibit 4). Petitioner subsequently filed an Amended Application for Adjustment of Claim which was identical to the prior Application, with the exception of the date of accident which was alleged to be August 4, 2010 (Arbitrator's Exhibit 2). Petitioner claimed she was entitled to payment of medical bills, temporary total disability benefits/maintenance benefits and permanent partial disability benefits. Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner testified she worked for Respondent as a caregiver for disabled individuals. Petitioner said that on August 4, 2010, one of her clients had a wheelchair that needed to be repaired. Petitioner described the wheelchair as being heavy and made of metal. Petitioner said that when she lifted the wheelchair to put it in her car, she sustained an injury to her low back.

Petitioner testified she reported the accident shortly after it occurred to an individual named "Nora." Petitioner stated Nora directed her to contact an individual in Springfield to report her having sustained an accident. According to Petitioner, the individual in Springfield she called was rude to her and did not provide her with any assistance. No individual named "Nora" testified at trial.

Approximately 11 months following the accident, on July 11, 2011, Petitioner completed and signed a "Notice of Injury" in which she indicated she had sustained a work-related accident on August 14, 2010. According to this document, Petitioner was taking a client's wheelchair to be repaired and when she picked it up to put it in her van, she felt her back "pop." Petitioner identified her supervisor as Anthony TJ Brooker, but responded "No" to whether she had reported the accident to her supervisor (Respondent's Exhibit 2).

On July 15, 2011, Petitioner prepared and signed another "Notice of Injury" in which she described the accident of August 14, 2010. She again described the accident as having occurred when she picked up a client's wheelchair and felt a "pop" in her low back. In regard to Petitioner's supervisor, that portion of the document was left blank; however, Petitioner again responded "No" as to whether she had reported the accident to her supervisor (Respondent's Exhibit 3).

Petitioner initially sought medical treatment on August 6, 2010, at St. Joseph Memorial Hospital. At that time, Petitioner complained of pain in the left buttock which radiated into her posterior leg to calf. There was no reference to Petitioner having sustained a work-related accident or any trauma at all. An x-ray was obtained which revealed a spondylolisthesis at L4 on L5 and degenerative disc disease at L4-L5 and L5-S1 (Petitioner's Exhibit 4). On August 6, 2010, Petitioner was also evaluated at the Murphysboro Health Center. At that time, Petitioner complained of right hip and leg pain which had been present for three weeks as well as constant pain across the left buttock going into the left calf. The medical record contained an entry of "0 injury" (Petitioner's Exhibit 1).

Petitioner subsequently underwent an MRI of the lumbar spine on March 8, 2011. According to the radiologist, it revealed a Grade 1 anterolisthesis of L3 on L4 and L4 on L5, spinal stenosis and a disc herniation at L5-S1 (Petitioner's Exhibit 1).

On May 23, 2011, Petitioner underwent an EMG of her left leg. It was positive for left L3-L4 radiculopathy (Petitioner's Exhibit 2).

On July 8, 2011, Petitioner was evaluated by Dr. Gerson Criste. At that time, Petitioner complained of low back pain which had been present for one year. It was described in the "context" of "lifting a heavy object"; however, there was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 3).

Petitioner was subsequently seen and treated by Dr. Jon Taveau, a neurosurgeon. When Dr. Taveau saw Petitioner on October 8, 2012, Petitioner informed him she had injured her back in August, 2010, while lifting a heavy wheelchair (Petitioner's Exhibit 3). This was the first time Petitioner provided a history of the work-related accident to a medical provider.

Dr. Taveau diagnosed Petitioner with spondylolisthesis at L4-L5, lumbar radiculopathy and degenerative disc disease at L4-L5 and L5-S1, lumbar spinal stenosis and lumbar spondylosis. On December 4, 2012, Dr. Taveau performed back surgery consisting primarily of a fusion and disc replacement at L4-L5 and L5-S1 (Petitioner's Exhibit 3). Dr. Taveau did not opine whether Petitioner's low back condition was related to the accident of August, 2010.

At the direction of Respondent, Petitioner was examined by Dr. Kevin Rutz, an orthopedic surgeon, on November 13, 2018. In connection with his examination of Petitioner, Dr. Rutz reviewed medical records provided to him by Respondent. Dr. Rutz opined Petitioner had degenerative spondylolisthesis which progressively worsened over time and was not work-related. This opinion was based, in large part, on the lack of evidence in the medical records of Petitioner having sustained a work-related accident and he noted there was also contrary evidence (Respondent's Exhibit 10).

Dr. Rutz was deposed on March 22, 2019, and his deposition testimony was received into evidence at trial. Dr. Rutz' testimony was consistent with his medical report and he reaffirmed the opinions contained therein (Respondent's Exhibit 11).

Conclusion of Law

In regard to disputed issues (C), (E), and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner did not sustain an accidental injury arising out of and in the course of her employment by Respondent on August 4, 2010; Petitioner did not give timely notice of the accident to Respondent and Petitioner's current condition of ill-being is not causally related to her employment by Respondent.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified she reported the accident shortly after it occurred to an individual named "Nora"; however, no one by that name testified at trial.

When Petitioner initially sought medical treatment on August 6, 2010, she did not inform the medical providers that she had sustained a work-related injury. Further, the medical record contained the entry of "0 injury."

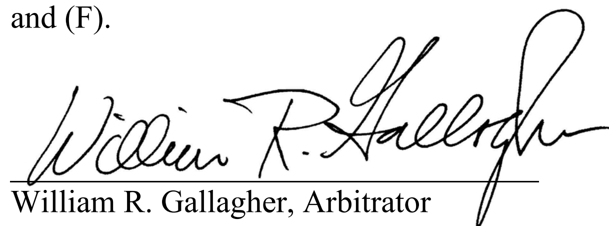
It was not until July 11, 2011, approximately 11 months following the accident, that Petitioner prepared a "Notice of Injury" wherein she reported having sustained a work-related injury on August 14, 2010. In this document, Petitioner identified her supervisor as Anthony TJ Brooker, but responded "No" as to whether she had reported the accident to her supervisor.

For some unknown reason, Petitioner prepared another "Notice of Injury" on July 15, 2011, in which she again reported a work-related accident as having occurred on August 14, 2010. However, in this document, Petitioner did not identify a supervisor, but again responded "No" as to whether the accident had been reported to her supervisor.

It was not until Petitioner was evaluated by Dr. Taveau on October 8, 2012, that Petitioner reported to a medical provider that she had sustained a work-related injury in August, 2010. Dr. Taveau subsequently performed low back surgery; however, he did not opine whether Petitioner's low back condition was work-related.

Respondent's Section 12 examiner, Dr. Rutz, opined Petitioner's low back condition was not work-related. This was the only expert medical opinion which specifically addressed this issue.

In regard to disputed issues (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 issues (C), (E) and (F).



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC022740
Case Name	FLOWERS, DOUG v. MCCORMACK BARON SALAZAR
Consolidated Cases	
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0118
Number of Pages of Decision	11
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Cynthia Hennessey
Respondent Attorney	Michael Powalisz

DATE FILED: 3/23/2022

/s/Carolyn Doherty, Commissioner

Signature

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MADISON)	☐ 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

DOUG FLOWERS,

Petitioner,

vs. NO: 18 WC 22740

McCORMACK BARON SALAZAR,

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 *ex parte* proceedings, accident, average weekly wage and benefit rates, causal connection, medical expenses, prospective care, permanent total disability, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. Prior to filing the Petition for Review, Respondent filed a separate Motion to Vacate Arbitration Decision and a Motion for Penalties and Fees which were to be taken with the case on Review. The Commission, after reviewing each of those motions, denies the Motion for Penalties and Fees and finds the Motion to Vacate Arbitration Decision is moot in light of the Commission's reversal of the Arbitrator's Decision on Review as stated below.

I. FINDINGS OF FACT

The Commission file reflects that Petitioner filed an Application for Adjustment of Claim in this matter on July 13, 2018. Respondent was not represented by Counsel at the time of the April 27, 2021 arbitration of this matter and did not appear at the hearing. As a result, Petitioner's claim proceeded to hearing on April 27, 2021 as an *ex parte* matter. At the outset of the hearing, the Arbitrator also noted that no one had appeared on behalf of Respondent. The Commission's records disclose that Respondent was not represented by counsel until after the arbitration hearing. Rather, at the time of the *ex parte* trial, the adjuster was involved for Respondent.[1]

[1] See *Flowers v. McCormack Baron Salazar*, Ill. Workers' Comp. Comm'n, No. 18 WC 22740 (Sept. 27, 2021) (Order denying Petitioner's Motion to Dismiss Review).

Petitioner's counsel represented that on March 23, 2021, Petitioner properly filed and served upon the Arbitrator and Respondent a Notice of Motion and Order requesting a pretrial conference, and that Respondent failed to reply. She also stated that on the same date, the Arbitrator requested Respondent's reply regarding availability on April 19, 2021 to conduct the pretrial conference, but as of March 31, 2021, Respondent had failed to reply or respond to the Arbitrator's request. Petitioner's counsel further stated that on March 31, 2021, the Arbitrator notified Respondent that a pretrial would be conducted on April 19, 2021 and that failure to appear would result in the matter being set for "an immediate default hearing," but Respondent failed to reply. The Commission notes here that the rules governing practice before the Commission do not provide for "default hearings." Aside from Petitioner's counsel's statements on the record, the Commission notes that no documentary evidence corroborating the notice to Respondent of the pre-trial conference was submitted into evidence at the arbitration hearing.

According to Petitioner's counsel, the pretrial conference was conducted on April 19, 2021 in Respondent's absence. Petitioner's counsel stated that on the same date, the Arbitrator notified Respondent that the pretrial conference had proceeded and that the matter was now set for Final Hearing on all issues for April 27, 2021 at 9:00 a.m., but Respondent failed to reply or respond. Petitioner's counsel further stated that on April 19, 2021, she properly filed and served upon Respondent a Notice of Motion and Order that the matter was set for Final Hearing on April 27, 2021 at 9:00 a.m., and Respondent failed to reply or respond. The Commission again notes that no supporting documentary evidence of any notice of the final hearing was provided by Petitioner's counsel at trial aside from her verbal representations on the record.

Following the April 27, 2021 *ex parte* hearing, on May 19, 2021, the Arbitrator issued a Decision finding that Petitioner sustained an accident in the course of and arising out of his employment with Respondent and that his current condition of ill-being was causally connected to the accident. The Arbitrator further ordered that Respondent shall pay Petitioner permanent total disability benefits of $1,463.80 per week for life, commencing June 21, 2018 as provided in section 8(f) of the Act. The Arbitrator also ordered that commencing on the second July 15th after the entry of this award, Petitioner could become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund as provided in section 8(g) of the Act.

On June 29, 2021, counsel entered an appearance for Respondent and filed a Petition for Review, listing "[w]hether proper notice of Final Hearing was provided to Respondent" as an issue to which Respondent took exception. On July 1, 2021, Petitioner filed a Motion to Dismiss Review, arguing that Respondent's Petition for Review was untimely. Following a briefing of the Motion to Dismiss, the matter was heard via WebEx on July 21, 2021 by Commissioner Barbara N. Flores. On September 27, 2021, Commissioner Flores found that this case was a legacy case predating the Commission's transition to the CompFile system, concluded that the Commission should have sought to provide notice of the Decision to Respondent outside the CompFile system, and entered an order denying Petitioner's Motion to Dismiss. Respondent's pending Motion for Penalties and Fees Pursuant to Section 25.5 of the Illinois Workers' Compensation Act and Motion to Vacate Arbitration Decision were taken with the case on review.

II. CONCLUSIONS OF LAW

Respondent argues that the Arbitrator erred in conducting the final hearing *ex parte*. Petitioner argues that Respondent incorrectly asserts that no notifications were sent to Respondent and that there is no evidence to support the Respondent questioning the truthfulness and veracity of the Arbitrator.

In this case, no documentary evidence was submitted into evidence at the hearing in support of the verbal representations made by Petitioner's counsel and the Arbitrator on the record regarding the provision of notice to Respondent. Given the lack of sufficient corroborating evidence regarding notice, the Commission cannot conclude that Respondent was given an adequate opportunity to appear for pre-trial or trial such that failure to do so would justify a finding that Respondent should pay an award under Section 8(f) to Petitioner for life. An *ex parte* trial on the merits resulting in such an award was not supported by the record in this matter, or by the principles of equity and due process, in light of the administrative changes thrust on the litigants during the COVID pandemic. Accordingly, the Commission vacates the Decision of the Arbitrator and remands the matter to the Arbitrator for a full hearing with both parties present. Given our conclusion, the remaining issues raised by Respondent in its Petition for Review are moot.

In addition, given the Commission's decision on Respondent's Petition for Review of the Arbitrator's Decision rendered herein, Respondent's separate Motion to Vacate Arbitration Decision, which was taken with the case on review, is made moot.

In its Motion for Penalties and Fees, Respondent also claims that Petitioner, by and through his attorney, intentionally made false or fraudulent representations or statements for the purpose of obtaining workers' compensation benefits in violation of section 25.5 of the Act. See 820 ILCS 305/25.5(a)(1),(2) (West 2016). The Commission has considered Respondent's arguments and Respondent's Motion for Penalties and Fees is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 19, 2021 following an *ex parte* hearing is hereby vacated and the case is remanded to the Arbitrator for a new hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's previously filed Motion to Vacate Arbitration Decision is moot.

22IWCC0118

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion for Penalties and Fees is denied.

