ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC001103
Case Name	SCAPARDINE, FRANK v. XPO LOGISTICS D/B/A CON-WAY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0441
Number of Pages of Decision	31
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Charles Given
Respondent Attorney	Michael Manseau

DATE FILED: 9/1/2021

/s/Stephen Mathis, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANK SCAPARDINE,

Petitioner,

vs. Nos: 17 WC 1103

XPO LOGISTICS
d/b/a CON-WAY FREIGHT,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, maintenance benefits, temporary total disability, permanent partial disability, and benefit rates, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the changes made below.

The Commission writes additionally on the issues of causal connection and the permanent partial disability (PPD) benefit rate.

1. Causal Connection

The Arbitrator found that Petitioner proved that his cervical, lumbar, and left shoulder conditions were causally related to the September 16, 2015 accident and that the cervical and lumbar conditions remained causally related to Petitioner's current condition of ill-being. In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land and Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). Thus, even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for

an accidental injury will not be denied as long as he can show that his employment was also *a* causative factor. *Id*. at 205. A claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 181 (1983); *Azzarelli Construction Company v. Industrial Comm'n*, 84 Ill. 2d 262, 266 (1981). A claimant also may rely on the "chain of events" in his or her case to demonstrate the aggravation or acceleration of a preexisting condition. See *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC, ¶¶ 25-29.

Respondent contends that the Arbitrator erred in finding that Petitioner's current cervical condition was casually connected to the accident. It contends that Petitioner's cervical symptoms resolved after the February 2016 C4-C5 anterior discectomy and fusion surgery and that his current cervical symptoms are related to a progression of degeneration. The Commission disagrees.

Petitioner's treatment records suggest that his cervical symptoms returned quickly after his surgery. On February 12, 2016, Petitioner followed up with Dr. Lim, reporting that his radicular symptoms had subsided, but that he had mild pain at the left supra-trapezial. On April 8, 2016, Petitioner informed Mr. Meeker that he felt worse, rating his neck pain at 3-4/10. On January 6, 2017, Dr. Lim noted that Petitioner had reported very significant improvement after the cervical fusion, but also reported recurring symptoms after approximately two and one-half months, corroborating the significance of Petitioner's complaints in April. Petitioner's August 26, 2016 report that his neck and arm pain was gone, but continued to experience left supra-trapezial neck discomfort and periscapular border tenderness on the left side must be read in the context of his full treatment records. On February 21, 2017, Dr. Lim noted that Petitioner continued to have ongoing left-sided neck pain with radiation into the left upper extremity. Dr. Lim also opined that: "[Petitioner had] objective evidence of neural impingement based on his MRI and I believe based on a reasonable degree of medical and orthopedic certainty that this is an ongoing condition from his initial work-related injury."

In short, Petitioner's treatment records indicate that his current cervical condition is not due solely to natural degenerative processes. The cervical surgery (much like Petitioner's lumbar surgeries) did not extinguish the causal connection between the accident and Petitioner's current condition of ill-being regarding the cervical spine. Accordingly, the Commission affirms the Arbitrator's finding of a causal connection.

2. Permanent Partial Disability Benefit Rate

The Arbitrator awarded PPD benefits in the form of a wage differential award, ordering Respondent to pay $994.69 per week commencing November 21, 2018 until he reaches the age of 67 or 5 years from the date the award becomes final.

Under the Act, when a claimant sustains a disability, an issue arises concerning what type of compensation he is entitled to receive: a wage differential award (under section 8(d)(1)) or a percentage-of-the person-as-a-whole award (under section 8(d)(2)). 820 ILCS 305/8(d) (West 2014); see *Gallianetti v. Industrial Comm'n*, 315 Ill. App. 3d 721, 727 (2000). Our supreme

court has expressed a preference for wage-differential awards. *Id*. (citing *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 438 (1982)). The purpose of a wage differential award under section 8(d)(1) is to compensate an injured claimant for his reduced earning capacity. *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App. 3d 581, 586 (2008).

Section 8(d)(1) of the Act provides:

> "If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-⅔% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later." 820 ILCS 305/8(d)(1) (West 2014).

Respondent acknowledges that there is no dispute that Petitioner cannot return to his pre-injury employment as a truck driver. Moreover, Respondent agrees in its Statement of Exceptions that the Arbitrator correctly determined that the average amount which Petitioner could expect to earn in some suitable employment or business after the accident was $12.85 per hour, or $514.00 per week. Respondent's objection is to the Arbitrator's calculation of the average amount which Petitioner would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident.

Respondent asserts that the Arbitrator failed to explain how he calculated a current average weekly wage (AWW) as a truck driver for Respondent of $2,006.04, but the Arbitrator set forth his calculation of the wage differential in detail on pages 22-23 of his Decision. The Arbitrator noted the current hourly wage and mileage rates Petitioner would be earning. Respondent stipulated to these figures during the hearing. The Arbitrator then assumed that Petitioner would have worked similar hours and driven similar miles with similar loads as he did during the 52 weeks prior to the accident. Respondent objects to this assumption. However, Respondent argues that the Arbitrator's calculation should have been based on his pre-accident AWW, which would be based on the same 52 weeks of data regarding hours, mileage and loads. See 820 ILCS 305/10 (West 2014). Moreover, the Arbitrator's assumption is reasonable based on Petitioner's unrebutted testimony that routes were assigned based on seniority and that Petitioner had been number two in seniority prior to the accident.

Petitioner identifies a typographical error on page 23 of the Decision of the Arbitrator, in which the correct weekly wage of $1,492.04 is incorrectly restated on the second line of the calculation as $1,402.94. The Arbitrator's ultimate wage differential calculation of $994.69 per

week is the correct sum, reflecting two-thirds of $1,492.04. Accordingly, the Commission corrects the typographical error in the Decision of the Arbitrator, but affirms the Arbitrator's wage differential award, including the benefit rate as calculated by the Arbitrator.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved that the conditions of his lumbar spine, cervical spine, and left shoulder were causally connected to the September 16, 2015 accident and the current condition of ill-being of Petitioner's lumbar spine and cervical spine remain causally connected to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits, commencing November 21, 2018, of $994.69 per week until Petitioner reaches age 67 or 5 years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in §8(d)(1) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 5, 2019 is hereby affirmed and adopted with the changes stated herein.

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

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

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

September 1, 2021

o: 8/19/21
SJM/kcb
044

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

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

/s/ *Marc Parker*
Marc Parker

21IWCC0441

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCAPARDINE, FRANK Case# **17WC001103**

Employee/Petitioner

XPO LOGISTICS D/B/A CON-WAY FREIGHT

Employer/Respondent

On 8/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
CHARLES R GIVEN
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
MICHAEL T MANSEAU
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

FRANK SCAPARDINE
Employee/Petitioner

v.

XPO LOGISTICS d/b/a CON-WAY FREIGHT
Employer/Respondent

Case # **17** WC **01103**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **November 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 16, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**92,727.44**; the average weekly wage was $**1,783.22**.

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

Respondent shall be given a credit of $**ALL PAID** for TTD, $**ALL PAID** for TPD, $**21,398.58** for maintenance, and $**0** for other benefits, for a total credit of $**21,398.58**.

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

ORDER

The Petitioner has shown by the preponderance of the evidence that his cervical, lumbar and left shoulder conditions are causally related to the September 16, 2015 accident. The Arbitrator finds that the ongoing cervical and lumbar conditions remain causally related to the accident as of the hearing date. The Arbitrator finds that the Petitioner reached maximum medical improvement as to the left shoulder as of 6/28/17, as he did not follow up with Dr. Leonard as instructed after that date.

Respondent shall pay Petitioner maintenance benefits of **$1,188.81 per week** for **20-4/7 weeks**, commencing **June 30, 2018 through November 20, 2018**, as provided in Section 8(a) of the Act.

Respondent is entitled to a credit of **$21,398.58** for maintenance benefits paid.

Respondent shall pay Petitioner permanent partial disability benefits, **commencing November 21, 2018**, of **$994.69 per week** until he reaches the age of 67 or 5 years from the date the award becomes final, whichever is later, because the injuries sustained caused a loss of earnings, as provided in **Section 8(d)1 of the Act**.

Respondent shall pay Petitioner compensation that has accrued from **September 16, 2015** through **November 20, 2018**, 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.

Scapardine v. XPO Logistics d/b/a Con-Way Freight, 17 WC 01103

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 30, 2019
Date

AUG 5 - 2019

STATEMENT OF FACTS

Petitioner testified he worked as a truck driver/Driver Sales Representative (DSR) since 1994, originally for Con-Way Freight, which was then purchased by XPO Logistics. He is right hand dominant. On 9/16/15, Petitioner was pulling "triples" (three 28' trailers) from Gary/Hammond, IN to Ohio. While connecting the trailers he testified he was pulling an approximate 2,500 pound wheeled dolly across a gravel area that also had debris on the ground, He testified his feet slipped and he fell backwards onto his buttocks, back, shoulders and head, and the dolly "kind of rolled up" to his legs.

The "Statement of Injury" Petitioner completed on 9/16/15 indicates complaints of low back, left shoulder and neck pain. (Px1). His initial visit to Comprehensive Care Occupational Medicine on 9/18/15 notes a consistent history of the accident with neck, left shoulder and low back complaints. The report notes a prior cervical fusion in 2010 at C5/6 and C6/7. Petitioner denied any radiating pain into the legs but did report some radiating pain into the left shoulder and upper arm. He was diagnosed with cervicothoracic and lumbar strains and aggravation of underlying degenerative disc disease in the cervical and lumbar spine. He was provided light duty work restrictions which Petitioner testified the Respondent accommodated. (Px3).

Physical therapy was prescribed on 9/21/15, along with Norco and a Medrol Dosepak. X-rays showed degenerative changes of the lumbar spine with mild disc space narrowing at L5/S1, and the prior cervical fusion was noted at C5 to C7 with discogenic and degenerative changes above and below those levels. Petitioner testified he attended therapy from 9/25/15 to 10/14/15. The initial report from 9/25/15 notes complaints of neck and low back pain, as well as left neck symptoms into the shoulder and upper left arm. At a 10/1/15 follow up with Dr. Foreit, therapy was continued, a cervical collar was issued, and Petitioner remained on light duty. The therapy reports don't reflect much subjective improvement, and Petitioner would sometimes complain he felt worse after therapy. It does appear that Petitioner at times was not fully compliant with the home exercise instructions he was provided. (Px3).

On 10/14/15, Petitioner reported essentially the same symptoms he had previously, including intermittent symptom radiation into the left leg. Noting it was entirely possible Petitioner aggravated conditions in his neck and back when he fell, Dr. Foreit prescribed cervical and lumbar MRIs. (Px3).

The films were obtained on 10/21/15. Lumbar MRI showed a 3 mm retrolisthesis of L5 over S1 and disc disease with degenerative changes from L3 to S1 causing varying levels of central canal, lateral recess and foraminal stenosis. Cervical MRI reflected prior C5 to C7 fusion, mild dextroscoliosis and degenerative changes. At C4/5, there was a disc/osteophyte complex resulting in bilateral foraminal stenosis. At C6/7, osteophytes and

hypertrophy resulted in bilateral foraminal stenosis, and a disc/osteophyte complex at C7/T1 also resulted in bilateral neuroforaminal stenosis and mild canal stenosis. (Px2).

On 10/23/15, Dr. Foreit reviewed the MRIs and referred Petitioner for an evaluation with an orthopedic surgeon. Petitioner indicated he was "very capable of driving his truck and notes he does not have to do any heavy lifting", so Dr. Foreit released him to do so, changing his medications so that he was not taking anything narcotic. (Px3). Petitioner testified he returned to full duty work on 10/24/15.

Petitioner opted to visit Dr. Lim on 11/4/15, reporting significant low back pain radiating into the buttocks and right leg to the knee and neck pain radiating into the left shoulder/arm to the hand following the 9/16/15 accident. He noted a prior 2010 cervical discectomy and fusion from C5 to C7 for radicular symptoms into the right arm. Cervical and lumbar x-rays were performed (cervical: prior C5 to C7 discectomy and fusion with large anterior C4/5 osteophyte; lumbar: moderate disc degeneration at L4 to S1 with no instability), and the MRIs were reviewed. Dr. Lim diagnosed spinal stenosis with radiculopathy and cervical spondylosis with myelopathy, indicating the conditions were causally related to the accident. Noting examination indicated subtle signs of myelopathy with marked hyperreflexia in knee and ankle jerk, Dr. Lim prescribed cervical discectomy and fusion at C4/5 with resection of the disc/osteophyte complex. As to the lumbar spine, he noted congenital stenosis that was exacerbated by the accident and recommended an epidural after weaning off anti-coagulants. He was prescribed Norco and advised he could work light duty with no truck driving. (Px2). Petitioner testified he returned to light duty work on 11/5/15 and continued to work in this capacity through 1/31/16.

Petitioner was examined by Dr. Hsu at the Respondent's request on 12/14/15. Petitioner reported falling backwards with immediate onset of headaches, low back pain, neck pain and left shoulder pain that worsened by the following day. He reported his prior cervical fusion, stating that his symptoms had completely resolved with that surgery and denying any chronic pain leading up to the current accident. Dr. Hsu noted his exam findings and the records and films he reviewed and diagnosed Petitioner with the following: 1) cervical spondylosis and adjacent segment degeneration following the C6/7 fusion, 2) lumbar spondylosis, 3) congenital lumbar stenosis and 4) C4/5 stenosis. He opined that the C4/5 and L3 to S1 stenosis was likely causing Petitioner's symptoms and that the work injury aggravated both of these preexisting conditions, noting this is consistent with the described mechanism of injury and Petitioner's history of being asymptomatic prior to the accident date. He further opined that the Petitioner had preexisting cervical and lumbar spondylosis that was unrelated to the accident. Dr. Hsu recommended lumbar epidurals and injections and/or discectomy and fusion surgery at C4/5. He noted Petitioner had early signs of myelopathy but seemed reluctant to have surgery versus trying conservative measures first. Dr. Hsu further opined that he believed Petitioner was capable of working with no lifting over 20 pounds and only occasional bending, crouching, stooping and overhead lifting. He anticipated Petitioner would eventually return to full duty. (Rx1).

On 1/8/16, Dr. Lim noted Respondent was not authorizing surgery pending the Section 12 exam. Petitioner testified he continued to work light duty through 1/31/16. Dr. Lim then performed surgery on 2/1/16 involving anterior C4/5 discectomy and fusion with hardware, and removal of the prior fusion hardware. A very large posterior osteophyte was also identified and removed. Post-operative diagnoses were C4/5 cervical stenosis with left-sided radiculopathy and severe cervical stenosis with myelopathy. On 2/12/16, Petitioner reported his radicular symptoms had subsided. Dr. Lim prescribed physical therapy, advising Petitioner to allow the cervical spine to heal prior to undergoing lumbar epidurals. On 2/26/16, Petitioner reported left leg pain that was radiating to the calf. (Px2).

Petitioner underwent post-operative physical therapy at Midwest Orthopaedics from 2/25/16 to 3/9/16. On 3/11/16, Petitioner reported significantly improved neck pain. A lumbar epidural was prescribed, and Petitioner

was continued off work. The epidural was performed at left S1 on 3/14/16 by Dr. Kim. Petitioner was held off work through 3/21/16 per Dr. Lim's work notes. On 3/18/16, Petitioner reported to Dr. Lim that the injection helped somewhat and that his neck was doing well. He indicated he wanted to return to work and Dr. Lim allowed him to do so without restrictions. (Px2).

On 4/8/16, Petitioner returned and reported he was doing worse, particularly with his low back, and a second epidural was requested. This was performed by Dr. Kim on 4/18/16. (Px2). Petitioner testified he was off work on 4/18 and 4/19/16. On 5/4/16, Petitioner reported his previously intermittent left leg pain had worsened and become constant, and he requested an updated lumbar MRI. (Px2).

The lumbar MRI of 5/9/16 noted diffuse spondylitic changes, right paracentral L5/S1 herniation with severe canal and bilateral neuroforaminal stenoses and moderate canal and foraminal stenoses at L2/3, L3/4 and L4/5. All of these findings were noted to be similar to what was seen in the prior 10/21/15 films. (Px2).

On 5/10/16, Petitioner reported radiating symptoms into the bilateral legs, left greater than right, and that the second epidural worsened his pain. Dr. Lim noted the MRI findings, indicating severe foraminal stenosis bilaterally at L5/S1, and that Petitioner felt that he couldn't continue to live with the symptoms. Dr. Lim prescribed decompression and posterior lumbar fusion at L5/S1. On 6/10/16, Dr. Lim noted Respondent was obtaining a Section 12 examination regarding the lumbar spine. Petitioner was continuing to work despite his pain and was advised to perform a home exercise program. (Px2). He testified he continued to work full duty through 7/8/16.

Petitioner returned to Dr. Hsu on 7/11/16 at the request of Respondent for a lumbar evaluation. Dr. Hsu noted that Petitioner reported the 2/1/16 cervical surgery resulted in significant relief of his neck and arm pain, and he opined Petitioner had reached maximum medical improvement (MMI) in this regard. He agreed that Petitioner was a reasonable candidate for lumbar surgery given ongoing symptoms despite therapy and injections, agreeing to L3 to S1 decompression "at the very least." (Rx11).

On 7/12/16, Dr. Lim took the Petitioner off work completely due to worsening symptoms. Norco was refilled. On 8/2/16, Dr. Lim noted Dr. Hsu's recommendations and reiterated his prior surgical recommendation, which included L5/S1 fusion, indicating he did not believe that decompression alone would work for Petitioner. (Px2).

Petitioner testified that on 8/9/16 he was released to light duty and continued to perform this work through 9/7/16. On 8/26/16, Dr. Lim encouraged Petitioner to continue to do so. (Px2).

On 8/26/16, in addition to the lumbar issues, Petitioner reported that his neck and arm pain had resolved since cervical surgery, but that he continued to have periscapular border tenderness on the left side. (Px2).

On 2/17/17, Dr. Hsu issued an 8/31/16 addendum report indicating he agreed with Dr. Lim that Petitioner would benefit from an L5/S1 facetectomy and fusion in addition to open L3 to S1 decompression. (Rx2).

On 9/8/16, Dr. Lim performed surgery on the lumbar spine involving posterior interbody fusion at L5/S1 with instrumentation and decompression of the bilateral nerve roots via laminotomies and foraminotomies from L3 to S1. Post-operative diagnosis was lumbar spinal stenosis with radiculopathy. (Px2; Px5).

On 10/18/16, Petitioner reported ongoing intermittent left shoulder and supertrapezial pain, and on 11/4/16 indicated the pain was increasing. Dr. Lim initially prescribed physical therapy and advised Petitioner to remain off work, and then ordered an updated cervical MRI. Left shoulder x-rays showed inferior glenohumeral joint

narrowing, while cervical films indicated apparent fusion with questionable osteophyte formation at C4/5. The 11/23/16 cervical MRI reflected the repeat and prior fusions with multilevel spinal stenosis that was most marked at C4/5 (severe) where a disc/osteophyte complex was indenting the spinal cord, though signal remained normal, as well as multilevel neuroforaminal stenosis. On 11/29/16, Petitioner reported his back was doing well but that his neck and left shoulder pain were as bad as they were prior to surgery. Noting the recurrent C4/5 osteophyte, Dr. Lim ordered a cervical epidural, keeping Petitioner off work in the interim. (Px2).

Petitioner attended physical therapy at Midwest Orthopaedics from 11/8/16 to 12/14/16. The last note states that he made excellent progress with no complaints in the low back, full range of motion and excellent strength in both legs. The therapist indicated he had minimal difficulties with activities and was ready to return to work as to the lumbar spine. (Px2).

On 12/23/16, Dr. Lim reported that Petitioner's back pain remained improved but that it was too early to determine if the cervical epidural was successful. He continued to keep Petitioner off work and refilled his Norco prescription. On 1/6/17, Petitioner reported his neck symptoms were worse after the epidural. He indicated 75% improvement in his back and leg pain with surgery. As Respondent wanted Petitioner to return to see Dr. Hsu, further treatment was on hold and Dr. Lim opined that Petitioner could work light duty (no bending, twisting, lifting or overhead work) and should continue with therapy and home exercise. (Px2).

Dr. Hsu examined the Petitioner on 1/30/17. Petitioner complained of pain in the neck, low back and left intrascapular. He reported mild improvement in his low back and leg with lumbar surgery with the new onset of left intrascapular pain and neck pain since the surgery. Noting Petitioner acknowledged he did not have neck pain at the last examination, Dr. Hsu opined that the cervical osteophytes seen on MRI were not related to the work injury, as Petitioner's neck symptoms arose since the last examination. He opined that the cervical symptoms were due to preexisting cervical spondylosis which is both age and genetic related. As Petitioner was still treating for the lumbar spine post-operatively, Dr. Hsu did not believe Petitioner was capable of returning to full duty but opined that he could work with the same restrictions that were indicated at the December 2015 evaluation. He recommended 4 to 6 weeks of work conditioning when Petitioner's post-op therapy was completed in order to allow him to return to full duty as a truck driver. While he indicated Petitioner was a candidate for cervical injections, he opined these would not be work related. (Rx2).

On 2/3/17, Petitioner told Dr. Hsu cervical epidural resulted in worsening neck and shoulder pain. At this point, he also reported continued back pain into both legs and that: "In general he states he is not significantly improved with either his neck or his back compared to how he felt prior to surgery. On 2/21/17, Dr. Lim noted Petitioner was not happy with his exam with Dr. Hsu, and that the doctor misrepresented that his indication that he was "fine" meant that he was not having any symptoms. Dr. Lim indicated there was objective evidence of cervical neural impingement based on MRI and that this problem remained causally related to the accident. Noting Dr. Hsu opined that Petitioner could work with a 20-pound restriction, Dr. Lim released him to do so, while Petitioner indicated he could not work and also perform the work conditioning Dr. Hsu recommended. Norco was refilled. (Px2).

On 3/7/17, Petitioner reported ongoing 5/10 pain in the neck, arm and low back. He was at the point that he wanted to return to work but said there were issues regarding his workers' compensation claim. An updated lumbar MRI was requested to confirm there was no other pathology to explain his symptoms, and his work status was continued. The 3/14/17 repeat lumbar MRI indicated multilevel spinal stenosis remained, most marked at L3/4 and L4/5, as well as multilevel foraminal stenosis. Signal at L4 indicated the possibility of osteomyelitis. (Px2).

On 3/17/17, Dr. Lim noted the MRI was "worrisome" for possible osteomyelitis given increased L4 signal. He indicated that Petitioner had an objective abnormality that could explain the symptoms he was experiencing and suggested a lab workup of the lesion to check for infection. (Px2).

On 3/21/17, Dr Lim noted blood work was normal and that the Petitioner was not convinced that further surgery would help. Based on this, Dr. Lim recommended a functional capacity evaluation (FCE). (Px2). The 4/10/17 FCE was indicated to be valid and showed Petitioner was unable to meet the physical requirements of his job. (Px2).

On 4/1/17, the Social Security Administration issued an award of monthly disability benefits (SSDI) to Petitioner dating back to a 2/27/17 date of disability with benefits to start in August 2017. (Rx9). Petitioner testified that a company called Allsup, which is a part of his Cigna group insurance, or the Respondent advised him to apply for SSDI as a condition of his continuing to get disability benefits. Petitioned testified he has been receiving SSDI benefits of $540 per month since August 2017, indicating it would have been $1,104 per month if there were no offset with workers' compensation benefits. He received a Medicare card as of 7/1/18, but still has health insurance through Cigna and so hasn't used it. He testified he essentially has let Allsup manage his SSDI claim.

On 4/14/17, Dr Lim prescribed work conditioning, as recommended in the FCE, noting the possibility of an additional lumbar surgery in the future, as Petitioner indicated the prior surgery helped but he still had chronic 5 out of 10 (5/10) low back pain. He also prescribed cervical and left shoulder MRIs, requested by Petitioner, due to the ongoing neck and left shoulder complaints. (Px2).

The 4/18/17 left shoulder MRI revealed rotator cuff tendinosis with focal full thickness tear of the anterolateral margin of the supraspinatus tendon without retraction of the myotendinous junction, tenosynovitis of the long head of the biceps, and loose body in the fluid adjacent to the long head of the biceps tendon. On 4/21/17, Dr Lim referred Petitioner to his colleague, Dr Leonard, for the shoulder, while prescribing continued work conditioning for the lumbar spine. On 4/25/17, Petitioner started the course of work conditioning, attending 15 sessions through 5/15/17 with minimal improvement. (Px2).

On 5/2/17, Petitioner presented to Dr Leonard with pain at the posterior shoulder blade region and laterally. X-ray showed moderate glenohumeral arthritis with inferior glenoid and humeral head osteophytes and joint space narrowing. Dr. Leonard indicated left shoulder MRI revealed a small full thickness rotator cuff tear. Clinical examination, however, indicated "pretty good" range of motion and strength. Dr. Leonard believed Petitioner may have reaggravated some underlying osteoarthritis and felt the rotator cuff tear was insignificant. He recommended and performed a diagnostic and therapeutic left intra-articular injection into the glenohumeral joint. (Px2).

On 5/16/17, Petitioner reported no significant improvement with work conditioning and wanted to consider lumbar surgery. Dr Lim prescribed a fusion with wide decompressions at the L3/4 and L4/5 levels but noted a risk of adjacent segment disease given his young age. (Px2).

Petitioner was re-examined by Dr Leonard on 5/31/17 and reported mild improvement following the left shoulder injection. On examination, Dr. Leonard noted a suggestion of rotator cuff tendinitis and impingement syndrome and performed a left subacromial cortisone injection. On 6/28/17, Petitioner reported the injection definitely helped him and he only had occasional remaining shoulder pains. The doctor advised Petitioner to follow up with him after lumbar surgery. (Px2).

On 6/14/17, Respondent again had Petitioner evaluated by Dr Hsu pursuant to Section 12 of the Act. He examined Petitioner and reviewed the 3/14/17 MRI films. Petitioner indicated his low back and left leg symptoms did not improve with work conditioning, that he had undergone an FCE and that he wanted to undergo another recommended surgery. Dr. Hsu indicated the MRI revealed spinal stenosis at L3/4 and L4/5 and that Petitioner's subjective symptoms in his low back and left leg were consistent with the MRI findings. Dr Hsu agreed with Dr Lim's surgical recommendation in the form of an open L3/4 and L4/5 decompression with possible fusion. He again opined Petitioner could work with a 20-pound lifting restriction with only occasional bending, stooping or crouching. (Rx3).

Lumbar MRI on 8/7/17 showed post-operative changes from L3 to S1, with decreased prominence of abnormal signal versus prior films. There was moderate stenoses at L3 to S1, mild from L1 to L3. (Px2).

On 8/24/17, Petitioner underwent a second lumbar surgery with Dr. Lim, which added a posterior L4/5 fusion along with complex revision decompression of the nerve roots at that level and removal of the L5/S1 hardware. This was performed based on the development of adjacent segment disease with severe spinal stenosis and facet arthropathy and bilateral L4 spondylolysis. Dr Lim referenced in his note that during surgery it was evident Petitioner had sustained bilateral pars defects at L4, rendering the segment entirely unstable: "This most likely is the reason why the patient developed recurrent stenosis as well as severe pain. Additionally noted, there was vertical instability evidenced on radiographs as the patient's disk space significantly opened while prone and under anesthesia compared to standing radiographs. It was determined at that point that because of the noted fractures, which were an unexpected finding, as well as the gross instability, instrumented fusion should be performed." Dr. Lim noted that he requested authorization to also fuse L3/4 given there was stenosis at that level as well, but that this was denied and decompression alone was authorized, though he noted he would have added that level "if there was a rational reason to proceed with stabilization." (Px2; Px5). Petitioner was thereafter held off work.

On 10/6/17, Petitioner reported his radicular symptoms were significantly improved but had burning type pain across the low back and had continued neck/left shoulder complaints. On 10/13/17, physical therapy was prescribed, and Petitioner attended a post-operative course of therapy at Midwest Orthopaedic from 10/19/17 through 1/8/18. (Px2).

On 11/28/17, Petitioner again was complaining of constant low back pain. X-rays showed good alignment of the hardware with no loosening. An FCE was recommended to determine if Petitioner was a work conditioning candidate, though Dr. Lim stated: "However after his multiple operations to his neck and low back it is unlikely he will physically be able to do his job." Petitioner requested another cervical epidural, and this was prescribed as well, and Petitioner continued to be held off work. (Px2). On 12/13/17, Petitioner reported "episodic" shoulder pain, where he can go several weeks without pain and then have a week of pain without an inciting event. Dr. Leonard noted Petitioner reported one or two months of improvement after the last shoulder injection and that it was unclear if Petitioner was performing a home exercise program as instructed. He was taking Norco, Oxycodone and Flexeril. Shoulder exam was essentially normal and Petitioner had good function. The diagnosis was left shoulder impingement with a small rotator cuff tear and mild glenohumeral arthritis. While Petitioner requested a shoulder injection, Dr. Leonard declined noting only mild improvement and that he wanted to see how a pending cervical epidural would impact the arm pain. He also wanted Petitioner to undergo therapy with any shoulder injection and did not want Petitioner doing both shoulder and back therapy. Petitioner was to return on an as needed basis. (Px2).

An FCE was performed on 1/10/18 with Midwest Orthopedic Consultants. The testing indicated Petitioner provided full physical effort and that his subjective complaints were identified as reasonable and reliable.

Findings indicated the Petitioner was not capable of returning to work at his pre-injury job without restrictions, as he was unable to perform the material handling demands. If he were to return to work, the therapist recommended restrictions of: No lifting/carrying over 50 pounds occasionally or 20 pounds frequently, and no pushing/pulling more than 50 pounds occasionally. Four weeks of work conditioning were also recommended. (Px7).

On 1/12/18, Dr Lim re-examined the Petitioner, who reported the cervical injection provided 50% relief. He indicated worsening low back pain and that the symptoms were suspicious for nonunion or delayed union. He indicated Petitioner could perform self-directed exercise for the cervical spine and could get a third epidural if needed. For the lumbar spine, an MRI and a course of work conditioning were prescribed. Petitioner was advised to quit smoking. (Px2).

The MRI of the lumbar spine was performed on 1/18/18 and revealed interval appearance of significant signal alteration consistent with edema, with post-contrast enhancement at the L3 to L5 vertebral bodies, most marked at L4. On 1/19/18, Dr Lim reviewed the MRI films and noted a progression of stenosis proximal to the fusion. He prescribed a lumbar epidural and opined Petitioner's symptoms were radicular in nature and associated with aggravation of pre-existing stenosis. (Px2).

Petitioner underwent a left S1 epidural steroid injection on 2/8/18. (Px2). He did not have much relief with the injection and he started a course of work conditioning on 2/13/18. On 2/23/18, Petitioner reported to Dr Lim that the lumbar epidural didn't help, and work conditioning was aggravating his symptoms. Dr. Lim told Petitioner it was normal to have pain with work conditioning and advised him to continue. He also prescribed a CT scan to evaluate the fusion. (Px2).

The 2/27/18 lumbar CT report indicated redemonstrations of postoperative sequelae of instrumented transpedicular screw and rod fusion of L4-S1 with intervertebral disc spacer device placement and laminectomies. There was also abnormally increased lucency about the right L4 transpedicular screw that was concerning for sequelae of loosening or infection. There also was multilevel degenerative disc disease. (Px2).

On 2/28/18, Dr Lim reviewed the CT scan and opined that it reflected evidence of a delayed union of the lumbar fusion with no severe compressive lesions. An external bone stimulator was prescribed, and he advised Petitioner to continue with work conditioning. On 3/6/18, Petitioner reported he still had not received the bone stimulator. Petitioner attended 20 sessions of work conditioning between 2/13/18 and 3/16/18. On 4/3/18, he had used the stimulator for two weeks. Dr. Lim also advised Petitioner of the addictive nature of opioids. He remained off work. (Px2).

On 4/23/18, Petitioner was examined at Respondent's request by orthopedic surgeon Dr Wehner pursuant to Section 12. Dr Wehner causally related the need for the cervical surgery to the work accident but did not believe the Petitioner's ongoing cervical symptoms were related to the accident given he'd had resolution of the symptoms following the initial surgery. She opined that the subsequent symptoms would be related to a progression of degeneration. She performed an AMA impairment rating evaluation and determined a 9% loss of the body with respect to the cervical spine. She also found that the lumbar condition and the need for the surgeries and subsequent medical care were related to the work accident, noting the lumbar condition itself is degenerative. She did not recommend any additional lumbar treatment, finding that Petitioner should be weaned from narcotic pain medication, as he was receiving 120 doses each of oxycodone and hydrocodone per month along with Fentanyl patches, and that he had otherwise reached maximum medical improvement (MMI). She noted he was inappropriately receiving narcotic medications from two different physicians and was also taking alprazolam and diazepam. She indicated he would not be able to return to work while using these medications.

As to the lumbar spine, she determined an AMA impairment rating of 8% of the body. She indicated Petitioner had a pseudoarthrosis at L4 due to a loose screw. Dr. Wehner opined that Petitioner could return to work with restrictions of no commercial driving while on medications. She did not believe any further treatment or surgery would improve his pain. She further opined that he should have permanent restrictions consistent with the last work conditioning note of 3/16/18. (Rx4).

On 5/1/18, Dr Lim noted Petitioner felt no real improvement and that the gains he had made with the external bone stimulator had not progressed further. X-ray indicated good alignment with no instability. Dr Lim recommended continued use of the stimulator, exercise and weaning from narcotics starting with reduction in the Norco dose to 7/5, as he was not safe to return to work using Norco 10. On 5/22/18, Petitioner reported worsening low back and leg pain at its highest level since he'd undergone surgery, to the point that he was having difficulty walking. Norco was increased back to 10 and a repeat lumbar MRI was prescribed. The 5/29/18 MRI reflected laminectomy and fusion at L4/5 and L5/S1 and laminectomy at L3/4. There was altered bone marrow signal within the L4 vertebral body with enhancement which was less conspicuous than previously. There was epidural soft tissue thickening with enhancement at the L4 and L5 levels. (Px2).

On 6/5/18, Dr Lim noted the MRI showed adjacent segment disease with stenosis, and he believed this was related to Petitioner's symptoms. He also stated that "the previous changes within the vertebral body had resolved." Treatment options were discussed and the report states Petitioner "does not feel as though he is capable of returning to work at a full duty level however is willing to attempt to return to work light duty level on a trial basis." Petitioner did not wish to pursue any additional surgical intervention. Dr Lim indicated work restrictions of no lifting, carrying, pushing or pulling more than 10 pounds on an occasional basis, no bending, twisting or squatting, occasional kneeling and climbing and occasional overhead work. Petitioner was to be allowed frequent breaks when sitting and no sitting longer than 2 hours without a break to stand and move around. (Px2).

The last visit with Dr. Lim prior to hearing was on 6/29/18. He reviewed Dr. Wehner's report at that time and agreed there might be a nonunion or pseudoarthritis at the L4/5 level that could be indicated by screw loosening. Dr Lim prescribed lumbar spine surgery with exploration of fusion, hardware removal and possible repair of pseudoarthritis. Dr. Lim discussed options with Petitioner, who indicated he wanted to try surgery which could involve fusion exploration/revision, hardware removal and/or repair of pseudoarthrosis. The same 6/5/18 light duty restrictions were continued. (Px2).

In a letter dated 6/29/18, the Respondent denied all medical treatment incurred after 4/28/18 based on the Section 12 examination and report of Dr. Wehner and indicated that TTD would be terminated as of 6/30/18. (Px12).

Respondent secured an addendum report from Dr Wehner dated 8/13/18. Dr Wehner reviewed the medical records through 6/29/18 and indicated she did not agree with Dr Lim's recommendation for surgery. (Rx5).

Based on Dr. Wehner's 8/13/18 report, the Respondent declined to authorize the lumbar surgery recommended by Dr Lim. However, the letter also indicates that Respondent's counsel recommended reinstatement of weekly benefits, and that Respondent was considering obtaining a vocational assessment and LMS. (Px13).

Petitioner testified he participated in work conditioning from 2/13/18 to 3/16/18, indicating he felt this worsened his low back and left shoulder pain, both in degree and frequency, and that he reported this to Dr. Lim.

On 6/11/18, Dr. Lim issued work restrictions that limited lift/carry/push/pulling to 10 pounds occasionally. Additionally, he was to only occasionally kneel, climb or perform overhead work, with no twisting, squatting, use of tools/equipment or vibrating tools. He was allowed to drive but was to be allowed frequent breaks when sitting with a maximum of 2 hours seated without a break to move around. (Px6).

On 6/29/18, Dr. Lim reviewed Dr. Wehner's report. Petitioner indicated he still had 5/10 pain with no change in his symptoms. Dr. Lim noted he agreed with the possibility that non-union/pseudoarthrosis at L4/5 may be indicated by screw loosening, and he offered Petitioner the options of fusion reexploration, hardware removal and possible repair of the pseudoarthrosis, and the Petitioner indicated he'd like to try the latter option versus being released with permanent disability as he still wanted to try to return to work. Otherwise, the Petitioner's 6/11/18 restrictions were continued. (Px6).

On 6/29/18, Respondent's insurer sent a letter to Petitioner's counsel indicating that TTD benefits and medical authorizations were being suspended based on the 4/23/18 examination with Dr. Wehner, and that TTD would not be issued after 6/30/18. (Px12).

On 7/17/18, Petitioner's counsel forwarded a request for hearing form to Respondent's counsel indicating that he would be proceeding pursuant to Sections 19(b)/8(a) for either the recommended surgery or, in the alternative, vocational counseling based on Petitioner's inability to return to his regular job. (Px14).

Dr. Wehner issued an addendum report on 8/13/18 after reviewing additional medical records. She indicated that the Petitioner's use of multiple medications and narcotics had a very sedative effect and was a potentially lethal combination that needed to be promptly addressed "and should follow current medical standards, which do not recommend multiple narcotics and multiple sedative/muscle relaxant type of medications." Despite her finding of a loose screw at L4 and Dr. Lim's offering of an option for exploratory surgery to Petitioner, Dr. Wehner opined that there was no reasonable medical expectation that a third lumbar surgery would alleviate Petitioner's pain or improve his function. She indicated the lucency around the screw should fill in over time. She strongly recommended against any type of further surgery, noting it was unclear why the Petitioner would want to pursue them given his less than optimal outcomes from the prior surgeries. (Rx5).

On 8/17/18, Respondent's counsel forwarded Dr. Wehner's 8/13/18 report to Petitioner's counsel indicating that the surgery prescribed by Dr. Lim was denied. Noting Petitioner's counsel indicated the case would be tried, Respondent's counsel indicated he was recommending the reinstatement of benefits and that a determination was being made if a vocational assessment and/or labor market survey would be sought. (Px13).

Petitioner testified he declined the lumbar surgery recommended by Dr. Lim, and that Respondent would not approve any further visits with Lim after the last 6/29/18 visit. The Respondent could not accommodate his final restrictions from that date. He testified that prior to the accident date he had no problems with his left shoulder, lumbar or cervical spine. He had undergone the prior cervical fusion with Dr. Stadlan on 4/30/10, after which he returned to full duty on 6/7/10 and was discharged as of January 2011.

Currently, Petitioner testified that he continued to have low back pain, and problems with prolonged walking (15-20 minutes), sitting (30 minutes) and standing (20-30 minutes). The longer he remains in one position, the worse it gets, so he always has to move around to get loose. He testified the back pain is stabbing and radiates into the leg. He indicated that he can't drive very long as it involves sitting in one position, and that Dr. Lim doesn't want him to drive. The back pain can awaken him, and he then has to get up and move around before going back to bed. Household chores, such as sweeping, also increase his symptoms, but he owns a home and has to maintain the inside, including vacuuming and cleaning floors and bathrooms. He hires someone to cut his

grass, which he used to do himself. He notices an intermittent stabbing pain in the left shoulder, which also impacts his activities, such as cleaning, lifting and laundry. As to the cervical spine, Petitioner testified that he has no specific neck pain but believes that the pain in his shoulder is coming from the neck. He does not have any problems on the right side, which is what was involved in his 2010 surgery.

Petitioner is now 59 years old. He graduated high school in 1977 and pursued no further education. He maintains a current CDL license. He has no military experience. He has a laptop computer but has had no formal computer training other than with one specific database while working for Respondent on light duty. He does use email. Petitioner worked for Orzak Cartage as a truck driver from 1981 to 1984 before starting with Respondent. He began working for Respondent when it was CCX, which then became Con-Way.

Petitioner testified that the job analysis for his position with Respondent (Px4) is accurate. While it is not exact, he testified he is required to do everything listed. A review of this document indicates the requirement that he have a CDL and a DOT medical card which allows him to operate a commercial vehicle inter/intra-state; lifting/carrying frequently up to 50 pounds, occasionally up to over 76 pounds; continuous reaching; bending, twisting and standing when handling freight; climbing; push/pulling items which included the use of assistive devices where appropriate; and, driving with frequent or constant use of neck rotation, steering and shifting gears. (Px4). His normal truck route/run was from Gary/Hammond to Sandusky, Ohio, which is four to four and a half hours one way. As he was the number two in seniority, this was his consistent run. Petitioner testified he last worked light duty in September 2016.

Petitioner testified he would be paid hourly while preparing to make his run, including loading and inspection, at which point he would punch out and begin his run, during which he would be paid by the mile. The parties stipulated that as of the hearing date the Petitioner would be earning $29.45 per hour while punched in, .697 per mile while en route with triple trailers and .677 per mile with double trailers. Petitioner testified as to what some of the abbreviations meant: XGH is Gary/Hammond, IN; XEL is Sandusky, OH (Eleria is the actual town); XSB is South Bend, IN; XCW is Coldwater, MI (which he said is now Fairfield, IN). As to the "VPP" designation, Petitioner testified that this payment represents what they used to call profit sharing and is based on goals for year in terms of tonnage, safety, etc. Every employee is entitled to a portion of this profit sharing and everyone gets a percentage of income. Petitioner had different routes on 11/24/14, 1/9/15, 1/24/15, 1/31/15 and one date in February 2015, which he indicated would have been weather related. He also has doubles instead of triples on some dates, again indicating this would have been due to weather.

Petitioner testified that he met with vocational counselor Steve Blumenthal on 8/28/18 and underwent vocational testing with him on 10/5/18. The Respondent referred him for an interview with vocational counselor Julie Bose on 10/10/18.

Petitioner testified he last looked for work on 11/16/18. He did have a job interview request from DialAmerica through Julie Bose, but he didn't go because it was in Aurora, about 50 to 60 miles from his home. He has not been offered a job so far. Petitioner testified he also has networked with family and friends trying to find employment. His job search logs (Px8) are accurate as far as all the jobs he looked for. He testified he found prospective employers through the local newspaper and by driving to industrial areas in nearby suburbs to ask for work. He testified he completed about 10 to 15 applications online, but had a difficult time doing so. He has a resume but testified it is limited because his only job the last 36 years has been truck driving. The Arbitrator notes that the Px8 documents reflect job logs dated from 8/28/18 to 11/16/18. The vast majority of these were either in person contacts or online applications. (Px8).

Petitioner's high school report cards were admitted into evidence as Px9. The Arbitrator notes his review of these records generally indicated a C to D student with some exceptions, including courses titled "CWT." (Px9).

Petitioner agreed that, according to the vocational counselors he will be able to find employment. He indicated he wants to work reasonably close to his home to avoid prolonged sitting, and that it doesn't make sense to travel 60 miles each way for a job like the DialAmerica job, though he agreed he had not found any employment close to home.

On cross examination, Petitioner testified that he's had three surgeries with Dr. Lim, didn't want to have a third lumbar surgery and is comfortable with and willing to live with the restrictions instituted by Dr. Lim. The Petitioner couldn't say whether he had been "officially" released by Dr. Lim, as he could not get authorization to return. He acknowledged that even another visit to Dr. Lim were authorized, he still did not plan to return to see him. He testified that he gave his best effort at the 1/10/18 FCE. He testified his job with Respondent as a truck driver was heavy duty as the activities are in excess of his restrictions, noting he has to load/unload if necessary, but he agreed that did not occur very often.

Petitioner testified his low back is currently his most significant problem, and that he doesn't currently have significant neck pain. He submitted his left shoulder treatment through Cigna insurance, though he believes the treatment is related to the work accident, as the symptoms that led to shoulder treatment are the same as what led to neck surgery. He continues to have left shoulder problems. He currently takes Oxycontin that is prescribed by his primary provider, Dr. Shaw. Dr. Lim last refilled his Norco prescription at the last visit, indicating he wanted Petitioner to wean off of it. He last received a hydrocodone prescription on 10/30/18. He only planned to return to Dr. Shaw when he needs a medication refill. He agreed that he received both Norco and Oxycodone simultaneously for about a month, but Dr. Shaw didn't think he should be taking both. He has used prescribed Fentanyl patches very sparingly, testifying he is afraid to use them as he is aware the drugs are addictive. He takes Oxycontin when he gets up in the morning and when his pain gets severe, noting "they do help."

Petitioner testified he has continued to perform a self-directed job search and has prepared his own logs in template forms. He also has a folder where he writes notes of his job search activities, which he would use to fill out the forms. Sometimes he would fill out the forms directly. When it was pointed out on cross-exam that he didn't receive the forms from Julie Bose, Petitioner testified he didn't know where he got the template from. He indicated the information contained in the forms is accurate, and that he would have checked the box if he'd submitted an application or obtained an interview. He indicated he had contacted up to 10 prospective employers per week and tried to enter as much information as possible in the forms. He agreed it is important to know what duties a job entails before applying and whether his restrictions would allow him to physically perform the job. and if the job would be limited by the work restrictions, and that he can physically do the job prior to applying. He has applied for counter sales because he has done this before. While he didn't think it made sense to apply for work as a machine operator, counselor Bose indicted he could do it, so he did so based on that. He testified he tried to apply for jobs in Bose's LMS. He didn't attach applications for online jobs as he is not a computer person and didn't know how to do it. While both counselors Blumenthal and Bose have recommended he get computer training, he testified he would prefer not to do so: "I just don't think I can do the computer stuff". He testified he is from a different era and gets aggravated when he can't get the computer to work the way he wants it to. He testified he didn't know that follow-ups with prospective employers would be required, indicating he didn't follow up because "no one ever called", though he agreed he didn't attend the interview with DialAmerica. Petitioner testified that he is aware of the vocational plans of both Blumenthal and Bose and that he believes he will be able to find work on his own.

Certified Rehabilitation (Vocational) Counselor Steven Blumenthal testified on behalf of the Petitioner via deposition on 10/30/18. He testified he has been a vocational rehabilitation counselor since 1980 and has had his own practice since 1980. After meeting with Petitioner and interviewing him on 8/28/18, Mr. Blumenthal recommended vocational testing to determine his aptitudes and abilities to perform work given the sedentary restrictions of Dr. Lim and Petitioner's lack of experience in that type of work. The restrictions of Dr. Lim that counselor Blumenthal relied on were: lifting, carrying, pushing, pulling of 10 pounds on an occasional basis; occasional standing, walking, sitting, kneeling, climbing and overhead work; no bending, twisting, squatting, use of tools or equipment; no sitting longer than two hours at a time without being able to take a break and move around. He testified that according to the U.S. Department of Labor, "occasional" means no more than 2.5 hours out of an 8-hour day. He did not consider any restrictions recommended by Section 12 examiner Dr. Wehner because he is ethically obligated to follow the treating physician's restrictions in an active vocational rehabilitation program, though such restrictions could be considered on a forensic basis, which would be more hypothetical. (Px10).

Counselor Blumenthal testified that he performed a transferrable skills and aptitude analysis, which involves both his own impressions based on Petitioner's prior work history and the work restrictions, and vocational testing further refines this analysis. Petitioner has been a truck driver for 37 years, and while he had experience as in auto part sales and entry level auto mechanics, that experience was from approximately 40 years ago. His analysis results indicated that with direct placement services, Petitioner would have access to jobs such as telemarketer. He did have any computer literacy skills but did have the aptitude and physical ability to be able to learn and develop computer literacy skills with training, and this would give him access to more clerical office type of work. With direct placement. Blumenthal opined that Petitioner could expect to earn $10.10 to 12.18 per hour. With the clerical/computer training, this would increase to $11.50 to $13.00 per hour, which would include jobs such as appointment clerk or general office clerk. Counselor Blumenthal testified that Respondent's expert, Julie Bose, did not perform any transferrable skills or aptitude analysis, which results in her making more subjective assumptions than objective determinations. In Blumenthal's experience, the bench assembly position Bose identified in most cases would not be sedentary and would require the ability to stand, walk, lift, carry and bend. Given Petitioner's restrictions, his opinion is there would be no stable labor market in this field for the Petitioner. Since Petitioner was receiving SSDI benefits, counselor Blumenthal recommended resolution of the case via the use of the expected earning figures. Otherwise, the options would be to attempt direct placement or the clerical/computer training. Direct placement would include resume development, interview training, basic computer template skills, how to follow-up with prospective employers, etc. He estimated job placement would take 4 to 6 months with direct placement, and the same period of time in the latter category but this would only be after the training was completed. He also estimated the vocational costs to be $12,000 to $20,000. Counselor Blumenthal opined that Petitioner's 8/28/18 to 10/19/18 job search logs were consistent with what he would expect given Petitioner's lack of experience looking for work as a truck driver for 37 years. While work can be sought in person, most employers now want applications to take place over the internet. (Px10).

On cross-examination, counselor Blumenthal testified that the restrictions of Dr. Lim he was relying on were from 6/5/18, which were continued on 6/29/18. He agreed a surgery was recommended at that time but could not say whether the Petitioner had since returned to Dr. Lim. Blumenthal agreed that further work conditioning took place subsequent to the Petitioner's FCE. He had no opinion on Dr. Wehner's restrictions being connected to Petitioner's last work conditioning report, since as a vocational counselor he has no medical opinion regarding Petitioner's restrictions. All he can say is that Dr. Lim's 6/29/18 restrictions were the last ones imposed before his vocational assessment. Whether they would ever be changed would be a question for Dr. Lim, not him. Blumenthal agreed the Petitioner provided his subjective tolerances for activities, but he did not consider it in his analysis. He agreed that he did not prepare a labor market survey in this case. While Ms. Bose

did, counselor Blumenthal testified that he wouldn't consider it valid unless the prospective employer were presented with each and every specific restriction issued by Dr. Lim versus, for example, sedentary restrictions with no lifting over 10 pounds and the ability to change positions (sit/stand) after prolonged activity. He agreed that he and counselor Bose agree that Petitioner would need computer training to work in most office environments, and that he can expect to earn wages in the $10 to $12 per hour range. Counselor Blumenthal opined that vocational training for Petitioner would take upwards of a year, noting he disagrees with Bose that this can be done simultaneous to a job search since the worker hasn't yet obtained the targeted skills until training is complete, but that at the end of this the Petitioner would be absolutely employable. (Px10).

Counselor Bose also testified via deposition, on 11/2/18. She testified that she has been a vocational rehabilitation counselor for 35 years with a master's degree in vocational rehabilitation services. She also testified that she is a CRC and licensed professional counselor. She was asked by Respondent to perform an initial vocational interview (10/10/18) and labor market survey (LMS) for Petitioner. Bose testified that Petitioner's job as a truck driver would be considered to be within the heavy physical demand level, noting he had been a truck driver essentially most of his entire adult life, or approximately 34 years. Counselor Bose acknowledged that the work restrictions issued by Dr. Lim (in June 2018, including no lifting in excess of 10 pounds, alternating between sitting, standing, and walking, no bending and twisting, and the ability to change positions after sitting for two hours) and Section 12 examiner Dr. Wehner (restrictions outlined in the January 2018 FCE and the March 2018 work hardening discharge summary, which would allow for work at the medium physical demand level). Ms. Bose testified that she prepared two different labor market surveys to account for the difference in restrictions. Specifically, Bose testified that she prepared two different LMS' to account for the different restrictions, sedentary for Dr. Lim and medium duty positions per Dr. Wehner. Bose testified that job placement specialist Lauren Egle contacted prospective employers, utilizing two separate labor market survey questionnaires, one assuming medium duty restrictions and the other assuming sedentary work restrictions, and recorded their responses. She testified that Egle had an understanding as to the specific work restrictions imposed by Dr. Lim and Dr. Wehner. Bose herself then spot-checked three prospective employers in each LMS (dated 9/2/18) to make sure they were accurate. Additionally, counselor Bose testified that she checked the math on the reported wages, reviewed the results of each of the contacts that Egle had made to finalize her report, and had Egle review the completed report to make sure it was accurate. (Rx6).

Counselor Bose testified regarding the results of her sedentary duty LMS, indicating truck driving is "semi-skilled" and that any such skills would not be readily transferrable. She testified that she looked at entry level positions that included bench assembly, bench sorting, bench packing, customer service, as well as call center positions. Of the 20 employers contacted, 15 indicated they could consider Petitioner, and these jobs had an average entry level wage of $12.85/hour. Of these, 8 had current hiring needs and 7 did not. As to the medium duty LMS, she looked at entry level positions including warehouse/forklift type positions. Of the 19 prospective employers contacted, 15 provided wage information, 14 were hiring, and the jobs had an average entry level wage of $12.85/hour. Ms. Bose testified it would be more advantageous for Petitioner to target sedentary work because the wages were slightly higher and, following her interview, Petitioner was more capable of doing sedentary work. The disadvantage is that there are less employment opportunities in sedentary work than there are with medium duty work. Counselor Bose interviewed Petitioner on 10/10/18, noting Petitioner had worked as a truck driver for 34 years, working about 11 hours per day for a 540 mile round trip in the last several years he worked. He had a 12th grade education and learned to drive a truck through on-the-job training, not through a truck driving school. Counselor Bose testified that she reviewed Petitioner's job search logs from 8/28/18 through 10/19/18, noting he primarily applied for entry level jobs, including: auto parts counter man, auto dealerships, and customer service type positions. She testified that there was no problem with the amount of employers contacted per week, which was just under 10 on average per week, but that he was a little bit heavy on phone contacts and that a better way to search for work would be either meeting with employers in person or

doing an online job search. She testified that Petitioner did not complete many applications. Up until the last two weeks of the logs she reviewed, Petitioner only filled out possibly six applications, and a total of no more than 2 per week. Counselor Bose testified that Petitioner did not always fill out applications when employers stated that he was available to do so, and she did not see any online confirmations indicating that he successfully completed applications or evidence of any follow up to any applications. (Rx6).

Petitioner had no formal computer training, used a "hunt and peck" method, and had no experience with Microsoft Excel, Word or Outlook. He was able to access the internet and had utilized his employer's proprietary software program while on light duty for 6 months. Given the quality of his search was lacking, she opined he would benefit from basic computer training and how to use a computer to look for work. Counselor Bose testified that she did not perform any vocational testing, opining it is more important to look at what skills he had based on work history and where the transferrable skills are for a worker over age 50, as long term training would be more applicable for a younger worker. Petitioner indicated no problems with reading or writing, noting he completed a complex written examination in order to get his CDL. She also did not believe that Petitioner had any learning disability or special need to indicate the need for vocational testing. Bose testified that she did not feel that Petitioner was capable of returning to work as a truck driver under either the sedentary or medium duty scenarios. He did not have any readily transferrable skills from his work as a truck driver. However, she opined that a stable labor market does exist for Petitioner, including those of a bench packer, bench assembler, customer service clerk or call center clerk, given his restrictions. He was a viable candidate for vocational rehabilitation services based on the fact that he has not been successful in his self-directed job search. One option would be to do vocational planning, which would include computer training, after which he could perform a self-directed job search, and the other option would be to offer vocational training and job placement services to petitioner directly. Bose recommended a computer training program along with simultaneous vocational training, given he had been out of work for over a year and the longer a person is out of work, the harder it is to find work. This would involve spending approximately three hours a day in a computer training and then a couple of hours a day looking for work, and the process would take at least 4 to 6 months. (Rx6).

Petitioner objected to testimony from counselor Bose regarding her review of the opinions of counselor Blumenthal pursuant to *Ghere*. This objection is overruled both because there is no real surprise that Ms. Bose would provide such opinions, and because there is no prejudice to Petitioner. This testimony essentially pointed out differences in their opinions, which are generally clear from the reports themselves anyway. Counselor Bose essentially testified that she and Blumenthal agree that Petitioner is employable, that he is capable of working as a call center clerk or telemarketer, and more or less agreed on the wages he would be capable of earning in these positions. They also agreed that Petitioner is a candidate for vocational services and that Petitioner does need some level of computer training. She disagreed with Blumenthal regarding the proposed timeframe of the vocational rehabilitation process, in that she recommended computer training simultaneously with job placement, while Blumenthal recommended one followed by the other. (Rx6). The Arbitrator notes that Mr. Blumenthal testified as to why he differed with Bose in this regard. Counselor Bose testified that she agrees with counselor Blumenthal's ultimate conclusion that Petitioner could perform appointment setting positions or telemarketer positions but believed he had very limited transferrable skills from truck driving and these would be very entry level jobs. She disagreed that any significant vocational training was indicated because Petitioner was at a later work life age, had no indicated learning disabilities and wasn't looking for a long-term career. Counselor Bose disputed Blumenthal's criticisms of how her labor market survey information was obtaining, indicating she did not target any positions in which there was a prerequisite for any computer literacy. (Rx6).

Counselor Bose testified that she prepared a vocational rehabilitation plan in accordance with Section 7110.10 of the Commission Rules, which she attached to her vocational assessment report. There was a letter sent to

Petitioner's attorney with her initial report and plan and asked the attorney to review it with Petitioner. Bose testified that if petitioner agreed to sign the plan, or if he recommended an alternative plan, to send her the same for consideration, but Petitioner did not sign the plan nor provide an alternative. Bose's ultimate conclusion is that Petitioner is employable, regardless of which restrictions are used, and even without vocational planning and without vocational rehabilitation, petitioner should be able to find employment. (Rx6).

On cross-examination, while she noted deficiencies in Petitioner's self-directed job search logs, Bose acknowledged they would not be unusual deficiencies for someone in the same job for so long with limited experience looking for work. She opined that a 30-mile drive to work would be reasonable for Petitioner given he is in a populated area, even for a $10 per hour job. Counselor Bose opined that Petitioner has two options: a self-directed job search or a full vocational rehabilitation program. With option one, vocational planning would be the first step, which would help cure the deficiencies seen in his job search to date, as it would include a resume workshop, a basic cover letter instruction, and basic instruction in how to search for employment online and in person. Vocational training typically would last from 4 to 6 weeks, with a minimum of four sessions. Bose agreed that any dispute regarding applicable work restrictions would ultimately be resolved by the Commission. Again, Petitioner is not a candidate for long-term retraining. (Rx6).

On further cross, counselor Bose was questioned regarding the questions contained in the labor market survey questionnaire. Bose testified that the restrictions in the questionnaire are essentially the same restrictions set forth by Dr. Lim, but not each and every specific restriction as they have to be cognizant of the time of the employers they call or they won't answer the surveys, so they try to summarize, noting several of Petitioner's specific restrictions would be encompassed by the term "sedentary" work. She also acknowledged that the questionnaire does not indicate the exact entry level wages. She explained that employers are very reluctant to give an exact wage because it can vary, and they are much more likely to give responses to wage ranges. She testified that she continues to believe that Petitioner would be employable at a range of approximately $12.58 per hour, using the restrictions used by Dr. Wehner, the FCE, and the work conditioning note, or by using the restrictions of Dr. Lim. She noted that this would be consistent with the $12.00 per hour minimum wage used in Chicago. Ms. Bose did not consider the Petitioner's job with Respondent to involve any true sales aspect. She agreed that her wage estimate includes jobs with employers who aren't currently hiring, testifying that whether they are hiring or not wouldn't change the wage determination. (Rx6).

On Redirect examination, counselor Bose testified that the targeted sedentary positions she looked into took into consideration the restrictions imposed by Dr. Lim. She testified that she looked up the postural activities in each one of the jobs via Job Browser to make sure that the jobs were sedentary, with no kneeling, twisting, and alternation between sitting, standing, and walking. She explained that sedentary jobs typically do not involve twisting or bending because they are primarily performed seated. Bose testified that MedVoc, and companies like it, are like telemarketers of the business world. She explained that if they went over the work capacity evaluation form with every single thing checked, employers would hang up on them. She testified that in order to facilitate the process, she would take the restrictions from Dr. Lim into consideration by targeting jobs based on the Dictionary of Occupational Titles within those sedentary work restrictions by Dr. Lim and reviewing the job descriptions prior to contacting the prospective employers. (Rx6).

Counselor Bose's job placement specialist, Lauren Egle, also testified via deposition on 11/2/18. She testified her job involves meeting with clients and working with them to help develop job seeking skills and job leads. She also creates resumes, conducts labor market surveys, and assists with computer skills. When she is assigned to perform a labor market survey, she is provided with an informational sheet and questionnaire from the case manager, which provides the information needed to conduct the labor market surveys (LMS). The LMS is conducted through a combination of cold calls and job search websites. Ms. Egle testified that she makes a lot of

phone calls to contact employers to basically inquire about the physical demand of the positions and whether or not they are currently hiring, and she then documents their responses. She then uses their responses to determine what the average potential wage would be, which she provides to counselor Bose. Some employers have a specific entry level wage set while others will provide an average range that they typically offer for the position. (Rx7).

Ms. Egle testified that in Petitioner's case she called the prospective employers. Two different questionnaires were used to prepare two different LMS reports, one targeting sedentary positions and one targeting medium duty positions. Ms. Bose suggested the targeted jobs/positions, and Ms. Egle decided which employers would be contacted. When she contacted the employers, she obtained the point of contact's information, the type of position and if its available, whether they could accommodate someone with specific physical restrictions given the prospective employee's background. Egle testified that Bose would target the specific jobs and Egle would then select the employers. Her understanding is Ms. Bose would spot-check the employers listed in the LMS. As her involvement in the LMS was solely to contact the employers and document the information she obtained, any opinions indicated in the LMS are deferred to Bose. She testified that based on the results of the sedentary duty LMS, entry level wages would be up to $12.85 per hour with 15 employers that could accommodate, and that based on the results of the medium duty LMS, the entry median wage would be $12.58 per hour. (Rx7).

On cross-exam, Ms. Egle acknowledged that she is not a certified rehabilitation counselor and has no formal education in vocational rehabilitation. She believed she obtained all of the information in the LMS' over a period of a week. Ms. Egle testified that she didn't provide definitions of some of the terms in the questions she asked and that she was not asked to. For the most part, she read the questions as indicated, and she would indicate if the employer had a question. She testified that counselor Bose provided the questions on the LMS questionnaires and that Bose if the one who determined the description of the indicated restrictions. Ms. Egle testified she herself was not aware of the Petitioner's specific restrictions. When she would get a wage range, she would use the midpoint to use to determine the average. Because she was targeting entry level jobs, she didn't generally ask if any significant computer skills would be required. If a prospective employer told her the specific physical demands of a job, she would list them. (Rx7).

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's lumbar, cervical and left shoulder conditions are causally related to the 9/16/15 work accident.

First, the Arbitrator notes that the Petitioner complained of all three of these body parts in his initial accident report and at his initial medical visit at Comprehensive Care Occupational Medicine. He testified he had no problems with these body parts in the time prior to the accident, and other than a prior 2010 cervical fusion for which he was released in 2011, there is no evidence in the record which would rebut this testimony. The evidence indicates the Petitioner had been working his full work duties for several years leading up to the accident date.

The accident itself involved pulling a heavy dolly and tripping and falling in a gravel area with an immediate onset of symptoms. Again, this evidence is unrebutted.

Surgeon Dr. Lim opined that the Petitioner had a congenital lumbar stenosis condition that was aggravated by the accident, and a cervical condition that was a direct result of the accident, noting Petitioner previously had right-sided cervical radiculopathy and now had left-sided radiculopathy.

Respondent's examining physician, Dr. Hsu, opined that the work accident aggravated preexisting conditions in both the Petitioner's cervical and lumbar spine, citing both the mechanism of injury and that Petitioner had been asymptomatic prior to the accident. Petitioner subsequently underwent fusion surgeries to both areas of the spine

The dispute on this issue from Respondent appears to revolve around the opinions of Dr. Hsu and Dr. Wehner, Respondent's Section 12 examining physicians.

Dr. Hsu opined on 1/30/17 that Petitioner's cervical condition at that point was degenerative and unrelated to the work accident, noting he had been symptom free post-surgery. Dr. Lim, on the other hand, opined that the cervical symptoms and condition at that point remained an ongoing condition since the work injury.

It was shortly after this that Dr. Lim referred Petitioner to Dr. Leonard to work up the Petitioner's left shoulder to see if it was contributory to the condition. Dr. Leonard noted an MRI showed a small full thickness rotator cuff tear, but he believed Petitioner may have aggravated an underlying osteoarthritic condition and that the tear was not significant. The shoulder was essentially treated with injections.

Petitioner underwent lumbar surgeries on 9/8/16 and 8/24/17. When he was reexamined by Dr. Hsu on 6/14/17, he agreed with an additional lumbar surgery and his report does not reflect any opinion indicating he believed the lumbar condition and need for surgery was no longer causally related to the accident.

On 4/23/18, Dr. Wehner opined that the Petitioner's cervical surgery was causally related to the accident, but that Petitioner's current cervical condition and symptoms were unrelated. She agreed that the lumbar condition remained causally related. Dr. Wehner opined that while the initial need for cervical surgery was causally related to the accident, she did not believe that the ongoing cervical symptoms were related since Petitioner had a resolution of his symptoms following that surgery. She opined that any ongoing symptoms were part of the degenerative process.

While Dr. Hsu and, essentially, Dr. Wehner, opined that Petitioner's recurrent cervical condition and osteophyte were no longer related to the work accident and due to preexisting and ongoing degeneration, the Arbitrator finds the opinions of Dr. Lim to be more persuasive. Specifically, it makes logical sense to the Arbitrator that the cervical surgery removed a prior osteophyte and that the healing process led to reformation of an osteophyte.

The fact that time may have passed does not lead the Arbitrator to conclude that the work accident and subsequent reasonable and necessary cervical surgery is not still a causative factor in the current cervical condition. The cervical fusion took place on 2/1/16 at C4/5, and this was superimposed on a prior C5 to C7 fusion. It was just over 8 months post-surgery that Petitioner was complaining of ongoing intermittent left shoulder and supertrapezial pain that was increasing. At that point Dr. Lim ordered a repeat MRI. The Arbitrator does not believe that this gap period following a fusion surgery somehow terminated causal connection. The Arbitrator would also note there is no evidence of any incident or new accident which could have triggered an onset of symptoms after the surgery.

Otherwise, it appears to the Arbitrator that all three doctors, Lim, Hsu and Wehner, agree that the initial cervical surgery are causally related to the accident. Dr. Leonard's records support a causal relationship of the left

shoulder to the work accident, and there is no causation opinion in evidence which would dispute this connection.

As such, the Arbitrator finds that Petitioner's cervical condition remained related to the work accident, and finds that his cervical and lumbar conditions remain causally related to the 9/16/15 work accident. The Arbitrator finds that the Petitioner reached maximum medical improvement as to the left shoulder as of 6/28/17. That was his last visit with Dr. Leonard, and at that time he reported significant improvement with the last injection and that he only had occasional remaining left shoulder pains. He was advised to follow up after his lumbar surgery, but there is no evidence that he ever did.

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 parties stipulated to the temporary total disability ("TTD") benefit periods and the temporary partial disability ("TPD") benefit periods and that the Respondent has paid same. Petitioner is alleging he is entitled to a disputed period of maintenance benefits for the period between 6/30/18 and the date of hearing, 11/20/18.

Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational program." W.B. Olson, Inc. v. Illinois Workers' Comp. Comm'n, 981 N.E.2d 25, 366 Ill. Dec. 960 (1st Dist. 2012).

Petitioner initially indicated he did not want to undergo surgery when he saw Dr. Lim for a review of his MRI on 6/5/18. Dr Lim specifically prescribed an additional lumbar surgery at the last 6/29/18 office visit, noting he reviewed the report of Dr. Wehner and agreed there might be a non-union or pseudoarthritis at L4/5 with screw loosening. Petitioner indicated at that point that he did want to undergo the surgery, but it then was not approved by the Respondent. Respondent denied any additional medical treatment, including the surgery, via letters dated 6/29/18 and 8/17/18. (Rx12, Rx13). After receiving the denial letters, Petitioner decided not to undergo the surgery recommended by Dr Lim. Petitioner submitted a demand for vocational rehabilitation on 7/17/18. (Px14).

Petitioner testified he performed a self-directed job search from 8/28/18 through 11/16/18 and provided job logs regarding same (Px8). Petitioner made contact with over 100 prospective employers during his job search, both in person and via internet applications, and conducted 1 telephone interview. He was not able to secure employment but testified he believes he will be able to secure gainful employment without formal vocational rehabilitation.

Both counselors Blumenthal and Bose agreed that Petitioner is a candidate for vocational rehabilitation. They both testified the Petitioner is capable of working as a telemarketer. Petitioner admitted he could likely secure employment as a telemarketer but he is not interested in this line of work. He declined formal vocational rehabilitation and plans to continue his independent job search. Ms. Bose reviewed the Petitioner's job logs covering the period between 8/28/18 and 10/19/18 and acknowledged that the defects she pointed out in his search were consistent with someone who had worked in the same job for many years and his experience looking for employment, and that these issues could be addressed with vocational rehabilitation and training. Given counselor Bose's statement that Petitioner should look within 30 miles of his home, his failure to attend an interview with DialAmerica that was at least 50 miles from his home was not unreasonable.

The Arbitrator has reviewed the evidence and finds Petitioner is entitled to maintenance benefits from 6/30/18 through 11/20/18. The Arbitrator finds it significant that Petitioner began his independent job search 11 days after receiving the letter from Respondent indicating all medical treatment, including the surgery recommended by Dr Lim, was not approved. In the roughly 12 weeks Petitioner searched for employment, he contacted a significant number of prospective employers. While not as well-directed as it may have been with vocational assistance, the Arbitrator believes the Petitioner's job search involved sufficient effort and direction given his age and the length of time he has worked for Respondent and its predecessors in the same job. The Arbitrator believes that Ms. Bose's testimony supports this finding. It was not unreasonable, in the Arbitrator's view, for the Petitioner not to have begun his search immediately on 6/30/18, and that starting it on 8/28/18 was reasonable under the circumstances of the case. The Arbitrator finds Petitioner conducted a good faith search through the time of hearing.

Part of the Respondent's argument in this case is with regard to the Petitioner's work restrictions, in that Dr. Lim did not indicate at the last visit with Petitioner that the restrictions he prescribed were meant to be permanent. However, the Petitioner testified in unrebutted fashion that he was not authorized by Respondent to see Dr. Lim again after that time. It is difficult for the Arbitrator to accept the Respondent's argument given its role in Petitioner not following up with Dr. Lim after 6/29/18.

Pursuant to stipulation (see Arbx1), Respondent is entitled to credit of $21,398.58 for maintenance benefits paid prior to the hearing date.

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

The Courts in Illinois have interpreted the Workers Compensation Act as favoring an award of permanency based on a wage differential (Section 8(d)1 of the Act) if applicable. Thus, the Arbitrator's initial analysis starts there.

Pursuant to Section 8(d)(1) of the Act, a claimant "shall ... receive compensation... equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he ... is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after 9/1/11, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later." *820 ILCS 305/8(d)(1)*. To qualify for a wage differential under Section 8(d)1 of the Act, the Petitioner must prove (1) partial incapacity which prevents him from pursuing his usual and customary line of employment and (2) an impairment of earnings. *Galianetti v. Illinois Industrial Comm'n*, 315 Ill. App.3d 721 (2000). A Petitioner who does not obtain alternative suitable employment still may qualify for a wage differential award under Section 8(d)1. *Crittenden v. Illinois Workers' Compensation Comm'n*, 2017 IL. App (1st) 160002WC.

The Arbitrator has reviewed the evidence and finds that the greater weight of the evidence supports that the Petitioner is entitled to a wage differential award under Section 8(d)1. There is no dispute Petitioner's permanent restrictions prevent him from pursuing his usual and customary line of employment with the Respondent. Even using the analysis of Dr. Wehner, the Petitioner would not be able to return to his regular job with Respondent and would be, at best, limited to medium duty work.

There is also no dispute Petitioner has suffered an impairment of earnings due to his injuries.

Section 8(d)1 of the Act provides that the Petitioner: "shall, ..., receive compensation..., equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he ... is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later." 820 ILCS 305/8(d)1.

The Arbitrator finds that the Petitioner has shown by a strong preponderance of the evidence that he is entitled to a wage differential award under Section 8(d)1. In order to determine the amount Petitioner is entitled to per week, there must be a determination of the amount he would be earning in the full performance of his duties and the average amount he is currently able to earn in some suitable employment.

The Arbitrator finds that if Petitioner had returned to work for the Respondent as a DSR, he would currently be earning $2,006.04 per week. Petitioner submitted the check stubs and driver detail logs from Respondent covering the period 8/17/14 through 9/10/16. (Px11). The parties stipulated that Petitioner's current hourly rate of pay would be $29.45 and the mileage rate to pull triples would be $.697 per mile, or $.677 per mile to pull doubles. Petitioner had worked as a DSR for Respondent since 1984. Due to his seniority with the company, he was able to choose the trips he made, and he testified his normal run was between his terminal in Gary, Indiana and the terminal in Sandusky, Ohio. This run was 536 miles round trip and required less lifting and dock work than the typical run because the majority of his workday was spent driving. The run from Gary, Indiana to Sandusky, Ohio allowed the Petitioner to "pull triples" instead of pulling "doubles". In the year before his accident, Petitioner had four occasions where he pulled doubles. In the year before his accident, Petitioner had five occasions where he ran a route other than Gary to Sandusky. These are minimal when reviewing the entirety of the exhibit. (Px11).

The weekly wage Petitioner would currently be earning in the full performance of his job as a Driver-Sales Representative for the Respondent can be calculated using the current prevailing wage of $29.45 per hour and the mileage rates of $.697 and $.677. The Arbitrator assumes, based on the evidence presented, that the Petitioner would work the same hours he worked and drive the same mileage he drove in the year before the accident. The checks from Respondent covering the periods between 9/14/14 and 9/12/15 provide this information. These are the same periods used in calculating the average weekly wage. This allows the Arbitrator to factor in the times where Petitioner only pulled doubles and ran a different route than Gary, IN to Sandusky, OH. If Petitioner had returned to work for the Respondent as a Driver-Sales Representative, he would currently be earning $2,006.04 per week.

MedVoc (Julie Bose) prepared an LMS that indicated Petitioner could expect to earn $12.58 per hour using the restrictions used by Dr. Wehner, the FCE, and the work conditioning note from 3/16/18. Interestingly, MedVoc's LMS utilizing the more significant restrictions of Dr. Lim, indicated that Petitioner could expect to earn $12.85 per hour, or $514.00/week (assuming a 40-hour work week). Counselor Blumenthal did not prepare an LMS, as he recommended vocational assistance, but ultimately reached the same conclusion as Ms. Bose that Petitioner is employable. Following his meetings with the counselors and his self-directed job search, Petitioner testified that he believes he can find a job on his own without vocational rehabilitation. This appears to be a reasonable determination on his part given his experience and current age. By doing so, he is not arguing that he is permanently and totally disabled pursuant to the Act. The Arbitrator finds and concludes that Petitioner is capable of finding suitable employment at the rate of $12.85 per hour.

The Arbitrator calculates the wage differential award as follows:

$2,006.04 - $514.00 ($12.85 x 40) = $1,492.04
$1,402.94 x 66-2/3% = $994.69

The Petitioner is entitled to $994.69 per week pursuant to Section 8(d)1 of the Act. The Arbitrator notes the Petitioner was 55 years old at the time of the 9/16/15 accident and 59 years old as of the 11/20/18 arbitration hearing (see Arbx1). As such, the award for wage differential benefits shall be effective through Petitioner's 67th birthday (if living), or the date of his death, whichever is first. The wage differential benefits shall begin on 11/21/18, the day after the hearing.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC033944
Case Name	BUTLER, MARIE v. IL DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0442
Number of Pages of Decision	27
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Drew Dierkes

DATE FILED: 9/1/2021

/s/ Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIE BUTLER,

Petitioner,

vs. NO: 14 WC 33944

ILLINOIS DEPARTMENT OF TRANSPORTATION (IDOT),

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, affirms Section (C) of the Arbitrator's decision that Petitioner's accident did not arise out of or in the course of her employment.

The Commission, herein, affirms Section (N) of the Arbitrator's decision that Respondent is due credit for all medical bills it has paid in addition to any amount paid through group insurance.

All other issues are rendered moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 25, 2019 is hereby, otherwise, affirmed and adopted.

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

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

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)*.

September 1, 2021

o-8/24/21
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0442

BUTLER, MARIE
Employee/Petitioner

Case# **14WC033944**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 11/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

NOV 25 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marie Butler Case # **14 WC 33944**

Employee/Petitioner

v. Arb. Kurt Carlson - Chicago

Illinois Department of Transportation
Respondent/Employer.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the City of **Chicago**, County of **Cook**, on **May 7, 2019 and September 9, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 24, 2014**, Respondent-Employer ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$76,856**; the average weekly wage was **$1,478**.

On the date of accident, Petitioner was **49** years of age, single with **0** dependent child.

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

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

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

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

ORDER

The Arbitrator finds that Petitioner has failed to prove that she sustained an accident on September 24, 2014 that arose out of and in the course of her employment.

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her injury.

Based on the aforementioned, the Arbitrator awards no benefits.

Please see attached Proposed Finding.

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

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

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

Signature of Arbitrator

11-22-19
Date

NOV 25 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARIA BUTLER,	)	**Case No.** **14 WC 33944**
	)	**15 WC 06417**
Petitioner,	)	
	)	Chicago, Illinois
v.	)	
	)	
STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF TRANSPORTATION,	)	
	)	
Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

An Application for Adjustment of Claim was filed by Petitioner, Marie Butler, seeking relief under the Illinois Workers' Compensation Act from Respondent, Illinois Department of Transportation (hereinafter, "IDOT"). Arbitrator Kurt Carlson held a hearing on May 7, 2019 and proofs were closed on September 9, 2019 in Chicago, Illinois. Petitioner was represented by Seidman, Margulis, and Fairman, LLP and Respondent was represented by the Illinois Attorney General's Office.

FINDINGS OF FACT

Petitioner's Testimony

Petitioner had been employed as a technical manager for six years and ten months. R. at 10-11. Within that position, Petitioner's role assisted Bureau Chief Jim Sterr analyze workers' compensation claims for IDOT's District 1. R. at 11.

June 5, 2014 Incident

On June 5, 2014, Petitioner lifted a box she thought contained office supplies, but rather contained files. R. at 12. This file box weighed between 20 to 30 pounds. *Id.* As a result, Petitioner felt a pull in her lower back. *Id.* After this occurred, Petitioner notified Chief Sterr via telephone. R. at 13.

September 24, 2014 Incident

On September 24, 2014, Petitioner had a meeting with her attorney and IDOT related to her EEOC claim. R. at 76. Petitioner walked her attorney out to his car. *Id.* When she was returning to the building and approximately 20 feet from the door of District 1, she stumbled on broken concrete. R. at 17. In an attempt to not fall and expose herself due to her dress, Petitioner twisted her back "like a pretzel." R. at 16. Petitioner did not fall to the ground. R. at 42. After this incident, Petitioner noticed her shoes were ripped, she composed herself in the bathroom, and called Chief Sterr. R. at 18.

Petitioner's Termination

On August 22, 2014, Petitioner was notified that she was being laid off on September 30, 2014. R. at 60-61. On September 30, 2014, Petitioner was laid off. R. at 20. While Petitioner acknowledges that 58 other staff assistants were also laid off at the same time, Petitioner testified that she was terminated as retaliation because she had workers' compensation claims. R. at 64. Petitioner filed her workers' compensation claims on October 6, 2014 and February 26, 2015.

Medical Treatment

The first medical record Petitioner claims is related to the accident is a physical therapy record from June 12, 2014. Px 4. This record does not mention Petitioner's June 5, 2014

accident. *Id.* On June 27, 2014, Petitioner told her physical therapist at Advocate South Suburban that her pain was related to her commute. *Id.* On July 1, 2014, Petitioner attended physical therapy and reported that she had a recent flair up again due to her commute. *Id.* On August 27, 2014, Petitioner was discharged from physical therapy due to lack of attendance. *Id.* None of these physical therapy records mention Petitioner injuring herself while lifting a box or a June 5, 2014 date of injury. *Id.*

On September 24, 2014, Petitioner went to Advocate Medical Group ("AMG") where she stated that she was walking back in from work when her left foot caught the open sidewalk. Px 2 at 7. Petitioner hurt her left ankle and back. *Id.* Petitioner characterized her pain as radiating from the lower region of her spine to the top of her head. *Id.* A cervical spine x-ray showed no fracture or acute bony pathology, but was suspicious of muscle spasm. *Id.* at 5. Petitioner's lumbar x-ray was normal. *Id.* at 6. Petitioner was diagnosed with muscle spasms of the neck and back pain. *Id.* at 9.

On September 26, 2014, Petitioner reported to her physician that she had radiating lower back pain that started gradually. Px 1 at 77. Dr. Imlach diagnosed Petitioner with lumbar spondylosis and lumbar radiculopathy. *Id.* at 79. He prescribed pain mediation, muscle relaxers, and a lumbar MRI. *Id.* Dr. Imlach's records do not show that Petitioner had tripped on the sidewalk. On October 9, 2014, Petitioner's lumbar MRI showed mild central canal stenosis at the L3-4 and L4-5 levels. Px 4.

On October 16, 2014, Dr. Imlach counseled Petitioner about her depressive symptoms and how these could be related to her back symptoms. Px 1 at 74. Petitioner was instructed to properly treat her depression. *Id.* On November 25, 2014, Petitioner followed up with Dr.

Imlach about her back pain. *Id.* at 62. Petitioner told Dr. Imlach that she was taking her prescription medication inconsistently. *Id.*

On April 14, 2015, Petitioner saw Dr. Imlach for her thyroid problem and her carpal tunnel syndrome. *Id.* at 59. She briefly mentioned back pain. *Id.* On April 25, 2015, Petitioner returned to receive medication refills and an injection for her left wrist. *Id.* at 52. On April 28, 2015, Petitioner underwent an EMG study that was negative. Px 4.

On August 11, 2015, Petitioner complained of back pain to Dr. Imlach and stated that this pain had been ongoing since her 2009 car collision. Px 1 at 47. Petitioner alleged her symptoms worsened in May 2014 when she was transferred to a different work site and in September 2014 when she fell. *Id.* In this patient history, Petitioner does not mention a back injury from lifting a heavy box in a storage room. *Id.* Dr. Imlach determined that her back pain was related to her depression and discontinuation of fluoxetine. *Id.* at 50.

Petitioner attended a physical therapy evaluation on June 5, 2015. Px 4. But, on July 20, 2015, Petitioner was discharged. *Id.* On September 8, 2015, Petitioner attended physical therapy at Advocate South Suburban. *Id.* Petitioner reported being in two major car collisions, one in 1996 and one in 2009. *Id.* On November 6, 2015, Petitioner was discharged again from physical therapy due to poor attendance. *Id.* She only attended two physical therapy sessions. *Id.*

On March 1, 2016, Petitioner told Dr. Imlach that her back flared up and that she felt sad, cried frequently, and had lost of interest in social activities. Px 1 at 43. Dr. Imlach found Petitioner had chronic back pain and depression. *Id.* at 46.

On June 21, 2016, Petitioner presented to the emergency room at Advocate South Suburban with a complaint of low back pain that radiated down into her right buttock and right hip. Px 4. Petitioner stated that she woke up at approximately 3 a.m. with this pain. *Id.* The ER

physician diagnosed her with low back pain with right-sided sciatica. *Id.* Petitioner's x-ray demonstrated a levoconvex curvature with lumbar spondylosis. *Id.*

On June 22, 2016, Petitioner presented to Dr. Imlach. Px 1 at 39. She woke up with a new onset of sharp pain in her lower back. *Id.* Petitioner described this pain as radiating down the sides of her legs into her feet. *Id.* Petitioner believed this pain was different than before since it was in her joints. *Id.*

On July 6, 2016, Dr. Imlach reviewed Petitioner's x-rays, which showed a narrowing of the spinal canal at L4, L5, and S1. *Id.* at 34. Petitioner described her pain as an "electric shock" and "burning." *Id.* Petitioner was told to undergo a repeat MRI and to see a neurosurgeon. *Id.* at 37. Petitioner did not follow up with this treatment.

On January 12, 2017, Petitioner returned to Dr. Imlach and reported that she had been in a second motor vehicle collision on December 16, 2016. Px 1 at 29. Since that accident, Petitioner had pain in her neck that radiated into her shoulders and arms. *Id.* Petitioner also had increased pain in her lower back that extended into her legs. *Id.* Dr. Imlach diagnosed Petitioner with cervical and lumbar strains and ordered MRIs of Petitioner's lumbar and cervical spine. *Id.* at 33.

Petitioner's lumbar MRI from January 24, 2017 showed mild degenerative changes and slight left neural foramina narrowing at L4-L5. *Id.* at 19. Overall, there was no significant change from her prior MRI. *Id.* Likewise, Petitioner's cervical MRI from the same date showed degenerative changes. *Id.* at 22. Petitioner's CT Scan of her brain was normal. *Id.* at 23.

On February 2, 2017, Petitioner reported to Dr. Imlach that her radicular symptoms were nearly resolved, but she now had generalized back pain. Px 1 at 13. Dr. Imlach cleared

Petitioner to drive, but deferred further treatment decisions to Dr. Chavez, Petitioner's neurosurgeon who treated her in 2008. *Id.*

On February 22, 2017, Petitioner followed up with Dr. Imlach after a neurosurgical evaluation with Dr. Chavez. *Id.* at 6. Dr. Chavez had found that Petitioner's symptoms were from soft tissue injuries and that surgical intervention was not needed. *Id.* Dr. Imlach diagnosed Petitioner with lumbar and cervical strains. *Id.* at 8. He recommended Petitioner begin physical therapy. *Id.*

On March 7, 2017, Petitioner attended physical therapy at Advocate South Suburban where she reported that she was involved in a car collision on December 16, 2016. Px 4. Physical Therapist Melissa Naegele found that Petitioner's reported and observable symptoms did not correlate with her referring diagnosis. *Id.* As such, Petitioner was discharged from physical therapy. *Id.*

On October 17, 2017, Petitioner went to an outpatient pain clinic at Advocate South Suburban. *Id.* Petitioner told Dr. Gastevski that while she was lifting heavy files at work she noticed a gradual extension of her low back and neck pain. *Id.* Dr. Gastevski diagnosed Petitioner with myofascial cervical, thoracic, and lumbar pain as well as asymptomatic minor foraminal narrowing in the cervical and lumbar spine. *Id.* He pointed out that Petitioner does not have a significant disk bulge or facet issue that could be causing her problem. *Id.* Dr. Gastevski opined that the majority of Petitioner's symptoms were caused by muscle pain and her overall level of inactivity. *Id.*

Nature and Extent

Prior to her June 5, 2014 injury, Petitioner had a preexisting lower back pain resulting from a motor vehicle collision that occurred in 2009. R. at 14. On April 2, 2009, Petitioner was

traveling at 50 miles per hour when she crashed in a concrete median wall. R. at 29. Petitioner's airbags deployed and Petitioner went to the hospital. R. at 30. Petitioner received facet injections in 2009 and 2010 for her back injury caused by this car collision. R. at 14. Petitioner admitted she was still receiving treatment for her back injury up until the June 2014 workplace injury. R. at 31. Additionally, Petitioner treated with Dr. Imlach at Advocate Medical Group for her back pain up until June 2014. *Id.* Petitioner testified that her back pain was worse after her June 2014 accident. R. 14-15.

On June 2, 2014, Petitioner's back pain was so severe that she requested an ADA accommodation to switch work locations from Schaumberg to Chicago because her commute was allegedly aggravating her back pain. R. at 31-32.

On December 16, 2016, Petitioner was involved in another motor vehicle collision while working as a Lyft driver. R. at 64. Petitioner was traveling on the Kennedy Expressway at approximately 40 miles per hour when she was rear-ended by another vehicle traveling approximately 60 miles per hour. R. at 65. As a result of this accident, Petitioner injured her back and neck and the pain extended into her legs. R. at 65-66. Petitioner was still experiencing lower back pain prior to her December 2016 car accident. R. at 26.

Currently, Petitioner has difficulty standing up and sitting down for extended periods of time. R. at 27. She has prescriptions for cyclobenzaprine, tramadol, and lidocaine patches. R. at 27.

Testimony of Bureau Chief James Sterr

James Sterr testified that he has worked for IDOT for 44 years. R. at 80. He has been the Bureau Chief of Claims for 20 years. R. at 78. As part of his job duties, Chief Sterr handles a

broad range of issues for IDOT including mechanic's liens, litigation defense, contract disputes, and workers' compensation matters. R. at 79.

In April 2014, Petitioner starting working for Chief Sterr's department as a staff assistant, but Chief Sterr was hoping to create a workers' compensation risk manager position for Petitioner. R. at 80. Chief Sterr testified that Petitioner received training from District 1, from his office, and from Tristar. R. at 81. Petitioner job was to investigate workers' compensation claims. R. at 82. Petitioner's job duties consisted of ensuring that accident reports, witness statements, and supervisory statements were completed. *Id.* She was instructed to make sure that IDOT had whatever it needed to allow employees to proceed with their claims or, conversely, investigate suspect claims. *Id.* In order to investigate claims, Petitioner was instructed to secure photographs, video footage, and witness statements. R. at 83. Chief Sterr was Petitioner's supervisor from April 14, 2014 until September 30, 2014. *Id.*

Chief Sterr testified that Petitioner was laid off on September 30, 2014 along with about 57 other staff assistants. R. at 58. Three staff assistants, including Petitioner, were not in the collective bargaining unit so they were terminated. R. at 86. 55 of the staff assistants were in the collective bargaining unit. *Id.* Approximately 30 of those staff assistants were eventually laid off as well. *Id.* These layoffs were due to an Office of the Inspector General Report that found IDOT was hiring individuals into staff assistant positions without interviews, job descriptions, or Central Management Service approval for allegedly political or policy-making (*Rutan* exempt) jobs when the actual positions were apolitical (*Rutan* covered). *See* Rx 5 and 6. Chief Sterr testified that Petitioner was not laid off because of her workers' compensation claim. R. at 91.

On September 25, 2014, Chief Sterr received an email from Petitioner that she had tripped the day before and that she was leaving work because she was sore. Rx 1. Once he

received this email, Chief Sterr ensured that the workers' compensation process was started and that Petitioner had the proper paperwork. R. at 93. In addition, Chief Sterr investigated as to whether there were cameras in the vicinity of Petitioner's fall. *Id.* However, the security camera for the main entrance was broken. R. at 95-96. Petitioner was aware that the camera for the front of the building was nonoperational and had previously made Chief Sterr aware of that fact weeks before the accident. R. at 96.

With regards to Petitioner's alleged June 5, 2014, Chief Sterr was never notified by Petitioner that she incurred a workplace injury. R. at 97. Petitioner never called or emailed Chief Sterr regarding her June 5, 2014 accident. R. at 97-99. Chief Sterr was not notified by Petitioner that she injured herself when she picked up a box in a supply room. R. at 98. Moreover, lifting boxes is not part of Petitioner's job duties. *Id.* The first time Chief Sterr was notified that Petitioner was potentially injured at work on June 5, 2014 was by the Attorney General's Office, who requested information about the claim; however, no IDOT file existed because the injury had not been reported. *Id.*

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Com'n*, 201 Ill. 2d 187, 194, 775 N.E.2d 908, 912 (2002). There are three general types of risks to which an employee may be exposed:

1) risks that are distinctly associated with the employment, 2) risks that are personal to the employee, and 3) neutral risks that do not have any particular employment or personal characteristic. *Potenzo v. Ill. Workers' Comp. Comm'n*, 378 Ill. App. 3d 113, 881 N.E.2d 523 (1st Dist. 2007). However, an injury is only accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Elayyan v. Indep. Mech. Indus, Inc.*, No. 09-WC-37192 (Dec. 10, 2014) (citing *Riteway Plumbing v. Indus. Comm'n*, 67 Ill. 2d 404, 367 N.E.2d 1294 (1977)); *Matthiessen & Hegeler Zinc Co. v. Indus. Bd.*, 284 Ill. 378, 383, 120 N.E. 249, 251 (1918).

June 5, 2014 Incident

The Arbitrator finds that Petitioner's June 5, 2014 injury did not occur. Petitioner testified that she injured her back when she picked up a heavy box in the storage room. The Arbitrator notes that Petitioner never told her any medical providers that she had injured her back picking up boxes until October 17, 2017, more than three years later. Petitioner never told Respondent about this accident, but rather Respondent only learned about this claim after it was filed with the Commission (*See* Section F for a detailed notice analysis). Chief Sterr testified that he had no idea why Petitioner would be lifting a heavy box since it was not in her job duties.

All of Petitioner's physical therapy records around the alleged June 5, 2014 accident point to Petitioner's commute as the source of her back pain. According to the Notice of Dismissal, a Primary Care Note from June 6, 2014 states that Petitioner continued to experience severe pain in her neck and upper shoulders, and was currently suffering from muscle spasms related to her daily commute. Rx 6. This is corroborated by the fact that Petitioner had requested to work out of the Thompson Center part of the week as an accommodation due to her

"back disability" just three days prior to her workplace accident. It should be noted that Respondent attempted to accommodate Petitioner's request for an ergonomic chair; however, Petitioner failed to follow up and specify which chair her doctor had recommended. Rx 7. The evidence only supports the conclusion that Petitioner had ongoing back pain from a prior motor vehicle collision that was aggravated by her commute. It was not until longer after Petitioner was let go that she first mentions a new date and mechanism of injury.

Accordingly, the Arbitrator finds that Petitioner's June 5, 2014 accident did not arise out of or in the course of her employment.

September 24, 2014 Incident

The Arbitrator finds that Petitioner's September 24, 2014 accident did not arise out of or in the course of Petitioner's employment. At the time of the accident, Petitioner was walking back into the office after walking her attorney to his car. Petitioner and her attorney had just met with IDOT due to Petitioner's EEOC allegations. The issue of whether an employee's injury arises out their employment as a result of work-related litigation is similar to cases that pertain to union activities. In those cases, the Illinois Supreme Court has found that Petitioner's must show that the union activity benefits the employer. *Schultheis v. Indus. Com'n*, 96 Ill. 2d 340, 348, 449 N.E.2d 1341, 1345 (1983). In this case, although Petitioner was clocked in and on the premises, Petitioner's injury did not arise out of her employment as actively pursuing litigation against one's employer is not in furtherance of one's employment. Conversely, Petitioner's EEOC discrimination claim engaged Respondent in an adversarial process at which both sides operated at arm's length as evident by the presence of Petitioner's attorney. Respondent did not benefit being required to defend itself from the Petitioner's accusations of discrimination.

In addition, Petitioner's lack of credibility calls into question whether this accident occurred. Recognizing that Petitioner has already filed a claim for an accident that did not occur and was not reported, Petitioner's claim stemming from her September 24, 2014 accident is questionable as well. It is highly suspect that Petitioner's injury occurred six days before she knew she was going to be laid off and occurred in an area where she knew the surveillance cameras were disabled. Petitioner testified that she called Chief Sterr after this accident occurred even though the email she sent the next day makes no mention of this phone call. Chief Sterr also denied that Petitioner ever made this phone call. Despite Petitioner's training in investigating workers' compensation, she failed to take any pictures of the alleged defect. All of these details together lead the Arbitrator to conclude Petitioner's testimony is not credible.

Petitioner actively worked against the advice of her own medical providers. Dr. Imlach noted that she did not take her medication as prescribed. Petitioner was also discharged from physical therapy on three separate occasions for noncompliance and one time because her objective symptoms did not match her subjective complaints.

Petitioner is a disgruntled ex-employee. She has filed claims against IDOT at the EEOC and Illinois Department of Human Rights. Petitioner's Employee Leave Balance Report (Rx 4) shows that Petitioner barely reported for work. She consistently and frequently missed work for hours and days at a time under various excuses. At hearing, she alleged that Respondent discharged her in retaliation for filing workers' compensation claims. This is impossible: Petitioner never even reported her June 5, 2014 accident and she was told prior to her alleged September 24, 2014 accident that she would be laid off. In contrast, Respondent presented ample evidence that Petitioner's employment was terminated based on the OEIG investigation

and report. Even Petitioner acknowledged that she was not the only staff assistant terminated. As Chief Sterr testified, many of those staff assistants were terminated as well.

Based on the aforementioned, the Arbitrator finds that Petitioner's accident did not arise out of or in the course of her employment.

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

Pursuant to the Illinois Workers' Compensation Act, "notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. 820 ILCS 305/6c (2012). As set forth in *Ristow*, "Section 6(c) explicitly provides that no proceeding can be maintained unless the employer has been given notice of accident within the statutory period. *Ristow v. Indus. Comm'n*, 39 Ill. 2d 410, 414, 235 N.E.2d 617 (1968). As in other statutes of limitation there is a *conclusive presumption* that the employer has been prejudiced by the failure to notify." *Id.* (emphasis added).

June 5, 2014 Incident

The Arbitrator finds that Petitioner did not notify Responder regarding her June 5, 2014 accident and that Respondent was prejudiced. While Petitioner testified that she called her supervisor, Chief Sterr, on the date of the accident, Petitioner never filed out a notice of injury form. She could not remember if she called the 1-800 number to report her injury, as all State employees are instructed to do, and could not remember if she sent an email to Chief Sterr. Chief Sterr, testified that he never received a phone call or email from Petitioner regarding this injury. Instead the first time Chief Sterr learned about this accident was months after it occurred from the Attorney General's Office.

Petitioner is well versed in workers' compensation claim handling and the reporting requirements. Unlike the typical employee, Petitioner worked as a risk manager or liaison

between Tristar and IDOT for workers' compensation claims. Petitioner's job duties consisted of monitoring and investigating workers' compensation claims. She knew what documents, including Illinois Form 45s and Employee Notice of Injury forms, were needed when a State employee reported an injury. Petitioner knew State employees were supposed to call the 1-800 number to report their injuries. In fact, Petitioner personally handled these documents in order to investigate and analyze workers' compensation claims in District 1. Petitioner knew that injured employees are required to report their injuries within 45 days.

Had Petitioner reported her injury in a timely matter, Chief Sterr would have taken the same steps he did when Petitioner filed her September 24, 2014 injury. Once Petitioner had sent Chief Sterr an email on September 25, 2014, Chief Sterr called District 1, made sure the proper paperwork was filed out, and investigated Petitioner's claim. None of this was done for Petitioner's June 5, 2014 accident. In fact, Chief Sterr stated that his office did not have a file for this claim when the Attorney General's Office requested information on it.

Because Petitioner never notified Respondent of her June 5, 2014 injury, Respondent was prejudiced. Respondent was unable to investigate Petitioner's claim. Chief Sterr was unable to talk to potential witnesses, look for video footage, or take any other additional investigative steps. Accordingly, the Arbitrator finds that Petitioner did not provide timely notice for her workplace injury that allegedly occurred on June 5, 2014.

September 24, 2014 Incident

The Arbitrator finds that Petitioner presented sufficient, credible evidence that she provided notice for her September 24, 2014 injury based on the testimony of Petitioner, Chief Sterr's testimony, Petitioner's email to Chief Sterr, and the Employee Notice of Injury form.

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

The Arbitrator finds that Petitioner condition is not causally connected to her workplace injury.

June 5, 2014 Incident

The Arbitrator finds that no medical evidence supports that Petitioner's alleged June 5, 2014 accident caused, aggravated, or accelerated Petitioner's preexisting back disability. While Petitioner testified that her back pain was worse after this alleged incident, the physical therapy records in closest temporal proximity do not mention that Petitioner suffered back pain because she lifted a heavy box. Instead, these records reflect that Petitioner's lengthy commute was the source of her increased back pain. There is no mention of Petitioner's June 5, 2014 incident in any medical records until 2017. Accordingly, the Arbitrator gives the medical records a greater weight than Petitioner's testimony.

September 24, 2014 Incident

The Arbitrator finds that no medical evidence supports that Petitioner's September 24, 2014 accident caused, aggravated, or accelerated Petitioner's preexisting back disability. Petitioner did report back pain the date of the accident; however, Dr. Imlach related Petitioner's back pain to her depression. Petitioner was already seeing Dr. Imlach for her preexisting back condition. Moreover, Petitioner's course of treatment did not change after this alleged accident occurred.

Petitioner's current condition is not causally related to her alleged workplace accidents. Petitioner suffered an independent intervening accident after September 24, 2014 to the same body part. On December 16, 2016, Petitioner was rear-ended in a motor vehicle accident while working as a Lyft driver. This case is very similar to *National Freight Industries* where a motor

vehicle accident was found to be an independent intervening cause since petitioner's symptoms worsened after the car accident. *Nat'l Freight Indus. v. Ill. Workers' Comp. Com'n*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473, 483-84 (2013). But-for Petitioner's motor vehicle accident, Petitioner would not have sought treatment from a neurologist. Petitioner had not sought treatment for her alleged work accident since 2015. Instead, Petitioner had returned to work as a Lyft driver. Because of this motor vehicle accident, the Arbitrator finds that Petitioner's current condition is not causally connected.

K. What temporary benefits are in dispute?

The Arbitrator has already found Petitioner's accidents did not arise out of and in the course of her employment, Petitioner did not give timely notice of her June 5, 2014 accident, and Petitioner's current condition of ill-being is not causally related to the injury. Thus, no temporary benefits are awarded and the Arbitrator makes no finding in regard to the temporary benefits.

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

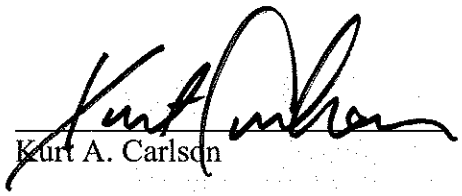
The Arbitrator has already found Petitioner's accident did not arise out of and in the course of her employment, Petitioner did not give timely notice of her June 5, 2014 accident, and Petitioner's current condition of ill-being is not causally related to the injury. Thus, no benefits are awarded and the Arbitrator makes no finding in regard to the nature and extent of Petitioner's alleged injury.

N. Is Respondent due any credit?

The Arbitrator concludes that group insurance, for which the employer contributed payments, has paid a portion of the medical bills. The amount paid by group medical is to be determined; therefore, Respondent receives a credit for those payments and is ordered to hold

Petitioner harmless in the event the company health insurance seeks reimbursement for those expenses.

Therefore, this Arbitrator finds that Respondent is due a credit for all medical bills it has paid in addition to any amount paid through group insurance.



Kurt A. Carlson

November 22, 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC021443
Case Name	SHAW, AARON v. IL DEPT OF CORRECTIONS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0443
Number of Pages of Decision	12
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Nicole Werner

DATE FILED: 9/3/2021

/s/Christopher Harris, 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

AARON SHAW,

Petitioner,

vs. NO: 18 WC 21443

STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF CORRECTIONS/CENTRALIA CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective treatment, and if applicable, the date Petitioner's condition reached maximum medical improvement (MMI) and the amount of permanent partial disability (PPD) benefits if at MMI, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 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.

September 3, 2021

CAH/pm
D: 9/2/2021
052

Christopher A. Harris
Christopher A. Harris

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

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

21IWCC0443

SHAW, AARON
Employee/Petitioner

Case# **18WC021443**

ST OF IL/IL DEPT OF CORRECTIONS/CENTRALIA CORRETIONAL CENTER
Employer/Respondent

On 2/4/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1580 BECKER SCHROADER & CHAPMAN PC
NATHAN BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

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

FEB - 4 2021

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Aaron Shaw
Employee/Petitioner

v.

State of Illinois/Illinois Department of Corrections/ Centralia Correctional Center
Employer/Respondent

Case # **18** WC **21443**

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 **Herrin**, on **11/12/2020**. 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] 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. [x] Other **Maximum Medical Improvement date, nature & extent if not at MMI**

FINDINGS

On the date of accident, **3/1/2018**, 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 $**79,488.00**; the average weekly wage was $**1,528.62**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **2** dependent children.

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

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit 11, directly to the medical providers, pursuant to the medical fee schedule, 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 and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. McIntosh, including, but not limited to, a left ulnar nerve decompression.

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

1/27/21
Date

ICArbDec19(b)

FEB 4 - 2021

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

AARON SHAW,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	**Case. No. 18-WC-21443**
	)	
STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF CORRECTIONS/ CENTRALIA CORRECTIONAL CENTER,	)	
	)	
Employer/Respondent.		

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Herrin on November 12, 2020. The issues in dispute are causal connection, medical bills, and prospective medical care with regard to Petitioner's left elbow, maximum medical improvement date, and the nature and extent of Petitioner's injuries if Petitioner is found to have reached MMI. All other issues have been stipulated.

The parties stipulate that on March 1, 2018 Petitioner sustained injuries to his left wrist as the result of an automobile accident involving a deer. The parties stipulate that Petitioner developed traumatic left carpal tunnel syndrome for which he received conservative treatment and surgery. Respondent agrees to pay all reasonable and necessary medical bills and temporary total disability benefits related to Petitioner's left hand. At Arbitration, Petitioner motioned to amend the Application for Adjustment of Claim to include Petitioner's left wrist, thumb, hand, and arm. Respondent had no objection to said motion to amend and the Arbitrator granted Petitioner's motion.

TESTIMONY

Petitioner was 47 years old, married, with two dependent children at the time of the accident. Petitioner testified he has been employed by Respondent for 25 years and has held the position of Senior Correctional Parole Agent since 2017. Petitioner testified that on 3/1/18 he was involved in an automobile accident when he struck a deer causing the driver's airbag to deploy. The airbag bent his left thumb back to his wrist causing an imprint of his wristwatch on the base of his thumb. Petitioner suffered bruising, swelling, pain, numbness, and tingling in his left thumb and hand.

Petitioner testified he sought treatment at SSM Express Care at Respondent's facility. He ultimately underwent a left carpal tunnel release on 1/30/19 performed by Dr. Jeffrey McIntosh. Despite surgery, Petitioner has constant numbness in his left middle, ring, and small fingers. He experiences shooting pain up his arm with gripping, particularly when driving. He did not have any of these symptoms prior to his accident on 3/1/18.

Petitioner testified he wants to undergo a left cubital tunnel surgery as recommended by Dr. McIntosh to alleviate his pain. He is currently working full duty since being released by Dr. McIntosh following his carpal tunnel surgery and is performing his job duties satisfactorily. He last saw Dr. McIntosh on 8/20/19 and he has not returned for treatment on his left wrist since that date. Petitioner takes over-the-counter Ibuprofen on a daily basis and Voltaren pills. He occasionally wears an over-the-counter driving impact glove. He takes medication for high blood pressure and pre-diabetes.

MEDICAL HISTORY

Petitioner sought medical treatment at SSM Express Care/SSM Health *at Work*, in Centralia, Illinois on the day of the accident. On 3/8/18, Petitioner returned to SSM Express Care with improved swelling and persistent numbness in his hand and first three digits of his left hand. Petitioner was instructed to follow up in 1-2 weeks if the numbness continued.

On 4/23/18, Petitioner's primary care doctor, Dr. James Schutzenhofer, ordered an EMG/NCS that revealed mild to moderate left carpal tunnel syndrome and possible left mild ulnar neuropathy. Petitioner was referred to orthopedic surgeon, Dr. Jeffrey McIntosh, who recommended physical therapy and splinting. Petitioner began physical therapy at Salem Township Hospital on 7/16/18 where it was noted he experienced numbness and tingling and a dull ache in the left hand/wrist that was progressing into his 4th and 5th digits. Petitioner's symptoms did not improve with conservative treatment and he underwent a left carpal tunnel decompression on 1/30/19.

On 2/20/19, Dr. McIntosh documented the numbness in Petitioner's left thumb, index, and middle fingers had improved, but the numbness in the left ring and small fingers persisted. Dr. McIntosh initiated physical therapy to address cubital tunnel at the left elbow. Conservative treatment did not resolve Petitioner's left cubital tunnel symptoms and Dr. McIntosh recommended a left cubital tunnel decompression.

Petitioner was examined by Dr. Richard Howard pursuant to Section 12 of the Act on 10/18/18 and 5/16/19. Dr. Howard opined that Petitioner's carpal tunnel syndrome was related to the 3/1/18 car accident, and that the left carpal tunnel decompression was reasonable and necessary. Dr. Howard testified Petitioner had complaints and a physical examination consistent with cubital tunnel, but he felt Petitioner needed a second EMG/NCS. On 7/29/19, Petitioner underwent a second EMG/NCS that revealed some sensory distal latency.

Dr. Howard testified via evidence deposition on 8/24/20. Dr. Howard testified he reviewed records from SSM Express, Dr. James Schutzenhofer's office note dated 4/23/18, an

NCS/EMG dated 4/27/18, and an MRI dated 8/14/18. Dr. Howard testified the MRI did not show evidence of significant trauma and some arthritic changes of the thumb joint. He testified the EMG showed mild to moderate left carpal tunnel syndrome. He diagnosed left carpal tunnel syndrome and a sprain of the left thumb. Dr. Howard performed a second physical examination of Petitioner on 5/18/19 following his carpal tunnel release. Dr. Howard testified Petitioner had full range of motion of the elbows and tenderness around the posterior aspect of his elbow. Petitioner complained of numbness and tingling radiating into his hand, with tapping around the posterior elbow, forearm, and upper arm. Petitioner had reproduction of numbness and tingling into his hand when his elbow was held at a flexed position for a period of time. Petitioner complained of increased numbness in his ring and small finger compared to his initial examination. Dr. Howard testified that Petitioner exhibited dramatic tenderness around the ulnar nerve but he did not have motor changes, such as loss of strength, intrinsic weakness or other signs of nerve dysfunction, which would be present in a patient with the degree of numbness Petitioner alleged. Dr. Howard noted a little bit of symptom magnification and opined that Petitioner's symptoms of numbness were not consistent with the previous EMG that did not show an ulnar nerve problem. Dr. Howard testified the repeat EMG did not indicate any significant ulnar nerve lesion and his measures of the nerve were within normal limits. Dr. Howard opined that Petitioner did not require additional treatment, he reached maximum medical improvement, and he could return to full duty work.

On cross-examination, Dr. Howard testified that after conducting a second physical examination on 5/16/19, Petitioner had clinical findings suggestive of cubital tunnel syndrome, which is why he recommended a second EMG. He testified that if Petitioner does have cubital tunnel syndrome, surgery would be necessary to correct this condition. Dr. Howard testified that, if it was determined Petitioner has cubital tunnel syndrome, the automobile accident of 3/1/18 was the cause of that diagnosis, at least in part, and the need for surgery would be directly related to the accident. Dr. Howard testified that during his approximate 30 years of medical practice he has performed multiple cubital tunnel releases on individuals who had not gotten an EMG/NCS. Also, he testified he has successfully treated cubital tunnel syndrome surgically in patients who had normal EMG/NCS's.

Dr. Howard testified he reviewed medical records for dates of service 3/1/18 through 1/30/19. He had not reviewed any medical records generated by Dr. McIntosh after Petitioner's carpal tunnel surgery on 1/30/19. Dr. Howard was unaware that Dr. McIntosh reviewed the 7/9/19 EMG/NCS. He was therefore unaware that Dr. McIntosh continued to recommend cubital tunnel decompression despite the essentially normal 7/29/19 EMG/NCS. When asked if it was unreasonable for Dr. McIntosh to perform a cubital tunnel decompression on Petitioner, Dr. Howard stated, "based on my available information, I would say yes but it sounds to me like there's records I haven't seen."

Dr. Howard testified it would be reasonable for Dr. McIntosh to perform a left cubital tunnel decompression if Dr. McIntosh had performed multiple physical examinations which were consistent with cubital tunnel and showed no signs of symptom magnification. Dr. Howard testified that the 7/29/19 nerve conduction study results, on their own, would not rule out the diagnosis of cubital tunnel syndrome. Dr. Howard disputes the diagnosis of cubital tunnel syndrome on the physical examination because he believed Petitioner was exaggerating his

symptoms. Absent any concerns of symptom magnification, Dr. Howard would perform surgery on a patient with the same EMG/NCS results.

Dr. McIntosh testified via evidence deposition on 10/21/20. He testified he had personal recollection that Petitioner was complaining of numbness and tingling in the 4th and 5th digits (the ulnar distribution) on his left hand prior to the 1/30/19 carpal tunnel surgery. Dr. McIntosh admitted he did not document the ulnar distribution numbness and tingling in the medical record until after the 1/30/19 surgery. He testified he wanted to perform the cubital tunnel decompression in the same procedure as the carpal tunnel release but Respondent disputed causal connection of the cubital tunnel condition.

Dr. McIntosh testified that after the carpal tunnel surgery he examined Petitioner on four occasions through 8/20/19. At all of these visits, Petitioner had physical findings and complaints consistent with cubital tunnel syndrome. Dr. McIntosh did not see any symptom magnification or exaggeration in any of the nine office visits he had with Petitioner. Dr. McIntosh testified that Petitioner required a left ulnar nerve decompression to effectively treat the diagnosis of left cubital tunnel syndrome. Dr. McIntosh opined the automobile accident of 3/1/18 was a causative factor in the development of Petitioner's left cubital tunnel syndrome.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (K): Is Petitioner entitled to any prospective medical care?

The parties stipulate that Petitioner suffered a traumatic injury to his left wrist/hand when the airbag deployed and struck his left hand resulting in the development of carpal tunnel syndrome. Respondent has agreed to pay all reasonable and necessary medical expenses and temporary total disability benefits related to Petitioner's left carpal tunnel condition. Respondent disputes liability based on causal connection for Petitioner's left cubital tunnel syndrome.

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). A chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident is sufficient to satisfy the claimant's burden. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm'n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 37 Ill. 2d 123, 227 N.E.2d 65, 67-68, (1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

The medical evidence supports that Petitioner suffered no prior injuries or had symptoms in his left elbow/arm prior to the undisputed accidental work injury. There is no evidence that Petitioner sought treatment for his left elbow/arm or underwent any diagnostic testing prior to 3/1/18. Following Petitioner's accident, the medical evidence supports that Petitioner immediately complained of numbness in his fingers. An EMG/NCS performed on 4/27/18 revealed mildly decreased left ulnar sensory amplitudes, suggestive of left ulnar neuropathy at the elbow or wrist, with normal findings on the right. Petitioner underwent physical therapy prior to undergoing a left carpal tunnel decompression and the therapy note dated 7/16/18 states Petitioner experienced numbness and tingling and a dull ache in the left hand/wrist that was progressing into his 4th and 5th digits. Petitioner underwent the carpal tunnel decompression on 1/30/19 and Dr. McIntosh testified he wanted to perform the left cubital tunnel release at the same time but Respondent denied the claim.

On 2/20/19, Dr. McIntosh documented that the numbness in Petitioner's left ring and small fingers persisted. Dr. McIntosh initiated physical therapy to address cubital tunnel symptoms. Section 12 examiner, Dr. Richard Howard, recommended a repeat EMG/NCS that revealed some sensory distal latency. The Arbitrator is not persuaded by the opinions of Dr. Howard. Dr. Howard examined Petitioner a second time on 5/18/19 following Petitioner's carpal tunnel release and noted reproduction of numbness and tingling into Petitioner's hand when his elbow was held at a flexed position for a period of time. He stated Petitioner exhibited dramatic tenderness around the ulnar nerve that he did not have at his initial examination on 10/18/18, and he had increased numbness in his ring and small finger compared to his initial examination. Therefore, Dr. Howard opined Petitioner was magnifying his symptoms.

Dr. Howard opined that Petitioner's symptoms were not consistent with the previous EMG that did not show an ulnar nerve problem and the repeat EMG did not indicate any significant ulnar nerve lesion and his measures of the nerve were within normal limits. However, the EMG performed on 4/27/18 revealed mildly decreased left ulnar sensory amplitudes, suggestive of left ulnar neuropathy at the elbow or wrist, with normal findings on the right, and the repeat EMG revealed some sensory distal latency. Dr. Howard admitted Petitioner had clinical findings suggestive of cubital tunnel syndrome, which is why he recommended a second EMG. He testified that if Petitioner does have cubital tunnel syndrome, surgery would be reasonable and necessary and causally related to his accident of 3/1/18. Dr. Howard testified it would be reasonable for Dr. McIntosh to perform a left cubital tunnel decompression if Dr. McIntosh had performed multiple physical examinations which were consistent with cubital tunnel and showed no signs of symptom magnification. He admitted he did not review any medical records following Petitioner's carpal tunnel surgery on 1/30/19.

Dr. McIntosh did perform multiple physical examinations that were consistent with cubital tunnel syndrome. He testified Petitioner consistently complained of numbness and tingling in the 4th and 5th digits (the ulnar distribution) on his left hand prior to the 1/30/19 carpal tunnel surgery and his findings were consistent with cubital tunnel syndrome. Dr. McIntosh did not see any symptom magnification or exaggeration in any of the nine office visits he had with Petitioner. Dr. McIntosh testified that Petitioner required a left ulnar nerve decompression to effectively treat the diagnosis of left cubital tunnel syndrome and that the automobile accident of 3/1/18 was a causative factor in the development of Petitioner's left cubital tunnel syndrome.

An employee is entitled to medical care that is reasonably required to relieve the injured employee from the effects of the injury. 820 ILCS 305/8(a) (2011). 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).

Based upon the chain of events, the medical evidence, and Petitioner's credible testimony corroborated by his treating records, the Arbitrator finds that Petitioner's current condition of ill-being in his left elbow is causally connected to his work injury of 3/1/18. The Arbitrator orders Respondent to authorize and pay for the treatment recommended by Dr. McIntosh, including, but not limited to, a left ulnar nerve decompression.

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 Arbitrator's findings as to the issue of causal connection, the Arbitrator finds that Petitioner is entitled to medical expenses related to his left cubital tunnel condition. Respondent shall pay reasonable and necessary medical services directly to the medical providers, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 11, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Issue (O): **Maximum Medical Improve date and the nature and extent of the injury?**

Based upon the Arbitrator's findings as to the issues of causal connection and prospective medical care, the Arbitrator finds Petitioner has not reached maximum medical improvement with respect to his left cubital tunnel condition. Therefore, the Arbitrator finds the issue of the nature and extent of Petitioner's injuries moot and makes no findings as to this issue.

Arbitrator Linda J. Cantrell

1/27/21
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC035846
Case Name	BROWER, LISA v. CAHOKIA SD #187
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0444
Number of Pages of Decision	13
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Reed Nelson
Respondent Attorney	Michael Karr

DATE FILED: 9/3/2021

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA BROWER,

Petitioner,

vs. NO: 17 WC 35846

CAHOKIA SCHOOL DISTRICT #187,

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, temporary total disability (TTD) benefits, and prospective medical 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 October 15, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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.

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

September 3, 2021

Christopher A. Harris
Christopher A. Harris

CAH/tdm
O: 9/2/21
052

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

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

21IWCC0444

BROWER, LISA
Employee/Petitioner

Case# **17WC035846**

CAHOKIA SCHOOL DISTRICT #187
Employer/Respondent

On 10/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0384 NELSON & NELSON
REED C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

0180 EVANS & DIXON LLC
MICHAEL KARR
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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lisa Brower
Employee/Petitioner

Case # 17 WC 35846

v.

Consolidated cases: n/a

Cahokia School District #187
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 August 28, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, October 13, 2017, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $71,547.64; the average weekly wage was $1,834.55.

On the date of accident, Petitioner was 54 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $73,381.80 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $73,381.80.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 11, excepting those incurred in connection with Petitioner's cervical spine condition, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the spinal cord stimulator trial, for treatment of the lumbar spine as recommended by Dr. Matthew Gornet and Dr. Helen Blake.

Respondent shall pay Petitioner temporary total disability benefits of $1,223.03 per week for 147 weeks, commencing October 30, 2017, through August 28, 2020, as provide in Section 8(b) 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 11, 2020
Date

OCT 15 2020

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 October 13, 2017. According to the Application, Petitioner sustained the accident "during the course of employment" and sustained an injury to her "back, left knee and other injuries as noted in medical records" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated Petitioner sustained a work-related accident, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of 147 weeks, commencing October 30, 2017, through August 28, 2020 (date of trial). Respondent claimed Petitioner was entitled to temporary total disability benefits of 60 weeks, commencing October 30, 2017, through December 23, 2018. In regard to Petitioner's claim of entitlement to temporary total disability benefits through August 28, 2020, Respondent disputed liability for same on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner was employed by Respondent as a teacher and, over several years, taught several grade levels. At that time she sustained the accident, Petitioner taught fifth grade. On October 13, 2017, Petitioner observed an object on the floor of her classroom in front of a student's desk. Petitioner got on her knees to pick up the object. At that time, the student forcefully shoved the desk into Petitioner's shoulder/chest area which caused Petitioner to fall backward. Petitioner experienced immediate pain in her low back which subsequently started to go down her legs.

Petitioner sustained a prior injury to her low back in 2001 for which she was treated by Dr. Matthew Gornet, an orthopedic surgeon. On July 11, 2001, Dr. Gornet performed surgery which consisted of an L4-S1 fusion with bone grafting and metal hardware (Respondent's Exhibit 2).

Petitioner testified that after the fusion surgery she continued to have some low back symptoms and was again seen by Dr. Gornet. When Dr. Gornet saw Petitioner on July 24, 2009, she complained of low back and right leg pain. Dr. Gornet ordered an MRI scan of the lumbar spine which was performed on October 1, 2009. According to the radiologist, the MRI revealed the prior L4-S1 fusion, a retrolisthesis and disc protrusion at L3-L4 and disc protrusions at L1-L2 and L2-L3 (Respondent's Exhibit 2).

Dr. Gornet saw Petitioner on October 1, 2009, and reviewed the MRI. He opined it revealed a disc herniation at L3-L4 on the right. He ordered a series of steroid injections. When Dr. Gornet saw Petitioner on December 3, 2009, Petitioner advised the steroid injections gave her significant relief (Respondent's Exhibit 2).

Dr. Gornet again saw Petitioner on May 2, 2011. At that time, Petitioner had low back and bilateral leg pain, more on the right than left. Dr. Gornet ordered an MRI scan with and without contrast. The MRI was performed on June 20, 2011. According to the radiologist, the MRI revealed the prior fusion at L4-S1, disc bulging at L3-L4, worse on the right, a paracentral disc herniation at L1-L2, but of uncertain clinical significance because of its small size and location. Dr. Gornet last saw

Petitioner on June 20, 2011, and reviewed the MRI. He recommended Petitioner undergo injections because Petitioner had responded well to them in the past. Dr. Gornet noted he would see Petitioner in six weeks time; however, he did not see Petitioner again until June 18, 2018 (Respondent's Exhibit 2). The Arbitrator notes it was not clear whether Petitioner underwent the injections Dr. Gornet had ordered on June 20, 2011.

Medical records of Dr. Roger Cole, Petitioner's family physician, were received into evidence. Petitioner tendered Dr. Cole's records for treatment provided from November 13, 2017, through January 21, 2019 (Petitioner's Exhibit 4). Respondent tendered Dr. Cole's records for treatment provided from February 3, 2012, through November 2, 2018 (Respondent's Exhibit 3). When Dr. Cole saw Petitioner as a new patient on February 3, 2012, he noted Petitioner had a number of health issues which included chronic back pain. Prior to the accident of October 13, 2017, Dr. Cole treated Petitioner for a number of other conditions, but did not diagnose or treat Petitioner for any low back symptoms until after the accident (Petitioner's Exhibit 4; Respondent's Exhibit 3).

At trial, Petitioner testified that in December, 2014, she went to the Mayo Clinic in Arizona because of her daughter's health issues. Petitioner stated she feared she had multiple sclerosis and underwent various diagnostic tests. The records from the Mayo Clinic were not tendered into evidence at trial. However, Dr. David Robson, an orthopedic surgeon, who evaluated Petitioner on October 30, 2017, reviewed diagnostic studies performed at the Mayo Clinic on December 31, 2014. Dr. Robson reviewed MRIs of the cervical, thoracic and lumbar spine and x-rays of the cervical and lumbar spine. Dr. Robson noted there were disc bulges in all three areas of the spine as well as the presence of the prior L4-S1 fusion (Petitioner's Exhibit 2).

Subsequent to the accident of October 13, 2017, Petitioner initially sought medical treatment from Dr. Robson and, as noted herein, was seen by him on October 30, 2017. Dr. Robson opined Petitioner had a healed fusion at L4-S1 and spondylosis with retrolisthesis at L3-L4. He prescribed medication and recommended Petitioner undergo a CT scan of the lumbar spine (Petitioner's Exhibit 2).

The CT scan of Petitioner's lumbar spine was performed on November 9, 2017. According to the radiologist, the CT scan revealed a solid fusion at L4-L5 and L5-S1; an angulation at L3-L4 with foraminal height loss, disc bulge and right greater than left foraminal stenosis; and a disc bulge with angulation and left greater than right foraminal stenosis (Petitioner's Exhibit 3).

Dr. Robson saw Petitioner on November 14, 2017, and reviewed the CT scan. Dr. Robson ordered an epidural steroid injection at L3-L4 on the right (Petitioner's Exhibit 2).

On November 27, 2017, Petitioner was seen by Dr. Kaylea Boutwell, a pain management specialist. At that time, Dr. Boutwell administered an epidural steroid injection on the right at L3-L4. Dr. Boutwell subsequently saw Petitioner on January 29, 2018, and administered an epidural steroid injection on the left at L3-L4 (Petitioner's Exhibit 5).

Dr. Robson evaluated Petitioner on February 13, 2018. At that time, Petitioner advised the injections did not help and she continued to have significant low back pain. Dr. Robson opined

conservative treatment had failed and he recommended Petitioner undergo surgery consisting of a laminectomy at L2-L3 and L3-L4 and extending the fusion to L2 (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Cole on February 21, 2018. Petitioner advised Dr. Cole of the accident and that she had back pain radiating to both legs. Dr. Cole also saw Petitioner in connection with other health issues and referred Petitioner to Dr. Gornet for her low back (Petitioner's Exhibit 4).

Petitioner was evaluated by Dr. Gornet on May 7, 2018. At that time, Petitioner informed Dr. Gornet of the accident and the medical treatment she received afterward. Dr. Gornet noted he had performed surgery on Petitioner in 2001 and Petitioner had sustained an exacerbation of her low back symptoms in May, 2016, but that Petitioner had "...been working full duty and tolerating her symptoms." Petitioner also advised she had been active prior to the accident. Dr. Gornet opined Petitioner had discogenic low back pain and ordered an MRI scan of Petitioner's lumbar spine (Petitioner's Exhibit 7).

The MRI was performed on May 7, 2018. According to the radiologist, the MRI revealed the prior fusion which was solid, a bilateral disc protrusion at L3-L4, more on the right than left, and disc protrusions at L2-L3, left greater than right (Petitioner's Exhibit 6).

Dr. Gornet reviewed the MRI and compared it to the one performed on June 20, 2011. He noted there were substantial changes at L3-L4 and opined Petitioner had injured that disc. Dr. Gornet recommended aquatic therapy, but if that failed, it might be necessary to the extend Petitioner's fusion up to the L4 level [the Arbitrator notes, this may have been a typographical error]. Dr. Gornet opined Petitioner remained totally disabled and her current symptoms were causally related to the accident (Petitioner's Exhibit 7).

Dr. Gornet saw Petitioner on June 18, 2018, and reviewed a CT scan that had recently been performed (the radiologist report of that procedure was not tendered into evidence). Dr. Gornet opined Petitioner had discogenic pain at L3-L4, but was uncertain if there was any involvement of the disc at L2-L3. He ordered a CT discogram (Petitioner's Exhibit 7).

Dr. Gornet attempted to perform a discogram at L2-L3 on June 29, 2018, but could not complete the procedure because of Petitioner's significant pain complaints. He did not attempt to perform a discogram at L3-L4. When he saw Petitioner on July 26, 2018, he opined Petitioner was not a good surgical candidate. At that time, Dr. Gornet opined the only treatment option he could offer was a spinal cord stimulator and he referred Petitioner to Dr. Boutwell for an evaluation of same (Petitioner's Exhibit 7).

Dr. Boutwell evaluated Petitioner on September 29, 2018. Dr. Boutwell noted that Dr. Gornet opined Petitioner was not a surgical candidate and the only option was the possibility of a spinal cord stimulator. Dr. Boutwell agreed with Dr. Gornet's treatment recommendation (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Gornet on October 11, 2018. At that time, Dr. Gornet reaffirmed his opinion Petitioner was not a surgical candidate. He noted Dr. Boutwell had left her prior

practice, but that he could refer Petitioner back to Dr. Boutwell or Dr. Helen Blake. He ultimately referred Petitioner to Dr. Blake (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. Russell Cantrell, a physiatrist, on November 14, 2018. In connection with his examination of Petitioner, Dr. Cantrell reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Cantrell opined Petitioner had chronic lumbar spine back pain complaints which he attributed to the prior L4-S1 fusion. He also opined Petitioner was at MMI, could return to work without restrictions and no further medical treatment, including the use of a spinal cord stimulator, was indicated (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Cantrell reviewed additional medical records and prepared a supplemental report dated April 24, 2019. His opinions regarding Petitioner's condition remained the same. Further, he opined Petitioner had an AMA impairment rating of three percent (3%) of the whole person (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Blake evaluated Petitioner on July 25, 2019. Petitioner continued to have significant low back pain. Dr. Blake opined the use of a spinal cord stimulator was the best option for Petitioner. She recommended a trial use of a spinal cord stimulator (Petitioner's Exhibit 10).

When Dr. Blake saw Petitioner on December 19, 2019, she opined Petitioner was an "excellent candidate" for spinal cord stimulation and noted that prior conservative treatment had not helped Petitioner with her pain symptoms. When Dr. Blake saw Petitioner on January 30, 2020, Petitioner's low back symptoms remained the same; however, Petitioner also had cervical spine symptoms as well. Dr. Blake recommended Petitioner undergo injections in both the lumbar and cervical spine (Petitioner's Exhibit 10).

On February 12, 2020, Dr. Blake administered an epidural steroid injection at L2-L3. On March 4, 2020, Dr. Blake administered an epidural steroid injection on the right at C6-C7. On July 15, 2020, Dr. Blake administered an epidural steroid injection at L2-L3 (Petitioner's Exhibit 10).

Dr. Cantwell was deposed on May 8, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Cantrell's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Cantrell testified Petitioner had a diagnosis of chronic low back pain which was temporarily exacerbated by the injury. He based his opinion on his findings on examination and his review of the diagnostic studies. Dr. Cantrell also stated Petitioner would not benefit from a spinal cord stimulator because her back complaints were multifactorial. He explained that this was because of the prior fusion which shifted stress to other levels of the spine, Petitioner had degenerative changes and it was difficult to determine how much each contributed to her total low back presentation (Respondent's Exhibit 1; pp 24-28).

On cross-examination, Dr. Cantrell agreed that in the 19 months preceding the accident, Petitioner had not sought medical treatment for low back symptoms. Further, he agreed no one had either recommended or provided any treatment to Petitioner for low back symptoms during that period of time (Respondent's Exhibit 1; pp 51-53).

Dr. Blake was deposed on May 29, 2020, and her deposition testimony was received into evidence at trial. On direct examination, Dr. Blake's testimony was consistent with her medical records and she reaffirmed the opinions contained therein. In regard to causality, Dr. Blake testified that, given Petitioner's prior spine surgery, a temporary exacerbation of pain complaints would not be surprising. However, in this case, Petitioner's complaints since the accident in 2017 had not resolved and Petitioner had been in pain since then. Dr. Blake testified Petitioner was capable of working, but only in a very sedentary capacity (Petitioner's Exhibit 12; pp 15- 17). Dr. Blake reaffirmed her opinion that Petitioner should undergo a trial of the spinal cord stimulator. She stated a trial was reversible in the event it did not work (Petitioner's Exhibit 12; pp 13-14).

On cross-examination, Dr. Blake agreed she was not aware of what level of the back was causing Petitioner's pain symptoms. In regard to Petitioner's cervical spine complaints, she could not relate those to the accident (Petitioner's Exhibit 12; pp 22, 28-29).

At trial, Petitioner testified she has experienced constant pain since the accident and has not been able to return to work. The Petitioner has been a teacher for 30 years and stated she loves teaching fifth grade. She wants to proceed with the treatment as recommended by Dr. Blake.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of October 13, 2017.

The Arbitrator concludes Petitioner's current condition of ill-being in regard to her lumbar spine is related to the accident of October 13, 2017, but Petitioner's current condition of ill-being in regard to her cervical spine is not related to the accident of October 13, 2017.

In support of these conclusions the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on October 13, 2017.

Petitioner previously underwent lumbar fusion surgery in 2001. Dr. Gornet performed the surgery and the procedure consisted of an L4-S1 fusion with bone grafting and metal hardware.

Following the fusion surgery, Petitioner continued to experience low back pain for which she sought medical treatment. Specifically, in 2009 and 2011, Petitioner experienced exacerbations of her low back symptoms and received conservative treatment including steroid injections. However, Petitioner did not experience any further lumbar spine symptoms and was able to work as a teacher.

Petitioner underwent spinal MRIs in December, 2014, at the Mayo Clinic in Arizona; however, none of the Mayo Clinic records were received into evidence.

Both Dr. Gornet and Dr. Blake opined Petitioner's lumbar spine symptoms were related to the accident of October 13, 2017.

Respondent's Section 12 examiner, Dr. Cantrell, opined Petitioner's current lumbar spine complaints were attributable to the prior fusion surgery and he based his opinion on his findings on examination and review of diagnostic studies. However, Dr. Cantrell agreed that for a period of time prior to the accident, Petitioner had not sought medical treatment for lumbar spine complaints.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Gornet and Dr. Blake in regard to causality of Petitioner's lumbar spine condition to be more persuasive than that of Dr. Cantrell.

In regard to Petitioner's cervical spine complaints, Petitioner did not complain of any cervical spine symptoms until she was seen by Dr. Blake on December 19, 2019. Further, when Dr. Blake was deposed, she could not relate Petitioner's cervical spine complaints to the accident of October 13, 2017.

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

Based upon the Arbitrator's conclusions of law in disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith with the exception of the medical bills Petitioner incurred in connection with treatment provided to her in regard to her cervical spine condition.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 11, excepting those incurred in connection with Petitioner's cervical spine condition, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Arbitrator's conclusions of law in disputed issue (F) the Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the spinal cord stimulator trial recommended by Dr. Gornet and Dr. Blake.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 147 weeks, commencing October 30, 2017, through August 28, 2020.

In support of this conclusion the Arbitrator notes the following:

Petitioner has not been able to return to work and has been authorized to be off work by her treating physicians.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC045927
Case Name	FRENCH, GLADYS R v. SOI DEPT OF HUMAN SERVICE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0445
Number of Pages of Decision	12
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Haris Huskic
Respondent Attorney	Thomas Owen

DATE FILED: 9/3/2021

/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

GLADYS FRENCH,

Petitioner,

vs. NO: 11 WC 45927

STATE OF ILLINOIS, DEPARTMENT OF HUMAN SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of whether Petitioner sustained accidental injuries arising out of her employment, causal connection for repetitive trauma injuries to the upper extremities, whether timely notice was provided, entitlement to medical expenses, entitlement to Temporary Total Disability benefits, and entitlement to 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 10, 2020 is hereby affirmed and adopted.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

September 3, 2021

DJB/mck
O: 8/25/21
43

/s/ *Deborah J. Baker*
/s/ *Stephen Mathis*
/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0445

FRENCH, GLADYS R
Employee/Petitioner

Case# **11WC045927**

ST OF IL DEPT OF HUMAN SERVICES
Employer/Respondent

On 1/10/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2221 VRDOLYAK LAW GROUP LLC
RACHEL PETER
100 N RIVERSIDE PLZ SUITE 2400
CHICAGO, IL 60606

6928 ASSISTANT ATTORNEY GENERAL
THOMAS OWEN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JAN 10 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GLADYS R. FRENCH
Employee/Petitioner

v.

STATE OF ILLINOIS, DEPT. OF HUMAN SERVICES
Employer/Respondent

Case # **11** WC **45927**

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 **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MARCH 14, 2019**. Thereafter, Arbitrator Bocanegra left the Commission and, pursuant to the parties' agreement, the matter was reassigned to the Honorable **DOUGLAS S. STEFFENSON** to issue this Arbitration Decision. After reviewing the trial transcript and all the evidence presented at the March 14, 2019 hearing, Arbitrator Steffenson 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 15, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned $**62,948.00**; the average weekly wage was $**1,210.54**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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**.

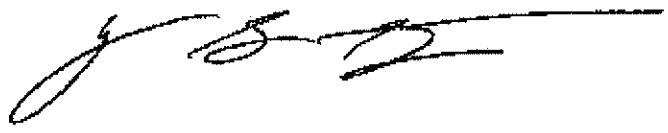
Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet her burden of proving both an accident and a causal connection between her employment and her bilateral wrist conditions. All other issues are moot. Accordingly, her claim for compensation is denied and her Application is dismissed

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

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



Signature of Arbitrator

JANUARY 10, 2020
Date

JAN 10 2020

GLADYS R. FRENCH v. STATE OF ILLINOIS, DEPARTMENT OF HUMAN SERVICES

11 WC 45927

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Bocanegra on March 14, 2019. Thereafter, Arbitrator Bocanegra left the Illinois Workers' Compensation Commission and, after the parties' agreement, this matter was reassigned to Arbitrator Steffenson to prepare this Arbitration Decision. The issues in dispute were accident, notice, causal connection, medical bills, Temporary Total Disability, 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. (Transcript at 5-6 *and* Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

Petitioner testified she had worked for various State of Illinois offices for 38.5 years, including Juvenile Parole, Adult Parole, Department of Children and Family Services, and Department of Aging. Petitioner was last hired as a Case Worker for the Department of Human Services and held the position at the time of the alleged injury. On May 31, 2011, Petitioner was 59-years-old and right-hand dominant. Petitioner worked five days a week, eight hours per day, for a total of 40 hours per week. Petitioner had one 30-minute lunch break and took one 15-minute break during the day.

Petitioner testified that she would manage a caseload of applications and determine eligibility of benefits for several public aid programs. Petitioner interviewed at least 15 applicants on any given day. Petitioner used her computer to handle the intake and update applicant information.

Petitioner testified that all her duties entailed typing with a computer. The Petitioner stated, "Everything that you filled out on a form, I had to put into a computer." (Transcript

(hereinafter, T.) at 13). In addition to inputting the applicant's information, she would type the summary and history of the case.

On cross examination, Petitioner admitted that her typing was intermittent because of her other duties. Petitioner answered phone calls from applicants with the communication often being lengthy. Petitioner would leave her station to retrieve files and she would review applications for five minutes each before entering the information on the computer. Petitioner also met with clients in person and attend office meetings once every three months.

Petitioner noticed the onset of symptoms in 2011. Petitioner testified that she began to experience symptoms of wrist pain but did not recall a specific event or time when she first noticed these symptoms. Petitioner experienced numbness and tingling while typing and retrieving case files, but she also experienced the same symptoms while sitting at home. Petitioner did not believe that typing caused her symptoms until she was later diagnosed with Carpel Tunnel Syndrome (CTS).

On June 15, 2011, Petitioner sought out medical treatment. She indicated to Dr. Timothy Putnam that she was experiencing numbness and tingling for six months. Dr. Putnam conducted an examination of the upper limbs and concluded that her injuries were consistent with bilateral CTS. Petitioner testified that she did not have any previous history of CTS or problems related to her hand.

On July 11, 2011, Petitioner completed a Workers' Compensation Employee's Notice of Injury. (Respondent's Exhibit 2). On her Notice of Injury, Petitioner described the injury as "Hand/Wrist/Arm" and wrote, "Hand and arm pain on a continuous basis..." (Respondent's Exhibit (*hereinafter*, RX) 2). Petitioner did not give further details of how the injury occurred or what duty she was performing at the time of injury. (RX 2). According to the report, Petitioner first reported the injury to her supervisor, Ms. Teil, on May 31, 2011. (*Id.*).

Dr. Putnam referred Petitioner to Dr. Orhan Kaymakcalan, who recommended surgical treatment. At Respondent's request, Petitioner was seen by Dr. Michael I. Vender on May 25, 2012 for a Section 12 Examination. Petitioner testified that she was honest in relating all her symptoms and histories to Dr. Vender. Petitioner also testified that she provided Dr. Vender with the same information that she provided the other treaters.

On February 22, 2013, Petitioner underwent surgery on her right hand and subsequently completed physical therapy before being released to return to work. Petitioner returned to work full duty and returned in the same position.

Petitioner testified that she sees a new physician, Dr. Millin. As of September 24, 2013, Petitioner was still complaining to her physician of left-hand pain, swelling and numbness, as well as complaining of her left middle finger being stuck when she flexes it. Petitioner takes Gabapentin for the nerve damage, applies a topical cream to her hands, and occasionally takes pain medication. Petitioner testified that she still feels minor pain and avoids cooking when her hands flare up. Petitioner's hands hurt and become numb faster with cold weather.

On June 1, 2011, Petitioner visited her regular physician, Dr. Vaughn Tatum, and complained of suffering serve bilateral hand wrist pain for six weeks. (Petitioner's Exhibit 4 at 3). Following that appointment, Petitioner presented to the Little Company of Mary Hospital on June 15, 2011, complaining of bilateral hand and finger pain, numbness and tingling. (Petitioner's Exhibit (*hereinafter*, PX) 1 at 5). Petitioner stated that she had experienced the symptoms for six months. (PX 1 at 5). Dr. Timothy Putnam conducted an EMG examination of the upper limbs and concluded that there was "a focal conduction abnormality of the median nerve at the wrist bilaterally", which was consistent with a bilateral severe CTS, and recommended clinical correlation. (PX 1 at 5-8).

Following that finding, Dr. Tatum prepared a letter on June 22, 2011, stating that Petitioner was being treated for severe bilateral CTS and she was not to write, type, or flex of wrists. (PX 4 at 6). On September 29, 2011, Petitioner presented to Mount Sinai Hospital and was examined by Dr. Orhan Kaymakcalan. (PX 2 at 16). Dr. Kaymakcalan recommended that the Petitioner start conservative therapy methods of splitting and physical therapy. *Id.* On the Outpatient Treatment Record, Dr. Kaymakcalan noted "EMPLOYED in CASE MGMT—SIGNIFICANT COMPUTER WORK" and approximated the computer work to be six hours. (PX 2 at 16).

From October 17, 2011 to November 17, 2011, Petitioner attended physical therapy at ATI one to two times a week as recommended by Dr. Kaymakcalan. (PX 5 at 7-8). On November 17, 2011, Dr. Kaymakcalan examined the Petitioner again. (PX 2 at 15). Dr. Kaymakcalan noted that Petitioner was not responding to the conservative therapy methods and recommended surgery, but the procedure was not yet approved by workers' compensation. (PX 2 at 15-18). In the meantime, Petitioner continued to attend physical therapy at ATI one or two times a week from November 17, 2011 to January 30, 2012. (PX 5 at 7).

At Respondent's request, Petitioner was seen by Dr. Michael I. Vender on May 25, 2012 for a Section 12 Examination. (RX 4 at 1). Dr. Vender affirmed the diagnosis of bilateral CTS and commented that Petitioner would be a candidate for surgery. (RX 4 at 2). On February 22, 2013,

Dr. Kaymakcalan obtained the necessary authorization and performed a surgery on the Petitioner to release the right carpal tunnel and the right long trigger digit. (PX 2 at 17-18). On February 26, 2013, Dr. Kaymakcalan signed a note stating that the Petitioner could not return to work for about six weeks. (PX 2 at 28).

Following surgery, Petitioner began another course of physical therapy at ATI twice a week until April 22, 2013. (PX 5 at 5). She then was discharged from physical therapy on April 22, 2013. (PX 5 at 37). Her discharge summary stated that the Petitioner had plateaued in strength, but she was to return to work and she was ready to continue with a home exercise program. (*Id.*). Thereafter, on April 28, 2013, Dr. Kaymakcalan signed a note stating that the Petitioner's job, which "may involve continuous and repetitious use of hand" is a contributing factor to her diagnosis of Right Hand CTS and Right Long Trigger Finger. (PX 2 at 26).

Dr. Vender examined Petitioner's bilateral wrists. (RX 4 at 1-2). Following his examination, Dr. Vender diagnosed Petitioner with bilateral CTS and right thumb flexor stenosing tenosynovitis. (RX 4 at 1). However, Dr. Vender opined that Petitioner's diagnosis was not a work-related condition. (RX 4 at 2). He based his opinion on written job information regarding Petitioner's job activities. (RX 4 at 2). Dr. Vender noted her work activities were not considered forceful or persistently repetitive and would not be contributory to the development of carpal tunnel syndrome. (*Id.*). He opined the Petitioner had high risk factors, including age, gender, and increased body mass index, that would be contributed to the development of CTS. Additionally, there were no activities performed with the thumb such as repeated forceful pinching that would be considered contributory to thumb flexor stenosing tenosynovitis. (*Id.*). Although Dr. Vender confirmed that Petitioner was a candidate for surgery, he further opined that Petitioner could perform her normal work activities at that time. (*Id.*).

CONCLUSIONS OF LAW

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

Issues C, D, & F: *Accident* and *Causal Connection*

It is axiomatic that a claimant, not an employer, bears the burden of proving by a preponderance of the credible evidence *all* the elements of his or her claim in order to recover

benefits under the Workers' Compensation Act. First Cash Financial Services v. Industrial Commission, 367 Ill. App. 3d. 102, 106 (2006), Illinois Bell Telephone Co. v. Industrial Commission, 265 Ill. App. 3d. 681, 685 (1994) (Emphasis added). The claimant's burden includes proving an accident that arose out of and in the course of her employment, Parro v. Industrial Commission, 167 Ill. 2d. 385, 393 (1995), and a causal connection between the accident and her condition of ill-being, Lee v. Industrial Commission, 656 N.E.2d 1084 (1995).

A claimant alleging a repetitive trauma injury must meet the same standard of proof as a claimant who alleges a sudden injury from a discrete event. Durand v. Industrial Commission, 224 Ill. 2d. 53, 64 (2006). A claimant who alleges an injury based on repetitive trauma must show that the condition is work related. Peoria County Bellwood Nursing Home v. Industrial Commission, 115 Ill. 2d. 524, 530 (1987). Liability cannot rest on imagination, speculation, or conjecture. First Cash, 367 Ill. App. 3d. at 106.

In reviewing the evidence, the Arbitrator notes the lack of testimony as the frequency, duration, or force of Petitioner's job activities. The Petitioner conflates the act of typing with overall computer usage. For example, when the Petitioner was asked how much of her duties entailed typing, she first states "All of it" before stating, "Everything we do is on that computer. For whatever various reasons I need that computer." (T. at 12-13). Petitioner did not quantify during her testimony the amount of time she spent typing, versus time she spent talking on her phone, interviewing applicants, retrieving files, or performing other tasks. While Petitioner stated that she would need to enter applicant information onto a computer, she did not testify as to the process or extent of typing involved in this data entry.

In support of her claim, Petitioner relies on the opinions of Dr. Kaymakcalan. On April 28, 2013, Dr. Kaymakcalan signed a note stating that the Petitioner's job, which "may involve continuous and repetitious use of hand" is a contributing factor to her diagnosis of Right Hand CTS and Right Long Trigger Finger. (PX 2 at 26). Dr. Kaymakcalan's letter in favor of a causal connection failed to demonstrate an accurate understanding of the Petitioner's job duties. The letter is predicated on the notion that the Petitioner's job involves a continuous and repetitious use of hand," but it does not describe a specific action or basis for his determination. The letter is noncommittal on the specific causation, as Dr. Kaymakcalan only states that the Petitioner's job may involve continuous and repetitious use of hand and the evidence does not support this presumption.

Dr. Vender's opinion is consistent with the Commission's prior findings, as well as more credible and convincing as to the issue of causation. Dr. Vender based his opinion on written job information regarding Petitioner's job activities. (RX 4 at 2). Dr. Vender opined that Petitioner's bilateral CTS was not a work-related condition. (RX 4 at 2). He opined that

Petitioner's job duties are not considered forceful or persistently repetitive and would not be contributory to the development of CTS. (*Id.*). He further opined that Petitioner has high risk factors, including age, gender, and increased body mass index, which would contribute to the development of CTS. (*Id.*).

Petitioner's claim that typing was the cause of her bilateral upper extremity CTS has been rejected by recent case law. See Ramona Davis v. Winnebago County, 14 I.W.C.C. 0609 (2014) (The Arbitrator's finding that Petitioner sustained compensable repetitive trauma injuries to her bilateral upper extremities was reversed and the Commission noted that more than "frequent" typing must be shown and other factors such as sustained hand positioning, force exerted, and duration of the continuous keyboarding should be considered.); Brandi Brooks v. Illinois-American Water, 16 I.W.C.C. 0152 (2016) (The Arbitrator's finding that Petitioner proved accident/causation of CTS was reversed and the Commission noted that it is not persuaded that work activities comprised only of substantial typing, using a computer mouse, and using a telephone with a headset significantly contributes to the development or aggravation of CTS). The Arbitrator notes that Petitioner also testified that her typing was intermittent and interspersed with other activities. Petitioner offered no testimony about any lifting, forceful gripping or grasping, or exposure to vibratory impact, which are now considered the greatest risk factors associated with occupational CTS. See Brooks, 16 I.W.C.C. 0152, 5 (2016).

Based on the evidence and testimony presented at hearing, the Arbitrator concludes that Petitioner failed both to prove that she sustained repetitive trauma injuries arising out of her employment and manifesting on May 31, 2011 and that her current condition of ill-being is causally connected to her alleged injury.

Accordingly, her claim for benefits under the Act is denied.

Issue E: *Notice*

Based on the above, the issue of Notice is moot.

Issue J: *Medical Bills*

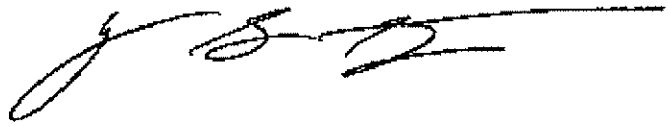
Based on the above, the issue of Medical Bills is moot.

Issue K: *Temporary Total Disability*

Based on the above, the issue of Temporary Total Disability is moot.

Issue L: *Nature and Extent*[1]

Based on the above, the issue of Nature and Extent is moot.



Signature of Arbitrator

JANUARY 10, 2020
Date

[1] As Petitioner's alleged accident date (June 15, 2011) precedes the June 28, 2011 effective date of 820 ILCS 305/8.1b, this Arbitration Decision ***will not*** utilize the factors set forth in Section 8.1b in determining the nature and extent of the Petitioner's injury, if such an analysis is needed. (AX 1).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC000744
Case Name	FEARS, JON v. ILLINOIS STATE UNIVERSITY/
Consolidated Cases	16WC000750
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0446
Number of Pages of Decision	16
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	William Trimble
Respondent Attorney	Bradley Defreitas

DATE FILED: 9/3/2021

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jon Fears,

Petitioner,

vs. NO: 16 WC 000744

Illinois State University/State of Illinois,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 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.

September 3, 2021

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MEP/ypv
049

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0446
NOTICE OF ARBITRATOR DECISION

FEARS, JON
Employee/Petitioner

Case# **16WC000744**
16WC000750

ILLINOIS STATE UNIVERSITY/ST OF IL
Employer/Respondent

On 12/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% 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:

0564 WILLIAMS & SWEE LTD
WILLIAM D TRIMBLE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

6079 ASSISTANT ATTORNEY GENERAL
BRAD DeFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

DEC -7 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jon Fears
Employee/Petitioner

v.

Case # **16** WC **744**

Consolidated cases: **16** WC **750**

Illinois State University/State of Illinois
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 16, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 23, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$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 **$0** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

With regard to the nature and extent of Petitioner's injury, the Petitioner has already been compensated as explained more fully in the decision of Petitioner's consolidated Case No. 16 WC 750. In that case, Petitioner was compensated for permanent partial disability stemming from his injuries on September 2, 2015 as a result of a consolidated full trial on the merits of both cases. Thus, the Arbitrator denies any additional award for further compensation as a result of Petitioner's injury.

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. Rose Gillman

Signature of Arbitrator

12/3/2020

Date

DEC 7 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jon Fears
Employee/Petitioner

Case # **16** WC **744**

v.

Consolidated cases: **16** WC **750**

Illinois State University/State of Illinois
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he has worked for Respondent as a cook for approximately 20 years. He further testified that on the two alleged dates of injury he was working as a cook in the dining halls at Illinois State University. Petitioner testified that he worked 7.5 hours per day which added up to 37.5 hours per week, and that he frequently worked overtime as well.

As to his specific job duties, Petitioner testified that he typically had a prep shift where he would cook food in large batches for easy reheat later on. He testified that he usually did this twice a week, and that it lasted 2-3 hours each time.

For example, Petitioner described the specific steps that he would take to make meat sauce which included "roughly a hundred pounds of beef and put it into a big steam kettle, and you have like it's a boat oar that you would stir it with to brown it; and then you would take…36 cans of different tomato puree and tomato sauce…and simmer it." Petitioner further testified that he then scooped the meat, using a 1/2-gallon scoop, into numerous pans to store for later use.

Petitioner further testified to the processes involved with making pizza, making taco meat, making pasta, making General Tao's chicken, and working the wok. Petitioner testified that his hands would cramp and ache while doing these activities, and that while working the wok his elbows repeatedly flexed past 90 degrees.

Petitioner testified that he has the same job now with Respondent, and that he still performs the same work activities. Petitioner testified that he used to do a lot of overtime, but that now he does not work as much overtime because he needs time to rest and that it is often too painful for him. He testified that he has changed the way he performs his functions at work, and that he does things a lot slower than he used to. He testified that he is right hand dominant. Petitioner further testified that that his hobbies have also been affected by his condition, including restoring classic cars and wood working.

On cross examination, Petitioner agreed that he would make multiple food items throughout his shift and that he did not stay at one station for the duration. When asked how long it took to make the meat sauce, Petitioner responded that it took 30-40 minutes and then he would add the cans of tomato sauce. Petitioner further testified that he did grip the oar with both hands, but that only his right hand was used for the fulcrum.

On cross examination, Petitioner agreed that there was no continuous vibration in any of his job duties. Petitioner further testified about his hobby of restoring old cars and agreed that when he used tools, he would have to forcefully grip it with his right hand. Petitioner also testified about his woodworking hobby, where he indicated that he used tools such as scroll saws, table saws, routers, and sanders. Petitioner agreed that there would be vibration from a hand sander, but further testified that he usually wears gloves in an attempt to minimize the vibration.

On redirect, Petitioner testified that he usually performs a task on his shift for 3-4 hours before he moves on to another task.

The transcript of the deposition of Dr. Jerome Oakey dated January 11, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Oakey testified that he has been practicing at McLean County Orthopedics from 2004 to present and that Petitioner was referred to him by his partner, Dr. Armstrong. He testified that Petitioner's chief complaint was that of a bilateral wrist problem, wrist pain, and numbness and tingling to both hands at night and at work. He testified that Dr. Armstrong had found decreased ulnar nerve distribution and median distribution for sensation on the right, and, as to sensation on the left, he had normal ulnar nerve distribution, radial nerve distribution, and median nerve distribution. He testified that Dr. Armstrong also found Tinel's sign on the ulnar nerve positive on the right, and that the test was done to evaluate nerves for potential areas of compression or irritation. He further testified that the test being positive would show that there was at least some sign of potential compression or irritation of the ulnar nerve. (PX1).

Dr. Oakey testified that Dr. Armstrong also found the carpal compression test to be positive. He testified that a positive result of the carpal compression test was suggestive of carpal tunnel syndrome. He testified that Dr. Armstrong also found Phalen's test to be positive, and that it was another provocative maneuver to bring about the symptoms of carpal tunnel syndrome. He testified that if a Phalen's test was positive it would also indicate the presence of carpal tunnel syndrome. He testified that a positive elbow hyperflexion test suggested compromise of the ulnar nerve at the cubital tunnel. (PX1).

Dr. Oakey testified that Dr. Carmichael was one of his partners who performed EMG testing, and that he was a physiatrist. He testified that Dr. Carmichael performed an exam of Petitioner on November 18th, and that he performed electrical testing and a physical examination. He testified that Dr. Carmichael found on EMG that there was an ulnar neuropathy at the right elbow, and that he also indicated that it seemed like a number of Petitioner's complaints related to mechanical wrist pain. (PX1).

Dr. Oakey testified that he first saw Petitioner two days after his EMG on November 20th, and that at that time he had the advantage of both Dr. Armstrong's examination and Dr. Carmichael's EMG. He testified that he did his own physical examination and history, and that he found that Petitioner had Tinel's at both ulnar nerves, that he had subluxation of the medial condyle, that he had a positive flexion and compression maneuver and Tinel's of the right median nerve, and that he had tenderness over his right thumb, scaphoid, trapezoid, trapezial joint, and thumb carpometacarpal joint, which was consistent with the osteoarthritis seen on x-rays from an outside institution. He testified that the diagnosis was that of bilateral cubital tunnel and right carpal tunnel syndrome, as well as pantrapezial osteoarthritis. (PX1).

Dr. Oakey testified that with the EMG showing normal muscles and normal conduction of the median nerve on the right side, this was not a long-standing condition that he was looking at on that date. He testified that not every cubital tunnel syndrome had subluxation where the nerve moved from the back of the medial epicondyle to the front, but that in Petitioner's case it was. He testified that with time and repetitive elbow flexion the nerve was compressed, and that it would cause typically numbness and tingling in the small finger as well as a portion of the ring finger. When asked whether at that point he found that Petitioner had had his cubital tunnel syndrome for a significant enough period of time that he had muscle death or wasting, Dr. Oakey responded that Petitioner's interossei muscles were normal on clinical exam

and also normal when Dr. Carmichael did the electrical needle testing on him. When asked whether it had been all that longstanding, Dr. Oakey responded that it was a difficult question to answer and that it was hard to say how longstanding it had been. He testified that it would be more the subluxation of the ulnar nerve as well as the EMG being positive which prompted them to action perhaps quicker than trying a prolonged course of conservative care, and that Petitioner had already done some bracing of his elbow. (PX1).

Dr. Oakey testified that cubital tunnel syndrome can exist and can be surgically indicated before it shows up electrodiagnostically, and that if he did not find something on EMG it did not mean that it was not there. He testified that the majority of cubital tunnel that he operated on did not show up on an EMG and that it showed up surgically. He testified that carpal tunnel was more consistently present on an electrical test, that electrical tests were performed compared against norms, and that carpal tunnel syndrome was a clinical diagnosis and not an electrodiagnostic one. He testified that he tended to obtain electrodiagnostic examinations for a variety of reasons such as elimination of other potential issues such as a cervical radiculopathy which could mimic carpal tunnel syndrome, and that it also gave him a baseline exam prior to performing surgery so that he had an idea where they started should there be issues afterwards. He testified that it was within the standard of care to not obtain an EMG for carpal tunnel syndrome. (PX1).

Dr. Oakey testified that he discussed treatment options with Petitioner and that he wished to proceed with a right ulnar nerve transposition and open carpal tunnel release under a general anesthetic, and that they also ordered screening labs for rheumatoid disease given the arthritic issue he had. He testified that Petitioner was also given a splint that was directed towards treatment of his arthritis at the base of his thumb. He testified that the screening labs were normal, so the problems that Petitioner had were not rheumatoid in nature. He testified that he performed surgery on December 8, 2015, at which time he performed a right open carpal tunnel release and a right ulnar nerve transposition. (PX1).

Dr. Oakey testified that the surgical findings were a moderate amount of synovitis and a moderate amount of nerve compression. He testified that he had no question that Petitioner had compression of the nerve of his carpal tunnel. He testified that there were no complications in surgery. He testified that at this time he did not consider that Petitioner could return to work. He testified that Petitioner returned to see his nurse practitioner Crystal on December 21st, where everything looked good and he was restricted from returning to work until he saw him at approximately six weeks following his surgery. He testified that he saw Petitioner on January 21st at which point he was doing well, that they gave him a five pound lifting restriction with his right upper extremity, and that they had him begin therapy. He testified that he did not have it documented whether Petitioner's employer took him back with restricted duty. He testified that he next saw Petitioner on February 29th at which time he was doing well, that he was going to finish up with therapy, and that he was increased to a 20-pound lifting restriction. He testified that Petitioner was seen by Crystal Sweeney on March 1st, at which point he was returned to work full duty. He testified that Petitioner was doing well at that point. (PX1).

Dr. Oakey testified that the last office visit occurred on April 28, 2016, at which time he was doing well and had only some mild symptoms. He testified that Petitioner was released with no further medical care anticipated with no work restrictions. He testified that all of his treatment addressed Petitioner's right arm, but that examinations showed some symptoms on the left as well. He testified that he did not originally take the case as a work comp case, and that Petitioner listed on his initial visit as Health Alliance which was his group medical. (PX1).

When posed a hypothetical of Petitioner's job duties for Respondent and whether these duties could cause or contribute to Petitioner's development of carpal tunnel syndrome and cubital tunnel syndrome, Dr. Oakey responded in the affirmative as to the carpal tunnel syndrome. He testified that his opinion was that repetitive grip activities as described by Petitioner's attorney were contributory and causally connected to

the development of carpal tunnel syndrome. He further testified that, as to the cubital tunnel syndrome, if those activities required repetitive elbow flexion beyond 50 degrees to about 90 or above, those were the types of activities that he felt would contribute to Petitioner's cubital tunnel syndrome given his subluxing ulnar nerve. (PX1).

When asked whether the fact that Petitioner's job had him pushing things in and out of a large cooler and whether that would have any further effect on his opinion as to causation, Dr. Oakey responded that he did not know that it really mattered that it was a cooler as much as it was the repetitive gripping and pushing as was described. When asked whether those things were Petitioner's duties and whether they had caused or contributed to what he found on examination and surgery, Dr. Oakey responded in the affirmative for the carpal tunnel findings and for the compression of the ulnar nerve. He testified that the subluxation and the nerve moving over the medial epicondyle was physiologic and was not caused by the activities. He testified that Petitioner's subluxation of the ulnar nerve could have been aggravated by the job duties that were posed to him in the hypothetical. He further testified that he thought that the repetitive bending of the elbow, even with a nerve that subluxed, could cause constriction of the nerve and compression of the nerve at the elbow, which was cubital tunnel. (PX1).

When asked if he were now given information that Petitioner's left arm was beginning to cause him more troubles and whether that would be consistent with what he had seen and examined him for, Dr. Oakey responded that he would have to see him back to evaluate him as he had not seen him in nearly two years. When asked to assume that Petitioner was experiencing symptoms on the left side more consistent with what he found on the right as for carpal tunnel syndrome and whether it would be possible that it was caused by the same things that caused carpal tunnel syndrome on the right side, Dr. Oakey responded that if Petitioner's duties had not changed and that he continued to do so and had carpal tunnel syndrome on the left side, then he would feel that the activities were causally connected. He testified that on clinical examination Petitioner had findings of cubital tunnel, but on the electrical examination he did not. (PX1).

When asked whether, on the right side which was surgically repaired, Petitioner was likely to have to have future surgery on that side, Dr. Oakey responded in the negative. He testified that Petitioner's symptoms were as improved as they were going to be, but that he had not seen him in two years. (PX1).

On cross examination when asked whether there was a certain amount of hours per day that he would say was needed with the forceful repetitive gripping and fine manipulation with the hands for his causation opinion for Petitioner, Dr. Oakey responded that he thought it was more of a cumulative discussion about what his activities were not only while he was doing food prep but also while he was not. He testified that he thought that diabetes and rheumatoid arthritis were the "two big ones" that were patient factors that he thought were more contributory to carpal tunnel syndrome, and that tobacco use, obesity, hypothyroidism, and female gender were other things that he had found to be more consistent with carpal tunnel syndrome but were not as strong of contributors as diabetes or rheumatoid arthritis. (PX1).

On cross examination, Dr. Oakey testified that Petitioner had findings on x-ray of osteoarthritis, (PX1).

The *Curriculum Vitae* of Dr. Jerome Oakey was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The EMG performed at McLean County Orthopedics dated November 18, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that the studies were interpreted as revealing an abnormal study, that there was an ulnar neuropathy at the right elbow, and that there was no electrophysiologic evidence of other upper extremity neuropathy, plexopathy, or radiculopathy on the study. (PX3).

The Operative Report dated December 8, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent right open carpal tunnel release and right subcutaneous ulnar nerve transposition on that date by Dr. Oakey for a pre- and post-operative diagnosis of right carpal tunnel syndrome and right cubital tunnel syndrome. (PX4).

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on April 28, 2016, at which time it was noted that he was doing well with only some patellar [*sic*] symptoms, that he was to return on an as needed basis, and that he was at maximum medical improvement with no further medical care anticipated. It was noted that Petitioner was given a note to return to work allowing him to return full duty. At the time of the March 31, 2016 visit, it was noted that Petitioner had been discharged from occupational therapy and was continuing with a home exercise program. It was noted that Petitioner stated that he was doing well and that his right arm was feeling better, that he continued to improve as time went, and that he had been tolerating his work restrictions without discomfort. It was also noted that Petitioner had full range of motion with his right arm, that his fingers had "woken up," and that he no longer had any numbness or tingling. It was further noted that Petitioner was to be progressed to full duty at work, and that he was to return in four weeks at which time it would be anticipated he would be ready for maximum medical improvement. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on February 29, 2016, at which time it was noted that he stated that he was doing pretty well, that there was some aching pain in his right elbow and wrist with stiffness in his fingers, that he continued with therapy which was helping but slow, and that there was no associated numbness or tingling. It was noted that Petitioner was continuing to improve and that they would have him perform a home exercise program only after his last therapy visit. It was noted that Petitioner's restrictions were to be increased to 20 pounds and that when he returned to see Crystal in a month, it was anticipated that he would be at full duty. At the time of the January 21, 2016 visit, it was noted that Petitioner was doing well, that they were going to give him a five pound lifting restriction with his right upper extremity, that they were also going to have him begin therapy, and that he was to return in one month at which point it was anticipated his restrictions would be advanced. At the time of the December 21, 2015 visit, it was noted that Petitioner stated that he was doing well 13 days out from surgery, that he stated that he took more pain medication to sleep than during the day, and that he continued use of the sling when needed. It was noted that Petitioner was to transition into a right boomerang splint to wear for comfort, that he could remove the splint to work on range of motion exercises, and that he worked as a chef and would not be able to use is right arm at work so he was to continue to be off work until his follow-up with Dr. Oakey in four weeks. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on November 20, 2015, at which time it was noted that he was a referral from Dr. Armstrong and that he had undergone an EMG on November 18, 2015. It was noted that Petitioner had a couple of different issues, the first of which was numbness in both hands more on the right than the left but worse at night and aggravated with elbow flexion, that it predominantly affected the small and ring fingers and had been refractory to conservative care including bracing, that he also had a moderate aching pain at the right radial aspect of the wrist that was worse with use, and that he had tingling and circulation problems in both legs and feet. The assessment was noted to be that of bilateral cubital tunnel syndrome, right carpal tunnel syndrome, numbness of hand, and osteoarthritis of the right wrist. It was noted that Petitioner's bilateral carpal tunnel syndrome was present with subluxing ulnar nerves and that the EMG showed slowing on the right, that the right carpal tunnel syndrome was present clinically but not electrodiagnostically, that the right basilar thumb pain including tenderness at the STT joint with degenerative changes seen on x-rays, that the left thumb had post-traumatic arthritis at the thumb CMC joint that was not clinically symptomatic, and that they were going to order screening labs for rheumatoid disease as well as provide Petitioner with a comfortable splint. It was noted that a discussion was had regarding treatment for nerve compression, and that Petitioner wished

to proceed with a right ulnar nerve transposition and open carpal tunnel release under general anesthetic. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on November 9, 2015, at which time it was noted that he was seen for a bilateral wrist problem. It was noted that Petitioner had bilateral wrist pain to the carpal tunnel area with numbness and tingling at night and at work, and that he was a cook at ISU. The assessment was noted to be that of 35-year-old right hand dominant male with bilateral carpal tunnel syndrome, right more symptomatic than left, and right cubital tunnel syndrome. It was noted that Petitioner was provided with bilateral wrist splints and a right elbow splint to wear at night, and that he was also scheduled for bilateral upper extremity EMGs on that date. It was noted that due to Petitioner's age he would most likely need repeat carpal tunnel releases. It was further noted that Petitioner was to undergo the EMG studies and then follow-up with Dr. Oakey. At the time of the November 18, 2015 visit with Dr. Carmichael, it was noted that Petitioner was a 35-year-old male with right greater than left hand symptoms, that he reported September 2, 2015 that he reported numbness and tingling and wrist pain and saw the doctor October 23rd, that he worked as a chef at ISU, that he complained of pain in the right wrist in particular but that he also had numbness and tingling in the fourth and fifth digit and occasionally the whole hand would fall asleep, that his symptoms were more in the right than the left, that aggravating factors including use of the wrist or trying to sleep, and that alleviating factors were rest. It was noted that on EMG there was an ulnar neuropathy at the right elbow and that it seemed like a number of his complaints related to mechanical wrist pain as well. Petitioner was recommended to follow-up with Dr. Oakey. (PX5).

The medical records of OSF Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The medical records of The Center for Outpatient Medicine, LLC were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent a right ulnar nerve transposition at the elbow and open carpal tunnel release on December 8, 2015 for a pre- and post-operative diagnosis of right carpal tunnel syndrome and cubital tunnel syndrome. (PX8).

The Incident Report dated September 2, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that on September 2, 2015 Petitioner reported that he was experiencing a numbing in his right hand and pain in his right wrist when he was cooking on the woks at Watterson. The report was prepared by Darn Ganci, Assistant Unit Chef, on September 2, 2015. (PX9).

The medical records of McLean County Orthopedics Occupational Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was discharged from occupational therapy on March 3, 2016, at which time it was noted that he reported that he had a few shooting pains the other day, that had no reports of numbness or tingling in the right thumb tip and fingertips, that he reported minor numbness at the elbow incision, that he was able to feel light touch in the thumb tip and fingertips, and that he reported that the right did not feel the same as the left. It was further noted that Petitioner was tender to palpation at the scars, that hypersensitivity was present at the elbow scar, that the scars had minimal underlying scar tissue, that the edema improved as well as range of motion since Monday, that strength tests were slightly weaker, and that he felt he would continue to progress with being back at work and continuing home exercises. (PX10).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report reflects that Petitioner on October 21, 2015 reported that his injury occurred while lifting, flipping, and stirring, and that it caused pain in the wrist/hands. (RX2).