March 23, 2022

d: 3/17/22
CMD/kcb
045

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

/s/ *Marc Parker*
Marc Parker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC022740
Case Name	Flowers, Doug v. McCormack Baron Salazar
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	Jeanne AuBuchon, Arbitrator

Petitioner Attorney	Cynthia Hennessey
Respondent Attorney	

DATE FILED: 5/19/2021

INTEREST RATE FOR THE WEEK OF MAY 18,2021 0.03%

/s/ *Jeanne AuBuchon, Arbitrator*
Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Doug Flowers
Employee/Petitioner

Case # **18** WC **022740**

v.

Consolidated cases: ______

McCormack Baron Salazar
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 **Jeanne L. AuBuchon**, Arbitrator of the Commission, in the city of **Collinsville,** on **April 27, 2021.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 6/21/2018 Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $133,205.00; the average weekly wage was $2,561.00.

On the date of accident, Petitioner was 53 years of age, single with 0 dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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.

Respondent was provided proper notice of Final Hearing and failed to appear.

Petitioner is permanently and totally disabled as a result of the accident.

ORDER

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of $1,463.80/week for life, commencing June 21, 2018 as provided in Section 8(f) of the Act.

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

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

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

Jeanne Au Buchon

MAY 19, 2021

Findings of Fact

This matter was set above the red line on the April 13, 2021 call docket in Collinsville. On March 23 Petitioner properly filed and served upon the Arbitrator and Respondent a Notice of Motion and Order requesting a Pre-Trial. Respondent failed to reply or respond. On March 23 the Arbitrator requested Respondent's reply regarding availability on April 19 to conduct the Pre-Trial. As of March 31 Respondent had failed to reply or respond to the Arbitrator's request. On March 31 the Arbitrator notified Respondent that a Pre-Trial would be conducted on April 19 and failure to appear would result in the matter being set for immediate Default Hearing. Respondent again failed to reply or respond. The Pre-Trial was conducted on April 19 and Respondent failed to appear. On April 19 the Arbitrator notified Respondent that the Pre-Trial was conducted in its absence and that the matter was set for Final Hearing on all issues for April 27 at 9:00 am. Respondent failed to reply or respond. On April 19 Petitioner properly filed and served upon Respondent a Notice of Motion and Order that the matter was set for Final Hearing on April 27, 2021 at 9:00 am. Respondent failed to reply or respond. On April 27 at 9:00 am the matter was called for Final Hearing at approximately 9:25 am. Respondent failed to appear. Petitioner presented evidence as follows:

Petitioner testified that on June 21, 2018 he was a 53-year-old, unmarried, employee of Respondent when he sustained an injury to his back while in the course and scope of his employment for Respondent. Both Petitioner and Respondent were working under and subject to the Workers' Compensation Act. He had no dependents and was earning an average weekly wage of $2,561.00. On the date of the accident, he sustained an injury to his low back when he heard a "pop" while twisting and bending down to pick up equipment. He felt immediate pain and gave notice of the accident to his supervisor. He first received medical treatment at the Emergency Department at Memorial Hospital. He then proceeded to treat at BarnesCare who referred him to a neurosurgeon. He thereafter came under the care and treatment of Dr. Kevin Rutz. Dr. Rutz examined him, ordered and MRI and discussed surgery. The Respondent sent him to Dr. Stiehl who recommended physical therapy. He received physical therapy which did not help. His condition has never improved. He continues to have radiculopathy, pain and numbness and burning going down his legs. He is unable to sit, stand or walk for extended periods of time. He has never returned to work in any capacity since the date of accident and is receiving Social Security Disability. Petitioner testified that he had a prior injury to his low back in approximately 2010 which he recovered from. He returned to work full duty following the 2010 injury and worked without problems or restrictions. As of the time of his testimony, Petitioner agrees with Dr. Stiehl and Dr. Rutz and does not believe he is capable of working in any capacity.

Petitioner introduced treatment records from Memorial Hospital on June 22, 2018. On that date, Petitioner presented to the Emergency Department complaining of lower back pain which had begun the day prior while at work. He gave a history that his back pain began when he felt "a pop" while twisting and bending down to pick up equipment. X-rays revealed a prior anterior fusion from L4-5 and L5-S1 with no evidence of hardware complication, as well as mild wedging of the superior endplates of L1 and L2. Petitioner was diagnosed with acute back pain, treated with medications and discharged.

Petitioner introduced treatment records from BarnesCare Midtown from June 29, 2018. At that time, he reported a pain scale of 9/10. The pain was described as numbness, burning, shooting and sharp. He was diagnosed with lumbar radiculopathy. The report from that date notes that the work accident was the prevailing factor in causing the patient's medical condition and need for treatment. Petitioner was given work restrictions and referred to a neurosurgeon for further care.

Petitioner returned to BarnesCare Midtown on July 6, 2018. At that visit he reported no improvement. His pain scale was again 9/10. He was still waiting for Work Comp approval to see the neurosurgeon. He was diagnosed with radiculopathy, lumbar region.

Petitioner returned to BarnesCare Midtown on July 20, 2018. At that visit he again reported no improvement. His pain scale was again 9/10.

An MRI was performed at Metro Imaging on August 3, 2018 which revealed disc bulging, degenerative changes, and ligamentous hypertrophy associated with mild stenosis at the L2-L3 level. This was associated with mild foraminal narrowing of the right which had progressed compared to the previous study.

Petitioner returned to BarnesCare Midtown on August 7, 2018 reporting that his back was feeling worse since his last visit. The pain was described as dull and aching with pins and needles and sharp. He continued to have problems with left lower extremity numbness, tingling and weakness and popping and clicking in his back.

Petitioner began treating with Dr. Kevin Rutz, MD on November 6, 2018. He presented with ongoing radiation of pain in the bilateral buttock and posterior lower extremities with tingling down the ankles. The symptoms were greater in the left leg and described as sharp, aching, and burning with dull burning and cramping in his legs. His pain awakened him from sleep on a regular basis and he felt that the pain continued to worsen. Dr. Rutz ordered an MRI, discussed the pros and cons of surgery and stated Petitioner was unable to work since the date of accident.

An MRI was performed at Excel Imaging on November 13, 2018 which revealed decompression instrumentation at L3-4 and L4-5. The hardware was found to be in satisfactory position with circumferential disc bulging and posterior element hypertrophy at L2-3 resulting in mild to moderate central canal stenosis and moderate bilateral foraminal stenosis.

Petitioner returned to Dr. Rutz on November 13, 2018 following the MRI. Dr. Rutz ordered discography at L2-3 and at L5-S1 and a CT scan for surgical planning. These tests were denied by Respondent.

Dr. Stiehl evaluated Petitioner on behalf of Respondent on June 13, 2019. He noted that Petitioner had completed 12 sessions of physical therapy without improvement. He diagnosed Petitioner with mechanical back strain which had failed to resolve and ordered physical therapy.

Petitioner saw Dr. Rutz on August 20, 2019 with persistent symptoms. Dr. Rutz noted that Petitioner failed to respond to physical therapy and again recommended a work up for possible surgical intervention. He stated that the chances of Petitioner having resolution of his symptoms without surgical intervention is extremely poor and that he did not recommend further physical therapy as this did not improve and in fact aggravated his symptoms.

Dr. Stiehl evaluated Petitioner again on behalf of Respondent on October 3, 2019. Portions of his report were entered into evidence. At this time, Dr. Stiehl noted that Petitioner continued to suffer from mechanical lower back pain with bilateral chronic radiculopathy into his lower extremities with severe back pain and objective chronic radiculopathy with muscle instability in both calves. Straight leg raising was positive bilaterally an Dr. Stiehl reported a “substantial deterioration” in Petitioner’s condition following the date of injury. He opined that Petitioner is “virtually disabled” and could not do any physical activity. He further stated that Petitioner has chronic spinal stenosis with significant claudication in his lower extremities if he walks only a short distance. He opined that Petitioner is unable to do even the most basic activities required for daily living and that he has chronic radiculopathy in both lower extremities with a probable diagnosis of chronic spinal stenosis. He noted that Petitioner is “not capable of working”, that he did not find any evidence of Waddell’s signs and stated that Petitioner was “quite honest” and gave appropriate information.

Dr. Volarich evaluated Petitioner on October 1, 2020. Portions of his report were introduced into evidence. Dr. Volarich noted that Petitioner continued to experience low back pain and pain into his lower extremity. He diagnosed “lumbar left leg radiculopathy incompletely evaluated and treated”. He opined that the work injury of June 21, 2018 was the competent producing factor causing the recurrent lumbar left leg radiculopathy and need for medical treatment.

Conclusions of Law

The Arbitrator concludes that based on the credible testimony of Petitioner, as well as the medical evidence presented, and in light of the fact that there are no disputed issues, the Petitioner suffered a compensable accident resulting in injury to his lumbar spine on June 21, 2018. As a result of this injury Petitioner is permanently and totally disabled. Petitioner is entitled to and Respondent is liable for Permanent Total Disability payments beginning on June 21, 2018 and continuing pursuant to law.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC040069
Case Name	KOHUT, WALTER v. BAKERS SQUARE
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	22IWCC0119
Number of Pages of Decision	8
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	David Menchetti
Respondent Attorney	Aukse Grigaliunas

DATE FILED: 3/24/2022

/s/Thomas Tyrrell, Commissioner

Signature

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WALTER KOHUT,

Petitioner,

vs. Nos. 08 WC 040069

BAKERS SQUARE,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §8(a) and §19(h)

This matter comes before the Commission on Petitioner's §8(a) and §19(h) Petition filed on September 6, 2018 seeking additional medical benefits and an increase in permanent disability under §19(h). Petitioner previously filed a motion pursuant solely to §8(a) on April 12, 2018.

On July 16, 2015, the Arbitrator awarded Petitioner permanent partial disability of 40% loss of use of the right arm for injuries suffered in a fall at work. The Commission modified the award to 20.25% loss of use of the person as a whole on September 7, 2017. On June 27, 2018, the Circuit Court of Cook County confirmed the Decision of the Commission. On May 31, 2019, the Workers' Compensation Division of the Appellate Court filed its Rule 23 Order affirming the judgement of the Circuit Court, which confirmed the Decision of the Commission.

A hearing was held before Commissioner Tyrrell on October 9, 2019, and a record was made. (PX1). On September 11, 2020, Commissioner Tyrrell granted Petitioner's Dedimus Potestatem motions to take the evidence depositions of Dr. Thometz and Mr. Timothy Bobrowski. Commissioner Tyrrell conducted a second evidentiary hearing on June 16, 2021, and closed proofs. Petitioner seeks medical benefits for post-arbitration treatment under §8(a) and prospective medical care. He also asserts a material increase in his disability.

Respondent filed a Motion to Dismiss Petitioner's §8(a) Petition on June 5, 2019. (RXA). Respondent filed a Motion for Reconsideration to Close Proofs Instanter, and Request for en banc Review on November 5, 2020. (RXA).

FINDINGS OF FACT

Petitioner sustained compensable injuries on August 21, 2008, when he slipped and fell while working as a cook for Respondent. At Arbitration on June 23, 2015, Petitioner sought prospective medical treatment and permanent total disability. The Commission found that Petitioner proved that his current condition of ill-being pertaining to his right shoulder was partially work-related. The Commission also found that Petitioner's current conditions regarding his neck, back, and right leg were not causally related to the work injury. The Commission relied on Dr. Marra's opinion that SLAP lesions were misdiagnosed and that the tear diagnosed by Dr. Thometz was not in a position expected to result from the accident as described and was thus a new tear unrelated to the accident.

The Commission determined that Petitioner failed to prove he was incapable of employment and that no stable labor market existed. The Commission found him capable of some employment within his restrictions. The Appellate Court held that the Commission's determination that the claimant was entitled to permanent partial disability rather than permanent total disability was neither contrary to law nor against the manifest weight of the evidence.

The Commission terminated temporary total disability benefits on the date Petitioner refused an offer of light duty work within his prescribed work restrictions. The Appellate Court held this was not against the manifest weight of the evidence.

At the first evidentiary hearing on Petitioner's Motions pursuant to §§8(a) and 19(h) on October 10, 2019, Petitioner testified that since the hearing on June 23, 2015, he continued to treat with Dr. Thometz. (PX3; T. 10/10/2019, p. 12). He continued to seek surgery to the right shoulder as recommended by Dr. Thometz. *Id.* Petitioner testified he had also seen physicians in relation to his application for Social Security Disability Insurance benefits: (1) Dr. Albert Osei on November 18, 2017; (2) Dr. Lauren Oganovich on January 22, 2018. (T. 10/10/2019, p. 15-17). He was declared disabled by the Social Security Administration on June 5, 2019. (PX2; T. 10/10/2019, p. 21).

Petitioner testified the range of motion of his right shoulder was getting progressively worse. (T. 10/10/2019, p. 24). He testified to no strength in his right hand, arm, and shoulder, which affected the neck and all his other alleged work-related injuries. (T. 10/10/2019, p. 25). He detailed difficulties with dressing himself. (T. 10/10/2019, p. 22-23). Petitioner presented to the hearing on October 10, 2019 with a sling on his right arm, as well as braces on his back and knees. (T. 10/10/2019, p. 26).

At the second evidentiary hearing on June 16, 2021, Petitioner testified that his work-related injuries from 2008 worsened. (T. 6/17/21, p. 7). He explained that his pain and range of motion worsened in his neck, back, right shoulder, and right knee. (T. 6/17/21, p. 7-8). He was not having medical treatment due to COVID-19 and the lack of authorization by Respondent. *Id.*

Prior to the initial hearing on June 23, 2015, Petitioner was evaluated by Dr. Thometz on January 21, 2015. At that time, Petitioner complained of pain and difficulties with the right shoulder, neck, right knee, and right ankle. On exam of the right shoulder, he could forward elevate

to about 125 degrees and externally rotate about 45 degrees. He had marked guarding for cervical range of motion, only rotating to the left about 30 degrees and to the right about 45 degrees. Petitioner discussed his desire to proceed with right shoulder arthroscopy and treatment for the labral tear. Dr. Thometz wanted him evaluated by a spine specialist for ongoing neck pain and radiating into the upper extremities with tingling. He was not capable of returning to his previous work.

Petitioner returned to Dr. Thometz on March 25, 2015. Since he was last seen, he had another orthopedic evaluation which recommended possible capsular release and biceps tenodesis. The exam was unchanged, with forward elevation to 110 degrees, external rotation to about 50-60 degrees. Dr. Thometz's impression was persistent right shoulder pain. Dr. Thometz recommended arthroscopic evaluation and indicated he was incapable of returning to work.

Petitioner returned to Dr. Thometz on May 27, 2015. There was no change in his activity level. He still had diffuse pain through his shoulder. He was using the pulleys and stretching at home with TheraBand to try and improve his current function, but was still quite limited. He could completely forward elevate to about 90 degrees. His shoulder condition was unchanged and he was not capable of returning to his previous work.

Petitioner's first post-Arbitration visit with Dr. Thometz was on July 22, 2015. There was no change since his last visit. Therapy and surgery were denied by Respondent. Recommendations were unchanged. He was not capable of returning to his regular work.

Petitioner returned to Dr. Thometz on September 16, 2015. He reported an episode where he had his arm slightly abducted, felt a pop, sharp pain and diffuse discomfort through his shoulder. On exam, he could comfortably forward elevate to about 90 degrees and internally rotate to about 60 degrees. He had reasonable resistance for external rotation strength as well as thumb down abduction. The impression was persistent shoulder pain and labral tear. He was still having difficulties with his right knee, right ankle, neck, and back. He was using a sling and doing home exercises as tolerated. He was not capable of returning to his regular work.

Petitioner returned to Dr. Thometz on November 11, 2015, with continued right shoulder pain. There was no change since last visit. He still had diffuse soreness through the anterior aspect of the right shoulder. He could forward elevate to about 100 degrees comfortably, externally rotate to about 60 degrees, with reasonable external rotation strength. Dr. Thometz explained that he had been treating Petitioner for this condition since November 2009, and he has not been able to get any additional treatment for his shoulder. He noted the recent MR Arthrogram showed evidence of the large SLAP tear for which surgical intervention was recommended. He remained unable to return to work.

Petitioner returned to Dr. Thometz on January 13, 2016. His right shoulder condition remained unchanged and he also complained of pain through the neck, right ankle, and lower back. The exam was about the same. He could comfortably forward elevate to about 120 degrees today on the right shoulder and externally rotate about 60 degrees. He had a brace on his right knee, no appreciable effusion, some pain on terminal extension and could flex to about 120 degrees. The recommendation for surgery and off work remained.

Petitioner returned to Dr. Thometz on April 6, 2016. In addition to ongoing difficulties with his shoulder, he reported difficulties with his right knee, right ankle, lower back, as well as his neck. He could forward elevate his right shoulder to about 145 degrees and externally rotate about 60-70 degrees. His condition remained unchanged and his no return to work status remained in place.

Petitioner returned to Dr. Thometz on June 29, 2016. His condition was unchanged. He continued to have complaints with his right shoulder, neck, low back, right hand, and right ankle. He reported some compensatory left-sided soreness particularly for his left knee. On exam, he had limited forward elevation, diffuse soreness through the proximal aspect of his right shoulder. Dr. Thometz ordered physical therapy for his shoulder.

Petitioner returned to Dr. Thometz on September 28, 2016. He was doing a home therapy program as outpatient physical therapy was not authorized. He was wearing a sling. He was not capable of returning to work. Petitioner returned to Dr. Thometz on December 14, 2016, and his condition remained unchanged.

Petitioner returned to Dr. Thometz on March 8, 2017. He was experiencing diffuse pain through the anterolateral aspect of his shoulder. He was also having pain by his ribs as well, and had been treated for some thoracic outlet symptoms. He could comfortably forward elevate to about 90 degrees. Dr. Thometz felt he would benefit from additional treatment for his shoulder, consideration for additional therapy and arthroscopic evaluation and treatment.

Petitioner returned to Dr. Thometz on June 7, 2017. He reported left knee, hip and shoulder difficulties from compensating due to the difficulties with his right side. He had limited range of motion due to pain for his right shoulder. He remained unable to return to his previous work. His condition was unchanged on September 29, 2017.

Petitioner was seen at Dr. Thometz's new practice on October 29, 2018, with bilateral knee and right shoulder pain. Examination showed forward elevation of the right shoulder to 70 degrees and 115 degrees on the left; external rotation on the right to 20 degrees and left to 45 degrees. Good strength with external rotation. Abduction to 30 degrees on the right and 70 degrees on the left. Tenderness to palpation anteriorly, medially, and posteriorly. Passive forward elevation to 135 degrees.

Petitioner returned to Dr. Thometz on April 29, 2019. Shoulder range of motion was not assessed due to pain. He returned again on October 28, 2019, with generalized body pain. MR Arthrogram of the right shoulder was ordered.

Dr. Thometz testified via evidence deposition pursuant to Petitioner's Dedimus Potestatem on November 23, 2020. (PX5). Dr. Thometz testified that his diagnosis on April 10, 2019 was "torn labrum of the right shoulder." (PX5, p. 13-14). This resulted in "spasms, difficulty sleeping, and numbness and tingling related to the right shoulder labral tear with continued pain." (PX5, p. 14). Petitioner also had "severe restriction of range of motion to his right shoulder." (PX5, p. 15). Dr. Thometz testified that Petitioner's current condition is related to his injury from August 21,

2008. (PX5, p. 18-19). Finally, while he had continued to recommend surgery to repair the labral tear, his most recent recommendation was to obtain an updated MR Arthrogram. (PX5, p. 21).

Mr. Timothy Bobrowski testified via evidence deposition pursuant to Petitioner's Dedimus Potestatem on November 20, 2020. (PX4). Mr. Bobrowski is a Certified Vocational Rehabilitation Counselor, but has never worked with workers' compensation in Illinois. (PX4, p. 9, 23, 25). He had previously testified as an impartial vocational expert at Petitioner's Social Security Disability hearing on May 2, 2019. (PX4, p. 12, 15). During that hearing, he was asked by the administrative law judge to consider Petitioner's age, education, work experience, and residual functional capacity. (PX4, p. 20). He did not find Petitioner to have any past relevant work experience. (PX4, p. 21). He did not find that there were any jobs that existed in significant numbers in the national economy that Petitioner could perform. *Id.* When reviewing Petitioner's residual functional capacity, he was asked to consider not only the right shoulder, but the right ankle and right knee pain. (PX4, p. 28). It was the "residual functional capacity" factor that tipped the scales in terms of Petitioner not being able to find work. (PX4, p. 27).

CONCLUSIONS OF LAW

Respondent's Motion to Dismiss

Respondent filed a Motion to Dismiss Petitioner's §8(a) Petition on June 5, 2019. Respondent argued that because Petitioner was found to have reached maximum medical improvement (MMI) by the Commission, the Petitioner's §8(a) Petition had no valid basis and was moot. Petitioner timely filed an §8(a) Petition on April 12, 2018, and a second §19(h)/8(a) Petition on September 6, 2018. As such, Petitioner has the opportunity to prove that since the original hearing his condition became unstable or continued to degenerate. *World Color Press v. Indus. Comm'n*, 249 Ill. App. 3d 105 (1993). The Commission hereby denies Respondent's Motion to Dismiss.

Section §8(a)

Pursuant to §8(a) of the Act, Petitioner is entitled to all necessary care to cure or relieve the effects of his work-related injuries. 820 ILCS 305/8(a). Upon establishment of a causal nexus between the injury and Petitioner's current condition of ill-being, Respondent is liable for all medical care reasonably required in order to diagnose, relieve, or cure the effects of his work injuries. *Plantation Mfg. Co. v. Industrial Comm'n,* 294 Ill. App. 3d 705, 709 (2d Dist. 1997). An employer's liability for medical services under §8(a) of the Act is continuous so long as it as the services are required to relieve the injured employee from the effects of the injury. *Efengee Elec. Supply Co. v. Industrial Comm'n,* 36 Ill. 2d 450, 453 (1967).

Petitioner contends that his ongoing complaints are related to his August 21, 2008 work accident. He seeks authorization for prospective medical care. The Commission finds that Petitioner's current right shoulder complaints are not related to the August 21, 2018 accident. The Commission previously accepted Dr. Marra's opinion that Petitioner did not have a new labral tear related to the original injury because a new tear in the 2 o'clock position was not in the posterior superior quadrant where the anchor was placed during the surgery on March 24, 2009. Dr.

Thometz testified that it is this same labral tear that the Commission already found to be unrelated to the work injury that is causing Petitioner's ongoing symptoms and need for MR Arthrogram and/or surgery.

Under the law of the case doctrine, a Court's unreversed decision on an issue that has been litigated and decided settles the question for all subsequent stages of the action. *Miller v. Lockport Realty Group, Inc.*, 377 Ill. App. 3d 369, 374 (2007). The principles underlying the doctrine apply to matters resolved in proceedings before the Commission. *Weyer v. Ill. Workers' Comp. Comm'n*, 387 Ill. App. 3d 297, 307 (2008); *Irizarry v. Indus. Comm'n*, 337 Ill. App. 3d 598, 606–07 (2003); *Help At Home v. Ill. Workers' Comp. Comm'n*, 405 Ill. App. 3d 1150, 1151 (4th Dist. 2010). In both *Irizarry* and *Health at Home*, the Appellate Court observed that once a causal connection determination became final, it became the law of the case, and could not be revisited in a subsequent proceeding. *Irizarry*, at 606–07; *Help at Home,* at 1152.

It is the law of the case that the labral tear diagnosed by Dr. Thometz is not causally-related to the accidental injury of August 21, 2008. Thus, Petitioner is barred from revisiting this determination and seeking additional medical care for this tear under Section 8(a).

Section 19(h)

Section 19(h) allows an award to be reviewed within 30 months on the grounds that the disability of the employee has subsequently recurred, increased, diminished or ended. A Petitioner's condition can become unstable and continue to degenerate resulting in an increase in permanent disability, as well as additional treatment to restabilize a condition previously thought to be permanent. *World Color Press v. Indus. Comm'n*, 249 Ill. App. 3d 105 (1993).

To obtain an award under §19(h), Petitioner herein must show that his disability at the time of his initial arbitration hearing on June 23, 2015, had increased by the June 16, 2021 review hearing, and that that increase was material. *Gay v. Industrial Comm'n,* 178 Ill. App 3d. 129, 132 (1989); *Motor Wheel Corp. v. Industrial Comm'n*, 75 Ill. 2d 230, 236 (1979). In order to determine whether Petitioner's condition materially deteriorated from the time of the Arbitrator's award to the present, it is necessary to compare his condition at those two relevant times. *Howard v. Industrial Comm'n,* 89 Ill. 2d 428, 430-31 (1982).

The Commission finds that Petitioner has not met his burden of proving a material increase in his disability. As indicated above, Dr. Thometz testified that Petitioner's ongoing complaints in regards to pain and restricted range of motion are attributable to the labral tear that is unrelated to the work injury. Further, Dr. Thometz's medical records (PX3) do not document a material change in these range of motion measurements. The new evidence does not show a material decrease in Petitioner's functioning as it relates to the right shoulder, nor does it show that it is his right shoulder alone that is keeping him from gainful employment. The restrictions used by Mr. Bobrowski and SSDI were related to multiple body parts, not just the shoulder.

Respondent's Motion for Reconsideration to Close Proofs Instanter, and Request for En Banc Review

Respondent filed the above-captioned Motion on November 5, 2020. Respondent raises multiple arguments regarding the proceedings in this matter, but cites to no authority in support of same. The Commission hereby denies said Motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(a) Petition for additional medical benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's §19(h) Petition for increased permanency is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion for Reconsideration to Close Proofs Instanter, and Request for en banc Review is 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.

March 24, 2022

o: 01/25/2022
TJT/ahs
51

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC032883
Case Name	GREEN, ALENTAY v. FAMILY DOLLAR
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0120
Number of Pages of Decision	18
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Lindsey Strom
Respondent Attorney	PETER SINK

DATE FILED: 3/28/2022

/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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALENTAY GREEN,

Petitioner,

vs. NO: 19 WC 32883

FAMILY DOLLAR,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under Sections 19(b) and 8(a)[1] of the Act having been filed by the Respondent and Petitioner herein, and notice given to all parties, the Commission, after considering the issues of statute of limitations, whether Petitioner sustained an accidental injury arising out of and occurring in the course of her employment, whether the accident is causally connected to Petitioner's current psychological condition of ill-being, entitlement to medical expenses, entitlement to prospective medical care, entitlement to temporary total disability benefits, whether a discussion about permanent disability benefits is ripe and whether Section 19(l) and Section 19(k) penalties and Section 16 attorney fees are 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 further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E. 2d 1322 (1980).