The Section 12 Report of Dr. James Williams dated May 31, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 3.[1] The report reflects that Dr. Williams performed an IME on May 31, 2017, at which time it was noted that Petitioner was a 36-year-old right-hand dominant male who worked at ISU in food service, that he denied any previous injuries to his right or left hand or arms, that he noted that he broke his thumb at the age of 9, and that he had worked in various kitchens, basically doing the same tasks at ISU. It was noted that Petitioner stated that in his job he opened up for the woks, that he also did grilled chicken, pizzas, and burgers, that when he was at the woks he deep fried boxes of chicken, that he did about 20-30 woks per shift, that he flipped burgers, did grilled chicken, that he served students about 600-800 burgers per day, that he did pizzas and that he made about 200-300 pizzas per day, that he made pasta about three times per day, that he made four pans of chicken, beef, rice, beans, and cheese, that he stirred pasta with a boat-type oar, that he made about 10 2-gallon pans of meat sauce, that he did about 100 pounds of chicken tacos, that he did about 100 pounds of beef tacos, that he did about 10 2-gallon pans of marinara sauce, and that he made about 12-14 pans of chicken tacos. The report further reflects that Petitioner indicated that he made sauces, six 5-gallon buckets at a time, placed them in a cart, pushed them into the cooler, and lifted them onto a shelf, and that he made pancakes, eggs, biscuits, and gravy when he worked overtime. It was noted that Petitioner indicated that he rated his pain on the right side at rest of 1-2/10, on the left at 3-4/10, that with activity it was 7-10 on the right, that he wore a brace on occasion but that it was better than before, and that he had numbness and tingling periodically with work or sleep in the ring finger and small finger. It was noted that Petitioner also indicated that he wakes up with pain and numbness and tingling on the left side, that he had weakness on both sides, that he was dropping things on both sides, that he still wears splints occasionally on the right side, and that he had no treatment to date on the left side. (RX3).

The report further reflects that Dr. Williams indicated that Petitioner's chief complaint was numbness, tingling, and pain in the hand and wrist since October 2015, that he stated working as he was using it made it worse, as did turning, twisting, and lifting, that he denied any history of diabetes or thyroid dysfunction, that he stated that as he worked the pain got unbearable and that tingling was waking him repeatedly at night, that he denied tobacco use, that his hobbies included the piano and working in the garden, and that he did occasional woodwork, about one time per month. (RX3).

The report reflects that Dr. Williams opined that it did not appear that Petitioner's job involved any exposure to vibration nor did it involve repetitive forceful gripping and/or pinching of a significant magnitude that would lead to a condition such as carpal or cubital tunnel syndrome, that he believed Petitioner's cubital tunnel syndrome was more the result of his ulnar nerve subluxation than any of the work duties of which he might have performed, and that he believed moreso Petitioner's increased body mass index and/or hypertension would more likely be a cause and/or idiopathic in nature than would be his work duties. It was noted that Dr. Williams opined that Petitioner's medical treatment incurred to date had been reasonable and necessary, that Petitioner may indeed need a left elbow ulnar nerve decompression with subcutaneous transposition as was performed on the right although he did not believe that it would be related to his work duties, and that he believed that Petitioner had a good prognosis. It was noted that Dr. Williams opined that Petitioner could work full duty as he had with no restrictions, and that Petitioner had reached maximum medical improvement as of the date Dr. Oakey released him from his care. (RX3).

The transcript of the deposition of Dr. James Williams dated April 23, 2020 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Williams testified that he is an orthopedic

[1] Any markings and/or underlining that appears in the exhibit was not made by the Arbitrator.

surgeon, and that he holds a board certification to the American Board of Orthopedic Surgery as well as a Certificate of Added Qualifications in hand and upper extremity surgery. (RX4).

Dr. Williams testified that he performed an IME of Petitioner on May 31, 2017. He testified that he noted that Petitioner's BMI was over 30, and that it was found that there was a higher association with carpal and cubital tunnel with a BMI over 30. He testified that Petitioner also had a history of hypertension, and that it was another co-morbidity for carpal and cubital tunnel. He testified that he went over Petitioner's job with him in detail when he examined him, and that he did not have any work duties that indicated to him that his job would have caused or contributed to his carpal tunnel or cubital tunnel. He testified that the stirring of foods would not cause carpal or cubital tunnel. When asked what type of repetitive activity was needed for carpal tunnel syndrome, Dr. Williams responded that he believed it was activity which was forceful, sustained, and repetitive over a long period of time. He further testified that he did not believe that any of the actions were forceful and sustained, as Petitioner did many different activities. (RX4).

On cross examination, Dr. Williams agreed that he saw Petitioner on May 31, 2017 and testified that he was testifying from his notes as it had been almost three years. When asked of Petitioner's blood pressure when he saw him, Dr. Williams responded that they did not take blood pressure when he was seen. He agreed that he testified that hypertension was associated with carpal tunnel syndrome. When asked whether it was independent of whether or not the hypertension was treated, Dr. Williams responded that he did not know what Petitioner's blood pressure was, but that he knew that he was on blood pressure medication. He testified that he did not ask Petitioner was his blood pressure was, and that all he said was that he had hypertension. (RX4).

On cross examination, Dr. Williams testified that it was important that the duties were forceful, sustained, and repetitive. He testified that he was relying on articles written in the *Journal of Hand Surgery*, as well as the American Board of Orthopedic Surgery's opinion. He agreed that Petitioner's increased body mass and/or hypertension would more likely be cause, or that it was idiopathic in nature, rather than his work duties. He testified that it was possible for a number of things to all come together to be a cause if the activities performed were repetitive, sustained, and forceful. (RX4).

On cross examination, Dr. Williams agreed that with determining whether there was sufficient force to cause carpal tunnel syndrome one thing to be considered was how many hours a day that force was applied, and he further testified that he had Petitioner's work hours. He testified that if one worked a lot of hours and did something that was not an activity that was going to lead to carpal tunnel syndrome, he did not think that it mattered the number of hours or the number of years one worked at a position. (RX4).

On cross examination, Dr. Williams agreed that Petitioner had no evidence of symptom magnification or malingering. He agreed that he found Petitioner to be honest and giving forthright efforts. He testified that he has not reviewed any additional medical records since the IME date. He agreed that the medical treatment that Petitioner received, regardless of the cause of his condition, was reasonable and necessary. (RX4).

On redirect, Dr. Williams testified that he did not believe that Petitioner's work activities were repetitive, sustained, and forceful enough to cause carpal tunnel or cubital tunnel. (RX4).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F) as it pertains to 16 WC 750, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 2, 2015 and that his current condition of ill-being is causally related to his work activities for Respondent.

In so concluding that Petitioner's carpal tunnel and cubital tunnel syndrome in his right hand and arm is related to his work activities, the Arbitrator finds the opinions of Dr. Oakey to be more persuasive than those proffered by Dr. Williams in this matter. The Arbitrator finds that the job duties as testified to by Petitioner at the time of arbitration were consistent with those as proffered to Dr. Oakey in the hypothetical posed by Petitioner's attorney at the time of the deposition. (PX1). Furthermore, the Arbitrator notes that the IME report of Dr. Williams reflects that he opined that it did not appear that Petitioner's job involved any exposure to vibration nor did it involve repetitive forceful gripping and/or pinching of a significant magnitude that would lead to a condition such as carpal or cubital tunnel syndrome, that he believed Petitioner's cubital tunnel syndrome was more the result of his ulnar nerve subluxation than any of the work duties of which he might have performed, and that he believed moreso Petitioner's increased body mass index and/or hypertension would more likely be a cause and/or idiopathic in nature than would be his work duties. (RX3). The Arbitrator infers this particular indication by Dr. Williams to be suggestive of an admission that Petitioner's work duties could, in fact, have been contributing to his condition of ill-being, but rather just not to the same extent of the other issues which were that Petitioner's condition was idiopathic or was related to his increased body mass index and/or hypertension.

The Arbitrator finds that Petitioner's job duties are sufficiently repetitive or cumulative to support a finding of causation and/or aggravation of both the right carpal and cubital tunnel syndrome conditions. Petitioner's testimony demonstrated that his job duties were forceful and required frequent gripping, and that he regularly held his right elbow in a flexed position while performing his job duties. As a result thereof, the Arbitrator finds that the job duties as described by Petitioner at the time of arbitration -- which involved the gripping and grasping of stirring with an oar-like object as well as gripping and grasping half-gallon scoops -- were sufficient to cause or aggravate both the right carpal tunnel syndrome and right cubital tunnel syndrome conditions in his right upper extremity.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 2, 2015, and that his current condition of ill-being is causally related to his work activities.

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 to his right hand and arm was reasonable, necessary, and causally related to his work accident of September 2, 2015. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth in Petitioner's Exhibit 7, 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 temporary total disability benefits from December 8, 2015 through March 31, 2016. (AX2). Related thereto, the Arbitrator notes that Petitioner testified that he underwent surgery on December 8, 2015, that he was unable to work on that date, and that as of the January 21, 2016 visit with Dr. Oakey he was given work restrictions that Respondent did not accommodate. Petitioner further testified that he remained under the restrictions by McLean County Orthopedics until March 31, 2016, at which time Ms. Sweeney allowed him to return to work full duty with no restrictions. The Arbitrator further notes that Petitioner's testimony on this issue is consistent with the testimony of Dr. Oakey as to the work restrictions

that were given during the course of Petitioner's treatment. (PX1). As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 16 2/7 weeks, addressing the timeframe of December 8, 2015 through March 31, 2016, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to work as a cook for Respondent. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 33 years old on his date of accident. Given the younger age of Petitioner and the fact that his treating physician, Dr. Oakey, has placed him under no permanent work restrictions, the Arbitrator places lesser greater on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to work for Respondent as a cook. As there was no definitive evidence of reduced earning capacity contained in the record beyond Petitioner's assertions that he now works fewer overtime hours, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has the same job now with Respondent, and that he still performs the same work activities. Petitioner testified that he used to do a lot of overtime, but that now he does not work as much overtime because he needs time to rest and that it is often too painful for him. Petitioner testified that he has changed the way he performs his functions at work, and that he does things a lot slower than he used to. Petitioner testified that he is right hand dominant, and that his hobbies have also been affected by his condition, including restoring classic cars and wood working. At the time of the April 28, 2016 visit with Dr. Oakey, it was noted that Petitioner was doing well with only some patellar [*sic*] symptoms, that he was to return on an as needed basis, and that he was at maximum medical improvement with no further medical care anticipated. It was noted that Petitioner was given a note to return to work allowing him to return full duty. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records at the conclusion of his treatment with Dr. Oakey. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. The Arbitrator further notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st App. Ct. Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and

no separate award is being made. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st App. Ct. Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing."). Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent **10% loss of use of the right hand and 10% loss of use of the right arm** as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC000750
Case Name	FEARS, JON v. ILLINOIS STATE UNIVERSITY/
Consolidated Cases	16WC000744
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0447
Number of Pages of Decision	18
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	William Trimble
Respondent Attorney	Bradley Defreitas

DATE FILED: 9/3/2021

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JON FEARS,

Petitioner,

vs. NO: 16 WC 750

ILLINOIS STATE UNIV./
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 accident, causation, medical expenses, temporary total disability and nature and extent, and being advised of the facts and law, affirms and adopts, with the following change, the Decision of the Arbitrator, which is attached hereto and made a part hereof along with the "Memorandum of Decision of Arbitrator" that is contained in companion case 16 WC 744.

The decisions that were issued by the Arbitrator in this case and the companion case are a little confusing. In 16 WC 744, the Arbitrator found that Petitioner sustained an accident on October 23, 2015 but made no awards. She wrote:

> With regard to the nature and extent of Petitioner's injury, the Petitioner has already been compensated *as explained more fully in the decision of Petitioner's consolidated Case No. 16 WC 750*. In that case, Petitioner was compensated for permanent partial disability stemming from his injuries on September 2, 2015 as a result of a consolidated full trial on the merits of both cases. Thus, the Arbitrator denies any additional award for further compensation as a result of Petitioner's injury.

Dec.(16WC744) at Order section (Emphasis added). The 16 WC 744 decision also contains an 11-page "Memorandum of Decision of Arbitrator" that includes Findings of Fact and a Conclusions of Law section that awarded medical expenses, temporary total disability (TTD) and permanent partial disability (PPD).

The problem is that the Arbitrator indicated, in 16 WC 744, that her decision regarding PPD is *"explained more fully in the decision of Petitioner's consolidated Case No. 16 WC 750,"* but that decision (16 WC 750) does not contain any Findings of Fact or Conclusions of Law. It only includes an Order section that awarded medical expenses, TTD and PPD.

Therefore, Petitioner was awarded benefits in 16 WC 750, although it contains no facts or conclusions, and Petitioner was denied further benefits in 16 WC 744, which contains all of the facts and conclusions, yet refers to 16 WC 750 to be "explained more fully."

We believe the Arbitrator inadvertently attached the "Memorandum of Decision of Arbitrator" to the 16 WC 744 case when it should have been attached to the 16 WC 750 case. In any event, we hereby attach the "Memorandum of Decision of Arbitrator" from the 16 WC 744 decision to the 16 WC 750 decision to clear up any confusion.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2020, is hereby affirmed and adopted with the addition of the "Memorandum of Decision of Arbitrator" that is contained in companion case 16 WC 744.

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.

September 3, 2021

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

SE/
O: 8/10/21
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0447

FEARS, JON
Employee/Petitioner

Case# **16WC000750**

16WC000744

ILLINOIS STATE UNIVERSITY/ST OF IL
Employer/Respondent

On 12/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% 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:

0564 WILLIAMS & SWEE LTD
WILLIAM TRIMBLE
2011 FOX CREEK RD
BLOOMINGTON, II 61701

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

6079 ASSISTANT ATTORNEY GENERAL
BRAD DeFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

DEC -7 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jon Fears
Employee/Petitioner

v.

Case # **16** WC **750**

Consolidated cases: **16** WC **744**

Illinois State University/State of Illinois
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 16, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 **September 2, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$32,651.15**; the average weekly wage was **$627.91**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$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 **$0** 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 as included in **Petitioner's Exhibit 7** 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 directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$418.61**/week for **16 2/7** weeks, for the timeframe of **December 8, 2015** through **March 31, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$376.75/week** for a further period of **44.3 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **10% loss of use of the right hand** and **10% loss of use of the right arm.**

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

12/3/2020

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jon Fears
Employee/Petitioner

Case # **16** WC **744**

v.

Consolidated cases: **16** WC **750**

Illinois State University/State of Illinois
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he has worked for Respondent as a cook for approximately 20 years. He further testified that on the two alleged dates of injury he was working as a cook in the dining halls at Illinois State University. Petitioner testified that he worked 7.5 hours per day which added up to 37.5 hours per week, and that he frequently worked overtime as well.

As to his specific job duties, Petitioner testified that he typically had a prep shift where he would cook food in large batches for easy reheat later on. He testified that he usually did this twice a week, and that it lasted 2-3 hours each time.

For example, Petitioner described the specific steps that he would take to make meat sauce which included "roughly a hundred pounds of beef and put it into a big steam kettle, and you have like it's a boat oar that you would stir it with to brown it; and then you would take…36 cans of different tomato puree and tomato sauce…and simmer it." Petitioner further testified that he then scooped the meat, using a 1/2-gallon scoop, into numerous pans to store for later use.

Petitioner further testified to the processes involved with making pizza, making taco meat, making pasta, making General Tao's chicken, and working the wok. Petitioner testified that his hands would cramp and ache while doing these activities, and that while working the wok his elbows repeatedly flexed past 90 degrees.

Petitioner testified that he has the same job now with Respondent, and that he still performs the same work activities. Petitioner testified that he used to do a lot of overtime, but that now he does not work as much overtime because he needs time to rest and that it is often too painful for him. He testified that he has changed the way he performs his functions at work, and that he does things a lot slower than he used to. He testified that he is right hand dominant. Petitioner further testified that that his hobbies have also been affected by his condition, including restoring classic cars and wood working.

On cross examination, Petitioner agreed that he would make multiple food items throughout his shift and that he did not stay at one station for the duration. When asked how long it took to make the meat sauce, Petitioner responded that it took 30-40 minutes and then he would add the cans of tomato sauce. Petitioner further testified that he did grip the oar with both hands, but that only his right hand was used for the fulcrum.

On cross examination, Petitioner agreed that there was no continuous vibration in any of his job duties. Petitioner further testified about his hobby of restoring old cars and agreed that when he used tools, he would have to forcefully grip it with his right hand. Petitioner also testified about his woodworking hobby, where he indicated that he used tools such as scroll saws, table saws, routers, and sanders. Petitioner agreed that there would be vibration from a hand sander, but further testified that he usually wears gloves in an attempt to minimize the vibration.

On redirect, Petitioner testified that he usually performs a task on his shift for 3-4 hours before he moves on to another task.

The transcript of the deposition of Dr. Jerome Oakey dated January 11, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Oakey testified that he has been practicing at McLean County Orthopedics from 2004 to present and that Petitioner was referred to him by his partner, Dr. Armstrong. He testified that Petitioner's chief complaint was that of a bilateral wrist problem, wrist pain, and numbness and tingling to both hands at night and at work. He testified that Dr. Armstrong had found decreased ulnar nerve distribution and median distribution for sensation on the right, and, as to sensation on the left, he had normal ulnar nerve distribution, radial nerve distribution, and median nerve distribution. He testified that Dr. Armstrong also found Tinel's sign on the ulnar nerve positive on the right, and that the test was done to evaluate nerves for potential areas of compression or irritation. He further testified that the test being positive would show that there was at least some sign of potential compression or irritation of the ulnar nerve. (PX1).

Dr. Oakey testified that Dr. Armstrong also found the carpal compression test to be positive. He testified that a positive result of the carpal compression test was suggestive of carpal tunnel syndrome. He testified that Dr. Armstrong also found Phalen's test to be positive, and that it was another provocative maneuver to bring about the symptoms of carpal tunnel syndrome. He testified that if a Phalen's test was positive it would also indicate the presence of carpal tunnel syndrome. He testified that a positive elbow hyperflexion test suggested compromise of the ulnar nerve at the cubital tunnel. (PX1).

Dr. Oakey testified that Dr. Carmichael was one of his partners who performed EMG testing, and that he was a physiatrist. He testified that Dr. Carmichael performed an exam of Petitioner on November 18th, and that he performed electrical testing and a physical examination. He testified that Dr. Carmichael found on EMG that there was an ulnar neuropathy at the right elbow, and that he also indicated that it seemed like a number of Petitioner's complaints related to mechanical wrist pain. (PX1).

Dr. Oakey testified that he first saw Petitioner two days after his EMG on November 20th, and that at that time he had the advantage of both Dr. Armstrong's examination and Dr. Carmichael's EMG. He testified that he did his own physical examination and history, and that he found that Petitioner had Tinel's at both ulnar nerves, that he had subluxation of the medial condyle, that he had a positive flexion and compression maneuver and Tinel's of the right median nerve, and that he had tenderness over his right thumb, scaphoid, trapezoid, trapezial joint, and thumb carpometacarpal joint, which was consistent with the osteoarthritis seen on x-rays from an outside institution. He testified that the diagnosis was that of bilateral cubital tunnel and right carpal tunnel syndrome, as well as pantrapezial osteoarthritis. (PX1).

Dr. Oakey testified that with the EMG showing normal muscles and normal conduction of the median nerve on the right side, this was not a long-standing condition that he was looking at on that date. He testified that not every cubital tunnel syndrome had subluxation where the nerve moved from the back of the medial epicondyle to the front, but that in Petitioner's case it was. He testified that with time and repetitive elbow flexion the nerve was compressed, and that it would cause typically numbness and tingling in the small finger as well as a portion of the ring finger. When asked whether at that point he found that Petitioner had had his cubital tunnel syndrome for a significant enough period of time that he had muscle death or wasting, Dr. Oakey responded that Petitioner's interossei muscles were normal on clinical exam

and also normal when Dr. Carmichael did the electrical needle testing on him. When asked whether it had been all that longstanding, Dr. Oakey responded that it was a difficult question to answer and that it was hard to say how longstanding it had been. He testified that it would be more the subluxation of the ulnar nerve as well as the EMG being positive which prompted them to action perhaps quicker than trying a prolonged course of conservative care, and that Petitioner had already done some bracing of his elbow. (PX1).

Dr. Oakey testified that cubital tunnel syndrome can exist and can be surgically indicated before it shows up electrodiagnostically, and that if he did not find something on EMG it did not mean that it was not there. He testified that the majority of cubital tunnel that he operated on did not show up on an EMG and that it showed up surgically. He testified that carpal tunnel was more consistently present on an electrical test, that electrical tests were performed compared against norms, and that carpal tunnel syndrome was a clinical diagnosis and not an electrodiagnostic one. He testified that he tended to obtain electrodiagnostic examinations for a variety of reasons such as elimination of other potential issues such as a cervical radiculopathy which could mimic carpal tunnel syndrome, and that it also gave him a baseline exam prior to performing surgery so that he had an idea where they started should there be issues afterwards. He testified that it was within the standard of care to not obtain an EMG for carpal tunnel syndrome. (PX1).

Dr. Oakey testified that he discussed treatment options with Petitioner and that he wished to proceed with a right ulnar nerve transposition and open carpal tunnel release under a general anesthetic, and that they also ordered screening labs for rheumatoid disease given the arthritic issue he had. He testified that Petitioner was also given a splint that was directed towards treatment of his arthritis at the base of his thumb. He testified that the screening labs were normal, so the problems that Petitioner had were not rheumatoid in nature. He testified that he performed surgery on December 8, 2015, at which time he performed a right open carpal tunnel release and a right ulnar nerve transposition. (PX1).

Dr. Oakey testified that the surgical findings were a moderate amount of synovitis and a moderate amount of nerve compression. He testified that he had no question that Petitioner had compression of the nerve of his carpal tunnel. He testified that there were no complications in surgery. He testified that at this time he did not consider that Petitioner could return to work. He testified that Petitioner returned to see his nurse practitioner Crystal on December 21st, where everything looked good and he was restricted from returning to work until he saw him at approximately six weeks following his surgery. He testified that he saw Petitioner on January 21st at which point he was doing well, that they gave him a five pound lifting restriction with his right upper extremity, and that they had him begin therapy. He testified that he did not have it documented whether Petitioner's employer took him back with restricted duty. He testified that he next saw Petitioner on February 29th at which time he was doing well, that he was going to finish up with therapy, and that he was increased to a 20-pound lifting restriction. He testified that Petitioner was seen by Crystal Sweeney on March 1st, at which point he was returned to work full duty. He testified that Petitioner was doing well at that point. (PX1).

Dr. Oakey testified that the last office visit occurred on April 28, 2016, at which time he was doing well and had only some mild symptoms. He testified that Petitioner was released with no further medical care anticipated with no work restrictions. He testified that all of his treatment addressed Petitioner's right arm, but that examinations showed some symptoms on the left as well. He testified that he did not originally take the case as a work comp case, and that Petitioner listed on his initial visit as Health Alliance which was his group medical. (PX1).

When posed a hypothetical of Petitioner's job duties for Respondent and whether these duties could cause or contribute to Petitioner's development of carpal tunnel syndrome and cubital tunnel syndrome, Dr. Oakey responded in the affirmative as to the carpal tunnel syndrome. He testified that his opinion was that repetitive grip activities as described by Petitioner's attorney were contributory and causally connected to

the development of carpal tunnel syndrome. He further testified that, as to the cubital tunnel syndrome, if those activities required repetitive elbow flexion beyond 50 degrees to about 90 or above, those were the types of activities that he felt would contribute to Petitioner's cubital tunnel syndrome given his subluxing ulnar nerve. (PX1).

When asked whether the fact that Petitioner's job had him pushing things in and out of a large cooler and whether that would have any further effect on his opinion as to causation, Dr. Oakey responded that he did not know that it really mattered that it was a cooler as much as it was the repetitive gripping and pushing as was described. When asked whether those things were Petitioner's duties and whether they had caused or contributed to what he found on examination and surgery, Dr. Oakey responded in the affirmative for the carpal tunnel findings and for the compression of the ulnar nerve. He testified that the subluxation and the nerve moving over the medial epicondyle was physiologic and was not caused by the activities. He testified that Petitioner's subluxation of the ulnar nerve could have been aggravated by the job duties that were posed to him in the hypothetical. He further testified that he thought that the repetitive bending of the elbow, even with a nerve that subluxed, could cause constriction of the nerve and compression of the nerve at the elbow, which was cubital tunnel. (PX1).

When asked if he were now given information that Petitioner's left arm was beginning to cause him more troubles and whether that would be consistent with what he had seen and examined him for, Dr. Oakey responded that he would have to see him back to evaluate him as he had not seen him in nearly two years. When asked to assume that Petitioner was experiencing symptoms on the left side more consistent with what he found on the right as for carpal tunnel syndrome and whether it would be possible that it was caused by the same things that caused carpal tunnel syndrome on the right side, Dr. Oakey responded that if Petitioner's duties had not changed and that he continued to do so and had carpal tunnel syndrome on the left side, then he would feel that the activities were causally connected. He testified that on clinical examination Petitioner had findings of cubital tunnel, but on the electrical examination he did not. (PX1).

When asked whether, on the right side which was surgically repaired, Petitioner was likely to have to have future surgery on that side, Dr. Oakey responded in the negative. He testified that Petitioner's symptoms were as improved as they were going to be, but that he had not seen him in two years. (PX1).

On cross examination when asked whether there was a certain amount of hours per day that he would say was needed with the forceful repetitive gripping and fine manipulation with the hands for his causation opinion for Petitioner, Dr. Oakey responded that he thought it was more of a cumulative discussion about what his activities were not only while he was doing food prep but also while he was not. He testified that he thought that diabetes and rheumatoid arthritis were the "two big ones" that were patient factors that he thought were more contributory to carpal tunnel syndrome, and that tobacco use, obesity, hypothyroidism, and female gender were other things that he had found to be more consistent with carpal tunnel syndrome but were not as strong of contributors as diabetes or rheumatoid arthritis. (PX1).

On cross examination, Dr. Oakey testified that Petitioner had findings on x-ray of osteoarthritis, (PX1).

The *Curriculum Vitae* of Dr. Jerome Oakey was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The EMG performed at McLean County Orthopedics dated November 18, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that the studies were interpreted as revealing an abnormal study, that there was an ulnar neuropathy at the right elbow, and that there was no electrophysiologic evidence of other upper extremity neuropathy, plexopathy, or radiculopathy on the study. (PX3).

The Operative Report dated December 8, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent right open carpal tunnel release and right subcutaneous ulnar nerve transposition on that date by Dr. Oakey for a pre- and post-operative diagnosis of right carpal tunnel syndrome and right cubital tunnel syndrome. (PX4).

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on April 28, 2016, at which time it was noted that he was doing well with only some patellar [*sic*] symptoms, that he was to return on an as needed basis, and that he was at maximum medical improvement with no further medical care anticipated. It was noted that Petitioner was given a note to return to work allowing him to return full duty. At the time of the March 31, 2016 visit, it was noted that Petitioner had been discharged from occupational therapy and was continuing with a home exercise program. It was noted that Petitioner stated that he was doing well and that his right arm was feeling better, that he continued to improve as time went, and that he had been tolerating his work restrictions without discomfort. It was also noted that Petitioner had full range of motion with his right arm, that his fingers had "woken up," and that he no longer had any numbness or tingling. It was further noted that Petitioner was to be progressed to full duty at work, and that he was to return in four weeks at which time it would be anticipated he would be ready for maximum medical improvement. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on February 29, 2016, at which time it was noted that he stated that he was doing pretty well, that there was some aching pain in his right elbow and wrist with stiffness in his fingers, that he continued with therapy which was helping but slow, and that there was no associated numbness or tingling. It was noted that Petitioner was continuing to improve and that they would have him perform a home exercise program only after his last therapy visit. It was noted that Petitioner's restrictions were to be increased to 20 pounds and that when he returned to see Crystal in a month, it was anticipated that he would be at full duty. At the time of the January 21, 2016 visit, it was noted that Petitioner was doing well, that they were going to give him a five pound lifting restriction with his right upper extremity, that they were also going to have him begin therapy, and that he was to return in one month at which point it was anticipated his restrictions would be advanced. At the time of the December 21, 2015 visit, it was noted that Petitioner stated that he was doing well 13 days out from surgery, that he stated that he took more pain medication to sleep than during the day, and that he continued use of the sling when needed. It was noted that Petitioner was to transition into a right boomerang splint to wear for comfort, that he could remove the splint to work on range of motion exercises, and that he worked as a chef and would not be able to use is right arm at work so he was to continue to be off work until his follow-up with Dr. Oakey in four weeks. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on November 20, 2015, at which time it was noted that he was a referral from Dr. Armstrong and that he had undergone an EMG on November 18, 2015. It was noted that Petitioner had a couple of different issues, the first of which was numbness in both hands more on the right than the left but worse at night and aggravated with elbow flexion, that it predominantly affected the small and ring fingers and had been refractory to conservative care including bracing, that he also had a moderate aching pain at the right radial aspect of the wrist that was worse with use, and that he had tingling and circulation problems in both legs and feet. The assessment was noted to be that of bilateral cubital tunnel syndrome, right carpal tunnel syndrome, numbness of hand, and osteoarthritis of the right wrist. It was noted that Petitioner's bilateral carpal tunnel syndrome was present with subluxing ulnar nerves and that the EMG showed slowing on the right, that the right carpal tunnel syndrome was present clinically but not electrodiagnostically, that the right basilar thumb pain including tenderness at the STT joint with degenerative changes seen on x-rays, that the left thumb had post-traumatic arthritis at the thumb CMC joint that was not clinically symptomatic, and that they were going to order screening labs for rheumatoid disease as well as provide Petitioner with a comfortable splint. It was noted that a discussion was had regarding treatment for nerve compression, and that Petitioner wished

to proceed with a right ulnar nerve transposition and open carpal tunnel release under general anesthetic. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on November 9, 2015, at which time it was noted that he was seen for a bilateral wrist problem. It was noted that Petitioner had bilateral wrist pain to the carpal tunnel area with numbness and tingling at night and at work, and that he was a cook at ISU. The assessment was noted to be that of 35-year-old right hand dominant male with bilateral carpal tunnel syndrome, right more symptomatic than left, and right cubital tunnel syndrome. It was noted that Petitioner was provided with bilateral wrist splints and a right elbow splint to wear at night, and that he was also scheduled for bilateral upper extremity EMGs on that date. It was noted that due to Petitioner's age he would most likely need repeat carpal tunnel releases. It was further noted that Petitioner was to undergo the EMG studies and then follow-up with Dr. Oakey. At the time of the November 18, 2015 visit with Dr. Carmichael, it was noted that Petitioner was a 35-year-old male with right greater than left hand symptoms, that he reported September 2, 2015 that he reported numbness and tingling and wrist pain and saw the doctor October 23rd, that he worked as a chef at ISU, that he complained of pain in the right wrist in particular but that he also had numbness and tingling in the fourth and fifth digit and occasionally the whole hand would fall asleep, that his symptoms were more in the right than the left, that aggravating factors including use of the wrist or trying to sleep, and that alleviating factors were rest. It was noted that on EMG there was an ulnar neuropathy at the right elbow and that it seemed like a number of his complaints related to mechanical wrist pain as well. Petitioner was recommended to follow-up with Dr. Oakey. (PX5).

The medical records of OSF Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The medical records of The Center for Outpatient Medicine, LLC were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent a right ulnar nerve transposition at the elbow and open carpal tunnel release on December 8, 2015 for a pre- and post-operative diagnosis of right carpal tunnel syndrome and cubital tunnel syndrome. (PX8).

The Incident Report dated September 2, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that on September 2, 2015 Petitioner reported that he was experiencing a numbing in his right hand and pain in his right wrist when he was cooking on the woks at Watterson. The report was prepared by Darn Ganci, Assistant Unit Chef, on September 2, 2015. (PX9).

The medical records of McLean County Orthopedics Occupational Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was discharged from occupational therapy on March 3, 2016, at which time it was noted that he reported that he had a few shooting pains the other day, that had no reports of numbness or tingling in the right thumb tip and fingertips, that he reported minor numbness at the elbow incision, that he was able to feel light touch in the thumb tip and fingertips, and that he reported that the right did not feel the same as the left. It was further noted that Petitioner was tender to palpation at the scars, that hypersensitivity was present at the elbow scar, that the scars had minimal underlying scar tissue, that the edema improved as well as range of motion since Monday, that strength tests were slightly weaker, and that he felt he would continue to progress with being back at work and continuing home exercises. (PX10).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report reflects that Petitioner on October 21, 2015 reported that his injury occurred while lifting, flipping, and stirring, and that it caused pain in the wrist/hands. (RX2).

The Section 12 Report of Dr. James Williams dated May 31, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 3.[1] The report reflects that Dr. Williams performed an IME on May 31, 2017, at which time it was noted that Petitioner was a 36-year-old right-hand dominant male who worked at ISU in food service, that he denied any previous injuries to his right or left hand or arms, that he noted that he broke his thumb at the age of 9, and that he had worked in various kitchens, basically doing the same tasks at ISU. It was noted that Petitioner stated that in his job he opened up for the woks, that he also did grilled chicken, pizzas, and burgers, that when he was at the woks he deep fried boxes of chicken, that he did about 20-30 woks per shift, that he flipped burgers, did grilled chicken, that he served students about 600-800 burgers per day, that he did pizzas and that he made about 200-300 pizzas per day, that he made pasta about three times per day, that he made four pans of chicken, beef, rice, beans, and cheese, that he stirred pasta with a boat-type oar, that he made about 10 2-gallon pans of meat sauce, that he did about 100 pounds of chicken tacos, that he did about 100 pounds of beef tacos, that he did about 10 2-gallon pans of marinara sauce, and that he made about 12-14 pans of chicken tacos. The report further reflects that Petitioner indicated that he made sauces, six 5-gallon buckets at a time, placed them in a cart, pushed them into the cooler, and lifted them onto a shelf, and that he made pancakes, eggs, biscuits, and gravy when he worked overtime. It was noted that Petitioner indicated that he rated his pain on the right side at rest of 1-2/10, on the left at 3-4/10, that with activity it was 7-10 on the right, that he wore a brace on occasion but that it was better than before, and that he had numbness and tingling periodically with work or sleep in the ring finger and small finger. It was noted that Petitioner also indicated that he wakes up with pain and numbness and tingling on the left side, that he had weakness on both sides, that he was dropping things on both sides, that he still wears splints occasionally on the right side, and that he had no treatment to date on the left side. (RX3).

The report further reflects that Dr. Williams indicated that Petitioner's chief complaint was numbness, tingling, and pain in the hand and wrist since October 2015, that he stated working as he was using it made it worse, as did turning, twisting, and lifting, that he denied any history of diabetes or thyroid dysfunction, that he stated that as he worked the pain got unbearable and that tingling was waking him repeatedly at night, that he denied tobacco use, that his hobbies included the piano and working in the garden, and that he did occasional woodwork, about one time per month. (RX3).

The report reflects that Dr. Williams opined that it did not appear that Petitioner's job involved any exposure to vibration nor did it involve repetitive forceful gripping and/or pinching of a significant magnitude that would lead to a condition such as carpal or cubital tunnel syndrome, that he believed Petitioner's cubital tunnel syndrome was more the result of his ulnar nerve subluxation than any of the work duties of which he might have performed, and that he believed moreso Petitioner's increased body mass index and/or hypertension would more likely be a cause and/or idiopathic in nature than would be his work duties. It was noted that Dr. Williams opined that Petitioner's medical treatment incurred to date had been reasonable and necessary, that Petitioner may indeed need a left elbow ulnar nerve decompression with subcutaneous transposition as was performed on the right although he did not believe that it would be related to his work duties, and that he believed that Petitioner had a good prognosis. It was noted that Dr. Williams opined that Petitioner could work full duty as he had with no restrictions, and that Petitioner had reached maximum medical improvement as of the date Dr. Oakey released him from his care. (RX3).

The transcript of the deposition of Dr. James Williams dated April 23, 2020 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Williams testified that he is an orthopedic

[1] Any markings and/or underlining that appears in the exhibit was not made by the Arbitrator.

surgeon, and that he holds a board certification to the American Board of Orthopedic Surgery as well as a Certificate of Added Qualifications in hand and upper extremity surgery. (RX4).

Dr. Williams testified that he performed an IME of Petitioner on May 31, 2017. He testified that he noted that Petitioner's BMI was over 30, and that it was found that there was a higher association with carpal and cubital tunnel with a BMI over 30. He testified that Petitioner also had a history of hypertension, and that it was another co-morbidity for carpal and cubital tunnel. He testified that he went over Petitioner's job with him in detail when he examined him, and that he did not have any work duties that indicated to him that his job would have caused or contributed to his carpal tunnel or cubital tunnel. He testified that the stirring of foods would not cause carpal or cubital tunnel. When asked what type of repetitive activity was needed for carpal tunnel syndrome, Dr. Williams responded that he believed it was activity which was forceful, sustained, and repetitive over a long period of time. He further testified that he did not believe that any of the actions were forceful and sustained, as Petitioner did many different activities. (RX4).

On cross examination, Dr. Williams agreed that he saw Petitioner on May 31, 2017 and testified that he was testifying from his notes as it had been almost three years. When asked of Petitioner's blood pressure when he saw him, Dr. Williams responded that they did not take blood pressure when he was seen. He agreed that he testified that hypertension was associated with carpal tunnel syndrome. When asked whether it was independent of whether or not the hypertension was treated, Dr. Williams responded that he did not know what Petitioner's blood pressure was, but that he knew that he was on blood pressure medication. He testified that he did not ask Petitioner was his blood pressure was, and that all he said was that he had hypertension. (RX4).

On cross examination, Dr. Williams testified that it was important that the duties were forceful, sustained, and repetitive. He testified that he was relying on articles written in the *Journal of Hand Surgery*, as well as the American Board of Orthopedic Surgery's opinion. He agreed that Petitioner's increased body mass and/or hypertension would more likely be cause, or that it was idiopathic in nature, rather than his work duties. He testified that it was possible for a number of things to all come together to be a cause if the activities performed were repetitive, sustained, and forceful. (RX4).

On cross examination, Dr. Williams agreed that with determining whether there was sufficient force to cause carpal tunnel syndrome one thing to be considered was how many hours a day that force was applied, and he further testified that he had Petitioner's work hours. He testified that if one worked a lot of hours and did something that was not an activity that was going to lead to carpal tunnel syndrome, he did not think that it mattered the number of hours or the number of years one worked at a position. (RX4).

On cross examination, Dr. Williams agreed that Petitioner had no evidence of symptom magnification or malingering. He agreed that he found Petitioner to be honest and giving forthright efforts. He testified that he has not reviewed any additional medical records since the IME date. He agreed that the medical treatment that Petitioner received, regardless of the cause of his condition, was reasonable and necessary. (RX4).

On redirect, Dr. Williams testified that he did not believe that Petitioner's work activities were repetitive, sustained, and forceful enough to cause carpal tunnel or cubital tunnel. (RX4).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F) as it pertains to 16 WC 750, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 2, 2015 and that his current condition of ill-being is causally related to his work activities for Respondent.

In so concluding that Petitioner's carpal tunnel and cubital tunnel syndrome in his right hand and arm is related to his work activities, the Arbitrator finds the opinions of Dr. Oakey to be more persuasive than those proffered by Dr. Williams in this matter. The Arbitrator finds that the job duties as testified to by Petitioner at the time of arbitration were consistent with those as proffered to Dr. Oakey in the hypothetical posed by Petitioner's attorney at the time of the deposition. (PX1). Furthermore, the Arbitrator notes that the IME report of Dr. Williams reflects that he opined that it did not appear that Petitioner's job involved any exposure to vibration nor did it involve repetitive forceful gripping and/or pinching of a significant magnitude that would lead to a condition such as carpal or cubital tunnel syndrome, that he believed Petitioner's cubital tunnel syndrome was more the result of his ulnar nerve subluxation than any of the work duties of which he might have performed, and that he believed moreso Petitioner's increased body mass index and/or hypertension would more likely be a cause and/or idiopathic in nature than would be his work duties. (RX3). The Arbitrator infers this particular indication by Dr. Williams to be suggestive of an admission that Petitioner's work duties could, in fact, have been contributing to his condition of ill-being, but rather just not to the same extent of the other issues which were that Petitioner's condition was idiopathic or was related to his increased body mass index and/or hypertension.

The Arbitrator finds that Petitioner's job duties are sufficiently repetitive or cumulative to support a finding of causation and/or aggravation of both the right carpal and cubital tunnel syndrome conditions. Petitioner's testimony demonstrated that his job duties were forceful and required frequent gripping, and that he regularly held his right elbow in a flexed position while performing his job duties. As a result thereof, the Arbitrator finds that the job duties as described by Petitioner at the time of arbitration -- which involved the gripping and grasping of stirring with an oar-like object as well as gripping and grasping half-gallon scoops -- were sufficient to cause or aggravate both the right carpal tunnel syndrome and right cubital tunnel syndrome conditions in his right upper extremity.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 2, 2015, and that his current condition of ill-being is causally related to his work activities.

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 to his right hand and arm was reasonable, necessary, and causally related to his work accident of September 2, 2015. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth in Petitioner's Exhibit 7, 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 temporary total disability benefits from December 8, 2015 through March 31, 2016. (AX2). Related thereto, the Arbitrator notes that Petitioner testified that he underwent surgery on December 8, 2015, that he was unable to work on that date, and that as of the January 21, 2016 visit with Dr. Oakey he was given work restrictions that Respondent did not accommodate. Petitioner further testified that he remained under the restrictions by McLean County Orthopedics until March 31, 2016, at which time Ms. Sweeney allowed him to return to work full duty with no restrictions. The Arbitrator further notes that Petitioner's testimony on this issue is consistent with the testimony of Dr. Oakey as to the work restrictions

that were given during the course of Petitioner's treatment. (PX1). As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 16 2/7 weeks, addressing the timeframe of December 8, 2015 through March 31, 2016, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to work as a cook for Respondent. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 33 years old on his date of accident. Given the younger age of Petitioner and the fact that his treating physician, Dr. Oakey, has placed him under no permanent work restrictions, the Arbitrator places lesser greater on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to work for Respondent as a cook. As there was no definitive evidence of reduced earning capacity contained in the record beyond Petitioner's assertions that he now works fewer overtime hours, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has the same job now with Respondent, and that he still performs the same work activities. Petitioner testified that he used to do a lot of overtime, but that now he does not work as much overtime because he needs time to rest and that it is often too painful for him. Petitioner testified that he has changed the way he performs his functions at work, and that he does things a lot slower than he used to. Petitioner testified that he is right hand dominant, and that his hobbies have also been affected by his condition, including restoring classic cars and wood working. At the time of the April 28, 2016 visit with Dr. Oakey, it was noted that Petitioner was doing well with only some patellar [*sic*] symptoms, that he was to return on an as needed basis, and that he was at maximum medical improvement with no further medical care anticipated. It was noted that Petitioner was given a note to return to work allowing him to return full duty. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records at the conclusion of his treatment with Dr. Oakey. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. The Arbitrator further notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st App. Ct. Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and

no separate award is being made. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st App. Ct. Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing."). Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent **10% loss of use of the right hand and 10% loss of use of the right arm** as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC000692
Case Name	TAYLOR, KYLE v. IL DEPT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0448
Number of Pages of Decision	12
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Dirk May
Respondent Attorney	Bradley Defreitas

DATE FILED: 9/3/2021

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kyle Taylor,

Petitioner,

vs. NO: 18 WC 000692

State of Illinois Department of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 19, 2020 is hereby affirmed and adopted.

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

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

September 3, 2021

o071321
MEP/ypv
049

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

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

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

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

21IWCC0448

TAYLOR, KYLE
Employee/Petitioner

Case# **18WC000692**

ST OF IL DEPT OF TRANSPORTATION
Employer/Respondent

On 11/19/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0564 WILLIAMS & SWEE LTD
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

6079 ASSISTANT ATTORNEY GENERAL
BRAD DeFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1430 BUREAU OF RISK MANAGEMENT
801 S 7TH ST
6TH FL
SPRINGFIELD, IL 62703

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

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

NOV 19 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kyle Taylor Case # **18** WC **692**
Employee/Petitioner
v.
State of Illinois Department of Transportation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Adam Hinrichs**, Arbitrator of the Commission, in the city of **Bloomington**, 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **12/11/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**59,400.00**; the average weekly wage was $**1142.31**.

On the date of accident, Petitioner was **50** 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 $**88,015.84** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**88,015.84**. Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

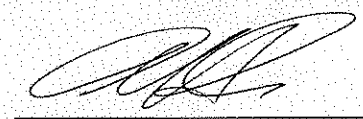
Petitioner has proven by a preponderance of the evidence that his current condition of ill-being in his head, left shoulder and cervical spine is causally related to his work accident on December 11, 2017. Respondent shall pay the following outstanding medical bills, as set forth in Petitioner's Exhibit 13: Persistent Labs $3,348.78, WCRX Solutions $10,773.72, Dr. Kube $1,108.75, Dr. Rhode $30,229.28, UPH/GSB collections $1366.18, Ft. Jesse imaging/Frost collections $3,092.00, ATI Therapy $1,157.21, Specialty Care $8,528.00, Bob Rady Anesthesia $3,795.00, Dr. Trudeau $2,378.00, and Prairie Surgi-center $23,707.63. Respondent shall pay these medical bill amounts directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act, and subject to reductions under the medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $760.68/week for 141 6/7 weeks, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $88,015.14 for temporary total disability benefits that has been previously paid. Respondent shall provide and pay for the revision fusion surgery as recommended by Petitioner's treating orthopedic surgeon, Dr. Kube.

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

November 17, 2020
Date

NOV 19 2020

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties proceeded to hearing on September 29, 2020, with the following issues in dispute: (1) causal connection, (2) medical bills, (3) prospective medical, and (4) temporary total disability benefits.

FINDINGS OF FACT

Petitioner testified that he has been employed by Respondent since May 1, 2014, as a highway maintainer. On December 11, 2017 he was asked to check a truck for an air leak. While he was doing so, the hood of the truck fell, hitting him in the head and pinning his left arm between the inner fender and the steering column. Petitioner testified the hood weighed between 400 and 600 pounds.

On December 14, 2017, Petitioner presented to Dr. Richard Kube, an orthopedic spine surgeon, giving a consistent history of accident, noting the hood that fell on him weighed "200-plus pounds," and complaining of pain in his upper back and neck, and left arm numbness. Dr. Kube was currently treating the Petitioner for his low back. Petitioner had a lumbar surgery scheduled with Dr. Kube for January 2018. Dr. Kube ordered a cervical MRI. On December 22, 2017, a cervical spine MRI was performed indicating "mild to moderate left neuroforaminal stenosis at C5-C6."

Petitioner testified that he had a cervical epidural steroid injection in January of 2018. On January 23, 2018, Petitioner underwent an EMG with Dr. Edward Trudeau, who interpreted it as showing left C6 radiculopathy. On January 31, 2018, Dr. Kube's chart note indicates that physical therapy and a steroid injection provided little relief of Petitioner's complaints. After this conservative course of care proved unsuccessful, Dr. Kube recommended a decompression and cervical spinal fusion.

On March 16, 2018, Dr. Kube performed an anterior C5-C6 decompression and fusion. Following this surgery, Dr. Kube referred Petitioner to Dr. Jacob Tony for his headache complaints, and Dr. Blair Rhode for his left shoulder complaints.

Petitioner underwent left shoulder surgery on September 11, 2018, with Dr. Blair Rhode.

On March 12, 2019, Dr. Kube noted that Petitioner's neck pain was improving and he would release him to return to work with some restrictions. However, Dr. Kube did "not want him involved with a lot of heavy vibration, so certainly [Petitioner] is permanently restricted from jackhammer use" and he does not "want him subjected greater than an hour or two of vibration on a motorcycle on any given day…Otherwise, I do not think I need to restrict him further with his neck…75 pounds overhead would be permanent in addition with respect to his neck."

Dr. Rhode released Petitioner to return to work full duty as it related to his shoulder on April 1, 2019.

Petitioner testified that he returned to work on May 1, 2019. The medical records indicate that Petitioner was released to return to work by his treating physicians by April 1, 2019. Petitioner testified that upon his return he was instructed that he had to learn a new machine for removing bumps on the highway. Petitioner testified that the machine he operated was a skid-loader. The new skid-loader had hard rubber tracks on it and "the machine shift so hard violently that I felt something in my neck at that point went wrong." Petitioner operated the skid-loader for approximately ten hours over a three-day period.

Petitioner testified that he was at work for approximately three weeks before he was taken off work again.

On April 30, 2019, Dr. Kube's records indicate that Petitioner had been operating a skid loader at work, and presented with severe neck pain. Dr. Kube noted "he probably had a stable arthrosis at the time of his last visit. At this point, unfortunately, my concern certainly is that being in the machine…that he was in for those couple of days is the opposite of what I wanted and instructed in my work restrictions. That would have subjected him to whole body vibration for a couple of days, and on a non-cushioned surface, the track is not going to absorb anything, which I did not want him doing…this is clearly not what I want him to do, and is an example of a job position that I would strictly…forbid him to do. Unfortunately, his employer did not follow that and now here we are. I am taking him completely off work at this time. My concern is that if this is now an aggravated pseudoarthrosis, we have a small window here to try and restabilize him…if we cannot do that, there is a strong chance he is looking at a revision surgery that barring this bump grinding event would likely not be necessary."

On October 22, 2019, after a course of conservative care, Petitioner presented to Dr. Kube complaining of significant neck pain. Dr. Kube reviewed a recent CT scan and performed a physical exam. Based on his review of the CT and the physical exam, Dr. Kube reiterated his opinion that there was a non-union of Petitioner's C5-6 fusion, and recommended a revision fusion with DTRAX.

Petitioner testified that he attempted to return to work again on April 1, 2020 but did not make it through the morning. Petitioner testified he was instructed by his supervisor that he could not be at work if he was unable to perform all the job duties, and should go on non-occupational disability ("non-occ").

Petitioner testified that he is now on non-occ disability pay and before that he used his personal time, vacation time, and sick time. Respondent claimed no credit for payment of non-occupational disability benefits. Petitioner testified that prior to the work accident on December 11, 2017 he had no prior neck or left shoulder complaints or medical treatment. Petitioner testified that he currently notices pain between his shoulder blades, like a knife was stuck there, and pain running across both shoulder blades. He also notices that two fingers and his thumb have started to tingle in his right hand. Petitioner notices that he has significantly decreased strength in his left arm and has trouble lifting a gallon of milk. He also notices cramping and swelling in his left bicep, and he cannot lift his left arm above shoulder level.

Evidence Deposition of Dr. Richard Kube

Dr. Kube testified that he began treating Petitioner for his neck injury on December 14, 2017. Dr. Kube testified that Petitioner provided a history of the neck and left arm pain after a heavy truck hood slammed onto his head, neck and left arm.

Petitioner underwent an MRI on his neck that showed "stenosis at C5-6…more foraminal than midline in nature. There was not any distinct large focal herniation on the scan superimposed on that stenosis." Dr. Kube testified that the diagnosis was cervical stenosis with radiculopathy of C-6, left side, corresponded with Petitioner's physical exam. After a failed course of physical therapy and injections, Dr. Kube recommended cervical discectomy for decompression with fusion at C5-6. The surgery was performed on March 16, 2018.

Dr. Kube testified that Petitioner returned on April 30, 2019 with significantly increased pain due to working on a skid loader for his employer. Petitioner complained of significant neck pain, stiffness, and

pain at the base of the neck. Dr. Kube had another MRI done and reviewed the film. Dr. Kube testified that the July 9, 2019 MRI showed non-union at C5-6 that corresponded to the continued C6 radiculopathy pain. Dr. Kube testified that the report showed stenosis at C5-6, and that the implants were in a satisfactory position. Dr. Kube testifies that a non-union, by itself, does not necessitate care, however, if it becomes symptomatic, you have to "do something, up to and including revising the fusion from before."

Dr. Kube testified that the truck hood falling on Petitioner's head and shoulder caused his neck condition based on the significant mechanism of injury to the head, neck, shoulder, and upper back region. Dr. Kube testified that when Petitioner returned to work and was operating the skid loader, he "aggravated his pseudoarthrosis or non-union," and since that time has had complaints of significant neck pain, stiffness, and pain at the base of the neck. Dr. Kube testified that operating a skid loader exposes one to heavy vibration. Doing heavy vibration work for thirty minutes could aggravate a non-union of a fusion, and the longer one operates a skid loader, the more that potential increases to aggravate a non-union.

Dr. Kube testified that the need for additional surgery is related to the December 11, 2017 accident because the first fusion did not become completely solid, and was then aggravated by operating the skid loader. Dr. Kube recommends a minimally invasive surgical procedure to achieve the fusion in Petitioner's cervical spine.

Petitioner testified that if Dr. Kube's recommended course of care were authorized, he would seek said care.

Evidence Deposition of Dr. Blair Rhode

Dr. Rhode testified he originally saw Petitioner on May 30, 2018, on a referral from Dr. Kube, to address left shoulder pain as a result of a truck hood forcing his left arm backwards. Dr. Rhode diagnosed Petitioner with rotator cuff tendonitis with biceps tendinopathy or biceps pathology. Dr. Rhode performed a surgery on September 11, 2018 to release the biceps tendon and reattach it with a biceps anchor.

Dr. Rhode testified that Petitioner developed a postoperative frozen shoulder, so Dr. Rhode performed a manipulation under anesthesia on January 8, 2019. Dr. Rhode opined that the truck hood falling on Petitioner's neck and left shoulder region caused his left shoulder condition and the need for the conservative medical care he provided, as well as the surgeries he performed.

Report of Dr. David Anderson: Respondent's Section 12 Examiner

On October 25, 2018, at Respondent's request, Petitioner presented to Dr. David Anderson for a Section 12 exam related to Petitioner's left shoulder. Dr. Anderson found Petitioner's medical care for his left shoulder through the date of exam, including his first surgery with Dr. Rhode, to be reasonable, necessary, and related to his work accident. Dr. Anderson anticipated Petitioner would be at MMI for his left shoulder arthroscopy and biceps tenodesis approximately six to nine months post-operatively. Dr. Anderson recommended Petitioner undergo a post-operative course of physical therapy and work conditioning.

On April 1, 2019, eight months after his initial surgery, Dr. Rhode released Petitioner to return to work full duty in relation to his left shoulder.

Evidence Deposition of Dr. Andrew Zelby: Respondent's Section 12 Examiner

On March 2, 2020, at the request of Respondent, Petitioner presented to Dr. Andrew Zelby for a Section 12 examination of his cervical spine. Dr. Zelby later testified that on physical exam he noted that "strength was normal except give way weakness and reverse flexion and extension in every muscle group of the upper left extremity." Dr. Zelby testified that his opinion was that Petitioner underwent an anterior cervical discectomy and fusion which showed up as a stable fusion construct on the CT scan that he reviewed. He further testified that the MRI showed satisfactory appearance with no significant stenosis and no neuro impingement. Dr. Zelby further testified that he does not believe Petitioner needs further treatment for his cervical spine irrespective of cause and that Petitioner is able to return to work at full duty.

Dr. Zelby disagreed with Dr. Kube that the operation of a skid loader with heavy vibration could aggravate Petitioner's cervical fusion. Dr. Zelby accepted what Dr. Trudeau found on his EMG, however, Dr. Zelby felt it must be clinically correlated and "when I evaluated [Petitioner], he did not have symptoms that followed a C-6 dermatomal distribution, he had no findings of C-6 radiculopathy and he had nothing on his diagnostic studies that would cause C-6 radiculopathy."

Dr. Zelby testified that neck pain would be consistent with the non-union of a spinal fusion. Dr. Zelby testified that a DTRAX fusion procedure is indicated if you have evidence of an unstable construct.

CONCLUSIONS OF LAW

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

Petitioner credibly testified that he had no neck or shoulder problems or treatment prior to his traumatic work-related accident on December 11, 2017.

In regard to Petitioner's left shoulder, both his treating physician, Dr. Rhode, and the Section 12 examiner, Dr. Anderson, agree that the initial arthroscopic surgical intervention was reasonable, necessary, and related to Petitioner's work accident. Petitioner suffered a frozen shoulder post-operatively. On January 8, 2019, Dr. Rhode performed a manipulation under anesthesia to correct Petitioner's frozen shoulder. This manipulation took place subsequent to Dr. Anderson's Section 12 exam. The manipulation under anesthesia helped the Petitioner to return to full duty in relation to the left shoulder on April 1, 2019, eight months after his first left shoulder surgery. Dr. Anderson opined in his report that a full duty release to return to work for the left shoulder within six to nine months was expected. Dr. Rhode opined that the truck hood falling on Petitioner's neck and left shoulder region caused his left shoulder condition and the need for both the conservative care he provided, and the surgeries he performed.

In regard to Petitioner's cervical spine, Dr. Kube's treatment through March 12, 2019, alleviated most of Petitioner's neck complaints, and Petitioner was much improved. At that time, Petitioner was released to return to work with restrictions. Dr. Kube released Petitioner with a very specific restriction to "avoid vibration" in his work duties and his activities of daily living. Dr. Kube did not want him operating a jackhammer, or even riding a motorcycle for more than a couple of hours due to high risk of aggravating his cervical fusion.

When Petitioner returned to work, Respondent placed him in a job operating a skid loader that shook and vibrated, sometimes violently, for approximately 10 hours over a three-day period. Petitioner noticed something wrong in his neck after operating the skid loader. On April 30, 2019, Petitioner returned to Dr. Kube with

extreme neck pain. Dr. Kube's chart note from that date reveals his frustration with Petitioner's restrictions being ignored by the Respondent. Dr. Kube noted that as a consequence of Petitioner operating a skid loader, he likely had a non-union of his cervical fusion, and may require a revision if he could not reduce Petitioner's pain through conservative measures. Petitioner's conservative course of care following his April 30, 2019 visit failed to alleviate the pain in Petitioner's neck.

Dr. Kube testified that when Petitioner returned to work and was operating the skid loader, he "aggravated his pseudoarthrosis or non-union," and since that time has had complaints of significant neck pain, stiffness, and pain at the base of the neck. Dr. Kube testified that operating a skid loader exposes one to heavy vibration. Dr. Kube testified that doing heavy vibration work for thirty minutes could aggravate a non-union of a fusion, and the longer one operated a skid loader, the more likely it is to aggravate a non-union of a fusion.

Dr. Kube testified that the need for a revision fusion surgery is related to the December 11, 2017 accident because the first fusion did not become completely solid, and was aggravated prior to becoming solid by Petitioner's operating a skid loader at work. Dr. Kube recommends a minimally invasive surgical procedure to achieve the fusion in Petitioner's cervical spine.

The Arbitrator is persuaded by the Petitioner's treating physician, Dr. Kube, on the issue of causation as his opinions correlate with the sequence of events and the record as a whole. Dr. Kube's initial course of care improved Petitioner's condition sufficiently in order for him to return to work with some restrictions to protect his neck. Further, Petitioner was assigned to learn how to operate a heavily vibrational skid loader upon his return to work, in direct violation of Dr. Kube's restriction to avoid vibratory work. Petitioner did so for 10 hours over a three-day period. Petitioner immediately noticed something went wrong in his neck, and complained of severe neck pain after operating the skid loader.

The Arbitrator is not persuaded by the opinions of Dr. Andrew Zelby, Respondent's Section 12 examiner. Dr. Zelby's opinions do not correlate with the sequence of events or the record as a whole. While Dr. Zelby disagrees, it is plainly evident that Petitioner's traumatic injury to his neck, subsequent complaints, objective and subjective findings, medical care, initial recovery, the foreseeable aggravation from heavy vibrational work, which Dr. Kube specifically restricted, and Petitioner's subsequent neck pain complaints, are all supported by the record.

Both Dr. Kube and Dr. Zelby agree that neck pain is consistent with a non-union of a fusion, and a revision fusion is reasonable if there is a non-union.

Given the preponderance of the credible evidence, the Arbitrator finds that Petitioner's current condition of ill-being in his head, cervical spine and left shoulder is causally related to his December 11, 2017, work accident.

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

Incorporating the above findings, the Petitioner is entitled to prospective medical care. Respondent is ordered, pursuant to Section 8(a) and 8.2 and subject to the medical fee schedule, to provide and pay for the recommended revision fusion surgery as recommended by Petitioner's treating surgeon, Dr. Kube.

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?

Incorporating the above findings, the Arbitrator finds that the medical services provided to Petitioner have been reasonable and necessary.

The Arbitrator finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services. Respondent shall pay the following outstanding medical bills, as set forth in Petitioner's Exhibit 13: Persistent Labs $3,348.78, WCRX Solutions $10,773.72, Dr. Kube $1,108.75, Dr. Rhode $30,229.28, UPH/GSB collections $1366.18, Ft. Jesse imaging/Frost collections $3,092.00, ATI Therapy $1,157.21, Specialty Care $8,528.00, Bob Rady Anesthesia $3,795.00, Dr. Trudeau $2,378.00, and Prairie Surgi-center $23,707.63.

Respondent shall pay these medical bill amounts directly to Petitioner pursuant to Section 8(a) and 8.2 of the Act, and subject to reductions under the medical fee schedule.

Issue (L): What temporary benefits are in dispute (TTD)?

Incorporating the above findings, the Arbitrator finds that the Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from 12/12/2017 through 4/1/2019, and from 4/30/2019 through 9/29/2020.

Respondent shall pay Petitioner temporary total disability benefits of $760.68/week for 141 6/7 weeks, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $88,015.14 for temporary total disability benefits that have been paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC005747
Case Name	PARIS, PEDRO v. HYVEE
Consolidated Cases	18WC005748
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0449
Number of Pages of Decision	27
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Steven Berg
Respondent Attorney	Christopher Crawford

DATE FILED: 9/3/2021

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pedro Paris,

Petitioner,

vs. NO: 18 WC 005747

Hy-Vee,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, temporary total 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 19, 2020 is hereby affirmed and adopted.

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

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

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

September 3, 2021

o071321
MEP/ypv
049

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0449

PARIS, PEDRO
Employee/Petitioner

Case# **18WC005747**
18WC005748

HY-VEE
Employer/Respondent

On 8/19/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% 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:

2046 BERG & ROBESON
STEVE BERG
1217 S 6TH ST
SPRINGFIELD, IL 62705

0358 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pedro Paris
Employee/Petitioner

v.

Hy-Vee
Employer/Respondent

Case # **18** WC **5747**

Consolidated cases: 18 WC 5748

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 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 **January 20, 2018 and on February 9, 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 January 20, 2018, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

On February 9, 2018, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident of January 20, 2018.

Petitioner's current condition of ill-being ***is*** causally related to the accident of February 9, 2018.

In the year preceding the injuries, Petitioner earned $**13,478.92**; the average weekly wage was $**259.21**.

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

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

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

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

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

ORDER

In regard to the alleged accident of January 20, 2018, 18 WC 5747, the Petitioner has failed to prove that his injury arose out of and in the course of his employment by Respondent and benefits for the injuries suffered in that incident are therefore denied.

In regard to the alleged accident of February 9, 2018, 18 WC 5748, the Petitioner suffered an injury which arose out of and in the course of his employment by Respondent, and has proved that his current condition of ill being, left Achilles tendon rupture and pulmonary embolism are causally connected to said February 9, 2018 accident,

Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibits 2 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from February 9, 2018 to present which are causally related to the accident of February 9, 2018. Respondent shall reimburse Petitioner for co-pays paid by him and evidenced by the bills included in PX 2 in the amount of $23.90, and shall reimburse the Illinois Department of Healthcare & Human Services for those amounts paid by them on account of the accident of February 9, 2018 from February 9, 2018 through August 18, 2018.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 6 2/7 weeks, commencing February 9, 2019 through March 26, 2018 as provided in Section 8(b) of the Act.

As a result of the accident of February 9, 2018 Petitioner has been disabled to the extent of 30% loss of use of his left foot pursuant to pursuant to §8(e) of the Act due to his left Achilles rupture, and to the extent of

7 ½% loss of use of the man as a whole pursuant to §8(d)(2) of the Act due to his multiple vein thromboses and his pulmonary embolism. Respondent shall be given credit for a prior workers' compensation settlement in case 15 WC 21464 for 10% loss of use of the Petitioner's left foot. and Respondent shall therefore pay Petitioner permanent partial disability benefits of $220.00 per week for a net total of 79.05 weeks after reduction of the award for prior credit.

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.

Dennis J. O'Brien

Signature of Arbitrator

August 13, 2020
Date

AUG 19 2020

Pedro Paris vs. Hy-Vee 18WC 5748

FINDINGS OF FACT

Petitioner has filed two Applications for Adjustment of Claim for accidents involving his same body part, the left foot, ankle, and calf. Petitioner's only claimed injury from the accident of January 20, 2018 is to the left foot and ankle. In regard to the second accident he has claimed injuries to his left ankle, low back, both hips, and a pulmonary embolism as a result of multiple deep venous thromboses. Both claims were consolidated for purposes of arbitration.

Testimony of Petitioner Pedro Paris

Petitioner testified that on January 20, 2018 he was employed by Respondent in Springfield, having begun employment with Respondent in December of 2015. He said he started working for Respondent as a line cook in the kitchen, but six months or so later was moved to work in the deli. On January 29, 2018 he was still working in the deli.

Petitioner said that his boss, the deli manager, Adam Hennenfent, kept asking him to go to the company's Christmas party, which was to be on January 20, 2018 at the Illinois State Fairgrounds in the Orr Building. He said Mr. Hennenfent began asking him to attend about a week before the party. He said he initially told him no, as he would not like a work party, but Mr. Hennenfent asked him three or four times to go and Petitioner felt like Mr. Hennenfent was going to take it out on him at work if he did not go, taking hours or days away from him.

Petitioner said that Mr. Hennenfert was supposed to pick him up to take him to the party, but he did not, that he sent a co-worker named Courtney over to Petitioner's house who took him to the party. They arrived at the party after dark, though he did not know the time. He said the deli department all sat together at the party in one section, with at least eight people at his table, including Mr. Hennenfent. Mr. Hennenfent then offered to buy Petitioner a drink and they went to the bar where Mr. Hennenfent purchased the drinks.

A type of contest was held during the party, and Petitioner did not initially want to participate, but he said Mr. Hennenfent kept egging him on, showing off in front of his wife and the other workers, asking him to participate six or seven times. Petitioner said he eventually agreed to participate, but that he felt pressured to do so. He said the game was a type of musical chairs where participants sat in chairs and then ran out into the crowd and got whatever the DJ asked them to get. While sitting on a chair during the game the DJ instructed them to go out and get eyeglasses from a person in the crowd. He said he rushed out and glasses were given to him, and while running back to his chair he slipped on an indentation from a water drain in the floor and fell. He said he noticed that his left ankle was sore, pointing at arbitration to the junction of the foot and the ankle on the top of the foot on both sides, right where the foot would bend.

Petitioner said he was concerned that if he did not go to this party or participate in this game something might happen to him, as before the Christmas party they had been changing work days around on the schedule and he had been asked to sign a form noting he had not showed up for work or called in and he refused to do so as he had not been scheduled for that day. He believed Mr. Hennenfent prepared the schedule but that another employee had gone in after him and made changes. He said Mr. Hennenfent in

the past, prior to the Christmas party, had reduced his hours when they got new employees or an employee came back to work during school breaks. He said this concerned him as he had to pay his rent and utility bills and that was difficult if his hours were cut. He said he also wanted to work the day shift but Mr. Hennenfent never gave him daytime hours. He said he was also upset because on the first day he worked for Respondent, while he was being trained, Mr. Hennenfent wrote him up for not seeing a customer.

Petitioner said that after he fell at the Christmas party a man gave him a towel with ice and he put it on the front and side of the ankle and sat down. He said Courtney and her husband dropped him off at home. He hadn't asked them to take him to the hospital as they had to get home and he did not have transportation and he could not have gotten home had they dropped him off at the hospital. He said he then just spent time in his house, only being on his feet to get a sandwich and glass of water and go to the bathroom, otherwise laying down. He said his pain did not change from that time until he went to St. John's emergency room on January 23, 2018. He said that he was treated by a man in the emergency room but did not know his name. He said he did not tell anyone in the emergency room that he had experienced a crunch or a pop in the back of his foot in this incident. He did not know if crutches were prescribed for him at that time, but he said he had crutches and he did tell someone that the crutches just made him more tired than just walking on his own, though he didn't know if this was after this incident or after his second accident. He said he was not taken off work by the emergency room staff, though he was provided a boot which did not fit properly as there was a lot of play where the heel would sit down. He said he put a washcloth at the bottom of the boot. He said that did not help much.

Petitioner said he did not receive any follow up care between his visit to the emergency room and the date of his second accident. He said the doctor had told him to wear the boot for three or four months.

Petitioner said he returned to work for Respondent. He said his typical amount of work was 28 hours per week

Petitioner said he suffered a second accident while working for Respondent on February 9, 2018. He said he injured his Achilles on February 9, 2018, while carrying two boxes of Italian bread on his shoulder from the freezer to the sandwich shop, where he was working. He said the boxes were about three feet long and 18 to 24 inches wide and 12 inches tall. He said he walked through a three foot wide door, and as he did so his path was blocked by another employee who was on the phone. He said there was a square four-wheeler cart approximately two and a half feet on a side on the floor which was used to move thing catering materials. He said there was an opening in the middle of the cart and it was approximately four inches high. He said in addition to the employee on the phone there was another employee in the area. Petitioner said he tried to maneuver out of the way and that while doing so his boot got stuck in the hole in the middle of the four-wheeler and he almost fell down. He said he tried to get the cart off of his boot but he could not, and he thought that he was going to fall over.

Petitioner said he noticed pain at the back of his Achilles tendon from the heel up into his calf. He said he heard some crunching and snapping. He said he reported this to his employer and he was sent home. He said his back was also bothering him. He noted that the boot he was wearing caused that leg to be higher than the other one and his waist was "out of whack," and with this incident he had to maneuver himself to stabilize his back.

Petitioner said that following the incident of February 9, 2018 he went to the emergency room of St. John's Hospital on February 10, 2018 as he could not press his foot down. He said he told the hospital staff everything he felt, including the popping and crunching he experienced with the four wheel dolly incident. Petitioner said his manager told him he could not come back to work until he had a doctor's release. He said he relayed that information to the hospital staff, advising them that he needed some kind of restriction or off work slip. He agreed that if the records from that visit showed he was placed on crutches, it would be accurate.

Petitioner said he did not have a primary care doctor at the time of either accident, and that the personnel at the emergency room referred him to Dr. Ben Stevens, an orthopedist. He said he saw Dr. Stevens a few days after the emergency room visit and that he described both accidents to that physician.

Petitioner said he has not had any new injuries involving his left foot or heel since the second accident, though he said he did get a blood clot in the ankle shortly after the second injury. He said he had been having intense back pain for three or four days and had gone to the hospital and told them of the pain. He said he had suffered a pulmonary embolism, and was in the intensive care unit for three or four days at Memorial Medical Center and then was in a regular room. He said he had to take blood thinners for the next six months. He said he completed that course of treatment and was not taking blood thinners as of the date of arbitration. He noted he had never had a pulmonary embolism prior to this.

Petitioner said he saw Dr. Stevens once but then was not seen as he did not have insurance with the company they accepted. He noted he got his insurance through Public Aid. He noted he did buy boot inserts from a prescription Dr. Stevens had given him.

Petitioner said he had suffered a workers' compensation accident in 2015 involving his ankle, and had settled that claim, though he could not remember what the settlement amount was. He said he was not having any problems with his left foot after he recovered from the 2015 injury until the accident of January 20, 2018. He said he had never injured his low back prior to February 9, 2018.

Petitioner said that as of the day of arbitration he still experienced shortness of breath while walking. He said he had been scheduled for pulmonary testing but it had not been performed due to a number of things occurring, including his becoming homeless and his need to take a Covid test before he could take the pulmonary tests.

Petitioner said that as of the date of arbitration his left foot and Achilles area made it more difficult to get around, and a doctor had told him not to do any dancing or running because there could be damage around his heart. He said he would get heavy breathing if he tried to go up and down steps due to his left foot and Achilles. He said he had to go up three flights of stairs to get to a job interview and that at the top he was winded. He said he still got occasional pain in his calf and Achilles, especially if he did a lot of walking. He said he noticed his balance was a little off and that he had a limp, which he had not had previously. He said he could not push off with his left foot as he had before and that it caused some discomfort, and a little strain of the Achilles. He said he went out and bought a wrap for the ankle, which he uses. Petitioner said he had some back pain in the low back, above his beltline, in the morning. He said this was in the area where he had pain immediately after the four wheel dolly incident.

Petitioner said he had not experience any additional injuries since the four wheel dolly incident.

Petitioner said he paid a small amount of his bills directly to his doctors and wanted to be repaid for that, but that the majority of his bills had been paid by Public Aid.

On cross-examination Petitioner again said the last time he injured his low back was in a car accident, but that he had strained his back at work. He agreed he had settled two prior workers' compensation claims in regards to his back, but could not recall if they were in July of 2015 and August of 2015, both against Quik-n-EZ. He said doctors had not told him he was obese but he felt he was obese as of the date of arbitration. He said he weighed about 250 when injured in January and February of 2018, when injured, and 317 on the date of arbitration.

Petitioner said Mr. Hennenfent was his manager at the time of the Christmas party and that Courtney was his supervisor. He agreed he had not called either to testify at the arbitration. He said there had been a sign up sheet for the January 20, 2018 party and he could not recall if he had signed up on it. He knew the party was going to take place elsewhere but did not know if employees from other stores were going to be working at the Springfield store during the party.

Petitioner agreed he did not have any documentation showing that he would be punished and his hours decreased if he did not attend the party, nor had he filled out any kind of statement indicating a fear of being punished if he did not attend. He imagined there were people who did not go to the party. He said he was not paid for the time he spent at the party. He did not know if he was scheduled to work the day of the party or whether he had worked that day as it was so long ago. He said he had concerns about his hours being shorted and had talked to the general manager of the store about it, the general manager who had gotten fired, asking him why they were cutting his hours. He said he did not know if other people complained about their hours, though he did know people had complained about days being switched around.

Petitioner said he was accurate and truthful with the doctors who treated him. He said he disagreed with the history listed by Dr. Stevens that said that on January 20, 2018 he was "running and heard a pop and fell." He said he did not recall seeing any bruising on his left foot, and that his pain was in the ankle, he did not feel anything in the back. He said he recalled the emergency room staff giving him material when he left, and when shown Respondent Exhibit 2 agreed that the materials he was shown talked about Achilles tendinopathy and Achilles tendon rupture. He said he knew the Achilles tendon was in the back of the foot.

Respondent's counsel read an emergency room note from January 23, 2018 which stated that the patient was complaining of left lateral and posterior ankle pain worse with weightbearing activity. Petitioner said he told them he had pain on his ankle, like a sprain. He did not believe the physicians at the hospital had anything out for him or would be untruthful about what he said.

Petitioner said that he did not fall during the February 9, 2018 incident, though he almost fell as he had two boxes on his shoulder and a boot on his foot and was entangled. He believed George Adams was in front of him at that time, though acknowledging that it was a long time ago. He said he remembered a phone cord was in his way even though it was a long time ago as he said he would not have been tripped up if the other employee had not been standing there.

When asked about doctors' records he had not introduced into evidence, Petitioner said he did see a doctor for diabetes which was a result of weight gain from the embolism and having to eat when taking Coumadin

and Warfarin for six months. He agreed he had not put in any records saying that, saying it was just common sense. He said his primary care physician for the last year was Dr. Malika Baig, prior to that it was Dr. Salman Saeed.

Petitioner said George Adams was present when the February 9, 2018 incident occurred and would have seen it. He said the store had cameras in that part of the store as well.

Petitioner said he was familiar with Jamie Vinger, one of the white shirt managers of the store, a man who was present at arbitration. Petitioner said he was working nights after the accident, working only one day shift. When asked how his employment ended Petitioner said that he was off the clock and was doing some grocery shopping. He said he got in a cash register line and a woman came back inside the store, stepped towards him, bent over and got in his face, saying he had cut in line. He said she looked like she was going to hit him and he told her to "fuck off." He said she was like 6 foot 4, he had two bags of groceries in his hand and all he was trying to do was go home. He felt that saying something to a person who acted like they were going to punch you in the face made sense. He said he got fired for that. He said he did not know the date he last worked for Respondent. He said everybody cusses in the store, that they just singled him out because he cussed off the clock. He felt they retaliated against him because he had an accident.

When asked about the days he was off work Petitioner said he could not be sure. He said he came back to work after the first accident and that after the second accident they told him not to come back until he got a doctor's release. He got a doctor's release and he returned to work.

He said he did fall to the ground during the first incident of January 20, 2018.

On redirect examination Petitioner said the only medical provider he saw on January 23, 2018 was Jason Coble. He said he was never diagnosed with an Achilles tendon rupture on January 23, 2018. He said he was diagnosed with an Achilles tendon rupture while in the emergency room on February 10, 2018.

Petitioner said Dr. Stevens did keep him off work for a period of time and issued off work slips, keeping him off work through at least March 27, 2018. He said he did not work during the time Dr. Stevens had him off work.

On recross examination Petitioner said he never had surgery on his left foot, that Dr. Stevens treated him after the February 9, 2018 accident and that he was believed he was referred to Dr. Stevens by the doctor's wife.

Testimony of Jamie Vinger

Mr. Vinger was called as a witness for Respondent. He testified that he had been employed by Respondent for five years, having been promoted to the position of store manager three days prior to arbitration. As store manager he oversees the entire store, inventory control, sales, customers, employees. In January and February of 2018 Mr. Vinger was manager of perishables for the store, and that perishables included the deli, floral, kitchen, bakery, produce, meat and seafood. He said he remembered January 20, 2018 as that was the holiday party for employees, held after the holidays as they were so busy before the holidays. He said the event was voluntary, with a sign-up sheet that noted that it was voluntary. Not all employees attend, less than 50 percent attend.

Mr. Vinger said he could not recall ever discussing the party with Mr. Hennenfent prior to its occurrence. He said he met with Mr. Hennenfent regularly in regard to employees and there was never any indication that an adverse action would be taken against Petitioner if he did not attend the party. He said the party was held at the Orr Building at the Illinois State Fairgrounds. He said the sign-up sheet tells them how many employees they would need to bring from other stores to man the store while they had the party. He said a prize is given to every employee whether they attend the party or not, with the prize being things like gift cards up to televisions.

Mr. Vinger said he did not see the incident involving Petitioner on January 20, 2018 but that he would have at some point spoken to him about both the January 20, 2018 incident and the February 9, 2018 incident. He said he would have been part of the termination meeting. He said Petitioner violated a company rule through actions unbecoming of a Hy-Vee employee. He said Petitioner was in uniform at the time he told a customer to "fuck off," and they did not feel that was appropriate. He said as far as he knew Petitioner was otherwise a good worker. He said he believed Petitioner was terminated in August of 2018.

Mr. Vinger said he understood Petitioner wore a walking boot after the January 20, 2018 incident. He said he did not recall being involved in the investigation of the February 9, 2018 incident.

Mr. Vinger testified that if Mr. Paris had a complaint about his immediate supervisor, Mr. Hennenfent, and followed the chain of command, he, as Mr. Hennenfent's direct supervisor would have been the next person to report an issue to. He said he never received a complaint about Mr. Hennenfent from Petitioner. He said Mr. Hennenfent still works for Respondent, now serving as manager of perishables, having taken that position when Mr. Vinger was promoted to the general manager position. Prior to being promoted to manager of perishables Mr. Hennenfent had been the deli manager.

On cross examination Mr. Vinger said he did not know why Mr. Hennenfent ws not present at the arbitration hearing. He said he did not have the sign-up sheet for the party with him, and was not aware whether or not it still existed. He said it is the same sign-up sheet they use every year so he is familiar with what it says. They have had this party since the store opened, so there have been six parties. He did not know if Petitioner had gone to any of the previous parties. He said he did not have Petitioner's termination paperwork with him at the hearing, though it would still exist.

Mr. Vinger said had been present when Petitioner testified, and that he did not have any reason to believe that the January 20, 2018 incident did not occur as Petitioner had indicated. He said he did not have any reason to believe that the incident of February 9, 2018 had not occurred as Petitioner had described.

Mr. Vinger said that managers did not get a bonus or any sort of incentive based upon employees attending the party, nor had they ever gotten such a bonus. He said Petitioner would have gotten a gift whether he attended the party or not.

When asked if he knew Petitioner's work schedule between January 20, 2018 and February 9, 2018 Mr. Vinger said he normally worked days and would see Petitioner during the day, but otherwise did not know. He said the average for part-time employees is 28 hours and noted that Petitioner said he averaged 28 hours, the maximum amount. Normally they would do those hours in a four day week. He said evening work could be done in a 2 to 10 shift or a 4 to 10 shift. He said he was not employed at this store when Petitioner

began working there in 2015, that he had come to the store in 2016, having come from a Hy-Vee store in Peoria.

In regard to Petitioner's termination Mr. Vinger said he did not know if the customer who confronted Petitioner was intoxicated. He said he did not know if the paperwork indicated that. He did not recall if he was the person who actually terminated Petitioner, though he had been involved in some manner. While he did not recall if Petitioner had indicated the patron who confronted him was intoxicated, he did recall that the register where this happened was in the liquor section of the store.

On redirect examination Mr. Vinger said that Respondent does have customers who come in and are belligerent, in which case an employee will typically seek out a manager to address the situation, asking the customer to leave the store. He said employees are told this as part of their training. He said role was not taken at the party to see who attended. He said there were no name cards directing where people sit, but they do have people check in so they know who can be called for prizes. He said there was no assigned seating, people could just sit where they wanted to sit. He said while all employees receive a physical gift, attending the party was not paid work.

On recross examination Mr. Vinger said he had no direct knowledge that Petitioner was officially advised of the protocol in the case of an irate customer. He said there was no formal practice for departments to sit at the same table, he thought people who knew each other better just did that.

Testimony of George Adams

Mr. Adams was called as a witness by Respondent. He testified that he had been employed by Respondent for six years. He said he was a kitchen clerk, making food and waiting on customers. Prior to being a kitchen clerk he was a dishwasher for Respondent for the first year. He said he knew Petitioner as he worked in the deli, next to the area where he worked. He said they were both working on February 9, 2018 and he remembered standing by the computer desk and Petitioner coming out of the freezer carrying some boxes, which he assumed were bread boxes. He said that as Petitioner turned the corner he tripped over the wheeled cart they used to push things on . Mr. Adams testified he said something like, "watch out," and asked Petitioner if he was all right. Petitioner asked him if he saw it, which he felt was strange as he had been standing right there. He could not remember if Petitioner fell down or just tripped. He did not remember Petitioner getting his foot stuck in the cart and having a hard time getting it out. He did not think this was a severe incident. He said the cart had been leaned up against the wall, and he did not think it was in the direct path of Petitioner as he exited the freezer. He did not recall if there was another employee on the telephone when this occurred. He said he was behind Petitioner when this happened as he had stepped up to the desk area to make sure he was not in Petitioner's way. He did not believe he obstructed Petitioner.

Mr. Adams said Petitioner was wearing his boot when this occurred. When asked if he thought Petitioner wanted him to see the incident Mr. Adams thought for a considerable period of time before saying he did not think he could answer that question.

Mr. Adams said he did not attend the Christmas party on January 20, 2018 as he just was not up to attending it that year. He said it was not a mandatory event, he had attended it in the past. He said everyone got a prize, that he got a gift card. He said he had not spoken to Mr. Paris about the events of January 20, 2018 or in regard to his medical condition.

On cross examination Petitioner described the area where the February 9, 2018 incident occurred as having a shelf on one side of the freezer door, a cardboard bin on the other side and shelves on both sides of what he described as a hallway. He said there was a small desk with a computer on it in the hallway. He felt two people could comfortably walk side by side in the area. He said there was a wall phone in the area of the freezer which had a cord on it. He could not remember if there was a person using the phone and stretching the cord across the opening at the time of the incident.

Mr. Adams said he knew Mr. Luckey, another employee of Respondent, and he said it was possible that Mr. Luckey was on the phone and that was why Mr. Adams was also back there, talking with him.

Mr. Adams said Petitioner did complain to him of his leg and foot hurting, but he assumed it was to the part of his foot which he had previously injured. He said he filled out a written report about this at some point but he did not have it with him at the hearing. He said he had spoken to Respondent's attorney on a prior occasion when the case was scheduled for hearing. He said he had never had issues with Petitioner.

Additional Testimony of Petitioner Pedro Paris

Petitioner was recalled as a witness. He said he did not recall saying anything like what Mr. Adams recollected he said, but went on to say that if you have previously been injured and you are concerned about your health he thought you would want a witness if you tripped or fell at work because medical bills can be quite expensive. He thought Mr. Adams had seen the incident.

On cross examination, when asked why he would want a witness Petitioner said that he'd had two accidents, one at the party and one at work, and it was kind of odd, so he thought anybody would say what he said.

Petitioner said he felt pressured to go to the party, that he had not gone to the holiday parties in the past.