The Commission hereby incorporates by reference the findings of fact contained in the Decision of the Arbitrator, which delineate the relevant facts and analyses. However, as an initial

[1] The Commission notes that while the Decision of the Arbitrator does not state this explicitly, based on the request For Hearing (the parties' stipulations) which indicates that the nature and extent of Petitioner's injuries was *not* at issue at the time of the Arbitration hearing, the transcript, and the parties' briefs, it appears that the parties intended for the instant case to be tried pursuant to sections 19(b) and 8(a) of the Act.

matter, the Commission clarifies and expounds on the decision, noting that the issues of statute of limitations and permanent partial disability were not raised at the Arbitration hearing and were not raised during oral arguments.

As it pertains to penalties and fees, the Commission modifies the Decision of the Arbitrator. The Commission reverses the denial of Section 19(k) penalties and Section 16 attorney fees, but affirms the denial of Section 19(l) penalties. The purpose of sections 16, 19(k), and 19(l) is to further the Act's goal of expediting the compensation of workers and penalizing employers who unreasonably, or in bad faith, delay or withhold compensation due an employee. *Avon Products, Inc. v. Industrial Commission*, 82 Ill. 2d 297, 301 (1980). The standard for granting penalties pursuant to Section 19(l) differs from the standard for granting penalties and attorney fees under Sections 19(k) and 16 of the Act. Section 19(l) provides in pertinent part, as follows:

> *If the employee has made written demand for payment of benefits* under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall *without good and just cause* fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission *shall* allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. (Emphases added.)

820 ILCS 305/19(1) (West 2018).

Penalties under Section 19(l) are in the nature of a late fee. *Mechanical Devices v. Industrial Commission*, 344 Ill. App. 3d 752, 763 (4th Dist. 2003). In addition, the assessment of a penalty under Section 19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Commission*, 93 Ill. 2d 1, 9-10 (1982).

The standard for awarding penalties under Section 19(k) is higher than the standard under Section 19(l). Section 19(k) of the Act provides, in pertinent part, as follows:

> In case where there has been any *unreasonable* or vexatious delay of payment or intentional underpayment of compensation, 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. (Emphasis added.)

820 ILCS 305/19(k) (West 2018).

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. Section 16 provides, in pertinent part, as follows:

> Whenever the Commission shall find 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, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

820 ILCS 305/16 (West 2018).

Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 514-15 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *Id*. at 515. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *Id*. In addition, while Section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under Sections 19(k) and Section 16 is discretionary. *Id*.

Considering the facts of this case, the Commission modifies the arbitration decision, and finds that penalties pursuant to Section 19(k) and attorney fees pursuant to Section 16 of the Act are warranted.

There is clear evidence that Respondent's conduct in denying benefits was unreasonable and vexatious, thus serving as the catalyst for the imposition of Section 19(k) penalties and Section 16 attorney fees. After the October 14, 2019 work-related accident where Petitioner endured an armed robbery at work when two masked gunmen entered Respondent's establishment, hopped over the cash register, and one pointed his gun at Petitioner's chest while demanding she open the cash register, Petitioner underwent treatment with therapist Paulette Eason-Williams, psychologist Dr. Daniel G. Kelley and Dr. Chukweloka N. Ikedionwu, all of whom diagnosed her with Posttraumatic Stress Disorder. Ms. Eason-Williams and Dr. Kelley took Petitioner off work, and Dr. Kelley recommended cognitive behavioral therapy, psychoeducation and a medical consultation. On February 7, 2020, Dr. Kelley noted Petitioner demonstrated increased emotional distress and dysregulation, poor coping skills and limited in-session attention which have compromised her ability to recall and implement therapeutic strategies. Dr. Kelley contemplated the possible benefit of a medication regimen to address Petitioner's anxiety and sleep disturbance. Similarly, just three days earlier on February 4, 2020, Dr. Ikedionwu opined that melatonin would be a good starting point to correct Petitioner's sleep disturbance.

On February 11, 2020, Dr. Stephen H. Dinwiddie performed a Section 12 examination on Petitioner at Respondent's request. He reviewed treatment records, psychological testing reports, a report detailing Petitioner's social media activities and evaluated Petitioner for two-and-a-half hours. Dr. Dinwiddie disagreed with the diagnosis of Posttraumatic Stress Disorder, but did diagnose her with Adjustment Disorder with Anxiety and Panic Disorder. He unmistakably opined that the Adjustment Disorder "appears to be related to the 10/14/2019 Incident." Further, he noted that Petitioner appears to have panic attacks, which are typically treated with antidepressants, and that her sleep disturbance has not been medically evaluated. Dr. Dinwiddie opined that "treatment to date appears to have been necessary, reasonable and appropriate. Given the lack of progress; however, at this time, it would be reasonable to consider additional interventions as noted above." He further opined that treatment to date had been related to the October 14, 2019 injury. Lastly, Dr. Dinwiddie opined that Petitioner had not reached maximum medical improvement, and that a return to her pre-accident employment location was "unlikely to be successful."

While Dr. Dinwiddie disagreed with the diagnoses of Petitioner's treating physicians, he clearly did not disagree that Petitioner required additional medical treatment, had not reached maximum medical improvement and was currently disabled from returning to her pre-accident employment. In fact, he opined that his diagnosis of Adjustment Disorder appeared to be related to the October 14, 2019 work incident. The parties stipulated to temporary total disability benefits from the date of accident through January 6, 2020. However, there is absolutely no evidence that Petitioner had been released back to work thereafter. In fact, Respondent's own Section 12 examiner had declined to release Petitioner to work.

To be entitled to temporary total disability benefits, a claimant must prove not only that he did not work, but that he was unable to work. *Freeman United Coal Mining Co. v. Industrial Commission*, 318 Ill. App. 3d 170, 175 (5th Dist. 2000). The dispositive test is whether the condition has stabilized, that is, whether the claimant has reached maximum medical improvement. *Mechanical Devices v. Industrial Commission*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). Here, Petitioner was precluded from work by her treating physicians immediately after the accident. In addition, Dr. Dinwiddie, Respondent's Section 12 examining physician, opined that she had not yet reached maximum medical improvement and she required additional treatment which was related to the instant accident.

Further, the Commission finds it was unreasonable, vexations and in bad faith for Respondent to continue relying on video exhibits of Petitioner's social media activities when Dr. Dinwiddie, Respondent's Section 12 examining physician, had already reviewed a document titled "Alentay Green Social Media Report[2]" provided by Respondent and opined that Petitioner's October 14, 2019 work accident, which has been stipulated to by the parties, was related to Petitioner's diagnosis of Adjustment Disorder. The Commission finds that Petitioner's social media activities as depicted by the video exhibits did not undermine her testimony or claim for benefits. Additionally, we find Respondent's argument that Petitioner could not engage in any social activities while [psychologically] debilitated from the October 14, 2019 incident, is unreasonable and unsupported by the expert opinions in this case.

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[2] The Social Media Report mentioned in Dr. Dinwiddie's March 18, 2020 report was not an exhibit in this case.

Accordingly, the Commission finds no genuine controversy with respect to Petitioner's entitlement to temporary total disability benefits from January 7, 2020 through the date of the Arbitration hearing, and further finds Respondent's delay in payment of benefits from January 7, 2020 through the arbitration date of September 29, 2020 (38 & 1/7ths weeks) to be unreasonable, vexatious and in bad faith. See *Jacobo v. Illinois Workers' Compensation Commission*, 959 N.E. 2d 772, 778 (3rd Dist. 2011). Petitioner's stipulated average weekly wage is $430.04, equaling a temporary total disability rate of $286.69. This amount multiplied by 38 & 1/7ths weeks equals $10,935.18. The Commission imposes Section 19(k) penalties totaling 50 percent of $10,935.18 on Respondent in the amount of $5,467.59 per Petitioner's request.

In addition to the imposition of Section 19(k) penalties, the Commission additionally awards Petitioner Section 16 attorney fees. The Commission finds that Respondent's delay in payment of benefits was deliberate and in bad faith, as Respondent chose to disregard the opinions of its' own Section 12 examining physician. Accordingly, the Commission awards attorney fees of 20 percent of the unpaid temporary total disability award, per Petitioner's request, or $2,187.04.

With respect to Section 19(l) penalties, the Commission finds no evidence that Petitioner made written demand for payment of benefits pursuant to the Act. With no such evidence, the Commission declines to award Section 19(l) penalties to Petitioner.

All else is affirmed and adopted.

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

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved by a preponderance of the evidence that she sustained an accidental injury arising out of and in the course of her employment with Respondent on October 14, 2019.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved causal connection between the October 14, 2019 work-related accident and her current psychological condition of ill-being by a preponderance of the evidence.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's psychological injury, including medical bills from Ms. Paulette Eason-Williams, LCPC, Integrated Behavioral Medicine (Dr. Kelley), and Englewood Health Clinic/Cook County Health, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for additional medical treatment recommended by Dr. Kelley and Dr. Dinwiddie, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.69 per week for a period of 38 & 1/7ths weeks, representing January 7, 2020 through September 29, 2020, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties of $5,467.59 as provided in Section 19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner attorney fees of $2,187.04 as provided in Section 16 of the Act.

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

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

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

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

March 28, 2022

O: 1/26/22
DJB/wde
043

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

/s/ *Stephen Mathis*
Stephen Mathis

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, ALENTAY
Employee/Petitioner

Case# **19WC032883**

FAMILY DOLLAR
Employer/Respondent

On 2/16/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2194 STROM & ASSOCIATES
LINDSEY STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

1886 LEAHY EISENBERG & FRAENKEL LTD
NICK NAVARRO
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alentay Green
Employee/Petitioner

v.

Family Dollar
Employer/Respondent

Case # **19** WC **32883**

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 **Christopher Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **September 29, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

Findings

On **10/14/2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**22,362.08**; the average weekly wage was $**430.04**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

Order

Petitioner's claim for prospective medical treatment pursuant to Section 8(a) of the Act is approved.

Respondent is liable for all medical bills from Paulette Eason-Williams, LCPC, Integrated Behavioral Medicine (Dr. Daniel Kelley), and Englewood Health Clinic/Cook County Health, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner TTD benefits for the period of January 7, 2020 through September 29, 2020 representing 38 1/7ths weeks or $10,935.18.

As Respondent did not act in an unreasonable or vexatious manner, no penalties or fees are imposed against Respondent.

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   2/11/21 Date

FEB 16 2021

FINDINGS OF FACT

Petitioner, Alentay Green ("Petitioner"), was an employee for the Respondent, Family Dollar[1] ("Respondent") on October 14, 2019. (Arb. Ex. 1). She had been employed with Respondent as a cashier for approximately one month and her duties included operating the cash registers, unloading pallets, and shelving merchandise. (Transcript of Proceedings on Arbitration "Trans" at 9, 11).

On October 14, 2019 Petitioner was working an evening shift with one other employee, shift manager Marlin. (Id. at 12-13). During this shift, at approximately 7:30 p.m., two armed and masked gunmen entered the store, jumped over the counter, pointed a gun at Petitioner's chest and began screaming and swearing at her to open the cash register. (Trans. at 13-14). Petitioner testified that she immediately fell to the floor and began scooting backwards while screaming at her assailants not to shoot her. (Id.). Petitioner testified that she also began screaming for Marlin during the robbery, but that he was "nowhere to be found". (Id. at 14). Petitioner stated that while one assailant pointed the pistol at her, the other attempted to rip out the cash register. (Id. at 14-15). Unable to dislodge the register by himself, the other gunman assisted in tearing out the register and they both immediately left the store. (Id. at 15).

After the robbers left the store, Petitioner testified that she picked herself up from the floor, locked the front door, and immediately called the police. (Id. at 15-16). Petitioner then discovered Marlin had locked himself in the manager's office in the rear of the store. (Id. at 16). Petitioner stated that the police arrived almost immediately; she was interviewed and provided a statement. (Id. at 23; Pet. Ex. 2a). Petitioner also testified that she contacted the store's General Manager, Alicia Louis, first by calling and then texting her to inform her of the armed robbery. (Trans. at 23-24). Ms. Louis instructed Petitioner to call the Respondent's Employee Assistance Program Hotline. (Id. at 24).

Petitioner testified to calling Employee Assistance Program Hotline the next day and subsequently began treatment with therapist Paulette Eason-Williams, LCPC, CADC ("Ms. Eason-Williams") on or about October 22, 2019. (Id. at 24; Pet. Ex 5). Ms. Eason-Williams recorded that Petitioner experienced constant unpleasant flashbacks, reported feelings of moderate depression and nervousness, and was experiencing sleep disturbances. (Pet. Ex. 5 at 4). Petitioner continued seeing Ms. Eason-Williams four additional times through November 19, 2019. (Id. at 5-8). During those visits, Petitioner continue reporting symptoms of "helplessness, fear and horror", was easily startled and hypervigilant, and that she was inclined to return to work if a security guard was present. (Id.). Ms. Eason-Williams referred Petitioner to psychologist Dr. Daniel Kelly, Ph.D. ("Dr. Kelley) with whom she began treating. (Pet. Ex. 4 at 17).

Petitioner was evaluated by Dr. Kelley on November 20, 2019. (Id.). Dr. Kelley conducted a Beck Depression Inventory, MMPI-2-RF[2] assessment and TSI-2A[3] assessment on the Petitioner, with results including: sleep disturbance, agitation, crying, dysphoria, anhedonia, hyperarousal, anxiety, heart pounding, headaches, hypervigilance, tremors, nightmares, flashbacks, excessive worry and social isolation and avoidance. (Pet. Ex. 4 at 18, 19). Dr. Kelly noted that her responses were indicative of mild levels of depression and severe anxiety and assigned her a diagnosis of Post-Traumatic Stress Disorder ("PTSD"). (Id. at 19). Dr. Kelley recommended a treatment plan including cognitive-behavioral therapy, psychoeducation, and medication consultation. (Id.). Dr.

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[1] The store's address is 1200 West 87th Street, Chicago, Illinois. (Trans. at 9; Pet. Ex. 2A).
[2] Minnesota Multiphasic Personality Inventory 2 - Restructured Form.
[3] Trauma Symptom Inventory.

Kelley noted Petitioner's level of distress as "severe" and placed her on no work status. (Id. at 21). Petitioner began attending psychotherapy sessions with Dr. Kelley after the initial assessment. (Id. at 22-30).

Dr. Kelly authored an update report on December 13, 2019. (Id. at 33). Petitioner continued to experience frequent nightmares and flashbacks of the October 14, 2019 work accident – with continued feelings anger, vulnerability and victimization. (Id. at 34). Petitioner indicated that she no longer liked being around strangers and continued to be emotionally distressed with episodic crying. (Id.).

Petitioner continued treating with Dr. Kelley through February 7, 2020 at which time Dr. Kelley authored a second update report on Petitioner's progress. (Id. at 54-55). Dr. Kelley noted that Petitioner had poor coping skills and limited in-session attention, which significantly compromised her ability to recall and implement therapeutic strategies. (Id. at 54). Dr. Kelley continued to focus therapy on coping mechanisms, negative attribution relative to herself and others, and examined Petitioner's beliefs as to her safety in her work environment. (Id.). Dr. Kelley continued to recommend therapy, but also indicated that Petitioner would benefit from a medication regimen to address her anxiety and sleep disturbance. (Id. at 55). Petitioner remained off duty and continued to receive therapy from Dr. Kelley through the date of trial. (Id.).

Petitioner was seen by Dr. Chukweloka Ikedionwu ("Dr. Ikedionwu") of Cook County Health from the medical referral provided by Dr. Kelley on February 4, 2020. (Pet. Ex. 6 at 6-10). Upon reviewing her symptoms, Dr. Ikedionwu believed that the trazodone recommended by Dr. Kelley would be able to improve Petitioner's poor sleep but believed it would not be a starting approach, and instead prescribed over-the-counter Melatonin. (Id. at 8, 10).

Petitioner was seen again at Cook County Health by Dr. Krista Santilli ("Dr. Santilli") on May 18, 2020. (Id. at 11-14). Petitioner reported that she had been taking the Melatonin nightly, but with little effect, and was experiencing continued insomnia, with difficulty falling asleep and maintaining sleep. (Id. at 11). It was also noted that Petitioner's nephew had been murdered the same week. (Id.). Dr. Stantilli prescribed an initial trial of trazodone and recommended additional psychotherapy. (Id. at 13).

Dr. Stephen Dinwiddie ("Dr. Dinwiddie") conducted an independent medical examination ("IME") of the Petitioner at the request of the Respondent on February 11, 2020 pursuant to Section 12 of the Act and authored a report of said examination on March 18, 2020. (Resp. Ex. 1). Dr. Dinwiddie reviewed the treatment records from Ms. Eason-Williams and Dr. Kelley, a document titled "Alentay Green Social Media Report", and Petitioner's MMPI-2 and TSI-2 results. (Id.). Dr. Dinwiddie noted that Petitioner reported no clinically significant symptoms prior to the October 14, 2019 injury, with no prior history of panic attacks or sleep disturbances. (Id. at 4).

Dr. Dinwiddie acknowledged that Petitioner's self-reported symptoms, could have merited a diagnosis of PTSD, but that the case history reflected inaccuracies in Petitioner's self-reporting. (Id. at 13). In particular, he pointed out that Petitioner continually reported sleep disruption, but demonstrated no sign of chronic sleep deprivation. (Id.). Petitioner also had inconsistencies in her subjective reporting of concentration impairment – a finding at odds with her participation in the MMPI-2 RF and TSI-2 tests previously administered by Dr. Kelley. (Id.). Further, Dr. Dinwiddie noted that Petitioner's descriptions of posttraumatic nightmares were atypical and that her reports of social withdrawal and anhedonia was contradicted by Petitioner's social media

reports. (Id.). Based upon these findings, Dr. Dinwiddie disagreed with the Dr. Kelley's diagnosis of PTSD and instead diagnosed Petitioner with Adjustment Disorder with anxiety.[4] (Id. at 14).

Dr. Dinwiddie concluded that the adjustment disorder was related to the October 14, 2019 accident, that the medical treatment provided to date was related to the work injury, and that Petitioner was not yet at MMI. (Id. at 15-16). Dr. Dinwiddie specifically noted that at one point, Petitioner could have merited a diagnosis of PTSD, but as of the date of the report, it had substantially or fully remitted. (Id. at 15). As such, it was abnormal for Petitioner to continue to exhibit the symptoms she continually self-reported to Dr. Kelley's diagnosis. (Id.). Dr. Dinwiddie opined that while she had been treated, Petitioner had not been treated effectively, insofar as the sleep disturbances had not been medically evaluated, and a trial of antidepressants was not prescribed to combat the stated panic attacks. (Id. at 15-16). Dr. Dinwiddie asserted that it would be reasonable to consider these treatments to improve Petitioner's condition. (Id. at 16).

On May 23, 2020, Dr. Kelley drafted a response to Dr. Dinwiddie's report. (Pet. Ex. 3; Dep. Ex. 3). Dr. Kelley acknowledged the mutual clinical agreement that Petitioner suffered from a DSM-5 trauma and stressor related disorder, but maintained his clinical opinion that Petitioner suffered from PTSD, and that the inconsistencies in her self-reporting did not negate that diagnosis. (Id.). Dr. Kelley believed that Petitioner did not objectively show signs of symptom magnification, malingering or exaggeration when he administered the TSI-2-A and MMPI-2-RF test. (Id.). Lastly, Dr. Kelley addressed the social events which Petitioner had attended periodically since the date of the accident, indicating that part of his treatment with Petitioner emphasized social engagement and discouraged social avoidance. (Id.).

Petitioner testified that neither Ms. Eason-Williams nor Dr. Kelley discouraged her from leaving her home and socializing. (Trans. at 73). Petitioner testified that she has both good and bad days - on good days, she may laugh and smile, but on bad days she is depressed and worried. (Id. at 68, 75-76). During cross-examination, Petitioner testified that she had attended a comedy show, a gospel concert, and hosted a birthday party for her daughter at a Dave & Buster's restaurant in the weeks following the robbery. (Id. at 40-42; Resp. Exs. 4-10, 12).[5] Petitioner acknowledged that she chose to go to the comedy and gospel shows because she felt safe in the knowledge that there was professional security at both places and her family and loved ones were there to protect her. (Trans. at 25-28, 44-54). Petitioner further testified that she held the birthday party in an attempt to minimize the psychological impact of the robbery on her daughter and that she felt comfortable surrounded by family. (Id. at 28).

Deposition Testimony of Dr. Daniel Kelley[6]

Dr. Kelley testified as to beginning treatment of Petitioner on November 20, 2019, approximately four weeks after the robbery. (Pet. Ex. 3 at 5, 8). Dr. Kelley testified that Petitioner did not have a past mental health history. (Id. at 14). He noted that Petitioner has poor frustration tolerance, poor coping skills, and diminished recollection of information from session to session. (Id. at 9-12). Dr. Kelley described her as "an emotional roller coaster who can't remember and

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[4] Dr. Dinwiddie also listed a diagnosis of Panic Disorder, but ultimately believed that this diagnosis was not causally connected to the October 14, 2019 incident. (Resp. Ex. 1 at 15). Dr. Kelley acknowledged Dr. Dinwiddie's conclusions. (Pet. Ex. 3; Dep. Ex. 3).

[5] Respondent also introduced evidence that Petitioner celebrated the graduation of her daughter. (Resp. Ex. 11).

[6] Dr. Kelley is a licensed clinical psychologist. (Pet. Ex. 3 at 5, 8).

can't think through her problems." (Id. at 11). He testified that she is emotionally reactive, behaviorally reactive and cognitively unaware. (Id. at 23).

In referring to his medical records, Dr. Kelley testified as to his administration of the MMPI-2-RF and TSI-2 evaluations upon Petitioner in an effort to assess the extent of Petitioner's lack of trust and hyperarousal. (Id. at 15). Dr. Kelley explained that Petitioner endorsed cynical behaviors such that she may perceive others as untrustworthy. (Id. at 20). Her profile was also notable for social avoidance, which Dr. Kelley described as not just avoiding going places outside of the home, but as emotional avoidance. (Id. at 20-21). Ultimately, Dr. Kelley testified that the TSI-2 data validly supported a PTSD diagnosis and the MMPI-2-RF assessment showed no evidence of inconsistent responding or symptom magnification. (Id. at 20-21, 65-67, 90-99).

Dr. Kelley testified that Petitioner's mood was initially anxious and mildly disorganized, except when she was recounting the robbery, when she would become tearful and extremely anxious. (Id. at 16). Dr. Kelley testified that Petitioner was extremely social prior to the work-related injury but was less social after the work injury. (Id. at 25, 26). Dr. Kelley explained that avoidance is not absolute: someone could be nonavoidant one day and avoidant the next because there is a continuum of improvement. (Id. at 26).

Dr. Kelley affirmed that he encouraged Petitioner to leave the house and socialize. (Id. at 28, 32-33, 36). He testified that Petitioner has been able to periodically engage in social events, which reflected the continued emphasis in treatment to socially engage with others, discourage avoidance, challenge over-generalizations of fear, and maintain routines. (Id. at 27, 28, 81-83, 90). He explained having these experiences challenged negative, unconscious, maladaptive thoughts resulting from the work incident with Dr. Kelley. (Id. at 87).

Deposition Testimony of Dr. Stephen Dinwiddie[7]

Dr. Dinwiddie opined that all of Petitioner's medical treatment to date had been related to her October 14, 2019 work injury. (Resp. Ex 1; Resp. Ex. 2 at 123). Dr. Dinwiddie agreed that Petitioner was, "not a very psychologically-minded person, and does not have a great deal of insight into her own motivations and psychological needs." (Resp. Ex 2 at 22). Dr. Dinwiddie testified regarding Dr. Kelley's treatment including exposure therapy, explaining that such efforts were clinically appropriate, and that Petitioner should not isolate at home. (Id. at 114-115). Dr. Dinwiddie testified that Dr. Kelley's records did not mention discussion or the effects of Petitioner's various social outings – circumstances which he opined would be important to document and discuss given Petitioner's self-reported social withdrawal symptoms. (Id. at 45-62). Dr. Dinwiddie, when asked to clarify his statement in his report as to Petitioner's possible remission from PTSD, testified that in his opinion Petitioner never qualified for a diagnosis of PTSD, but could not foreclose the possibility that Petitioner's condition had improved during treatment. (Id. at 109-111).

Testimony of Luz "Patti" Morales

Petitioner called to testify Family Dollar Employee Luz "Patti" Morales ("Ms. Morales"). (Id. at 79). Ms. Morales began working for Respondent in September of 2019 but was not present when the robbery occurred. (Id. at 12, 13, 79). She further testified that she lives approximately one block away from the store location and has been living in the neighborhood for approximately

[7] Dr. Dinwiddie is a board-certified psychiatrist and professor of psychiatry. (Resp. Ex. 2 at 5-6).

one year. (Id. at 80). Ms. Morales testified that she believed Respondent's store was in a dangerous neighborhood as she had witnessed shootings, stealing, and drug transactions near her home. (Id. at 80-81). She further testified that other stores in the area of the Respondent's store had been robbed. (Id. at 84).

Testimony of Alica Louis

Respondent called to testify the store manager of the Family Dollar at issue, Alicia Louis ("Ms. Louis"). Ms. Louis testified that she was not present when the robbery occurred. (Id. at 90). Ms. Louis testified that she did not feel unsafe at the store in question. (Id. at 91). Ms. Louis further testified that she had not seen gang activity near the store, but that police occasionally visited the store. (Id. at 91-92). Ms. Louis also testified that as a store manager for that location, she reviewed the video surveillance footage every morning. (Id. at 101).

Petitioner testified that she lives two blocks from the store location and believes that the neighborhood is a dangerous one. (Id. at 10). Petitioner testified that gang activity in the area and around the store is common and she has both seen and heard shootings. (Id. at 10-11). Petitioner has a conceal-carry license and has a weapon for safety purposes due to the dangerousness of the area. (Id. at 18). Petitioner testified that in the few weeks she worked there prior to the incident in question, the police had been called to the store several times. (Id. at 129-130).

CONCLUSIONS OF LAW

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

Ghere Objections

At trial, there were a series of objections raised by Petitioner regarding admissibility of evidence. At the evidence deposition[8] of Dr. Dinwiddie on August 11, 2020, the witness was offered information the night before or the morning of the deposition by the Respondent's counsel. (Resp. Ex 2 at 35-62; Trans. at 45-46). The specific information related to public internet postings and media from Petitioner's personal social medial pages, available to the public, which had been obtained by the Respondent. (Id; Resp. Exs. 4-12; Trans. at 44-45). The information included videos of Petitioner at various social events which occurred after the October 14, 2019 work injury. (Id.). There is no dispute that Dr. Dinwiddie tendered his report months prior to his evidence deposition, but Dr. Dinwiddie testified that he had reviewed Petitioner's social medial postings at some point between the submission of his Section 12 report in February 2020 and his evidence deposition in August 2020. (Id.). Petitioner raised a *Ghere* objection.