Medical Evidence

Petitioner was seen at St. John's Hospital emergency room on January 23, 2018 with a history of twisting his left ankle two days earlier with lateral and posterior ankle pain. Physicians Assistant Jayson Coble His physical examination of Petitioner was negative for calf tenderness, deformity or swelling. Petitioner was discharged in a Cam walking boot. PA Coble's primary impression was ankle pain with additional impressions of ankle sprain, ankle swelling and left Achilles tendinitis. PX4; RX 2

Petitioner's next medical treatment was subsequent to the alleged accident in this case. It was again at St. John's emergency room, on February 10, 2018, The history given to Dr. Janda Stevens at that time was of his boot getting caught in a four-wheeler while lifting a box at work the day prior to being seen, his not falling at that time, but that he started having left heel and pain in both feet. He advised her that he had received his boot 30 days earlier in the emergency room to protect his Achilles from injury. He also complained of right foot swelling which had gone down as well as left hip pain and right calf tightness and pain. He also noted a loss of strength in his left calf. On physical examination it was noted that he could not plantar flex his left foot Dr. Janda Stevens noted that "The Achilles tendon on the left foot appears to be not intact." She

contacted Dr. Benjamin Stevens who recommended no weight bearing and the use of crutches. Petitioner was provided with crutches and restricted from work until released by his orthopedist. PX 5; RX 3

Petitioner was seen by Physician Assistant Zachary Sims at SIU on February 12, 2019. The history given to him was consistent with that given in the emergency room and included the emergency room findings, noting the referral to Dr. Stevens for orthopedic care. Petitioner was complaining at that time of his Cam boot being uncomfortable and not adequately cushioned. PA Sims' physical examination noted the Achilles tendon appeared to be grossly intact with the calf having proximal lateral discomfort to palpation and the Achilles tendon being tender to palpation approximately 3 cm from the insertion site on the heel. A prescription was given for calf muscle spasms and Petitioner was advised to put mole skin in his boot at the pressure points and to use a gel shoe insert. PX 7

Petitioner was seen for the first time by Dr. Benjamin Stevens on February 15, 2018. On his surgeon intake form Petitioner noted his pain was 5/10 and was complaining of pain in both hips, the right side and spinal area of his low back, the back of his foot, ankle and back of calf, as well as having pins and needles sensation in the back of his foot. Dr. Stevens took a consistent history of the February 9 accident as well as a history of an accident on January 20 while running, where he heard a pop and fell. The physical examination on February 15, 2018 revealed a palpable defect about the left Achilles tendon. Dr. Stevens assessment at that time was of a left Achilles rupture and he recommended conservative treatment consisting of non weight bearing, bracing day and night until seen again, and the use of a knee scooter. He said it would be four months until Petitioner could return to full duty work. He issued Petitioner a slip noting he was excused from work until released by physician due to left Achilles rupture. PX 6

On February 22, 2018 Petitioner went to Memorial Medical Center's emergency room with complaints of right sided neck pain from coughing. He noted that he had chest pain which started the night before when he had an episode of coughing. He also had right shoulder proximal pain. He noted the pain continued through the night and increased with deep breaths. It was noted that he had been in a walking boot since an injury in January. A chest x-ray showed decreased aeration of the right lung base in the region of a pulmonary infarct. A venous duplex study of his right, uninjured, leg was normal, but a similar study in the injured left leg revealed total occlusions of the femoral, popliteal, post tibial and peroneal veins. The final diagnosis included not only deep vein thrombosis of those veins but also to the gastrocnemius veins of the calf. PX 9

A CT scan of the chest done during that admission revealed a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner was admitted to the intensive care unit from the emergency room. That hospital record noted on multiple occasions Petitioner having been immobilized since an early February rupture of his Achilles tendon After a five day admission Petitioner was discharged from the hospital with instructions to get ongoing anticoagulant management by Dr. Saeed and told to continue non-weight bearing activity with a knee scooter to prevent further strain to the Achilles tendon. Petitioner dd continue to get follow up treatment for anticoagulation testing and treatment through Dr. Saeed. PX 9; PX 7

Dr. Ben Stevens saw Petitioner on March 6, 2018, noted he was still ambulating with his boot, discussed treatments which could be pursued and allowed him to return to work light duty handing out food samples. That limitation was to apply until March 27, 2018, at which point he was to return to work with no restrictions. This was the last occasion Petitioner was seen by Dr. Stevens. PX 6

Petitioner was seen by Dr. Aldridge at SIU on June 29, 2018 in regard to his pulmonary embolism and his anticoagulation. Dr. Aldridge noted, "He presented to SJH ER after a fall recently. Imaging as per Orthopedic clinic note shows left Achilles tendon rupture. After that he presented to MMC ER with SOB and was found to have PE on 2/22." Dr. Aldridge opined that it was "most likely secondary to Achilles tendon rupture as he does not have any other risk factors." PX 7

On November 1, 2018 Dr. Ben Stevens wrote a "To Whom It May concern" letter in regard to Petitioner's treatment by him. In that letter he noted consistent histories of the January 20, 2018 and February 9, 2018 incidents. He noted that following the second accident Petitioner experienced a great deal more pain. Dr. Stevens stated, "It appears that the Achilles tendon rupture likely occurred in January and it was exacerbated in his February incident." He did not place great certainty on when the rupture actually occurred, however, as he had not examined him on January 20, "and certainly this would have been the definitive physical examination to determine when the rupture occurred." RX 1

On December 4, 2019 Physician Assistant Coble wrote a letter to Petitioner's attorney in response to an inquiry from that attorney. In his letter PA Coble wrote,

> Mr. Paris exhibited physical pain on physical examination and palpation of his Achilles tendon during this patient encounter. On further physical examination, there was NO palpable defect of his Achilles tendon. He was subsequently diagnosed with an Achilles tendon strain in addition to other diagnoses listed in his existing medical record. Based on these physical examination findings, I do NOT reasonably believe Mr. Paris had a complete rupture of his Achilles tendon at the time of his emergency department encounter. PX 8

Testimony of Dr. Benjamin Stevens

Dr. Stevens was called as a witness by Respondent. He said he was an orthopedic surgeon with a subspecialty of foot and ankle reconstruction. His testimony in regards to physical findings and treatment was consistent with the medical summary, above. He noted that during his physical examination of February 15, 2018 he noted a palpable defect at the Achilles tendon area. He noted his diagnosis was Achilles tendon rupture and that he prescribed non-operative treatment of it. Petitioner was to return to see him in 10 days. RX 7 p.5,7,8

Dr. Stevens said he next saw Petitioner on March 6, 2018 and that the reason it was longer than ten days between appointments might be because he had sustained a pulmonary embolism in the interim. He noted that "Anytime you have an injury to the lower extremity, you're at higher risk (of a pulmonary embolism). And if you place someone in a boot, you're at a higher risk. So he had three factors against him with a rupture, a boot and smoking." RX 1 p.9

He noted that Petitioner's attorney wrote him a letter about the two incidents and he had written him back advising him, "Which one cause which, based on the description -- again, I can't prove this. But with, you know, I think I put it that, while its my medical opinion, I can't necessarily prove it. But the description and the injury and the fact he went to the emergency department on January 20th suggests that the injury occurred there. Not that it occurred on -- whatever it was -- February 9th." Dr. Stevens went on to say that

to the best of his knowledge, having reviewed the emergency department records for January 23, 2018, there was no diagnosis of an Achilles tendon rupture during the January 23 visit. RX 1 p.12,16

In regard to permanent effects of the injury Dr. Stevens said the Achilles tendon would develop scar tissue in between the rent caused from the rupture which would elongate the Achilles tendon to a length that was not very functional. The other muscles in the lower leg would then start to compensate and help the person get around, "but its certainly not a normal leg if you compare them side by side. So it heals, but it heals improperly." He said that an elongated Achilles can cause balance issues, difficulty with pushing off with the foot, and impact any activity that requires pushing off. He said it generally causes a difficulty with heel pain. RX 1 p.21,22

Testimony of Dr. David Fletcher

Dr. Fletcher was called as a witness by Respondent. He said he was board certified in both occupational and preventive medicine. He said he was asked to perform a medical record review by Respondent and had not personally performed a physical examination of Petitioner. He said his review of the records was to address causal connection and not nature and extent of injury or the ability of Petitioner to work. He felt the records from the January 23, 2018 emergency room visit reflected an acute injury while the records following the February 9, 2018 injury did not seem to show an acute injury, but instead an Achilles tendon rupture which required follow up treatment. He did not believe the February 9, 2018 incident had any impact on Petitioner's Achilles injury, as there was nothing acute on physical examination to indicate an injury on February 9, 2018. RX 8 p.4,7,8,10-12,19

On cross-examination Dr. Fletcher agreed that the diagnosis on January 23, 2018 at the emergency room was of pain in the left ankle and joints of the left foot and did not mention an Achilles tendon rupture, though Petitioner was given instruction materials about Achilles tendonopathy. Dr. Fletcher agreed that the January 23, 2018 emergency room record did not refer to a history of a pop being given at that time while the emergency room history given to the emergency room staff on February 10, 2018 did indicate a history of a pop being heard and felt at the time of that accident. Dr. Fletcher said he had not been provided with either the accident report signed by Petitioner on February 20, 2018, and it was a surprise to him, nor the first report of injury report of February 9, 2018 filled out by Respondent's human resources manager, Mr. Knuffman, RX 8 p.22,23,27-30

Dr. Fletcher agreed that the history in the emergency room records of February 10, 2018 where Petitioner indicated he had left heel pain after the cart incident and that he was not able to raise himself on his heel was a classic sign of both acute and chronic Achilles tendon injury. He also agreed that those complaints were not contained in the history given during the January 23, 2018 emergency room visit. Dr. Fletcher further agreed that the February 10, 2018 records made a definitive diagnosis of Achilles tendon not being present, being detached, which had not been made in the January visit. He also agreed that the primary diagnosis on February 10 was Achilles rupture. RX 8 p.33,34

Dr. Fletcher testified that an Achilles tendon rupture that was not repaired surgically might not have a good result which could cause impairment in activities using the lower extremities, walking on uneven surfaces, climbing stairs, prolonged walking and running, it could be career ending for a professional athlete. He said it could result in some permanency of functionality with that type of an injury. RX 8 p.37

Arbitrator's Credibility Assessment

The arbitrator finds the testimony of all witnesses to be credible. Petitioner appeared to be consistent in his overall description of events and physical complaints without any apparent exaggeration. Mr. Vinger and Mr. Adams testimony also appeared to be factual in regard to events they observed and knowledge of procedure and practices of the company.

CONCLUSIONS OF LAW

In regard to whether an accident occurred that arose out of and occurred in the course of Petitioner's employment on January 20, 2018 the Arbitrator finds the following:.

An injury is compensable under the Workers' Compensation Act only if the claimant proves by a preponderance of the evidence that it arose out of and in the course of his or her employment. An injury arises out of one's employment if its origin is in some risk connected with, or incidental to, the employment so that there is a causal connection between the employment and the accidental injury.

> Section 11 of the Worker's Compensation Act provides
> "Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program."
> 820 ILCS 305/11

The evidence as presented by Petitioner indicates that his participation in the holiday party on January 20, 2018 was voluntary. He noted that while he had been employed by Respondent for several years he had never attended the party in the past and he did not testify to any punishment or retaliation which had occurred as a result of his not attending prior holiday parties.

Mr. Vinger, Respondent's General Manager, and Mr. Adams, a co-employee of Petitioner's, both testified that attendance at the party was voluntary. Mr. Vinger testified that less than 50% of the employees attended the party. He said that all employees received a git or prize, regardless of whether they attended the party or did not attend the party. Employees were not paid to attend the party. Mr. Adams said he did not feel like attending the party that evening, did not do so and received a gift/prize anyway, a gift card.

While he may have felt pressured by his supervisor to attend, noting he was encouraged on a number of occasions to attend after saying he did not plan to do so, and he "felt" he might be punished for doing so, his perception when compared to the testimony of Mr. Vinger and Mr. Adams indicating that fewer than 50% of the employees attended the party, that everyone got a gift or prize regardless of whether they attended the party, including Mr. Adams, who did not attend the January 20, 2018 party, and Petitioner's having never attended the party in the past several years he had been employed with Respondent. Petitioner did not testify to any retaliation from prior failures to attend the party.

The Arbitrator finds that Petitioner has failed to prove that he suffered an accidental injury on January 20, 2018 which arose out of and in the course of his employment by Respondent. This finding is based on the evidence cited above which indicates that Petitioner was not ordered or assigned by his employer to participate/attend the holiday party of January 20, 2018, that it was a voluntary party despite the fact that Respondent paid some or all of the cost of the party.

Benefits for injuries arising out of the January 20, 2018 incident are therefor denied.

In regard to whether Petitioner's current condition of ill-being is causally related to the accident of February 9, 2018 the Arbitrator finds the following:

The findings of fact in regard to the alleged accident of January 20, 2018 are incorporated herein.

The accident of February 9, 2018 was not in dispute.

Petitioner was examined by only one medical provider following the incident of January 23, 2018, Physician Assistant Coble. His physical examination of Petitioner on that date was negative for calf tenderness, deformity or swelling. Petitioner was discharged in a Cam walking boot. PA Coble's primary impression was ankle pain with additional impressions of ankle sprain, ankle swelling and left Achilles tendinitis. PX4; RX 2

In a letter to Petitioner's counsel dated December 4, 2019 PA Coble, referring to his January 23, 2018 treatment of Petitioner said, "Mr. Paris exhibited physical pain on physical examination and palpation of his Achilles tendon during this patient encounter. On further physical examination, there was NO palpable defect of his Achilles tendon. He was subsequently diagnosed with an Achilles tendon strain in addition to other diagnoses listed in his existing medical record. Based on these physical examination findings, I do NOT reasonably believe Mr. Paris had a complete rupture of his Achilles tendon at the time of his emergency department encounter." PX 8

Petitioner testified to an immediate increase in his symptoms after the February 9, 2018 accident and he sought medical attention at St. John's emergency room the next day. After examining Petitioner on February 10, 2018 Dr. Janda Stevens wrote, "The Achilles tendon on the left foot appears to be not intact." Her primary impression was, "Achilles Tendon Rupture." This was the first occasion when that diagnosis was made. PX 5; RX 3

Subsequent to February 9, 2018 new orders were given in regard to the treatment of the left foot, including the prescribing of crutches and the use of a knee scooter. Petitioner's work was restricted for the first time, first by Dr. Janda Stevens in the emergency room, and then by Dr. Benjamin Stevens when he first saw Petitioner on February 15, 2018. PX 5; RX 3; PX 6

Respondent deposed both Dr. Benjamin Stevens and Dr. David Fletcher in support of their position that Petitioner's Achilles rupture was a result of the January 20, 2018 incident and not the February 9, 2018 accident. In a letter dated November 1, 2018 Dr. Stevens stated that Petitioner had a great deal more pain following the accident of February 9, 2018. He felt that the Achilles tendon rupture likely occurred in January but he then immediately went on to note that the February incident exacerbated the rupture. In addition, Dr. Stevens limited the value or strength of his opinions on causation by noting in that letter that, "(w)hile

this is my medical opinion, there is no certainty as I was unable to examine him on January 20, 2018, and certainly this would have been the definitive physical examination to determine when the rupture occurred." RX 1

Dr. Stevens agreed that to the best of his knowledge, having reviewed the emergency department records for January 23, 2018, there was no diagnosis of an Achilles tendon rupture during the January 23 visit. Dr. Stevens said he suspected Petitioner had a rupture on January 23rd that just wasn't diagnosed, but he further said he cannot prove that suspicion. RX 7 p.16,19 "Liability under the Workmen's Compensation Act cannot rest upon imagination, speculation or conjecture * * * but such liability must arise out of facts established by a preponderance of the evidence." Immaculate Conception Church v. Industrial Commission, 395 Ill. 615,623 (1947)

In his deposition Dr. Fletcher voiced his opinion in regard to causal connection in his deposition, saying he did not believe the February 9, 2018 incident had any impact on Petitioner's Achilles injury, that there was nothing acute on physical exam to indicate an injury on February 9, 2018. RX 8 p.19 On cross-examination, however, Dr. Fletcher agreed that the history in the emergency room records of February 10, 2018 where Petitioner indicated he had left heel pain after the cart incident and that he was not able to raise himself on his heel was a classic sign of both acute and chronic Achilles tendon injury. He also agreed that those complaints were not contained in the history given during the January 23, 2018 emergency room visit. Dr. Fletcher further agreed that the February 10, 2018 records made a definitive diagnosis of Achilles tendon not being present, being detached, which had not been made in the January visit. He also agreed that the primary diagnosis on February 10 was Achilles rupture. RX 8 p.33,34

Dr. Fletcher's opinions are of far lesser weight than those of PA Coble, Dr. Janda Stevens or Dr. Benjamin Stevens as those three medical providers actually examined Petitioner, while Dr. Fletcher was merely performing a medical records review. PA Coble, the only medical provider to see Petitioner in the days immediately after the January 20, 2018 incident, was quite clear in his statements that when he saw Petitioner on January 23, 2018 there was no palpable defect of his Achilles tendon. His diagnosis on that date was an Achilles tendon strain. In his letter to Petitioner's attorney he was fairly adamant that he did not reasonably believe Petitioner had a complete rupture of his Achilles tendon at the time of his emergency department visit on January 23, 2018. PX 8

In regard to Petitioner's multiple left leg thromboses and his pulmonary embolism, on February 22, 2018, 13 days following the accident of February 9, 2018, Petitioner went to Memorial Medical Center's emergency room with complaints of right sided neck pain from coughing. He noted that he had chest pain which started the night before when he had an episode of coughing. He also had right shoulder proximal pain. It was noted that he had been in a walking boot since an injury in January. A chest x-ray showed decreased aeration of the right lung base in the region of a pulmonary infarct. A venous duplex study of his right, uninjured, leg was normal, but a similar study in the injured left leg revealed total occlusions of the femoral, popliteal, post tibial and peroneal veins. The final diagnosis included not only deep vein thrombosis of those veins but also to the gastrocnemius veins of the calf. PX 9

A CT scan of the chest done during that admission revealed a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner was admitted to the intensive care unit from the emergency room. That hospital record noted on multiple occasions Petitioner having been immobilized since an early February rupture of his

Achilles tendon After discharge from the hospital Petitioner received follow up anticoagulant management by Dr. Saeed. PX 9; PX 7

Petitioner was seen by Dr. Aldridge at SIU on June 29, 2018 in regard to his pulmonary embolism and his anticoagulation. Dr. Aldridge noted, "He presented to SJH ER after a fall recently. Imaging as per Orthopedic clinic note shows left Achilles tendon rupture. After that he presented to MMC ER with SOB and was found to have PE on 2/22." Dr. Aldridge opined that it was "most likely secondary to Achilles tendon rupture as he does not have any other risk factors." PX 7

Dr. Benjamin Stevens testified that, "(a)nytime you have an injury to the lower extremity, you're at higher risk (of a pulmonary embolism). And if you place someone in a boot, you're at a higher risk. So he had three factors against him with a rupture, a boot and smoking." RX 1 p.9

The Arbitrator finds that Petitioner's left Achilles tendon rupture is causally related to the accident of February 9, 2018. This finding is based upon the medical records of St. John's hospital emergency room for January 23, 2018 and PA Cobles letter of December 4, 2019, the findings of Dr. Janda Stevens of February 10, 2018 and the opinion of Dr. Benjamin Stevens that at the very least the accident of February 9, 2018 exacerbated Petitioner's left foot Achilles injury.

The Arbitrator further finds that Petitioner's multiple deep vein thromboses and his pulmonary embolism are causally related to the accident of February 9, 2018 based upon the records and opinions of Dr. Aldridge and Dr. Stevens as well as the chain-of-events.

In regard to whether Respondent is liable for medical bills the Arbitrator finds the following:

The findings of fact in regard to accident and causal connection, above, are incorporated herein.

All medical bills for services rendered between February 9, 2018 and August 28, 2018 were for medical conditions previously found to be causally related to the accident of February 9, 2018.

Some of the medical bills have been paid by the State of Illinois Department of Healthcare & Family Services, Petitioner has paid $23.90 in co-pays, and the remainder of the medical bills appear to remain unpaid.

The Arbitrator finds that all medical bills pre-dating February 9, 2018 (PX 1) are denied on the basis of the finding of no accident occurring on January 20, 2018 which arose out of and in the course of Petitioner's employment by Respondent.

The Arbitrator further finds that Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibit 2 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from February 9, 2018 to present which are causally related to the accident of February 9, 2018. Respondent shall reimburse Petitioner for co-pays paid by him and evidenced by the bills included in PX 2 in the amount of $23.90, and shall reimburse the Illinois Department of Healthcare & Human Services for those amounts paid by them on account of the accident of February 9, 2018 from February 9, 2018 through August 28, 2018.

In regard to the period of time that Petitioner was temporarily totally disable on account of the accident of February 9, 2018 the Arbitrator finds the following:

On February 10, 2018 Dr. Janda Stevens of St. John's Hospital emergency room restricted Petitioner from work until released by his orthopedist. PX 5; RX 3

Dr. Benjamin Stevens on March 6, 2018 noted Petitioner was still ambulating with his boot and allowed him to return to work light duty handing out food samples. That limitation was to apply until March 27, 2018, at which point he was to return to work with no restrictions. PX 6

No testimony was given in regard to whether Respondent could accommodate Dr. Stevens' restrictions.

Petitioner claimed disability from February 10, 2018 through March 27, 2018. Arb X 2

The Arbitrator finds that Petitioner is entitled to temporary total disability of $220.00 per week from February 10, 2018 to March 28, 2018, a period of was temporarily disable from February 10, 2018 to March 27, 2018, a period of 6 2/7 weeks, and not thereafter.

In regard to the nature and extent of injury the Arbitrator finds the following:

The findings of fact in regard to accident and causal connection, above, are incorporated herein.

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 reported level of impairment pursuant to the AMA Guidelines, 6th Edition, the Arbitrator notes that neither Petitioner nor Respondent introduced an evaluation report promulgated pursuant to the AMA Guidelines. As such, only the remaining four factors are considered in arriving at a determination of permanent partial disability.

With regard to subsection (ii) of §8.b(b), the occupation of the employee, Petitioner was at the time of this accident a a deli worker Respondent. He testified in regards to having to make sandwiches and carry material, such as boxes of sandwich bread, to his work station from the freezer. The Arbitrator gives this moderate weight.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 50 years of age at the time of the accident. As such the Petitioner is currently 52 years of age and could potentially work for another ten to fifteen years in his occupation. Petitioner was neither young nor of advanced years at the time of the accident. The Arbitrator gives this moderate weight.

With regards to subsection (iv) of §8.1b(b), employee's future earning capacity, the Arbitrator notes that Petitioner is no longer in the employ of Respondent for reasons unrelated to this accident and his injuries. No evidence was introduced of Petitioner's current occupation or earnings. The Arbitrator gives this little weight.

With regards to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes:

- Prior to the date of this accident Petitioner had a March 24, 2015 left ankle sprain while working for Arlington's LLC. A workers' compensation claim was filed and subsequently settled with a settlement contract approved in case number 15 WC 21464 reflecting a 10% loss of use of the left foot, RX 6
- As a result of the accident of February 9, 2018 Petitioner suffered a serious orthopedic injury, a rupture of the left Achilles tendon. Petitioner said that as of the date of arbitration his left foot and Achilles area made it more difficult to get around, and a doctor had told him not to do any dancing or running because there could be damage around his heart. He said he would get heavy breathing if he tried to go up and down steps due to his left foot and Achilles. He said he had to go up three flights of stairs to get to a job interview and that at the top he was winded. He said he still got occasional pain in his calf and Achilles, especially if he did a lot of walking. He said he noticed his balance was a little off and that he had a limp, which he had not had previously. He said he could not push off with his left foot as he had before and that it caused some discomfort, and a little strain of the Achilles. He said he went out and bought a wrap for the ankle, which he uses. Petitioner was last seen by Dr. Benjamin Stevens on March 6, 2018. At that time he was still in a Cam boot and his work was still restricted but he had been given a date to return to work without restrictions.
- Dr. Stevens testified that Petitioner's Achilles tendon would develop scar tissue in between the rent caused from the rupture which would elongate the Achilles tendon to a length that was not very functional. The other muscles in the lower leg would then start to compensate and help the person get around, "but its certainly not a normal leg if you compare them side by side. So it heals, but it heals improperly." He said that an elongated Achilles can cause balance issues, difficulty with pushing off with the foot, and impact any activity that requires pushing off. He said it generally causes a difficulty with heel pain. RX 1 p.21,22
- Dr. Fletcher testified that an Achilles tendon rupture that was not repaired surgically might not have a good result which could cause impairment in activities using the lower extremities, walking on uneven surfaces, climbing stairs, prolonged walking and running. He said it could result in some permanency of functionality with that type of an injury. RX 8 p.37
- Petitioner suffered multiple left lower leg deep vein thromboses as a result of this accident, resulting in a saddle pulmonary embolism a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner received follow up care for anticoagulation therapy and continued to complain of shortness of breath as of the date of arbitration.
- While Petitioner did make some complaints in regard to his low back as of the date of arbitration, he described it as a little back pain in the area of the belt when he got up in the morning. No medical records were introduced to corroborate any ongoing low back injury. No current complaints in regard to the right foot or either hip were made at the time of arbitration.
- Petitioner was able to return to his former employment in the deli, performing that work for several months prior to being terminated for unrelated reasons.

The Arbitrator gives this significant weight.

The Arbitrator, having considered the foregoing factors, the medical evidence submitted into evidence and Petitioner's testimony in regard to ongoing complaints, finds that as a result of the accident of February 9, 2018 Petitioner has been disabled to the extent of 30% loss of use of his left foot pursuant to pursuant to §8(e) of the Act due to his left Achilles rupture, and to the extent of 7 ½% loss of use of the man as a whole pursuant to §8(d)(2) of the Act due to his multiple vein thromboses and his pulmonary embolism. Respondent shall be given credit for a prior workers' compensation settlement in case 15 WC 21464 for 10% loss of use of the Petitioner's left foot. and Respondent shall therefore pay Petitioner

permanent partial disability benefits of $220.00 per week for a net total of 79.05 weeks after reduction of the award for prior credit.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC005748
Case Name	PARIS, PEDRO v. HYVEE
Consolidated Cases	18WC005747
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0450
Number of Pages of Decision	32
Decision Issued By	Maria Portela, Commisioner, Kathryn Doerries, Commisioner

Petitioner Attorney	Steven Berg
Respondent Attorney	Christopher Crawford

DATE FILED: 9/3/2021

/s/Maria Portela, Commissioner

Signature

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PEDRO PARIS,

Petitioner,

vs. NO: 18 WC 5748

HY-VEE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical expenses and nature and extent, and being advised of the facts and law, 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 on the issues of accident and causation and affirms the medical award.

Regarding temporary total disability (TTD), we note that the Order and Conclusions sections contain clerical and computational errors. We find that on March 6, 2018, Dr. Stevens released Petitioner to return to work full duty "after 3/27/18." Therefore, we modify the decision to reflect that Petitioner is entitled to 6-4/7 weeks of TTD benefits from February 10, 2018 through March 27, 2018.

Regarding the nature and extent of Petitioner's injuries, although we generally agree with the Arbitrator's analysis of the weights given to the five permanency factors in §8.1(b)b of the Act, we find the awards excessive under the circumstances.

As for the left foot, Dr. Stevens's opinion that Petitioner could notice some balance

problems and difficulty with push off was only a forecast of possibilities and these symptoms were not corroborated in the notes when Petitioner was discharged from care with a full duty release on March 6, 2018. Furthermore, Petitioner did not attend his final scheduled visit with Dr. Stevens, so there are no records to corroborate Petitioner's claims of balance problems and difficulty pushing off. We also note that Petitioner did not require surgery. Therefore, we hereby reduce the award of permanent partial disability (PPD) benefits from 30% to 20% loss of use of the left foot under §8(e) of the Act. After deducting the 10% credit to which Respondent is entitled, this results in a net award of 10% of the left foot or 16.7 weeks.

Regarding the nature and extent of Petitioner's deep vein thrombosis and pulmonary embolism, Petitioner's most recent medical records do not corroborate his complaints of shortness of breath. *T.61*. Petitioner never underwent any pulmonary tests because he cancelled them "due to some other things" including being told he would have to take a COVID test before the pulmonary tests. *T.62-63*. The last treating record from Dr. Aldridge, on June 29, 2018, indicates:

> no cough, no wheezing and no SOB
> …
> Exam: …no increased work of breathing or signs of respiratory distress. …

The August 21, 2018 record indicates that Petitioner's anticoagulation treatment was to end on August 23, 2018 after six months. Petitioner testified that he is "done with my blood thinner regimen." *T.60*. There is no medical evidence to support Petitioner's testimony that, "My doctor told me if I ever get another blood clot again I would be stuck on that medication for the rest of my life." *Id*. We note that Petitioner has no work restrictions and, even if Petitioner does experience shortness of breath, there is no medical opinion to causally relate that symptom to his resolved pulmonary embolism as opposed to his smoking and obesity. We therefore reduce the PPD award of 7.5% to 4% loss of use of Petitioner as a whole under §8(d)2 of the Act, which equates to 20 weeks of PPD benefits.

Petitioner is therefore entitled to a combined PPD award of 36.7 weeks as described above.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 6-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 16.7 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 20% the left foot (33.4 weeks). As Respondent is entitled to a credit of 10% of the left foot (16.7 weeks), this results in a net award of 16.7 weeks.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 4% of Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses in Px2, as outlined by the Arbitrator, under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $15,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 3, 2021 /s/ *Maria E. Portela*

SE/ /s/ *Thomas J. Tyrrell*
O: 8/10/21
49

Dissenting Opinion

I disagree with the majority's opinion that Petitioner's conditions of ill-being, namely his Achilles tendon rupture and the DVT/pulmonary embolism, were caused by the February 9, 2018, work accident. The overwhelming evidence in this case shows Petitioner's Achilles tendon rupture condition was caused by the January 20, 2018, non-work related accident, a burden Respondent does not bear but satisfied by the evidence, nonetheless. I would find the opinions of Drs. Stevens and Fletcher to be more persuasive than that of Mr. Coble, a physician assistant (PA). Further, I would find that since Petitioner failed to prove causation with respect to the Achilles tendon rupture, Petitioner has failed to prove causation between the DVT/pulmonary embolism and the compensable work-related accident of February 9, 2018. Thus, I would vacate the awards for TTD benefits, medical expenses and permanency for the following reasons.

Petitioner sustained two accidents, January 20, 2018 (18 WC 5747) and February 9, 2018 (18 WC 5748). The first accident was found non-compensable and the decision affirmed. However, the mechanism of injury, findings on initial exam, the medical treatment, the diagnosis, the complaints after this accident are significant and refute that Petitioner's condition of ill-being was caused by the second accident sustained on February 9, 2018.

In the January 20, 2018, case, Petitioner voluntarily attended a company picnic and was running during a "musical chairs" type contest. (T.32) As he was running to his chair, there was

an indentation in the floor and he slipped and fell injuring his left ankle. (T.33) Petitioner sought medical treatment at St. John's ER on January 23, 2018, and reported he was running two days ago and injured his left ankle. He complained of left lateral and posterior ankle pain worse with weightbearing activity. (PX4) He rated his pain as a 7 out of 10. Examination of the musculoskeletal system revealed ecchymosis (lateral ankle), left (ankle and hindfoot) limited range of motion, no Lisfranc joint tenderness or metatarsal tenderness, soft tissue swelling, strength intact, tenderness (lateral ankle, posterior Achilles), negative for calf tenderness, deformity, edema. The Extremity Film Reading section stated: "abnormal (Mild lateral ankle swelling)." Petitioner was diagnosed with an ankle sprain, ankle swelling and left Achilles tendonitis. He was advised to elevate the extremity for swelling as needed and to apply a cool compress as needed for swelling or discomfort. He was to wear a brace when standing or walking. The Narrative Course further stated:

> 49 year old male with acute left ankle and Achilles injury. Patient will be immobilized in a Cam walker boot. RICE precautions given. Patient will follow-up as an outpatient with primary care.

Petitioner was given discharge instructions for Achilles tendinopathy and it included treatment for tendon rupture. He was to follow up with his primary care physician. (PX4)

Petitioner testified he was told to wear the Cam walker boot for 3-4 months. (T.42) He returned to work for Respondent wearing the Cam walker boot and sustained a second accident on February 9, 2018. While exiting a freezer with boxes on his shoulder, his boot got caught in the wheels of a four wheel dolly. Petitioner did not fall. (T.50-51) This accident was witnessed by co-worker George Adams who testified on behalf of Respondent. Mr. Adams testified Petitioner was coming out of the freezer area carrying some boxes, and as he was coming around the corner, tripped over the wheels of a cart. (T.122) Mr. Adams said, "Watch out, are you all right…" to which Petitioner responded, "…hey did you see that…" (T.122) Mr. Adams testified, "It was a strange way of asking it like - because I was standing right there." (T.122)

Petitioner returned to St. John's ER on February 10, 2018, complaining of left Achilles pain, right thigh burning pain and sharp pains up his back. (PX5) He reported left heel and bilateral foot pain. He advised he received this boot 30 days ago in the ED to protect his Achilles from injury. Petitioner reported he heard a crunching sound and swelling in his *right* foot. On exam, a small amount of swelling was noted in Petitioner's right foot. The walking boot was removed from the left foot and there was no edema, redness or ecchymosis to the area. Petitioner was able to dorsiflex but not plantarflex his left foot. Dr. Janda Stevens examined Petitioner and stated the Achilles tendon on the left foot appears to be "not intact." Dr. Janda Stevens further stated:

> …sustained an injury to his L ankle on the 20th. Was evaluated and placed in a boot and had negative x-rays. Since that time the pain has continued. He reinjured the area and also his back recently…on exam he is in no acute distress. He does have a defect of the L Achilles tendon. He cannot plantarflex. Tenderness of the calf and the posterior ankle. (PX5)

Petitioner stated he needed a note for work restrictions. He was diagnosed with an Achilles

tendon rupture. He was recommended to continue the boot but no weightbearing until follow up with Dr. Benjamin Stevens, orthopedic surgeon.

Petitioner returned on February 12, 2018, and saw PA Zachary Sims who examined Petitioner and found on exam the Achilles tendon to be grossly intact. (PX7) Petitioner saw Dr. Benjamin Stevens on February 15, 2018. Dr. Stevens noted: "He explains his foot got stuck in a four-wheeled dolly while at work. He explains he also had an injury while running, heard a pop and fell on 1/20." (PX6, RX7) Petitioner was able to perform single and double-leg heel rise, no ecchymosis or edema was noted. Petitioner was diagnosed with an Achilles tendon rupture. Dr. Stevens stated they will continue with conservative treatment.

Petitioner sought medical treatment for chest pain at MMC ED on February 22, 2018, and was diagnosed with a saddle pulmonary embolus. (PX9) Dr. Aldridge at SIU opined it was most likely secondary to his Achilles tendon rupture as he did not have any other risk factors. (PX7)

The issue in this case is whether Petitioner has proven by a preponderance of the evidence that his Achilles tendon rupture was caused by the second accident. Based on the evidence presented by both Petitioner and Respondent, this burden has not been met. First, I would rely on the opinion of Dr. Fletcher who testified on behalf of Respondent. Dr. Fletcher is board certified in both occupational and preventative medicine. He reviewed emergency room notes from St. John's Hospital dated January 23, 2018, and treating records from Dr. Stevens, orthopedic surgeon at Springfield Clinic. He testified the ER records from January 23, 2018, showed Petitioner exhibited clinical findings that one sees with an Achilles tendon rupture or tear. It was noted Petitioner had bruising on the lateral ankle, left hindfoot, limited range of motion (ROM), and tenderness to the posterior Achilles and lateral ankle. He testified Petitioner sustained a "very acute injury" to his ankle following the January 2018 accident. Dr. Fletcher noted Petitioner had not been released from care at the time of the second accident. (RX8)

With respect to his opinion on causation, Dr. Fletcher stated that it was significant that Petitioner was prescribed a CAM walking boot after the January 2018 incident stating, "…I mean it gets back to this was hardly a minor ankle sprain that you could just put an Ace wrap or an ankle brace on it. The fact that you gave a CAM walking boot means that there's [a] pretty significant injury." (RX8, T.16) He further stated, "It's pretty significant when a patient leaves your office or emergency room or your clinic in a CAM walker. I mean, you know, basically it's like it's in a cast but it's removable. So that indicates that there was significant trauma." (RX8, T.21)

Dr. Fletcher's opinion is supported by the opinion of Dr. Stevens, Petitioner's treating orthopedic surgeon. In response to Petitioner's counsel's request for an opinion as to whether Petitioner suffered the ruptured tendon during the accident of February 9, 2018, Dr. Stevens' response is telling. He notes the specific description of the accident of January 20, 2018: Petitioner was running and **heard a pop** and fell. (RX3) He further notes the treatment subsequent to the accident. Dr. Stevens notes the second accident on February 9, 2018, when Petitioner's foot was stuck in a dolly and he was in a great deal of more pain. He states in his letter that it is likely the rupture occurred in January and it was exacerbated by the February incident. He acknowledges he did not examine him after the first accident, however states, "…we will never be able to tell for certain if it occurred in January or February though **by the description he gives, it is likely that**

it did occur in January rather than February (emphasis added)." (RX3)

Dr. Stevens testified at the request of Respondent. He testified, "The fact that Petitioner reported a pop [in January] was significant because with that description, and given his physical exam, you would expect an Achilles tendon rupture or some type of tear." (RX7, T.7) He further testified, "But the description and the injury and the fact he went to the emergency department on January 20th suggests that the injury occurred there. Not that it occurred on--whatever it was--February 9th. Again, that's my opinion. You don't know for certain. But when you've got a description like that, it's very classic." (RX7, T.12-13) Dr. Stevens' opinion is consistent with Dr. Fletcher's opinion that the Achilles tendon rupture occurred or likely occurred in January. These two opinions are persuasive and more credible than the opinion of PA Coble.

PA Jayson Coble's narrative letter, dated December 4, 2019, prepared at the request of Petitioner's counsel, is not persuasive to establish causation. PA Coble stated in his letter, "there was NO (emphasis original) palpable defect of his Achilles tendon" on January 23, 2018, and "I do NOT (emphasis original) reasonably believe [P] had a complete rupture of his Achilles tendon at the time of this ED encounter." (PX8) His statement that there was "no palpable defect" in his Achilles tendon is directly contradicted by the medical records. The examination findings showed tenderness in the Achilles, ecchymosis in the lateral ankle, limited ROM, and soft tissue swelling. Further, he was diagnosed with an acute left ankle and Achilles injury. Moreover, he was immobilized in a Cam walker boot to, per the Petitioner, *protect the Achilles tendon*. He was told to elevate and ice and to follow up with a primary care or specialist. Finally, he was provided instructions for Achilles tendonitis and the instruction included rupture care. PA Coble's letter is rebutted by his own treating records and is thus not credible.

Moreover, Dr. Stevens was asked on cross examination if the emergency room personnel who saw Petitioner on January 23, 2018, concluded there was no Achilles tendon rupture during that visit, would he defer to that opinion. Dr. Stevens responded, "Not necessarily. Because for me, as a subspecialist, we see the end stage for every problem. And one of the most commonly missed injuries is an Achilles tendon rupture. So once again, I cannot prove that the rupture happened there, but I—you know, my suspicion, and my high suspicion is, he had a rupture at and on January 23rd at that visit. And it just wasn't diagnosed." (RX7, T.18-19)

Notably, PA Coble was never called to testify on behalf of Petitioner. Therefore, PA Coble never submitted a curriculum vitae or any evidence regarding his education and training, whereas two board certified doctors went on record regarding their education and training, the very basis for their expert opinions. Without any evidence to the contrary, I would infer the board certified doctors had more education and training than the PA. Further, without the benefit of his opinion standing up to the rigors of cross examination to test its truth and examine its foundation, I would afford it little weight in light of the other two medical opinions.

I would also find Petitioner failed to prove his pulmonary embolism was causally related to the February 2018 accident. Dr. Stevens testified Petitioner had three risk factors for developing a pulmonary embolism: a rupture, a boot and a smoking habit. Clearly the boot and smoking habit are unrelated to the February 2018 accident as Petitioner was prescribed the CAM walking boot after the January 2018 incident. Based on the opinions of Drs. Fletcher and Stevens, Petitioner has

failed to prove the Achilles tendon rupture was caused by the February 2018 accident as well. Thus, I would find Petitioner failed to prove the pulmonary embolism was causally related to the work accident.

Based on the foregoing, I would find Petitioner failed to prove his condition of ill-being, his Achilles tendon rupture, was caused by his work-related accident of February 9, 2018. I would further find that Petitioner failed to prove his pulmonary embolism was causally related to the work accident and vacate the awards for TTD benefits, medical expenses and permanency. For these reasons, I dissent.

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PARIS, PEDRO
Employee/Petitioner

Case# **18WC005747**
18WC005748

HY-VEE
Employer/Respondent

On 8/19/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% 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:

2046 BERG & ROBESON
STEVE BERG
1217 S 6TH ST
SPRINGFIELD, IL 62705

0358 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pedro Paris
Employee/Petitioner

v.

Hy-Vee
Employer/Respondent

Case # **18** WC **5747**

Consolidated cases: 18 WC 5748

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 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 **January 20, 2018 and on February 9, 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 January 20, 2018, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

On February 9, 2018, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident of January 20, 2018.

Petitioner's current condition of ill-being ***is*** causally related to the accident of February 9, 2018.

In the year preceding the injuries, Petitioner earned $**13,478.92**; the average weekly wage was $**259.21**.

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

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

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

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

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

ORDER

In regard to the alleged accident of January 20, 2018, 18 WC 5747, the Petitioner has failed to prove that his injury arose out of and in the course of his employment by Respondent and benefits for the injuries suffered in that incident are therefore denied.

In regard to the alleged accident of February 9, 2018, 18 WC 5748, the Petitioner suffered an injury which arose out of and in the course of his employment by Respondent, and has proved that his current condition of ill being, left Achilles tendon rupture and pulmonary embolism are causally connected to said February 9, 2018 accident,

Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibits 2 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from February 9, 2018 to present which are causally related to the accident of February 9, 2018. Respondent shall reimburse Petitioner for co-pays paid by him and evidenced by the bills included in PX 2 in the amount of $23.90, and shall reimburse the Illinois Department of Healthcare & Human Services for those amounts paid by them on account of the accident of February 9, 2018 from February 9, 2018 through August 18, 2018.

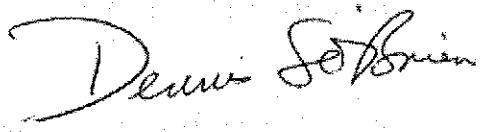
Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 6 2/7 weeks, commencing February 9, 2019 through March 26, 2018 as provided in Section 8(b) of the Act.

As a result of the accident of February 9, 2018 Petitioner has been disabled to the extent of 30% loss of use of his left foot pursuant to pursuant to §8(e) of the Act due to his left Achilles rupture, and to the extent of

7 ½% loss of use of the man as a whole pursuant to §8(d)(2) of the Act due to his multiple vein thromboses and his pulmonary embolism. Respondent shall be given credit for a prior workers' compensation settlement in case 15 WC 21464 for 10% loss of use of the Petitioner's left foot. and Respondent shall therefore pay Petitioner permanent partial disability benefits of $220.00 per week for a net total of 79.05 weeks after reduction of the award for prior credit.

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

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



Signature of Arbitrator

August 13, 2020
Date

AUG 19 2020

FINDINGS OF FACT

Petitioner has filed two Applications for Adjustment of Claim for accidents involving his same body part, the left foot, ankle, and calf. Petitioner's only claimed injury from the accident of January 20, 2018 is to the left foot and ankle. In regard to the second accident he has claimed injuries to his left ankle, low back, both hips, and a pulmonary embolism as a result of multiple deep venous thromboses. Both claims were consolidated for purposes of arbitration.

Testimony of Petitioner Pedro Paris

Petitioner testified that on January 20, 2018 he was employed by Respondent in Springfield, having begun employment with Respondent in December of 2015. He said he started working for Respondent as a line cook in the kitchen, but six months or so later was moved to work in the deli. On January 29, 2018 he was still working in the deli.

Petitioner said that his boss, the deli manager, Adam Hennenfent, kept asking him to go to the company's Christmas party, which was to be on January 20, 2018 at the Illinois State Fairgrounds in the Orr Building. He said Mr. Hennenfent began asking him to attend about a week before the party. He said he initially told him no, as he would not like a work party, but Mr. Hennenfent asked him three or four times to go and Petitioner felt like Mr. Hennenfent was going to take it out on him at work if he did not go, taking hours or days away from him.

Petitioner said that Mr. Hennenfert was supposed to pick him up to take him to the party, but he did not, that he sent a co-worker named Courtney over to Petitioner's house who took him to the party. They arrived at the party after dark, though he did not know the time. He said the deli department all sat together at the party in one section, with at least eight people at his table, including Mr. Hennenfent. Mr. Hennenfent then offered to buy Petitioner a drink and they went to the bar where Mr. Hennenfent purchased the drinks.

A type of contest was held during the party, and Petitioner did not initially want to participate, but he said Mr. Hennenfent kept egging him on, showing off in front of his wife and the other workers, asking him to participate six or seven times. Petitioner said he eventually agreed to participate, but that he felt pressured to do so. He said the game was a type of musical chairs where participants sat in chairs and then ran out into the crowd and got whatever the DJ asked them to get. While sitting on a chair during the game the DJ instructed them to go out and get eyeglasses from a person in the crowd. He said he rushed out and glasses were given to him, and while running back to his chair he slipped on an indentation from a water drain in the floor and fell. He said he noticed that his left ankle was sore, pointing at arbitration to the junction of the foot and the ankle on the top of the foot on both sides, right where the foot would bend.

Petitioner said he was concerned that if he did not go to this party or participate in this game something might happen to him, as before the Christmas party they had been changing work days around on the schedule and he had been asked to sign a form noting he had not showed up for work or called in and he refused to do so as he had not been scheduled for that day. He believed Mr. Hennenfent prepared the schedule but that another employee had gone in after him and made changes. He said Mr. Hennenfent in

the past, prior to the Christmas party, had reduced his hours when they got new employees or an employee came back to work during school breaks. He said this concerned him as he had to pay his rent and utility bills and that was difficult if his hours were cut. He said he also wanted to work the day shift but Mr. Hennenfent never gave him daytime hours. He said he was also upset because on the first day he worked for Respondent, while he was being trained, Mr. Hennenfent wrote him up for not seeing a customer.

Petitioner said that after he fell at the Christmas party a man gave him a towel with ice and he put it on the front and side of the ankle and sat down. He said Courtney and her husband dropped him off at home. He hadn't asked them to take him to the hospital as they had to get home and he did not have transportation and he could not have gotten home had they dropped him off at the hospital. He said he then just spent time in his house, only being on his feet to get a sandwich and glass of water and go to the bathroom, otherwise laying down. He said his pain did not change from that time until he went to St. John's emergency room on January 23, 2018. He said that he was treated by a man in the emergency room but did not know his name. He said he did not tell anyone in the emergency room that he had experienced a crunch or a pop in the back of his foot in this incident. He did not know if crutches were prescribed for him at that time, but he said he had crutches and he did tell someone that the crutches just made him more tired than just walking on his own, though he didn't know if this was after this incident or after his second accident. He said he was not taken off work by the emergency room staff, though he was provided a boot which did not fit properly as there was a lot of play where the heel would sit down. He said he put a washcloth at the bottom of the boot. He said that did not help much.

Petitioner said he did not receive any follow up care between his visit to the emergency room and the date of his second accident. He said the doctor had told him to wear the boot for three or four months.

Petitioner said he returned to work for Respondent. He said his typical amount of work was 28 hours per week

Petitioner said he suffered a second accident while working for Respondent on February 9, 2018. He said he injured his Achilles on February 9, 2018, while carrying two boxes of Italian bread on his shoulder from the freezer to the sandwich shop, where he was working. He said the boxes were about three feet long and 18 to 24 inches wide and 12 inches tall. He said he walked through a three foot wide door, and as he did so his path was blocked by another employee who was on the phone. He said there was a square four-wheeler cart approximately two and a half feet on a side on the floor which was used to move thing catering materials. He said there was an opening in the middle of the cart and it was approximately four inches high. He said in addition to the employee on the phone there was another employee in the area. Petitioner said he tried to maneuver out of the way and that while doing so his boot got stuck in the hole in the middle of the four-wheeler and he almost fell down. He said he tried to get the cart off of his boot but he could not, and he thought that he was going to fall over.

Petitioner said he noticed pain at the back of his Achilles tendon from the heel up into his calf. He said he heard some crunching and snapping. He said he reported this to his employer and he was sent home. He said his back was also bothering him. He noted that the boot he was wearing caused that leg to be higher than the other one and his waist was "out of whack," and with this incident he had to maneuver himself to stabilize his back.

Petitioner said that following the incident of February 9, 2018 he went to the emergency room of St. John's Hospital on February 10, 2018 as he could not press his foot down. He said he told the hospital staff everything he felt, including the popping and crunching he experienced with the four wheel dolly incident. Petitioner said his manager told him he could not come back to work until he had a doctor's release. He said he relayed that information to the hospital staff, advising them that he needed some kind of restriction or off work slip. He agreed that if the records from that visit showed he was placed on crutches, it would be accurate.

Petitioner said he did not have a primary care doctor at the time of either accident, and that the personnel at the emergency room referred him to Dr. Ben Stevens, an orthopedist. He said he saw Dr. Stevens a few days after the emergency room visit and that he described both accidents to that physician.

Petitioner said he has not had any new injuries involving his left foot or heel since the second accident, though he said he did get a blood clot in the ankle shortly after the second injury. He said he had been having intense back pain for three or four days and had gone to the hospital and told them of the pain. He said he had suffered a pulmonary embolism, and was in the intensive care unit for three or four days at Memorial Medical Center and then was in a regular room. He said he had to take blood thinners for the next six months. He said he completed that course of treatment and was not taking blood thinners as of the date of arbitration. He noted he had never had a pulmonary embolism prior to this.

Petitioner said he saw Dr. Stevens once but then was not seen as he did not have insurance with the company they accepted. He noted he got his insurance through Public Aid. He noted he did buy boot inserts from a prescription Dr. Stevens had given him.

Petitioner said he had suffered a workers' compensation accident in 2015 involving his ankle, and had settled that claim, though he could not remember what the settlement amount was. He said he was not having any problems with his left foot after he recovered from the 2015 injury until the accident of January 20, 2018. He said he had never injured his low back prior to February 9, 2018.

Petitioner said that as of the day of arbitration he still experienced shortness of breath while walking. He said he had been scheduled for pulmonary testing but it had not been performed due to a number of things occurring, including his becoming homeless and his need to take a Covid test before he could take the pulmonary tests.

Petitioner said that as of the date of arbitration his left foot and Achilles area made it more difficult to get around, and a doctor had told him not to do any dancing or running because there could be damage around his heart. He said he would get heavy breathing if he tried to go up and down steps due to his left foot and Achilles. He said he had to go up three flights of stairs to get to a job interview and that at the top he was winded. He said he still got occasional pain in his calf and Achilles, especially if he did a lot of walking. He said he noticed his balance was a little off and that he had a limp, which he had not had previously. He said he could not push off with his left foot as he had before and that it caused some discomfort, and a little strain of the Achilles. He said he went out and bought a wrap for the ankle, which he uses. Petitioner said he had some back pain in the low back, above his beltline, in the morning. He said this was in the area where he had pain immediately after the four wheel dolly incident.

Petitioner said he had not experience any additional injuries since the four wheel dolly incident.

Petitioner said he paid a small amount of his bills directly to his doctors and wanted to be repaid for that, but that the majority of his bills had been paid by Public Aid.

On cross-examination Petitioner again said the last time he injured his low back was in a car accident, but that he had strained his back at work. He agreed he had settled two prior workers' compensation claims in regards to his back, but could not recall if they were in July of 2015 and August of 2015, both against Quik-n-EZ. He said doctors had not told him he was obese but he felt he was obese as of the date of arbitration. He said he weighed about 250 when injured in January and February of 2018, when injured, and 317 on the date of arbitration.

Petitioner said Mr. Hennenfent was his manager at the time of the Christmas party and that Courtney was his supervisor. He agreed he had not called either to testify at the arbitration. He said there had been a sign up sheet for the January 20, 2018 party and he could not recall if he had signed up on it. He knew the party was going to take place elsewhere but did not know if employees from other stores were going to be working at the Springfield store during the party.

Petitioner agreed he did not have any documentation showing that he would be punished and his hours decreased if he did not attend the party, nor had he filled out any kind of statement indicating a fear of being punished if he did not attend. He imagined there were people who did not go to the party. He said he was not paid for the time he spent at the party. He did not know if he was scheduled to work the day of the party or whether he had worked that day as it was so long ago. He said he had concerns about his hours being shorted and had talked to the general manager of the store about it, the general manager who had gotten fired, asking him why they were cutting his hours. He said he did not know if other people complained about their hours, though he did know people had complained about days being switched around.

Petitioner said he was accurate and truthful with the doctors who treated him. He said he disagreed with the history listed by Dr. Stevens that said that on January 20, 2018 he was "running and heard a pop and fell." He said he did not recall seeing any bruising on his left foot, and that his pain was in the ankle, he did not feel anything in the back. He said he recalled the emergency room staff giving him material when he left, and when shown Respondent Exhibit 2 agreed that the materials he was shown talked about Achilles tendinopathy and Achilles tendon rupture. He said he knew the Achilles tendon was in the back of the foot.

Respondent's counsel read an emergency room note from January 23, 2018 which stated that the patient was complaining of left lateral and posterior ankle pain worse with weightbearing activity. Petitioner said he told them he had pain on his ankle, like a sprain. He did not believe the physicians at the hospital had anything out for him or would be untruthful about what he said.

Petitioner said that he did not fall during the February 9, 2018 incident, though he almost fell as he had two boxes on his shoulder and a boot on his foot and was entangled. He believed George Adams was in front of him at that time, though acknowledging that it was a long time ago. He said he remembered a phone cord was in his way even though it was a long time ago as he said he would not have been tripped up if the other employee had not been standing there.

When asked about doctors' records he had not introduced into evidence, Petitioner said he did see a doctor for diabetes which was a result of weight gain from the embolism and having to eat when taking Coumadin

and Warfarin for six months. He agreed he had not put in any records saying that, saying it was just common sense. He said his primary care physician for the last year was Dr. Malika Baig, prior to that it was Dr. Salman Saeed.

Petitioner said George Adams was present when the February 9, 2018 incident occurred and would have seen it. He said the store had cameras in that part of the store as well.

Petitioner said he was familiar with Jamie Vinger, one of the white shirt managers of the store, a man who was present at arbitration. Petitioner said he was working nights after the accident, working only one day shift. When asked how his employment ended Petitioner said that he was off the clock and was doing some grocery shopping. He said he got in a cash register line and a woman came back inside the store, stepped towards him, bent over and got in his face, saying he had cut in line. He said she looked like she was going to hit him and he told her to "fuck off." He said she was like 6 foot 4, he had two bags of groceries in his hand and all he was trying to do was go home. He felt that saying something to a person who acted like they were going to punch you in the face made sense. He said he got fired for that. He said he did not know the date he last worked for Respondent. He said everybody cusses in the store, that they just singled him out because he cussed off the clock. He felt they retaliated against him because he had an accident.

When asked about the days he was off work Petitioner said he could not be sure. He said he came back to work after the first accident and that after the second accident they told him not to come back until he got a doctor's release. He got a doctor's release and he returned to work.

He said he did fall to the ground during the first incident of January 20, 2018.

On redirect examination Petitioner said the only medical provider he saw on January 23, 2018 was Jason Coble. He said he was never diagnosed with an Achilles tendon rupture on January 23, 2018. He said he was diagnosed with an Achilles tendon rupture while in the emergency room on February 10, 2018.

Petitioner said Dr. Stevens did keep him off work for a period of time and issued off work slips, keeping him off work through at least March 27, 2018. He said he did not work during the time Dr. Stevens had him off work.

On recross examination Petitioner said he never had surgery on his left foot, that Dr. Stevens treated him after the February 9, 2018 accident and that he was believed he was referred to Dr. Stevens by the doctor's wife.

Testimony of Jamie Vinger

Mr. Vinger was called as a witness for Respondent. He testified that he had been employed by Respondent for five years, having been promoted to the position of store manager three days prior to arbitration. As store manager he oversees the entire store, inventory control, sales, customers, employees. In January and February of 2018 Mr. Vinger was manager of perishables for the store, and that perishables included the deli, floral, kitchen, bakery, produce, meat and seafood. He said he remembered January 20, 2018 as that was the holiday party for employees, held after the holidays as they were so busy before the holidays. He said the event was voluntary, with a sign-up sheet that noted that it was voluntary. Not all employees attend, less than 50 percent attend.

Mr. Vinger said he could not recall ever discussing the party with Mr. Hennenfent prior to its occurrence. He said he met with Mr. Hennenfent regularly in regard to employees and there was never any indication that an adverse action would be taken against Petitioner if he did not attend the party. He said the party was held at the Orr Building at the Illinois State Fairgrounds. He said the sign-up sheet tells them how many employees they would need to bring from other stores to man the store while they had the party. He said a prize is given to every employee whether they attend the party or not, with the prize being things like gift cards up to televisions.

Mr. Vinger said he did not see the incident involving Petitioner on January 20, 2018 but that he would have at some point spoken to him about both the January 20, 2018 incident and the February 9, 2018 incident. He said he would have been part of the termination meeting. He said Petitioner violated a company rule through actions unbecoming of a Hy-Vee employee. He said Petitioner was in uniform at the time he told a customer to "fuck off," and they did not feel that was appropriate. He said as far as he knew Petitioner was otherwise a good worker. He said he believed Petitioner was terminated in August of 2018.

Mr. Vinger said he understood Petitioner wore a walking boot after the January 20, 2018 incident. He said he did not recall being involved in the investigation of the February 9, 2018 incident.

Mr. Vinger testified that if Mr. Paris had a complaint about his immediate supervisor, Mr. Hennenfent, and followed the chain of command, he, as Mr. Hennenfent's direct supervisor would have been the next person to report an issue to. He said he never received a complaint about Mr. Hennenfent from Petitioner. He said Mr. Hennenfent still works for Respondent, now serving as manager of perishables, having taken that position when Mr. Vinger was promoted to the general manager position. Prior to being promoted to manager of perishables Mr. Hennenfent had been the deli manager.

On cross examination Mr. Vinger said he did not know why Mr. Hennenfent ws not present at the arbitration hearing. He said he did not have the sign-up sheet for the party with him, and was not aware whether or not it still existed. He said it is the same sign-up sheet they use every year so he is familiar with what it says. They have had this party since the store opened, so there have been six parties. He did not know if Petitioner had gone to any of the previous parties. He said he did not have Petitioner's termination paperwork with him at the hearing, though it would still exist.

Mr. Vinger said had been present when Petitioner testified, and that he did not have any reason to believe that the January 20, 2018 incident did not occur as Petitioner had indicated. He said he did not have any reason to believe that the incident of February 9, 2018 had not occurred as Petitioner had described.

Mr. Vinger said that managers did not get a bonus or any sort of incentive based upon employees attending the party, nor had they ever gotten such a bonus. He said Petitioner would have gotten a gift whether he attended the party or not.

When asked if he knew Petitioner's work schedule between January 20, 2018 and February 9, 2018 Mr. Vinger said he normally worked days and would see Petitioner during the day, but otherwise did not know. He said the average for part-time employees is 28 hours and noted that Petitioner said he averaged 28 hours, the maximum amount. Normally they would do those hours in a four day week. He said evening work could be done in a 2 to 10 shift or a 4 to 10 shift. He said he was not employed at this store when Petitioner

began working there in 2015, that he had come to the store in 2016, having come from a Hy-Vee store in Peoria.

In regard to Petitioner's termination Mr. Vinger said he did not know if the customer who confronted Petitioner was intoxicated. He said he did not know if the paperwork indicated that. He did not recall if he was the person who actually terminated Petitioner, though he had been involved in some manner. While he did not recall if Petitioner had indicated the patron who confronted him was intoxicated, he did recall that the register where this happened was in the liquor section of the store.

On redirect examination Mr. Vinger said that Respondent does have customers who come in and are belligerent, in which case an employee will typically seek out a manager to address the situation, asking the customer to leave the store. He said employees are told this as part of their training. He said role was not taken at the party to see who attended. He said there were no name cards directing where people sit, but they do have people check in so they know who can be called for prizes. He said there was no assigned seating, people could just sit where they wanted to sit. He said while all employees receive a physical gift, attending the party was not paid work.

On recross examination Mr. Vinger said he had no direct knowledge that Petitioner was officially advised of the protocol in the case of an irate customer. He said there was no formal practice for departments to sit at the same table, he thought people who knew each other better just did that.

Testimony of George Adams

Mr. Adams was called as a witness by Respondent. He testified that he had been employed by Respondent for six years. He said he was a kitchen clerk, making food and waiting on customers. Prior to being a kitchen clerk he was a dishwasher for Respondent for the first year. He said he knew Petitioner as he worked in the deli, next to the area where he worked. He said they were both working on February 9, 2018 and he remembered standing by the computer desk and Petitioner coming out of the freezer carrying some boxes, which he assumed were bread boxes. He said that as Petitioner turned the corner he tripped over the wheeled cart they used to push things on . Mr. Adams testified he said something like, "watch out," and asked Petitioner if he was all right. Petitioner asked him if he saw it, which he felt was strange as he had been standing right there. He could not remember if Petitioner fell down or just tripped. He did not remember Petitioner getting his foot stuck in the cart and having a hard time getting it out. He did not think this was a severe incident. He said the cart had been leaned up against the wall, and he did not think it was in the direct path of Petitioner as he exited the freezer. He did not recall if there was another employee on the telephone when this occurred. He said he was behind Petitioner when this happened as he had stepped up to the desk area to make sure he was not in Petitioner's way. He did not believe he obstructed Petitioner.

Mr. Adams said Petitioner was wearing his boot when this occurred. When asked if he thought Petitioner wanted him to see the incident Mr. Adams thought for a considerable period of time before saying he did not think he could answer that question.

Mr. Adams said he did not attend the Christmas party on January 20, 2018 as he just was not up to attending it that year. He said it was not a mandatory event, he had attended it in the past. He said everyone got a prize, that he got a gift card. He said he had not spoken to Mr. Paris about the events of January 20, 2018 or in regard to his medical condition.

On cross examination Petitioner described the area where the February 9, 2018 incident occurred as having a shelf on one side of the freezer door, a cardboard bin on the other side and shelves on both sides of what he described as a hallway. He said there was a small desk with a computer on it in the hallway. He felt two people could comfortably walk side by side in the area. He said there was a wall phone in the area of the freezer which had a cord on it. He could not remember if there was a person using the phone and stretching the cord across the opening at the time of the incident.

Mr. Adams said he knew Mr. Luckey, another employee of Respondent, and he said it was possible that Mr. Luckey was on the phone and that was why Mr. Adams was also back there, talking with him.

Mr. Adams said Petitioner did complain to him of his leg and foot hurting, but he assumed it was to the part of his foot which he had previously injured. He said he filled out a written report about this at some point but he did not have it with him at the hearing. He said he had spoken to Respondent's attorney on a prior occasion when the case was scheduled for hearing. He said he had never had issues with Petitioner.

Additional Testimony of Petitioner Pedro Paris

Petitioner was recalled as a witness. He said he did not recall saying anything like what Mr. Adams recollected he said, but went on to say that if you have previously been injured and you are concerned about your health he thought you would want a witness if you tripped or fell at work because medical bills can be quite expensive. He thought Mr. Adams had seen the incident.

On cross examination, when asked why he would want a witness Petitioner said that he'd had two accidents, one at the party and one at work, and it was kind of odd, so he thought anybody would say what he said.

Petitioner said he felt pressured to go to the party, that he had not gone to the holiday parties in the past.

Medical Evidence

Petitioner was seen at St. John's Hospital emergency room on January 23, 2018 with a history of twisting his left ankle two days earlier with lateral and posterior ankle pain. Physicians Assistant Jayson Coble His physical examination of Petitioner was negative for calf tenderness, deformity or swelling. Petitioner was discharged in a Cam walking boot. PA Coble's primary impression was ankle pain with additional impressions of ankle sprain, ankle swelling and left Achilles tendinitis. PX4; RX 2

Petitioner's next medical treatment was subsequent to the alleged accident in this case. It was again at St. John's emergency room, on February 10, 2018, The history given to Dr. Janda Stevens at that time was of his boot getting caught in a four-wheeler while lifting a box at work the day prior to being seen, his not falling at that time, but that he started having left heel and pain in both feet. He advised her that he had received his boot 30 days earlier in the emergency room to protect his Achilles from injury. He also complained of right foot swelling which had gone down as well as left hip pain and right calf tightness and pain. He also noted a loss of strength in his left calf. On physical examination it was noted that he could not plantar flex his left foot Dr. Janda Stevens noted that "The Achilles tendon on the left foot appears to be not intact." She

contacted Dr. Benjamin Stevens who recommended no weight bearing and the use of crutches. Petitioner was provided with crutches and restricted from work until released by his orthopedist. PX 5; RX 3

Petitioner was seen by Physician Assistant Zachary Sims at SIU on February 12, 2019. The history given to him was consistent with that given in the emergency room and included the emergency room findings, noting the referral to Dr. Stevens for orthopedic care. Petitioner was complaining at that time of his Cam boot being uncomfortable and not adequately cushioned. PA Sims' physical examination noted the Achilles tendon appeared to be grossly intact with the calf having proximal lateral discomfort to palpation and the Achilles tendon being tender to palpation approximately 3 cm from the insertion site on the heel. A prescription was given for calf muscle spasms and Petitioner was advised to put mole skin in his boot at the pressure points and to use a gel shoe insert. PX 7

Petitioner was seen for the first time by Dr. Benjamin Stevens on February 15, 2018. On his surgeon intake form Petitioner noted his pain was 5/10 and was complaining of pain in both hips, the right side and spinal area of his low back, the back of his foot, ankle and back of calf, as well as having pins and needles sensation in the back of his foot. Dr. Stevens took a consistent history of the February 9 accident as well as a history of an accident on January 20 while running, where he heard a pop and fell. The physical examination on February 15, 2018 revealed a palpable defect about the left Achilles tendon. Dr. Stevens assessment at that time was of a left Achilles rupture and he recommended conservative treatment consisting of non weight bearing, bracing day and night until seen again, and the use of a knee scooter. He said it would be four months until Petitioner could return to full duty work. He issued Petitioner a slip noting he was excused from work until released by physician due to left Achilles rupture. PX 6

On February 22, 2018 Petitioner went to Memorial Medical Center's emergency room with complaints of right sided neck pain from coughing. He noted that he had chest pain which started the night before when he had an episode of coughing. He also had right shoulder proximal pain. He noted the pain continued through the night and increased with deep breaths. It was noted that he had been in a walking boot since an injury in January. A chest x-ray showed decreased aeration of the right lung base in the region of a pulmonary infarct. A venous duplex study of his right, uninjured, leg was normal, but a similar study in the injured left leg revealed total occlusions of the femoral, popliteal, post tibial and peroneal veins. The final diagnosis included not only deep vein thrombosis of those veins but also to the gastrocnemius veins of the calf. PX 9

A CT scan of the chest done during that admission revealed a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner was admitted to the intensive care unit from the emergency room. That hospital record noted on multiple occasions Petitioner having been immobilized since an early February rupture of his Achilles tendon After a five day admission Petitioner was discharged from the hospital with instructions to get ongoing anticoagulant management by Dr. Saeed and told to continue non-weight bearing activity with a knee scooter to prevent further strain to the Achilles tendon. Petitioner dd continue to get follow up treatment for anticoagulation testing and treatment through Dr. Saeed. PX 9; PX 7

Dr. Ben Stevens saw Petitioner on March 6, 2018, noted he was still ambulating with his boot, discussed treatments which could be pursued and allowed him to return to work light duty handing out food samples. That limitation was to apply until March 27, 2018, at which point he was to return to work with no restrictions. This was the last occasion Petitioner was seen by Dr. Stevens. PX 6

Petitioner was seen by Dr. Aldridge at SIU on June 29, 2018 in regard to his pulmonary embolism and his anticoagulation. Dr. Aldridge noted, "He presented to SJH ER after a fall recently. Imaging as per Orthopedic clinic note shows left Achilles tendon rupture. After that he presented to MMC ER with SOB and was found to have PE on 2/22." Dr. Aldridge opined that it was "most likely secondary to Achilles tendon rupture as he does not have any other risk factors." PX 7

On November 1, 2018 Dr. Ben Stevens wrote a "To Whom It May concern" letter in regard to Petitioner's treatment by him. In that letter he noted consistent histories of the January 20, 2018 and February 9, 2018 incidents. He noted that following the second accident Petitioner experienced a great deal more pain. Dr. Stevens stated, "It appears that the Achilles tendon rupture likely occurred in January and it was exacerbated in his February incident." He did not place great certainty on when the rupture actually occurred, however, as he had not examined him on January 20, "and certainly this would have been the definitive physical examination to determine when the rupture occurred." RX 1

On December 4, 2019 Physician Assistant Coble wrote a letter to Petitioner's attorney in response to an inquiry from that attorney. In his letter PA Coble wrote,

> Mr. Paris exhibited physical pain on physical examination and palpation of his Achilles tendon during this patient encounter. On further physical examination, there was NO palpable defect of his Achilles tendon. He was subsequently diagnosed with an Achilles tendon strain in addition to other diagnoses listed in his existing medical record. Based on these physical examination findings, I do NOT reasonably believe Mr. Paris had a complete rupture of his Achilles tendon at the time of his emergency department encounter. PX 8

Testimony of Dr. Benjamin Stevens

Dr. Stevens was called as a witness by Respondent. He said he was an orthopedic surgeon with a subspecialty of foot and ankle reconstruction. His testimony in regards to physical findings and treatment was consistent with the medical summary, above. He noted that during his physical examination of February 15, 2018 he noted a palpable defect at the Achilles tendon area. He noted his diagnosis was Achilles tendon rupture and that he prescribed non-operative treatment of it. Petitioner was to return to see him in 10 days. RX 7 p.5,7,8

Dr. Stevens said he next saw Petitioner on March 6, 2018 and that the reason it was longer than ten days between appointments might be because he had sustained a pulmonary embolism in the interim. He noted that "Anytime you have an injury to the lower extremity, you're at higher risk (of a pulmonary embolism). And if you place someone in a boot, you're at a higher risk. So he had three factors against him with a rupture, a boot and smoking." RX 1 p.9

He noted that Petitioner's attorney wrote him a letter about the two incidents and he had written him back advising him, "Which one cause which, based on the description -- again, I can't prove this. But with, you know, I think I put it that, while its my medical opinion, I can't necessarily prove it. But the description and the injury and the fact he went to the emergency department on January 20th suggests that the injury occurred there. Not that it occurred on -- whatever it was -- February 9th." Dr. Stevens went on to say that

to the best of his knowledge, having reviewed the emergency department records for January 23, 2018, there was no diagnosis of an Achilles tendon rupture during the January 23 visit. RX 1 p.12,16

In regard to permanent effects of the injury Dr. Stevens said the Achilles tendon would develop scar tissue in between the rent caused from the rupture which would elongate the Achilles tendon to a length that was not very functional. The other muscles in the lower leg would then start to compensate and help the person get around, "but its certainly not a normal leg if you compare them side by side. So it heals, but it heals improperly." He said that an elongated Achilles can cause balance issues, difficulty with pushing off with the foot, and impact any activity that requires pushing off. He said it generally causes a difficulty with heel pain. RX 1 p.21,22

Testimony of Dr. David Fletcher

Dr. Fletcher was called as a witness by Respondent. He said he was board certified in both occupational and preventive medicine. He said he was asked to perform a medical record review by Respondent and had not personally performed a physical examination of Petitioner. He said his review of the records was to address causal connection and not nature and extent of injury or the ability of Petitioner to work. He felt the records from the January 23, 2018 emergency room visit reflected an acute injury while the records following the February 9, 2018 injury did not seem to show an acute injury, but instead an Achilles tendon rupture which required follow up treatment. He did not believe the February 9, 2018 incident had any impact on Petitioner's Achilles injury, as there was nothing acute on physical examination to indicate an injury on February 9, 2018. RX 8 p.4,7,8,10-12,19

On cross-examination Dr. Fletcher agreed that the diagnosis on January 23, 2018 at the emergency room was of pain in the left ankle and joints of the left foot and did not mention an Achilles tendon rupture, though Petitioner was given instruction materials about Achilles tendonopathy. Dr. Fletcher agreed that the January 23, 2018 emergency room record did not refer to a history of a pop being given at that time while the emergency room history given to the emergency room staff on February 10, 2018 did indicate a history of a pop being heard and felt at the time of that accident. Dr. Fletcher said he had not been provided with either the accident report signed by Petitioner on February 20, 2018, and it was a surprise to him, nor the first report of injury report of February 9, 2018 filled out by Respondent's human resources manager, Mr. Knuffman, RX 8 p.22,23,27-30

Dr. Fletcher agreed that the history in the emergency room records of February 10, 2018 where Petitioner indicated he had left heel pain after the cart incident and that he was not able to raise himself on his heel was a classic sign of both acute and chronic Achilles tendon injury. He also agreed that those complaints were not contained in the history given during the January 23, 2018 emergency room visit. Dr. Fletcher further agreed that the February 10, 2018 records made a definitive diagnosis of Achilles tendon not being present, being detached, which had not been made in the January visit. He also agreed that the primary diagnosis on February 10 was Achilles rupture. RX 8 p.33,34

Dr. Fletcher testified that an Achilles tendon rupture that was not repaired surgically might not have a good result which could cause impairment in activities using the lower extremities, walking on uneven surfaces, climbing stairs, prolonged walking and running, it could be career ending for a professional athlete. He said it could result in some permanency of functionality with that type of an injury. RX 8 p.37

Arbitrator's Credibility Assessment

The arbitrator finds the testimony of all witnesses to be credible. Petitioner appeared to be consistent in his overall description of events and physical complaints without any apparent exaggeration. Mr. Vinger and Mr. Adams testimony also appeared to be factual in regard to events they observed and knowledge of procedure and practices of the company.

CONCLUSIONS OF LAW

In regard to whether an accident occurred that arose out of and occurred in the course of Petitioner's employment on January 20, 2018 the Arbitrator finds the following:.

An injury is compensable under the Workers' Compensation Act only if the claimant proves by a preponderance of the evidence that it arose out of and in the course of his or her employment. An injury arises out of one's employment if its origin is in some risk connected with, or incidental to, the employment so that there is a causal connection between the employment and the accidental injury.

> Section 11 of the Worker's Compensation Act provides
> "Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program."
> 820 ILCS 305/11

The evidence as presented by Petitioner indicates that his participation in the holiday party on January 20, 2018 was voluntary. He noted that while he had been employed by Respondent for several years he had never attended the party in the past and he did not testify to any punishment or retaliation which had occurred as a result of his not attending prior holiday parties.

Mr. Vinger, Respondent's General Manager, and Mr. Adams, a co-employee of Petitioner's, both testified that attendance at the party was voluntary. Mr. Vinger testified that less than 50% of the employees attended the party. He said that all employees received a git or prize, regardless of whether they attended the party or did not attend the party. Employees were not paid to attend the party. Mr. Adams said he did not feel like attending the party that evening, did not do so and received a gift/prize anyway, a gift card.

While he may have felt pressured by his supervisor to attend, noting he was encouraged on a number of occasions to attend after saying he did not plan to do so, and he "felt" he might be punished for doing so, his perception when compared to the testimony of Mr. Vinger and Mr. Adams indicating that fewer than 50% of the employees attended the party, that everyone got a gift or prize regardless of whether they attended the party, including Mr. Adams, who did not attend the January 20, 2018 party, and Petitioner's having never attended the party in the past several years he had been employed with Respondent. Petitioner did not testify to any retaliation from prior failures to attend the party.

The Arbitrator finds that Petitioner has failed to prove that he suffered an accidental injury on January 20, 2018 which arose out of and in the course of his employment by Respondent. This finding is based on the evidence cited above which indicates that Petitioner was not ordered or assigned by his employer to participate/attend the holiday party of January 20, 2018, that it was a voluntary party despite the fact that Respondent paid some or all of the cost of the party.

Benefits for injuries arising out of the January 20, 2018 incident are therefor denied.

In regard to whether Petitioner's current condition of ill-being is causally related to the accident of February 9, 2018 the Arbitrator finds the following:

The findings of fact in regard to the alleged accident of January 20, 2018 are incorporated herein.

The accident of February 9, 2018 was not in dispute.

Petitioner was examined by only one medical provider following the incident of January 23, 2018, Physician Assistant Coble. His physical examination of Petitioner on that date was negative for calf tenderness, deformity or swelling. Petitioner was discharged in a Cam walking boot. PA Coble's primary impression was ankle pain with additional impressions of ankle sprain, ankle swelling and left Achilles tendinitis. PX4; RX 2

In a letter to Petitioner's counsel dated December 4, 2019 PA Coble, referring to his January 23, 2018 treatment of Petitioner said, "Mr. Paris exhibited physical pain on physical examination and palpation of his Achilles tendon during this patient encounter. On further physical examination, there was NO palpable defect of his Achilles tendon. He was subsequently diagnosed with an Achilles tendon strain in addition to other diagnoses listed in his existing medical record. Based on these physical examination findings, I do NOT reasonably believe Mr. Paris had a complete rupture of his Achilles tendon at the time of his emergency department encounter." PX 8

Petitioner testified to an immediate increase in his symptoms after the February 9, 2018 accident and he sought medical attention at St. John's emergency room the next day. After examining Petitioner on February 10, 2018 Dr. Janda Stevens wrote, "The Achilles tendon on the left foot appears to be not intact." Her primary impression was, "Achilles Tendon Rupture." This was the first occasion when that diagnosis was made. PX 5; RX 3

Subsequent to February 9, 2018 new orders were given in regard to the treatment of the left foot, including the prescribing of crutches and the use of a knee scooter. Petitioner's work was restricted for the first time, first by Dr. Janda Stevens in the emergency room, and then by Dr. Benjamin Stevens when he first saw Petitioner on February 15, 2018. PX 5; RX 3; PX 6

Respondent deposed both Dr. Benjamin Stevens and Dr. David Fletcher in support of their position that Petitioner's Achilles rupture was a result of the January 20, 2018 incident and not the February 9, 2018 accident. In a letter dated November 1, 2018 Dr. Stevens stated that Petitioner had a great deal more pain following the accident of February 9, 2018. He felt that the Achilles tendon rupture likely occurred in January but he then immediately went on to note that the February incident exacerbated the rupture. In addition, Dr. Stevens limited the value or strength of his opinions on causation by noting in that letter that, "(w)hile

this is my medical opinion, there is no certainty as I was unable to examine him on January 20, 2018, and certainly this would have been the definitive physical examination to determine when the rupture occurred." RX 1

Dr. Stevens agreed that to the best of his knowledge, having reviewed the emergency department records for January 23, 2018, there was no diagnosis of an Achilles tendon rupture during the January 23 visit. Dr. Stevens said he suspected Petitioner had a rupture on January 23rd that just wasn't diagnosed, but he further said he cannot prove that suspicion. RX 7 p.16,19 "Liability under the Workmen's Compensation Act cannot rest upon imagination, speculation or conjecture * * * but such liability must arise out of facts established by a preponderance of the evidence." Immaculate Conception Church v. Industrial Commission, 395 Ill. 615,623 (1947)

In his deposition Dr. Fletcher voiced his opinion in regard to causal connection in his deposition, saying he did not believe the February 9, 2018 incident had any impact on Petitioner's Achilles injury, that there was nothing acute on physical exam to indicate an injury on February 9, 2018. RX 8 p.19 On cross-examination, however, Dr. Fletcher agreed that the history in the emergency room records of February 10, 2018 where Petitioner indicated he had left heel pain after the cart incident and that he was not able to raise himself on his heel was a classic sign of both acute and chronic Achilles tendon injury. He also agreed that those complaints were not contained in the history given during the January 23, 2018 emergency room visit. Dr. Fletcher further agreed that the February 10, 2018 records made a definitive diagnosis of Achilles tendon not being present, being detached, which had not been made in the January visit. He also agreed that the primary diagnosis on February 10 was Achilles rupture. RX 8 p.33,34

Dr. Fletcher's opinions are of far lesser weight than those of PA Coble, Dr. Janda Stevens or Dr. Benjamin Stevens as those three medical providers actually examined Petitioner, while Dr. Fletcher was merely performing a medical records review. PA Coble, the only medical provider to see Petitioner in the days immediately after the January 20, 2018 incident, was quite clear in his statements that when he saw Petitioner on January 23, 2018 there was no palpable defect of his Achilles tendon. His diagnosis on that date was an Achilles tendon strain. In his letter to Petitioner's attorney he was fairly adamant that he did not reasonably believe Petitioner had a complete rupture of his Achilles tendon at the time of his emergency department visit on January 23, 2018. PX 8

In regard to Petitioner's multiple left leg thromboses and his pulmonary embolism, on February 22, 2018, 13 days following the accident of February 9, 2018, Petitioner went to Memorial Medical Center's emergency room with complaints of right sided neck pain from coughing. He noted that he had chest pain which started the night before when he had an episode of coughing. He also had right shoulder proximal pain. It was noted that he had been in a walking boot since an injury in January. A chest x-ray showed decreased aeration of the right lung base in the region of a pulmonary infarct. A venous duplex study of his right, uninjured, leg was normal, but a similar study in the injured left leg revealed total occlusions of the femoral, popliteal, post tibial and peroneal veins. The final diagnosis included not only deep vein thrombosis of those veins but also to the gastrocnemius veins of the calf. PX 9

A CT scan of the chest done during that admission revealed a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner was admitted to the intensive care unit from the emergency room. That hospital record noted on multiple occasions Petitioner having been immobilized since an early February rupture of his

Achilles tendon After discharge from the hospital Petitioner received follow up anticoagulant management by Dr. Saeed. PX 9; PX 7

Petitioner was seen by Dr. Aldridge at SIU on June 29, 2018 in regard to his pulmonary embolism and his anticoagulation. Dr. Aldridge noted, "He presented to SJH ER after a fall recently. Imaging as per Orthopedic clinic note shows left Achilles tendon rupture. After that he presented to MMC ER with SOB and was found to have PE on 2/22." Dr. Aldridge opined that it was "most likely secondary to Achilles tendon rupture as he does not have any other risk factors." PX 7

Dr. Benjamin Stevens testified that, "(a)nytime you have an injury to the lower extremity, you're at higher risk (of a pulmonary embolism). And if you place someone in a boot, you're at a higher risk. So he had three factors against him with a rupture, a boot and smoking." RX 1 p.9

The Arbitrator finds that Petitioner's left Achilles tendon rupture is causally related to the accident of February 9, 2018. This finding is based upon the medical records of St. John's hospital emergency room for January 23, 2018 and PA Cobles letter of December 4, 2019, the findings of Dr. Janda Stevens of February 10, 2018 and the opinion of Dr. Benjamin Stevens that at the very least the accident of February 9, 2018 exacerbated Petitioner's left foot Achilles injury.

The Arbitrator further finds that Petitioner's multiple deep vein thromboses and his pulmonary embolism are causally related to the accident of February 9, 2018 based upon the records and opinions of Dr. Aldridge and Dr. Stevens as well as the chain-of-events.

In regard to whether Respondent is liable for medical bills the Arbitrator finds the following:

The findings of fact in regard to accident and causal connection, above, are incorporated herein.

All medical bills for services rendered between February 9, 2018 and August 28, 2018 were for medical conditions previously found to be causally related to the accident of February 9, 2018.

Some of the medical bills have been paid by the State of Illinois Department of Healthcare & Family Services, Petitioner has paid $23.90 in co-pays, and the remainder of the medical bills appear to remain unpaid.

The Arbitrator finds that all medical bills pre-dating February 9, 2018 (PX 1) are denied on the basis of the finding of no accident occurring on January 20, 2018 which arose out of and in the course of Petitioner's employment by Respondent.

The Arbitrator further finds that Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibit 2 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from February 9, 2018 to present which are causally related to the accident of February 9, 2018. Respondent shall reimburse Petitioner for co-pays paid by him and evidenced by the bills included in PX 2 in the amount of $23.90, and shall reimburse the Illinois Department of Healthcare & Human Services for those amounts paid by them on account of the accident of February 9, 2018 from February 9, 2018 through August 28, 2018.

In regard to the period of time that Petitioner was temporarily totally disable on account of the accident of February 9, 2018 the Arbitrator finds the following:

On February 10, 2018 Dr. Janda Stevens of St. John's Hospital emergency room restricted Petitioner from work until released by his orthopedist. PX 5; RX 3

Dr. Benjamin Stevens on March 6, 2018 noted Petitioner was still ambulating with his boot and allowed him to return to work light duty handing out food samples. That limitation was to apply until March 27, 2018, at which point he was to return to work with no restrictions. PX 6

No testimony was given in regard to whether Respondent could accommodate Dr. Stevens' restrictions.

Petitioner claimed disability from February 10, 2018 through March 27, 2018. Arb X 2

The Arbitrator finds that Petitioner is entitled to temporary total disability of $220.00 per week from February 10, 2018 to March 28, 2018, a period of was temporarily disable from February 10, 2018 to March 27, 2018, a period of 6 2/7 weeks, and not thereafter.

In regard to the nature and extent of injury the Arbitrator finds the following:

The findings of fact in regard to accident and causal connection, above, are incorporated herein.

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 reported level of impairment pursuant to the AMA Guidelines, 6th Edition, the Arbitrator notes that neither Petitioner nor Respondent introduced an evaluation report promulgated pursuant to the AMA Guidelines. As such, only the remaining four factors are considered in arriving at a determination of permanent partial disability.

With regard to subsection (ii) of §8.b(b), the occupation of the employee, Petitioner was at the time of this accident a a deli worker Respondent. He testified in regards to having to make sandwiches and carry material, such as boxes of sandwich bread, to his work station from the freezer. The Arbitrator gives this moderate weight.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 50 years of age at the time of the accident. As such the Petitioner is currently 52 years of age and could potentially work for another ten to fifteen years in his occupation. Petitioner was neither young nor of advanced years at the time of the accident. The Arbitrator gives this moderate weight.

With regards to subsection (iv) of §8.1b(b), employee's future earning capacity, the Arbitrator notes that Petitioner is no longer in the employ of Respondent for reasons unrelated to this accident and his injuries. No evidence was introduced of Petitioner's current occupation or earnings. The Arbitrator gives this little weight.