The purpose of *Ghere* is to protect due process and protect against unfair surprise in upholding Section 12's 48-Hour rule. However, in this case, the Petitioner's due process rights were not circumvented, and she did not suffer any unfair surprise. The notes of Dr. Kelly consistently describe Petitioner's social avoidance and isolation purportedly resulting from the October 14th accident. (Pet. Ex. 4 at 17-19, 29, 33). His notes also confirmed Petitioner's positive responses to treatment, including increased socialization. (Pet. Ex. 3 at Dep. Ex. 3). On direct testimony, Petitioner confirmed that the pictures and videos taken were from her Facebook page

[8] Petitioners objections were again made a trial.

and that she had uploaded them. (Trans. at 44-45). The question of Petitioner's social interactions and isolationism has been ongoing throughout the course of this case and was thoroughly reviewed by both physicians. Petitioner cannot now claim to be surprised by specific evidence of her own creation and control which then offers a specific challenge to her self-reported and documented symptoms. Moreover, Petitioner's social media report appears to have been made available during the IME. Petitioner was aware for months preceding Dr. Dinwiddie's deposition that her social media habits and their potential relevance to her worker's compensation case were at issue. As such, Petitioner objection pursuant to *Ghere* is overruled.

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

The Arbitrator finds that the Petitioner's work accident arose out of and was in the course of her employment with Respondent on October 14, 2019. It is undisputed that Petitioner was an employee of the Respondent on the date of the accident and that she was working her shift on Respondent's premises at the time of the injury. (Arb. Ex. A, Trans, Pet. Ex. 1).

The risk of robbery is distinctly associated with the employee's employment as a cashier, and the injuries specifically resulting therefrom arose out of her employment with Respondent. Petitioner was a cashier for the Respondent and was manning the cash register at the time of the robbery. (Trans. at 13-14; Pet. Ex. 4 at 17). Petitioner testified that one of her assailants jumped over the counter, landed next to her, pointed a pistol at her chest and instructed her to open the register. (Trans. at 14). Further, both Petitioner and Ms. Louis testified that Respondent has corporate policies in place should theft occur in the store. (Trans. at 91, 128-129). Specifically, the employees are instructed to never give chase or go outside the store and not never approach the perpetrators. (Id.). Employees were instructed to offer customer service. (Id.).

At the time of the occurrence, Petitioner was performing her duties as a cashier, and acted in a manner she was expected to pursuant to the company's policies regarding robberies or thefts on the premises. Petitioner did not interfere with the robbers taking of the cash registers, did not give chase upon their departure from the store, and called the police after they left. (Id. at 21).

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

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

The Arbitrator finds credible the opinions and testimony of both Dr. Kelley and Dr. Dinwiddie that Petitioner's present condition was causally related to the work incident that occurred on October 14, 2019. (Pet. Ex. 3 at 98-99; Resp. Ex. 1 at 15-16). Both Dr. Kelley and Dr. Dinwiddie agree that Petitioner suffers from a DSM-5 trauma-stressor related injury and disagree only as to whether the specific traumatic diagnosis should be PTSD or adjustment disorder. (Pet. Ex. 3 at 80; Resp. Ex. 1 at 13-15).

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

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

The Arbitrator finds that the treatment that Petitioner received from Integrated Behavioral Medicine (Dr. Daniel Kelley)[9], Paulette Eason-Williams, LCPC[10], and Englewood Health Clinic/Cook County Health[11], constituted necessary medical care reasonably required to cure or relieve her of the effects of the her work injury, and therefore said bills resulting from said treatment are the responsibility of the Respondent pursuant to Section 8(a) of the Act, as applied through the fee schedule or as otherwise negotiated. In support of this finding, the Arbitrator cites and incorporates by reference Petitioner's Exhibits 4 through 6, as well as the credible testimony of the Petitioner. Furthermore, Dr. Dinwiddie confirmed that Petitioner has "had an adequate course of evidence-based psychotherapy, without sufficient response" – treatment which was all related to the October 14, 2019 incident. (Resp. Ex. 1 at 16).

K. Is Petitioner entitled to any prospective medical care?

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

The Arbitrator finds that Petitioner is entitled to prospective medical care and finds the proposed ongoing psychotherapy sessions offered by Dr. Kelley to be reasonable, necessary and causally related to Petitioner's October 14, 2019 work accident. However, the Arbitrator notes that the testimony of Dr. Dinwiddie is persuasive in that Petitioner may be currently suffering from adjustment disorder as opposed to PTSD due to the ongoing progress resulting from her sessions with Dr. Kelley. Further, the Arbitrator finds credible Dr. Dinwiddie's testimony that Petitioner lacked sufficient diagnostic testing and medication which may have potentially aided in the alleviation of her consistent, self-reported symptoms – including prescribed antidepressant medication, and medical evaluation and potential treatment for her sleep disturbances. Accordingly, Respondent shall also authorize and pay for same, along with related services in line with Dr. Dinwiddie's recommendations referenced in his report.

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

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

The Arbitrator finds that Petitioner is entitled to TTD benefits from the date of accident through September 29, 2020. The Arbitrator notes that the parties stipulated that TTD benefits had previously been paid to Petitioner from the date of injury through January 6, 2020 in the amount of $3,692.70. Petitioner is therefore entitled to TTD benefits from January 7, 2020 through September 29, 2020 representing represent 38 1/7 weeks or $10,935.18, based upon a stipulated average weekly wage of $430.04 per week. (Arb. Ex. 1).

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[9] Pet. Ex. 4
[10] Pet. Ex. 5
[11] Pet. Ex. 6

M. Should penalties or fess be imposed upon Respondent?

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

The medical records submitted into evidence decides against the award of penalties or fees against the Respondent. It is clear from Dr. Dinwiddie's report and testimony that Petitioner suffered from psychological trauma related to the October 14, 2019 work accident. However, his report acknowledges that in her sessions with Dr. Kelley, Petitioner self-reported inconsistent or atypical symptoms for a PTSD diagnosis, with specific emphasis on her social withdrawal and anhedonia which was contradicted by the evidence of her social activities included in the record. Although the Arbitrator disagrees with Respondent's argument that Petitioner could not engage in any social activities while debilitated from the October 14, 2019 incident, the Arbitrator does find that such inconsistencies in Petitioner's reporting minimally gave Respondent a good faith basis for denial of liability.

Signed:
SIGNATURE OF ARBITRATOR

2/11/21
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC002473
Case Name	OLEKSY, SZYMON v. WK HEATING INC
Consolidated Cases	
Proceeding Type	Remanded from the Appellate Court Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0121
Number of Pages of Decision	14
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Natalia Olejarska
Respondent Attorney	Leslie Johnson

DATE FILED: 3/30/2022

/s/Thomas Tyrrell, 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

Szymon Oleksy,

Petitioner,

vs. NO: 15 WC 002473

WK Heating, Inc.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to a remand from the Appellate Court in *Oleksy v. Ill. Workers' Comp. Comm'n*, 2021 IL App (1st) 191929WC-U, entered February 5, 2021.

I. **Procedural Background**

Petitioner previously appealed the Decision and Opinion on Review of the Commission dated December 12, 2018, finding that he failed to prove the existence of an employer-employee relationship between himself and the Respondent on the date of the accident. On August 23, 2019, Judge Michael F. Otto of the Circuit Court of Cook County confirmed the Commission's Decision. On February 5, 2021, the Appellate Court of Illinois reversed the judgment of the Circuit Court of Cook County that confirmed the Commission's Decision, reversed the Commission Decision, and remanded the matter back to the Commission with directions to find that an employer-employee relationship existed between claimant and Respondent on the date of the accident.

In his Decision on October 26, 2017, the Arbitrator found that on January 9, 2015, Petitioner sustained an accident that arose out of and in the course of his employment and that timely notice of this accident was given to Respondent. The Arbitrator also found Petitioner's current condition of ill-being causally related to the accident. These issues were not reviewed.

II. **Findings of Fact**

The Commission hereby incorporates by reference the findings of fact contained in the Arbitration Decision to the extent it does not conflict with the Illinois Appellate Court's opinion dated February 5, 2021. The Commission also incorporates by reference the Illinois Appellate

Court's opinion, which delineates the relevant facts and analysis, attached hereto and made a part hereof. Any additional findings of fact in this Decision and Opinion on Remand will be specifically identified in the discussion of particular issues.

III. Conclusions of Law

The Commission hereby finds that an employer-employee relationship existed between Petitioner and Respondent on January 9, 2015. The Commission now finds Petitioner is entitled to reasonable and necessary medical expenses, temporary total disability, and prospective medical care for the reasons stated herein, and modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

A. Temporary Total Disability Benefits (TTD)

Petitioner did not return to work for Respondent following his injury on January 9, 2015. Petitioner was released to return to work light duty on June 19, 2015. He began to work side jobs in carpentry and painting at this time. Petitioner subsequently underwent L4-S1 decompressive laminectomy, foraminotomy, discectomy, and facetectomy on February 2, 2016. On April 8, 2016, Dr. Sokolowski released him to light duty as of April 18, 2016. Accordingly, the Commission concludes that Petitioner was entitled to TTD benefits from January 10, 2015 through June 19, 2015 and from February 2, 2016 through April 17, 2016.

B. Reasonable and Necessary Medical Expenses

Petitioner submitted reasonable and necessary medical expenses detailed in PX1 through PX16, totaling $105,899.74.

C. Prospective Medical Care

After being released back to full duty work on May 13, 2016, Petitioner returned to Dr. Sokolowski with increased back pain on May 31, 2016. Petitioner's last visit with Dr. Sokolowski was November 14, 2016, with complaints of unbearable pain with activity. Dr. Sokolowski recommended future fusion surgery. Accordingly, the Commission finds Petitioner entitled to prospective medical care, as recommended by Dr. Sokolowski.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 26, 2017, is hereby reversed regarding employer-employee relationship, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $475.53/week for 32-3/7 weeks, commencing January 10, 2015 through June 19, 2015, and from February 2, 2016 through April 17, 2016, as provided in Section 8(b) of the

Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses of $105,899.74, subject to §8(a)/§8.2 of the Act.

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

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

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

March 30, 2022

o: 02/15/2022
TJT/ahs
51

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION **22IWCC0121**
NOTICE OF 19(b) ARBITRATOR DECISION

OLEKSY, SZYMON
Employee/Petitioner

Case# **15WC002473**

WK HEATING INC
Employer/Respondent

On 10/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

2234 CHEPOV & SCOTT LLC
NATALIA OLEJARSKA
5440 N CUMBERLAND AVE STE 150
CHICAGO, IL 60656

0286 SMITH AMUNDSEN LLC
LESILE JOHNSON
150 N MICHIGAN AVE SUITE 3300
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)

Szymon Oleksy
Employee/Petitioner
v.
WK Heating Inc.
Employer/Respondent

Case # **15** WC **02473**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **August 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

S. Oleksy v. WK Heating, Inc., 15 WC 02473

FINDINGS

On the date of accident, **January 9, 2015**, 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 sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner's average weekly wage was **$713.29**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **3** dependent children.

Respondent *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

Claim for compensation denied. Petitioner failed to prove an employee-employer relationship existed between Respondent and him.

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 26, 2017

Date

ICArbDec19(b)

OCT 26 2017

INTRODUCTION

This matter was tried as a §§19(b)/8(a) proceeding with the disputed issues being: Act/Employer-employee; Accident; Notice; Causal connection; Wages; Incurred and prospective medical expenses; TTD; and Whether Petitioner opted out of coverage under §1(a)3 of the Act.

Petitioner and a colleague of his, Pawel Cembala, testified on behalf of Petitioner. Wojtek Kowalczyk, the owner of the Respondent corporation, testified on behalf of Respondent. All witnesses testified via a Polish/English interpreter.

FINDINGS OF FACT

Petitioner is originally from Poland. He has lived in the United States for approximately 10 years. He attended high school and a technical school in Poland. When Petitioner first came to the U.S., he worked at Belmont Sausage Company in a shop in Elk Grove Village. He was employed as "a contractor and maintenance". He worked at Belmont for 6 or 7 years and then began a relationship with Respondent, WK Heating, Inc. ("Respondent" or "WK").

Petitioner began receiving checks from Respondent in May or June of 2014. The checks were made out to a business that Petitioner owned, "SO System, Inc." (PX 20; RX 5) SO System, Inc. (SO) was incorporated on September 11, 2013. (RX 5) Petitioner was the president of SO. (RX 1, RX 3) According to Petitioner, Respondent's business was "the same as I did, heating and cooling." According to the workers' compensation insurance policy issued by Liberty Mutual for SO System, Inc., on May 21, 2014, SO's business was: "Heating, ventilation, air conditioning and refrigeration systems-installation, service and repair." (RX 1)

The owner of Respondent was Wojtek Kowalczyk (Wojtek) Petitioner testified that he heard about work at Respondent through Wojtek's mother, who worked at Belmont. Petitioner contacted Wojtek and met with him at a job site. Wojtek said that he had a lot of jobs and needed a worker. Respondent's other workers, Pawel and Mercin, would show Petitioner what to do. Wojtek required Petitioner to form his own business and get workers' compensation insurance in order to work with WK. Petitioner already owned SO. Petitioner obtained workers' compensation insurance for SO System, Inc., for the policy period of 5/21/2014 to 5/21//2015. (RX 1) Petitioner elected to decline coverage for himself, as an officer of SO. (RX 1; RX 3) Petitioner first testified that Wojtek told him to buy his own insurance "and in case I have my own insurance, that it would cover any kind of accidents." "If I have my own worker he –he pays with checks. And on that base, and in case of accident, he has his own insurance to cover for it." Pawel and Mercin would do the main system and Petitioner would finish it. There was no written contract regarding the relationship between Petitioner, SO, and Respondent. Petitioner said that he started as a helper, and later did the same work that the other guys were doing. He would install the whole system, including duct work and vents.