With regards to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes:

- Prior to the date of this accident Petitioner had a March 24, 2015 left ankle sprain while working for Arlington's LLC. A workers' compensation claim was filed and subsequently settled with a settlement contract approved in case number 15 WC 21464 reflecting a 10% loss of use of the left foot, RX 6
- As a result of the accident of February 9, 2018 Petitioner suffered a serious orthopedic injury, a rupture of the left Achilles tendon. Petitioner said that as of the date of arbitration his left foot and Achilles area made it more difficult to get around, and a doctor had told him not to do any dancing or running because there could be damage around his heart. He said he would get heavy breathing if he tried to go up and down steps due to his left foot and Achilles. He said he had to go up three flights of stairs to get to a job interview and that at the top he was winded. He said he still got occasional pain in his calf and Achilles, especially if he did a lot of walking. He said he noticed his balance was a little off and that he had a limp, which he had not had previously. He said he could not push off with his left foot as he had before and that it caused some discomfort, and a little strain of the Achilles. He said he went out and bought a wrap for the ankle, which he uses. Petitioner was last seen by Dr. Benjamin Stevens on March 6, 2018. At that time he was still in a Cam boot and his work was still restricted but he had been given a date to return to work without restrictions.
- Dr. Stevens testified that Petitioner's Achilles tendon would develop scar tissue in between the rent caused from the rupture which would elongate the Achilles tendon to a length that was not very functional. The other muscles in the lower leg would then start to compensate and help the person get around, "but its certainly not a normal leg if you compare them side by side. So it heals, but it heals improperly." He said that an elongated Achilles can cause balance issues, difficulty with pushing off with the foot, and impact any activity that requires pushing off. He said it generally causes a difficulty with heel pain. RX 1 p.21,22
- Dr. Fletcher testified that an Achilles tendon rupture that was not repaired surgically might not have a good result which could cause impairment in activities using the lower extremities, walking on uneven surfaces, climbing stairs, prolonged walking and running. He said it could result in some permanency of functionality with that type of an injury. RX 8 p.37
- Petitioner suffered multiple left lower leg deep vein thromboses as a result of this accident, resulting in a saddle pulmonary embolism a large acute saddle pulmonary embolism with a large clot volume and a right heart strain. It further noted a relatively large right lower lobe pulmonary infarct. Petitioner received follow up care for anticoagulation therapy and continued to complain of shortness of breath as of the date of arbitration.
- While Petitioner did make some complaints in regard to his low back as of the date of arbitration, he described it as a little back pain in the area of the belt when he got up in the morning. No medical records were introduced to corroborate any ongoing low back injury. No current complaints in regard to the right foot or either hip were made at the time of arbitration.
- Petitioner was able to return to his former employment in the deli, performing that work for several months prior to being terminated for unrelated reasons.

The Arbitrator gives this significant weight.

The Arbitrator, having considered the foregoing factors, the medical evidence submitted into evidence and Petitioner's testimony in regard to ongoing complaints, finds that as a result of the accident of February 9, 2018 Petitioner has been disabled to the extent of 30% loss of use of his left foot pursuant to pursuant to §8(e) of the Act due to his left Achilles rupture, and to the extent of 7 ½% loss of use of the man as a whole pursuant to §8(d)(2) of the Act due to his multiple vein thromboses and his pulmonary embolism. Respondent shall be given credit for a prior workers' compensation settlement in case 15 WC 21464 for 10% loss of use of the Petitioner's left foot. and Respondent shall therefore pay Petitioner

permanent partial disability benefits of $220.00 per week for a net total of 79.05 weeks after reduction of the award for prior credit.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC012435
Case Name	TINER, JUSTIN v. ENTERPRISE RENT-A-CAR
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0451
Number of Pages of Decision	27
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Russell Haugen
Respondent Attorney	Torrie Poplin

DATE FILED: 9/3/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Justin Tiner,

Petitioner,

vs. NO: 20 WC 12435

Enterprise Rent-A-Car,

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, prospective medical expenses, credit 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 December 2, 2020, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 3, 2021

MP:yl
o 9/2/21
68

/s/ *Marc Parker*
Marc Parker

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

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

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

21IWCC0451

TINER, JUSTIN
Employee/Petitioner

Case# **20WC012435**

ENTERPRISE RENT-A-CAR
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:

2333 WOODRUFF JOHNSON & EVANS
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JUSTIN TINER
Employee/Petitioner

v.

ENTERPRISE RENT-A-CAR
Employer/Respondent

Case # **20** WC **12435**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Dennis S. O'Brien**, Arbitrator of the Commission, in the city of **Urbana**, on **October 16, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 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 $**55,538.08**; the average weekly wage was $**1068.04**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **1** dependent child.

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

ORDER

Petitioner's injury arose out of and in the course of his employment by Respondent, and his current condition of ill being, Post-Traumatic Stress Disorder, with an anxiety disorder and a major depressive disorder, is causally related to the accident of June 1, 2020.

Petitioner's average weekly wage for the 26 weeks he was employed as a branch manager is $1,068.04.

Petitioner was temporarily totally disabled as a result of the accident of June 1, 2020 from June 2, 2020 through October 16, 2020, the date of arbitration, a period of 19 4/7 weeks, at a rate of $712.03 per week.

Respondent shall pay reasonable and necessary medical services contained in Petitioner Exhibits 4 as provided in Sections 8(a) and 8.2 of the Act, those constituting all medical bills from June 2, 2020 to October 16, 2020 which are causally related to the accident of June 1, 2020. Respondent shall reimburse Petitioner for co-pays paid by him in the amount of $50.00.

Respondent is to be given credit for all amounts paid by its group health insurer pursuant to Section (j)(1) of the Act. Respondent is also given credit for having paid 15 1/7 weeks of temporary total disability in the form of continued salary from June 2, 2020 through September 15, 2020.

Petitioner is entitled to a psychological evaluation by a medical treater of his choice and that Respondent is to pay for said evaluation subject to the Medical Fee Schedule.

The Arbitrator awards penalties in the amount of 50% of the temporary total disability owed, a total of $1,576.64, pursuant to Section 19(k) of the Act.

The Arbitrator awards $30.00 per day for the 31 days commencing on September 16, 2020 that Respondent withheld or failed to pay temporary total disability, a total of $930.00, pursuant to Section 19(l) of the Act.

The Arbitrator awards attorney fees of $630.66, 20% of the temporary total disability benefits of $3,153.28 unreasonably and vexatiously withheld by Respondent pursuant to Section 16 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.

Dennis J. O'Brien

Signature of Arbitrator

November 29, 2020
Date

ICArbDec19(b)

DEC 2 - 2020

Testimony of Petitioner

Petitioner testified that on June 1, 2020 he was employed by Respondent as a branch manager in Denville, Illinois. He said he had been employed by Respondent since November 2, 2017, initially as a management trainee in Springfield, Illinois, then as an assistant manager in Champaign, Illinois, and finally, after a lateral transfer, as the assistant manager in Danville, where, after a month, he was promoted to branch manager in November of 2019.

As a branch manager his duties included running the business from opening until closing, managing the other employees. He would be in charge of getting rentals ready, setting up direct billing and generally overseeing the everyday running of the business. He said he would deal with customers, and train employees. He said there were several matrixes he had to work with in regard to utilization, net sales, all of which effect promotions at his branch and being considered a good business operator.

Petitioner said that on June 1, 2020 they were dealing with COVID issues and kept their doors locked and served customers one at a time, and on the previous day there had been a good deal of looting going on in the surrounding cities because of the George Floyd death in Minneapolis. At 9:45 a.m. on June 1 he was helping a lady inside the office. There was an attached garage bay at the office where service agents clean the cars and he could hear a customer speaking to one of his service agents, James, in a very disrespectful manner, saying, "Hey, how long is this shit going to take?" He said he left the lady he was helping and told the person talking to his agent that there was a line of people waiting to get their cars and that he should get into line and they would be right with him. The customer said he had a reservation, had ten businesses in the city, that everyone knew him and basically was saying his service needed to be expedited because of who he was. Petitioner said he told the gentleman that they would take care of him but they were serving people one by one and he needed to get in line and be respectful and not talk to his service agent. The man continued to argue with him and told Petitioner that he should show him respect. Petitioner said he told the man that if he wanted respect he had to give respect, that he would treat him right, but he needed to get in line. He said the man saw that two people were waiting and he went back to his car with his wife.

Petitioner said he then went back in to the office to help the lady there, and he saw that the man had left his car and was walking back to the office. He tried getting into the office and Petitioner stepped outside. The man told Petitioner he needed the name of the manager and Petitioner advised him that he was the manager. The man said he needed Petitioner's boss's name and Petitioner told him that if he had a problem he could call corporate. He said the man then in a disrespectful manner reminded him that he owned ten businesses and everyone in the city knew him and he had never been treated like this. Petitioner said he asked the man what he would do if he showed up at one of those ten businesses and acted like he just had, how would he feel, what would he do? The man then said he would just shoot Petitioner, making a shooting motion, saying, "I'll shoot you. I'll lay you down and I'll shoot you." Petitioner demonstrated the motion the man made while saying this, the man used his right hand in front of him in a grip style, as if he were holding a gun or a stick, and when he said the word "shoot" pulled the hand upwards towards his shoulder as if he had just shot a gun. The man did this a total of four times. Petitioner could not remember what he said in response, but he said he then went back in the building and the man tried to entice him to come out, saying "You don't think I'll shoot you? Come over here."

Petitioner said one of the customers outside then intervened, telling the man he was crossing the line and should get out of there. Petitioner said the man then left, but before doing so said, "Watch. I'll get you. I'll be back."

Petitioner said he had customers waiting so he returned to his duties. Seventeen minutes later the man returned, at exactly 10:00 a.m.. He said he heard the man talking to another one of his agents, Megan, asking, "Where's he at? Tell him to get out here. He's going to call my wife a bitch? Tell him to get out here. I'm not going to let him get away with that. Go get him." Petitioner said he had never called the man's wife "out of her name. Never."

Petitioner said he had never before felt like he did at that moment, he got in a panic mode, he opened one of his closet doors to find a weapon, and he found a pole and he locked himself in the bathroom, because the man had just threatened his life and he was now back. He said he thought he was going to have to protect himself with deadly force because he did not want the man to have the opportunity to live out what he said he was going to do. He said all he could think about was going home to his family. He said the man tried to open the exterior door, but Petitioner had locked it, and the man left.

Petitioner said the man came back a second time, with another car following him. He said all of this was caught on surveillance videotape which he had reviewed. The tape showed Petitioner talking to Megan, trying to get in the building, leaving and returning, followed by another car, both cars being white Dodge Chargers. It showed him talking to the other driver. He said when the man left again he was again followed by the second car. He said the two cars had parked in an adjacent parking lot in front of a bank, but that area was seen on his company's parking lot surveillance camera.

After the man on this occasion Petitioner said he texted Elizabeth Messick and explained what had just happened, noting that a customer had just threatened him, saying would shoot him, and had come back to the branch but nothing had happened and then man was now gone. He said after sending the text he put his phone down to help customers. He said Liz had texted him and called him while he was doing this and he did not know this as he did not have his phone on him. When he checked his phone to check his notifications liz actually was calling him and he answered the call. She wanted to know if he was okay and wanted to know what was going on. He told her what he had texted to her was the situation, he explained the threats and that he had told the man to just get in line and wait, he told her of the threat of a gun and the man coming back and his having hid in the building and the man leaving again.

He said she then informed him she had called the police because of someone being there with a gun and telling him he needed to be careful and look out.

Petitioner said that at that moment he looked outside the window and saw police starting to surround his building with guns drawn. He said he helped the Danville police almost daily, providing them with information such as when they had cars returned which were shot up or other unusual things. He therefore thought he could go outside and tell the police it was a false alarm that there was no gun, he could explain the situation. He said he had seen guns in the police officers' hands but they were not pointed at anyone. He said when he went outside the police thought he was the suspect and the guns were pointed at him. He actually only saw one officer who was in front of him, but he knew there were other officers behind him. The officer in front of him said he wanted to see Petitioner's hands. In 10 to 15 seconds he was able to tell the officer he was the branch manager, but in his mind he was thinking if he would have gone to his pocket while telling them he was the branch manager it could have gone very bad for him. Once he was cleared as being the branch manager they told him to sit off to the side and they cleared his employees as well and he and Megan told the officers that

there was no one else in the building, but four or five officers with their guns drawn went in and searched the building.

After three or four minutes the lead detective came up to him and asked what the guy inside looked like, and Petitioner advised him that there was no one in the building, and the detective yelled at the other officers that there was no one in the building, asking what they were doing. The officer who had spoken to him earlier then came up to Petitioner claiming he had told him there was a man with a gun in the building and both he and Megan said that Petitioner had told him there was no one inside. They argued about this for a short time before the detective told the other officer to stop arguing with Petitioner.

Petitioner then made a threat report for the police, which he did not think they took as seriously as he felt they should have. He said he showed the surveillance video of the man to the police, identifying the man for them. He then talked to Liz by phone again and told her he did not feel safe and would like to go home. She said she would have to call the general manager, Brian. She called him back abut 10 minutes later at about 1:00 p.m., and said that he had deals scheduled at 3:00 and 3:30 and asked him to call them and ask that they come in early and that after he got through all of his deals he could go home. Petitioner said he did not do that, he left right away, at about 2:00 p.m., as he was scared for his life. At about 4:00 p.m. he received a text from Liz asking him if he had left and if everything was okay, and he told her he was at home, but did not feel comfortable telling his wife what had happened because she would freak out. He said Liz thanked him for keeping his team safe.

Petitioner said he was actually in his parking lot at home when this text occurred, as he did not get off work until after 5:00 p.m. and did not get home until nearly 6:00 p.m., so he did not want to go inside and have his wife ask why he was home early, and because at that point he was still quite shaken up. He said that at 5:04 p.m., while still in the parking lot, he got a text from the manager of the Champaign branch, Breana, asking if he had left his branch, he texted back that he had. About five minutes later he again texted her asking if she needed something, and she replied saying that she did not need anything, but wanted to let him know she had just rented a guy a car and he asked her if she knew Petitioner. She said she told him she did, and he told her that there were going to be people at his branch at 5:00 p.m. to hurt him. She just wanted to make sure he had left okay. Petitioner said he then called her and asked what the guy looked like and she described the man who he dealt with earlier in the day and sent him a photo of the contract she had written him and he saw it was the same man he had dealt with that morning. He said he explained the situation to her and she was in shock as she knew nothing about it.

Petitioner then texted Liz and the company's risk boss, George McNair, and told them that he felt it was not in his best interest to go to work as the man had threatened his life, he had sent all of the videos to them and yet the man had been able to go down the street to another Enterprise location, pick out a rental and then make more threats about him to his coworkers. He advised them he was not going to work the next day. Petitioner said that after that text exchange he went and told his wife what had happened. He said that he knew he was the only person working in his family and he thought he would be able to put this behind him and get back to work. He said he knew he was in shock when he told his wife what happened, but reality hit him when his wife, after being told, freaked out. She had not wanted him to go to work that day, a Monday, because of all the post-George Floyd death looting that had occurred that Sunday. He said she pointed out that the events which had occurred could have resulted in his getting seriously hurt and that his daughter would have to grow up without him as he would no longer be around if he did not take this matter seriously.

Petitioner said that he could not sleep the evening of June 1, 2020, he was shaking and throwing up. On the morning of June 2, 2020 he went to Carle Convenient Care and was diagnosed with post-traumatic stress

disorder and was instructed to undergo a consultation with a psychologist. He was advised not to return to work until he was cleared to do so by a psychologist. The medical records of Carle Foundation Hospital reflect that Petitioner at that time was obviously distressed and tearful. They noted this was due to significant stress due to his having a person threaten to shoot him and then having guns drawn on him by the police. Petitioner requested a referral to the Psychology Department. He was given a referral to see the first available adult psychology provider and was given the telephone number for Carle Psychology/Psychiatry to make an appointment. (PX #1)

The arbitrator notes that the hospital records entered into evidence only referred to Petitioner's race as being "Non-Hispanic or Latino Ethnicity," but the arbitrator takes judicial notice that at arbitration Petitioner's race appeared to be African American, the same race as George Floyd who had died days earlier while being arrested by the Minneapolis police. (PX #1. 2)

Petitioner testified that he saw Dr. Stanley Wu at Carle Clinic on June 17, 2020 and that he diagnosed him with posttraumatic stress disorder also and that he also referred Petitioner for a consultation with a psychologist. Petitioner said he has continued to be treated by Dr. Wu and that Dr. Wu on three occasions made referrals for him to consult with a psychologist. He said he had not undergone a consultation with a psychologist as of the date of arbitration as he had been advised on three occasions by the psychology department at Carle that Enterprise had denied the consultation, and Carle did not accept his insurance.

Petitioner said that as of the day of arbitration he was still interested in undergoing a psychological consultation.

Petitioner testified that prior to June 1, 2020 he had never experienced this kind of interaction with a customer while working for Respondent. He said that prior to June 1, 2020 he had never suffered from any type of mental health issue, nor had he ever received treatment for any type of anxiety, depression of posttraumatic stress disorder.

Petitioner said that he was promoted to branch manager on November 29, 2019, a promotion which resulted in a raise in his salary. His annual salary as a branch manager was $47,500 but he also could get a commission each month based on performance and production. Those extra payments were paid in the last paycheck of the month. Petitioner was shown Respondent's Exhibit #2, which was a pack of pay stubs, and noted that on December 25, 2019, for instance, the line labeled "I-profit Bonus-GP" was his percentage of his commission. For the month of December he had earned a $763 commission.

Petitioner said that since June 1, 2020 he had been experiencing emotional disconnect from his family, nonstop anger, anxiety, depression, sleepiness, nervous feeling, and he always feels like he is doing something wrong. He said he feels like he is lost. He said he still takes medication which is prescribed by Dr. Wu, though he could not remember their names.

Petitioner said he had not been back to work for Respondent since June 1, 2020, nor had he worked anywhere else. He said Respondent did continue to pay him his full salary for a period of time. Petitioner identified Petitioner's Exhibit #9 as screenshots of an Enterprise ADP app which showed his pay and deductions from his paychecks. He said these screenshots accurately reflected the wages that he received from Respondent on those dates. He said that payments for "Leave 100 percent" on August 7, 2020 was pay he received due to his FMLA leave. He said it reflected his salary being paid. Petitioner said he was last paid his full salary on September 4, 2020. He said any earnings received after that date were reflected on additional screenshots in that exhibit. And they reflected all of his earnings from Respondent since August 2, 2020.

On cross-examination Petitioner agreed that when he went to the doctor on June 2, 2020 the doctor prescribed anxiety medication for him but he refused that medication as he had always been a "natural guy" who was against taking medicine. After being seen at the emergency room Petitioner said he realized he needed to have a primary care provider, which is why he retained Dr. Wu.

Petitioner said that he did receive paperwork via email from Meaghan Jenkins which included FMLA paperwork and information in regard to Respondent's Employee Assistance Program. He said he did not know what the Employee Assistance Program was and he did not call it as recommended. He said he did not know that the program offered three face-to-face visits with a psychologist and unlimited phone appointments. He said this was not conveyed to him. He said he had been rushed to come back to work by Respondent and he did not want anything to do with them as of June 2, 2020.

Petitioner said he hired an attorney as soon as he left the hospital on June 2, 2020. Petitioner said he had a telephonic follow-up with Dr. Wu, on June 17, 2020 at which time the doctor recommended sleep medication, Zoloft. Petitioner said that while he had turned it down the first time the doctor recommended it, this time he took the medication, saying that while he tried getting through without medication it did not work for him so when he next saw the doctor he started taking it. He said Dr. Wu took him off work as of the first time he saw him. He said he followed up with Dr. Wu on June 18, 25 and 30, 2020. On June 30, 2020 he indicated to Dr. Wu that Respondent had offered him a position in Bloomington, and that he wanted to go back to work after he saw a psychologist.

Petitioner told the doctor that he was troubled about the events and news going on in the world and that he felt like the daily events of the world added to his condition. He told the doctor that he had an issue with the police when they arrived at the scene, and he felt the police also added to his condition.

Petitioner said he could not remember the exact dates he followed up with Dr. Wu, nor was he sure if Dr. Wu backdated an off work slip on July 1 taking him off from June 17.He said that might have been around the time they did the FMLA paperwork.

Petitioner agreed that by July 17 the Zoloft was helping. He agreed that he told the doctor that Respondent had offered him a job in Bloomington but that he had not accepted the position, which was not near Danville. He said that while he had been living in Champaign when the incident occurred but had moved back to Springfield with his mother in the middle or end of July.

Petitioner said he could not recall if he told Dr. Wu on September 3, 2020 that he wanted to find another job. He said Dr. Wu gave him an off work slip on September 14th though he did not see him on that date. When asked why Petitioner testified that Meaghan send him an email saying she did not have a recent off-work slip and his benefits were going to expire if she did not get something from the doctor. He said the doctor wrote him a slip taking him off work from September 14 through September 30.

Petitioner said the initial altercation where the man threatened to shoot him while using hand gestures took place over about five minutes. He said he did not see any weapons. He said at first the man's wife was with him, the second time he came back with a second car as well though he came out of the car by himself. He said he only spoke to the man's wife when she came to the door and tried to get in, at which time he told her they were dealing with people one on one and he would be right with her. He said she was fine, she just walked back to her car.

Petitioner said that when the police came with their guns drawn it was a whole different problem from the customer who had threatened him. He said the police actions added to the customer actions. He said he would rather Enterprise had not called the police, as Liz's telling someone with a gun was there initially had the police thinking he was the suspect, which made it worse. He felt he should have been the one to call the police since

he had been the person involved, though he knew their calling the police was not with ill-intent, that they were concerned for his safety. He felt that he would be in a better position, mentally, if they had not called the police. He said he did not know Liz had called the police, and as she told him of her calling them and telling them someone might be there with a gun, he looked out and saw the police were already there. He said he videotaped the police officers while they were there as he didn't feel safe and he wanted to make sure he had everything on camera.

Petitioner said his co-worker, Megan Scott, did not escort the customer away from him, the man's wife did that.

Petitioner again testified that his wife had not wanted him to go to work that day due to all of the looting but he told her he had to as Monday was their busiest day. When he got home that night they did not discuss George Floyd, they discussed what had occurred that day, at which point she "freaked out," and he then "freaked out" at her reaction. When asked if the civil unrest had any effect on his current condition he noted that 11 days later Rayshard Brooks was shot by police in Atlanta, which played into his fear due to being held at gunpoint by police. He again noted that if he had made an honest mistake when the police to show his hands, reaching to get his wallet to show his branch manager card, instead of not moving, "who's to say he wouldn't have been, hey, gun and shoot me," in which case he would not be present for the arbitration hearing.

Petitioner said he believed another person who witnessed the incident was present. He said he did not know the person's name, and had not spoken to him. He said he spoke to the man on the day of the accident as he had served him as a customer before the man who threatened him showed up. He said he did not talk to that customer after the altercation, but he got his information from Megan, who was still working in Danville, so he could be a witness. He said he contacted the man within the month prior to the arbitration hearing and asked him if he would accept a call from his attorney. He said he did not talk to the man abut the incident at all, or about his condition and how he was feeling. He said he only spoke to the man that one time. He said the phone call to the man was done on his own initiative and the conversation only took about a minute, and he gave him his attorney's information.

Petitioner said he was not aware that the individual who threatened him and his wife had both been banned from renting from Respondent. When asked if he knew the man's name Petitioner said it was in his phone, his first name was Abraham and he had a very long last name. He said he had not looked the man up and other than the initial police report he had not file any restraining orders against the man as he had left Champaign and had moved back to Springfield.

Petitioner said he made a threat report to the police on the day it happened and Liz and George sent another threat report in and George told him on June 1 that the Danville police were on it. Petitioner said he was aware that there was a lot of crime in Danville including around the Enterprise location.

Petitioner said Danville was 35 minutes from where he was living in Champaign, and almost two hours from where he now lived in Springfield.

Petitioner said that while a second automobile came with the man when he returned, he did not see anyone who was in the second car.

Petitioner said he had not gotten any payment from Respondent since October 2.

On re-direct examination Petitioner said that when Meaghan offered him a position in Bloomington he told her he was interested in the position but wanted to be cleared by a psychologist first. He said neither at that time nor at any other time did Meaghan tell him of his right to see a psychologist via the Employee Assistance Program.

Testimony of Layton Warstler

Layton Warstler was called as a witness by Petitioner. Mr. Warstler testified that as of the date of arbitration he was a disabled veteran and a stay-at-home father. He said he was appearing at the hearing pursuant to a subpoena he had received the day before the hearing. He said he first spoke to Petitioner's attorney two days prior to the hearing. He said he was at the Enterprise location in Danville on June 1, 2020 at approximately 9:45 as his reservation was for 10:00 a.m.

Mr. Warstler said that while waiting to get his rental vehicle, he spoke with Petitioner, and Enterprise did not have his vehicle of choice, a Tahoe, but were going to give him an SUV which was on the parking lot. Since there was already someone in the office Petitioner asked him to stand outside until the earlier person left and if there wasn't someone in the office he could enter. He and his mother-in-law, who had driven him there, then drove down to a doctor's office where his father-in-law had a credit card with high enough limits for the rental. Shortly after they arrived back at Enterprise a gentleman arrived and became belligerent when Petitioner told him he could not be in the office when another customer was inside. Mr. Warstler said the man began to pace back in forth to his vehicle and yelled back curse words and made obscene gestures, saying he had enough money to buy the place. Mr. Warstler said Petitioner did not acknowledge the man as he was assisting another customer and was trying to deal with a number of customers and the need to keep them socially distant and not crowded int the office.

Mr. Warstler said the man then came back from his car, waving his hands around, saying that he was going to go back to a business he or his family owned and was going to get his "piece," and then come back and seal the deal. Mr. Warstler said the man used a slang word for getting his gun, also showing a hand gesture for a gun and gesturing as if he planned on shooting somebody. He said the man did the gun gestures quite a few times right in Petitioner's face. He said Petitioner was trying to get away from the man to deescalate the situation, all the while receiving deadly threats to his life.

Mr. Warstler was then shown a portion of the surveillance video which was one minute and 26 seconds long but was frozen at the two second mark. Mr. Warstler identified himself as wearing tan shorts and a gray T-shirt, facing the man in the video. He said the man was wearing a baseball cap. He said the man as 5'6" to 5'8 tall and weighed about 140 pounds. He said the man was wearing gym shorts, a T-shirt and flip-flops. He said the man went back to his car as his girlfriend had corralled him to get him back in the car. He said it looked like the man reached into his glove box, but he could not see that clearly.

Mr. Warstler said he told to the man he needed to leave and to stop. Petitioner was walking in between cars and the man was trying to talk to Petitioner and the man actually shoulder bumped Mr. Warstler, Mr. Warstler said he was not present when the man came back, nor was he present when the police arrived.

On cross-examination Mr. Warstler said he had spoken to Petitioner since the incident, the same day he spoke to Petitioner's attorney. He said he wanted to know if he was the person who was present or if it was his father-in-law, and he told Petitioner he would talk to Petitioner's attorney. He said he spoke to the attorney that same day, two days before the arbitration hearing. He said he had not spoken with Petitioner from the time he rented his vehicle until he spoke to him two days prior to arbitration. He said he told Petitioner it was unfortunate that this had occurred, but he did not discuss what had actually happened with him. He said their conversation was probably two to three minutes long. He said the conversation with the attorney was probably

10 to 15 minutes long. He said Petitioner's attorney at the arbitration hearing is who he spoke with. He said he did not know how Enterprise had obtained his contact information.

Mr. Warstler said that he had interacted with the angry individual and that the man's wife or girlfriend did not calm him down, but she shoved him towards his vehicle. He said he had stepped in not because Petitioner was having issues with the man but because he was in fear for everybody's life at that point. He said he saw and heard the man leave as the "peeled out" as he left.

On redirect examination Mr. Warstler said nothing Petitioner or his attorney said to him in their telephone conversations changed his account of what happened. Mr. Wartzler said he was not in the hearing room when Petitioner testified and had not heard any of his testimony.

On recross-examination Mr. Warstler said he had not been paid to be at the hearing, that he was losing money by being present.

Testimony of Meaghan Jenkins

Meaghan Jenkins was called as a witness for Respondent. She testified that she had a bachelor's degree from Western Illinois University and had worked for 15 and a half years for Respondent, currently working as a human resources generalist, working with employee development, workers' compensation and unemployment claims and scheduling. She had assumed that job in February of 2020. She said that in her position she could place employees at different Enterprise locations. She said she was familiar with Petitioner and would communicate with him regularly as part of her job in regards to employee development, training classes, and branch scheduling.

Ms. Jenkins said that on June 1, 2020 she did not receive a telephone call from Petitioner, Liz Messick did. She and Ms. Messick were teaching a training class, and as Ms. Messick was speaking when she looked at her phone, so she asked Ms. Jenkins to contact Petitioner. Ms. Jenkins said she called Petitioner and he answered and said he would call her back as he was in the middle of something. She said he did not call her back and she waited about seven minutes. She said she was a little panicked and she called him back again, and he answered. She said Petitioner told her that a customer had threatened to shoot him, the man had approached a service agent in the wash bay and tried to jump in line, with Petitioner asking him to wait his turn. After the man walked around the building he and Petitioner had an altercation and the man made a shooting motion and told Petitioner he was going to shoot him.

Ms. Jenkins said that during that phone call Petitioner told her he wanted to leave, saying he needed to get out of there. She told him not to walk outside the building as it was not safe, adding that they needed to call the police. As she was saying that she said that Ms. Messick walked into Ms. Jenkins' office and heard the end of the call with Petitioner. Ms. Messick then got on her phone and called the police while Ms. Jenkins was still on the phone with Petitioner. She said she told Petitioner that Ms. Messick was calling the police.

Ms. Jenkins said they spoke to Petitioner after the police were there and he sounded more calm and said the police were reviewing the surveillance tape. She said the police had not arrived while they were on the phone with Petitioner. She said the first time she spoke to Petitioner on the phone he sounded concerned and upset, but he sounded calmer when the police were there. She said she did not speak to him after the police left, Ms. Merrick did, over a speaker phone with Ms. Jenkins in the room. In response to Ms. Merrick's request for

information about the man Petitioner put a police officer on the phone. The police officer told them he could not give them the person's name. Ms. Merrick asked if they should be concerned, and the police officer told them he knew who the person was, and he "felt it's always better to err on the side of caution."

Ms. Jenkins said she texted Petitioner later in the evening of the event asking if he was okay and, the next day asking when he would have time to discuss returning to work. On the afternoon of June 2 he responded that he was not okay and would need to seek medical help from a psychologist. He told her he understood Ms. Messick's intent was to protect him, but by calling the police he was put in a position where he feared for his life and thought about his daughter growing up without him, and it had given him anxiety. She said he seemed more concerned about the police than about the customer.

Ms. Jenkins said she continued to communicate with Petitioner through text messaging and email, checking on him and saying she hoped he was doing well. She checked in about doctor's notes, telling him of the opportunity for him at the Normal store. She said at no time did she force him to return to work. She said she never discussed avenues for psychological treatment, though she did tell him of the Employee Assistance Program. On June 2 she asked him for a personal email address so she could forward FMLA paperwork and Employee Assistance Program information, which she emailed to him on June 3. She said she never explained the Employee Assistance Program to Petitioner, nor did she ever tell him it would help with psychological treatment. She said an explanation of the Employee Assistance Program is given to every employee as it is in the benefits information and is emailed out twice a year. To her knowledge Petitioner has not availed himself of the Employee Assistance Program.

Ms. Jenkins testified that she did discuss the events of June 1 with the other two employees who were present at that time. She said neither of those employees took time off work following the incident. Ms. Jenkins said she learned that later on the evening of the incident she found out that the customer involved in the incident had rented a vehicle at the company's Champaign location. She discovered this from the employee who rented him the car and via Petitioner who had contacted Respondent's risk and group rental manager. She said two customers filed complaints, although she did not know if they did that telephonically or online.

Ms. Jenkins said she could make a recommendation to the risk manager to block or prohibit certain customers from renting cars from the company, using the customer name, phone number and driver's license number so if any of those were used in an attempt to rent a car they would not be able to do so.

Ms. Jenkins said she had offered Petitioner at job in Normal, Illinois, as a branch manager, at the same salary level he had, but he had not taken the job. She said that job was still open for him. While he got the same base salary as all other branch managers, she did not know the specifics of his commission percentage or his target. She said commission checks are not guaranteed, no bonuses are guaranteed. She said commission checks varied from month to month, and were based on net profit for the previous month. As profits fluctuated, so did commission checks. She said April and May the company was hit very hard and the did allow two months of guaranteed commissions for managers, even though the business was not profitable.

Ms. Jenkins said that prior to becoming a branch manager Petitioner was an hourly employee working a targeted 48 and a half hours per week, with all hours over 40 being overtime. She said hours over 48 and a half were optional, but the company tried to control it.

Petitioner applied for FMLA benefits and they were paid through August 21. Ms. Jenkins said he received a combination of FMLA pay, sick leave and PTO through September 14. Ms. Jenkins said Respondent's Exhibit #1 was Petitioner's earnings from June 3 through September 25 as provided by Respondent's payroll department. She indicated that what was identified as "sick" was FMLA pay, which totaled 60 days, a total of $12,971.13. She said daily pay was $182.69 and there were 71 days noted on the document.

On cross-examination Ms. Jenkins said she knew the ADP app was an app for Respondent's employees on their phones so they could track their paychecks. She said she had never used it herself. She said she recognized the meaning of the numbers or figures on Petitioner's Exhibit #9, the dates, what was paid and the taxes. It showed profit-based bonus as commission checks, vacation pay, FMLA leave. She said the amount entitled "I-Profit Bonus" on the exhibit was the commission, which was based on the performance of the store per their target, which is based on the previous year's performance for that location. She said that if the manager met and exceeded the target Respondent was obligated to pay them that bonus on top of their base salary.

Ms. Jenkins testified that the customer's being placed on Respondent's no-rent list was based on his interaction with Petitioner on June 1, 2020. She said of the two other employees who were at the Danville location on June 1, 2020 one was still an employee, and the other was not. She said Liz Messick's job title was group rental manager.

On redirect examination Ms. Jenkins testified that the employee who was no longer employed by Enterprise left on September 11th to take a job with a railroad in Georgia, and he gave them four weeks' notice.

Summary of Medical Evidence

On June 2, 2020 Petitioner was seen at Carle Clinic. He gave a history of the altercation with a customer consistent with Petitioner's testimony summarized above. This included the history of the customer saying he would shoot Petitioner. It also included his saying he was advised that that his manager had called the police as the police arrived with guns drawn. He told the hospital staff that when he tried to tell the police that the only people present were himself and another employee the police had their guns drawn on him. He also noted that another co-employee in Champaign called him at 5 p.m. and told him that a customer came in and rented a car telling the employee that he was going to be at Petitioner's store when it closed to finish dealing with Petitioner. Petitioner told the medical staff that he feared for his life and did not feel returning to the Danville store was safe. He said he did not want to lose his job because he was the sole provider for his family, but he did not feel it was safe to return to work. He said he sought a referral to counseling or someone who could help him. (Pet. Exh. #1)

The medical provider during that visit noted that Petitioner appeared nervous and anxious, with an affect that was tearful. They discussed a prescription for Vistaril or another anxiety medication, which Petitioner declined as he did not want to take medication but did not know what he should do. Upon examination Petitioner was found to be obviously distressed and tearful. When a request to Psychology was requested by Petitioner paperwork for workers' compensation was filled out and they noted they found this was the result of an incident that occurred at work. They advised Petitioner at that time that he could return to work once he had been cleared. The diagnosis given at this visit was Post-Traumatic Stress Disorder (PTSD). (Pet. Exh. #1)

Petitioner was seen by Dr. Stanley Wu in the Family Medicine department at Carle Clinic on June 17, 2020. Petitioner was offered and accepted a telephone visit to reduce exposure to COVID-19. The history given to Dr. Wu was again consistent with Petitioner's testimony at arbitration. He advised Dr. Wu that his work had not been very sympathetic and he had taken time off work as he feared for his life. It was noted he was to see a psychologist but no appointment had been scheduled yet. It was noted that FMLA paperwork needed to be

filled out so another appointment with Dr. Wu was scheduled for the next day. Petitioner advised Dr. Wu that his sleep was affected, that his energy was low, that he ate perhaps one meal per day, and that he felt sad/down/worried/anxious. Dr. Wu diagnosed PTSD. (Pet. Exh. #1)

On June 18, 2020 Petitioner saw Dr. Wu. Dr. Wu noted that Petitioner was having a hard time sleeping, had decreased interest, feelings of guilt, and decreased energy and appetite. Dr. Wu noted that Petitioner appeared to be tearful at times. Dr. Wu filled out FMLA paper work, and referred Petitioner for psychiatric/psychological counseling. His diagnosis remained PTSD. At that time a prescription for Trazodone to help him sleep was given. (Pet. Exh. #2)

Dr. Wu filled out FMLA paperwork on June 18, 2020. In his certification for Petitioner's health condition Dr. Wu noted that Petitioner had been seen by him on two occasions at that point and that he had been referred for treatment by a psychologist. He further noted that Petitioner was unable to perform his job functions as he was unable to focus/concentrate due to fear and anxiety. He stated that since Petitioner had been threatened for his life three times on the same day while at work he had significant anxiety and distress. (Pet. Exh. #5)

On June 25, 2020 Petitioner had a telemedicine visit with Dr. Saman Misbah of Carle Clinic. He gave Dr. Misbah a consistent history and noted he was very traumatized by what had happened, and had been unable to return to work because he is scared for his life. He was also worried about the person who threatened him finding him outside of work. He was also worried about his finances due to not working, as well has the safety of his wife and daughter. He said he had not been taking the Trazodone which had been prescribed, and Dr. Misbah assured him that medication would help him fall asleep. Petitioner said he would try to take the medication soon. (Pet. Exh. #2)

On July 1, 2020 Dr. Wu signed an off work slip based upon his visits with Petitioner on June 17, 2020, via telephone, and June 18, 2020, in person. (Pet. Exh. #6)

Petitioner was seen for counseling in Carle Physician's Group Family Medicine Resident's Clinic on June 30, 2020. He voiced frustration at what he perceived to be a lack of support and compassion by Respondent.

Petitioner was seen on July 1, 2020 by Dr. Wu, who noted that Petitioner was still quite distraught and scared for his life. He still had not tried the Trazodone, and was encouraged to try it for his sleep. Petitioner said he was still only eating one meal a day as he was not hungry or was feeling nauseated. Dr. Wu prescribed a trial of Zoloft at that time for Petitioner's symptoms. His diagnosis for Petitioner remained post-traumatic stress disorder, with an anxiety disorder and a major depressive disorder. (Pet. Exh. #2)

Dr. Wu next saw Petitioner on July 16, 2020. Petitioner advised him that he was taking the Zoloft and Trazodone and both seemed to be helping, He said the latter drug had improved his sleep. Dr. Wu observed Petitioner to still be tearful at times, but felt his overall affect seemed to be more cheerful. His diagnoses remained the same. (Pet. Exh. #2)

Petitioner had a telemedicine visit with Dr. Wu on August 14, 2020. Petitioner advised the doctor at this visit that Respondent had twice declined the process for Petitioner's being seen by a psychologist. He had been offered a position with Respondent in Bloomington but was waiting to see a psychologist. He advised the doctor that he was having mood swings. He said he continued to take the Zoloft and Trazodone medications. Dr. Wu's diagnoses on this date were anxiety and depression as well as PTSD. (Pet. Exh. #2)

Petitioner was seen via a telemedicine visit by Dr. Misbah on September 3, 2020. He was advised that Petitioner was awaiting trial and his FLMLA leave had run out and he was not longer getting paid. It was noted that Petitioner continued to have anxiety, but it was better, he was eating more and gaining weight. Petitioner still had anger and sadness about the situation. (Pet. Exh. #3)

Dr. Wu authored a "To Whom It May Concern: letter on September 14, 2020 in which he stated Petitioner was still under his care and was awaiting an appointment with a psychologist, continuing his off work status through September 30, 2020. (Pet. Exh. #7)

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner's rendition of the facts at arbitration, to the police at the time of the incident, to company personnel, and to medical providers was consistent and was supported by the surveillance video of two altercations with the customer, which, while not aided by audio recordings, did show the threatening attitude of the customer and the hand gestures simulating repeated firing of a hand gun. (Resp. Exh. #5) His presentation at arbitration was quite believable, and his retelling of the events of that day made him appear sincerely upset, tearful, and did not appear to be exaggerated. The Arbitrator finds Petitioner's testimony to be credible.

Layton Warstler appeared pursuant to subpoena. He was another customer in line waiting to pick up a vehicle. He has no relationship with any of the parties or witnesses to this action. He was a non-interested bystander to the altercation between Petitioner and the customer in question at the time the irate customer insinuated he was going to go get a gun and when he simulated the repeated shooting of a hand gun in Petitioner's direction. Mr. Warstler's only post-accident contact with Petitioner was when Petitioner contacted him two days before the arbitration and asked if he would talk to his attorney. Mr. Warstler's testimony was consistent with Petitioner's testimony at arbitration. The Arbitrator finds Mr. Warstler's testimony to be credible.

Meaghan Jenkins testified on behalf of Respondent. She is a Human Resources Generalist for Respondent and had some contact with Petitioner on the day of the incident, via telephone, as she was not present at the store in question. Ms. Jenkins seemed honest and sincere in her testimony. While there were minor differences in her rendition of timing of events, her testimony was basically consistent with Petitioner's testimony, with the exception of when the police arrived. The Arbitrator accepts Petitioner's rendition of when he was advised that police were coming over that of Ms. Jenkins, as he was present and his surprise at the arrival of the police with guns drawn just as he was being advised they had been called is something which would have a much more lasting impression upon him than it would have upon her. His rendition is also supported by a history consistent with his testimony at the arbitration hearing given to medical providers in the days and weeks immediately following the incident. The Arbitrator finds Ms. Jenkin's testimony to be credible, though in this one regard, inaccurate.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to whether an accident occurred which arose out of and in the course of Petitioner's employment by the Respondent, the Arbitrator makes the following findings:

Petitioner is attempting to prove he suffered a psychological or psychiatric injury as the result of the activities he was a part of at Respondent's Danville, Illinois store, where he was manager, on June 1, 2020.

Petitioner has not claimed or proven any physical injury occurred on that date, and is not seeking a finding of a "physical-mental" injury. Instead he is alleging he sustained a "mental-mental" injury as a result of the June 1, 2020 activities he observed, the threats upon his life by an irate customer, the pointing of guns at him by police who, unknown to him until the time of their arrival, responded to a report of a problem by one of Petitioner's superiors, and the report by a co-employee later in the afternoon that the irate customer had rented a car at another of Respondent's stores, in Champaign, Illinois, and advised Respondent's employee at that location that there were going to be people at Petitioner's store at 5:00 p.m. to hurt him.

The Illinois Supreme Court set out the requirements for a "mental-mental" claim in Pathfinder Co. vs. Industrial Commission, 62 Ill.2d 556 (1976), stating,

> It has been consistently held that the Act should be liberally construed to accomplish its purposes and objects. (citations omitted) We have held broadly that the term "accident" is not "a technical legal term but encompasses anything that happens without design or an event which is unforeseen by the person to whom it happens" (citation omitted), and that a psychological disability is not of itself noncompensable under the Workmen's Compensation Act (citation omitted). We must conclude that an employee who, like the claimant here, suffers a sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained.
>
> * * *
>
> We conclude there is little to support a rule that allows an award for a claimant under the Workmen's Compensation Act who is suffering from psychological disabilities caused by an often minor physical injury but denies an award to a claimant with a similar psychological disability brought about, as here, by a sudden, severe emotional shock and who fortuitously did not sustain any physical injury in his accident. Pathfinder Co. vs. Industrial Commission, 62 Ill.2d 556, 563-565 (1976)

In a case somewhat analogous to this, Diaz vs. Ill. Workers' Comp. Commission, 2013 IL App (2d) 120294WC, a policeman suffered PTSD after a man became angry that he did not move his squad car immediately while the policeman was responding to a complaint of a disturbance. The man became upset, went into his house, and came out holding what appeared to be a handgun. The claimant testified that after seeing the handgun, he drew his weapon and commanded the man to drop the gun. The man did not comply, and instead continued to walk toward the claimant and another officer. Claimant said that when the man got to within ten feet of him he saw the gun had an orange tip, meaning it could be a BB gun or a toy gun, but he could not be sure. The man eventually retreated into his house, a standoff began and a special response team was called in with a negotiator. The claimant left the scene before tear gas and smoke bombs were used to enter the house. The claimant had remained on the scene until approximately 11 p.m., but left prior to the resolution of the standoff. Petitioner subsequently received psychiatric treatment as a result of this event. These circumstances were found by the Appellate Court to be sufficient to meet the requirements of Pathfinder, the accident was found compensable and benefits were paid.

While some minor differences in factual testimony exist in this case, to wit whether Petitioner had been advised the police had been called before their actual arrival, the principal facts of the incident are unrebutted, and indeed are supported by the testimony of a customer who was present at the altercation where the irate

customer threatened Petitioner, said he was going to get his "piece," made repeated motions towards Petitioner of his hand simulating the shooting of a gun, and surveillance video which showed the altercation and the hand gestures of shooting a gun as well as the irate customer's leaving the store area and returning minutes later accompanied by person or persons unknown in another car and trying to enter the locked store. Petitioner's testimony that he had been informed by a co-employee that the irate customer had rented a car from another location later on June 1, 2020 and had informed that co-employee there were going to be people at Petitioner's store at 5:00 p.m. to hurt him was also unrebutted.

Petitioner testified that this incident was the day after there had been a good deal of looting going on in the surrounding cities because of the George Floyd death in Minneapolis, which the Arbitrator takes judicial notice occurred on May 25, 2020. The Arbitrator notes Petitioner appeared to be African American, though that question was never posed to him.

Petitioner was not the only person present at the store that morning that thought the irate customer's actions constituted a threat. Mr. Warstler testified that he had stepped in not because Petitioner was having issues with the man, but because he was in fear for everybody's life at that point.

The Arbitrator finds that Petitioner suffered an accident on June 1, 2020 which arose out of and in the course of his employment by Respondent. This finding is based upon the actions of the irate customer on June 1, evidenced not only by the testimony of Petitioner by the supporting testimony by Mr. Warstler and the video surveillance tape, as well as Petitioner's testifying at length of his reactions to the interactions with the irate customer who threatened him, including multiple hand gestures simulating the shooting of a gun, with the simulated gun being pointed directly at Petitioner. It is further based upon Petitioner's reactions to the irate customer's returning to the store after previous saying he was going to get his "piece," and Petitioner's response and fears when police officers pointed their guns directly at him. Petitioner's reactions on the date of the incidents as evidence by his testimony at arbitration, his statements to his superiors at work and his history to medical providers the next day indicate fear for his life as a result of these actions on the part of the irate customer and the police who responded to a call from his superiors to the police which included an erroneous statement that there was a man with a gun at the store. These multiple incidents in rapid succession constitute multiple sudden, severe emotional shocks to Petitioner, and are not of the sort normally experienced by people at work, with no evidence introduced in this case indicating that having one's life threated repeatedly was normal in a person holding Petitioner's position or in this store's location.

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being is causally related to the accident of June 1, 2020, the Arbitrator makes the following findings:

The findings of fact relating to accident, above, are incorporated herein.

The summary of medical evidence, above, is incorporated herein.

Petitioner was seen the day following these events at Carle Clinic. The medical provider during that visit noted that Petitioner appeared nervous and anxious, with an affect that was tearful. Upon examination Petitioner was found to be obviously distressed and tearful. When a request to Psychology was requested paperwork for workers' compensation was filled out as they found this was the result of an incident that occurred at work. They advised Petitioner at that time that he could return to work once he had been cleared. The diagnosis given at this visit was Post-Traumatic Stress Disorder (PTSD). (Pet. Exh. #1)

Dr. Wu's records of June 17, 2020 reflect Dr. Wu was given a history consistent with Petitioner's testimony at arbitration. He advised Dr. Wu that he had taken time off work as he feared for his life. It was noted he was to see a psychologist but no appointment had been scheduled yet. Petitioner advised Dr. Wu that his sleep was affected, that his energy was low, that he ate perhaps one meal per day, and that he felt sad/down/worried/anxious. Dr. Wu diagnosed PTSD. (Pet. Exh. #1)

Petitioner saw Dr. Wu again on June 18, 2020, at which time Dr. Wu noted that Petitioner was having a hard time sleeping, had decreased interest, feelings of guilt, decreased energy and appetite and was tearful at times. Dr. Wu referred Petitioner for psychiatric/psychological counseling. His diagnosis remained PTSD. (Pet. Exh. #2)

Petitioner was still quite distraught and scared for his life when again seen by Dr. Wu on July 1, 2020. Petitioner said he was still only eating one meal a day as he was not hungry or was feeling nauseated. Dr. Wu prescribed a trial of Zoloft at that time for Petitioner's symptoms. His diagnosis for Petitioner remained post-traumatic stress disorder, with an anxiety disorder and a major depressive disorder. (Pet. Exh. #2)

Dr. Wu next saw Petitioner on July 16, 2020. Petitioner advised him that he was taking Zoloft and Trazodone and both seemed to be helping. Dr. Wu observed Petitioner to still be tearful at times, but felt his overall affect seemed to be more cheerful. His diagnoses remained the same. (Pet. Exh. #2)

Petitioner had a telemedicine visit with Dr. Wu on August 14, 2020, and advised the doctor that Respondent had twice declined the process for Petitioner's being seen by a psychologist. He advised the doctor that he was having mood swings. Dr. Wu's diagnoses on this date were anxiety and depression as well as PTSD. (Pet. Exh. #2)

Respondent did not avail itself of an examination pursuant to Section 12 of the Act, nor did it introduce into evidence any medical records to otherwise refute the records and opinions of Dr. Wu and the other medical providers at Carle Clinic.

The Arbitrator finds that Petitioner's Post-Traumatic Stress Disorder, with an anxiety disorder and a major depressive disorder, is causally related to the accident of June 1, 2020. This finding is based on the testimony of Petitioner and Mr. Wartsler as well as the findings, diagnoses and opinions of Dr. Wu. Dr. Wu did not mention any pre-existing history of a psychological or psychiatric disorder or symptoms. In addition to the diagnoses and opinions of Dr. Wu this causal connection is also based upon a chain-of-events theory of causation based upon his having no ongoing history of prior psychological or psychiatric disorders or symptoms and no medical treatment for symptoms of Post-Traumatic Stress Disorder or any other psychological or psychiatric disorders in the period immediately prior to the accident, a series of sudden, severe emotional shocks traceable to a definite time, place and cause which causes psychological injury or harm, and immediate complaints and findings of injuries following the accident.

In support of the Arbitrator's decision relating to what Petitioner's earnings were in the year preceding the accident the Arbitrator makes the following findings:

Petitioner had a job change while employed by Respondent in the year prior to this accident, having been promoted from an hourly employee to a branch manager on November 29, 2019. All branch managers receive the same base salary, $47,500.00 per year, plus additional pay based upon the performance of their store. While this extra pay, referred to as a bonus or an I-Bonus, is referred to as a bonus, it is in actuality a commission, as Ms. Jenkins testified that there was a formula which was used to arrive at the amount each

month, and that if the store exceeded a certain amount the company was obligated to pay the "bonus" to the manager. As it was obligated to pay the amount the end of the month commission, the I-Bonus-GP is included in the earnings used to calculate average weekly wage.

Due to the change in job only those paychecks for entire pay periods where Petitioner was paid as a branch manager, dated December 13, 2019 through May 29, 2020 are used in the calculation of Petitioner's average weekly wage. Only those amounts labeled as "Salary" and "I-Profit Bonus-GP" are included in the earnings calculation as no explanation was made for other amounts paid, including "I-Bonus Tax On," "OT Prem Pay," "LTD taxes," "DR Bonus," and "GTL> $50K."

The gross amount for "Salary" and "I-Bonus-GP" for that period of time is $27,768.96. Dividing that amount by the number of weeks he was paid as a branch manager, 26, results in an average weekly wage for those 26 weeks of $1,068.04.

The Arbitrator finds that Petitioner's average weekly wage for the 26 weeks he was employed as a branch manager is $1,068.04.

In support of the Arbitrator's decision relating to what temporary benefits Petitioner is entitled to as a result of the accident of June 1, 2020, the Arbitrator makes the following findings:

The findings of fact relating to accident and causal connection, above, are incorporated herein.

The testimony of Petitioner and Ms. Jenkins agree, Petitioner has not worked since the day of this accident, having commenced missing work on June 2, 2020. Both also agreed that Petitioner had not returned to work as of the date of arbitration, October 16, 2020.

Dr. Wu and other medical providers noted in their medical records that Petitioner was not to return to work until "cleared" by a psychologist. On June 18, 2020 Dr. Wu filled out the FMLA paperwork Respondent had forwarded to Petitioner by email on June 3, 2020. In his certification for Petitioner's health condition Dr. Wu noted that Petitioner had been seen by him on two occasions at that point and that he had been referred for treatment by a psychologist. He further noted that Petitioner was unable to perform his job functions as he was unable to focus/concentrate due to fear and anxiety. He stated that since Petitioner had been threatened for his life three times on the same day while at work he had significant anxiety and distress. (Pet. Exh. #5)

Respondent in its Response to Petitioner's Motion for Section 19 Penalties notes that while Petitioner had alleged that it had unreasonably and vexatiously failed to authorize Petitioner's medical treatment, including an appointment with a psychologist, it had "offered mental health counseling through (Respondent's) Employee Assistance Program. It provides three face to face counseling sessions and unlimited phone sessions. Petitioner has turned down this offer." (Resp. Exh. #3) The Act does not allow Respondent to pick Petitioner's treating medical providers. Section 8(a) of the Act clearly states that the employee "may at any time elect to secure his own physician, surgeon and hospital services at the employer's expense" unless the Employer and the employees, or the employees' exclusive representatives agree to a panel of physicians and that panel is approved by the Commission. No evidence of such an agreement was introduced at arbitration.

Petitioner testified that Dr. Wu made a referral to a psychologist on three occasions. He said he had not undergone a consultation with a psychologist as of the date of arbitration as he had been advised on three occasions by the psychology department at Carle that Enterprise had denied the consultation, and Carle did not accept his insurance.

The Arbitrator finds that Petitioner was temporarily totally disabled as a result of the accident of June 1, 2020 from June 2, 2020 through October 16, 2020, the date of arbitration, a period of 19 4/7 weeks. This finding is based upon the medical records of Dr. Wu and Carle Clinic, the FMLA reports of June 18, 2020, Petitioner's need for a psychological evaluation prior to his returning to work, his inability to get such an evaluation as Respondent would not authorize same despite repeated requests, and Respondent's relying upon an employee benefit and a medical provider of its choosing rather than complying with Petitioner's right to see a physician of his choice as set out in the Act.

In support of the Arbitrator's decision relating to whether the medical services that were provided to Petitioner were reasonable and necessary as a result of the Accident of June 1, 2020, the Arbitrator makes the following findings:

The findings of fact relating to accident, causal connection, and temporary total disability, above, are incorporated herein.

Petitioner introduced into evidence itemized bills of Carle Foundation Hospital and Carle Physician Group. (Pet. Exh. #4) While the dates of treatment for these charges are from June 2, 2020 through September 3, 2020, the detailed billing is dated September 14, 2020.

Some of these bills were apparently paid by Respondent's group health insurer. The medical providers issued write-offs for all of the bills which had been processed by the group insurance carrier, with one bill still pending processing. All of the bills appear to be related to medical care given as a result of this accident.

The Arbitrator finds that the medical bills contained in Petitioner's Exhibit #4 were reasonable and were necessitated as a result of the accident of June 1, 2020. Respondent shall pay these bills in accordance with the Medical Fee Schedule. Respondent shall also reimburse Petitioner for $50.00 in co-payments he has made in regard to these bills. These findings are based upon Respondent Exhibit #4 and the medical records introduced into evidence by Petitioner.

In support of the Arbitrator's decision relating to whether Respondent is entitled to any credit, the Arbitrator makes the following findings:

The findings of fact relating to accident, causal connection, and temporary total disability, above, are incorporated herein.

As noted above, portions of Petitioner's medical bills have been paid by Respondent's group health insurer.

Ms. Jenkins testified that Petitioner applied for FMLA benefits and they were paid through August 21.2020. Ms. Jenkins said he received a combination of FMLA pay, sick leave and PTO through September 14, 2020. Ms. Jenkins said Respondent's Exhibit #1 was Petitioner's earnings from June 3 through September 25 as provided by Respondent's payroll department. She indicated that what was identified as "sick" was FMLA pay, which totaled 60 days, a total of $12,971.13. She said daily pay was $182.69 and there were 71 days noted on the document.

Respondent's Exhibit #1 includes in the days of benefits claimed to have been paid by Respondent eight days designated as "vacation." Vacation pay is an earned benefit which would have been payable to Petitioner regardless of his suffering an injury.

After reduction for vacation days for which Respondent is not entitled to credit, Respondent is entitled for credit for having paid temporary total disability benefits from June 2, 2020 through September 15, 2020. Actual payments to Petitioner were his salary, an amount in excess of his temporary total disability rate of $712.03,

The Arbitrator finds that Respondent is to be given credit for all amounts paid by its group health insurer pursuant to Section (j)(1) of the Act. Respondent is also given credit for having paid 15 1/7 weeks of temporary total disability in the form of continued salary from June 2, 2020 through September 15, 2020. These findings are based upon Respondent's Exhibit #1 and #4 and the medical records introduced into evidence by Petitioner.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to any prospective medical treatment, the Arbitrator makes the following findings:

The findings of fact relating to accident, causal connection, medical bills and temporary total disability, above, are incorporated herein.

On multiple occasions starting on June 2, 2020 Petitioner was referred for psychological or psychiatric evaluation. Despite repeated attempts to have that treatment authorized Petitioner was unsuccessful in obtaining that authorization from Respondent. While Respondent did offer Petitioner assistance through an employee assistance program, that does not satisfy the requirements of Section 8(a) of the Act which states Petitioner can be treated by a physician of his choice. Petitioner was instructed not to return to work until he had received that psychological evaluation. Petitioner testified that as of the date of arbitration he had not yet received a psychological evaluation.

The Arbitrator finds that Petitioner is entitled to a psychological evaluation by a medical treater of his choice and that Respondent is to pay for said evaluation subject to the Medical Fee Schedule. This finding is based upon the testimony of Petitioner and Ms. Jenkins as well as the medical records of Dr. Wu and Carle Clinic.

In support of the Arbitrator's decision relating to whether penalties should be imposed upon Respondent, the Arbitrator makes the following findings:

The findings of fact relating to accident, causal connection, medical, and temporary total disability, above, are incorporated herein.

Petitioner filed a Petition for Penalties and Attorneys' Fees on August 17, 2020. (Pet. Exh. #10)

Respondent filed a Response to Petitioner's Motion for Section 19 Penalties. (Resp. Exh. #4)

Petitioner alleged in his penalty petition that Respondent was unreasonable and vexatious in failing to authorize Petitioner's psychological evaluation. The Appellate Court in Hollywood Casino-Aurora, Inc. vs. IWCC, 2012 IL App (2d) 110426WC in denying penalties for failure to authorize medical treatment, stated:

> The statute addresses "delay in payment" and "underpayment" of compensation. It says nothing about any award of additional compensation (penalties) for an employer's delay in authorizing medical treatment, even assuming *arguendo* that an employer has an obligation to give authorization in advance of medical treatment for an injured employee. Hollywood Casino-Aurora, Inc. vs. IWCC, 2012 IL App (2d) 110426WC ¶15

No penalties are therefore awardable in regard to the failure to authorize Petitioner's psychological evaluation.

Respondent introduced no evidence whatsoever, either via testimony from witnesses to the altercation between Petitioner and the irate customer or through a Section 12 examination or other medical evidence to contest this accident or Petitioner's diagnosed post-traumatic stress disorder or its causal relationship to the accident of June 1, 2020.

In their response to Petitioner's penalty petition they argue that their denial of compensation in the case was based on their contention that Petitioner would not be able to "satisfy the elements of a mental/mental claim" and therefore did not have a compensable injury under the Act. Yet they introduced no evidence which would rebut his claim, and all medical records and information in their possession would apparently support such a mental/mental claim, as they were aware of the repeated threats of death made to Petitioner, considered them serious enough to call the police themselves and were made aware of Petitioner's having had guns pointed at him by the police upon their arrival, just days after George Floyd's death and of looting in the area surrounding Respondent's store.

Neither Respondent's workers' compensation carrier nor Respondent's group health carrier paid for the medical treatment beginning on June 2, 2020, and treated on that date and subsequent treatment on June 15 and 18, 2020, and July 1 and 16, 2020 have not been paid as of the date of arbitration. Later medical treatments on June 17, 18, 25, and 28, 2020, and July 1 and 16, 2020, and August 6 and 14, 2020 were paid in part by Respondent's group health insurer.

No evidence was introduced to indicate when Respondent received the medical bills which were not paid. The medical bills introduced into evidence were prepared on September 14, 2020, but there is no indication that they were delivered to Respondent on that date or any specific subsequent date.

Respondent did not pay temporary total disability to Petitioner but did pay full salary to him pursuant to its FMLA policy for the first 15 1/7 weeks following the date of accident. No benefits have been paid, however since September 15, 2020. Respondent has in its response to the petition for penalties filed by Petitioner argued that Petitioner only provided off work slips for the period of time between June 17, 2020 and July 15, 2020 and again from September 14, 2020 through September 30, 2020, but despite that Respondent had paid full salary to Petitioner through September 25, 2020. It also asserts that it has offered Petitioner his same job at a different location but Petitioner had refused. (Resp. Exh. #3)

Petitioner's Exhibit #5 is the FMLA paperwork which Respondent requested from Petitioner. It was filled out and signed by Dr. Wu on June 18, 2020. It does not have a definite period of disability noted, it says the duration of his condition is "unknown." That record further notes Petitioner has been referred to a psychologist, and that he is unable to perform his job functions due to his inability to focus/concentrate, and de to fear and anxiety. In another section of the report the doctor noted the period of his incapacity was June 1, 2020 to "unknown." In regard to what treatment was needed Dr. Wu in that report stated, "counseling with psychology." Petitioner's continued temporary total disability was contributed to in part by the delay in treatment due to Respondent's failure to authorize the psychological evaluation.

The Arbitrator finds that Respondent was unreasonable and vexatious in its failing to pay temporary total disability from September 16, 2020 through the date of arbitration, October 16, 2020, a period of 31 days, 4 3/7 weeks. The temporary total disability benefits payable for that time, at $712.03 per week, are $3,153.28.

The Arbitrator awards penalties in the amount of 50% of the temporary total disability owed, a total of $1,576.64, pursuant to Section 19(k) of the Act.

The Arbitrator further awards $30.00 per day for the 31 days Respondent withheld or failed to pay temporary total disability, a total of $930.00, pursuant to Section 19(l) of the Act.

The Arbitrator further awards attorney fees of $630.66, 20% of the temporary total disability benefits of $3,153.28 unreasonably and vexatiously withheld by Respondent pursuant to Section 16 of the Act.

The bases for these awards of penalties are stated in the paragraphs preceding the finding and awards.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC021476
Case Name	MURGUEITIO, RUDOLPH v. UNITED SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0452
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Carl Salvato
Respondent Attorney	Mark Rusin

DATE FILED: 9/3/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rudolph Murgueitio,

Petitioner,

vs. NO: 17 WC 21476

United Service Companies,

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, and permanent partial disability and causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

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

The 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.

September 3, 2021

MP:yl
o 9/2/21
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/s/ *Marc Parker*
Marc Parker

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0452

MURGUEITIO, RUDOLPH
Employee/Petitioner

Case# **17WC021476**

UNITED SERVICE COMPANIES
Employer/Respondent

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

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

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

2731 SALVATO O'TOOLE FROYLAN
DAVID FROYLAN
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

0507 RUSIN & MACIOROWSKI LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rudolph Murgueitio
Employee/Petitioner

v.

United Service Companies
Employer/Respondent

Case # **17** WC **21476**

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 **Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **6/24/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On, **3/5/2017** Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**19,203.08**; the average weekly wage was $**369.29**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent children.

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

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

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

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

ORDER

The Petitioner failed to prove by a preponderance of the evidence that the alleged accident arose out of and in the course of his employment with Respondent and that the incident is the cause of his current condition of ill-being.

All other issues are moot.

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

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

Signature of Arbitrator

04/01/2020
Date

APR 30 2020

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on June 24, 2019 in Chicago, Illinois. The submitted records have been examined and the decision by Arbitrator Kay.

The parties proceeded to hearing with the following issues in dispute: whether Rudolph Murgueitio's (hereinafter "Petitioner") accident arose out of and in the course of his employment with United Services Companies (hereinafter "Respondent"), whether Petitioner's current condition of ill-being is causally related to his employment with Respondent, and the nature and extent of Petitioner's injury. (Arb.X1)

The parties stipulated that on March 5, 2017, Respondent was operating under the Illinois Worker's Compensation Act (hereinafter "Act"), that their relationship was one of employee and employer, and that Petitioner gave notice to the Respondent of the incident with the time limits stated in the Act. In addition, the parties stipulated that the Petitioner's average weekly wage pursuant to Section 10 of the Act was $369.29, he was married, 55 years of age and had 1 dependent child. (Arb.X1)

SUMMARY OF FACTS AND EVIDENCE

Petitioner was employed as a janitor for Respondent. Petitioner testified that the bags can weigh between 15 pounds and 75 pounds. On March 5, 2017, Petitioner testified he suffered an accident, as Petitioner lifted a bag of garbage with his left hand and attempted to place his right hand under the bag, Petitioner felt pain in his left shoulder. He testified to working late in his shift and picking up garbage. He stated the garbage was heavy and he was finishing his last set of garbage bins for the day. Petitioner was working a shift that began at 7:00 a.m. and concluded at 2:30 p.m. While picking up a heavy garbage bag, Petitioner testified he felt pain in his left shoulder and trapezius muscle. Petitioner testified he subsequently cleaned one additional bathroom, which only took a short time and finished his shift for the day, clocking out. (T. 10-11, 26-27). Petitioner claims to have reported the accident verbally and in writing.

On March 6, 2017, Petitioner sought care with his primary care physician, Dr. Gomez. Dr. Gomez referred Petitioner for an MRI at St. Mary Hospital and then referred him to Dr. Randon Johnson (hereinafter "Dr. Johnson"). Dr. Johnson recommended physical therapy and shoulder injections. Dr. Johnson also recommended left distal clavicle resection, but Petitioner refused the surgery. Petitioner continued to treat with Dr. Johnson, undergoing approximately five shoulder injections. Petitioner missed no time from work related to the accident.

CONCLUSIONS OF LAW

With respect to issues (C), whether the accident that occurred arose out of and in the course of Petitioner's employment with Respondent and issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury that occurred, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. Petitioner testified that he was employed as a janitor for Respondent. On March 5, 2017, Petitioner testified he suffered an accident, injuring his left shoulder. He testified to working late in his shift and picking up garbage. He stated the garbage was heavy and he was finishing his last set of garbage bins for the day. Petitioner was working a shift that began at 7:00 a.m. and concluded at 2:30 p.m. While picking up a heavy garbage bag, Petitioner testified he felt pain in his left shoulder and trapezius muscle. Petitioner testified he subsequently cleaned one additional bathroom, which only took a short time and finished his shift for the day, clocking out. (T. 10-11, 26-27).

Petitioner acknowledged awareness of Respondent's company policy with respect to reporting of work accidents. Petitioner testified he reported the accident the same day it occurred to a supervisor. However, he could not identify the supervisor to whom he allegedly reported the accident. (T. 27-28). Petitioner denied having any problems with his left shoulder before the March 5, 2017 alleged accident. He denied receiving any treatment for his shoulder before the alleged accident. (T. 15).

The Arbitrator heard the testimony of Petitioner and witnessed his demeanor. Further, the Arbitrator has reviewed various company records, a handwritten statement of Petitioner, medical records and reports in evidence. These records contradict Petitioner's testimony and allegations. The Arbitrator does not find Petitioner credible.

Contrary to Petitioner's testimony, Petitioner admitted in his handwritten statement that he did not immediately report a work accident on the alleged accident date of March 5, 2017. (RX. 8). Further, Petitioner testified the March 5, 2017 accident occurred at the end of his shift. The shift ended at 2:30 p.m. (RX. 2, T. 23). This statement is inconsistent with Petitioner's previous reports to management. In his statement, he alleged the accident occurred at 10:45 a.m. Similarly, the Company Accident Report in evidence shows Petitioner reported the accident allegedly occurred at 10:45 a.m., and not at the end of his shift. (RX. 1). The Company Accident Report further shows the alleged accident was not promptly reported to management. It was reported to the employer a week later on March 12, 2017 and not on March 5, 2017 as Petitioner alleged at trial. (RX. 1, Page 2). Petitioner could not identify the supervisor to whom he allegedly reported an accident on March 5, 2017. (T. 27-28).

Similarly, the medical records in evidence contradict Petitioner's allegations. Petitioner contended he first saw Dr. Gomez on March 6, 2017 due to a left shoulder injury that occurred the previous day. He testified he told Dr. Gomez about the accident that occurred on March 5, 2017. (T. 29). Petitioner claimed he never had shoulder pain prior to this alleged accident. (T. 15). Contrary to Petitioner's testimony, the records of Dr. Gomez show Petitioner's left shoulder condition and complaints pre-date the alleged accident date of March 5, 2017. Petitioner first saw Dr. Gomez with a complaint of shoulder pain (presumably the left shoulder) on February 27, 2017. He complained the pain was present for the last three days and he had not sustained any trauma or falls. He denied improvement with medication. Dr. Gomez ordered an x-ray of the left shoulder. This was done the next day on February 28, 2017 at Presence St. Mary of Nazareth Hospital. X-rays of the left shoulder did not show evidence of acute fracture or dislocation. The results were essentially normal. (RX. 3).

Petitioner subsequently saw Dr. Gomez in follow-up on March 6, 2017. This was a follow-up visit due to Petitioner's pre-existing left shoulder condition. Contrary to Petitioner's testimony, Petitioner did not give any history of an accident occurring the previous day. Petitioner simply complained of left shoulder pain that had not improved despite being compliant with the medication that had been prescribed. Petitioner also had complaints of chest pain this date. Dr. Gomez recommended a stress test and an MRI. (RX. 3).

Petitioner underwent an MRI of the left shoulder at Presence St. Mary of Nazareth Hospital on March 24, 2017. According to the radiologist, the MRI showed minimal tendinopathy, moderate AC joint osteoarthritis and a labral tear. Petitioner also underwent myocardial profusion scan this same date.

Petitioner returned to Dr. Gomez on March 31, 2017. He now gave a new history this date in which he alleged having left shoulder pain due to an injury at work on March 5, 2017. This statement is not consistent with the prior records of Dr. Gomez in which Petitioner denied trauma. Further, Dr. Gomez's prior records show Petitioner's condition and complaints pre-dated the March 5, 2017 accident date. Dr. Gomez reviewed

the MRI results with Petitioner and diagnosed left infraspinatus tendonitis. Dr. Gomez prescribed medication and referred Petitioner to an orthopedic surgeon. (RX. 3).

Thereafter, Petitioner pursued treatment with Dr. Johnson, an orthopedic surgeon. He first saw Dr. Johnson on April 25, 2017. He now gave a history of a work accident on March 5, 2017 lifting heavy trash bags. Once again, this history is inconsistent with the original history Petitioner provided. It is inconsistent with the contemporaneous medical records of Dr. Gomez, which note Petitioner's symptoms began three days prior to a February 27, 2017 visit and was not trauma-related. Dr. Johnson subsequently treated Petitioner's left shoulder condition conservatively with therapy, injections and medication over the next approximately six months. Petitioner also treated during this time for arthritic knees for which he received conservative treatment including injections as well.

Petitioner stopped working for Respondent in March 2018. (T. 35). He obtained employment in April 2018 as a janitor for a different company, Sodexo. Petitioner has been working for Sodexo on a full-time basis since that time. He claimed an accident while working for Sodexo in July 2018. He claims to have suffered a back injury at that time. (T. 35-37). Petitioner has pursued treatment with Dr. Gomez for this condition. (RX. 4).

Petitioner was examined by Dr. Kevin Walsh at the request of Respondent on June 18, 2018. (RX. 7). Dr. Walsh is an orthopedic surgeon associated with DuPage Medical Group. Dr. Walsh examined Petitioner and reviewed available medical records. Dr. Walsh noted that Petitioner's condition and complaints pre-date the alleged accident date of March 5, 2017. Dr. Walsh noted the medical records document that Petitioner was seen and evaluated on February 27, 2017 on account of left shoulder complaints in which he specifically denied sustaining any injury. Dr. Walsh notes that Petitioner changed his history regarding the alleged onset of symptoms in later medical records. Dr. Walsh finds Petitioner clearly had a condition that pre-existed the alleged accident date. Dr. Walsh states the alleged injury in March 2017 did not cause Petitioner's symptoms and need for treatment commencing in March 2017. (RX. 7). Petitioner has not offered any evidence of medical opinion, which contradicts Dr. Walsh's opinions or conclusions as to causal connection. The contemporaneous medical records are clear that Petitioner's left shoulder condition pre-dated the accident date alleged and was not caused by any traumatic event.

Based on the aforementioned the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that an accident occurred that arose out of and in the course of his employment with Respondent and that the his condition of ill-being is casually connected to his injury.

With respect to issue (L), what is the Nature and Extent of the injury, the Arbitrator finds as follows:

In accordance to the Arbitrator's findings regarding issues (C) and (F), all other issues are moot.

Signature of Arbitrator

04/01/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC000899
Case Name	HAMILTON, ANTHONY v. CHABERIAIN GROUP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0453
Number of Pages of Decision	18
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	William A. Lowry, Sr.

DATE FILED: 9/8/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Hamilton,

Petitioner,

vs. No. 13 WC 899

Chamberlain Group,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2020, is hereby affirmed and adopted.

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

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

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

SEPTEMBER 8, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-7/15/21
068

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAMILTON, ANTHONY Case# **13WC000899**
Employee/Petitioner

CHAMBERLAIN GROUP
Employer/Respondent

On 1/8/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1,52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anthony Hamilton
Employee/Petitioner

v.

Chamberlain Group
Employer/Respondent

Case # **13** WC **899**

Consolidated cases: **N/A**

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

DISPUTED ISSUES

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

FINDINGS

On **December 5, 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 **$40,016.08**; the average weekly wage was **$769.54**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **5** 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 **$9,349.78** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and for other short term or long term disability benefits paid for the period of TTD awarded.

Respondent is entitled to a credit for any bills paid by group insurance under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $513.03/week for 59 6/9 weeks, commencing December 10, 2012 through April 10, 2013, April 15, 2013 through May 20, 2013, and January 1, 2014 through September 17, 2014 as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$9,349.78** for TTD, and for short term or long term disability benefits paid for the period through September 17, 2014 under Section 8(j) of the Act. Petitioner's claim for maintenance benefits is denied.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,165.98 to Equity Medical Solutions, $22,226.00 to Goldcoast Surgical Associates, $3,489.96 to ION, $1,327.60 to Neurological Surgery & Spine Surgery, S.C., $10,725.07 to Hind Hospital, $1,715.00 to Edgebrook Open MRI, and $2,612.67 to Metro Anesthesia Consultants, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $461.72/week for 150 weeks, because the injuries sustained caused the 30% 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

January 6, 2020
Date

JAN 8 - 2020

Statement of Facts

Petitioner Anthony Hamilton testified that he was hired by the Chamberlain Group through Staffmark. As of December 2012, he had worked for Chamberlain Group for approximately four years performing duties as an Order Picker and Forklift Driver. He had been performing this type of work for 17 years. Order picking was accomplished by hand. He would have to lift items up to 125 or 150 pounds. Petitioner would go from location to location picking items that needed to be shipped. He would use a scanner gun to determine the number of pieces he needed and place the items on a pallet. The pallets were moved from location to location by forklift. The forklift he operated was a 1980 Mitsubishi which Petitioner considered to be sturdy, heavy-duty forklifts. He was earning $21.00 per hour. He testified he would work overtime every day.

Petitioner testified that on December 5, 2012, he was paged to the door to unload for a customer. While driving his forklift, another forklift came out of an aisle and "rammed me" in the side of his forklift. He was going from one side of the warehouse to the door where customers arrive, a trip that takes approximately 30 seconds. The forklift was fast-moving. He was struck while crossing the dock. Petitioner described the impact, stating that his forklift went up on two wheels and came back down, causing the scanner and clipboard and everything on the forklift to fly off. He testified that his body jerked forward and backward due to the impact. He was wearing a seatbelt. At the time of the impact, his body stiffened up, but he did not lose consciousness.

The forklift did not flip over. Petitioner testified that if Dr. Salehi's records show that on January 22, 2013 he was told that the forklift fell over, those records would be incorrect. If Dr. Salehi believed that his forklift flipped over, he would be incorrect. If the records of Dr. Murtaza from February 7, 2013, reflect that he was told that the forklift flipped over, those records would be incorrect. Petitioner testified that he looked at the two forklifts, both of which had dents in them. The side of the other forklift struck the side of his forklift. That part of the other forklift was dented as was the body on the side of his forklift.

Respondent offered video of the forklift collision (RX 5). The video shows the impact to the right side of Petitioner's forklift. Petitioner's forklift is pushed to the left about 30 degrees. The wheels do not leave the ground. It does not flip over. It appears that the other driver's clipboard falls to the ground. The video shows Petitioner continuing to drive his forklift later that day. Petitioner is also seen later that day taking a break. The video does not have a visible time stamp, so the Arbitrator does not know how much later it is. Petitioner stops his forklift. He easily dismounts and walks out of the building in no apparent distress (RX 5). Petitioner was disciplined for the accident. The April 12, 2013 letter states that a review of the camera shows he was traveling at an unsafe speed. It notes the forklifts incurred minor damage (PX 10).

Petitioner testified that he had pain of 6/10. He was stiff. He testified that he was walking in a normal fashion. The pain increased as the day went on. Petitioner testified that he spoke with a supervisor about 10 minutes later who asked if he was all right. He responded that he was not. Petitioner prepared an accident report on the day of the accident (RX 1). The Employee Accident Report is dated December 5, 2012. Petitioner prepared the document. Question 23 on the first page of the Report asks, "Body part 'note left or right'" to which Petitioner wrote "neck injury and upper body." In response to Question 24, 'Type of Injury,' Petitioner wrote 'neck' (RX 1).

Petitioner testified that he was sent to Alexian Brothers Hospital on the date of the occurrence. He testified he was diagnosed at Alexian Brothers Hospital with a thoracic strain and sent back to work on light duty. He testified that he also went to the emergency room at Edward Hospital on the same day. He was referred to a

specialist, Dr. Naveed at Neurological Consultants Group. Petitioner testified he went into work on December 6, 2012, but did not do any work. The records of Dr. Cohen note he went in for 2 hours, but was unable to work because of pain (PX 4). Petitioner first saw Dr. Naveed on December 6, 2012 (PX 1), complaining of severe neck, shoulder and low back pain following a work-related forklift accident the day before. Examination revealed decreased back range of motion, neck tenderness, positive straight leg raising, decreased ankle reflexes and slightly decreased right lateral leg sensation and decreased range of motion in the shoulders. Dr. Naveed's assessment was cervical and lumbar radiculopathy/strain. He administered bilateral cervical and lumbar facet blocks and bilateral upper myofascial trigger point injections to the trapezius. Petitioner was taken off work (PX 1).

Petitioner was referred to Dr. Cohen for physical therapy (PX 4). The pain diagram prepared December 10, 2012 notes pain in the neck, left shoulder and low back with radiation down the back of both legs. Petitioner remained under the care of Dr. Cohen through January 17, 2013 (PX 4). A lumbar MRI performed on December 11, 2013 revealed disc bulging at L4-5 and L5-S1 with mild canal and bilateral foraminal stenosis at L5-S1. A cervical MRI performed on December 11, 2012, revealed mild spondylotic changes. Dr. Naveed administered a right occipital nerve block, and cervical and lumbar facet blocks on December 12, 2012. On December 18, 2012, he diagnosed cervical and back sprains and ordered EMG/NCV studies. The December 18, 2012 lumbar EMG was consistent with bilateral L5-S1 radiculopathy. The cervical EMG/NCV study performed December 26, 2012, was consistent with mild bilateral C6-7 radiculopathy and mild bilateral distal median mononeuropathy, worse on the left (PX 1). Petitioner saw Dr. Naveed on January 2, 2013 with continued complaints. He was taking medication and having physical therapy with some improvement. Dr. Naveed recommended that he continue in physical therapy and pain management (PX 1).

Petitioner was referred to Dr. Salehi by Dr. Naveed on January 10, 2013 (PX 2). He was seen on January 22, 2013. Petitioner provided a history of driving a forklift that was hit perpendicular by another forklift. He stated his forklift fell over. He reported that after the incident, he started feeling stiff in the neck and low back which was then followed by shooting pain and numbness/tingling down his upper and lower extremities. He denied any previous worker compensation or sport injuries to the neck or low back and denied any prior symptoms in these regions. Physical examination noted tenderness and reduced range of motion in the cervical and lumbar spine. Lying straight leg raising was positive. Sitting straight leg raising was negative. Gait was slow but normal. Strength was normal. Sensation was decreased on the left side. Reflexes were normal. Dr. Salehi noted the cervical MRI was normal. The lumbar MRI found bulges at L4-5 and L5-S1. There was no loss of disc height. There was no foraminal stenosis, but mild facet arthropathy at L5-S1. His impression was cervical strain and lumbar degenerative disc disease. Dr. Salehi referred Petitioner for an additional therapy evaluation on January 30, 2013. The therapist recommended outpatient therapy three times weekly for four weeks; 9 sessions continued through March 4, 2013 (PX 1).

On February 7, 2013, Petitioner saw Dr. Murtaza (PX 1). He reported he was struck from the side at a high rate of speed. His vehicle was flipped over. He reported localized cervical pain and lumbar pain radiating bilaterally. Physical examination notes sensation, upper extremity strength and reflexes are normal. Petitioner reported pain with range of motion and palpation. Straight leg raising was negative. Some dorsiflexion and plantar flexion weakness were noted. Dr. Murtaza assessed cervical sprain/strain and lumbar spine pain with possible radiculopathy. He recommended physical therapy (PX 1).

On March 5, 2013, Petitioner reported to Dr. Salehi that he had completed a course of physical therapy and his neck pain is significantly decreased. He continues to have low back pain with occasional shooting down his

legs and numbness and tingling. Dr. Salehi ordered aqua therapy. He released Petitioner to sedentary/desk work (PX 2). Petitioner underwent aqua therapy at Atlas from March 7, 2013 through April 10, 2013 (PX 5).

Petitioner was examined at Respondent's request by Dr. Ghanayem on March 23, 2013 (RX 2, Ex. 2). He told Dr. Ghanayem that his forklift skidded but did not roll over. He complained of neck pain and back pain with referral into the buttock, upper thigh and calves bilaterally. His leg symptoms are both anterior and posterior. Examination noted normal posture and gait. There was no cervical tenderness with full range of motion. Lumbar examination noted tenderness with no spasm. Waddell signs were positive. Range of motion was reduced. Petitioner was neurologically intact. Dr. Ghanayem noted the cervical MRI was normal. The lumbar MRI revealed small annular tears at L4-5 and L5-S1. There was well preserved disc hydration, no neuro compressive lesions and no disc herniation. Dr. Ghanayem diagnosed a cervical and lumbar strain. He opined that the radiographic findings are not acute in nature, given the mechanism of injury, being a low speed accident. He found Petitioner needed no further treatment and was at MMI (RX 2, Ex. 2).

On April 2, 2013, Dr. Salehi notes Petitioner's neck pain is almost gone, but he continues with constant 8/10 back pain. He recommended additional conservative care and continued the sedentary work restrictions (PX 2). Petitioner testified he attempted a brief return to work in April 2013. On April 30, 2013, Dr. Salehi notes he attempted a return to regular work but only lasted 4 days because he could not tolerate the pain. Physical examination noted sensation decreased generally in the lateral legs. Dr. Salehi ordered a discogram based on a diagnosis of disc degeneration/annular tear at L4-5 and L5-S1. He released Petitioner to light duty with lifting up to 15 pounds and push/pull up to 35 pounds (PX 2).

Dr. Chunduri performed a discogram on May 16, 2013. This produced a concordant pain response at both L4-5 and L5-S1. No pain was noted at the L3-4 control level. Dr. Chunduri diagnosed L4-5 and L5-S1 disc herniation with bilateral radiculitis, lumbar degenerative disc disease with provocative discogram at those levels. A post-discogram CT scan revealed a 5-6 mm posterior central disc herniation with a mildly extruded nucleus pulposus indenting the thecal sac with central stenosis and mild bilateral neuroforaminal narrowing at L4-5 and loss of normal disc height and a broad-based posterior central disc herniation also with an extruded nucleus pulposus measuring 6-7 mm indenting the ventral surface of the thecal sac with central stenosis but no significant neuroforaminal narrowing at L5-S1 (PX 2). On May 21, 2013, Dr. Salehi recommended an L4-S1 fusion. Petitioner remained on his light duty restrictions (PX 2). Petitioner testified he returned to work within his restrictions. He was sorting screws. Dr. Salehi's records note ongoing periodic visits with Petitioner through January 10, 2014. He continued to recommend the fusion which was denied. He was also in correspondence with Aetna contesting the basis for the denial of treatment. Petitioner remained on light duty restrictions (PX 2).

Petitioner was reexamined by Dr. Ghanayem on November 11, 2013 (RX 2, Ex. 3). Dr. Ghanayem reviewed video (RX 5). He notes Petitioner reports his neck pain is resolved, but he continues to have back pain. He presented with a limp and using a cane. There is pain to light palpation and axial compression of the head, truncal rotation through the knees, and distraction though the shoulders. Lumbar motion is 10 degrees, but when moving from the chair is 45 degrees. Neurological testing notes breakaway weakness. Motor testing and sensation are intact. Dr. Ghanayem noted the MRI findings and discogram results. His diagnosis remains lumbar and cervical sprains. He notes multiple nonorganic findings consistent with symptom magnification. His subjective complaints of leg pain are not anatomically possible. Dr. Ghanayem opined that Petitioner is not a surgical candidate, requires no further treatment and is at MMI (RX 2, Ex. 3).

Petitioner applied for and Dr. Salehi completed Cigna Leave form for disability and coverage beginning on January 1, 2014. Dr. Salehi ordered preoperative testing on January 21, 2014 (PX 2). Petitioner testified that he stopped working light duty in January 2014 when he was told there was no light duty available. Petitioner testified he began receiving short term and long term disability. Dr. Salehi performed surgery on February 17, 2014. The operative report states pre- and post-operative diagnoses of mechanical back pain, degenerative disc disease at L4-5 and L5-S1, and annular tear at L4-5 and L5-S1. The procedure performed was L4-5 and L5-S1 transforaminal lumbar decompression and fusion with instrumentation. Petitioner was discharged on February 18, 2014 (PX 3).

Petitioner reported improvement following surgery. Dr. Salehi referred Petitioner for therapy to Atlas following surgery. Sessions began on March 10, 2014 and continued through May 8, 2014 (PX 5). On April 15, 2014, Petitioner reported that leg symptoms were much better and physical therapy was helping. He was taking 1-2 tabs of Norco daily in addition to Robaxin. On May 13, 2014, Petitioner was undergoing more therapy and doing a lot better. Dr. Salehi released him to return to work with restrictions of no lifting over 20 pounds, no pushing/pulling over 35 pounds, no repetitive bending or twisting, and to alternate sitting/standing every 30 to 45 minutes as needed. On September 18, 2014, Petitioner reported some aching in the low back. Dr. Salehi notes he is off work because the employer could not accommodate his restrictions. Dr. Salehi issued permanent medium-duty restrictions at that time: no lifting over 35 pounds, no pushing/pulling over 50 pounds, and no repetitive bending and twisting (PX 2).

Dr. Salehi authored a narrative report on October 28, 2014 (PX 7). He reviewed his treatment notes from January 22, 2013 through his release of Petitioner with permanent restrictions on September 18, 2014. He reviewed Dr. Ghanayem's reports. He opined that the condition he treated was causally related to the accident and that his treatment was reasonable and necessary. He stated that the speed of the crash would not change his opinion. The IME reports and Utilization reviews did not change his opinions (PX 7). Petitioner was seen by Dr. Salehi on February 19, 2015, March 12, 2015 and May 7, 2015. Dr. Salehi noted Petitioner did not return to work and that his September 2014 permanent restriction remained (PX 2).

Dr. Salehi testified by evidence deposition taken December 11, 2014 (PX 6). He testified to his initial visit with Petitioner including the history taken and complaints. He noted the physical examination included some decreased sensation on the left side, but nothing dermatomal. He noted his treatment and that Petitioner's cervical symptoms improved. He testified to the discogram and its results. He recommended the lumbar fusion. In making this recommendation, he considered the lack of conservative care including therapy and injections. He testified to the postoperative care and release with permanent restrictions. He opined that Petitioner suffered a cervical sprain, which resolved and lumbar annular tear resulting in disc disease at L4-5 and L5-S1. He opined that the condition was causally related to the accident on December 5, 2012, given the fact that he had no prior history of a similar condition. His treatment was reasonable and necessary. Petitioner needs no further treatment beyond a home exercise program and a follow up x-ray one year postop. He opined that Petitioner should be restricted to medium work due to the nature of his surgery and the fact that he was still having some symptoms (PX 6).

Dr. Salehi testified that the MRI findings would occur over time. They would not occur within a week. The test cannot tell when the condition occurred. He uses the patient's complaints in determining treatment and restrictions. In the case of a traumatic problem, the nature of the trauma is something that would be important in the assessment of the case. The extent and severity of the trauma has a role in the resulting injury. If a patient was not truthful, he would not offer aggressive treatment. Petitioner did not tell him how fast the forklift

was traveling at the time of the accident, and the doctor did not ask him about it. He did record that the forklift fell over but did not get into the details of whether there was damage to the forklift. He had no history of whether Petitioner resumed work immediately, or whether there was a delay. Petitioner was not specific as to when his symptoms began for either the neck or the low back, but his impression was that it was relatively immediately. He did not review treatment records from Alexian Brothers Hospital from the date of the accident and did not know if Petitioner complained at that visit as to both cervical and lumbar symptoms. His history indicated that Petitioner denied prior motor vehicle accidents. Dr. Salehi was not aware that Petitioner was in a motor vehicle accident in June 1997, or a motor vehicle accident in July 2002, when he injured his back and neck. He would expect that Petitioner would have told him about that (PX 6).

Dr. Salehi testified he reviewed Dr. Ghanayem's reports and wrote an addendum report dated October 28, 2014 stating that it did not change his opinions. If there was a low-speed impact accident, would be only one factor. Dr. Salehi did not note if Petitioner was wearing a seat belt. Wearing a seat belt mitigates the force, but the spine still sees some force. He had not noted that Dr. Ghanayem noted positive Waddell's signs. Dr. Salehi took into consideration the history Petitioner provided, that he never had prior vehicle accidents. He testified that if it happened years ago it may be irrelevant. He would look at ongoing back issues. Even if the vehicles were moving at a slower speed and the forklift did not tip over, his opinion would be the same (PX 6).

Dr. Ghanayem testified by evidence deposition taken October 21, 2015 (RX 2). He is a Board-certified orthopedic surgeon who examined Petitioner on two occasions, March 25, 2013, and November 11, 2013. On March 25, 2013, Petitioner provided a history of driving a forklift when someone hit him on the back-right side. The forklift skidded but did not roll over. He was wearing his belt as required. Wearing a seat belt can minimize the degree of injuries. Petitioner complained of neck and low back pain. The back pain referred to the buttock regions, upper thighs and calves. The leg symptoms were in the front and back of the legs. Examination showed no tenderness, and normal range of neck motion; there was tenderness at the lumbar base, and no spasm in the back muscles. Waddell signs were positive. Lower extremity neurologic exam was normal. Backward bending was normal; forward bending was less than normal (RX 2).

Dr. Ghanayem testified that Waddell testing means that certain maneuvers are causing low back pain, which should not when there is a structural organic cause for back pain. These were all positive. These indicated that Dr. Ghanayem could not relate Petitioner's symptoms to a structural disease process. The sensory exam was normal, specifically, the tension sign for radicular pain. This test is performed with the patient seated. The doctor straightens the knee out and looks for a pain response. Here, it was negative, telling the doctor that there was no pinching of the nerve. Typically, the response is positive when there is a disc herniation (RX 2).

Dr. Ghanayem reviewed the MRI films. The cervical MRI was normal. The lumbar MRI showed small annular tears at L4-5 and L5-S1. Disc hydration was reasonably well-preserved at both levels. There were no herniations; there was nothing pinching a nerve. Dr. Ghanayem's impression, given the nature of the accident, was that Petitioner sustained cervical and lumbar strains. The basis for these diagnoses were the mechanism of injury, physical exam findings, and the diagnostic studies. He felt Petitioner needed no further treatment and could return to regular duty. Treatment for an annular tear where there is preservation of disc height and hydration would include anti-inflammatories and physical therapy (RX 2).

Dr. Ghanayem re-examined Petitioner on November 11, 2013. Exam findings on that date had changed. Initially, Petitioner had walked normally; now, he was limping and using a cane. Flexion had decreased from 30 degrees to 10 degrees. However, when he moved from the exam chair to the exam table, he could easily flex

or bend 45 degrees. Initially, strength was normal. Now he exhibited breakaway weakness, which reflected malingering. None of these findings were objective. They pointed toward illness behavior. Axial compression of the head and truncal rotation are Waddell tests. These were positive during the second evaluation. There were consistent findings of non-organic behaviors. Being able to bend only 10 degrees when being tested purposefully but bending four and a half times that amount when you do not think you are being tested, that shows non-organic behaviors. Also, there were symptom mismatches. Leg symptoms involved the front and back of the legs, which is anatomically impossible if there is disc pathology at L4-5 and L5-S1. It is simply not possible to have circumferential leg symptoms with lower lumbar disc problems (RX 2).

Dr. Ghanayem reviewed video footage of Petitioner moving without difficulty around the dock after the accident. This also included images of the actual impact of the forklifts. This showed that Mr. Hamilton's forklift skidded, but otherwise came to a stop. This footage is inconsistent with the January 22, 2013 Dr. Salehi report and a February 7, 2013 note from Dr. Murtaza stating that the forklift was flipped over as a result of the accident. Stating that your forklift flipped over when it did not is a concern when you put the non-organic illness behaviors together with that. Dr. Ghanayem could find no objective reason for Petitioner's condition to change from the time of his first visit to the second relative to the work accident. Dr. Ghanayem stated that there is absolutely no way to substantiate that Petitioner sustained an acute tear as a result of the accident. Petitioner did not require surgery (RX 2).

Petitioner was examined by Dr. Allen Brecher at the request of Respondent's disability carrier on January 23, 2017. He testified by evidence deposition taken on February 26, 2019 (PX 11). He provided a physical ability assessment on a form provided by Dane Street. Petitioner reported subjective symptoms of spasms and numbness in his legs. He reported a forklift accident in 2012, and a two-level lumbar fusion in 2014. Dr. Brecher reviewed Dr. Salehi's records through 2015. The only objective findings were lumbar spine tenderness and slightly limited motion. He diagnosed low back pain following the fusion. He felt that Petitioner could work with limitations for safety: no lifting more than 35 pounds, pushing/pulling of 50 pounds, and occasionally bounce, stoop, kneel, crouch and crawl (PX 11).

Dr. Brecher testified that, given the limited information provided, he thought the low back pain and surgical procedure were related to the accident. Petitioner did not mention prior motor vehicle accidents. Dr. Brecher did not review the operative report or any medical records from 2012 or 2013. He did not know details of the accident. He did not know the speed of the vehicles, angle of the impact, or consequences to the vehicle. He did not know if Petitioner was wearing a seat belt. He did not review Dr. Ghanayem's reports or the MRI reports. Dr. Brecher agreed that the merits of a medical opinion, the strength or value of an opinion, can be affected by the extent of information, medical records, or information that is made available to a physician. Dr. Brecher did not see any reference to a small annular tear in the records. There were inconsistencies in the exam. The numbness did not follow a dermatomal pattern. Petitioner reported subjective spasm and numbness. He had tenderness that could be construed as subjective. Dr. Brecher did not check for Waddell signs (PX 11).

Petitioner testified he continued to receive long term disability. The disability carrier sent him a few different categories he could apply to. He testified they were not consistent with his abilities. He did not get work. He returned to the job market in April 2017. He went back to Staffmark. He also did searches on Indeed. Petitioner identified PX 12 as documents relating to his return to work. He began work July 17, 2017 at $13.50 per hour with RR Donnelley. He identified a job request and the jobs he sought on Indeed (PX 12). Petitioner testified he

had no documentation of job searches in 2014 through 2016. He was hired full time at RR Donnelly and is making $15.50 per hour. He is doing customer service work. He does not have lifting over 15 pounds.

Petitioner testified his back is a lot better than it was. He has occasional back pain getting up and down or standing or sitting too long. He takes Aleve. His pain does not interfere with his ability to do his current position. He had not injured his back since December 5, 2012. His pain limits playing sports with his kids.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct. 3d Dist. 2014). The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 182, 457 N.E.2d 1222, 1226, 75 Ill. Dec. 663 (1983). However, expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982). A chain of events suggesting a causal connection may suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994). Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000).

Petitioner suffered an undisputed accident on December 5, 2012 as documented in the video when his forklift was struck from the side by a coworker's forklift. The causation dispute is as to whether Petitioner injured his low back in addition to his neck at that time, and as to the extent of any low back injury including whether Petitioner's lumbar disc disease and subsequent surgery were causally related to the accident. Petitioner relies on the chain of events theory and the opinion of Dr. Salehi. Respondent challenges the basis of that report, in large part challenging the credibility of the Petitioner's reporting, and based upon Dr. Ghanayem's opinion.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

The Arbitrator heard the Petitioner's testimony and had the opportunity to observe him, as well as to review the evidence offered. The Arbitrator notes multiple inconsistencies and embellishment in the Petitioner's presentation. Petitioner's descriptions of the accident itself is exaggerated to Dr. Salehi and Dr. Murtaza. Even his testimony that his forklift went on two wheels is not supported by the video. But the unrebutted evidence that

there was a collision sufficient to push Petitioner's forklift sideways and to inflict at least some damage to each forklift. Respondent determined Petitioner was driving fast. Petitioner's testimony that he had immediate 6/10 pain is not supported by the video, but the Arbitrator does not know how much time past before that was taken and it is too brief to be dispositive in light of the contemporaneous reporting of the accident and immediate referral for medical treatment. The Arbitrator also notes that while Petitioner only alleged neck and upper body injuries, he reported low back and radiating pain the next day. The initial records from Alexian Brothers were not offered to contradict that his low back part of the complaints made, or treatment rendered. Petitioner's MRI finding the L4-5 and L5-S1 annular tears was taken shortly after the accident. Respondent questioned Dr. Salehi and Dr. Brecher about the failure of Petitioner to advise of prior accidents, but no evidence was offered of these alleged incidents. Petitioner was not even cross examined about this issue. The uncontroverted evidence is that he was able to work his full duty job up to the date of the accident. Petitioner's physical presentation to his treaters is also questionable. Dr. Ghanayem noted multiple Waddell's signs and nonorganic findings. He also noted the exaggerated presentation at his second examination. The Arbitrator finds no reference in the Petitioner's treating records of the need for a cane or such significant restrictions of motion. All medical records note few objective findings and Petitioner is found neurologically negative in most examinations. Dr. Brecher also noted non dermatomal complaints in the legs. The Arbitrator has considered these factors in assessing the weight to be given to Petitioner's testimony, medical histories and physical presentation with respect to all the issues raised in this matter.

The unrebutted evidence is that Petitioner sustained the accident and underwent immediate medical treatment for his neck and back. He underwent initial treatment including the MRI findings noted and EMG findings of radiculopathy. He began treatment with Dr. Salehi within weeks. Conservative treatment resulted in resolution of the cervical sprain. Dr. Salehi performed the L4-S1 fusion. He opined that Petitioner's condition was causally related to the accident and the treatment was reasonable and necessary. Dr. Ghanayem opined that Petitioner suffered only sprain injuries and that the surgery was not necessary.

Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Having heard the testimony and reviewed the evidence, the Arbitrator finds the opinions of Dr. Salehi persuasive. While Petitioner provided an exaggerated description of the accident, the Arbitrator notes that Dr. Salehi testified that the speed of the collision did not change his opinion of causation. The Arbitrator notes that his physical examinations do not reflect a consideration of any exaggerated positive

findings. His decision was supported by the MRI finding, the EMG report and the discogram and post discogram CT scan. While Dr. Salehi notes that the MRI findings may have preexisted the accident, he notes that the condition was aggravated by the accident given the lack of prior symptoms. Dr. Ghanayem noted the nonorganic findings and therefore discounted that there could be an underlying medical condition.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his condition of ill-being in the neck and low back is causally connected to the accidental injury sustained on December 5, 2012.

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based on the Arbitrator's finding with respect to Causal Connection, reasonable and necessary treatment related to Petitioner's condition of ill being in the neck and low back is causally related. The Arbitrator finds that Petitioner's treatment began with Dr. Naveed and thereafter was with providers in a chain of referral from him. Petitioner did not exceed his choices allowed under the Act. The Arbitrator, as discussed with respect to Causal Connection, finds the opinions of Dr. Salehi persuasive, including his opinion that Petitioner's surgery was reasonable, necessary and causally related to the accident.

Petitioner provided unpaid bills as PX 8. Respondent offered its workers compensation payment log as RX 7. Petitioner stipulated that any bill paid by group insurance was paid pursuant to Commission rules, which the Arbitrator understood to mean pursuant to Section 8(j). The Arbitrator has reviewed the bills and underlying medical exhibits and finds that the bills represent reasonable and necessary causally connected treatment. The Arbitrator notes that RX 7 states that Workers Compensation paid $25,978.73 rather than group insurance as claimed on the Request for Hearing. The bills submitted do reflect group payments to Hind and Dr. Salehi for which Respondent is entitled to appropriate credit. The Arbitrator was not provided with a payment log from the group carrier and notes that other bills submitted may have been processed through the group insurance as well since many of the bills submitted are not current.

Based upon the record as a whole, and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,165.98 to Equity Medical Solutions, $22,226.00 to Goldcoast Surgical Associates, $3,489.96 to ION, $1,327.60 to Neurological Surgery & Spine Surgery, S.C., $10,725.07 to Hind Hospital, $1,715.00 to Edgebrook Open MRI, and $2,612.67 to Metro Anesthesia Consultants, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Petitioner claims temporary total disability beginning December 10, 2012 (Arb. Ex. 1). Petitioner was disabled by Dr. Naveed and Dr. Cohen. His unrebutted testimony is that he attempted a return to work on April 11, 2013. Dr. Salehi notes he attempted a return to regular work but only lasted 4 days. This is the most accurate information provided. Petitioner was then off work until he began light duty on May 22, 2013. Petitioner testified that he continued light work until sometime in January 2014. The records note he submitted his claim for disability effective January 1, 2014. Petitioner was disabled and underwent surgery. He reached MMI upon receiving permanent medium duty restrictions from Dr. Salehi on September 17, 2014.

Petitioner is also seeking maintenance benefits following reaching MMI. Section 8(a) of the Act provides that an "employer shall *** pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a) (West 2006). Section 8(a) provides for both physical rehabilitation and vocational rehabilitation and mandates that the employer pay all maintenance costs and expenses "incidental" to a program of "rehabilitation." Id.; see also *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1075, 820 N.E.2d 570, 289 Ill. Dec. 794 (2004). The statute is flexible and does not limit "rehabilitation" to formal training. *Connell v. Industrial Comm'n*, 170 Ill. App. 3d 49, 55, 523 N.E.2d 1265, 120 Ill. Dec. 354 (1988); see also *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 506, 812 N.E.2d 65, 285 Ill. Dec. 476 (2004). We have construed the statutory term "rehabilitation" broadly to include an injured employee's self-initiated and self-directed job search. See, e.g., *Roper*, 349 Ill. App. 3d at 506. However, by its plain terms, Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *W.B. Olson, Inc.*, 2012 IL App (1st) 113129WC at ¶ 39; see also *Nascote Industries v. Industrial Comm'n.*, 353 Ill. App. 3d 1067 at 1075. Thus, if the claimant is not engaging in some type of "rehabilitation" (whether it be physical rehabilitation, formal job training, or a self-directed job search), the employer's obligation to provide maintenance is not triggered. Petitioner did not provide any evidence of a job search until March 2017, after his long term disability was terminated. The Arbitrator finds his testimony of being sent job categories from the disability provided not credible. The Arbitrator has reviewed PX 12 and does not find the few efforts documented constitute a good faith job search.

The inquiry does not end here, however. The claimant also argues that the employer violated section 8(a) of the Act and Commission Rule 7110.10(a) (50 Ill. Admin. Code § 7110(a) (eff. June 22, 2006)) by failing to provide him with vocational rehabilitation. If that were true, then the claimant's argument that the employer should have provided maintenance benefits incidental to such rehabilitation would likely succeed because section 8(a) requires employers to pay all maintenance costs and expenses incidental to any prescribed

vocational-rehabilitation program. *W.B. Olson, Inc.*, 2012 IL App (1st) 113129WC at ¶ 39. Thus, we must also consider whether, under the facts presented in this case, the employer was obligated to provide vocational rehabilitation. A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. *National Tea Co. v. Industrial Comm'n*, 97 Ill. 2d 424, 432, 454 N.E.2d 672, 73 Ill. Dec. 575 (1983); see also *Greaney*, 358 Ill. App. 3d at 1019. However, "the primary goal of rehabilitation is to return the injured employee to work." *Schoon v. Industrial Comm'n*, 259 Ill. App. 3d 587, 594, 630 N.E.2d 1341, 197 Ill. Dec. 217 (quoting *Hartlein v. Illinois Power Co.*, 151 Ill. 2d 142, 165, 601 N.E.2d 720, 176 Ill. Dec. 22 (1992)). Thus, if the injured employee has sufficient skills to obtain employment without further training or education, that is a factor that weighs against an award of vocational rehabilitation. *National Tea Co.*, 97 Ill. 2d at 432; *Connell,* 170 Ill. App. 3d at 53-54. An injured employee is generally not entitled to vocational rehabilitation if the evidence shows that he does not intend to return to work (i.e., if he voluntarily remains out of the workforce even though he is able to work). *Schoon,* 259 Ill. App. 3d at 594.

Again, there is no evidence that Petitioner had any interest in returning to work until his long term disability benefits were ended, over 2 years after he was at MMI. The Arbitrator notes that PX 12 documents Petitioner's ability to apply on Indeed. But searched only a few days. PX 12 also notes he was limiting the shifts he was willing to work. Petitioner testified he returned to Staffmark and was placed in the job. The record clearly demonstrates Petitioner's ability to find work and that jobs were available within Dr. Salehi's restrictions. Petitioner failed to prove that vocational services were required.

The parties stipulated that Petitioner received $9,349.78 in temporary total disability. RX 6 documents these payments through March 27, 2013. The parties also stipulated that Petitioner received $76,278.99 in short term and long term disability for which Respondent would be entitled to credit under Section 8(j). But these payments were for the entire period from January 2014 through January 2017. No payment ledger was entered to allow the Arbitrator to establish what payments were made for the period through September 17, 2014.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability from December 10, 2012 through April 10, 2013; April 15, 2013 through May 21, 2013 and January 1, 2014 through September 17, 2014, a period of 59 6/7 weeks. Petitioner's claim for maintenance is denied. Respondent is entitled to credit for $9,349.78 for temporary compensation paid and for any disability payments made through September 17, 2014, pursuant to Section 8(j).

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

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an Order Picker/Forklift Driver at the time of the accident and that based upon his description of the heavy lifting required and Dr. Salehi's restrictions, he is not

able to return to work in his prior capacity as a result of said injury. The Arbitrator notes, as discussed earlier, that Petitioner's subjective complaints as well as his other testimony and medical history is often embellished or exaggerated. The medical restrictions are based in part on these complaints and therefore must be weighed accordingly. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 36 years old at the time of the accident. This would make him a younger worker, expected to be in the labor market for an extended period of years. Because of this, 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 is currently earning less that he was with Respondent at the time of his accident. As noted herein, this is in part due to his medical restrictions which are in part due to his subjective complaints. Petitioner presented no evidence that the job he took was the best available. He also testified he is applying for promotions within the company. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner suffered injuries to his neck and low back. He was diagnosed with a cervical sprain. His cervical MRI was normal, and his symptoms resolved. A lumbar MRI performed on December 11, 2013 revealed disc bulging at L4-5 and L5-S1 with mild canal and bilateral foraminal stenosis at L5-S1. The EMG found L5-S1 radiculopathy. The discogram was positive for concurrent pain at L4-5 And L5-S1. Petitioner underwent an L4-S1 fusion. He was released to return to work in the medium level physical demand level. The Arbitrator has discussed above the weight to be given to Petitioner's subjective complaints due to the inconsistencies and exaggerations disclosed in his testimony and medical records. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of person as a whole pursuant to §8(d)2 of the Act.

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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC002052
Case Name	NIPPE, MONICA v. ST OF IL/IDOC/ MURPHYSBORO
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0455
Number of Pages of Decision	9
Decision Issued By	Deborah Simpson, Commisioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Aaron Wright

DATE FILED: 9/8/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MONICA NIPPE,

Petitioner,

vs. NO: 19 WC 2052

STATE OF ILLINOIS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below, finds that Petitioner did not sustain her burden of proving accident or causal connection to current conditions of ill-being, and denies compensation.

Findings of Fact – Testimony

Petitioner testified that she was currently unemployed and "blissfully retired." She resides in Illinois but travels between Illinois and Florida. She started working for Respondent in 1994 as a correctional officer ("CO") at Menard. In that job, she performed "inventory, bar rapping, shakedowns, escorts, towers." She estimated she spent 75-80% of her time as a gallery officer. She used the "big Folger keys" in that job. Bar rapping caused tingling in her hands and fingers.

Petitioner was a CO for about a year, thereafter she became an "LTS supervisor." In that job, she organized "all recreational activities for the offenders." That activity involved the use of

her hands and arms. In that job, she also used keys, including the Folger keys. Sometimes the Folger keys got stuck. Menard was a maximum security facility and she had to unlock everything to get and return recreational equipment. Each opening of a cabinet *etc.*, required "four episodes of locking and unlocking." She also used chuckholes as a CO at Menard, which required the use of the Folger keys.

In 1997, she went to Murphysboro juvenile boot camp. She had one year as a CO, two years as a leisure specialist at Menard, and 15 years as a leisure specialist (LTS) at Murphysboro. She had to engage in the recreational activities including "wall climbing where you use your fingers and climb up the wall repelling. A-course obstacle course and final challenges." "That was part of the boot camp philosophy, that everybody there would partake and do it all." She had to be physically fit to engage in the activities with the inmates. Each LTS would run two to three courses each day lasting between an hour and an hour and a half. She agreed that it translated into three to four and a half hours of physical activity a day. The boot camp had less doors/locks than Menard, but you still needed to use keys a lot to get into your desk, the bathroom, filing cabinet, and the equipment room.

After the boot camp closed in 2012, she returned to Menard as a correctional counselor in segregation. In that job she had to get mail every day from a locked area using a master key. She would also have to do a background inventory to see if an inmate could bunk with another inmate. In that activity, she would be "typing, pulling up all their disciplinary history on a computer and disciplinary tracking and writing on the sheets." About 25% of it was handwriting and 75% typing. She agreed that "virtually [her] entire job was using [her] hands either writing or on a computer." She agreed with the job description dated 1/7/19 which indicates use of hands 6 to 8 hours a day.

During her employment, Petitioner began to notice symptoms including numbness/tingling, and especially symptoms in her right hand, which would lock up. She does not have diabetes, gout, hypothyroidism, rheumatoid arthritis, is female, and is a bit overweight. Since retirement, she lost weight and no longer took hypertension medication. She sought treatment from her primary care physician, who referred her to Dr. Alam, a hand specialist, who performed an NCS. She filled out an accident report on January 4, 2019 because the doctor recommended "to get the surgery done because of progressive work." In addition, her hands were hurting more than before.

Petitioner's lawyer sent her to Dr. Kutnik, presumably for a Section 12 medical examination. She read his report, but she thought he misunderstood "the whole depth of work" she performed in her jobs with the State of Illinois. She specifically noted the rigor of wall climbing and that only people with military training would understand. She also disagreed with the report of Dr. Sasso, Respondent's IME. Petitioner believed "she was also confused about prisons and maximum security and that's that" she did.

Petitioner testified that currently she awoke two or three times a night with her hands completely numb all the way up her arm. Her condition had gotten progressively worse since her retirement. She did not have any recreational activities that involve the repetitive use her of her arms or hands.

On cross examination, Petitioner testified both her hands hurt, but the right was worse. She was still dropping things; she dropped her "entire cup of coffee" four days earlier. Over the past month or so, she also dropped keys and she had difficulty picking up small things. She did not recall dropping anything from her left hand. Regarding her elbows, whenever she tried to unscrew something, she felt " the tension and it [went] all the way through here" (indicating on her right arm). The symptoms in her left arm were not as severe. She reiterated that she no longer took medication for hypertension. She agreed that she was still obese and was an occasional smoker; "maybe once a week." She retired in February 2019. At that time, she probably smoked every day. She also drank alcohol occasionally, again about once a week.

Petitioner did not recall that medical records from October 26, 2018 included the mention of carpal tunnel syndrome ("CTS"), but she did not have any reason to dispute that notation. She also did not remember telling the doctor at that time, that her symptomatic episodes lasted three months. She had arthritis in her knees but not her hands. She also had no knowledge that Dr. Alam's report noted bilateral CTS, but no mention of any condition of her elbows. She did not remember anything she told Dr. Kutnik. She was a CO at Menard for 11 months up to January 1995. In 1994-1995, she did not have the symptoms she currently complained about. During her stint at Menard, she heard talk about CTS.

In the job description she prepared, Petitioner noted that as leisure specialist at Menard from 1995 to 1997, she lifted weights, probably every other day with the inmates. She both participated and taught the inmates proper technique. During that time, she also played basketball with the inmates, but rarely. She did not recall feeling numbness/tingling in her hands at that time. At Menard, they would inventory the equipment twice a day and she had to lock/unlock the equipment shed.

The obstacle course she referred to was at the boot camp. She described the activity. "You would run and you would do hurdles. There were bars and you'd jump over the hurdles and then you'd jump on a wall. Climb over the wall and then you'd run zigzag and you would go through the tires and then you'd come around the corner and do the monkey bars across and then you'd jump like a little mud pit and you'd go through and run through a belly crawl." She could matriculate the course in a minute and a half. In the beginning she probably did it once a day training the kids. The rock wall was about 20 to 22 feet. She climbed the rock wall "a lot." She had to screw in the safety hooks on the wall, which connects to the harnesses on the inmates. She had to make sure that each kid was properly secured. She had to use "quite a bit of" force to secure the inmates in the harnesses. There were about 22 kids in each unit. They repelled the wall on weekends. She did not believe she had symptoms in 2011.

Petitioner did not file any accident report until January 7, 2019. In it she reported that on January 4, 2019 she developed bilateral numbness/tingling/weak grip and locking fingers due to repetitive trauma with both hands/wrists involving cuffing/uncuffing, locking/unlocking steel doors, rapping bars, repelling, screwing/unscrewing harnesses, and typing. She based the accident date on receiving the results of the EMG.

Petitioner testified that she did not have the symptoms in the beginning of her job at Menard as leisure specialist. She returned to Murphysboro for "just a year" before she retired. She took some days off of work to take care of her ailing mother. She still helps her as much as she could. Her care of her mother does not involve use of her hands/arms. They did renovations of her house in Southern Illinois, her mother's house in Southern Illinois, and their house in Florida. She only did some "deck labor" on the Florida house and nothing else.

Respondent's description for a Correctional Activities Specialist indicates Petitioner had to use her hands for gross/fine manipulation each 6-8 hours a day. Petitioner prepared a timeline of her work activities for Respondent:

1994-1995 – CO at Menard, which involved counts, cuffing/uncuffing inmates, locking/unlocking steel and entry doors, rapping bars, escorting cuffed inmates, shakedowns/searches of large property boxes.

1995-1997 – Correctional Leisure Specialist at Menard, which involved planning/implementing inmate activities, weight lifting, basketball, maintaining inventories, doing shakedowns of the gym, carrying equipment, and organizing guest speakers and statewide tournaments.

1997-2012 – Correctional Leisure Specialist at Murphysboro, which involved planning/directing/participating in various sporting activities, organizing special events/guest speakers, cleaning gym floors/equipment, inventorying tools, and recording data. She reported prior injuries: blowing out her right knee while repelling and breaking her left knee breaking up a fight.

Findings of Fact – Medical Records

On March 18, 2019, Petitioner presented to Dr. Kutnik, an orthopedic surgeon, for a one-year history of progressively worsening pain/numbness in both hands. She had virtually constant symptoms in her right hand, had difficulty with daily activities, and dropped things. She retired the prior month after a 25-year career at Illinois Department of Corrections. Dr. Kutnik diagnosed bilateral CTS/CUTS. He noted that even though the EMG failed to show CUTS, there was a 15% false negative rate for the test. Dr. Kutnik recommended staged (right then left) bilateral CTS/CUTS surgeries due to the progressive and worsening symptoms.

On August 2, 2018, Petitioner presented to Dr. Fasnacht, her primary care physician for recheck of hypertension. Dr. Fasnacht noted "recheck of unspecified hypothyroidism." Symptoms included weight gain, cold intolerance, and fatigue." Petitioner described the condition as mild and unchanged. There does not appear to be any mention of CTS and Cubital Tunnel Symptom ("CUTS"). An EMG/NCS showed moderate-to-severe CTS on the right, mild left CTS, and no evidence of cervical radiculopathy.

On October 26, 2018 Petitioner returned to Dr. Fasnacht for chronic pain management for the diagnoses of hypertension, low back pain, bilateral CTS, eustachian tube dysfunction, sinusitis, and obesity (41.82 BMI). Her episodes of paresthesia lasted three months and occurred seven times a week. Her symptoms were consistent with "ulnar and Carpal tunnel syndromes."

Findings of Fact – Doctor Depositions

Dr. Kutnik testified by deposition on August 20, 2019. He is a board-certified orthopedic surgeon. He just took the test for hand qualification but was awaiting the results. He sees about 120 patient a week, mostly for hand and arm complaints, and performed about 15 surgeries a week. About a half of his surgeries involve CTS. "Jobs that involve repetitive use of the hand, particularly the more force, grip, squeeze, weights, or lifting involved, all can contribute or increase the risk of developing either compression neuropathy," including CTS and CUTS. There are nonoccupational risk factors as well. He reviewed some medical records and examined Petitioner on March 18, 2019. She complained about worsening bilateral pain and numbness. It involved all fingers on the right hand and the 4th and 5th fingers of the left hand. She had symptoms for about a year.

Petitioner attributed "a great deal of" her symptoms to her 25 years of work at the Department of Corrections. She retired a month before he saw her. They briefly discussed her work history. She provide the basic job description of a CO. Part of her job had changed, and she and she was involved with setting up and arranging gym activities. She described activities involving both fine and gross manipulation with her hands. He briefly outlined her jobs, as described by Petitioner. As she described it, her job as correctional counselor had a more supervisory aspect. She did more administrative activities, including clerical, handwriting, and typing. She also described shakedowns, but he believed that applied more to her job as CO. Clinically, he found CUTS, but it was not evidenced on the NCS. He noted that the test is far more sensitive in detecting CTS than it is in detecting CUTS.

Dr. Kutnik opined that based on Petitioner's description of her job activities, those activities were a contributing factor in her conditions. He noted that "around the time of when her symptoms really developed and got a lot worse, she was using her hands quite readily for all manner of activities, and a bit more excessively so certainly as a leisure specialist where she was organizing the activities and participating in some of these weightlifting and other gym-type motions."

He acknowledged that she had co-morbidities such as being female, being obese, and having hypothyroid disease. He recommended surgery. He thought she would not likely improve without the surgeries.

On cross examination, Dr. Kutnik testified he only saw Petitioner once and did not know her current condition. He has not had a hand certificate in the past. He agreed that her age was a co-morbidity factor but not her hypertension or smoking. He also did not consider opioid use as a co-morbidity factor, but he was not sure there was enough research on the issue.

Petitioner did not bring the job description Dr. Kutnik had; he received it sometime after her visit. Because of the temporal remoteness, he did not consider her work as CO ending in 1995 to be a contributing factor in her conditions. Causation has more to do with repetition, but the higher the force/weight the "more substantial the contribution would be." He thought she actually participated in weightlifting to help demonstrate. He did not know how much weight she was lifting. He assumed "she was spending a majority of her time doing these things."

On redirect examination, Dr. Kutnik noted that in studying for the hand certification, he read literature that there was no definitive evidence that smoking contributed to CTS/CUTS, and hypertension was not even mentioned. He has not seen definitive evidence that typing plays a role in developing these conditions. He did not believe her activities as leisure specialist at Menard and Murphysboro were very different.

Dr. Sasso testified by deposition on November 18, 2019. She is a board-certified orthopedic surgeon with a subspecialty fellowship in hand surgery, also known as a hand certificate. She performed about four hand surgeries a week. About 10% of her surgeries involve CTS and 7% CUTS.

Dr. Sasso performed a Section 12 medical examination on Petitioner on August 12, 2019 to evaluate bilateral CTS/CUTS. Initially, Petitioner had night time symptoms and it was worse with driving. She reported dropping things, including while using a chainsaw. She had weakness and could not tighten a water hose. Dr. Sasso noted that occupational factors for CTS/CUTS, involve "heavy repetitive lifting such as those seen in factory workers that are doing the same job over and over. People who use vibratory tools such as jackhammers, they have a higher incidence" of CTS. The studies about smoking and CTS are conflicting, but there were "studies that had increased nerve compression associated with tobacco use;" nicotine does constrict the blood vessels.

Petitioner reported starting at Menard in 1994, moving to Murphysboro in 1997, where she was doing repelling, rock climbing, and running an obstacle course. She moved back to Menard in 2012 and back to Murphysboro in 2018, where was she was doing predominantly office work and organizing physical activities. Her BMI of 42 classified her as "very severely obese," which is a co-morbidity factor for CTS/CUTS.

Dr. Sasso diagnosed bilateral CTS/CUTS. However, she opined that her conditions were not causally related to her work activities. Her work activities did not involve significant risk factors such as heavy lifting, and she did not report continual typing. She had multiple other risk factors such as obesity and the use of "a garden hose and using vibratory work tools at home," which can cause or aggravated CTS.

On cross examination, Dr. Sasso testified that she performed maybe six Section 12 examinations and gave about three depositions year. She was not provided Dr. Kutnik's deposition. She had description of Petitioner's job duties written out by Petitioner. Dr. Sasso had not been to Menard or Murphysboro. She was not aware of the shift Petitioner worked at Menard. She was not sure what type of correctional facility Menard was. She never heard the term bar-rapping, or a shakedown. The literature about the association of typing and CTS is controversial, but it can possibly be a factor for a person typing all day every day. She never saw any association between handwriting and CTS. She did not examine Petitioner's work station, but Petitioner indicated it was ergonomically correct. She agreed that Petitioner's job included cleaning weights and workout equipment, gross manipulation of her hands, and lifting.

Dr. Sasso also agreed that using hands for fine manipulation, gross manipulation, grasping, twisting, and handling or typing six to eight hours a day could possibly cause or aggravate CTS, "depending on what she's doing." However, the variety of activities she reported militate against CTS; "she's not doing anything repetitive. She's typing, playing intramural sports, she's doing some cleaning, she's opening some doors. That's not repetitive. If what you're suggesting is the case, then we should all have" CTS. She believed a person must perform the same action over and over to cause CTS.

Conclusions of Law

The Arbitrator found Petitioner sustained her burden of proving accident and causation. She noted that Petitioner's activities were distinctly work related and not the activities performed by members of the public at large. In addition, she cited *City of Springfield v. IWCC*, 388 Ill. App. 3d 297 (4th Dist. 2009) for the proposition that hand intensive repetitive work can cause CTS even if the work activities were varied. She also noted that the Commission had frequently found the work as CO at Menard can cause or aggravate peripheral neuropathies such as CTS and CUTS. Finally, she found the opinions of Dr. Kutnik persuasive and discounted the opinion of Dr. Sasso because she believed a person must perform the same action over and over again to cause CTS.

Respondent argues the Arbitrator erred in finding accident/causation. It notes that there was no testimony that Petitioner had symptoms while performing her work activities. It also noted that Petitioner testified that her symptoms actually increased after her retirement.

In looking at the entire record before us, the Commission finds that Petitioner did not sustain her burden of proving she sustained a compensable accident or that her work activities caused or contributed to her conditions of ill-being. Accordingly, we reverse the Decision of the

Arbitrator on the issues of accident and causation and deny compensation. The Commission agrees with Dr. Sasso's opinion that Petitioner's activities were varied and neither ultimately repetitive or involved extensive awkward positioning or forceful grasping. Furthermore, while the Commission has previously held that work activities by a CO at Menard had contributed to peripheral neuropathies, we do not believe that the Arbitrator should have relied on Petitioner's activities as a CO at Menard, which occurred 25 years prior to her developing her current symptoms. Even Petitioner's Section 12 medical examiner, Dr. Kutnik, found her activities as CO were too temporarily remote to be a causative factor in her developing CTS/CUTS and Petitioner even testified that she had no symptoms while working at Menard.

In addition, the work activities Petitioner was performing at the time of the onset of symptoms appear to have been particularly benign for developing peripheral neuropathies. The Commission agrees with Respondent that it is very significant that Petitioner's symptoms actually got worse after her retirement, which is established both through her testimony and her report to Dr. Kutnik. That fact strongly militates against finding her work activities caused her conditions of ill-being. In addition, Petitioner had non-occupational co-morbidity factors for developing peripheral neuropathies including her age (51 at the alleged date of manifestation), gender, obesity, and possibly her history of tobacco use. Finally, it is interesting to note that she reported to Dr. Sasso that she dropped a chainsaw. There is no evidence of her using a chainsaw in her work. Therefore, her use of such a vibratory tool would be another non-occupational risk factor.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued December 2, 2020 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that it finds Petitioner has not sustained her burden of proving accident or that her work activities caused her current conditions of ill-being of bilateral Carpal Tunnel Syndrome and bilateral Cubital Tunnel Syndrome and compensation is denied.

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

September 8, 2021

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC008640
Case Name	MILLER, STEVE v. STATE OF ILLINOIS - IDOT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0456
Number of Pages of Decision	25
Decision Issued By	Thomas Tyrrell, Commisioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Shannon Rieckenberg

DATE FILED: 9/9/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0456

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Miller,

Petitioner,

vs. NO: 18 WC 8640

Illinois Dept. of Transportation,

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 all issues, and after being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of Fact

Petitioner has worked for Respondent as an engineering technician since January 2017. His job duties include inspecting work done by contractors and ensuring that work is completed in the correct manner. He also writes evaluations used for determining progress pay. Petitioner testified that he currently works on erosion control reports and must make sure the soil erosion on projects does not run off. He testified that he conducts traffic control audits which involve making sure the barrels and signs are in good condition and in the proper place. Petitioner testified that he currently works out of a field office. He testified that in the winter, Respondent has winter assignments where workers are randomly assigned to various departments to provide extra help.

On February 28, 2018, Petitioner was assigned to the bridge department. His assignment involved checking box culverts and looking for cracks and other signs of erosion buildup. That day, Petitioner worked with Anthony Graham setting up signs in Marion, IL. Petitioner testified that it began sleeting and he had to use the restroom. Petitioner testified that after he and Mr. Graham finished setting up the signs, they went to the closest field office with a restroom. He testified that he had visited this field office previously and had even been assigned to the office for a few months. Petitioner testified that after using the restroom he sat at a desk he used when he was assigned to that field office a few months earlier. A few workers were gathered and talking, and Petitioner joined the conversation. Petitioner testified that he was also looking at his personal cell phone.

At around 2:30 p.m., Craig Lester arrived and demanded Petitioner get out of his chair. Petitioner testified that he refused and was sitting at the desk holding his cell phone and a pop. Petitioner testified that Mr. Lester demanded Petitioner give him the chair a second time and Petitioner again refused. Petitioner testified:

> "About the third time he said, 'Come on, man, I need my chair.' And I looked at him, I shook my head no, and I believe I said no. And then at that time he said something to the likes of, 'Get out of my fucking chair', or 'Give me my fucking chair', as to which I tried to ignore him, and I shook my head no. I went about looking at my phone, and I'm not quite certain how it happened, I don't know, the chair had been lifted in some way."

(Tr. at 15). Petitioner testified that he assumes Mr. Lester grabbed the left arm of the chair. Petitioner testified that he was "tossed out" on the right side. *Id*. The office chair had wheels. Petitioner then stood up and sat in a different chair. He did not notice any symptoms immediately. However, after driving the IDOT truck back to the central office, Petitioner first felt symptoms as he got into his personal truck to drive home. He testified that it felt like his toes were almost on fire. He testified that these symptoms became evident approximately 1.5 hours after the work incident.

Under cross-examination, Petitioner testified that he and the other workers were discussing future job openings and who might apply to the positions. He testified that he was sitting at the desk waiting for the clock to run out. He believed he had 20 minutes left in the workday. He testified that all the workers were wrapping up for the day and he agreed that they were just sitting around conversing. Petitioner admitted that he was not performing any work duties when the incident occurred; instead, he was checking his cell phone. Petitioner testified that if Mr. Lester politely asked him to move, he probably would have moved. However, Petitioner testified that he did not want to "enforce" negative behavior, particularly when there were other available chairs. (Tr. at 28). Petitioner testified that he never had any prior issues or disputes with Mr. Lester.

Petitioner readily admitted that he experienced ongoing low back pain prior to this work incident. Petitioner underwent a lumbar injection only five days before the date of accident. However, Petitioner testified that his lumbar pain significantly worsened following the work incident. He testified that he would like to proceed with the lumbar surgery recommended by Dr. Gornet.

Craig Lester testified on behalf of Respondent. He has worked for Respondent for 25 years and is a PCC supervisor. Mr. Lester testified that on the date of accident he was working in the field. He testified that when he returned to the office, he saw Petitioner sitting in his chair. Mr. Lester testified that he told Petitioner he was sitting in his chair twice, but Petitioner did not respond. Mr. Lester testified:

> "And so I said…it's been a while, but I think it was like, 'Would you please get out of my f'ing spot'…And he shook his head no and then started to slide the chair away from me…So I put my right hand

> on the chair, and I kind of took the arm, and I went, 'Come on, get up'…just kind of shaking the arm. So he had taken and he started sliding, trying to slide on the chair and I had got the arm's reach, and I had it. And it was like within just an instant, the legs had flipped on the tile, came up and kind of hit me in the shins, and that was it…"

(Tr. at 42-43). He testified that he then picked up the chair and sat down. Petitioner then sat in a different chair. Mr. Lester testified that he did not know if there were officially assigned desks; however, this desk was where he had all his work items, including reports. He testified that Petitioner was not actually sitting at the desk; instead, Petitioner was sitting with his back to the desk. Mr. Lester testified that he had no prior disagreements with Petitioner.

Anthony Graham testified on behalf of Respondent. Mr. Graham works as a technician for Respondent. He has worked for Respondent for 18 years. He testified that on the date of accident, he and Petitioner visited the field office to use the restroom and to warm up. He believed they were in the office for approximately 10-15 minutes and agreed that they were sitting and talking with some of the other office workers. Mr. Graham testified that Mr. Lester came in and asked Petitioner at least two times to get out of the chair. He testified that he saw Mr. Lester hold the arm of the chair and finally pick up the arm of the chair. He testified that Petitioner then got up and sat in a different chair. He did not believe Petitioner fell completely to the floor; instead, he testified that Petitioner got out of the chair as it was turning over.

Donald Rightnowar testified on behalf of Respondent. He has worked for Respondent for approximately 29 years and is a civil engineer. Mr. Rightnowar testified that he did not see what happened, but he did hear the encounter between Petitioner and Mr. Lester. He testified that he saw Mr. Lester enter the office and then heard him tell Petitioner to get out of his chair more than once. He then heard the chair rolling, but he did not see any part of the incident when he stood up. He testified that when he stood up, Petitioner was already seated in a different chair and Mr. Lester was sitting in the contested chair. Mr. Rightnowar testified that the desk is not assigned to any worker; instead, it is a floating desk for whoever needs to use it that day.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). He must show by a preponderance of the evidence that he suffered a disabling injury which arose out of and in the course of his employment. *Id*. The phrase "in the course of employment" refers to the time, place and circumstances surrounding the injury. *Id*. To satisfy the "arising out of" prong, Petitioner must show that the injury "…had its origin in some risk connected with, or incidental to, the employment." *Id*. The compensability of Petitioner's claim rests on the question of whether he suffered an accident arising out of his employment. After carefully considering the totality of the evidence, the Commission finds Petitioner did not meet his burden of proving his injury arose out of his employment.

The Commission notes that Respondent disputed the issue of accident at the arbitration

hearing. However, Respondent did not dispute the Arbitrator's conclusion that Petitioner's injury arose out of and in the course of his employment in either its Petition for Review or its Statement of Exceptions. The Commission exercises original jurisdiction. *See, e.g.*, *Caterpillar Tractor Co. v. Industrial Comm'n*, 215 Ill. App. 3d 229, 238-39 (1991). This means it has the authority to determine all unsettled questions and is not bound by the Arbitrator's findings. The Commission's review of a case is not restricted to the information found in the Petition for Review or the reviewing party's Statement of Exceptions. Instead, Illinois courts have determined that the Commission may *sua sponte* consider a new theory of recovery as long as a party's substantial rights are not prejudiced. *Id*. at 239. Thus, the Commission has the authority to review all questions of law or fact which are evident in the record as long as a party's substantial rights are not prejudiced. In this case, Petitioner is not prejudiced by the Commission's review of the question of whether Petitioner's injury was the result of a compensable accident because the parties fully litigated this disputed issue during the arbitration hearing.

After carefully considering the evidence, the Commission finds Petitioner failed to meet his burden of proving his injury arose out of his employment. An injury that occurs during work hours and even on an employer's property does not necessarily arise out of a claimant's employment. Instead, Petitioner must show that "…there is apparent to the rational mind a causal connection between the conditions under which the work is to be performed and the resulting injury." *Castaneda v. Industrial Comm'n*, 97 Ill. 2d 338, 342 (1983) (internal citations omitted). The Illinois Supreme Court has determined that "[w]here a physical confrontation is purely personal in nature, the resulting injuries cannot be said to have arisen out of the employment." *Id*. The Commission finds that the totality of the circumstances surrounding this altercation reveals that Petitioner's injuries are the result of a purely personal confrontation.

The undisputed evidence reveals that at the time of the incident, Petitioner was sitting in a chair facing away from the desk. Petitioner was looking at personal items on his personal cell phone and was also participating in a conversation with other workers. Petitioner admittedly was not performing any work-related duties and was instead running out the clock on the last approximately 20 minutes of his workday. The other workers were also sitting around the office casually chatting as they also waited for the final minutes of their workday to tick away. Mr. Lester entered the office and immediately ordered Petitioner to get out of the chair. The altercation escalated and Mr. Lester grabbed the chair and shook it while Petitioner tried to roll away in the chair. Nothing about this altercation relates to either Mr. Lester's or Petitioner's performance of their work duties. There is absolutely no evidence that either person wanted or needed to sit in that specific chair at that specific desk to complete their work. Instead, the Commission is faced with two men behaving like children and tussling over a chair in a personal dispute. While Petitioner may very well have sustained injuries as a result of this altercation, he failed to meet his burden of proving the altercation arose out of his employment.

For the foregoing reasons, the Commission denies benefits to Petitioner because he did not sustain 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 29, 2020, is reversed in its entirety and all benefits are denied.

September 9, 2021

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

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

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

21IWCC0456

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

MILLER, STEVE
Employee/Petitioner

Case# **18WC008640**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 1/29/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

JAN 29 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Steve Miller
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **18** WC **8640**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **November 21, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 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 $**37,020.00**; the average weekly wage was $**711.92**.

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

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

Respondent shall be given a credit of $**30,608.32** for TTD, $ for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**30,608.32**.

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

ORDER

The Arbitrator finds the petitioner suffered a work injury that arose out of and in the course of his employment with the Respondent on February 28, 2018 and that to an extent his current condition of ill-being is causally related to that accident.

Respondent shall pay the petitioner temporary total disability benefits of $474.61 as the Petitioner was \ temporarily totally disabled from September 25, 2018 through November 12, 2018. The Respondent is entitled to a credit to the extent they have paid TTD for that period.

The Arbitrator denies prospective medical treatment pursuant to sections 8(a) of the Act consisting of the surgery recommended by Dr. Gornet.

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

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

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

Carl Lee — Signature of Arbitrator

1/23/20 — Date

ICArbDec19(b)

JAN 29 2020

Findings of Fact:

Steven Joe Miller is 40 years old married with two sons that are 6 and 10. (AT p. 8). He is employed as an engineering technician with Illinois Department of Transportation and has been employed in that position since 2017. (AT p. 9). His job duties include going out to inspect work being done by the contractor, referencing field guidelines and insuring the project is done according to department specifications, and documenting quantities on construction sites. (AT p. 9). At the time of Arbitration Mr. Miller was working on erosion control reports to make sure soil erosion on projects doesn't run off and also doing traffic control audits to make sure barrels and signs are placed properly. (AT p. 10).

Mr. Miller works out of field offices during this time of year or when they are on winter assignment. (AT p. 11). This involves people getting assigned to random departments to utilize the extra help to get things done that did not get done earlier in the year. (AT p. 11). In February of 2015 he was assigned to the Bridge Department to check box culverts and go on the road to check for cracks. (AT p. 12).

On February 28, 2018 the Petitioner was working with Tony Graham to assist setting up signs in Marion. (AT p. 13). It starting sleeting and misting and they needed to use the restroom so they completed their sign work and went to the closest field office which was run by Donnie Rightnower . (AT p. 13). After using the restroom Mr. Miller sat down at a desk he had used a few months earlier when assigned this office and at approximately 2:30 p.m. Craig Lester came in. (AT p. 14). Craig came over to Mr. Miller and said you are in my chair let me have my chair. (AT p. 14). Mr. Miller said no and Mr. Lester continued to ask for his chair. (AT p. 15). After a couple exchanges where Mr. Lester was demanding his chair Mr. Lester yelled at Mr. Miller and said get out of my f***ing chair at which point Mr. Miller ignored him. (AT p. 15). Mr. Miller went back to looking at his phone at which time the chair was lifted and he was tossed out of the chair to the right side landing on his tippy toes and on the pad of his hand and forearm. (AT p. 15). He didn't notice an injury until they went to another field office to drop the IDOT truck and get into his personal vehicle around 4 or 4:30. (AT p. 16). At that

time he began to feel like his toes were almost on fire and it was at that point he called his supervisor John Vancil. (AT p. 16). He reported to Mr. Vancil what happened and that there was something not right in his foot at which point he was instructed to decide whether he wished to attempt to sleep it off or precede to the doctor. (AT p. 17). In the following days the Petitioner completed the IDOT accident reports which were offered into evidence at Arbitration. (AT p. 18).

The day after the accident Mr. Miller went to his family doctor, Dr. Lutchka at Shawnee Health. (AT p. 18). The evening before Mr. Miller pain had become so bad that he had to go to the ER. (AT p. 19). Dr. Lutchka increased his medications and recommended physical therapy. (AT p. 19).

Prior to the work accident of February 28, 2018 the Petitioner had an ongoing back condition and had received an injection from Dr. Christe. (AT p. 20). He had also gone to physical therapy and had a small amount of tingling in his toes, but the back incident made his symptoms worse. (AT p. 20). After the work accident he went to see Dr. Lutchka who referred him to Dr. Gornet. (AT p. 21). Dr. Gornet recommended some injections with Dr. Boutwell which did not provide relief. (AT p. 21). Dr. Gornet has now recommended surgery. (AT p. 22). Mr. Miller was off work after the accident at the recommendation of his treating physicians and was paid workers' compensation benefits (AT p ??)

Mr. Miller was sent for an examination with Dr. Robson in St. Louis and his benefits were cut off in January once the report was received. Mr. Miller returned to work full duty at the recommendation of Dr. Robson however his back continues to hurt and has not improved. (AT p. 23).

On cross examination Mr. Miller clarified that time of the incident he was sitting there discussing future jobs openings with his co-workers. (AT p. 25). The reason they were in that office was to use the restroom. (AT p. 25). They had about 20 minutes to kill did not make sense to load everything back in the truck and try to go hang another sign and get to another field office. (AT p. 25). When asked what he was arguing with Mr. Lester about Mr. Miller stated, "I don't feel like I was arguing." Mr. Miller explained that he did not feel it was an argument as Mr. Lester came in and said give me my chair and he did not respond because he was not going to reinforce bad behavior. (AT p. 28). Outside of this one

incident he and Mr. Lester had never had any issues and have worked together on other jobs. (AT p. 28). The chair Mr. Miller was sitting at was a spot he used for a month or so previously before being assigned to another job. (AT p. 30). At the time of the incident everyone was sitting around talking or acting like any other day when this incident occurred. (AT p. 30).

When he got to his truck and began noticing symptoms was approximately 4:00 to 4:30 or one and half to two hours after he fell. (AT p. 31). Dr. Lutchka took him off for two weeks Mr. Miller noted that he had back issues and had increase in pain and Dr. Lutchka wanted an MRI. (AT p. 33). Mr. Miller admitted that prior to this work accident he was on pain medication and undergoing physical therapy for his back issues. He had an MRI in December of 2017 and had already undergone one injection prior to the accident. (AT p. 33). He disputed that he did not report the prior injection to Dr. Gornet. (AT p. 34). Mr. Miller disputed that he had severe back complaints prior to the accident. (AT p. 35). Mr. Miller clarified that prior to the accident he had a small amount of back pain and tingling in his tips of his feet. Mr. Miller also clarified that he has not filed a criminal complaint or civil lawsuit against Craig Lester.

The Respondent called Craig Lester to testify. Mr. Lester has worked for IDOT since 1995 as a PCC supervisor. (AT p. 40). Mr. Lester had been using the construction field office in Marion and sitting at the desk using the chair just inside the door. (AT p. 41). When he arrived at the field office Steven was sitting in the chair at the desk he had been using and Mr. Lester told Mr. Miller that you are in my spot. (AT p. 41). Mr. Miller responded by shaking his head no at which point Mr. Lester said get out of my f***ing spot. (AT p. 43). Mr. Miller again shook his head no at which point Mr. Lester reached with his right hand for the chair and took the arm and wouldn't come on shaking the arm and as the chair starting sliding the legs flipped on the tile and came down and hit him in the shins. (AT p. 43). Mr. Lester picked up the chair and sat down and slid back to the desk at which point Mr. Miller went to get another chair. (AT p. 43). Mr. Lester confirmed that they do not have assigned desk. (AT p. 43). When asked what he was in disagreement with Mr. Miller about Mr. Lester stated I don't have a disagreement with Mr. Miller. (AT p. 44). The incident occurred at approximately 2:30 and he was still on the clock

for IDOT. (AT p. 46). While they don't actually punch a clock they are still working for IDOT. (AT p. 47). Steven was in the chair Mr. Lester had been using and Mr. Lester asked him to move. (AT p. 47). Steve said no and Mr. Lester put his hand on the chair at which point Steve came out of the chair when the wheels tipped. (AT p. 48). The Respondent also called Anthony Graham to testify. (AT p. 50). Mr. Graham is a Technician for IDOT a position he has held for eighteen years. (AT p. 51). He was on winter assignment which means they are moving them around when they have slack time on jobs they do. (AT p. 51). On February 28, 2018 they entered the field office because they needed to use the restroom and were just sitting there warming up. (AT p. 52). They were not planning on staying long but they were just warming up and it was close to the end of the day. (AT p. 52). Mr. Graham stated, "I seen Craig come in and he wanted Steve to get out of the chair, so he asked him, and I think two times maybe so I seen him come over, take the arm of the chair, and there was moving around and finally Craig picked up the arm of chair, and he got up and went to another chair and sat down. (AT p. 53). They left the field office shortly after that to go back and get his truck. (AT p. 54). It is the normal course of his job for him and Steve to be in and out of the field offices on winter assignment. (AT p. 55). If they are close to a field office they can go in and warm up or do whatever they need to do. (AT p. 56). They can sit in their trucks to warm up or find a field office but they needed to use the restroom which is why they were in the field office. (AT p. 56). He also stated that there was nothing unique about the particular chair that Mr. Miller was sitting in and there were plenty of chairs.

The Respondent also called Donald H. Rightnower who is a Civil Engineer III for the Department of Transportation a position he has held for twenty-nine years. (AT p. 58-59). Mr. Rightnower didn't see a whole lot other than Mr. Lester walk in and make the comment get the f*** out of my chair. (AT p. 60). He heard it one more time and then heard the chairs and the rollers roll around but didn't see anything. (AT p. 60). The seats are assigned to whoever needs to use it because the employees rotate. (AT p. 62). Mr. Rightnower testified that when Mr. Miller worked for him previously he had back issues and there was one incident where Mr. Miller came in late, but it was not otherwise a problem. (AT p.

65). Mr. Rightnower also testified that when Steve worked out of that office that he used that desk. He also clarified that on February 28, 2018 other than this incident there was nothing different going on for what happens in an IDOT field office generally on any other day. (AT p. 66).

The TriStar Workers' Compensation Employee Notice of Injury was offered into evidence as Petitioner's exhibit 1 and Respondent's exhibit 2. The document was completed on March 6, 2018. It states that the Petitioner was doing nothing more than discussing work related news in a field office. The description of how the injury occurred on page 2 is consistent with the Petitioner's testimony regarding how the accident occurred noted above. It is noted that the Petitioner reported pain and numbness on the left side of his body primarily in the foot lower leg thigh hip and groin low back and possibly neck pain on both sides.

Witness statement were offerd into evidence as Petitioner's exhibit 2. These were secured via subpoena from David Goldstein Senior Claims Manager at MetLife by the Petitioner. They contain witness statements from Don Rightnower, Craig Lester, Lee Estel, Tony Graham and Steve Miller. These statements for the most part are consistent with the testimony of these witnesses at Arbitration that is summarized above. It is also noted for the record that the Petitioner was questioned on cross examination whether he had filed a lawsuit against Mr. Lester for this incident. However the subpoena to the MetLife Claims Adjuster indicates there is an open claim with Mr. Lester's insurance carrier.

Medical records from Lutchka and Shawnee Health Services were offered into evidence as Petitioner's exhibit 3. The Petitioner was examined on February 20, 2018 for a depressive disorder and low back pain. (PE p. 2). On March 1, 2018 he was examined for low back pain and provided gabapentin and physical therapy. (PE 3 p. 15) He was given an off work slip for one week. (PE 3p. 20). The history provided indicates that the patient was in an altercation at work where he was sitting in a chair and another office worker came in and asked him to get out of the chair when the patient declined the other worker picked up the arm of the chair and forced the patient out where he fell to the ground caught with his right hand and feet patient thought he would be ok but soon notice pain in the left leg and

back burning type pain happening yesterday about 2 pm he went to the ER at 10 pm and having some issues. (PE 3 p. 24). On March 8, 2018 he followed up with Dr. Lutchka reporting pain that started yesterday he went to the ER but no imaging was done. They recommended follow up with a neurologist He noted that there was pain in the left groin which he did not have at the time of the initial injury, but wondered if he pulled something when he was pulled out of his chair he noticed foot numbness persists. (PE 3 p. 34). He was seen again on September 12, 2018 where there is an indication that he had two more injections with ortho and if there was no improvement he would need surgery. (PE 3, p. 47). On April 2, 2018 the Petitioner was examined for a follow up for his back problem reporting there is not much significant improvement in his low back pain with radiation of lower extremities remain persistent left side is more painful than the right side the patient states neither trunk flex nor extension motions helped decrease his pain. The MRI from March 29, 2018 was reviewed illustrating loss of disc and disc desiccation most pronounced at L4-5 and L5-S1 levels. (PE 3, p. 130).

Medical records from SIH Memorial Hospital of Carbondale were offered into evidence as Petitioner's exhibit 4. Records document that he was examined on October 10, 2017 with chronic low back pain which increased last week in unusual way (PF 4, p 6) This assessment indicates that the patient presents in multiple areas of pain and numbness with this most intense pain arises from the L glenohumeral joint. (PE 4, p. 9). It also noted in the history of bulging disks. (PE 4, p. 9). The discharged therapy note on November 9, 2017 indicates that the patient was referred back to MD secondary improvement in pain at this time the current state is unknown we're able to address functional limitations and our goals the episode of care will be closed and there will be discharged from therapy and the patient will need a new referral to return to further therapy if physician so desired. (PE 4 p. 40). Patient went to SIH March 1, 2018 with leg pain and underwent a CT of the lumbar spine. (PE 4, p. 41). On March 6, 2018 he had worsening radiculapothy and impotence. After consultation with a neurologist he was recommended to call neurosurgery for an appointment tomorrow. (PE 4, p. 48). He was given steroids and a 3 day work note and was not allowed to return to work until he sees his primary doctor.

(PE 4, p. 48). He was reevaluated on March 7, 2018 and provided history of he referred back pain started while he was sitting at a computer chair when one of his coworkers yanked one side of his chair he was sitting and tilted and making him fall on the side. He is scheduled to see his MD on the eighth. (PE 4, p. 50). He returned to physical therapy on March 9, 2018. (PE 4 p. 56). On March 10, 2018 he was again examined at SIH Memorial Hospital of Carbondale for right upper extremity numbness and tingling which he states he had for the last two days it has been constant and had gotten worse not made better or worse by anything. Patient stated he was involved in an altercation about two weeks ago and he was picked up and states he was thrown to the ground and he does believe he landed on his right upper arm. (PE 4 p. 60). An MRI was performed on March 29, 2018 with the report of left lumbar radiculopathy fall with left buttock and leg pain radiating to the left foot. (PE 4 p. 195). The report indicates broad-base bulge with posterolateral slightly caudally directed extrusion and annular fissure impressing the thecal sac. (PE 4, p. 197). The AP diameter in the midline was reduced to about 7 mm there is stenosis in the subarticular space greater left and disk impression of the L5 nerve root.(PE 4, p. 197). Also noted broad-base disk bulge and small posterior protrusion impressing the ventrolateral thecal sac abutting the S1 nerve root at L5-S1. The diameter of canal of the midline is about 7mm. (PE 4, p. 197). He returned to physical therapy on March 14, 2018. (PE 4, p. 64).

An MRI from December 6, 2017 he underwent an MRI of the lumbar spine with contrast showed disk space desiccation and broad-based bulge eccentric to the left with an annular fissure. (PE 4, p. 180). This bulge demonstrates the left foraminal component there is some degenerative endplate changes as well as some moderate facet and ligamentous hypertrophy.(PE 4, p. 180). Also noted is this disk space desiccation and broad-based bulge and facet ligamentous hypertrophy at L5-S1. (PE 4 p. 180).

Medical Records from Dr. Gornet were offered into evidence as Petitioner's exhibit 5. The Petitioner was initially seen on May 21, 2018 with complaints in neck and the low back pain with the low back pain being the bigger issue. (PE 5, p. 9). The pain was centered to the left buttocks and left

numbness and tingling also had neck to the base of neck on bilateral trapezial pain with occasional tingling to his right forearm and hand. (PE 5, p. 9). Current problem began at least to this level of severity on February 28, 2018. (PE 5, p. 9). "He readily admits to a history of low back problems in the past." (PE 5, p. 9). He was working for IDOT and had an employee grab the chair causing the fall of the chair and land forward onto his right forearm hand and feet. (PE 5, p. 9). He does not feel that he fell all of the way to the ground but he has since had increasing pain in his low back left hip left groin and left leg. (PE 5, p. 9). He specifically reported a history of low back pain and noted to the doctor a history of low back pain of approximately three to four months prior to this current episode. (PE 5, p. 9). Dr. Gornet indicates the MRI shows foraminal narrowing left L5-S1 and disk herniation/annular tear at L4-5. Dr. Gornet recommended some medications and series of injections. (PE 5, p. 11). Patient was taken off work as of May 21, 2018. (PE 5, p. 12). He was again seen on June 7, 2018 bringing with him additional medical records including an op note from Dr. Backer he also provided notes from the Southern Illinois Healthcare and Dr. Gerson Criste and noted he had two epidural steroid injections. (PE 5, p. 34). Dr. Gornet's recommendation was for a transforaminal steroid injection at L4-5 and L5-S1 and Dr. Gornet advised it is our belief is that he has aggravated his underlying condition at L4-5 and L5-S1. (PE 5, p. 34). Dr. Gornet indicated that if the previous compression according to the operative note from Dr. Backer was at L4-5 on the right side and the symptoms were not on the left side. (PE 5, p. 34). Dr. Gornet indicated he continued to be off work.

Dr. Gornet reevaluated the Petitioner on September 17, 2018 and with still left sided pain. Pain was particularly in the low back left buttock and left hip, left groin left posterior thigh left anterolateral calf to the top of his foot. (PE 5, p. 39). This CT myelogram showed herniation at L5-S1 and L4-5. Dr. Gornet reviewed prior MRI scan of good quality from Memorial Hospital in Carbondale. (PE 5, p. 39). Dr. Gornet recommended an L5-S1 fusion and L4-5 disk replacement with stage posterior foraminotomy if necessary. Dr. Gornet specified that he does not believe this simple decompression will address the disc

pathology present at L4-5 and L5-S1 and then not believe the simply addressing the structural disc pathology would address the neural compressive pathology. (PE 5, p. 2).

Medical Records from Dr. Kaylea Boutwell were offered into evidence as Petitioner's Exhibit 6. Petitioner underwent a left L4-5 TFESI procedure on July 12, 2018. (PE 6, p. 3). A second injection was performed on July 26, 2018. (PE 6, p. 17).

Medical Records from CT Partners of Chesterfield were offered into evidence as Petitioner's Exhibit 7. This is the CT lumbar spine post myelogram indicated large central L4-5 and smaller central L5-S1 disk protrusions thicker to the left of the midline than the right at both levels. There is mild to moderate central canal stenosis at L4-5 and mild central canal stenosis at L5-S1.

Medical bills were offered into evidence as Petitioner's Exhibit 8. However to the party's knowledge there are no outstanding medical issues to date as to the best of their knowledge the medical bills had been paid by the Respondent's Workers' Compensation Third Party Administrator or the Petitioner's Group Health for which the Respondent is entitled to credit.

The Deposition of Dr. Matthew Gornet was offered into evidence as Petitioner's Exhibit 9. Dr. Gornet was educated at John Hopkin's School of Medicine and he is a board certified orthopedic surgeon. (PE 9, p. 4). Dr. Gornet noted that in the history from the patient was very forthright in regards to his prior issues in his low back including prior back surgery in 2005 and more recent episodes in 2017. (PE 9, p. 8). An MRI from March 29, 2018 was reviewed which revealed a foraminal narrowing on the left at L5-S1 and a central herniation/annular tear at L4-5. (PE, 9 p. 9) The working diagnosis was irritation of some disc pathology at L4-5 and L5-S1 and a recommendation for further conservative care with epidural steroid injections. (PE 9, p. 9). Dr. Gornet indicated that the mechanism of injury described by the patient pulled out of the chair by a coworker is consistent with the type of mechanism can cause or aggravate the type of spine condition he is treating. (PE, 9 p. 9). He reevaluated the patient on June 6, 2018 were in the patient brought in his prior medical records consisting of operative reports and injections from Dr. Criste. (PE 9, p. 10). Dr. Gornet recommended steroid injections at L4-5 and L5-S1

for purpose of trying to calm down the inflammation that occurs from this type of injury. (PE 9 p. 11). On August 6, 2018 the patient was evaluated for neck pain and back pain and they placed his neck on hold. (PE 9, p. 11). They reviewed the injections done June 12 and June 26, 2018 which did not provide any sustained relief. (PE 9, p. 11). Recommendation was made for CT myelogram. (PE 9, p.12). The failure of the injections indicates the patient has not returned back to base line and therefore going to require additional treatment because he is not maximized conservative care. (PE 9, p. 12). The purpose of the myelogram was to locate any bony issues such as facet changes foraminal narrowing that would not be readily seen as well on an MRI. (PE 9, p. 12). The next examination was on December 17, 2018 in the CT myelogram showed the similar pathology as seen on the MRI of herniation on the left at L5-S1 and the facets at L4-5 appeared to be normal. (PE 9, p. 13). Dr. Gornet advised the patient that he did not feel that a simple decompression would address the problems at L4-5 and that he would probably require a fusion at L5-S1 and it is disc replacement at L4-5. (PE 9, p. 13). Dr. Gornet continued to have the patient temporary totally disabled and reevaluated him on February 18, 2019. Dr. Gornet advised the basis of the L4-5 disc replacement and L5-S1 fusion was the best option to give him a result of returning to work full duty with no restrictions. (PE 9, p. 14). The goal is to cure and relieve the effects of the work related injuries and Dr. Gornet believes he's suffered an aggravation of his underlying condition. (PE 9, p. 14). Dr. Gornet also noted that he may still require posterior foraminotomy at L4-S1 in addition to what we're treating him anteriorly but the hope is that can be avoided. (PE 9, p. 14). Dr. Gornet further noted that there is structural back pain that will not be cured with the simple decompression. (PE 9, p. 14). Dr. Gornet clarified that his causal of connection opinion assumes that his verbal history is factually correct that the event did occur and again his complaints have not return to baseline. (PE 9, p. 15). Dr. Gornet clarified that this is a different problem that had occurred in 2005 and although he clearly had structural back pain with the test ordered 2017 by Dr. Criste significant mention of leg pain which would further indicate that this is progression at least symptomatically. (PE 9, p. 15). Dr. Gornet had an opportunity to review the IME report of Dr. Robson and stated that aggravation of a preexisting condition

does not always indicate a change in the MRI. (PE 9, p. 15). He clarified that if there was a significant change in the MRI that would be a new injury so aggravation is some change in his status or will being before he was coping with this albeit symptomatically he was working full duty he now has at least by the record new onset of symptoms and change in his physical examination and those changes have not resolved. (PE 9, p 15-16). Dr. Gornet stated that answering the question honestly he does not believe the MRI has changed and therefore there's probably a different inflammatory state involved in his low back and that nerve root is irritated that unfortunately not be able to calm it down and his only option is surgery. (PE 9 p. 16). Symptoms are always the major component of disc surgical decision making and there have been many studies shown that you can have a pathology on an MRI and be asymptomatic (PE 9, p. 16). In this situation symptoms are what drive him to the doctor the symptoms are what drive him toward an intervention because they have not returned to baseline and still affect his quality of life his ability to function and his ability to work at the most productive levels. (PE 9, p. 17). Dr. Gornet reiterated he believes the patient aggravated his underlying degenerative condition in his lumbar spine making him more now symptomatic regarding his back pain because he clearly had a problem there before but also more significate left-sided pain and these symptoms have not been brought back to baseline. (PE 9, p. 17).

On cross examination Dr. Gornet was asked to pin point the symptoms he has provided as causation opinion for and he clarified that it is his opinion that subjectively he has increased his symptoms in his neck but his back has been the bigger issue so he placed his neck on hold until they addressed the issues with the back. (PE 9, p. 21). He stated with a reasonable degree of medical certainty that he feels that he has some increase symptom in his neck as result of this, but he can clarify beyond that. (PE 9, p. 21). He also was able to pin point as to the L4-5 and L5-S1 levels of the lumbar spine. Dr. Gornet also clarified that the leg pain at least at this level of severity is a direct on the left side direct result of the accident of 2/28. (PE 9, p. 22). Dr. Gornet did not contribute any opinion related to just foot numbness only numbness in the L5 distribution. (PE 9, p. 23). Dr. Gornet indicated that the abdominal and pelvis pain

is something he rather a medical doctor to rule out but the groin pain could be connected with narrowing of the L5-S1 pathology but abdominal pain is unlikely related to this injury. (PE 9, p. 23). Dr. Gornet also clarified that he believes testicular pain is related to this injury. (PE 9, p. 23). Dr. Gornet was asked about the mechanism of injury and indicating he came out of the chair landed on his arm and feet, but did not fall all the way to the ground that is what he reported to the doctor. (PE 9, p. 26). The Petitioner did not fall all the way to the ground does not speak to the level of force because the force is the same it's just whether that force is dissipated through the arm or legs and so forth so the force of him moving his body from the chair to the ground is identical. (PE 9, p. 27). The force may have been dissipated through the use of his arm and leg it could also in addition still cause an injury to the low back. (PE 9, p. 27).

At the initial examination the issues that caught Dr. Gornet's attention was the fact the patient had a little bit of decreased sensation in the L5 dermatome as well as EHL ankle dorsiflexion and plantar flexion on the left. (PE 9, p. 28). So a little bit of foot issues as far as strength and the L5 distribution to light touch as well as a decrease in the C6 dermatome on the right side of his upper extremities. (PE 9, P. 28). It was Dr. Gornet's impression that neurological symptoms were not as much as an issue as the back buttock and hip, but issue as the back buttock hip and groin pain so those were more significant as far as disabling to him with the leg pain being a component of that but not as big as the structural back, buttock and groin pain. (PE 9, p. 29). Dr. Gornet reviewed both the March 29, 2018 and the December 6, 2017 film and his opinion there is no sustainable change in comparison. (PE 9, p. 30).

Dr. Gornet's opinion as to causation is based upon the subjective increase in complaints and the verbal history provided by Mr. Miller. (PE 9, p. 35).

Dr. Gornet was not concerned with the amount of opiate pain medications the petitioner had received in the past as he reviewed the State website for him and there were two minimal prescriptions of 20 tablets so the issue was minimal. (PE 9, p. 39). By FDA clinical standards, an exacerbation would have resolved or been nearly resolved after six weeks where people rapidly change back to normal and there is no indication Mr. Miller was on that pathway. (PE 9, p. 46). In February of 2019 Dr. Gornet

encouraged Mr. Miller to try and work the best he can as it is better for him to remain active. (PE 9, p. 52).

When asked if the MRI's do not correlate due to the increase in pain without change on the MRI, Dr. Gornet explained that symptomology is based on an inflammatory response. (PE 9, p. 56). You can have a herniation and it be asymptomatic. (PE 9, p. 56). Dr. Robson agreed that injections were appropriate which are not going to relieve the nerve compression, but it changes the inflammatory environment which is causing the symptoms. (PE 9, p. 56).

The form 45 first report of injury was offered into evidence as Respondent's exhibit 1. It lists that the injury occurred when a co-workers picked up the left side of the chair and lifted it and swung the employee out of the chair. Petitioner reported the left side of his body was numb, leg him, and groin, left knee aches with stabbing pain in the left groin.

The supervisor's report of injury was offered into evidence as Respondent's exhibit 3. The document states, "I was told Craig Lester dumped Steve Miller out of a chair." It also lists Craig Lester as the negligent part. The witness statement of Tony Graham was offered into evidence as Respondent's exhibit 4. It states that Craig Lester went over to the chair and took a hold of the back and arm of the chair and tipped Steve Miller over until Steve got out.

The IME report of Dr. Robson was offered as Respondent's exhibit 5. Dr. Robson examined the petitioner on December 4, 2018. (RE 5, p. 1). Dr. Robson took a history of the patient and provided a comprehensive summary of the medical documentation he reviewed. (RE 5, pp. 1-4). Dr. Robson diagnosed a disc herniation at L4-5 and disc protrusion at L5-S1). (RE 5, p. 5). Upon comparison of the pre and post injury MRI, Dr. Robson did not see any interval changes in the disc pathology. (RE 5, p. 5). He opined the patient had a temporary exacerbation of his underlying calcified disc herniation at L4-5 and L5-S1. (RE 5, p. 5). Dr. Robson believes the physical therapy and injections were appropriate, but does not believe surgery is related to the work accident. (RE 5, p. 5). He also believed the Petitioner suffered a

temporary exacerbation of the cervical spine. (RE 5, p. 5). He placed the Petitioner at MMI for the work injury. (RE 5, p. 5).

Dr. Robson's deposition was offered into evidence as Respondent's exhibit 6. Dr. Robson is a board certified orthopedic spine surgeon that practices in St. Louis MO. (RE 6, p. 5). Dr. Robson reiterated the findings and opinions summarized in his report, but believed the petitioner's conditions were exacerbated by the trauma he received. (RE 6, p. 11). It was his belief the exacerbation was temporary until there is a return to baseline. (RE 6, p. 11). His review of the MRI from before the injury and the MRI after the injury was that they were virtually identical with no structural change. (Re 6, p. 12). Dr. Robson agreed the physical therapy and injections received by the petitioner related to the work injury were reasonable and necessary. (RE 6, p. 16). He also believed the Petitioner could be a candidate for surgery,but did not relate it to the work accident. (RE 6, p. 16). Although the Petitioner had been seeking treatment prior to the work accident, he had not been Offered surgery. (RE 6, p. 22). Dr. Robson agreed that he has seen patients that do not have a change in the objective studies, but the subjective pain increases. (RE 6, p. 22).

Respondent offered the reports of the MRI of the Petitioner's lumbar spine of the dated December 6, 2017 and March 29, 2018 into evidence. The MRI's were discussed at length by both experts.

Medical records from Shawnee Health were also offered into evidence as Respondent's exhibit 9. The relevant portions of these records have been summarized above and discussed by both Dr. Gornet and Dr. Robson.

The Arbitrator Hereby makes the Following Conclusions:

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

The parties did not dispute an incident occurred while the petitioner was at work. Dr. Robson, the Respondent's section 12 examiner agreed the petitioner did suffer an injury at the time of the events in this case that exacerbated his underling medical condition. It appears the Respondent is disputing the case on an arising out of theory. However, it is not clear what specific arising out of defense it is raising

in this case. All of the witnesses confirmed that the employees were sitting in an IDOT field office. The petitioner had specifically gone to this office to use the rest room and warm up due to the bad weather. Sitting in a field office discussing work is within the normal course and scope of employment for IDOT employees on winter assignment to field offices. Petitioner was not engaged in any activity that would take him out of the course and scope of his employment as he was in an IDOT office during work hours as they would be any day of the year.

While this incidence may be classified as an altercation, it was a disagreement over a work chair, bringing it under the coverage of the Act. No evidence was presented to suggest that at any time the petitioner was the aggressor and removed himself from his employment. No evidence was presented that this dispute was about anything other than a work chair. The supervisor's report of injury lists Craig Lester as the Negligent party in the eyes of IDOT. Therefore, the Arbitrator concludes the Petitioner suffered an accident that arose out of and in the course of his employment with the Respondent.

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

The Respondent's section 12 examiner and Dr. Gornet agree that the petitioner injured his low back at the time of the chair incident on February 28, 2018. Both parties agree the petitioner had a preexisting medical condition and had been treating for that condition. The causation issue in this case hinges on whether the petitioner's condition had returned to "base line" or his pre accident state by the time of the December 4, 2018 IME by doctor Robson or whether his condition was on going at the time of Arbitration. Dr. Gornet was able to not only review the medical records provided to him, but also the IME report of Dr. Robson which contained a comprehensive summary of the petitioner's pre-existing medical condition. The only evidence that the pre-accident medical condition affected his ability to work is that the petitioner was late to work one day due to back pain. After the accident the petitioner was taken off work due to the increase in pain by his physicians. The escalation in both the frequency of the treatment and the nature of the symptoms being reported after the accident leads the Arbitrator to conclude the petitioner's condition is causally related to the accident.

K. Is Petitioner entitled to any prospective medical care?

The Respondent's IME physician Dr. Robson did not dispute that additional medical care consisting of surgical intervention may be necessary. However, Dr.Robson found the Petitioners need for surgery was not caused by the accident. Moreover, the Arbitrator found Dr. Robson to be more credible than Dr. Gornet. Accordingly, the Arbitrator does not award prospective medical care as recommended by Dr. Gornet.

L. What temporary benefits are in dispute?

The Petitioner claims temporary total disability benefits from September 25, 2018 through November 12, 2018. Pursuant to Dr. Gornet's recommendations regarding Petitioner working, the Arbitrator finds the Petitioner to be temporarily totally disabled for the time claimed, which is within the period of time Dr. Gornet had him off work.

Therefore, the Arbitrator awards TTD from September 25, 2018 to November 12, 2018. The Respondent is entitled to a credit for TTD they have paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC007557
Case Name	MAC DONALD, CINDY v. PLAINFIELD SCHOOL DISTRICT 202
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0457
Number of Pages of Decision	42
Decision Issued By	

Petitioner Attorney	Gary Newland
Respondent Attorney	Nathan Bernard

DATE FILED: 9/09/2021

/s/Kathryn Doerries, Commissioner

Signature

21IWCC0457

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CINDY MAC DONALD,

Petitioner,

vs. NO: 13 WC 07557

PLAINFIELD SCHOOL DISTRICT 202,

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, notice, temporary total disability, medical expenses, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's decision as to accident, causal connection, notice, denial of maintenance, medical expenses, permanent partial disability regarding the left leg, and other-any and all other issues raised at hearing. The Commission modifies the Arbitrator's award regarding temporary total disability (TTD) and permanent partial disability (PPD) as stated below.

The Commission modifies the award of TTD benefits based on a careful review of the evidence. The Arbitrator awarded TTD benefits from February 7, 2013 through April 8, 2014 (60-4/7 weeks) when Petitioner was determined to be at MMI. The Commission notes that that Petitioner applied for and was approved for disability retirement benefits by the Teachers Retirement System effective November 30, 2013 (RX 6). However, Petitioner was offered a position within her restrictions but voluntarily chose to retire. Respondent's witness, Ms. Orlos, testified a teaching job with a 15 pound lifting restriction was definitely one they could accommodate. She further testified she was sure they had accommodated Petitioner's restrictions as of October 28, 2013. Ms. Orlos testified they have accommodations for people in wheelchairs, sitting and teaching. (T.193-198) Ms. Orlos testified when they offer job accommodations, they just want the employee to do essential functions of the job as the main goal. For Petitioner, they had accommodated the weight limit and hours, and, if she needed to lay down, she could. Ms. Orlos testified that in her opinion, the accommodations from October 2013 through the date of

hearing have always been offered and continue to be offered. It was open ended. (T.202-203).

Although Dr. Sokolowski did not find Petitioner to be at MMI until April 9, 2014, after the FCE, Respondent is not liable for TTD benefits after November 29, 2013 as Petitioner was offered a job within the restrictions stated by Dr. Sokolowski, and Petitioner opted to retire. Again, Respondent's witness, Ms. Orlos, testified to the ongoing offer of an accommodated position since that time to the date of the hearing. The Commission finds Ms. Orlos' testimony credible and corroborated by the written letters confirming the accommodation. (RX9) Based on the foregoing, the Commission finds that Petitioner was offered a job within her restrictions and she chose not to accept the job. Therefore, she is not entitled to TTD benefits after November 29, 2013.

The Commissioner further finds that Petitioner returned to work from October 28, 2013 through October 30, 2013, as noted in RX10, and is therefore not entitled to TTD benefits for that period. Petitioner testified she was unable to work again starting October 31, 2013.

Based on the evidence, the Commission modifies the TTD award to February 7, 2013 through October 27, 2013 (37-4/7 weeks) and October 31, 2013 through November 29, 2013 (4-2/7 weeks).