Petitioner was paid by check, every week or two weeks. He first testified that he was paid "either way", weekly or per hour. Petitioner testified on cross-examination that he was not paid on a per job basis; he thinks that he was paid on an hourly basis. He started at $14.00 per hour and made $20.00 per hour at the highest. His standard work week was 50 hours, working 7:00am to 5:00pm. The payment checks were made out to SO System, Inc. (PX 20) He received an IRS Form 1099 from Respondent at the end of the year. No taxes or social security was deducted from Petitioner's pay. (RX 4) Petitioner informed Wojtek regarding the hours that he worked via little pieces of paper and then in a notebook that Wojtek gave him. Neither Party submitted any copies of these documents. Petitioner thought that Wojtek was his employer. He would receive instructions

regarding a job from Wojtek over the phone or via text. Petitioner's Exhibit 18 documents several calls and texts from or to Respondent's phone number. Wojtek would tell Petitioner what time to report to a job site and what Petitioner was supposed to do.

Petitioner testified that Wojtek was often not on the job with him, but would stop by the job site, usually every day. Wojtek and Pawel would communicate regarding how the job should progress and Pawel would tell Petitioner what they were going to do and how to do it.

Petitioner testified that at some point in his relationship with Respondent he received T-shirts from Wojtek with Respondent's name and phone number on them. Petitioner testified that Wojtek gave him basic tools, like a screwdriver and scissors (tin snips?) because he had no tools when he started at WK. He then worked with these basic tools and WK furnished a welder, the leather, driller and hammer.

At various times, Petitioner would pick up materials and supplies from Munch Supply on behalf of Respondent. (PX 17)

When Respondent did not have work for him, Petitioner would work somewhere else. Petitioner testified that he worked with Pawel somewhere else during a slow period at WK.

On the date of accident, January 9, 2015, Petitioner was working at a job site on Campbell Street. He had been told by Wojtek to go with Marek (the General Foreman on the Campbell job) to Munch Supply and pick up a furnace. The job was to install the whole system in the building. Petitioner and Marek carried the furnace (weighing 140 to 150 pounds) up some stairs. Petitioner was on top, climbing backwards. He missed a step with his left foot and his foot slipped on the step. He felt pain in his low back. Petitioner and Marek put the furnace down. Marek was leading the job and he showed Petitioner how the system was supposed to look like. Petitioner picked up the furnace by himself and worked on the installation. When asked if he worked until the end of the shift that day, Petitioner replied that he worked till the end of the job, so it is assumed that Petitioner completed the installation. Midway through the job, the pain became more intense and Petitioner had to take a break and lay down. He had pain in his low back on the left side and down his left leg. Wojtek came by the job site and Petitioner told him that he could not walk. "My leg is hurting, I can't walk." Petitioner did not tell Wojtek how the injury occurred. He did not tell Marek that he was feeling pain. Neither Party called Marek to testify. Marek was not employed by Respondent; he appears to have been the General Foreman on the job.

January 9, 2015 was a Friday. Petitioner did not work for Respondent after this date. He was not scheduled to work on Saturday and Sunday. He did not work on Monday, January 12, 2015, because his back hurt. Petitioner testified that he first sought medical treatment from Dr. Sabrina Indyk, on January 13, 2015. The history charted by Dr. Indyk was of a back injury on Friday. The pain started a few days ago - he thinks that he might have injured it at work because he was lifting something heavy and going up/down stairs - he is a contractor. He had seen another doctor before and received Saleto 600 mg, but has had no improvement. The pills helped initially, but wore off. The diagnosis was: sciatica, left; musculoskeletal pain; gait abnormality; and back pain. Petitioner was given a Medrol dose pak and a shot of Toradol. Naproxyn and Flexerill were prescribed, along with Ativan for relaxation. The patient refused PT. An MRI was recommended if there was no improvement. Petitioner was instructed to go to the ER if the pain worsened. (PX 1) No evidence was adduced regarding the identity of the doctor who allegedly saw Petitioner first and who had prescribed the Saleto.

Petitioner testified that he had not injured his back prior to this event and was in good health on January 9, 2015.

Petitioner testified that within a week after the accident Wojtek came to his house and dropped off a check. At that time, Petitioner advised Wojtek that he had injured his back carrying a furnace. It looks like the last check to SO System from Respondent was dated January 20, 2015. (PX 20) The Arbitrator finds that the date of this conversation was January 20, 2015.

On January 17, 2015, Petitioner was taken from his house by ambulance to Northwest Community Hospital (NWCH) due to excruciating low back pain. The records of the paramedics reveal severe low back pain with sciatica for 1 week. There was no history of an injury, although it was charted that the patient was released from the hospital on 1/13/2015 with a diagnosis of sciatica. Petitioner was given fentanyl by the paramedics for pain management. The paramedics noted that the patient did not speak English and the history was given through a translator. (PX 2)

At NWCH, the patient presented with a history of sciatica. He had increasing pain over the last week. The NWCH records state that there was no language barrier for the patient, but then state that a translator was used. He was seen at Resurrection Hospital last week and was discharged with a rx for Naprosyn and Flexeril, which has not helped. Petitioner improved at NWCH and was discharged home to follow up with his PCP for an MRI. He was to continue with Naprosyn and take Valium as well. (PX 3) No records from Resurrection were submitted.

Petitioner followed up with Dr. Indyk on January 22, 2015. He had low back pain and left leg pain. Petitioner was given a script for PT, a script for an MRI and was excused from work for a month. (PX 1)

Petitioner began PT at Global Rehabilitation on January 19, 2015. He had therapy at Global from January 19, 2015 to April 2, 2015. The therapy consisted of therapeutic strengthening, stretching exercises, modalities, taping and manual therapy. Petitioner also had post-surgery therapy at Global from February 24, 2016 through May 6, 2016, utilizing e-stim, core strengthening, ultrasound, HEP and other modalities. (PX 6)

Petitioner began treatment with Dr. Mark Sokolowski, an orthopedic surgeon, on January 29, 2015. This was on a referral from Dr. Indyk. Petitioner gave a history of injuring his low back carrying a furnace at work. He has left sided low back pain, down the buttock and down the left leg. The physical exam was consistent with a herniated lumbar disc. Dr. Sokolowski reviewed a lumbar MRI of January 22, 2015 and thought that it showed a large annular tear at L4-5 and a very large disc herniation at L5-S1 with complete displacement of the thecal sac to the right. The Assessment/Plan was: 1.) L4-5 annular tear; 2.) Left L5-S1 very large disc herniation. The recommendation was to continue PT and undergo lumbar injections. Petitioner was excused off work. If therapy and injections were not successful, lumbar decompression from L4-S1 would be appropriate. Dr. Sokolowski communicated with the patient in Polish. (PX 7)

Petitioner had injections performed by Dr. Hussain at Global Rehab on February 2, 2015 and May 11, 2015. (PX 6) Petitioner followed up with Dr. Sokolowski on several occasions. On June 19, 2015, Petitioner was seen by Dr. Sokolowski and was released to modified work duty, with restrictions of 20 pounds lifting and frequent position changes. A home TENS unit and dendracin lotion was recommended. Full duty work was contemplated in 2 weeks. (PX 7)

Petitioner testified that he began doing carpentry work for "David" about six months after the accident. He installed baseboards on windows and floors. He had helpers to carry heavy materials. Petitioner then worked for "Vydas" doing painting and patching. Petitioner had helpers to carry heavy items. Petitioner had no injuries working for David or Vydas.

Petitioner had an urgent visit with Dr. Sokolowski on September 8, 2015, due to intolerable back pain. Dr. Sokolowski recommended surgery. Petitioner underwent a L4-S1 decompressive laminectomy, foraminotomy, discectomy and facetectomy, by Dr. Sokolowski with the assistance of Dr. Ivankovich, at Westlake Hospital on February 2, 2016. (PX 11)

Petitioner was released by Dr. Sokolowski to modified duty work, on April 15, 2016. He was released to full duty work, as of May 13, 2016. Petitioner returned to Dr. Sokolowski on May 31, 2016 with increased back pain after returning to full duty work. Modified duty work was recommended. Another MRI was done on June 18, 2016 and Dr. Sokolowski thought that it showed desiccatory changes. The study was said to show satisfactory resection of the herniated discs. Continued modified duty, with the possibility of L4-S1 fusion was recommended. Petitioner's last visit with Dr. Sokolowski was on November 14, 2016. He complained of 2/10 pain at rest, but unbearable pain with activity. Dr. Sokolowski recommended HEP and modified duty work. If the back pain became intolerable, fusion surgery would be necessary. A provocative discogram should be performed before fusion surgery. If the symptoms continue, PRN. If there was a regression, Dr. Sokolowski would be happy to see the patient. (PX 7)

Petitioner denied any back injuries occurring after January 9, 2015.

Petitioner is awaiting approval for the proposed fusion surgery. He can't drive for a long distance. He doesn't play soccer or ride a bike. He can't jump. He doesn't go for long walks with his kids. He has to be careful when going down stairs. He has to change positions a lot. He has trouble sleeping. He does continue to work at modified duty. He has pain. He has numbness in his left leg and spasms. He would like to have the proposed surgery, but he cannot afford it.

Pawel Cembala (Cembala) testified at the request of Petitioner. He knows Petitioner from HVC work. Cembala thinks that he was employed by Respondent. When he worked at Respondent, Cembala was paid hourly on a weekly basis. Cembala would provide Respondent with little slips of paper to substantiate his claimed wages. He was paid by check or cash. He did not have a definite starting time, as that was coordinated with the other trades and the general contractor. The GC would contact Wojtek to schedule jobs. Cembala used some of his own tools and used Respondent's tools for specialized tasks. At the time of the accident, Cembala had not worked for Respondent for 2 to 3 months. Cembala did show Petitioner how to do the heating and cooling trade. Cembala also owned his own company.

Magdalana Bilski testified at the request of Respondent. She is the insurance agent who sold Petitioner the workers' compensation insurance policy for SO System, Inc. She explained the documents to Petitioner in Polish. Petitioner chose to exclude himself from coverage. He understood the effects of being excluded from coverage.

Wojtek Kowalczyk (Wojtek) testified at the request of Respondent. He is the sole owner of Respondent and has been so since 2008. WK's business is to install whole new systems, the furnaces, new construction. WK has no employees other than Wojtek. Basically, general contractors contract with WK and then WK hires subcontractors to do the work. Wojtek does not recall how he became involved with Petitioner. Typically, WK has written contracts with its subcontractors. Some agreements are verbal, not in writing. There was no written contract with Petitioner or SO. Everybody has to have insurance. Respondent is not responsible for them. WK does not withhold taxes from its payments to the subs. WK did not provide any benefits, such as paid time off, vacation, holiday pay or health insurance. Wojtek did not give ant T-shirts to sub-contractors. He did not require subs to wear WK T-shirts. WK required Petitioner to get insurance. Wojtek would advise Petitioner of

the job site location and meet Petitioner at the site and he should show Petitioner what to do. He would show Petitioner the plans. Wojtek would not stay at the job and watch Petitioner work. WK provided materials. Wojtek would tell the subs the way to install the HVAC, based on the blueprints. Wojtek testified that Petitioner had back pain before the accident date. Wojtek did not tell Petitioner that WK's wc insurance would pay for Petitioner. WK did not give Petitioner any tools. Petitioner's job was to install furnaces. He was not paid hourly. He was paid per unit. Petitioner's actions at the Campbell project were part of the regular course of business for Respondent. Petitioner's actions benefitted WK. Wojtek did not bring a copy of WK's IC agreement with him to the hearing. Wojtek believes that Petitioner had prior HVAC experience before working with WK. Wojtek does not recall Petitioner using Respondent's tools. Wojtek would tell Petitioner what to do on the job. He would show Petitioner where to install the furnace and then Petitioner was left to do it. Wojtek would rely on Petitioner to see to the details of the installation.

Petitioner testified in rebuttal that his prior experience in HVAC was watching others do it in the maintenance shop (at Belmont ?). He never had tools that could be used to install heating and cooling systems. Wojtek got them for Petitioner, even the basic ones. Wojtek brought the ladders and the concrete drills. Petitioner got 10 shirts from Respondent. He was paid hourly, not $500.00 per job.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980) 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)

The Arbitrator was not impressed with the credibility of the testimony of both Petitioner and Wojtek Kowalczyk. They both knew the consequences of the subcontractor/contractor relationship that they entered into. They both were trying to avoid the expenses of payroll taxes, unemployment taxes and wage and hour laws, along with workers' compensation insurance premiums in structuring their relationship as they did. Petitioner and Kowalczyk do have a level of sophistication regarding construction business relationships and that persuades the Arbitrator that neither took advantage of the other in their relationship. Shame on them both for not defining the relationship in a written agreement.

WITH RESPECT TO ISSUE (A), WAS THE RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION OR OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent's business was to install and work on HVAC systems. Thus, coverage under the Act is "Automatic", pursuant to §3(2) of the Act.