The Commission performs an analysis under Section 8.1(b) as follows:

1) There was no impairment rating performed so this factor is given no weight.
2) Petitioner worked as a teacher for Respondent prior to her right wrist/forearm, left shoulder, left knee, and low back injuries. Petitioner testified she has been unable to return to her same occupation, even though Respondent did provide accommodations to return her to her same occupation. Petitioner, however, voluntarily retired when she was approved for disability benefits effective November 30, 2013. This factor is given moderate weight.
3) Petitioner was 54 years old at the time of her injury. This factor is given some weight.
4) Petitioner testified she had been unable to return to her former vocation, however, Ms. Orlos testified Respondent had, from October 2013 through date of hearing, offered Petitioner work within her restrictions. Petitioner did not make any further attempts to return to the accommodated work offered. Petitioner applied for and was approved for disability retirement benefits effective November 30, 2013. Petitioner essentially removed herself from the job market rather that returning to the accommodated work continually offered. This factor is given some weight.
5) Petitioner sustained a work-related low back injury, right wrist/forearm injury, and left shoulder injury. Dr. Sokolowski's diagnosis was lumbar pain with radiculopathy. (PX11) The MRI of April 12, 2013, showed T12-L1 disc protrusion, L4-5 disc bulge, facet arthrosis at different levels, stenosis, disc desiccations, annular fissure L5-S1 and multiple levels of degenerative disc disease. (PX 9) The MRI of November 7, 2017, noted L4-5 trace left paracentral posterior disc protrusion, improved from the prior examination. (PX11) Petitioner was diagnosed with a right forearm/wrist contusion strain by Dr. Meyer at Rezin Orthopedic on February 11, 2013. Petitioner underwent numerous treatment modalities, including

injections, and at no time was surgery recommended or suggested. Petitioner continues to take medications, including hydrocodone, Gabapentin, Tizanidine, and Pantoprazole (T.115-123). Petitioner testified she has ongoing low back pain and radiating leg pain. Petitioner testified that her right wrist and forearm were "okay". Petitioner testified her main source of pain was her low back and right shoulder, which was not causally related. Petitioner received very minimal left shoulder treatment. Respondent's IME physician, Dr. Zelby, opined Petitioner's complaints were inconsistent with objective medical findings and with the natural history of Petitioner's objective medical condition. Dr. Zelby opined Petitioner did not need any injections for her lumbar spine and he found Petitioner to have reached MMI by June 2013 with no restrictions needed. (RX 1) Respondent's IME physician, Dr. Monaco, opined Petitioner had suffered a mild strain/contusion to her right wrist/forearm. He indicated there were signs of symptom magnification. (RX 2) This factor is given considerable weight.

In reviewing the totality of the evidence, including records of Rezin Orthopedics, Illinois Sports Medicine, Dr. Sokolowski, Dr. Campobaso, Dr. Prodromos, Kalina Pain Institute, Athletico, Champion Fitness Physical Therapy, Modern Pain Consultants, Section 12 examiners, Dr. Zelby and Dr. Monaco, vocational evaluator, Lisa Helma, and vocational consultant, Sharon Babat, the Commission finds that the Arbitrator issued an award for permanency that is excessive and not supported by the evidence, and not specific to address the different body parts injured.

The Commission notes that Petitioner returned to work for Respondent on October 28, 2013, in a position within her restrictions. Petitioner testified that on that day, she went to the nurse's office to lay down but left because there were children present. Petitioner did not ask the nurse if she could lay down elsewhere in the office. Ms. Orlos testified she sent an e-mail to Petitioner who responded the day had gone fine and Petitioner outlined what her 4 hours would be for the next day. Ms. Orlos testified Petitioner had no complaints regarding the accommodations at that time. Ms. Orlos testified she was unaware of any 'lay-down' complications. (T.200-201)

Petitioner agreed the accommodations were the same at that time as the FCE in 2014, and Petitioner did not contact Respondent about returning to work at that point. The Commission finds accommodations were continually offered. (PX30T) Ms. Orlos testified a teaching job with a 15 pound lifting restriction is definitely one they could accommodate and one she was sure they had accommodated on October 28, 2013. She indicated they have accommodations for people in wheelchairs, sitting and teaching. (T.193-198) Ms. Orlos testified that, in her opinion, the accommodations from October 2013 through current have always been offered, and continue to be offered, as it was open ended. (T.202-203)

Petitioner's vocational expert, Lisa Helma testified Petitioner suffered a loss of occupation given the FCE restrictions and Petitioner had no access to any type of stable job market. (PX27, p.13) Petitioner, however, testified she currently has a tutoring business that she operates out of the local library. (T.161) Petitioner's income tax records further show Petitioner operated two other side-businesses, i.e., authoring a book, "Embracing the Self", and Inspiring Home Solutions Real Estate Investing. (RX12) The Commission does not find Ms. Helma's opinion persuasive.

Respondent's vocational expert, Sharon Babat, testified Petitioner could return to work in a stable job market earning the same income as before the accident. (RX3). Ms. Babat testified Petitioner had transferable skills and could apply for other teaching jobs, as well as receptionist, clerk, customer service and sales jobs. Ms. Babat noted Petitioner had not conducted any self-directed job search. She noted given the restrictions set out in the April 2014 FCE, there were several positions, including teaching, that Petitioner could obtain that allowed for alternating positions as needed. (RX 3, p.23) Ms. Babat testified that even considering the restrictions per the FCE, Petitioner could return to work as a teacher. (RX 3, p. 32)

The Commission finds the opinions of Ms. Babat to be more persuasive than Ms. Helma. Ms. Babat opined Petitioner had the ability to return to work as a teacher, even with the restrictions set forth by the FCE, and the same restrictions prescribed by Dr. Sokolowski in October 2013. Petitioner voluntarily applied for and received disability retirement, which became effective November 30, 2013, therefore, Petitioner removed herself from the work force. The Commission finds that Petitioner failed to meet her burden, by a preponderance of the evidence, to prove loss of trade.

Based on the above, when considering the five factors, the Commission modifies the Arbitrator's award of 35% loss of use of a person as a whole to an award of 10% loss of use of a person as a whole for her low back injuries under Section 8(d)(2) of the Act. The Commission further finds Petitioner is entitled to an award of 2% loss of use of a person as a whole for her left shoulder injury under Section 8(d)(2) of the Act. The Commission finds Petitioner is entitled to an award of 3% loss of use of a right arm for Petitioner's right wrist/forearm injuries under Section 8(e)(10) of the Act. The Commission affirms the 1% loss of use of the left leg.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $743.68 per week for a period of 41-6/7 weeks-(2/7/13-10/27/13 and 10/31/13-11/29/13), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.31 per week for a total period of 69.74 total weeks, as provided in §8(d)(2) and §8(e)(10) & (12) of the Act, for the reason that the injuries sustained caused the 12% loss of use of Petitioner's person as a whole (60 total weeks for person as a whole for low back & left shoulder) and a 3% loss of use of Petitioner's right arm (7.59 weeks) and 1% loss of use of the left leg (2.15 weeks).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses as identified in PX 2, PX 4, PX 6, PX 8, PX10, PX12, PX14, PX 16, PX18, PX20, PX24, and PX33 under §8(a) of the Act.

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

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

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

SEPTEMBER 9, 2021

o-7/13/21
KAD/jsf

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

MacDONALD, CINDY Case# **13WC007557**
Employee/Petitioner

PALINFIELD SCHOOL DISTRICT 202
Employer/Respondent

On 10/2/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.79% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4963 NEWLAND & NEWLAND LLP
GARY A NEWLAND
121 S WILKE RD
ARLINGTON HTS, IL 60005

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

STATE OF ILLINOIS

COUNTY OF WILL

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

Cindy MacDonald
Employee/Petitioner

Case # **13 WC 7557**

v.

Consolidated cases:

Plainfield School District 202
Employer/Respondent

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

DISPUTED ISSUES

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

ORDER

On **February 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $58,007.04; the average weekly wage was **$1,115.52**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $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 $22,391.24 under Section 8(j) of the Act.

ORDER

The Arbitrator finds Petitioner's left knee, left shoulder, right lower back, and right wrist and forearm conditions are causally related to her work accident of February 7, 2013. The Arbitrator finds that Petitioner's right shoulder condition is not causally related to her accident of February 7, 2013, as set forth in the Conclusions of Law attached hereto;

Respondent shall pay for only those services related to Petitioner's low back, left shoulder, left knee and right wrist and right forearm, pursuant to sections 8(a) and 8.2 of the Act, subject to medical fees schedule, as identified in Petitioner's exhibits 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24 and 33. Respondent shall receive a credit, pursuant to Section 8(j), for medical bills paid by Respondent , as set forth in the Conclusions of Law attached hereto;

Petitioner was temporarily and totally disabled from February 7, 2013 through April 8, 2014 that date Petitioner was determined to be at MMI. As such, Petitioner is awarded TTD benefits from February 7, 2013 through April 8, 2014 or 60 4/7 weeks at the TTD rate of $743.68, as set forth in the Conclusions of Law attached hereto;

Petitioner has sustained a loss of occupation due to her permanent restrictions related to the accident and she may have some difficulty finding comparable alternate employment. Based upon the evidence presented, the Arbitrator finds that the Petitioner remains employable. Therefore, the Arbitrator finds that Petitioner suffered permanent partial disability to the extent of 35% loss of man as a whole pursuant to Section 8(d)(2) of the Act, as set forth in the Conclusions of Law attached hereto;

Respondent shall Petitioner compensation that has accrued from February 7, 2013, though June 12, 2019, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator — 6/2/2019 Date

OCT 2 - 2019

Procedural History

This case was tried on June 12, 2019. The disputed issues are whether Petitioner sustained an accidental injury 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 medical bills; whether Petitioner is entitled to TTD, TPD and/or maintenance benefits; whether Respondent is entitled to a credit for benefits claimed to have been paid totaling $22,391.24 and the nature and extend of the injuries. The parties stipulated that Petitioner's average weekly wage was $1,115.52, Petitioner was 54 years old at the time of the injury and the Parties stipulated that Respondent paid $22,391.24 of Petitioner's medical expenses. (Arb. Ex.# 1), (T. 10).

Petitioner claims to have injured her right arm, hand, low back, knees and shoulders as a result of a fall at work. Petitioner claims to be permanent and totally disabled, pursuant to Section 8(f) of the Act, under an odd lot category. Respondent acknowledges that Petitioner fell at work but only injuring her right wrist and forearm, not her back and shoulders, and she could return to work.

Finding of Facts

Cindy MacDonald (hereinafter referred to as "Petitioner") testified that she worked for Plainfield School District 202 (hereinafter referred to as "Respondent") as a second-grade teacher. Prior to February 7, 2013, Petitioner was employed by Respondent for 13 years. Petitioner testified that she has a master's degree in educational leadership, a Bachelor of Arts degree and is certified in teaching and education leadership. (T. 138). Petitioner testified that prior to February 7, 2013, she had no prior problems with her low back, arms and right shoulder. Petitioner received medical treatment for her left shoulder prior to 2013. (T. 130).

Petitioner testified that on February 7, 2013, she tripped and fell in a classroom. Petitioner testified that she assumed she tripped over one of the children's chairs as they pulled them out after returning from a bathroom break. (T. 60). Petitioner testified that she tripped falling hard on her hands and knees. Petitioner testified that her back bent forward as her stomach struck the floor. Petitioner described the position of her body as a "concaved" position. Petitioner testified that she felt immediate sharp pain in her lower right back, right arm and right wrist. Petitioner testified that her right arm was in bad shape and that she could barely move it. (T. 61, 62).

Petitioner testified that she found another teacher to cover for her, so she could go to the school nurse, Marie Taylor. Petitioner testified that she told Ms. Taylor what happened, and Ms. Taylor asked Petitioner to come back later because there was a lot of kids in her room. Petitioner returned to Ms. Taylor after lunch and, at that time, Ms. Taylor filled out an accident report. Petitioner testified that she signed the accident report without reviewing it and that she was advised, Ms. Taylor, to go to Corwin Medical Center. (T. 63, 64).

Respondent submitted the Employee Accident and Injury Investigation Form, completed by Ms. Taylor, signed by Petitioner, into evidence, which stated that on February 7, 2013, at 10:30, Petitioner was injured after tripping and falling in a classroom. The Employee Accident Form also stated that Petitioner injured her right wrist and she complained of forearm pain and that no edema or redness was noted. (RX 4b).

Later that day, on February 7, 2017, Petitioner sought medical care at Adventist Bolingbrook Hospital. The medical records states that Petitioner reported falling forward onto her right wrist and forearm. The records further state that Petitioner had forearm pain at the proximal area, the wrist was tender and that no edema or discoloration was present. X-rays of the right forearm was taken showed no evidence of a fracture. (PX1).

Petitioner testified that after being released from the hospital she scheduled an appointment at Rezin Orthopedic. Petitioner testified that over the weekend she was unable to use her right arm and she developed left shoulder and knee pain. (T. 65, 66).

On February 11, 2013, Petitioner sought treatment at Rezin Orthopedics. Petitioner was examined by Dr. Raymond Meyer. The records indicate that Petitioner weighed 130 pounds and she was 5 feet 5 ½ inches tall. The records state that "*The patient is a 54-yer-old left-hand-dominant female who presents for initial evaluation regarding right wrist and forearm injury she sustained while teaching at work on 02/07/2013. The Patient states that she caught her foot possibly on a desk chair and fell landing on her bilateral wrist and knees. She complained primarily of right wrist and forearm pain. She states she was having some knee pain as well, but this was not initially reported. She has only been cleared to evaluate her forearm and wrist.*" The examination showed subtle swelling about Petitioner's right hand and digits with diffused tenderness from the proximal middle and distal third of the forearm, primarily over the interosseous region and radius. Tenderness was noted at the elbow or radiocapitellar joint. Petitioner was diagnosed with a right forearm/wrist contusion and sprain and was placed on light duty. (PX 3)

Petitioner testified that she reported additional complaints to Dr. Meyer but he refused to treat her other complaints because workers' comp only approved treatment for the arm. Petitioner testified that she argued with Dr. Meyer who refused to treat her other complaints. (T. 67).

Petitioner testified that she contacted Nurse Taylor on February 16, 2013, via email, and advised her that she was having problems with her back, knee and left shoulder. Petitioner testified that Nurse Taylor did not respond. Petitioner testified that she contacted Nan Burt, at the District Office, via email on February 20, 2013, and informed Ms. Burt that she was experiencing problems with her back, left shoulder and knee. Petitioner testified that she wanted to amend the injury report but was told that she could not and that she could only receive treatment for her right arm. Petitioner testified that she wanted to amend the injury report, so she could

receive treatment for her back, left knee and left shoulder. Petitioner testified that she did not know what to do so she went to a different doctor. (T. 67-75).

Petitioner introduced into evidence an email sent to Nurse Taylor, dated February 16, 2013, which states "*THANKS FOR CHECKING ON ME. I'M OK. Sore. My arm, knee back, other shoulder, the one I hurt last year because I am using it so much. Today my neck hurts. This has been an experience. Workman's comp as been a trip too. I am hanging in there. Go back to the ortho in a week from Tuesday...*" (PX 30A). Petitioner also introduced into evidence an email sent to Nan Burt, dated February 20, 2013, which states "*Since Marie did not put my lower right back, my left knee, and left shoulder on my accident report, I would like those added right away please. I want to make sure that the doctor can look at those when I return to see him on Monday...I was in shock when Marie filled out the report and signed without looking at it. I assumed she put those things on it.* (PX 30A1)

On February 25, 2013, Petitioner was examined by Dr. Prodromos. At that time, Petitioner completed a Patient Registration form. Petitioner listed the problems to address as the left knee, left shoulder, right lower back, and right wrist and forearm. Petitioner told Dr. Prodromos that she was injured, on February 7, 2013, after tripping and falling in a classroom. On the form, Petitioner wrote that the injury occurred when she went down on her hands, knees and stomach.

The medical records show that Petitioner's chief complaints were left knee pain, left shoulder pain and low back pain. Petitioner's left knee pain was primarily anterior and the records state that Petitioner's pain was resolving. Petitioner was diagnosed with a left patella contusion. The records also state that Petitioner's shoulder was still painful but feeling much better and the examination showed full range of motion, no AC tenderness, negative Speed Test, good strength and positive mild coracoid tenderness. Dr. Prodromos noted that, the previous year, Petitioner was diagnosed the prior year with a frozen shoulder, which required many months of physical therapy to resolve and that a prior MRI, showed a partial-thickness rotator cuff tear. Petitioner was diagnosed with left shoulder mild rotator cuff strain and possible SLAP injury. Petitioner reported that her back hurt after falling and was feeling better but some pain was still present. The examination showed pain in the right paralumbar area and centrally. Petitioner could forward bend to 90 degrees with only mild discomfort. Petitioner was diagnosed with a resolving lumbar strain. (PX 5).

Petitioner returned to Dr. Prodromos on February 28, 2013. At that visit, Petitioner reported her left shoulder pain was feeling much better but still painful. Dr. Prodromos noted the left knee pain was resolving. Petitioner reported that she was experiencing some pain the pain back was resolving. Petitioner followed up with Dr. Prodromos on March 8, 2013. The examination of the left knee showed mild tenderness to deep palpation over the patella. Petitioner had no patellofemoral crepitus, no effusion, no joint line tenderness.

Petitioner's gait was normal. Dr. Prodromos diagnosed left patellar contusion. The examination of the left shoulder full range of motion, no AC joint tenderness, Negative Speed Test, good strength and mild coracoid tenderness. Dr. Prodromos diagnosed a left shoulder mild rotator cuff strain. Regarding the low back, Dr. Prodromos noted that Petitioner was feeling but that she still reported some pain.

On March 11, 2013, Petitioner returned to Dr. Prodromos. Petitioner reported that her left knee pain was feeling much better. Dr. Prodromos also noted that the left shoulder strain was improving, and Petitioner needed no treatment. Petitioner complained of right shoulder pain. Petitioner reported that her right shoulder was bothering her a little bit and she believes it may be from overusing it since she was using her left arm less. The examination showed a full range of motion, good strength, no tenderness. Petitioner described some posterior pain. Dr. Prodromos assessed shoulder strain or possible SLAP injury.

On March 23, 2013, Petitioner underwent an MRI of the Right shoulder. The MRI showed no evidence of a full thickness rotator cuff tear, a mild area of T2 high signal intensity within the humeral neck was nonspecific and could be due to mild marrow contusion, there was a small fluid collection in the subdeltoid and subacromion bursa.

On April 1, 2013, Petitioner returned to Dr. Prodromos. Petitioner's chief complaint was listed as right shoulder pain. Dr. Prodromos noted the MRI was negative except for some tendinopathy. Dr. Prodromos noted that Petitioner was complaining of posterior pain in the right shoulder. Dr. Prodromos stated that because the MRI was negative and Petitioner was having clinical signs of a SLAP lesion he ordered an MRI arthrogram of the right shoulder. As to the low back, Petitioner reported that she was feeling better but it was still sore. The examination of the low back showed full range of motion. Dr. Prodromos recommended physical therapy which Petitioner declined.

On April 3, 2013, Petitioner was examined by Dr. Joseph Monaco, pursuant to Section 12 of the Act. Petitioner told Dr. Monaco that she fell after both of her feet got tangled up with the children and possibly a chair causing her to fall on all fours. Petitioner stated that most of the fall went on the left knee and right wrist and then to her belly. Petitioner reported pain in her right lower back.

Regarding he left knee, Petitioner reported that her knee was better, but she still had some pain over the patella that was worse with kneeling or sitting. Regarding the low back, Petitioner reported constant low back pain with tingling and numbness down her right leg.

Regarding he right shoulder, Petitioner reported more pain in the anterior shoulder than the posterior shoulder which, she said, increased with use. Regarding the left shoulder, Petitioner reported pain mostly over the lateral aspect of the left shoulder and in the pectoral areas.

Dr. Monaco noted that Petitioner's was 5 foot 6 ½ inches tall and she weighed 132 pounds. Dr. Monaco's examination of the lumbar spine showed no acute distress, no paralumbar muscle spasms and she had a negative straight leg raise test. Dr. Monaco opined that, as result of the work-related incident of February 7, 2013, Petitioner sustained a strain/contusion of her right wrist and forearm, mild contusion of the left knee in the patella area. Dr. Monaco opined that Petitioner's low back, right and left shoulder complaints were unrelated to her work-related incident of February 7, 2013. Dr. Monaco noted that Petitioner's initial treatment records showed no complaints of back pain and that the mechanism of injury was inconsistent with Petitioner's complaints of low back pain. Dr. Monaco further opined that there was evidence of symptom magnification and that Petitioner's complaints were inconsistent with the objective findings. Dr. Monaco placed Petitioner at maximum medical improvement. (RX 2a).

On April 12, 2013, Petitioner underwent the MRI of the right shoulder arthrogram injection and an MRI of the low back. The MRI arthrogram of the right shoulder showed a partial-thickness articular surface subscapularis tendon tear and mild acromioclavicular joint hypertrophy. The right shoulder arthrogram showed a partial-thickness articular surface subscapularis tendon tear and mild acromioclavicular joint hypertrophsy. The MRI of the low back showed multilevel degenerative spondylosis, a diffused disc bulge at L4-L5, which was asymmetric to the right encroaching upon the inferior aspect of the right neural foramen, and a disc desiccation with a small disc bulge and annular fissure at L5-S1. (PX 5).

On April 15. 2013, Petitioner followed up with Dr. Prodromos. At this visit, Petitioner reported that her shoulders felt better. Petitioner stated that her left shoulder was still bothering her a little in the front. Dr. Prodromos discharged Petitioner from care for both shoulders. Dr. Prodromos indicated the lumbar MRI showed a herniated disc at the thoracolumbar junction and he referred Petitioner to a doctor for her back. (PX 5).

On April 25, 2013, Petitioner started treating with Dr. Sokolowski an orthopedic surgeon. At that time, Petitioner complained of lumbar pain with radiation into the right buttock and right lower extremity subsequent to a work-related injury. Petitioner reported falling at work injuring her shoulder, knee and lumbar spine. Petitioner stated that she had immediate lumbar pain but as her peripheral joints improved her back had not. Petitioner reported pain levels of 5-6/10 in the back and 7-8/10 in the leg and buttock.

Dr. Sokolowski's examination noted that Petitioner ambulated with a mildly antalgic right-sided gait pattern, mildly positive sagittal profile, extensions to neutral produced concordant back pain with radiation into the right buttock and leg, forward flexion beyond 40 degrees also produced concordant back pain, lumbar paraspinal tenderness to palpation and right sciatic notch tenderness to palpation, positive right-sided straight leg raise test, sensation decreased in the right L4-S1 distribution relative to the left side. Dr. Sokolowski

reviewed the MRI, dated April 12, 2013, and noted that the MRI was showed an L5-S1 annular tear and small right-sided disc pathology at L4-L5 with mild neural impingement on the right. Dr. Sokolowski diagnosed lumbar pain and lumbar radiculopathy and her proscribed physical therapy. Dr. Sokolowski also took Petitioner off work. (PX 11).

Petitioner returned to Dr. Sokolowski on June 3, 2013. At that time, Petitioner reported that her back pain was 5/10 and that she was not experiencing leg/buttock pain. Dr. Sokolowski issued light duty work restrictions consisting of no bending/twisting, lifting more than 15 pounds and frequent position changes. (PX 11).

On July 29, 2013, Petitioner followed up with Dr. Sokolowski. At that time, Petitioner reported that her low back pain was 2/10 and her leg/buttock pain was 1/10. The examination noted a positive sagittal profile, restoration to neutral reproduced concordant back pain with radiation to the right leg and buttock, forward flexion beyond 40 degrees also reproduced same back pain. The right sided straight leg test was positive. Dr. Sokolowski recommended a home exercise program and continue light duty work restrictions of no bending, squatting or twisting, lifting more than 15 pounds and frequent position changes or breaks. To get Petitioner back to working a full schedule, Dr. Sokolowski restricted Petitioner to working 4 hours a day, for 2 weeks, 6 hours of work a day, for the next 2 weeks, and 8 hours a day thereafter. (PX 11).

On October 4, 2013, Petitioner was sent an email which stated that if she does not return to work she will be found to have abandoned her job. (PX 30h).

Petitioner testified that Respondent agreed to accommodate her work restrictions and that she returned to work in October of 2013. Petitioner testified that another teacher was assigned work with her and that she was allowed to lay down as needed. (T. 85, 86). Petitioner testified that after the second day of working she was in extreme pain and she realized she could only stand for a few minutes. (T. 98).

Petitioner testified that Respondent offered her a place to lay down, but she was unable to lie down in the nurse's office. Petitioner testified that when she went to the nurse's office she saw that the kids were in the seats, so she walked away. Petitioner testified the nurse's office was busy and she did not want to have the kids move so she went to an empty classroom to lie down. (T. 86). Petitioner testified that she did not notify anyone there was a problem accommodating her restrictions. (T. 144). Petitioner testified that she only worked 4-hours a day for three days, the last day being October 30, 2013. (T. 152-155). Petitioner testified that she can't teach because she can't stand, and she cannot teach without standing. (T. 142).

On October 30, 2013, Petitioner returned to Dr. Sokolowski. In his records, Dr. Sokolowski indicated that Petitioner reported to returning to teaching and that working in a 4-hour capacity caused severe pain when standing or walking for an extended period of time. Petitioner also reported that she was not able to tolerate her

symptoms and her back pain had become significant. Petitioner rated her back pain as 7-8/10 and her leg/buttock pain as 2-3/10. Dr. Sokolowski noted that Petitioner said that she was experiencing considerable difficulties working in a restricted capacity, so he took Petitioner off work and ordered an FCE. (PX 11).

From June 27, 2013 through September 5, 2013, Petitioner also treated with Dr. Joseph Campobasso, a chiropractor. At the first visit, Petitioner complained of back, right shoulder pain and neck stiffness. Petitioner was treated with ultrasound, interferential current and fomentation and cryotherapy. (PX 13).

On December 6, 2013, Petitioner returned to Dr. Sokolowski complaining of lumbar pain with radiation to right buttock and right lower extremity. Petitioner reported that her right shoulder pain had returned. Petitioner also reported significant tightness and muscle spasms and stabbing pain in her right shoulder. The examination noted full range of motion for the left shoulder and 135 degrees range of motion for the right shoulder. Dr. Sokolowski noted right anterior glenohumeral tenderness to palpation and pain with resisted supraspinatus strength testing. Dr. Sokolowski diagnosed lumbar pain, lumbar radiculopathy and right rotator cuff tendinitis. (PX 11).

On December 9, 2013, Petitioner returned to Dr. Prodromos. Petitioner complained of right shoulder pain. Petitioner rated her pain as 4/10. Petitioner stated that her high shoulder has been painful and recently became stiff. Dr. Prodromos examined Petitioner and noted that Petitioner's range of motion had decreased, her forward flexion was at 120 and her abduction was at 60 degrees. Dr. Prodromos diagnosed frozen shoulder and recommended physical therapy. Dr. Prodromos indicated that the onset of Petitioner's frozen shoulder as December 9, 2013. (PX 5).

Petitioner returned to Dr. Prodromos on March 17, 2014. Petitioner complained of mild right shoulder pain. Petitioner reported decrease range of motion and stiffness. The range of motion was found to be 150 forward flexion and 105 abduction. Dr. Prodromos noted that Petitioner' symptoms were improving, and he discharged her from care for her right shoulder. (PX 5).

On April 1, 2014, Petitioner underwent the FCE at Athletico. The FCE determined that Petitioner could not perform the duties of an elementary school teacher because Petitioner could static stand for a total of 20 minutes, in 5 minutes sustained durations, and dynamic standing for a total of 80 minute, in 30 minutes sustained duration, and that Petitioner could only occasionally lift 20 pounds. The FCE was found to be valid. (PX 15).

On April 8, 2014, Petitioner returned to Dr. Sokolowski to review the FCE. Dr. Sokolowski noted that Petitioner put forth high levels of physical effort and, based upon the FCE, Petitioner was not capable of performing the physical demand of an elementary school teacher. Dr. Sokolowski placed Petitioner at maximum medical improvement and he issued permanent light duty restrictions consistent with the FCE. Dr.

Sokolowski indicated that Petitioner could obtain pain management treatment with her family doctor or a pain management specialist. (PX 11).

Petitioner testified that after the FCE she did not request to return to work within her restrictions. Petitioner testified that she did not because the FCE said no teaching. Petitioner further testified since 2014 that she made no attempt to contact Respondent regarding returning to work within her restrictions. (T. 156-158).

On or before April 10, 2014, Petitioner applied for disability benefits pursuant to the Teachers' Retirement System of the State of Illinois. Petitioner started receiving benefits effective November 30, 2013. Petitioner testified that to remain eligible for her benefits, she could not resume teaching in any capacity. (T. 146, 147). Petitioner testified that her full retirement went into effect as of April 19, 2017. (T. 146).

On October 16, 2014, Petitioner followed up with Dr. Sokolowski. The examination of the low back noted lumbar tenderness to palpation, right greater than left, positive sagittal profile, restoration to neutral reproduces concordant back pain with radiation to the right buttock and leg, pain with forward flexion beyond 40 degrees, positive straight leg test on the right. The examination of the right shoulder showed that Petitioner's range of motion was limited to 135 degrees of active forward flexion and abduction. Dr. Sokolowski diagnosed lumbar pain, lumbar radiculopathy, and right rotator cuff tendinitis. Petitioner was proscribed Norco and told to follow up as needed. (PX 11).

Petitioner returned to Dr. Sokolowski on October 9, 2015. At this visit, Petitioner reported difficulty standing and walking and lying down periodically provided relief from her symptoms. Petitioner rated her pain as 4-5/10 for back and 3/10 for the leg pain. Dr. Sokolowski indicted that Petitioner was still at nonoperative MMI and he referred Petitioner to a Dr. Kalina for pain management. (PX 11).

Petitioner treated with Dr. Kalina from December 7, 2015 through February 23, 2018. Dr. Kalina recommended a right L4-5 and L5-S1 TF ESI to reduce the radicular leg pain. He proscribed Norco, Flexeril, Protonix and Tramadol. (PX 19).

Petitioner treated with Dr. Farooq Khan, of Modern Pain Consultants, from November 11, 2016 through August 29, 2019. Dr. Khan recommended a TF ESI (lumbar trans foraminal epidural steroid injection) on right at L5-S1. On June 5, 2017, Dr. Khan noted that no surgery was recommended and that Petitioner had stable lumbar sacral pain with radicularopathy into the right lateral lower extremity. Dr. Khan assessed spinal stenosis, interventebral disc displacement, intervertebral disc degeneration, low back pain and chronic pain syndrome. Dr. Khan proscribed Norco and Gabapentin. In June and July of 2017, Petitioner underwent 2 TF ESI. After the second injection, Petitioner reported a decrease in symptoms and an improvement in her ability to drive and ambulate. (PX 23).

On March 21, 2016, Petitioner was examined by Dr. Andrew Zelby, pursuant to Section 12 of the Act. Petitioner reported tripping on a chair leg at work on February 7, 2013. Petitioner told Dr. Zelby that she fell forward landing hard on her hands and knees. Petitioner's back went downward, and her stomach hit the floor. Petitioner complained of pain along the right side of the low back as well right arm, wrist, forearm and left knee. Petitioner reported that her right upper extremity and left knee pain subsided over a period of several months but, about a month after the accident, she developed pain and tingling through the right buttock and down the back of the right lower extremity to the heel. Petitioner complained of constant right-sided low back and right buttock pain and intermittent pain down the back of the right lower extremity. Petitioner reported that her symptoms were exacerbated with any activities and that she receives little relief while lying down supine with a pillow under her knees. Petitioner reported no prior episodes of similar symptoms. At the time of the examination, Petitioner was 57 years old and she weighed 175 pounds.

Dr. Zelby examined Petitioner and noted no sciatic notch tenderness, normal gait, normal strength in the lower extremities, normal sensation to pin in the lower extremities, normal deep tendon reflexes in the lower extremities, and Petitioner's extremities were symmetric without atrophy. Dr. Zelby reviewed Petitioner's prior medical records and the surveillance videos from August 31, 2013 and February 27, 2016.

Dr. Zelby opined that Petitioner did not sustain an injury to lumbar spine or spinal elements. Dr. Zelby noted that the medical records do not contain any low back pain complaints for more than 2 weeks after her fall at work. Dr. Zelby further opined that had Petitioner injured her low back she would have complaints of back pain within 24-48 hours after of her fall. Dr. Zelby testified that Petitioner had no symptoms or findings, on any exam, remotely suggestive of L4 distribution of pain. Dr. Zelby further testified that Petitioner's neurologic exam was normal and that she had a preserved right patellar reflex.

Dr. Zelby stated the radiographic findings at L4-5, in April of 2013, appear to be chronic in appearance. Dr. Zelby opined that Petitioner's lack of symptoms and the lack of exam findings show that the MRI results had nothing to do with Petitioner's symptoms or injury. The MRI revealed no evidence for any acute or post-traumatic abnormalities or any changes suggestive of any spinal condition that was aggravated or accelerated as a consequence of her February 2013 fall.

Dr. Zelby testified that Petitioner's persistent and the severity of her complaints were inconsistent with the objective medical findings and were also inconsistent with the natural history of her objective medical condition. Dr. Zelby opined that Petitioner's medical treatment had been prolonged and excessive for no identifiable medical reason. Dr. Zelby stated that Petitioner's lack of improvement was not surprising since her treatment was not reasonable or necessary for her objective spinal condition. Dr. Zelby opined that the use of multiple compounded creams has not been reasonable or necessary and never provided any benefit. Dr. Zelby

further opined that Petitioner does not have a condition which supports the use of narcotic medications. Dr. Zelby also opined that the FCE made no sense in the clinical context with the objective medical findings which do not represent an accurate representation of Petitioner's abilities. Dr. Zelby opined that Petitioner was at maximum medical improvement as of June of 2013, at the latest, and that she could return to work without restrictions. (RX 1a).

In August of 2017, Petitioner returned to Dr. Sokolowski. At this time, Petitioner reported the epidural injections diminished some of her radiating pain but had not materially improved her back pain. Petitioner reported pain levels of 6/10 for the back and 3/10 for the buttock. Dr. Sokolowski noted that Petitioner had attempted to return to work in a light duty capacity and that she found her symptoms intolerable. Dr. Sokolowski recommended continuing with pain management and he reaffirmed the restrictions as outlined in the FCE. (PX 11).

Petitioner returned to Dr. Sokolowski on February of 2017, September of 2017 and on February 5, 2018. On that last date, Dr. Sokolowski compared an MRI, dated November 8, 2018, to the MRI dated April 12, 2013. Dr. Sokolowski noted the new MRI showed a mild compression fracture involving the superior endplate of L1 which was new but appeared to be chronic. Dr. Sokolowski further noted that the trace left paracentral posterior disc protrusion at L4/5 showed an improvement when compared to the prior exam. (PX 11).

Functional Capacity Examination

On April 1, 2014, Petitioner underwent the FCE at Athletico which determined that Petitioner was not capable of performing the physical demands of her job as an elementary school teacher based, primarily upon, Petitioner's limitations with static standing, dynamic standing, spine twisting and stooping. The FCE was found to be valid. The FCE determined that Petitioner could perform static standing for a total of 20 minutes in 5 minutes sustained durations while Petitioner's job demand requires her to occasional static stand up to 1/3rd day. The report indicated that Petitioner could perform dynamic standing for a total of 80 minutes in 30 minutes sustained duration while her job demand required Petitioner to perform frequent dynamic standing between 1/3 to 2/3 of the day. The report also found that Petitioner could only lift 20 pounds occasionally while her job demand required Petitioner to lift 25 pounds occasionally. [1] (PX 15).

Physician's Testimony

[1] The FCE states that the physical demand of Petitioner's job were derived from Petitioner's job description, Petitioner and the Dictionary of Occupational Titles. The physical requirement, in Petitioner's Job Description, lists only performing the physical tasks necessary to monitor, supervise and physically assist students throughout the school day during a variety of instructional activities. (PX 15).

Dr. Sokolowski, an orthopaedic surgeon whom concentrates in spine surgery, testified that he examined Petitioner on April 25, 2013. At the first visit, Petitioner reported falling at work on February 7, 2013 injuring her shoulder, knee and her lumbar spine. Petitioner reported that her lumbar pain began immediately thereafter. At the time of the examination, Petitioner indicated that her peripheral joint complaints improved but her lumbar pain worsened due to radiation into the right leg. Dr. Sokolowski reviewed the MRI, dated April 12, 2013, which, he said, showed a right-sided disc herniation at L4-5 with associated neural impingement and an annular tear at L5-S1. Dr. Sokolowski opined that Petitioner's history, the exam, and the MRI findings all correlate. Dr. Sokolowski testified that Petitioner had provocative findings on physical examination which include a positive right-sided straight leg raise and decreased sensation in her right leg with radiating right leg pain. Dr. Sokolowski opined that Petitioner had lumbar radiculopathy. Dr. Sokolowski further opined that the annular tear were likely the cause of Petitioner's back pain, which may occasionally cause radicular symptoms, and Petitioner's disc herniation at L4-5 also contributes to the radiculopathy. (PX 28).

Dr. Sokolowski testified that Petitioner's condition was improving with physical therapy and home exercises so, on July 29, 2013, he placed Petitioner on light duty with a graduated schedule to return to work full duty. Dr. Sokolowski testified that, on October 30, 2013, Petitioner reported that standing and walking for extended periods, at work, increased her symptoms and the magnitude of her pain including the return of radicular symptoms. Dr. Sokolowski testified that, at that time, he ordered an FCE to objectively delineate Petitioner's capabilities. (PX 28).

Dr. Sokolowski opined that Petitioner has an annular tear at L5-S1 which likely contributes to her axial back pain and a herniation on the right at L4-L5 which is consistent with her radiculopathy. Dr. Sokolowski testified that seated positions load the disc and may increase Petitioner's radicular complaints. Dr. Sokolowski further testified that positions of flexion, such as sitting, could increase axial back pain and standing, in a position of extension, the cross-sectional area of the spinal canal, could diminish and increase impingement worsening radiculopathy. (PX 28).

Dr. Sokolowski opined that as of April 8, 2014, Petitioner was as good as she will be, and she will continue to have some ongoing pain and she is at nonoperative functional maximum medical improvement. Dr. Sokolowski issued permanent work restrictions consistent with the capabilities outlined in the FCE. (PX 28).

Dr. Sokolowski testified that he saw Petitioner on August 1, 2016, after she received epidural steroid injections, and she reported that the injections improved her radiating leg pain but not improve her back pain. Dr. Sokolowski opined that the relief of radiating leg pain confirms his diagnosis of radiculopathy. Dr. Sokolowski further opined that his medical treatment was necessary and causally related to Petitioner's work accident. (PX 28)

Dr. Joseph Monaco, a general orthopedic surgeon, examined Petitioner on March 28, 2013, pursuant to Section 12 of the Act. Dr. Monaco testified that her reviewed the medical records from Advocate Health Partners, of February 7, 2013, Rezin Orthopedics, and Dr. Prodromos. Dr. Monaco testified that Petitioner complained of right wrist and hand pain when she treated at Advocate Health Partners. Petitioner later complained of left shoulder and left knee pain when she treated with Dr. Prodromos. Dr. Monaco testified that Petitioner's first back and right shoulder complaints occurred on March 11, 2013.

Dr. Monaco testified that Petitioner reported falling when she tripped after returning to the classroom from the bathroom. Petitioner said she landed on all fours and then proceeded to a prone position on her stomach and felt pain in her lower back which she described as intense. Dr. Monaco testified that Petitioner's history of back pain was inconsistent with the initial medical records which show no complaints of back pain. (RX 2c).

Dr. Monaco noted that Petitioner was for left shoulder problems a year before her fall at work. At that time, an MRI of Petitioner's left shoulder, showed a partial rotator cuff tear with impingement, bursitis and adhesive capsulitis. Petitioner was treated with physical therapy which ended in 2013. Petitioner's right and left shoulder complaints were located more anteriorly than posteriorly. (RX 2c).

Dr. Monaco examined Petitioner and he noted that Petitioner's low back examination was normal with a negative straight-let test at 90 degrees, no evidence of any neurologic deficit and no evidence of any radicular complaints or findings. The examination of the left knee was completely normal other than some tenderness to palpation over the inferior pole of the patella which was graded trace to one plus. The examination of the right wrist showed no tenderness or tenderness to light palpation only over the volar aspect of the forearm. No swelling was noted. The examination of the right shoulder was completely normal and equal to the left shoulder. Dr. Monaco noted a slightly decreased external rotation of 70 degrees compared to 80 degrees on the right, otherwise the range of motion was normal. There was some mild discomfort with cross-body adduction of both shoulders, but the pain was in the sub-clavicular area and not the AC joint as would be expected. The Jobe's test was positive on the left. (RX 2c).

Dr. Monaco opined that Petitioner sustained a contusion/strain of the wrist/forearm and a contusion of the left knee, which resolved, as a result of her work-related incident. Dr. Monaco further opined that Petitioner did not injury her low back. Dr. Monaco testified that the initial medical records did not show evidence of an injury to the back by clinical complaints or evaluation for three weeks following the incident. Dr. Monaco also testified that Petitioner's low back examination was normal at the time of his examination. Dr. Monaco further opined that Petitioner did not injury her left or right shoulders. He testified that here was no evidence in the

medical records or by his evaluation of any acute injury or condition involving the right or left shoulders. (RX 2c).

Dr. Andrew Zelby, a neurosurgeon, examined Petitioner in March 16, 2016, pursuant to Section 12 of the Act. At that time, Petitioner reported an injury at work, on February 7, 2013, after tripping on a chair leg falling forward and landing hard on both hands and both knees. Petitioner also reported that her back went downward and her stomach hit the floor. Petitioner complained of pain along the right side of the low back as well as her right arm, right wrist, right forearm and left knee. Petitioner reported that her right upper extremity and left knee complaints subsided over a period of several months but, a month after the incident, she developed pain and tingling through the right buttock and down the back of the right lower extremity to the heel. (RX 1b).

Dr. Zelby examined Petitioner's lumbar spine which showed no feelings to palpation, normal range of motion, squatting was normal, sitting straight leg raise was negative, reverse straight leg raise was negative, lying straight leg raise was positive on the right, no sciatic notch tenderness was noted, toe walking and heel walking was normal, Patrick's test and Fabere test were normal, gait was normal, there was no paraspinal muscle spasm, strength in the lower extremities was normal, sensation to pin and vibration was normal, deep tendon reflexes in the lower extremities was normal, no atrophy was present, the distal pulses were normal and symmetric bilaterally and the posture revealed a very mild thoracic kyphoscoliosis. Dr. Zelby testified that he reviewed the MRI dated April 12, 2013 which showed minimal degenerative disc disease throughout affecting the L3-4 level the least. The disc space heights were normal and the spinal canal was capacious on a congenital basis. There was a tiny chronic partial-thickness annular tear at L2-3 and a chronic partial-thickness annular tear at L4-5 and minuscule bulging discs at L5-S1 and L4-5. Dr. Zelby also noted a right inferior foraminal disc/osteophyte complex at L4-5 with mild to moderate foraminal stenosis but no impingement on the exiting L4 nerve root. No acute or post-traumatic abnormalities were noted, and he said the study showed less degeneration than one would expect for a 55-year old. (RX 1b).

Dr. Zelby testified that he reviewed the medical records from Drs. Myer, Prodromos, Sokolowski, Kalina and the FCE, surveillance video and records from Corwin Medical care. Dr. Zelby noted that Petitioner said that she made immediate complaints of low back pain after the fall but that the medical records do not reflect that Petitioner reported back pain.

Dr. Zelby opined that the lack of complaints immediately following the fall indicates that Petitioner did not injury her lumbar spine as a result of the fall at work on February 7, 2014. Dr. Zelby testified that had Petitioner sustained an injury to her spinal elements, she would have had complaints of back pain within 24 to 48 hours of her fall. Dr. Zelby opined that based upon Petitioner's complaints contemporaneous with her injury

and the MRI findings the only possible injury that could be supported by the objective medical findings was a lumbar strain. (RX 1b).

Dr. Zelby further opined that Petitioner's current complaints were not causally connected to her fall at work. Dr. Zelby testified that Petitioner had no symptoms or findings, on exam, even remotely suggestive of an L4 distribution of pain that corresponds to the MRI finding. Dr. Zelby opined that the April 2013 MRI findings were chronic appearance based upon Petitioner's lack of symptoms, exam findings, including a preserved right patella reflex, show that the MRI finding had nothing to do with her symptoms or with her injury. Dr. Zelby testified that Petitioner had mild lumbar spondylosis which is a condition of mild aging in the spine but, it was possible, although unlikely, that Petitioner sustained a lumbar strain. (RX 1b).

Dr. Zelby opined that Petitioner was at maximum medical improvement by June of 2013 and she could return to work without restrictions. Dr. Zelby further opined that the FCE, although valid, made no sense in the clinical context and objective medical findings context and does not represent an accurate representation of Petitioner's abilities based upon the objective medical findings. Dr. Zelby testified that Petitioner's MRI was normal, if not better than you'd expect, a normal spine exam and she had a normal neurologic exam. (RX 1b).

Dr. Zelby opined that Petitioner's treatment was excessive for no identifiable medical reason and she needs no additional treatment for her spine irrespective of cause. Dr. Zelby further opined that Petitioner's use of Norco and Tramadol and physical therapy was wildly excessive for no identifiable reason. Dr. Zelby also opined that there was no medical basis to suggest that Petitioner suffered any permanent partial disability as it relates to her spine and as a result of her February 7, 2013 fall at work. (RX 1b).

On cross-examination Dr. Zelby testified that he disagreed with Dr. Sokolowski's review of the MRI and finding of mild neural impingement on the right. Dr. Zelby testified that given the fact that the film showed no neural impingement, no symptoms related to neural impingement and no findings on the exam related to neural impingement, he would be hard-pressed to understand how Dr. Sokolowski came up with that conclusion. Dr. Zelby testified that radiculopathy is a symptom of neural impingement but that Petitioner does not have any symptoms even closely remotely related to the L4 dermatome and Petitioner's patella reflex, which is in the L4 nerve, was normal. Dr. Zelby opined that Petitioner had no symptoms, no findings on the exam that had anything to do with radiographic finding. Dr. Zelby also testified that annular tears could be acute but that they look different when they are acute rather than chronic. (RX 1b).

Petitioner's Current Complaints

Regarding her current complaints, Petitioner testified that her right shoulder is still stiff, and she cannot lift her arm away from her body. Petitioner testified that as the day goes on the pain in her back and right shoulder gets worse. Petitioner testified that she must lay down 3-4 times per day because laying down takes

the pressure off her spine. Petitioner also testified that she can't stand, she does go anywhere, and she takes medicines including hydrocodone, Gabapentin, Tizanidine and Pantoprazole. (T. 115-123). Petitioner also testified that she has driving restrictions. On cross-examination, Petitioner testified that her driving restrictions should be in the doctor's records because she always talks about it when she is with the doctor. Petitioner testified that she hadn't recently reviewed her doctor's records to see if she was issued driving restrictions but if the driving restrictions are not in the records than she would disputes the accuracy of the records. (T. 169-171).

Testimony About Returning to Work for Respondent

Petitioner testified that she is unable to teach because teaching is standing. (T. 123). Petitioner testified that in April of 2019 Respondent offered her a job which incommoded her restriction. Petitioner testified that if Respondent really wanted to accommodate her, she prefers a different job that's not standing because she can't stand. (T. 102). Petitioner testified that she would accept a job if Respondent would accommodate her. (T. 106).

Petitioner testified that she never attempted to apply for any other positions Respondent may of had because she already had a job and she didn't know she had too. (T. 158). Petitioner also testified that she would return to work for Respondent but that can't work in a standing position and no other job were offered to her. (T. 160). Petitioner testified that Respondent never offered her a job she could perform and that she would accept a job if all the accommodations, she needed, were accepted. Petitioner further testified that Respondent really did not previously accommodate her restrictions because she was not provided a place to lay down. (T. 161).

Jenifer Orlos testified for Respondent. Ms. Orlos is the Director of Administrations and Personnel. Ms. Orlos testified that Respondent could accommodate Petitioner's restrictions. Ms. Orlos testified that Respondent previously accommodated Petitioner's restrictions. Ms. Orlos testified that when Petitioner returned to work, she contacted Petitioner via email asking how working 4 hours a day was going. Ms. Orlos testified that Petitioner never expressed any issues regarding her accommodations or her ability to lay-down. (T. 199-201). Ms. Orlos testified that in October of 2013, Petitioner stopped working after she going to her doctor and being taken off work. (T. 201).

Ms. Orlos testified that there has always been an opportunity for Petitioner to return to work and Respondent would accommodate her restrictions. Ms. Orlos further testified that Respondent was extended to Petitioner, in April of 2019. Ms. Orlos testified that the offer to return to work is open-ended. (T. 202). Ms. Orlos testified that the last correspondent she had with Petitioner was to remind Petitioner to continue providing medical documentation and to advise when she wants to return to work. The last medical documentation Petitioner provide was in 2013 or 2014. (T. 216).

Ms. Orlos testified that prior to accepting her current position she was a teacher, an assistant principal, principal and had supervised teachers. Ms. Orlos testified that there's nothing that requires one to stand to teach. Ms. Orlos testified what is important to teach is the delivery of the instruction, so the kids are learning, not standing. Ms. Orlos testified that training could help Petitioner change the way she teaches. (T. 218, 219).

Petitioner's Job Search

Petitioner testified that she conducted a job search which consisted of placed her resume on two websites for remote teaching positions for colleges. Petitioner testified that she received no responses or no full-time responses. (T. 130). Petitioner testified that she never applied for any jobs. When asked whether she applied for a job, Petitioner responded, "*...I don't think I did. I don't remember. I don't think I did because it was a lot of work to do that. I would have had to research and type up a cover letter, and that was a lot on my back. Just to get my resume done, it was a lot on my back.*" Petitioner testified that it took her awhile to get her resume because of her back issues. (T. 159).

Petitioner testified that she also contacted the Illinois Department of Rehabilitation for assistance in finding employment which would allow her to lie down but she was told they could not help her. Petitioner also testified that she contacted the National Telecommunications Institute, an entity that works with people who are disabled, like her, and cannot work outside of the home. Petitioner testified that she was not qualified to obtain a job through those entities because neither Social Security or Will County Illinois Department of Rehibition fund the National Telecommunications Institute. (T. 111).

Petitioner testified that she currently works as a tutor. Petitioner testified that tutoring allows her to stand up and move around. (T. 106). Petitioner testified that she started tutoring in 2017 and that she earned about $200.00 per month in 2017 and 2018. (T. 106, 107). Petitioner testified the amount she makes tutoring depends upon the number of students she has, and it slows down in the summer. Petitioner testified that she drives about 30-40 minutes to tutor. (T. 108).

Petitioner testified that she also tried to sell Shaklee or nutritional things from home, but it did not work out because she's not a salesperson. (T. 110). Petitioner testified that in 2013 she owned a business called Embracing the Self which involved a book she was writing. Petitioner testified that when she fell, she thought, it would be an opportunity to finish the book. Petitioner testified that she was unable to finish the book because she couldn't sit long enough. (T. 162). Embracing the Self was listed on Petitioner's income tax returns for the years 2013, 2014, 2015, and 2016. (RX 12).

In 2013, Petitioner also owned a business called Inspiring Home Solutions Real Estate Investing. Petitioner testified that it was something she tried to do because she needed money. Petitioner testified that she could not drive to the places. (T. 162).

Vocational Consultants Testimony

Lisa Helma, a certified rehabilitation counselor with Vocamotive, testified for Petitioner. Ms. Helma testified that Petitioner reported sustaining injuries of February 7, 2013 to her back, shoulders, right forearm, right wrist and left knee. Petitioner reported participating in two rounds of physical therapy and having two injections in her back. Petitioner also reported that Dr. Sokolowski was her current treating physician, who she sees every six months, and she last seen him was in September of 2017. Petitioner also reported that she was treating with Dr. Kalina, a pain management physician, once a month, who restricted her to working only three hours per day[2]. Ms. Helma testified to reviewing Dr. Sokolowski's medical records and the FCE. Ms. Helma testified that she based her opinions upon Dr. Sokoloski's records and the FCE. (PX 27).

Ms. Helma opined that Petitioner suffered a loss of occupation and she does not have access to any type of stable labor market. Ms. Helma testified that she took into consideration Petitioner's age, 59, education, work experience, current physical capabilities and any transferable skills. Ms. Helma testified that Petitioner would not have access to the majority of light-duty occupations, including teacher, because of the limitations on dynamic standing and static standing identified in the FCE. Ms. Helma further opined that given Petitioner's restrictions she is not be qualified for any type of employment at this point. Ms. Helma testified that the most significant factor supporting her opinions was Petitioner's restrictions. (PX 27).

Ms. Helma opined that Petitioner does not have access to a stable labor market and the lack of a stable labor market existed as of the time her doctor issued the restrictions incorporating the FCE limitations. (PX 27).

Sharon Babat, a vocational consultant from CompAlliance Managed Care, testified for Respondent on May 15, 2018. Ms. Babot testified that she works with injured workers performing evaluations, labor market surveys and job placement services. Ms. Babot performed an in-person vocational assessment with Petitioner using a system called OASYS to evaluate her transferable skills and then surveys the local labor market. Ms. Babot used the restrictions outlined in Petitioner's FCE.[3] Ms. Babat noted that Petitioner has a Bachelor of Arts degree, master's degree in education leadership, and additional certifications in teaching. Ms. Babat also noted that Petitioner owned a daycare business and she had worked as a distribution clerk. Petitioner told Ms. Babot that she had a resume but had no idea where it was. Petitioner also reported that she had not performed a self-directed job search and that she did not know what her vocational interest would be. Ms. Babat generated an aptitude profile which placed Petitioner's skilled work category at 7 out of 9. Based upon Petitioner's

[2] On cross-examination, Ms. Helma testified that Petitioner mentioned having a 3-hour a day work restriction, issued by her pain doctor, but she did not use the restriction because no medical documentation of the restriction was provided.

[3] In the Medical Background of Sharon Babat's report dated 11/7/2018, Petitioner reported seeing a physician every six months who placed her at MMI. The history Petitioner provided to Ms. Babat did not report seeing Dr. Kalina, a pain management, or any work restrictions limiting Petitioner to working 3 hours a day or any driving restrictions.

transferable skills Ms. Babat identified various jobs Petitioner could perform including receptionist, office clerk, teacher, distribution clerk/order taker, customer service clerk and sales clerk. (RX 3c)

Ms. Babot performed a labor market survey using Petitioner's FCE restrictions and transferable skills. Ms. Babot testified that her assessment incorporated Petitioner's limitations on sitting and standing. Ms. Babot opined, based upon her employability assessment analysis, that there are viable alternative occupational categories for Petitioner with her physical restrictions. (RX 3c).

Ms. Babot also performed a labor market survey as of November 7, 2016. Ms. Babot testified that all of the positions found were within the physical limitations outlined in the FCE. Ms. Babot further testified that all of the jobs were open, Petitioner was capable of performing and the salary range was from $9.87 to $31.25 per hours.

Ms. Babot testified the labor market survey included identifying specific positions, contacting the employers and asking them a series of questions related to the open positions and the physical demands and the qualifications and schedule as well as salary and wages. Ms. Babot testified the positions included a head start teacher with a starting salary of $45,000.00. The position did not require any lifting and allowed standing or sitting as needed. Ms. Babot also identified another teaching position at Goodard School with a starting salary of $43,000.00. This positions also allowed Petitioner to sit or stand as needed and had no lifting requirement. Ms. Babot testified that that the other positions identified included: (3) Teacher, Children's Road to Success, starting salary of $24,960.00; (4) Teacher mentor, Child Time Learning, starting salary of $29,120.00; (5) Teacher, Joliet Public School district, starting salary of $65,000.00; (6) Customer service, Office Team, starting pay was $12.00 -$14.00 per hour; (7) Logistics clerk, Kelly Services, starting salary of $27,040.00; (8) Admissions and registration clerk, Kankakee Community College, starting salary of $20,530.00-$22,800.00; (9) Receptionist, Park Pointe Senior Living, starting salary of $21,840.00; (10) Office clerk, Accurate Personnel, starting salary of $28,800.00; (11) Administrative Clerk/outbound order clerk, On Time Staffing, starting salary of $26,520.00; (12) Dispatch clerk, Joliet Staffing, starting salary of $27,040.00; (13) Elementary schoolteacher, Plainfield Consolidated School District #202, starting salary of $50,297.00 to $62,000.00; (14) Elementary schoolteacher, Bourbonnias Elementary School District #53, starting salary $52,330.00; (15) elementary schoolteacher, Coal City Community Dist. #1, starting salary of $53,860.00. (RX 3c).

Other Testimony

Chris Pehlke, a private investigator with CovenantBridge, testified for Respondent. Mr. Pehlice, testified that he performed surveillance of Petitioner on February 26, 2016 and February 27, 2016. Mr. Pehlice

testified that he observed and taped Petitioner leaving her residence and driving 30 minutes to a church in Bolingbrook and getting out of her car caring her purse over her right shoulder and holding a bottle of water with her right hand. Two hours later he observed Petitioner exit the church, enter her car and drive 15 minutes and shop at a Kohl's Department Store. Mr. Pehlice testified that he followed Petitioner into the store and observed her shopping for shoes. When Petitioner left the store, she carried a bag in her left hand and she used her right had to open the trunk to put the shoes inside the trunk of her vehicle. Mr. Pehlice testified observed Petitioner driving back to her residence. (T. 231, 232).

Petitioner called David Myrick, Bill Nowarity, Patty Rose and Donna Johnston to testify. Each witness testified to knowing and observing Petitioner prior to and subsequent to her February 7, 2013 accident. David Myrick testified that prior to February 7, 2013 he did not observe Petitioner suffering from any physical ailments but after February 7, 2013 he observed Petitioner laying down about every half hour and that Petitioner needs to stop driving every 20 minutes. Bill Nowarity testified that he noticed changes in Petitioner's physical condition after February 7, 2013 and that she stops and gets out of the car every 20-30 minutes. Patty Rose testified that she did not observe Petitioner with any physical disabilities prior to February 7, 2013. Donna Johnston testified that she has known Petitioner for over 20 years. Ms. Johnston testified that Petitioner was very active prior February 7, 2013. Ms. Johnston also testified that after February 7, 2013, she did not notice any immediate changes but, eventually, we did not talk as often and, I felt, that she was pulling away from life. (T. 22-51).

The Arbitrator found Petitioner credible regarding her initial complaints of low back pain because her testimony was supported by emails made contemporaneously with her complaints. The Arbitrator does not find Petitioner's testimony credible regarding the standing/siting requirement of a teacher and efforts to return back to work. The Arbitrator also finds that Petitioner's claimed physical limitations were not supported by the medical records.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

In support of the Arbitrator's decision 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:

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his injury "arose out of" and "in the course of" his employment. 820 *ILCS* 305/1(d) (West 2014).

Both elements must be present to justify compensation. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill.App.3d 102, 105, 853 N.E.2d. 799, 803 (2006).

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

After determining the mechanism of a claimant's injury, the Commission's first task in determining whether the injury arose out of the claimant's employment is to categorize the risk to which the claimant was exposed in light of its factual findings relevant to the mechanism of the injury. *First cash Financial Services*, 367 Ill.App.3d at 105. There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n,* 378 Ill. App. 3d 113, 116 (881 N.E.2d 523, 527 (2007); see also *Brady v. Louis Ruffolo & Sons Construction Co.,* 143 Ill.2d 542, 552, 578 N.E.2d 925 (1991) (noting that "neutral" in workers' compensation terms means "neither personal to the claimant nor distinctly associated with the employment" (internal quotation marks omitted)).

"injuries resulting from a risk distinctly associated with employment, *i.e.* an employment-related risk, are compensable under the Act." *Steak 'N Shake v. Illinois Workers' Compensation Comm'n,* 2016 IL App (3d) 150500WC Par. 35, 67 N.E.3d 571. "Risks are distinctly associated with employment when, at the time of injury, 'the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties." *Id.* (*quoting Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989)); see also *The Venture—Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 115728, Par 18, 1 N.E.3d 535 (stating the supreme court "has found that injuries arising from three categories of acts are compensable: (1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his assigned

duties"). "A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling his duties. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 45, 509 N.E.2d. 1005, 1008 (1987).

The Arbitrator has carefully reviewed and considered all the evidence and finds that Petitioner has proven by the preponderance of the evidence that she sustained an injury what arose out of and in the course of her employment with Respondent. Petitioner testified that she tripped over a chair as she returned to the classroom after taking her students to the bathroom. The Arbitrator finds that Petitioner was performing a task that Respondent would reasonably expect her to do. Petitioner reported the accident to the school nurse who authored an accident report. The fall was described in the accident report and was consistent with Petitioner's testimony. Petitioner sought medical treatment the same day as her fall at work. Petitioner described the same accident as was contained in the accident report which was similar to Petitioner's testimony.

In support of the Arbitrator's decision relating to issue "E," whether timely notice was given to Respondent, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner proved by the preponderance of the evidence she she provided timely notice of the accident was required under the Act. Petitioner's testimony is unrebutted that she gave immediate notice of the accident to Respondent on February 7, 2013. Petitioner notified the school nurse, Ms. Taylor, of the Accident and Ms. Taylor completed an accident report. (RX4B)

In support of the Arbitrator's decision related to issue (F): Is Petitioner's Current Condition of Ill-Being Causally Connected to the Accidental Injuries of March 21, 2007, the Arbitrator makes the following conclusions:

Accidental injuries need not be the sole cause of the Petitioner's current condition of ill-being as long as the accidental injuries are a causative factor resulting in the current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003). Causal connection between accidental work injuries and an injured worker's current condition of ill-being may be established by a chain of events, including Petitioner's ability to perform work duties before the date of accidental injuries and inability to perform those same duties following that date. *Darling v. Industrial Commission*, 176 Ill.App.3d 186 (1988). Petitioner's condition of health prior to the accidental injuries need not be perfect, if after an accident occurs and following the accident, the Petitioner's condition has deteriorated, and it is plainly inferable that the intervening injury caused the deterioration; the salient factor is not the precise previous condition, it is the deterioration from whatever the previous condition had been. *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC.

The Arbitrator finds, after reviewing all of the evidence, that Petitioner has proven by the preponderance of the evidence, that her left knee, left shoulder, right lower back, and right wrist and forearm are causally related to her February 7, 2013 work accident.

Petitioner testified that on February 7, 2013, she tripped and fell in a classroom. Petitioner testified that she tripped falling on her hands and knees. Petitioner testified that her back bent forward as her stomach struck the floor. Petitioner described the position of her body as a "concaved" position. Petitioner testified that she felt immediate sharp pain in her lower right back. Petitioner testified that her right arm was in bad shape and that she could barely move it. (T. 61, 62). The Employee Accident and Injury Investigation Form completed by Ms. Taylor, signed by Petitioner, that states that on February 7, 2013, at 10:30, Petitioner injured "*Right wrist & Forearm pain.* (RX 4b). Petitioner sought medical care at Adventist Bolingbrook Hospital and the records state that Petitioner had forearm pain at the proximal area. On February 20, 2013, Petitioner sent an email to Nan Burt which stated "*Since Marie did not put my lower right back, my left knee, and left shoulder on my accident report, I would like those added right away please. I want to make sure that the doctor can look at those when I return to see him on Monday...I was in shock when Marie filled out the report and signed without looking at it. I assumed she put those things on it.* (PX 30A1) On February 25, 2013, Petitioner was examined by Dr. Prodromos and, at that time, Petitioner complained of pain in her left knee, left shoulder, right lower back, and right wrist and forearm. Petitioner told Dr. Prodromos that she was injured, on February 7, 2013, after tripping and falling in a classroom. The examination of the lumbar back showed pain in the right paralumbar area and centrally. Petitioner was diagnosed with left shoulder mild rotator cuff strain and lumbar strain. (PX 5). Dr. Sokolowski testified that Petitioner sustained a right-sided herniated disc at L4-5 with neural impingement and an annual tear at L5-S1 as a result of the fall on her hands and knees at work on February 7, 2013. Dr. Sokolowski testified that the annual tear continues to cause Petitioner back pain and her L4-5 disc herniation continues to case Petitioner persistent radiculopathy. Dr. Sokolowski issued permanent restrictions consistent with the FCE.

Petitioner testified that she had not suffered any prior back issues nor undergone any treatment for her back. A year before her work accident, Petitioner was treated for frozen shoulder, in her left shoulder, but was released from care prior to February 7, 2013 without restrictions.

Petitioner further testified that she never returned to work after her fall of February 7, 2013 other than returning to restricted work for 3 days in the end of October of 2013 working 4 hours a day. (T. 152-155).

The Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive than the opinions of Drs. Monaco and Zelby regarding Petitioner's low back condition. Drs. Monaco and Zelby opined that Petitioner's low back condition was unrelated to her work-related incident of February 7, 2013, in part, because Petitioner's

initial medical records did not show that Petitioner reported low back complaints and Petitioner received no treatment for her low back. Dr. Zelby opined that had Petitioner sustained an injury to her spinal elements, she would have had complaints of back pain within 24 to 48 hours of her fall. The Arbitrator find that the absence of initial medical records referencing low back complaints does not mean that Petitioner was not experiencing low back symptoms during that period of time. Petitioner testified that she started treating with Dr. Prodromos because Dr. Meyer would not treat her other complaints. Dr. Meyer's medical records of February 11, 2013 states, "...*she complained primarily of right wrist and forearm pain. She states she was having some knee pain as well, but this was not initially reported. She has only been cleared to evaluate her forearm and wrist.*" (PX 3). Petitioner testified that she was experiencing low back pain immediately after her fall. The Arbitrator finds that Petitioner's testimony was supported by the email, dated February 16, 2013 and February 20, 2013 which show that Petitioner was experiencing back pain and she wanted to amend the accident report to include the back because the doctor would not treat her other complaints. (PX 30a).

The Arbitrator also finds that Petitioner failed to prove by the preponderance of the evidence that her right shoulder condition was causally related to her accident of February 7, 2013. On February 25, 2013, Petitioner was examined by Dr. Prodromos and, at that time, Petitioner complained of only left knee, left shoulder, right lower back, and right wrist and forearm pain. On March 11, 2013, Dr. Prodromos noted that the left shoulder strain was improving, and no further treatment was warranted. At that same visit, Petitioner complained of right shoulder pain. Petitioner told Dr. Prodromos that she believes her right shoulder pain may be from overuse. On April 15. 2013, Dr. Prodromos found that Petitioner's shoulders felt better and he discharged Petitioner from care. The Arbitrator notes that Dsr. Prodromos nor Sokolowski opined that Petitioner's right shoulder condition was caused by overuse. The Arbitrator further notes that Petitioner's left shoulder complaints were minimal and the records did not prohibit Petitioner from using her left arm. Dr. Prodromos discontinued treatment of the left shoulder on March 11, 2013 and her released her from care for both shoulders on April 15, 2013 without restrictions.

On December 9, 2013, Petitioner returned to Dr. Prodromos reporting that her right shoulder had "recently became stiff". Dr. Prodromos examined Petitioner and noted that Petitioner's range of motion had decreased. Petitioner's forward flexion was at 120 and her abduction was at 60 degrees. Dr. Prodromos diagnosed frozen shoulder and he indicated the onset of Petitioner's frozen shoulder was December 9, 2013.[4] (PX 5). The Arbitrator notes that Petitioner's complaints of right shoulder stiffness and the decrease in her range of motion did not exist when she was released from care on April 15, 2013 and represent a new condition unrelated to her fall at work on February 7, 2013. The Arbitrator having previously found that Petitioner's

original right shoulder complains were not causally related to her work accident, the Arbitrator further finds that Petitioner's frozen shoulder condition is also not causally related to her work accident of February 7, 2013. At the time the right frozen shoulder diagnoses, Petitioner was not working and had been released from care for her left shoulder since April 15, 2013. The Arbitrator also notes that neither Drs. Prodromos or Sokolowski proffer an opinion that Petitioner's frozen shoulder condition is causally related to her work accident of February 7, 2013.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions:

Pursuant to Section 8(a) of the Act, the Respondent shall pay for all related and necessary first aid, medical and surgical services that are reasonably required to cure or relieve the Petitioner from the effects of the accidental injuries.

Based on the conclusions relating to causal connection, as stated above, the Arbitrator concludes that the medical treatment Petitioner received for her low back, left shoulder, left knee and right wrist and right forearm was related and necessary treatment reasonable required to cure or relieve Petitioner from the effects of her injuries. As such Respondent shall pay for only those services related to Petitioner's low back, left shoulder, left knee and right wrist and right forearm, pursuant to sections 8(a) and 8.2 of the Act, subject to medical fees schedule, as identified in Petitioner's exhibits 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24 and 33. Respondent shall receive a credit, pursuant to Section 8(j), for medical bills paid by Respondent.

In Support of the Arbitrator's decision related to issue (K): What temporary total disability benefits, if any, is Petitioner entitled, the Arbitrator makes to following conclusions:

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, "*i.e.*, whether the claimant has reached maximum medical improvement." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill.2d 132, 142, 923 N.E.2d 266, 271, 337 Ill. Dec. 707 (2010).* "Once an injured employee's physical condition stabilizes, he is no longer eligible for TTD benefits." *Archer Daniels, 138 Ill.2d at 118, 561 N.E.2d at 627.* This court has held, "[t]he duration of TTD is controlled by the claimant's ability to work and his continuation in the healing process." *City of Granite City v. Industrial Comm'n, 279 Ill. App. 3d 1087,1090, 666 N.E.2d 827, 828, 217 Ill.Dec. 158 (1996).* A claimant reaches maximum medical improvement when he is as far recovered or rested as the permanent character of his injury will permit. *Nascote Industries v. Industrial Comm'n* 353 Ill. App. 3d 1067 (Citing *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118 (1990). In determining

[4] The Arbitrator finds the date of the examination as the onset of symptoms was intended to demonstrate a new unrelated condition.

whether the claimant has reached maximum medical improvement, a court may consider such factors as a release to return to work, and medical testimony or evidence concerning the claimant's injury, the extent thereof, and most importantly, whether the injury has stabilized. *Id.* Once a claimant has reached maximum medical improvement, an injury has become permanent and he is no longer eligible for TTD benefits. *Nascote . Industries*, 353 Ill. App. 3d at 1072 (Citing *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118 (1990).

Based on the conclusions relating to causal connection above, the Arbitrator also finds that the Petitioner was temporarily and totally disabled from February 7, 2013 through April 8, 2014 that date Petitioner was determined to be at MMI. As such, Petitioner is awarded TTD benefits from February 7, 2013 through April 8, 2014 or 60 4/7 weeks at the TTD rate of $752.67.

Petitioner reached MMI on April 8, 2014 and, as such, Petitioner was no longer eligible for TTD benefits. The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that she was entitled to receive maintenance benefits. Respondent proffered testimony that work was available for Petitioner, within Petitioner's restrictions. Petitioner testified since 2014 that she made no attempt to contact Respondent regarding returning to work within her restrictions. (T. 156-158). Petitioner testified that she never attempted to apply for any other positions Respondent may have had because she had a job and that she didn't know she had too. (T. 158). The Arbitrator further finds that Petitioner failed to make a reasonable job search. Petitioner testified that she never applied for a single job. The full extent of Petitioner's job search efforts included posting her resume on two websites and contacting two agencies. When asked whether she applied for a job, Petitioner responded, "*...I don't think I did. I don't remember. I don't think I did because it was a lot of work to do that. I would have had to research and type up a cover letter, and that was a lot on my back. Just to get my resume done, it was a lot on my back.*" Petitioner testified that it took her awhile to get her resume because of her back issues. (T. 159).

In support of the Arbitrator's related to issue (L), the nature and extend of Petitioner's injury, the Arbitrator makes the following conclusions:

Petitioner seeks a finding that Petitioner is permanently totally disabled pursuant to Section 8(f) of the Act. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill.2d 482, 487, 34 Ill.Dec. 132, 397 N.E.2d 804 (1979). However, the employee need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. V. Industrial Comm'n*, 95 Ill.2d 278, 286-87, 69 Ill.Dec. 407, 447 N.E.2d 842(1983). Rather the employee must show that he is unable to perform

services except those that are so limited in quantity, dependability or quality that there is no reasonably stable market for them. *Alano v. Industrial Comm'n*, 282 Ill.App.3d 531, 534, 217 Ill.Dec 836, 668 N.E.2d 21 (1996). If the claimant's disability is limited in nature so that he is not obviously unemployable or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove by a preponderance of the evidence that he fits into the "odd-lot" category-one, though not altogether incapacitated to work, is so handicapped that he will not be employed regular in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n,* 84 Ill.2d 538, 546-47, 50 Ill.Dec 710, 419 N.E.2nd 1159 (1981); *Alexander v. Industrial Comm'n*, 314 Ill.App,.3d 909, 915-16, 247 Ill.Dec. 834, 732 N.E.2d 1166 (2000).

The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because if his age, skill, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Alano,* 282 Ill.App.3d at 534-35, 217 Ill.Dec. 836, 668 N.E.2d 21. Once the claimant establishes that he falls into the "odd-lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill.App.3d 477, 484, 236 Ill.Dec. 890, 708 N.E.2d 476 (1999).

The Arbitrator finds that Petitioner failed her burden of proving that she conducted a diligent but unsuccessful attempt to find work. Petitioner testified that she never applied for any jobs. When asked whether she applied for a job, Petitioner responded, "*...I don't think I did. I don't remember. I don't think I did because it was a lot of work to do that. I would have had to research and type up a cover letter, and that was a lot on my back. Just to get my resume done, it was a lot on my back.*" Petitioner testified that it took her awhile to get her resume because of her back issues. (T. 159). The Arbitrator finds that placing a resume on two websites, contacting two places for assistance, and not applying for a single job is not a diligent and unsuccessful attempt to find work.

The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that because of her age, skill, training, and work history she would not be regularly employed in a well-known branch of the labor market. Petitioner is highly educated. Petitioner has a master's degree, bachelor's degree and teaching certifications. Petitioner previously owned and operated a daycare business and previously worked as a distribution clerk. Petitioner continues to work as a tutor. After her work accident of February 7, 2013, while off work with Respondent, Petitioner owned and operated a business called Inspiring Home Solutions Real Estate Investing and she also sold Shaklee and nutritional products. Regarding the sales businesses, Petitioner testified that she isn't a sales person. For the years 2013, 2014, 2015, and 2016 owned a business called Embracing the Self, which was listed on her tax returns. (RX 12). Petitioner testified that Embracing the Self

involved a book that she was writing. Petitioner testified that when she fell, she thought, it would be an opportunity to finish the book. (T. 162).

Ms. Babot, who performed the in-person vocational assessment and labor market survey for Respondent, testified that Petitioner's aptitude profile placed Petitioner's skilled work category as 7 out of 9, based on the OASYS system. Based upon Petitioner's transferable skills, Ms. Babot opined that Petitioner, with the FCE restrictions, could perform various jobs including receptionist, office clerk, teacher, distribution clerk/order taker, customer service clerk and sales clerk. (RX 3c).

The Arbitrator finds the opinions of Ms. Babot to be more persuasive than the opinions of Ms. Helma. The Arbitrator notes that Petitioner advised Ms. Helma, the vocational counselor hired by Petitioner, that she had restrictions wlimiting her working just three hours a day. Petitioner also advised Ms. Helma that she could drive only 15 to 20 minutes per day and that she was unbale to drive for 2 consecutive days. The Arbitrator notes that Petitioner was not issued restrictions prohibiting her from driving more than 20 minutes, limiting her work day to three hours, and that she was prohibited from driving for 2 consecutive days. The evidence did not support Petitioner's testimony.

Ms. Helma, in her, February 28, 2018 report, opined that based upon the results of the FCE, Petitioner' most significant barrier to employment was her need to frequently alternate positions and that given Petitioner's current restrictions she does not possess any transferable skills. Ms. Helma testified that Petitioner could not perform her occupation as a teacher and would not have access to the majority of light-duty occupations due to Petitioner's limitations on static standing and dynamic standing as outlined in the FCE. The Arbitrator finds that Ms. Helma's opinions that need to frequently alternate positions prevented Petitioner from teaching was somewhat inconsistent with her testimony that limitations on static and dynamic sitting prevented her from teaching and from having any transferable skills. The Arbitrator finds the discrepancies between the causes of what adversely impacts Petitioner's employability undermines Ms. Helma's opinions.

The Arbitrator also finds the amount of static and dynamic standing a teacher is required to perform, as contained in the FCE, is unreliable. Ms. Helma testified that she relied upon the FCE to determine whether Petitioner possesses the physical abilities to her job as an elementary school teacher. The FCE states that the job demands of a teacher require static standing occasional up to 1/3rd of the day, dynamic standing frequently from 1/3rd to 2/3rd of the day, and occasional lifting 25 pounds from floor to waist. The FCE states, in the Physical Abilities and Job Match section, that the physical demand of the target job was determined by Petitioner's job description, Petitioner, and the Dictionary of Occupational Titles. The FCE determined that Petitioner was not capable of performing the physical demand of a teacher because she could not meet the requirement of static standing, dynamic standing and lifting.

The Petitioner's description listed a teacher's physical requirements as "performing the physical tasks necessary to monitor, supervise and physically assist students throughout the school day." (PX 15). Petitioner's job description does not list the percentage of the day a teacher is must be capable of static standing, dynamic standing or lifting. Because the Petitioner's job description does not contain physical demands for static standing, dynamic standing and lifting the information must have been obtained from Petitioner and/or The Dictionary of Occupational Titles. The Arbitrator notes that FCE does not list the source of the static standing, dynamic standing and lifting job demands. The Arbitrator is unable to determine which information was obtained from Petitioner or from The Dictionary of Occupational Titles. As such, it is a reasonable inference that some of the information was obtained from Petitioner. The Arbitrator finds that the FCE job demand for standing, dynamic standing and lifting was based, in part, upon information obtained from the Petitioner. Petitioner testified that she is unable to teach because teaching is standing. (T. 123). Petitioner testified that she does not know any other way to teach except for to be standing up. (T. 124). Jenifer Orlos testified for Respondent. Ms. Orlos, who was a teacher, assistant principal, principal and had supervised teachers, testified that there's nothing that requires one to stand to teach and what is important is the delivery of the instruction, not standing. (T. 218, 219).

The Arbitrator previously found that Petitioner's testimony was not credible regarding the standing/siting requirement of a teacher, efforts to return back to work, and Petitioner's claimed physical limitations and/or restrictions were not supported by the medical records. The Arbitrator finds that amount of the time a teacher dynamic stands, static stands and lifts to be unreliable because the information conflicts with Petitioner's job description, testimony of Ms. Orlos, and appears to be based, in part, upon the subjective information provided by the Petitioner.

Based upon the above, the Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that she falls into the odd-lot category.

Assuming that Petitioner satisfied her burden, the Arbitrator finds that Respondent has proven that some kind of suitable work is available for Petitioner. Once an employee satisfied the burden of proof that he or she falls into the odd-lot category, the burden sifts to the employer to show that some kind of suitable work is available to the employee. *Westin Hotel v. Industrial Comm'n*, 372 Ill.App.3d 527, 544 (2007). Ms. Babat, Respondent's vocational consultant, testified that testified that Petitioner had transferable skills and she could perform various occupations including receptionist, office clerk, distribution clerk/order taker and sales clerk. The Arbitrator notes that Ms. Babat also testified that Petitioner could find teaching positions within the limitations identified in the FCE. The Arbitrator further notes that Dr. Sokolowski indicated Petitioner was unable to perform the physical demand of an elementary school teacher and he issued work restrictions pursuant

to the limitations identified in the FCE. Ms. Babot performed a labor market survey, for Respondent, testified that Petitioner was capable of earning, with her restrictions, between $9.87 to $31.25 per hours, which included other teaching positions. After removing the teaching position's, from Ms. Babat's labor market survey, the non-teaching positions earned between $20,530.00 to $29,120.00 per year or $11.94 per hour [$29,120.00 + $20,530.00=$49,650.00/2= $24,825.00/52(# of weeks a year) =$477.40/40 (hours a week) =$11.93 per hour]. Based upon Ms. Babat's labor market survey, it appears that Petitioner would likely incur a wage loss with such alternate employment.

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of Section 8.1b(b), the reported level of impairment pursuant to Section 8.1b(a), the Arbitrator notes that neither party submitted into evidence an AMA impairment rating. Thus, the Arbitrator considers the parties to have waived their right to do so and assigns no weight to this factor.

With regard to subsection (ii) of Section 8.lb(b), the occupation of the injured employee, the evidence established that Petitioner was an elementary school teacher. The physical requirements of a teacher, as listed on Petitioner's Job Duties, include performing physical tasks necessary to monitor, supervisor and physically assist students during the school day. Pursunt to the FCE, the Dictionary of Occupational Titles state that teacher occasional astatic stands up to 1/3 of the day, dynamic stands frequently between 1/3 to 2/3 a day, and lifts occasionally 25 pounds from floor to waist. (PX 15). As such the Arbitrator find that this factor significantly increases the amount of permanency.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, the evidence established that Petitioner was 56 years old on the date of the accident. People in the later portion of the work life tend to recover more slowly than people who are younger. As such, the Arbitrator finds that this factor slightly increased the amount of Permanency.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the evidence reflects that Petitioner was released from care with significant restrictions. The FCE states that Petitioner is unable to return to work as an elementary school teacher. Ms. Helma, Petitioner's vocational expert, opined that Petitioner suffered a loss of occupation. Ms. Babot performed a labor market survey, for Respondent, testified that Petitioner was capable of earning, with her restrictions, between $9.87 to $31.25 per hours, which included other teaching positions. After removing the teaching position's, from Ms. Babot's labor market survey, the non-teaching positions, Petitioner could earn between $20,530.00 to $29,120.00 per year or $11.94 per hour [$29,120.00 + $20,530.00=$49,650.00/2= $24,825.00/52(# of weeks a year) =$477.40/40 (hours a week) =$11.93 per hour]. Based upon the inability to return to work as a teacher, Petitioner's future earnings would be significantly adversely impacted. As such, the Arbitrator finds that this factor has significant impact upon the amount of permanency.

With regard to subsection (v) of Section 8.lb(b), evidence of disability corroborated by the treating medical records, Petitioner testified that as the day goes on the pain in her back gets worse. Petitioner testified that she must lay down 3-4 times per day because laying down takes the pressure off her spine. Petitioner also testified that she can't stand, she does go anywhere, and she takes medicines including hydrocodone, Gabapentin, Tizanidine and Pantoprazole. (T. 115-123). Petitioner also testified that she has driving restrictions. On cross-examination, Petitioner testified that her driving restrictions should be in the doctor's records because she always talks about it when she is with the doctor. Petitioner testified that she hadn't recently reviewed her doctor's records to see if she was issued driving restrictions but if the driving restrictions are not in the records than she would disputes the accuracy of the records. (T. 169-171). The Arbitrator finds that Petitioner's testimony to conflict with the treating medical records. The Arbitrator finds

that the treating medical records do not contain any driving restrictions. The Arbitrator further finds that Petitioner's testimony regarding her complaints and symptoms are not reflected in the treating medical records. However, the medical records of Dr. Sokolowske reflect ongoing complaints of pain and symptoms which were also reflected the records of Petitioner's other treating doctors although not to the extent of Petitioner's testimony. The Arbitrator notes that the FCE was deemed valid and that Petitioner was only able to static stand for a total of 20 minutes, 5 minutes sustained, dynamic stand for a total of 80 minutes, 30 minutes sustained, and lift 20 pounds from floor to waist occasional. As such, the Arbitrator finds that this factor still significant increases the amount of permanency.

In consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has sustained a loss of occupation due to her permanent restrictions related to the accident and she may have some difficulty finding comparable alternate employment. Based upon the evidence presented, the Arbitrator finds that the Petitioner remains employable. Therefore, the Arbitrator finds that Petitioner suffered permanent partial disability to the extent of 35% loss of man as a whole pursuant to Section 8(d)(2) of the Act.

Regarding issues (N) and (O), the Arbitrator makes the following conclusions:

The Arbitrator addressed issues (N) and (O) above and, as such, will not be separately addressed

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC037657
Case Name	BUFFINGTON, QUENTIN v. ACE HARDWARE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0458
Number of Pages of Decision	12
Decision Issued By	Stephen Mathis, Commisioner

Petitioner Attorney	David Olivero
Respondent Attorney	George Klauke

DATE FILED: 9/10/2021

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Quentin Buffington,

Petitioner,

vs. NO. 06WC037657

Ace Hardware,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Respondent herein and notice given, the Commission, after considering the issues of accident, medical expenses, prospective surgery, causal connection, "application of law, 8(d)2 vs. 8e10, credit due Respondent, causation of current alleged condition to the original alleged accident", 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 28, 2020 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. 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.

SEPTEMBER 10, 2021
o-7/13/2021
SM/sj
44

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

/s/ *Deborah Baker*
Deborah Baker

/s/*Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUFFINGTON, QUENTIN
Employee/Petitioner

Case# **06WC037657**

ACE HARDWARE
Employer/Respondent

On 9/28/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0400 LAW OFFICES OF LOUIS E OLIVERO
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

1832 KLAUKE LAW GROUP LLC
GEORGE F KLAUKE JR
1900 E GOLF RD SUITE 950
SCHAUMBURG, IL 60173

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

QUENTIN BUFFINGTON
Employee/Petitioner

v.

ACE HARDWARE
Employer/Respondent

Case # **06** WC **37657**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **08/28/20**. 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. xx What temporary benefits are in dispute?
☐ TPD ☐ Maintenance xx TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. xx Is Respondent due any credit?
O. ☒ Other **In the alternative to 19(b)/8(a), What is the Nature & Extent of the injury?**

FINDINGS

On the date of accident, **09/21/05**, 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 through August 14, 2015 ***is*** causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned $**3,232.20**; the average weekly wage was $**323.22**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **no** 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 $**18,469.13** for TTD, $**0** for TPD, $**0** for maintenance, and $**67,660.44** for other benefits, for a total credit of $**69,509.57**. ARB EX 1.