WITH RESPECT TO ISSUE (B), WAS THERE AN EMPLOYEE-EMPLOYER RELATIONSHIP, THE ARBITRATOR FINDS AS FOLLOWS:

According to the Supreme Court, an employment relationship is a prerequisite for an award of benefits under the Act. A fact specific inquiry is required to determine whether an employment relationship exists. The Parties designation of their relationship is not controlling, but may be considered, along with the following other factors: 1.) Respondent's right to control the manner in which Petitioner performs the work; 2.) Does Respondent dictate Petitioner's schedule? ; 3.) Is Petitioner paid hourly, or on a per job basis? ; 4.) Are taxes and social security withheld from the payments to Petitioner? ; 5.) Does Respondent's business encompass Petitioner's work? 6.) Can Petitioner be discharged at will? . Roberson v. The Industrial Commission, 225 Ill. 2d 159 (2007)

After considering all of the evidence adduced and the above factors, the Arbitrator finds that Petitioner failed to prove that he had an employee/employer relationship with Respondent.

First, Petitioner's testimony regarding his novice status in the HVAC industry prior to working with WK is not believable. Petitioner formed SO System, Inc. before a relationship with Respondent was even contemplated. The primary business of SO was said to be HVAC and refrigeration systems – installation, service and repair. Petitioner formed SO to get subcontractor jobs in the HVAC field. He would not have incorporated a business if he did not know the trade. Further, Petitioner's testimony that he had no tools when he started with WK is not believable. He had incorporated a business in a trade and he had no tools? Wojtek gave him a screwdriver and scissors and he used WK's tools for the rest of a furnace installation? Would other tradesmen freely let Petitioner use their tools? – No. Common sense and experience lead the Arbitrator to conclude that Petitioner did not show up at a job site with no tools. The Arbitrator finds that Petitioner had HVAC experience before he became involved with WK. He used some of his own tools on the job. He would not have been hired if he did not demonstrate knowledge in the trade.

Regarding the issue of control of the manner of the work, Wojtek told Petitioner where to place a furnace, based on the blueprints or the contractor's plans. The proofs do not show that Wojtek dictated or controlled the manner in which Petitioner installed a furnace – he did not direct that Petitioner use a certain fitting on a certain pipe, for example. While Respondent supplied job materials, this is more a function of complying with Codes and the requirements specified by the General Contractor. Wojtek was clearly not monitoring Petitioner's work in a detailed manner. Respondent's level of control over Petitioner's work does not persuade the Arbitrator that Petitioner was an employee of Respondent.

Petitioner's schedule is dictated by when the General Contractor has the job site open and when the other trades are on site. This factor does not support an employment relationship.

Petitioner and Wojtek disagreed on whether Petitioner was paid hourly, or per job. Even considering Cembala's testimony that he was paid hourly (sometimes in cash, albeit at a time prior to the accident), the Arbitrator cannot conclude that Petitioner was paid on an hourly basis, given the evidence adduced.

Petitioner and Wojtek agreed that SO System received a Form 1099 from Respondent at the end of the year and that no taxes or Social security was deducted from payments to it. Petitioner received no employee benefits such as paid time off, vacation or health insurance from Respondent. The checks were made out to SO System, Inc. This factor implies that there was no employment relationship.

Respondent's business certainly encompasses Petitioner's work, but SO's business was said to include HVAC work as well. This factor is not persuasive on the issue of employee/employer, given the remainder of the evidence.

There was no evidence on the issue of whether Petitioner could be discharged at will. This should have been addressed in a written agreement. Given the lack of evidence, this factor is given no weight on the issue of employment relationship.

Petitioner was able to work elsewhere when there was no work from WK. This weighs against the existance of an employee/employer relationship.

Petitioner testified that he believed that he was an employee of Respondent. Wojtek's testimony was that Petitioner was a subcontractor. Of course, these conflicting opinions are regarding a legal conclusion and do not provide persuasive weight on the ultimate issue of employment. Further, SO System, Inc. obtained workers' compensation insurance and appears to have had a bank account (as evidenced by the endorsements on the checks in PX 20, albeit six of the checks having been signed by Petitioner's wife), thus implying that it was a distinct entity from Petitioner and actually negating any employee/employer relationship with Respondent.

Petitioner has the burden of proof on the issue of employee/employer relationship and the Arbitrator finds that the preponderance of the evidence does not support a finding that such a relationship existed.

The claim for compensation is, therefore, denied.

REMAINING ISSUES

As the Arbitrator has found that Petitioner failed to prove that an employee/employer relationship existed between him and Respondent, the Arbitrator needs not decide the remaining issues of: Accident; Notice; Causal Connection; Wages; Incurred and prospective medical expenses; and TTD.

Regarding the issue of Average Weekly Wage, the Arbitrator calculated the AWW based upon Petitioner's Exhibit 20. Petitioner's testimony regarding the AWW is deficient, in that he testified that he started with Respondent making $14.00 per hour and was making $20.00 per hour at the time of the accident, working 50 hours a week. This does not explain what the actual earnings of the Petitioner were in the employment during the 52 weeks preceding the date of accident. Therefore, the Arbitrator calculated that the checks in PX 20 total $12,228.00 and the covered time period was 8/27/2014 to 1/8/2015 (17-1/7 weeks), yielding an AWW of $713.29.

As to the issue of whether Petitioner elected out of coverage for himself under the Act, the Arbitrator finds that Petitioner voluntarily and knowingly excluded himself from coverage under SO System, Inc.'s workers' compensation insurance policy, based upon the unrebutted and credible testimony of Bilski and Respondent's Exhibit 3. This finding, of course, has no effect on the other disputed issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC034316
Case Name	CORLEY, KIMBERLY v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0122
Number of Pages of Decision	10
Decision Issued By	Thomas Tyrrell, Commissioner

Pro Se	(Pro Se) Kimberly Corley
Respondent Attorney	Barrett Long

DATE FILED: 3/31/2022

/s/Thomas Tyrrell, 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

KIMBERLY CORLEY,

Petitioner,

vs. NO: 16 WC 34316

CHICAGO TRANSIT AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020 is hereby affirmed and adopted.

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

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

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

March 31, 2022

o032922
TJT/ldm
051

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CORLEY, KIMBERLY
Employee/Petitioner

Case# **16WC034316**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
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CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
DANIELA ROEHM
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY CORLEY
Employee/Petitioner
v.
CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **16** WC **34316**

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 **April 9, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **9/15/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**19,420.00**; the average weekly wage was $**388.40**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **0** dependent children.

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

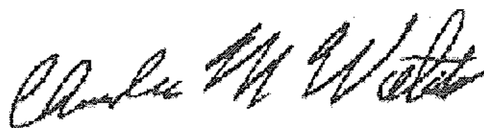
Respondent shall be given a credit of $**0.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

The Arbitrator finds Petitioner failed to prove accident and therefore all other issues are moot. The Arbitrator notes that Respondent stipulated to the issue of TTD payments at trial (See Arbitrator's Exhibit 1) so that issue was moot before the trial began.

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

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



Signature of Arbitrator

April 8, 2020
Date

ICArbDec19(b)

APR 14 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY CORLEY,	)	
	)	
Petitioner	)	
v.	)	
	)	Case No. 16 WC 34316
CHICAGO TRANSIT AUTHORITY,	)	
	)	
Respondent.	)	

Findings of Facts & Conclusions of Law

I. FINDINGS OF FACT

Kimberly Corley (hereafter "Petitioner") testified that on September 15, 2016, she was employed as a servicer apprentice by the Chicago Transit Authority (hereafter "Respondent"). Petitioner had been employed by the Respondent since 2015. Petitioner testified that on September 15, 2016, she was 44 years old and a physically fit woman. Petitioner briefly described that her duties included cleaning two train cars per shift. Petitioner testified to enter the train car she has to step up slightly. Petitioner also testified that the train car is not usually more than two feet above the platform while she is cleaning.

Petitioner testified a group of mechanics boarded the train and closed all doors. One of the mechanics then announced on the train intercom that they were providing maintenance to the air conditioner and to keep the doors closed. Petitioner testified after she completed her cleaning she sat down to wait while the mechanics finished their work. After waiting 10-15 minutes, Petitioner decided to exit the train car and opened the doors. Upon opening the doors Petitioner realized the train car had been lifted more than four feet in the air. Petitioner testified that she did not feel the train rise. As a result, the Petitioner held on to the train car while lowering herself until she was able to drop to the ground. Petitioner testified that she landed on both her feet and felt tightness in her left knee afterwards. Petitioner further testified that another employee witnessed her get down from the train. That employee did not testify on behalf of the Petitioner to confirm he witnessed an accident occurred. Petitioner testified that she went home after getting down from the train.

Three days later the Petitioner spoke with her manager about her alleged injury. The Petitioner testified that her manager was unable to help because she needed to report to another person. Instead of reporting to another person and completing an injury on duty form she continued to work. Petitioner also testified she was unaware she was required to complete an injury on duty form when an injury occurred on duty. Petitioner then sought treatment at St. Bernard Hospital. Petitioner gave a history of left knee pain that had been ongoing for months.

While at the hospital the Petitioner underwent an X-ray to her left knee. The X-ray found no fracture, dislocation, or joint effusion.

Petitioner testified that on approximately October 11, 2016, she attempted to resign to two other managers because of her alleged injury. Those managers told her she needed to talk to someone else about her injury. Again, the Petitioner did not complete an injury on duty form, but alleges that she told four different managers or persons above her position. None of those persons testified on behalf of Petitioner to confirm a report was made to them.

On October 24, 2016, the Petitioner went to Jackson Park Hospital for an additional X-ray on her left knee. The findings were the same as the first, no fracture, dislocation, or joint effusion.

Petitioner next sought treatment at Cook County Health & Hospital System on November 7, 2016. Petitioner's Cook County treatment included her primary care physician, Dr. Sully Cardona, M.D. and physical therapy.

Petitioner also reported to Concentra Medical Center on November 14, 2016. Petitioner continued treatment for physical therapy at Concentra through November 23, 2016.

On November 16, 2016, the Petitioner was approached by a fifth manager for her absenteeism. After being written up for absenteeism the Petitioner completed an injury on duty form, 62 days after the alleged accident.

Petitioner underwent an MRI of her left knee at Cook County on December 19, 2016. The MRI found "changes likely relating to red marrow reconversion within the metadisaphysis of the femur and tibia, a non-specific finding which can be seen in a variety of clinical settings such as anemia, amongst others." *(Petitioner's Exhibit 3).*

The Petitioner's primary care physician, Dr. Cardona submitted a disability and medical leave statement of incapacity on behalf of the Petitioner on December 22, 2016. Dr. Cardona diagnosed Petitioner with no condition but rather chronic left knee pain and opined that Petitioner's current complaints were not a result of an accident at work. Further, Dr. Cardona stated the MRI findings did not warrant disability.

On January 13, 2017, Petitioner went to Cottage Medical Center for evaluation of her left knee. Petitioner did not follow up.

Petitioner testified she felt she was not getting help from her other medical providers. Based on those feelings, Petitioner searched for another provider on the internet and found Holy Cross Hospital. On February 22, 2017, Petitioner went to Holy Cross Hospital for another X-ray on her left knee. Petitioner followed up on two occasions to see an orthopedic physician.

The Petitioner then changed her primary care physician to Dr. Narayan Prabhakar, M.D. at Auburn Gresham Family. During Petitioner's treatment, Dr. Prabhakar referred Petitioner to Schwab Rehab for physical therapy.

Petitioner testified she again felt she was not getting help and had heard "pretty good things" about the University of Chicago Medicine. On August 30, 2017, Petitioner went to University of Chicago Medicine for a fourth X-ray on her left knee. The X-ray findings were the again the same; no fracture, dislocation, or joint effusion.

Petitioner testified that she also received treatment from Providence for physical therapy. Petitioner completed physical therapy in December 2018, but testified that she continues to have symptoms in her left knee. Petitioner testified that her symptoms include swelling, bone shifting, swollen feet, and edema. Petitioner also testified that she is not currently treating, but may resume treatment. Petitioner's last physical therapy noted continued complaints of the above symptoms and the Petitioner's desire for another MRI of her left knee.

II. <u>CONCLUSIONS OF LAW</u>

ACCIDENT

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 not credible. Petitioner's demeanor at trial seemed evasive at times. The pace at which she answered questions varied such that it seemed Petitioner was searching for answers that would line up. Petitioner disputed those records that did not support her claim. The earliest medical records prior to and just after the accident show that Petitioner had longstanding complaints of knee pain.

Liability cannot rest upon imagination, speculation or conjecture. Petitioner has failed in her burden because she did she provide credible evidence that her condition was caused by getting down off the train car. The Petitioner sought treatment at St. Bernard Hospital three days after the alleged accident. However, the Petitioner's medical history to the ER physician reflects her injury had been ongoing for months. (*Respondent's Exhibit 4).* The Petitioner's primary care physician even opined she had no condition but rather chronic left knee pain that could not be related to work (*Respondent's Exhibit 3).* Additionally, Petitioner waited 62 days to report an injury on duty and only and directly after being written up for absenteeism. (*Respondent's Exhibit 1, 2).*

The Arbitrator finds Petitioner failed to prove accident and therefore all other issues are moot. The Arbitrator notes that Respondent stipulated to the issue of TTD payments at trial (See Arbitrator's Exhibit 1) so that issue was moot before the trial began.