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

ORDER

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with the care and treatment of his causally related condition of ill-being in his right shoulder through August 14, 2015 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner TTD benefits for the period of 34-2/7 weeks commencing 12/18/14 through 8/14/15. Respondent shall receive credit for amounts paid or overpaid.

Petitioner's request for prospective medical treatment pursuant to Section 8(a) is denied.

Respondent shall pay petitioner permanent partial disability benefits of $193.93 /week for 50 weeks as provided in Section 8(d)(2) of the Act because the injuries sustained caused a 10% loss of use of a person as a whole. Respondent is denied credit for a prior shoulder/arm settlement against this award under Section 8(d)(2).

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

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

Carolyn M. O'Neely

Signature of Arbitrator

9/25/20
Date

SEP 28 2020

FINDINGS OF FACT

By way of background, the Arbitrator notes that this matter was first tried pursuant to Petitioner's Section 19 B motion before a different Arbitrator on several dates beginning in December 2007. Proofs were ultimately closed in May 2008. RX 1. Following those hearings, the originally assigned Arbitrator found that Petitioner sustained accidental injury to his right shoulder on September 21, 2005 which was causally related to his work for the Respondent Ace Hardware. Petitioner injured his right shoulder after crouching down and pulling a 50-60 pound box of bird seed from a lower shelf. RX 2. Petitioner was also awarded TTD and medical bills. Prospective medical expenses were not ordered by the Arbitrator. RX 2. The Commission affirmed the award with a slight change to the Arbitration decision language, and the Circuit Court affirmed the Commission. Thereafter, on December 16, 2011, the Appellate Court affirmed the judgment of the Circuit Court confirming the Commission decision. The case was remanded. RX 2. The Appellate Court noted that "While prospective medical expenses were not ordered, the claimant is not foreclosed from seeking medical, surgical, and hospital expenses that are reasonably required to relieve his work related condition of ill-being." RX 2.

This matter was brought before this Arbitrator for trial on September 28, 2020 pursuant to a 19b 8A Petition filed by Petitioner. Petitioner placed nature and extent in dispute in the alternative. ARB EX 1. At trial, Petitioner testified that in addition to his job with Respondent, he has also worked on and off over the years as an EMT and as a photographer. He further testified that he had no treatment to his right shoulder between 2007 and 2012 while awaiting a final appellate decision. Petitioner testified that he worked as an EMT full duty during that time period. Following the Appellate Court decision issued in December 2011, Petitioner returned to his treating physician Dr. Wolin in 2012. Petitioner testified that he was financially unable to obtain further treatment for his right shoulder during the pendency of the appeals.

On February 15, 2012, Petitioner returned to Dr. Wolin for further care and indicated to Dr. Wolin that he did not have any recent injury to his right shoulder. Dr. Wolin's assessment was continued right shoulder pain with probable labral involvement as a result of the work injury on September 21, 2005. PX 5. Dr. Wolin ordered a new MRI arthrogram to determine if Petitioner was a candidate for arthroscopy with possible labral repair. On April 17, 2012, Petitioner underwent the MRI arthrogram at Weiss Memorial Hospital and the findings suggested a SLAP tear at both the superior labrum and anterior labrum.

On December 17, 2013, Petitioner saw Dr. Wolin with pain complaints to the superior aspect of the right shoulder. Dr. Wolin's diagnosis was a right shoulder labral tear and subscapularis tear per prior MRI. Treatment options were discussed, including surgery. On October 21, 2014, Petitioner returned to Dr. Wolin with right shoulder pain complaints. Dr. Wolin ordered a current MRI arthrogram since Petitioner was proceeding with surgery.

On December 18, 2014, Petitioner was admitted to Weiss Memorial Hospital for arthroscopy surgery. Dr. Wolin's operative report stated:

"There was a glenoid labrum tear running from the 3 o'clock position anteriorly to 7 o'clock position posteriorly. There was a superior glenoid labrum tear running from the 12 o'clock to the 10 o'clock

position. The capsule labral complex anterior and inferior aspect of the shoulder were mobilized. The area of detachment was debrided down to bleeding bone. The 3 anchors were placed at the appropriate positions. They were double-loaded. Sutures were placed in alternating horizontal and vertical mattress fashion and tied. Good apposition to bone was noted. Superior labral tear was mobilized again with detachment and debridement down to bleeding bone. Two BioComposite PushLock anchors were placed in appropriate position. These were deployed."

On February 3, 2015, Petitioner returned to Dr. Wolin for follow-up care to his right shoulder. At that time, Dr. Wolin ordered physical therapy 3 times per week for 6 weeks.

On February 25, 2015, Dr. Wolin's records indicated that Petitioner's physical therapy had been cancelled or put on hold by the insurance carrier. Dr. Wolin noted that interrupting physical therapy could affect Petitioner's long term recovery.

On April 7, 2015, Petitioner returned to Dr. Wolin for his right shoulder condition and indicated that the workers' compensation carrier had denied further physical therapy. Petitioner stated that he had been doing a home program.

On May 1, 2015, Petitioner returned to Dr. Wolin to discuss a FCE. Petitioner was still having pain in his right shoulder, so Dr. Wolin gave him an injection for pain relief. Dr. Wolin believed that Petitioner's biggest problem was that he was under-rehabilitated due to the termination of physical therapy prematurely. On August 13, 2015, Petitioner was discharged from work conditioning/hardening at the very heavy physical demand level. The report of that date indicates, "the client has expressed a desire to return to work full duty." His abilities were determined to meet and exceed the medium duty level required of an order picker for Respondent. RX 6. On August 14, 2015, Petitioner returned to see Dr. Wolin for his right shoulder condition. Petitioner indicated that he had completed his work conditioning program. Dr. Wolin found that Petitioner had some persistent anterior shoulder pain. Dr. Wolin's assessment stated:

"Assessment/Plan: I reviewed his work conditioning summary. He now meets his job demands. I reviewed his condition with him in detail. I believe he may return to work full duty as of this writing in that he is at maximal medical improvement. He will be seen as needed in the future. Specifically, he understands that if there is further irritation of the biceps that may require additional attention. Due to the prolonged nature of the rehabilitation, he will require ongoing conditioning and maintenance of his upper extremity and core musculature. Continue to work with a training individual is indicated."

Dr. Wolin also prescribed an H-Wave device for Petitioner due to the fact that he was still experiencing pain, swelling and limited range of motion. Petitioner testified that Dr. Wolin has not told him to discontinue the use of this device. Petitioner was off work following the surgery of 12/18/14 and claims TTD through 9/23/15. ARB EX 1. Petitioner testified that he returned to work as an EMT firefighter and photographer upon his full duty release in August 2015.

Seven months after the full duty release at MMI, on March 29, 2016, Petitioner presented to Dr. Wolin with right shoulder pain. Dr. Wolin gave him an injection into the anterior glenoid humeral joint for the pain. Nine months thereafter, on December 16, 2016, Petitioner returned to Dr. Wolin complaining of a pinching sensation in the shoulder. Dr. Wolin's assessment was that his biceps anchor was causing the

pain. Dr. Wolin recommended an arthrogram and also gave him an injection for his pain. Nine months thereafter, on September 5, 2017, Petitioner underwent his MRI arthrogram at Weiss Memorial Hospital. He later saw Dr. Wolin that day complaining of increased right shoulder pain. Dr. Wolin was able to access the radiologist's report which stated:

"Impression:

1. Postsurgical changes of the labrum. Superior labral findings may be secondary to surgery versus re-tear.

2. No rotator cuff tear."

Dr. Wolin then personally reviewed the MRI and found that there was a suggestion of a posterior superior labral tear.

Seventeen months later on February 14, 2019, Petitioner presented to Dr. Wolin for his right anterior shoulder pain. Dr. Wolin's examination findings were consistent with recurrent tear of the glenoid labrum. Dr. Wolin did not believe Petitioner was at maximum medical improvement and recommended that he undergo arthroscopy with possible labral repair. Dr. Wolin gave Petitioner an injection for his shoulder pain. One year later, on February 11, 2020, Petitioner returned to Dr. Wolin because of his right shoulder pain. Dr. Wolin believed that Petitioner's pain may be from a labral tear or development of osteoarthritis and that he was a candidate for arthroscopy of the shoulder to determine the source of the pain.

Petitioner testified that after his full duty release on August 14, 2015, he continued to work as a firefighter EMT which he testified was a heavy duty position. Petitioner testified that he continues to perform that work to date with the help of co-workers when patient lifting is required. Petitioner testified that he also continues to work full time as a photographer. Petitioner takes over the counter 8 hour Tylenol arthritis medication 4 to 5 times per week. He testified that he has learned to live with the pain in his right shoulder and is not limited in activities by the pain. Yard work including raking and pulling weeds will cause a pain flare up and he on occasion uses the H Wave machine to help alleviate the pain. He testified that his every day pain level starts at a 2-3 and after activity changes to 7 -8.

Respondent's Section 12 physician Dr. James Cohen testified via 2 evidence depositions. RX 4, RX 9. With regard to Petitioner's December 2014 right shoulder arthroscopy, Dr. Cohen testified at his November 9, 2016 deposition that the surgery was a success given Petitioner's ability to return to heavy duty work status. RX 4, p. 21. His impairment rating provided was 2% person as a whole. RX 4, p. 26. At the deposition of September 12, 2018, RX 9, Dr. Cohen testified as to his next exam of Petitioner on May 3, 2017. RX 9. He also reviewed results of the September 5, 2017 MRI arthrogram and opined that a second surgery was not necessary given the relatively mild symptoms reported by Petitioner and the changes noted on the MRI which he opined were not significant nor indicative of a labral "retear". RX 9, p. 9-10,18. He opined that any continued pain complained of by Petitioner would be the result of usual and expected post surgical pain and not the result of any anchor failure. RX 9, p. 32.

The last evidence deposition was of a different Section 12 physician, Michael Dr. Cohen taken on October 16, 2019 and followed his report issued dated April 17, 2018, following a records review conducted. RX

10, p, 8. He notes all of Petitioner's prior treatment records and the MMI full duty determination rendered by Dr. Wolin in August 2015. RX 10, P. 19. He reviewed the September 5, 2017 MRI arthrogram results were consistent with Petitioner's previous surgeries. He did not find any indication of an additional or new acute injury or any condition requiring additional surgery. RX 10, P 25-26.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In support of the Arbitrator's decision relating to (F) Whether Petitioner's present condition of ill being is causally related to the injury, and (N) prospective medical, the Arbitrator concludes as follows:

The Arbitrator again notes that causal connection for Petitioner's right shoulder condition as found by the prior Arbitrator at the time of the first 19b decision issued in 2008, and affirmed by the Appellate Court in 2011, is not at issue in connection with the instant 19 b/8(a) tried by this Arbitrator on 8/28/20 and was not revisited at the current trial or in this Decision. Specifically, the parties stipulated at the current trial that casual connection for Petitioner's condition of ill-being in his right shoulder prior to December 21, 2007 (the date of the final testimony given at the first 19 b trial with proofs closed in May 2008) RX 1, ARB EX 1, was not at issue. At the current trial, Respondent disputed causal connection for Petitioner's ongoing complaints of right shoulder problems subsequent to December 21, 2007 and "post Appellate Court Decision" in 2011. ARB EX 1, TR p. 4-8.

Based on a preponderance of credible evidence at trial, the Arbitrator finds that Petitioner's ongoing complaints and condition of ill-being in his right shoulder from December 21, 2007 (the date of the last substantive testimony on Petitioner's original 19 B) through August 14, 2015 are causally related to his work related accident of 9/21/05. Petitioner's condition of ill-being after August 14, 2015 is not causally related to the work accident.

In so finding, the Arbitrator is not dissuaded by Petitioner's absence of medical care or his ability to work during the pendency of the appeals process from the prior Arbitrator's 2008 19 B decision finding accident and causal connection for Petitioner's continued condition of ill-being in his right shoulder. The Arbitrator notes that upon receipt of the Appellate Court's Decision affirming the finding of causal connection for his right shoulder condition in December 2011, Petitioner resumed treatment of his continued and unresolved right shoulder complaints with Dr. Wolin shortly thereafter in February 2012 as detailed above. After additional conservative care and MRI testing of the continued condition and complaints of his previously determined causally related right shoulder condition, the Petitioner ultimately underwent surgical repair of the labral tear as originally suspected and subsequently confirmed by Dr. Wolin. Thereafter, Petitioner underwent post surgical care through his discharge from work conditioning with a very heavy work ability determination on August 13, 2015. Dr. Wolin released Petitioner on August 14, 2015 to full duty work without restriction having reached maximum medical improvement.

The Arbitrator finds that Petitioner's complaints after his full duty release in August 2015 are not causally related to his accident of 9/21/05. This finding is supported by the significant gaps in treatment after his

MMI release while Petitioner continued to work full duty as both an EMT and photographer. The Arbitrator's finding is further based on the opinions of both Dr. Cohen's and their reading of Petitioner's medical records and his MRI arthrogram as stated above. The Arbitrator places greater weight on the opinions of Drs. Cohen as they are buttressed by the significant gaps in treatment following Petitioner's MMI release in August 2015.

Based on the Arbitrator's finding of no causal connection after the August 14, 2015 release date, the Arbitrator further finds that any treatment prescribed by Dr. Wolin after that release date is not causally related to the accident of 9/21/05. Further, the Arbitrator finds no causal connection for any recommended treatment subsequent to August 14, 2015 and no such treatment is awarded to Petitioner. Petitioner's request for prospective medical treatment pursuant to Section 8(a) is denied.

In support of the Arbitrator's decision relating to (J) Reasonableness or necessity of medical, surgical or hospital bills or service the Arbitrator concludes as follows:

Based on the Arbitrator's findings on the issue of causal connection through August 14, 2015 only, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with his right shoulder condition, including the December 2014 surgery and its post surgical attendant care, through August 14, 2015 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

In support of the Arbitrator's decision relating to (K) Amount of compensation due for temporary total disability, the Arbitrator concludes as follows:

Based on the Arbitrator's findings on the issue of causal connection through August 14, 2015, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 34-2/7 weeks commencing 12/18/14 through 8/14/15. Respondent shall receive credit for amounts paid or overpaid. Respondent agreed to pay the period of TTD covered by the first 19 B hearing commencing 1/10/06 through 5/3/06 indicating that this period is not in dispute and has been paid. ARB EX 1.

In support of the Arbitrator's decision relating to (L) nature and extent of injury, the Arbitrator concludes as follows:

Based on the Arbitrator's finding of causal connection through August 14, 2015 and not thereafter, Petitioner's alternative request for a nature and extent finding, and on the record in its entirety, the Arbitrator finds Petitioner sustained 10% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. The Arbitrator initially notes that no analysis under Section 8.1b is necessary given that the accidental injury did not occur on or after September 1, 2011.

Petitioner sustained a labral tear to his right shoulder on 9/21/05 which required surgical repair and post surgical therapy. Petitioner was released to work very heavy duty on 8/14/15 which exceeded his required job duties for Respondent. Petitioner testified that he has consistently worked in some capacity as an EMT before, during and after this right shoulder injury and treatment stemming from the 9/21/05 accident. He credibly testified that he has help from co-workers while performing EMT duties and that he is able to work full time as a photographer without difficulty. He testified that he has learned to live with

residual shoulder pain post surgery and that he takes over the counter medication for any residual pain. He has some flare up pain after every day activities at home. Accordingly, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% man as a whole pursuant to Section 8(d)(2) of the Act as a result of his 9/21/05 work accident. *Will County Forest Preserve District v. IWCC*, 2012 Ill.App. LEXIS 109. Respondent is not entitled to credit for a prior 29% loss of use of the right arm/shoulder against the man as a whole award for Petitioner's right shoulder injury in this case and no such credit is awarded or applied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC008522
Case Name	COLLIER, DERIK v. NORTH AMERICAN LIGHTING, INC.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0459
Number of Pages of Decision	10
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Keith Sparks
Respondent Attorney	Stephen Carter

DATE FILED: 9/10/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derik Collier,
Petitioner,

vs. NO: 20 WC 8522

North American Lighting, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 28, 2020, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

SEPTEMBER 10, 2021
o8/18/21
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLIER, DERIK
Employee/Petitioner

Case# **20WC008522**

NORTH AMERICAN LIGHTING
Employer/Respondent

On 12/28/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH SPARKS
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CHICAGO, IL 60602-2983

5791 LAW OFFICE OF STEPHEN A 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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Derik Collier,
Employee/Petitioner
v.
North American Lighting,
Employer/Respondent

Case # **20** WC **08522**

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 **Mt. Vernon, IL**, on **11-5-2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS:

On **5-17-2019**, 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 regarding his shoulder injury and facial disfigurement are causally related to the accident.

In the year preceding the injury, Petitioner earned $**48,632.48**; the average weekly wage was $**935.24**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

Petitioner has received all reasonable and necessary medical services.

Respondent has paid or will pay all appropriate charges for all reasonable and necessary medical services through maximum medical improvement of 12/16/2019.

Respondent shall be given a credit of $**3,117.45** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**24,395.81** for other benefits, for a total credit of $**27,513.26**.

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

ORDER:

Respondent shall pay temporary total disability benefits of **$ 623.49** / week for a period of **5.0 weeks** from **9-4-2019 through 10-8-2019** as provided in Section 8(b) of the Act for the time that Petitioner lost from work on account of the accident on 5-17-2019, as Petitioner established that said lost time was related to the accident.

Respondent shall pay the reasonable, necessary and related medical bills through Petitioner's maximum medical improvement date of December 16, 2019 as provided in Section 8(a) of the Act at the appropriate Illinois workers' compensation fee schedule rate, as Petitioner established that the treatment provided by said provider was related to the accident on 5-17-2019.

Respondent shall pay disfigurement benefits of **$561.14** / week for a period of **12 weeks** as provided in Section 8(c) of the Act for the disfigurement to Petitioner's face, as Petitioner established that the disfigurement was related to the accident.

Respondent shall pay permanent partial disability benefits of **$561.14** / week for a period of **70 weeks** as provided in Section 8(d)(2) of the Act, as Petitioner established that he was entitled to an award of **14%** loss of use to the person-as-a-whole for his shoulder injury.

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

DEC 28 2020

12/16/20
Date

PROCEDURAL HISTORY

This matter proceeded to trial on November 5, 2020, pursuant to Sections 8(a), 8(b)2 and 8(c) of the Illinois Workers' Compensation Act (hereinafter "the Act"). The issues in dispute are: 1) admissibility of photographs of the Petitioner's disfigurement; 2) the causal connection between the accident and the Petitioner having a weird sensation on his forehead for which he sought treatment on January 22, 2020, and February 5, 2020; and 3) the nature and extent of the Petitioner's injuries. Initially, the parties disputed the Petitioner's earnings during the year preceding the injury and the Petitioner's average weekly wage. At the arbitration hearing, the parties agreed to use the Respondent's figures, resulting in an agreed average weekly wage of $935.24.

FINDINGS OF FACT

At the time of the accident, the Petitioner, who was 38 years old, was employed by the Respondent as a technician fixing equipment, programming robots and performing general maintenance. (T. 19-20) On May 17, 2019, went into a paint booth to modify the program on a painting robot, which already had a job cued up to perform. (T. 20-21) When the Petitioner tried to take control of the robot, it proceeded with the job in the cue, and the robotic arm struck the Petitioner in the right cheek and caused him to fall. (T. 21,22)

The Petitioner went to the Salem Township Hospital emergency room, where he sought treatment for a laceration to his face. (T.22, PX1). He reported having a headache but no loss of consciousness and stated that the robot knocked him down onto his back (PX1). The laceration measured 4 cm in length, with some separation of the upper one-third of the cut and some irregular edges. (Id.) He received five stitches, a tetanus shot and a CT scan of his head, which found no abnormalities. (Id.)

Shortly thereafter, the Petitioner experienced right shoulder pain and numbness into his hand, for which he received physical therapy at Apex Network Physical Therapy from June 3, 2019, through July 3, 2019. (RX7) He was then referred to Dr. Jason Young at Motion Orthopaedics, who examined the Petitioner on July 25, 2019, and ordered an MRI of the Petitioner's right shoulder. (RX4) On August 5, 2019, Dr. Young diagnosed a right shoulder superior labral tear, a partial thickness long head biceps tear and an upper border subscapularis tear and stated that the robot accident was a substantial factor in causing the Petitioner's right shoulder symptoms. (Id.) Dr. Young recommended surgery. (Id.)

On September 4, 2019, Dr. Young performed a right shoulder scope with subacromial decompression, distal clavicle excision and biceps release. (Id.) The Petitioner was written off work until his next appointment and referred for physical therapy. (Id.) He underwent physical therapy at Apex from September 9, 2019, through December 12, 2019. (RX7) The Petitioner also had several follow-up appointments with Dr. Young, who progressively reduced the Petitioner's work restrictions. (RX4) The Petitioner returned to work October 9, 2019, on light duty. (T. 27-28) At his follow-up appointment on November 25, 2019, Dr. Young gave the Petitioner a subacromial injection to reduce some bursitis, reduce a pinching sensation the Petitioner was experiencing and speed up his recovery. (Id.) Dr. Young found the Petitioner to be at maximum medical improvement and released him to full duty on December 16, 2019, after the Petitioner reported that he thought he was back to his normal baseline. (RX4)

The Petitioner saw Nurse Practitioner Dawn Drewes of SSM Health Medical Group on January 22, 2020, at his workplace (T. 38, RX6) He complained of a "weird sensation" on his forehead that he described as tingling or "like someone is dragging hair" across his forehead. (RX6) N.P. Drewes advised him to monitor his blood pressure and start a healthy lifestyle. (Id.)

She noted that she wasn't "really sure" if this complaint was work-related. (Id.) The Petitioner followed up on February 5, 2020, and reported that the sensation was gone. (Id.)

At the arbitration hearing, the Petitioner testified that before the accident, his shoulder was fine, but now it did not feel the same, and he doubted it would ever be the same. (T. 29-30) He stated that he experiences pain when working overhead and that his shoulder is not as strong. (T. 29) He said that on occasions when playing catch with his son, he feels a pinch in his shoulder. (T. 30) He also reported difficulty in starting a weed eater or chain saw. (T. 31) He experienced pain when picking up something heavy. (Id.)

The Petitioner displayed the scar on his cheek during the hearing and at a pretrial meeting prior to arbitration. The scar measured about two inches, with the top third being wider than the rest and having an indentation and discoloration. It was visible from at least six to 10 feet away. The Petitioner testified that he took the photographs in Petitioner's Exhibit 3 on the day before the arbitration hearing. (T. 54) The Arbitrator finds that this disfigurement is serious and permanent.

CONCLUSIONS OF LAW

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

Admissibility of photographs of the Petitioner's disfigurement.

At arbitration, the Respondent objected to the admission of Petitioner's Exhibit 3 – four photographs of scarring to the Petitioner's face – simply stating that the photographs were inadmissible as proof of disfigurement. Neither party submitted any law specifically relevant to whether the photographs are admissible in a disfigurement case. The Arbitrator did find a Commission decision affirming and adopting an arbitration decision wherein the arbitrator based

his conclusion, in part, on photographs of disfigurement. *Cuffy v. American International Hospital*, 92 IIC 0308. Furthermore, the Illinois Supreme Court noted an absence of disfigurement photos in finding that it had no basis to overturn a disfigurement award. *Corn Products Co. v. Industrial Com.*, 51 Ill.2d 338, 341-342 (1972).

The Petitioner laid the proper foundation for the photographs at the hearing. Therefore, the Arbitrator finds the photos to be admissible.

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

The Respondent agreed that the Petitioner's facial disfigurement and shoulder injury were causally related to the accident of May 17, 2019, but disputed the Petitioner having a weird sensation across his forehead as being causally related to the accident.

The only evidence of this condition was the SSM Health Medical Group records cited above. The nurse practitioner was equivocal as to an opinion on a causal relationship between this condition and the accident.

Therefore, the Arbitrator finds that the Petitioner failed to prove that his forehead condition was causally related to the accident, and the Respondent will not be responsible for payment of the SSM Health Medical Group bills for January 22, 2020, and February 5, 2020.

Issue L: What is the nature and extent of the Petitioner's injury?

Pursuant to Section 8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011, is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of 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.** Neither party submitted an AMA rating. Therefore, the Arbitrator uses the remaining factors to evaluate the Petitioner's permanent partial disability.

(ii) **Occupation.** The Petitioner continues to work as a technician for the Respondent without any restrictions. Therefore, the Arbitrator places no weight on this factor.

(iii) **Age.** The Petitioner was 38 years old at the time of the injury. He has many years left during which time he will need to deal with the residual effects of the injury. The Arbitrator places significant weight on this factor.

(iv) **Earning Capacity.** There was no evidence of limitation of the Petitioner's earning capacity. Therefore, the Arbitrator places no weight on this factor.

(v) **Disability.** Although the medical records showed that the Petitioner has returned to his baseline condition, the Arbitrator finds the Petitioner's testimony credible that there are certain activities that causes him pain or discomfort – working overhead, starting a weed eater or chain saw, playing catch with his son and lifting heavy objects. The Arbitrator puts some weight on this factor.

Therefore, the Arbitrator finds the Petitioner's temporary total disability to be 14 percent of a person as a whole regarding the shoulder injury. In addition, the Arbitrator finds the Petitioner is entitled to compensation for 12 weeks at the rate specified in Section 8(b)2.1 of the Act for disfigurement.

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	15WC032569
Case Name	FISCHBACH, EDWARD v. PURE METAL RECYCLING LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0460
Number of Pages of Decision	16
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Craig Manchik
Respondent Attorney	Nicole Hanlon

DATE FILED: 9/10/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Fischbach,
Petitioner,

vs. NO: 15 WC 32569

Pure Metal Recycling LLC,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay $1,341.07/week for life, commencing August 12, 2020, as provided in Section 8(e)18 of the Act, because the injury caused 100% loss of the ***right arm***. 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 pay to Petitioner interest under §19(n) of the Act, if any.

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

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

SEPTEMBER 10, 2021
o8/18/21
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FISCHBACH, ED
Employee/Petitioner

Case# **15WC032569**

PURE METAL RECYCLING LLC
Employer/Respondent

On 11/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4151 MANCHIK & ASSOCIATES PC
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4412 ACCIDENT FUND HOLDINGS, INC
NICOLE BUBAN HANLON
PO BOX 40785
LANSING, MI 48901

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

Ed Fischbach
Employee/Petitioner

v.

Pure Metals Recycling, LLC
Employer/Respondent

Case # **15** WC **032569**

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 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. ☒ 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 **Are Ongoing Vocational Rehab Services Merited?**

FINDINGS

On **12/22/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$107,999.84**; the average weekly wage was **$2,076.92**.

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

Respondent shall be given a credit of **$316,358.17** for TTD, **$0** for TPD, **$11,333.27** for maintenance, and **$0** for other benefits, for a total credit of **$327,691.44**, per the agreement of the Parties, all lost time benefits have been paid as of the time of trial.

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 $58,178.53, as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below.

Respondent shall pay Petitioner permanent and total disability benefits of $1,341.07/week for life, commencing August 12, 2020, as provided in Section 8(f) of the Act.

Petitioner's claims for penalties pursuant to Sections 19(k) and 19(l) and for attorney's fees pursuant to Section 16 are denied.

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

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

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

Signature of Arbitrator

October 30, 2020
Date

NOV 2 - 2020

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 22, 2014.

Petitioner was 48 years old on the date of accident and was employed by Respondent as a heavy equipment mechanic. He had been so employed by Respondent since 2009. Petitioner worked as a heavy equipment mechanic since graduating high school in 1985. His job was to maintain and repair equipment, such as excavators, wheel loaders and cranes. He worked on engines and hydraulics in the machines, using tools and ladders to work on machines, climbed into machines and lifted up to 80 pounds. Petitioner is right-handed. He has several certifications related to the heavy equipment repair trade, including computer diagnostics for Caterpillar equipment.

On December 22, 2014, Petitioner was hit in the right hand with a projectile and suffered a penetrating wound to his right wrist. He was assembling a track with a co-employee and the co-employee miss-hit a pin, causing the wound and a partial extensor carpi radialis brevis tendon laceration and fracture of the scaphoid.

Petitioner received first aid at Respondent's facility and later went to the Sandwich/Valley West Hospital ER, where an x-ray revealed a foreign body and an attempt to evacuate the FB was made. Petitioner was given antibiotics and a stat referral to an orthopod was made. (PX 1)

Petitioner was next seen by Dr. David Burt at Midwest Sports Medicine Institute on December 23, 2014. Dr. Burt performed surgery on Petitioner's right wrist on December 24, 2014 to remove the foreign body. The procedure was: 1.) Open exploration and removal of foreign body, right wrist; 2.) Subcutaneous presumed infectious process, right wrist; 3.) Partial, less than 50% laceration extensor carpi radialis brevis. (PX 2 & 3) IV antibiotic therapy was initiated due to an infection. Dr. Burt referred Petitioner to Kleiser Physical Therapy post-surgery for improvement of motion and strength and scar revision. Petitioner continued to treat with Dr. Burt through May 26, 2015, when Dr. Burt deferred further treatment to Dr. Alan Chen, a hand specialist. Dr. Burt's diagnosis at the last visit was Residual FB. (PX 2)

Petitioner had PT at Kleiser From January 14, 2015 to April 21, 2016. The final report to Dr. Chen documents limited progress noted with pain and strength. "Swelling continues to fluctuate." (PX 4)

Petitioner was seen for an IME by Dr. John Fernandez on May 14, 2015. Dr. Fernandez diagnosed stiffness relating to adhesions of the extensor tendons of the wrist, residual to the penetrating wound. An MRI and a Stat-A-Dyne splint were recommended. (RX 12)

Petitioner began treatment with Dr. Chen on May 19, 2015. Dr. Chen concurred with Dr. Fernandez's diagnosis and recommended MRI, PT and CPM therapy. The MRI showed extensor tenosynovitis, possible scaphoid fracture, TFCC tear and synovitis of the radial-carpal joint, per D. Chen. (PX 6) Dr. Chen ordered a CT of the hand, which was said to show no fracture and possible developing osteonecrosis of the scaphoid. (PX 7) Petitioner underwent extensive hand surgery by Dr. Chen on July 23, 2015. The procedure was: 1.) Neuroma excision; 2.) Extensive neurolysis of right radial sensory nerve; 3.) Tenosynovectomy of the 2nd extensor compartment; 4.) Tenosynovectomy of the 3rd extensor compartment; Tenosynovectomy of the 4th extensor compartment; and Vascularized bone grafting to the scaphoid proximal pole, some of which was under microscope. (PX 6) Post surgery, Petitioner had therapy at Midwest Hand Care, and was also provided with orthosis devices from this facility. OT and hand therapy at Midwest ran through November 2, 2015. Authorization for more therapy was requested, but was apparently not approved. The last orthosis service was on June 20, 2016. (PX 8) Petitioner had treatment with Dr. Chen through June 20, 2016. At the last visit, the

diagnosis was CRPS of the RUE. Adhesions were noted, but further surgery was deferred, as Petitioner had developed CRPS. Petitioner was to continue with treatment by Dr. Patel and follow up as necessary. (PX 6)

Petitioner underwent a FCE study on January 16, 2016 at ATI. The study was ordered by Dr. Chen. The conclusion was that Petitioner functioned at the medium demand level and his job was classified as "heavy". The study was deemed valid and right upper extremity deficits were noted. (PX 10)

Petitioner was referred by Dr. Chen to Dr. Udit Patel at Pain and Spine Institute for palliative treatment for CRPS. He continues to see Dr. Patel approximately one time a month. The first visit to Dr. Patel was on February 12, 2016. Dr. Patel diagnosed right hand pain and tingling and prescribed Gabapentin. As of March 26, 2016, Dr. Patel began to suspect RSD/CRPS. By May of 2016, Dr. Patel confirmed RSD/CRPS of the RUE. Eventually, Petitioner underwent 5 stellate ganglion block procedures, with no permanent relief. A spinal cord stimulator (SCS) was recommended. At the last visit Petitioner had with Dr. Patel (August 10, 2020), the assessment was Complex regional Pain Syndrome, Type 1 and right hand pain. Petitioner was instructed to continue the medications Cymbalta and Norco and had a work restriction of no use of the right hand. Photos of Petitioner's right hand taken on August 10, 2010 were consistent with what the Arbitrator observed at trial. (PX 11)

Petitioner underwent a second FCE on April 29, 2016 at Physical Therapy Providers. This study was ordered by Dr. Patel. The conclusion of the FCE was that office work or retraining were thought to be appropriate for Petitioner. Return to work as a heavy equipment mechanic was not indicated. (PX 12)

Petitioner was seen by Dr. Elliot Nacke at Hinsdale Orthopaedics for a second opinion on May 10, 2016. Dr. Nacke diagnosed CRPS and recommended follow up with Dr. Patel. (PX 13)

On October 14, 2016, Petitioner presented to Dr. Patel and had decided to proceed with the spinal cord stimulator. Dr. Patel ordered an MRI of the spine and a neuropsychologic evaluation for which he referred him to Dr. Brown. (PX 11) On December 21, 2016, Dr. Patel reviewed the recent, fourth IME of Dr. Fernandez, and noted that Dr. Fernandez agreed with Dr. Patel's diagnosis of CRPS and recommended course of treatment. (PX 11)

On July 17, 2017, Dr. Patel saw Petitioner and noted that he had started to develop tolerance to his medications and there is no other option but the spinal chord stimulator to control his pain. (PX 11)

In accordance with protocol for the recommended SCS, Petitioner was seen by Dr. Brown on November 10, 2017 for psychological evaluation. Dr. Brown determined that Petitioner was an acceptable SCS candidate from a psychological perspective. (PX 23)

On May 2, 2017, Petitioner presented to Dr. Nancy Landre for a psychological evaluation at Respondent's request. (RX 7 and PX 24) Dr. Landre opined that Petitioner sustained a work-related injury on December 22, 2014, in connection with which he underwent an extensive course of treatment with little or no improvement. As part of the evaluation by Dr. Landre, Petitioner underwent a clinical review, performance and symptom validity testing, and standardized psychological assessment. An objective assessment of risk factors for spinal surgery was completed. During the clinical interview, Petitioner presented as stable, friendly and fully cooperative with a mildly dysphoric mood and variety of injury related complaints include severe pain, tingling and numbness, depression, change in his family life and memory problems. Performance and symptom validity testing revealed some abnormal findings with evidence of possible over and under reporting. Dr. Landre further noted that Petitioner had a number of risk factors that reduce his likelihood of having a good surgical outcome,

including previous spine surgery, Being significantly overweight and suffering from a condition more than 12 months in duration. (PX 24, RX 7)

Dr. Landre opined that the test results and history most strongly suggest a diagnosis of adjustment disorder with mixed anxiety and depression. Furthermore, Petitioner showed some evidence of somatoform disorder. Nevertheless, she agreed with the recommendation that Petitioner receive a spinal cord stimulator versus other treatment. Although Petitioner was not an ideal candidate for the procedure, his outcome could be improved by the provision of additional psychological services. Specifically, Petitioner would likely benefit from cognitive behavioral psychotherapy with a doctoral level provider who has particular experience in pain management. She said that there are several on staff at RIC with these qualifications. Furthermore, she believed that Petitioner would benefit from weekly cognitive behavioral psychotherapy to address the psychological components of his pain syndrome. (PX 24, RX 7)

On June 5, 2017, Dr. Landre prepared an addendum IME report. (RX 6) The doctor noted that she previously indicated that Petitioner was suffering from adjustment disorder with mixed anxiety and depression, as well as from a possible somatoform disorder. Based upon the findings and all of the other available information it was her opinion that Petitioner was not an optimal candidate for placement of a SCS. With treatment of his psychological dysfunction and successful completion of a comprehensive interdisciplinary pain program such as the one offered by RIC however it was her opinion that he may become a better SCS candidate in the future. To clarify her initial report, Petitioner would benefit from such services prior to the placement of a SCS. Indeed, with such services, Petitioner may demonstrate a significant improvement in his pain symptomatology such that surgery would no longer be necessary. (RX 6)

Petitioner was seen by Dr. Konowitz for a Section 12 exam at Respondent's request on March 14, 2017. (RX 8) Dr. Konowitz diagnosed CRPS and opined that Petitioner can't return to work at his regular job. He endorsed a SCS in order to reduce the quantity of pain medication that Petitioner was taking. A five pound work restriction with continued use of a wrist support was recommended. Return to work at regular duty or without restriction was unlikely. Vocational rehabilitation should be considered. (RX 8)

Petitioner was seen by Dr. Salehi, for a surgical consult regarding the SCS on January 16, 2018. (PX 19) Petitioner had a spinal cord stimulator placement on February 10, 2018. Dr. Salehi also performed a Spinal Cord Stimulator generator revision on September 12, 2018. On September 25, 2018. Dr. Salehi released Petitioner to return to him as needed and he was to continue following up with Dr. Patel. (PX 19)

Petitioner attended physical therapy at ATI from May 25, 2018 – November 2, 2018. (PX 9).

Petitioner testified that he started vocational rehabilitation services with Jacky Ormsby from CorVel Corporation in 2017. Ormsby was retained by Respondent's carrier. She helped him with his resume and helped him look for jobs.

Petitioner testified that he got a job after the SCS was implanted, even with the five-pound restriction that had been given. He was hired at Equipment Services Plus as a shop clerk in April of 2018. His duties while working as a shop clerk were to take notes and to obtain parts when mechanics needed them. He functioned as a jobber/facilitator in this job.

Petitioner testified that he returned to Dr. Patel because his hand condition got horrible. Dr. Patel prescribed a permanent work restriction of no use of the right hand on July 10, 2018. (PX 11) Petitioner testified that this job then ended.

Petitioner testified that he continued thereafter with vocational rehab efforts with Ormsby. Petitioner testified that he sent out approximately 1500 resumes with Ormsby's assistance. Petitioner testified that when he would appear for an interview, they see his see brace, ask about his injury. Because he tells them that he could not use his right hand, they would not hire him. Petitioner was thereafter referred to Vocamotive and he went there for training services. The training efforts did not go well for this 50 plus year old mechanic with work restrictions of no use of his dominant hand.

Petitioner testified that he was doing one handed typing, trying to learn Microsoft programs that he had no clue what he was doing. Petitioner was disappointed in the vocational services that were provided at Vocamotive. He was frustrated with one handed typing. Dragon software did not work out. The typing was something he wasn't used to doing, and it was very aggravating and disappointing. Petitioner testified that Dr. Kelley was teaching him some techniques to deal with the agitation and the disappointment that he was experiencing as a result of his change of life.

Petitioner testified that the mental agitation causes an aggravation of physical symptom of his CRPS condition. Petitioner testified that Vocamotive never sent out any resumes for him, or provided any job seeking assistance. Petitioner testified that writing and working with his right hand aggravated it and caused it to swell and the CRPS acted up. Petitioner testified that Respondent did not want him to continue working in vocational rehabilitation with CorVel and Ms. Ormsby. Petitioner testified that he has continued a diligent but unsuccessful attempt to find work.

Petitioner testified that Dr. Patel referred him to Dr. Kelley about three months after he began with Vocamotive. Petitioner testified that his understanding as to why Dr. Patel referred him to Dr. Kelly was that he had some stress and anxiety going on, because his hand was getting huge being at Vocamotive.

Petitioner was under the care of Dr. Kelley at Integrated Behavioral Medicine from November 16, 2019 up to July 28, 2020 on a referral by Dr. Patel. (PX 22) He was authorized off of work on November 16, 2019. The petitioner was initially examined on November 16, 2019 and November 22, 2019. Petitioner underwent extensive psych testing. Thereafter, he was diagnosed with major depressive disorder; anxiety disorder and pain disorder with related psychological factors. It was noted that Petitioner experienced more depressive mood symptoms than the average patient. In addition, the reported level of anxiety is not unusual for a pain patient; however, the anxious distress may complicate symptom perception. Dr. Kelley noted multiple factors in combination are associated with heightened report of pain, heightened levels of emotional distress and an increased probability of chronicity of Petitioner's pain condition. Furthermore, there was a high level of functional complaints and perceived disability. Petitioner reported that vocational rehabilitation was aggravating and emotionally overwhelming. Dr. Kelley recommended cognitive-behavioral therapy. (PX 22

Petitioner has continued with therapy with Dr. Kelley. It was noted in the visit on February 1, 2020 that he discussed with Petitioner the possible benefits of re-initiating participation in vocational rehabilitation. Thereafter, on February 15, 2020 Petitioner was released to resume vocational rehabilitation with one-on-one didactic interaction. There was a notation from Dr. Kelley dated March 27, 2020 wherein it was referenced that Petitioner reported, "I can't stand sitting around. I'm going nuts." Dr. Kelley continued to work with the Petitioner to help with coping skills and to provide therapy. At the last visit on July 28, 2020, Petitioner reported that he had stress with using his hand and it worsened his pain. (PX 22)

Petitioner was seen by Dr. Obolsky for an Independent Forensic Psychiatric Examination at the request of Respondent. (RX 3) Dr. Obolsky prepared a report dated August 4, 2020. The dates of the evaluation were on January 29, 2020 and February 25, 2020.

Following the evaluation and testing, Dr. Obolsky opined that Petitioner exhibited the conditions of mental ill-being of exaggeration of symptoms (malingering). Dr. Obolsky noted Petitioner reported fewer symptoms in a narrative than when he had a choice to endorse them, which Obolsky said points toward symptom exaggeration. The complaints of memory deficits were inauthentic. During the interview, Petitioner showed normal short and long-term memory and had no memory impairments on the comprehensive memory test. There were also other tests where he exaggerated cognitive symptoms at a level indicative of malingering. Dr. Obolsky noted that Petitioner exaggerates the symptoms of stress and anxiety. Petitioner reported that the experienced stress when he took part in vocational training which worsened his pain. Dr. Obolsky further noted that Petitioner exaggerated his anxiety symptoms, his complaints of depression, his irritability and his physical and pain symptoms. (RX 3)

Dr. Obolsky also reviewed Dr. Kelley's report from November 22, 2019 and said that the results of the psychological testing were most consistent with malingering, given validity test results and inconsistent symptom reports. Dr. Obolsky said that Dr. Kelley's summary of Petitioner's validity scores "raised the potential" for "intentional negative bias" due to high self-disclosure scale score. Dr. Obolsky noted that Dr. Kelley diagnosed Petitioner with moderately severe major depressive disorder and pain disorder; however, Dr. Obolsky believed that the psychological testing was most consistent with malingering. Dr. Obolsky opined that the evidence from the available records, psychological and cognitive testing and the forensic interview indicated that Petitioner was exaggerating and feigning his mental, emotional and cognitive symptoms. Also, Petitioner's report of symptoms and pain levels were also exaggerated. Dr. Obolsky opined that Petitioner's mental, emotional, and cognitive symptoms were not causally related to the work accident. Dr. Obolsky did not believe that Petitioner required any further mental health treatment and had reached MMI. Dr. Obolsky believed that Petitioner was malingering and there was no evidence to support his complaints of mental, emotional or cognitive symptoms. He further did not believe that any mental health treatment would be reasonably and safely provided since Petitioner was malingering. Dr. Obolsky believed that from a medical and psychiatric perspective Petitioner was mentally fit for competitive employment consistent with his education, training experience and skills and there was no objective evidence indicating that the petitioner was experiencing authentic mental, emotional or cognitive symptoms interfering with his participation and receiving benefits vocational rehabilitation if he chooses to do so. (RX 3)

Dr. Patel testified at Petitioner's request via evidence deposition on April 27, 2018. (PX 25) Dr. Patel diagnosed CRPS and described Petitioner's course of treatment. Dr. Patel endorsed causation. (PX 25)

Dr. Salehi testified at Petitioner's request via evidence deposition on May 1, 2018. (PX 26) He described his treatment of Petitioner, including the placement of the SCS. Dr. Salehi endorsed causation. (PX 26)

Dr. John Fernandez authored 4 IME reports regarding Petitioner. (PX 5) On May 14, 2015, the diagnosis was: residual stiffness relating to adhesions of the extensor tendons of the wrist and hand creating significant extrinsic tightness making it difficult for the patient to grip with associated pain and weakness, residual to the penetrating injury that he sustained on 12/22/14. Subjective complaints were consistent with objective findings. Dr. Fernandez recommended proceeding with an MRI scan to evaluate the local extensor tendons in the area where he is having his complaints at the wrist, specifically looking at the extensor carpi radialis brevis. It is possible that it is significantly attenuated or ruptured. He should be fitted for a Stat A Dyne splint. If, in the next four weeks, he does not have significant response to that type of treatment, I believe that he would be a candidate for possible surgical intervention. The other option is to live with it and work within the limitations. Dr. Fernandez agreed to a 5 pound lifting restriction and light duty, concurring with Dr. Burt and Dr. Chen. Treatment to date has been reasonable and necessary. Prognosis without surgery is extremely poor. (PX 5)

The second report was December 10, 2015. The diagnosis was: residual pain and stiffness with associated weakness postsurgical from the recent surgery of 7-23-15; Right hand, wrist and arm pain with associated swelling and color changes, possible type 2 CRPS,Right wrist and hand stiffness, likely extensor tendon adhesions. The condition was causally related to the injury. Treatment has been reasonable and necessary and related to the work injury. He should undergo further definitive care management with Dr. Patel at the Pain Management Center in treatment of CRPS. He can do sedentary work with activities under 5-10 pounds. Prognosis beyond this very guarded and likely restrictions should be considered permanent. (PX 5)

The third report was dated May 5, 2016. The diagnosis was: 1.) Right hand, wrist and arm pain with associated swelling and color changes, possible CRPS; 2.) Right wrist and hand stiffness, likely extensor tendon adhesions. Continued follow up for pain management care with Dr. Patel was endorsed, with the possibility of sympathetic ganglion blocks and medications for CRPS. He is at MMI for his surgical procedure, but remains symptomatic and in need of care for the CRPS. (PX 5)

The fourth report was November 10, 2016. The diagnosis was: CRPS, he continues to have objectifiable evidence of that as fulfilled by the Budapest Criteria including both his subjective complaints as well as objective findings in terms of discoloration, swelling, allodynia and temperature difference. Dr. Fernandez agreed with conducting the necessary diagnostic studies in order to evaluate for placement of a Spinal Cord Stimulator. Work restrictions "would be one of sedentary to light duty in nature essentially average under five (5) pounds with regard to force and repetition, particularly use of tools and/or operative machinery...There may be other restrictions that may be provided depending on the types of medications he is taking and again, these would be referenced to his pain management specialist." Prognosis for this is extremely guarded. (PX 5)

Petitioner presented the testimony of Jacky Ormsby, MS, CRC, LCPC. She was engaged by Respondent's carrier to provide vocational services to Petitioner. It is difficult to place an injured worker with restrictions of no use of his dominant hand. There really is not a stable job market for such a case. Petitioner is not a good candidate for one-handed work. Petitioner is not an employable candidate. He is 54 years old with a complete restriction on the use of his right (dominant) hand. Petitioner has some transferable skills, he is friendly, positive and motivated. There is no stable labor market for Petitioner. He has exhausted vocational services and it is not likely that he will be employed.

Respondent presented the testimony of Joseph Belmonte, CRC of Vocamotive. Mr. Belmonte was retained to provide educational services/testing and assessment to Petitioner. He did prepare a rehabilitation plan for Petitioner, but this was made without contact with Petitioner. (RX 5) An assessment and formal interview would be required to move forward with rehab services, per Vocamotive's standards. Belmonte testified that it is not outside of the realm of possibility that Vocamotive could place Petitioner in an unarmed security guard position.

Petitioner testified that he had no prior problems with or injuries to his right arm, wrist or hand. He had no prior workers' compensation claims or injuries and had, in fact, received safety bonuses. He liked his job and regularly worked overtime in order to finish jobs. Being right-handed, petitioner did not use his left hand for tools. He now has weakness in his right hand. He has no grip strength and gripping increases swelling in the hand, causes the hand to change colors, and "agitating pain". His right fingers have a flexion deformity. Nail growth is decreased in the right hand. Per the FCE, he can't do heavy or medium work. He can't perform general labor. He is restricted to no use of the right upper extremity. He has increased sensitivity in the right hand. He notices swelling, burning pain and a purplish color. He experiences tremors in his RUE and hand. The hand is sweaty and cold. The symptoms are worsened by activity and weather changes. It is painful to shake hands. If his hand is bumped, it is very painful. He experiences pain with ADLs, such as brushing his

teeth and with household chores. The SCS gives Petitioner relief, but it is less effective now. Petitioner wears a compression glove that helps keep the swelling down and supports his finger. He is currently treating with Dr. Patel (who prescribes Norco, Lyrica Cymbalta and vitamins, and orders testing for organ function related to the medications. He also follows up with Dr. Kelly for psych sessions and Dr. Salehi for the SCS.

The Arbitrator observed a scar on Petitioner's wrist and on the dorsal aspect of the outside of the forearm below what would be the wrist bone. There was a keloid scar, which from six feet away, was two and a half inches, and it's an eighth to a quarter each wide and raised and there is a slight pigmentation difference in it. The hands were also viewed. The right hand was swollen, and the skin appeared to be tight. Petitioner was having difficulty extending all of his fingers, and it looked puffy like somebody had injected something into it. It appeared that the soft tissue in the hand on the dorsal aspect of the hand again was raised up a good amount, less than an inch above the plane that would be shown on the dorsal aspect of the left hand. There was soft tissue swelling in the hand, and the skin appeared to be different.

CONCLUSIONS OF LAW

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

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

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

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

The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. Walker v. Chicago Housing Authority, 2015 IL App (1st) 133788, ¶ 47 Petitioner's testimony is found to be credible.

WITH RESPECT TO ISSUE (F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? THE ARBITRATOR FINDS:

Respondent agrees that Petitioner's current condition of ill-being regarding the physical injuries sustained to his right upper extremity are causally related to the injury. Respondent disputes that Petitioner's psychological treatment is causally related to the injury.

Petitioner's current condition of ill-being regarding his right upper extremity, to wit: CRPS, status post penetrating wound with laceration of extensor tendons and scaphoid fracture, with implantation of SCS is causally related to the work injury of December 22, 2014. This finding is based upon the testimony of

Petitioner, Drs. Patel and Salehi and the medical records, including the opinions of Drs. Fernandez and Konowitz. The CRPS condition disables Petitioner from work and has resulted in his permanent and total disability from work, as is set forth below.

The Arbitrator finds Petitioner's credible testimony and the medical records support a finding that the psychological symptoms that Petitioner experiences and the treatment that Petitioner has received from Dr. Kelley is causally related to the injury and is reasonable and necessary to cure or relieve the effects of the work injury of December 22, 2014.

Dr. Obolsky's opinion that Petitioner is malingering is not persuasive. Petitioner has suffered an injury that has led to his not being able to work at a vocation that he obviously loved and that he encaged in for 30 plus years. He is understandably upset with this development and it has affected his life such that he has depression and pain disorder with related psych factors, as diagnosed by Dr. Kelley. If Petitioner could get back to work as a heavy equipment mechanic, he would. He is not feigning his difficulties.

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:

Petitioner claimed $63,118.61 in unpaid medical expenses, per ArbX 1, the Request for Hearing. The Parties agreed that Respondent was entitled to a credit for awarded bills that it has paid or satisfied.

The following medical expenses are awarded:

Physical Therapy Providers: (PX 12, DOS: 4/29/2016, FCE)	**$ 1,600.00**
Premier Healthcare Services: (PX 15, DOS: 10/5/2016-3/12/2018, Medications)	**8,668.53**
Premier Healthcare Services: (PX 16, DOS: 10/6/2016-10/17/2019, Toxicology)	**37,400.00**
Oakbrook X-Ray & Imaging: (PX 17, DOS: 2/28/2017, MRI Thoracic and Cervical Spine)	**5,800.00**
Integrated Behavioral Medicine, Ltd.: (PX 22, DOS: 11/16/2019-7/31/2020, Psych Treatment)	**4,710.00**
TOTAL:	**$58,178.53**

The above expenses are found to be reasonable and necessary to cure or relieve the effects of the injury sustained and are awarded based upon the Arbitrator's findings on the issue of causation, above. The award of medical expenses is in accordance with Sections 8(a) and 8.2 of the Act and Respondent is entitled to a credit for all awarded bills that it has paid or satisfied.

The claimed expenses from ATI, Pain & Spine, Edward Hospital and Edward Health Ventures are not awarded, as no supporting bills were submitted.

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

As a result of the injuries sustained, Petitioner is found to be permanently and totally disabled from work, in accordance with Section 8(f) of the Act.

This finding is based upon the credible testimony of Petitioner, the medical records and the credible and persuasive testimony of Jacky Ormsby, along with the Arbitrator's findings on the issue of causation, above.

The unfortunate injury that Petitioner sustained has resulted in CRPS of the right upper extremity, which prevents him from returning to his job as a heavy equipment mechanic, a trade which he practiced for 30 years. Petitioner now has a restriction of no use of his right (dominant) upper extremity, which is supported by the medical records, Petitioner's testimony and the Arbitrator's observation of Petitioner at trial.

Jacky Ormsby, MS, CRC, LCPC, was retained by Respondent to provide vocational services for Petitioner, as it appeared that he could not return to work at his usual occupation. Ormsby testified that there is no stable labor market for Petitioner. He is not an employable candidate. It is unlikely that he will be employed. Vocational services for Petitioner have been exhausted. The Arbitrator finds Ormsby's opinions to be credible and persuasive and to best comport with the evidence adduced. If viable employment for Petitioner was available, Ormsby would have help him obtain it. Petitioner has demonstrated a diligent but unsuccessful job search as well.

Respondent submitted the testimony of Joseph Belmonte, CRC. Belmonte's testimony was basically that additional vocational services might lead to employment for Petitioner as a security guard or a service writer. Given the no use of the right upper extremity restriction, and the failed placement efforts of Petitioner and Ormsby, the Arbitrator finds Belmonte's opinions to be not persuasive.

Accordingly, an award pursuant to section 8(f) is appropriate in this case.

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

Petitioner's claim for Section 19(l) penalties is denied, as he failed to show compliance with Section 19(l)'s requirement of a written demand for payment of the claimed medical expenses. Estate of Edward P. Meyer v. Jewel Food Stores, 20 IWCC 0451

Petitioner's claim for Section 19(k) penalties and Section 16 attorney's fees is denied. Respondent's failure to pay the awarded medical bills in this complicated case is found to be not unreasonable or vexatious, given the evidence adduced, including the fact that Respondent has paid some $275,000.00 in medical expenses as shown in RX 1.

WITH RESPECT TO ISSUE (O), ARE ONGOING VOCATIONAL REHAB SERVICES MERITED? THE ARBITRATOR FINDS:

Based on the Arbitrator's findings above on the issue of nature and extent, the Arbitrator finds that ongoing vocational rehab services are not merited.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC016758
Case Name	DORSEY, GREGORY v. ST OF IL-ILLINOIS STATE POLICE
Consolidated Cases	
Proceeding Type	Petition for Review with Special Concurrence
Decision Type	Commission Decision
Commission Decision Number	21IWCC0461
Number of Pages of Decision	14
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Michael Hellman
Respondent Attorney	Danielle Curtiss

DATE FILED: 9/13/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREGORY DORSEY,

Petitioner,

vs. NO: 14 WC 16758

STATE OF ILLINOIS – ILLINOIS STATE POLICE,

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, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner worked as an investigator for the Illinois State Police in the gaming division. On February 3, 2014 he stopped at his office to get material for his field investigations for the day. He got out of his car in the assigned parking lot, slipped on snow on the pavement, and fell. His back and buttocks hit the ground and his head struck the door frame. Petitioner had excruciating pain his lower back and buttocks. He had to call a fellow officer to help him up and he eventually took Petitioner to a hospital Emergency Room.

A lumbar MRI taken on February 19, 2014 showed spondylosis at L4-5 and L5-S1 causing foraminal stenosis without significant central canal stenosis. Petitioner developed mid-back pain and an MRI taken on April 3, 2014, showed no acute osseous abnormalities, a prominent right osteophyte at T1-2 narrowing the adjacent neural foramen, a tiny paracentral/foraminal disc protrusion at T9-10, and no evidence of significant herniation or central canal stenosis.

Petitioner treated through May 28, 2015 with prescription medication, physical therapy/work hardening, epidural steroid injections, median block injections, and radiofrequency ablation. Petitioner was unable to complete the work hardening program due to pain. Upon completion of treatment, Petitioner still demonstrated deficits in strength, range of motion, gait, and subjectively reported 7/10 pain. Petitioner's treating doctor released him from treatment and to work without restrictions on May 28, 2015. Petitioner retired from Respondent in July of 2015. Petitioner testified that the work-related accident/injury sped up the timing of his retirement.

Petitioner acknowledged a previous injury to his back doing a military exercise when he fell from a truck. It was 15 to 17 years before the instant accident. Petitioner testified he enlisted in the armed forces in 1982 upon finishing high school. He was in active service for over 20 years and continued in the army reserves for a total of 34 years of service. The only treatment he received for the prior injury was a shot in the back. He had no other treatment for his back until the instant accident. Petitioner testified he had not worked anywhere since his retirement from Respondent. The accident changed his plans to work as a Department of Defense government contractor overseas, which would have been very lucrative. He could not perform that type of work physically after the injury.

The Arbitrator awarded Petitioner 75 weeks of permanent partial disability benefits representing loss of the use of 15% of the person-as-a-whole. He gave greater weight to Petitioner's credible testimony that he retired before he wanted due to impairment related to his injury. He gave some weight to his age (49). He gave moderate weight to his testimony about other job opportunities that he could no longer perform. He also gave greater weight to Petitioner's credible testimony about his ongoing disability and lifestyle change. Respondent argues that the permanent partial disability award is excessive. It stresses that great weight should have been placed on Petitioner's release to work without restrictions. No weight should be given to the possibility of loss of future income. It recommends a permanent partial disability award of 8% of the person-as-a-whole.

Initially, the Commission notes that there is a clerical error in the Findings section of the Corrected Decision of the Arbitrator. The decision notes an accident date of November 19, 2014, but the record establishes that February 3, 2014 was the correct date of accident. Accordingly, the Commission changes the accident date from November 19, 2014 to February 3, 2014.

Secondarily, we do not believe the Arbitrator should have given consideration to Petitioner's testimony about his "lost opportunity" for working as a contractor with the Department of Defense after his retirement. Without any evidence that Petitioner was offered any such employment or even that he applied for any such position, the Commission finds that that such an opportunity was speculative at best and should not be considered in determining the permanent partial disability award.

Nevertheless, we do not find the Arbitrator's permanent partial disability award to be excessive. Although we find that the Arbitrator should not have considered Petitioner's

speculative potential post-retirement income, the Commission notes that Petitioner had extensive conservative treatment that extended for 15 months and had significant deficiencies and pain after treatment was completed. These deficiencies appear to be permanent. Therefore, the Commission affirms the Arbitrator's permanent partial disability award.

IT IS THEREFORE ORDERED BY THE COMMISSION that in the Findings section of Corrected Decision of the Arbitrator "November 19, 2014" is changed to "February 3, 2014."

IT IS FURTHER ORDERED BY THE COMMISISON that the Corrected Decision of the dated March 12, 2021 is changed as noted above and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMMISSION that Respondent shall pay to the Petitioner the sum of $1,336.91 per week for a period of 70&3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $721.66 per week for a period of 75 weeks because the work-related injuries caused the loss of the use of 15% of the person-as-a-whole pursuant to §8(d)(2) of the Act.

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

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

SEPTEMBER 13, 2021

/s/Deborah L. Simpson
Deborah L. Simpson

/s/Stephen J. Mathis
Stephen J. Mathis

DLS/dw
O-8/18/21
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DORSEY, GREGORY Case# **14WC016758**
Employee/Petitioner

ILLINOIS STATE POLICE
Employer/Respondent

On 3/12/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5934 LAW OFFICES OF MICHAEL HELLMAN
515 JAMES ST
SUITE 4
GENEVA, IL 60134

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

6212 ASSISTANT ATTORNEY GENERAL
DREW DIERKES
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAR 12 2021

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Gregory Dorsey
Employee/Petitioner

v.

Illinois State Police
Employer/Respondent

Case # **14** WC 16758

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 **February 6, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 19, 2014** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was **$2,115.38**.

On the date of accident, Petitioner was **49** years of age, **married** with **three** 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 **$24,446.36** for TTD, **$0** for TPD, **$0** for maintenance, and **$90,140.74** for other benefits, for a total credit of **$114,587.10**.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$1,336.91/week** for **70 3/7** weeks, as provided in Section 8(b) of the Act. Respondent receives a credit for paying $114,587.10 in TTD and other benefits.

Permanent Partial Disability

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the man as whole, $721.66/weeks for 75 weeks, pursuant to §8(d)(2) of the Act.

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

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

Signature of Arbitrator

February 23, 2021

Date

MAR 12 2021

STATEMENT OF FACTS

The Petitioner, Gregory Dorsey, is a retired former special agent for the Division of Gaming and state trooper for the Illinois State Police. Petitioner retired from the State Police in July 2015. Petitioner had been employed with the State Police for nearly 20 years prior to that.

On February 3, 2014, the Petitioner was employed as a special agent out of the Tinley Park facility located at 8151 West 183rd Street and reported to work that day. On that day, Petitioner had gone into the State Police office to gather paperwork for interviews and investigations needed for that day and had returned to his car. Due to the geographic distance of some of the investigations for that day, Petitioner made a secondary check of the paperwork files that he had and noticed that he had omitted something and attempted to go back into the office to retrieve the files that he had omitted. Petitioner testified that his vehicle was a State issued vehicle in the form of an unmarked State Police vehicle. Once Petitioner realized that he had forgotten something inside, he attempted to exit his police vehicle and while stepping out of the driver's side of his vehicle he slipped on the pavement and sustained an injury to his back and his head. Petitioner testified that the conditions that day were wintry and there was snow covered on the roadway. Petitioner testified that he fell and slid underneath the driver's side door of his vehicle. Petitioner's back and buttock hit the ground and his head hit the back portion of the door casing. Petitioner attempted to get up but the pain in his lower back and buttock was excruciating. Petitioner had to call another Trooper Moreno inside of the building to come out and help him up and take him into the building and later drove Petitioner to the hospital.

Petitioner testified that he was parked that day in the parking lot area south of the physical address known as the south parking lot. Petitioner also testified that there was an east parking lot for the State Police, but he had parked in the south parking lot as he was not in a supervisory capacity and therefore, he had to park in the south parking lot. Petitioner testified that this was a direction for people who were not supervisors that they must park in the south parking lot. Petitioner testified that he had been parking in the south parking lot since June or July of 2012 when he had started working at the Tinley Park facility. Petitioner also testified that his fellow troopers and detectives who were not supervisors also parking in the south parking lot. Petitioner testified that he would be subject to discipline if he were to park in the east parking lot and that he was directed to park where he parked. Petitioner identified the south parking lot on the photographs shown to him as depicted in Petitioner's Exhibit number 1A through 1D.

Michael Lort was called to testify by Petitioner. Mr. Lort testified that he has been an Illinois State Trooper for 23 years and worked out of the Tinley Park facility located at the same address as previously stated. Trooper Lort had worked with the Petitioner since June of 2012 and was also a special agent for the Division of Gaming. Agent Lort testified that the east parking lot was for supervisor parking and the south parking lot was for all the troopers, special agents and investigators. Agent Lort reviewed Petitioner's Exhibit #1A and testified that the side door depicted was the door that they were directed to use to enter the building so that they did not have to walk all the way down to the front east side door. Agent Lort testified that they were able to park in the south parking lot and that they were directed to do so by their Lieutenant and Master Sergeant at the time. On cross examination, Agent Lort testified that he did not believe

that there were any signs in the south parking lot which stated "Illinois State Police parking only" and that he was not aware of any other people that use the building or come to the building that would park in the south parking lot.

Respondent then called Mr. Theodore B. Ellis, III to testify. Mr. Ellis was employed by the State of Illinois Department of Central Management Services as a property manager. Mr. Ellis was involved with the property in question located at 8151 W. 183rd Street in Tinley Park. Mr. Ellis identified the lease agreement between CMS and the property address in question. The lease in question took effect on March 12, 2013 and was in place through March 11, 2018. The lease agreement is Respondent's Exhibit #4. The lease agreement shows that the State of Illinois State Police did not own the property in questions but rather leased said property for the use of the State Police.

Trooper Moreno drove the Petitioner to St. Mary's hospital for treatment of his injuries sustained during the fall. The history at St. Mary's indicated that the Petitioner was a 49 year old male who was getting out of his squad car and slipped on ice and hit his buttock on ground and his low back and head on the car and had to try and scoot himself back into the car. Petitioner's Exhibit #6, hereinafter P.X. 6. Petitioner underwent a CT scan of the lumbar spine which revealed broad-based annular bulging at L4-5 and L5-S1. P.X. 6 Petitioner followed up on February 4, 2014 with Presence St. Mary's Occupational Health Center and was diagnosed with a lumbar contusion with radiculopathy and lumber disc disease. P.X. 6. Petitioner returned to Occupational Health on February 7, 2014 and was diagnosed with lumbar contusion, radiculopathy and two bulging lumbar discs. P.X. 6. Petitioner underwent a lumbar MRI scan on February 19, 2014 at Riverside Medical Center which revealed a herniated nucleus pulposis at L4-5 with left foraminal stenosis and a bulging disc at L5-S1. P.X. 7.

Petitioner then presented to Dr. Charles Harvey at Neurosurgery Consultants on March 13, 2014. P.X. 7. Dr. Harvey recommended an MRI of the thoracic spine which Petitioner underwent on April 3, 2014 at Riverside Medical Center. P.X. 7. The thoracic MRI revealed a tiny left paracentral/foraminal disc protrusion at T9-T10. P.X. 7. Petitioner began physical therapy for his spine at St. Mary's Hospital. P.X. 6.

Petitioner then presented to Oak Orthopaedics and Dr. Hasan for pain management treatment for his spine on June 3, 2014. P.X. 8. Petitioner underwent the following injections to his lumbar spine by Dr. Hasan:

- June 30, 2014: Transforaminal lumber epidural steroid injection using fluoroscopic guidance at L4-L5.
- July 7, 2014: Transforaminal lumbar epidural steroid injection using fluoroscopic guidance at L4-L5.
- July 29, 2014: Transforaminal lumbar epidural steroid injection using fluoroscopic guidance at L4-L5.
- September 25, 2014: Transforaminal lumbar epidural steroid injection using fluoroscopic guidance at L4-L5.

- November 3, 2014: Diagnostic median branch block of the lumbar facet joints at L3-4, L4-5 and L5-S1.
- May 7, 2015: Radiofrequency median branch facet neurotomy at L4-5 and L5-S1 right side.
- May 14, 2015: Radiofrequency median branch facet neurotomy at L4-5 and L5-S1 left side. P.X. 8.

Petitioner also performed work conditioning at Axcess Physical Therapy from January 12, 2015 through January 27, 2015. P.X. 9.

Petitioner was then released from care by Dr. Hasan on May 28, 2015 with no work restrictions. P.X. 8. Petitioner also presented to Dr. Michael Kornblatt for a Section 12 examination at the request of the Respondent on November 24, 2014. R.X. 2. Dr. Kornblatt's physical examination of the Petitioner revealed complaints of discomfort with palpation of the lumbosacral junction and left posterior iliac spine, and left lower lumbar paraspinal muscles. Range of motion of the lumbar spine revealed Petitioner could flex to 30 to 40 degrees, extend to 20 degrees, lateral bending and rotation were noted to be 20 degrees bilaterally. R.X. 2. Atrophy was also noted. R.X. 2. Dr. Kornblatt diagnosed work-related thoracic and lumbar strains and lumbar contusion and an episode of left lumbar radiculopathy and non-work related two-level lumbar degenerative disc disease. R.X. 2. Dr. Kornblatt determined that Petitioner need a three week course of work conditioning and then could return to work full duty following said work conditioning. R.X. 2. Dr. Kornblatt authored a second report on January 19, 2015 wherein he opined that the Petitioner did not need a radiofrequency ablation and said procedure would not be related to the work incident of February 3, 2014 as said incident did not result in a facet injury. R.X. 3. Petitioner testified about the Dr. Kornblatt examination and stated that the "exam" was less than three minutes long with no physical contact and no real examination and described the interaction with Dr. Kornblatt as "ridiculous."

Petitioner testified that he also was in the armed services for a total of 34 years having enlisted in 1982 with 10 years of active duty and then to the Army reserves. Petitioner held positions in the armed services as a military policeman, engineer, combat medic, and supervisory post from Private to Command Sergeant Major. Petitioner testified that he had prior back pain from an incident in the military which occurred at Camp Dawson in West Virginia when he fell off a two-and-a-half ton truck approximately 15 to 17 years prior to his work related injury in February 2014. Petitioner testified that he received a shot in his back at that time and that was the extent of his treatment for that prior injury and never received any further treatment for his back until his work related accident on February 3, 2014. Petitioner further testified that he has not suffered any new injuries to his lower back since February 3, 2014.

Petitioner testified that his work injury altered his life plan of working as a Government contractor overseas for the Department of Defense or other private contractors following his retirement from the State Police. Petitioner testified that he cannot perform this type of work due to the injury that he sustained on February 3, 2014. Petitioner testified that his lower back is sensitive with pain and positioning and that it has altered his lifestyle and that he can no longer do things that he used to enjoy before the work accident like golf and taking part in thing with

his five-year old grandson. Petitioner also testified that he has trouble attending his son's football games at ISU and walking the mall with his daughter. Petitioner's sex life with his wife has also suffered as a result of this injury per Petitioner's testimony. The Petitioner testified on cross examination that his decision to retire in July of 2015 from the State Police was sped along by the work related injury that he had suffered.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner did suffer a work related accident which arose out of and in the course of his employment for the Respondent on February 3, 2014. While the evidence in Respondent's Exhibit #4, the lease agreement concerning the property located at 8151 W. 183rd Street in Tinley Park, Illinois, reveals that the State of Illinois did not own the parking lot in question, it does reveal and is supported by the evidence in this case that the State of Illinois provided said south parking lot for use by its employees and the fact that the employer State of Illinois did not own the lot is immaterial. C. Iber & Sons, Inc. vs. Industrial Commission, 81 Ill.2d 130,135, 40 Ill.Dec. 808, 407 N.E. 2d 39, 42 (1980). The Petitioner in this case testified that he was directed to park his State issued police vehicle in the south parking lot. Petitioner's testimony was corroborate by Special Agent Lort's testimony who also testified that all non-supervisory personnel were required to park their State issued police vehicles in the south parking lot and were to use the Suite F door located in the south parking lot for access into the building. Both Petitioner's testimony as well as Special Agent Lort's testimony concerning the requirement to utilize the south parking lot went unrebutted by Respondent.

In the case of Suter vs. Illinois Workers' Compensation Commission, 998 N. E. 2d. 971, 376 Ill.Dec. 261 (2013), the facts are similar to the case at hand. In Suter, the State's lease agreement with the building owner required the owner to provide parking for 410 vehicles, 24 hours a day, 7 days a week. The Court in Suter therefore determined that the State, through its negotiated lease with the building owner, provided parking spaces specifically for state employees. In the case at hand, Respondent's Exhibit #4, the lease agreement, states that Parking for 55 vehicles and parking shall be available and accessible to Lessee for Lessee's use 24 hours a day, seven days per week. The Court went on to decide in Suter that, "The uncontroverted evidence, therefore, established that a state employee slipped and fell as a result of the conditions of a parking lot provided by the State specifically for state employees." Id. The Court in Suter determined that the claimant's accidental injuries were caused by an accident that arose out of her employment as a matter of law. Id.

Finally, the case of De Hoyos vs. Industrial Commission, 185 N.E. 2d. 885, 26 Ill.2d 110, (1962), the Supreme Court of Illinois found in favor of a claimant that had slipped and fell in a snowy and icy parking lot that had been provided by the employer and was regularly used by the employer's employees to park , but was not owned by the employer. The Court determined, "..when an employer provides a parking for employees and an employee falls on the parking lot,

this fact being uncontroverted on the record, the employee is entitled to recover as a matter of law." Id. The Court went on to state, "We have previously pointed out that whether the employer owns or does not own the parking lot is immaterial so long as the employer has provided the parking lot for its employees." Id.

The Respondent did not own the parking lot in this case as established by the lease agreement in Respondent's Exhibit #4. However, the lease agreement states that parking was being provided for 55 vehicles for use 24 hours per day, 7 days per week, so the Respondent provided said parking to its employees including the Petitioner in this case. Not only did the Respondent in this case provide parking to its employees including the Petitioner, but the Respondent also directed the Petitioner as to where to park, that being the south parking lot. Again, this testimony from Petitioner and Agent Lort in terms of being directed to park in the south parking lot by Respondent, went completely unrebutted by Respondent. Therefore, the Arbitrator finds that the Petitioner's work related injury of February 3, 2014 arose out of and in the course of his employment with the Respondent.

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

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work related injury of February 3, 2014. The Petitioner testified that his only prior problems with his back before his work accident mentioned above, was 15 to 17 years prior when he was at Camp Dawson in West Virginia in the military and he fell off a truck and received one injection into his lumbar spine. No further treatment was had by Petitioner for his low back following that prior injection and Petitioner had no further problems with his low back until the work accident in this case. Petitioner further testified that he had not suffered any new lower back injuries since his date of accident on February 3, 2014. The Petitioner's testimony immediately above went unrebutted and the Arbitrator determines Petitioner's testimony to be credible.

The Arbitrator notes that all of the medical records in this case have a consistent history of the Petitioner slipping on ice while exiting his police vehicle and striking his buttocks, low back and head. Respondent's own Section 12 examiner, Dr. Kornblatt, also determined that the Petitioner had suffered lumbar and thoracic strains as a result of the work accident. Dr. Kornblatt determined that the Petitioner's two-level lumbar degenerative disc disease was not work-related, but failed to offer any opinion concerning whether or not the work accident aggravated or accelerated said degenerative disc disease thus necessitating treatment for same. The Arbitrator can draw the inference that considering the Petitioner's lumbar degenerative disc disease was asymptomatic prior to the work accident of February 3, 2014, and then became symptomatic immediately following the work accident thus necessitating medical care consisting of five lumbar injections and two radio frequency procedures, that the work accident aggravated the condition of Petitioner's lumbar spine and therefore was causally related to the work accident.

K. What temporary benefits are in dispute?

Respondent's Exhibit #1 is a payment summary which reveals that the Petitioner was paid $90,140.74 in regular pay for the first year off work following the work accident, and then an additional amount of $24,446.36 in TTD benefits for the period of 2/4/2015 to 6/1/2015. The Petitioner was properly compensated during his entire period of off-work status from February 4, 2014 through June 11, 2015 totaling 70 3/7 weeks. The Respondent disputed the temporary total disability benefits based on its argument that there was not a compensable accident. Having already determined that there was a compensable accident in this case which arose out of and in the course of the Petitioner's employment with the Respondent on February 3, 2014, the Arbitrator finds that TTD benefits were properly paid by the Respondent in this case for the above-mentioned period of time from February 4, 2014 through June 11, 2015, that the Respondent was required to pay said benefits, and that the Petitioner properly received said full benefits and is not owed anything further in terms of TTD or lost time benefits.

L. What is the nature and extent of the 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 a Special Agent for the Illinois State Police at the time of the accident and that he was able to return to work in his prior capacity, albeit for a shorter duration than Petitioner would have liked as he credibly testified that he decided to retire early due to the injury. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. 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 Petitioner returned to work in his same capacity. Petitioner also testified to the job opportunities that he has lost out on after retiring from the State in terms of using his military expertise to work for the Department of Defense overseas due to the injury suffered to his low back at work. The Arbitrator therefore gives moderate weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was diagnosed with lumbago, lumbar disc degeneration, lumbar spondylosis, and lumbosacral radiculitis. As a result of the work related accident of February 3, 2014, the Petitioner suffered a herniated disc to L4-5, and bulging discs to L5-S1 and T9-T10. As a result of the herniated disc and bulging discs, the Petitioner had to undergo five lumbar injections and two radio frequency procedures along with physical

therapy, work conditioning and 70 3/7 weeks of lost time from work. Despite the medical treatments mentioned above, the Petitioner credibly testified that he continues to suffer pain to his low back at this time, must sometimes take over-the-counter medications for his low back, has had to refrain from doing certain activities like golfing, attending his son's football games and walking the mall with his daughter or playing with his grandson. The Arbitrator therefore gives greater weight to this factor.

Based on the medical evidence in the record as well as Petitioner's credible testimony, the Arbitrator determines that the Petitioner has suffered permanency in the amount of 15% loss of use of the Man as a Whole pursuant to Section 8(d)(2) of the Act.

CONCURRING OPINION

I concur with the majority's affirmance of the 15% loss of the person-as-a-whole permanent partial disability (PPD) award. I write separately to provide additional bases and facts to support the PPD award.

The Arbitrator found that on February 3, 2014, Petitioner sustained a work-related accident while working as a state trooper and special agent for Respondent. The Arbitrator further found that Petitioner's current condition of ill-being is causally related to the work accident on February 3, 2014 and awarded all requested medical bills and 70-3/7 weeks of temporary total disability benefits. The Arbitrator noted that all of the medical records in the case consistently documented a history of the work accident, and even Dr. Kornblatt, Respondent's section 12 examining physician, opined that Petitioner suffered lumbar and thoracic injuries (strains) as a result of the work accident. However, the Arbitrator found Dr. Kornblatt's opinion that Petitioner only sustained strains to be unpersuasive. Respondent did not seek review of these findings. The only issue on review is the nature and extent of Petitioner's disability.

I would find that the Arbitrator's analysis of the §8.1b(b) factors, although reasonable, did not sufficiently acknowledge the extent and length of Petitioner's medical treatment, as well as the resulting disability in analyzing subsection (v). I would include the facts below in my analysis.

Petitioner underwent a lumbar spine MRI on February 19, 2014. On March 3, 2014, Petitioner sought treatment with Dr. Harvey who reviewed the February 19, 2014 lumbar spine MRI and interpreted it to show small disc herniations at L4-L5 and L5-S1. Dr. Harvey diagnosed Petitioner with a lumbar disc herniation and thoracic back pain, and recommended Petitioner undergo a thoracic spine MRI. Petitioner underwent a thoracic spine MRI on April 3, 2014. On April 8, 2014, Petitioner returned to Dr. Harvey who reviewed the thoracic spine MRI and interpreted it to show a small left paracentral disk herniation and mild facet degeneration which produced mild right and moderate left foraminal stenosis at L4-L5, but found nothing that required urgent neurosurgical attention. Dr. Harvey recommended Petitioner continue physical therapy.

On May 22, 2014, Dr. Harvey recommended Petitioner consult with pain management and referred Petitioner to Dr. Ashraf Hasan. On June 30, 2014, Petitioner underwent a transforaminal lumbar epidural steroid injection performed by Dr. Hasan. On July 7, 2014, Petitioner underwent a second transforaminal lumbar epidural steroid injection performed by Dr. Hasan. On July 29, 2014, Petitioner underwent a third transforaminal lumbar epidural steroid injection performed by Dr. Hasan. On September 25, 2014, Petitioner underwent a fourth transforaminal epidural steroid injection performed by Dr. Hasan.

On October 9, 2014, Dr. Hasan recommended Petitioner undergo bilateral L3-L4, L4-L5, and L5-S1 median branch blocks while continuing physical therapy. On November 3, 2014,

Petitioner underwent median branch blocks of the lumbar facet joints at L3-L4, L4-L5, and L5-S1. Petitioner continued physical therapy through November 2014. On January 12, 2015, Petitioner began work conditioning. Petitioner testified that he was was unable to complete the work conditioning program due to worsening symptoms.

On May 7, 2015, Petitioner underwent radiofrequency median branch facet neurotomies on the right at L4-L5 and L5-S1. On May 14, 2015, Petitioner underwent radiofrequency median branch facet neurotomies on the left at L4-L5 and L5-S1. On May 28, 2015, Dr. Hasan noted Petitioner had temporary pain relief of about 85% of his symptoms from the radiofrequency ablation procedures and recommended Petitioner undergo repeat bilateral radiofrequency ablation at L3-L4, L4-L5, and L5-S1. Dr. Hasan noted that the procedure had been denied by the workers' compensation insurance carrier. Dr. Hasan recommended Petitioner continue a home exercise therapy program, return PRN, and released Petitioner to full duty work. Petitioner retired from Respondent in July of 2015. Petitioner testified that the work-related accident/injury sped up the timing of his retirement.

Based on the foregoing, which details the extensive medical treatment Petitioner underwent for his lumbar and thoracic spine for approximately 15 months, I concur that the Arbitrator's PPD award was not excessive. These facts, in conjunction with the Petitioner's credible testimony that his lower back is now very sensitive, it is difficult for him to swing a golf club like he used to, he has difficulty doing activities with his grandson, he has to sit in a special chair when he goes to football games with his son, and he has trouble walking around a mall with his daughter, indicate that Petitioner has substantial permanent disability to his lower back.

September 13, 2021

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031608
Case Name	UNGLESBEE, CHRISTY A v. HELP AT HOME
Consolidated Cases	18WC031609
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0462
Number of Pages of Decision	39
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Frank Johnston

DATE FILED: 9/13/2021

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0462

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTY UNGLESBEE,

Petitioner,

vs. NO: 18 WC 31608

HELP AT HOME,

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, average weekly wage, causal connection, medical expenses, temporary total disability, maintenance, permanent disability, penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, and reverses on the threshold issue of causal connection, 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 partial disability, if any, pursuant to *Thomas v. Industrial Comm'n.* 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission affirms and adopts that part of the Arbitrator's Decision finding that Petitioner sustained an accident arising out of and in the course of her employment on November 4, 2016, and regarding the calculation of Petitioner's average weekly wage, however, the Commission reverses the Arbitrator's Decision finding that Petitioner's current condition of ill-being including, but not limited to, headaches, her cervical spine, brachial plexopathy or thoracic outlet syndrome is causally related to the November 4, 2016, accident and vacates the Arbitrator's award of temporary total disability, maintenance, medical expenses and penalties under §19(k) and §19(l) and attorney's fees under §16, for the reasons explained below. Therefore, the Commission strikes all portions of the Arbitrator's Findings of Fact and Conclusions of Law except the paragraphs under Accident and Average Weekly Wage.

Findings of Fact

Petitioner alleges that she sustained an accident on November 4, 2016, that arose out of and in the course of her employment with Respondent. She had no contemporaneous medical treatment as a result of this alleged injury.

Petitioner's Testimony

Petitioner testified that on November 4, 2016, she was employed with Respondent as home care. She worked for Respondent since 2009. Her responsibilities with Respondent included helping clients with whatever was needed, including cleaning, errands, laundry, bathing, and dressing. (T. 8-9)

She testified that on November 4, 2016, she had a client that was going to stand up and she put her arm out for him to steady himself. He pulled her left arm with his whole weight and they both fell. She experienced numbness in her fingers (ring and pinky), pain going down her left shoulder and arm area, her neck hurt, and she has headaches. She testified that she reported the accident but did not seek any medical care for her symptoms. She was able to continue to work for Respondent. (T. 9-10)

Petitioner testified that a similar accident occurred on May 9, 2018. She put out her left arm to help steady the client and the client pulled her left arm back as she fell. She experienced the same symptoms as before but noted that the pain was even sharper going down her left arm, shoulder, neck and headaches. (T. 13) She later presented to Quincy Medical Group, but because she was not satisfied with the level of care, saw Dr. Fletcher in Urbana starting on November 1, 2018. (T. 16, 18)

Dr. Fletcher managed Petitioner's care starting on November 1, 2018, including her work restrictions. She advised that she had a light duty offer for work at the Respondent's Pittsfield office, but could not make it as her car was repossessed in early January 2019. Petitioner testified about her course of treatment. (T. 25-40)

Petitioner testified that she was placed at MMI on May 20, 2020, with permanent work restrictions of occasional 15 pound lifting floor to waist, 15 pound carrying, 10 pounds lifting waist to overhead with the right hand only and two pounds lifting from the waist to shoulder with her left hand. (T. 39)

Petitioner advised that she had a second job at the time of the May 2018 work accident as a personal assistant with the Illinois Department of Human Services. (T. 42)

She next testified that she has symptoms of tingling and numbness, sharp pain, and her shoulder blade sticking out all the time causing pain on the left side. The sharp pain goes down her arm. She noted occasional headaches and neck pain as well. (T. 43)

Petitioner testified on cross-examination that she did not seek any treatment for the November 2016 accident in 2016 or 2017. During this time frame, she held multiple jobs at the

same time. Petitioner was able to continue working her multiple jobs through October of 2018. (T. 45) She did not recall if she was ever contacted to work additional hours and she did not recall if she refused those hours due to obligations with her other job. (T. 46)

Petitioner testified that Dr. Allen was her primary care physician, who she saw on August 23, 2018, for symptoms related to the work accident. Petitioner could not recall her presentation of symptoms when she presented to Dr. Allen on June 1, 2018, nor could she recall if she reported any symptoms related to the neck or shoulder. (T. 47) She later testified that she rated her symptoms as severe during the summer of 2018. (T. 60)

Petitioner saw both Dr. Kimple and Dr. Dayoub for her pain complaints. She testified that she did not discuss work restrictions with either physician. When asked about the October 16, 2018, phone call requesting a medical causation opinion from Dr. Kimple, she did not have a recollection. (T. 49-50)

Petitioner testified that Dr. Fletcher was the fourth physician that she saw and the first one to provide a medical causation opinion. He was also the first one to authorize the Petitioner off work. Petitioner testified that she found Dr. Fletcher's information online and was referred to him by Dr. Allen. She admitted that to see Dr. Fletcher in Urbana, it is more than a six hour round trip drive from Quincy. (T. 51, 63)

Petitioner advised that it was fair to say that the majority of treatment was for the left side. She testified that she had symptoms on her right side. She testified that both Dr. Fletcher and Dr. Hazelrigg recommended a surgery for the right side that she decided to not undergo. (T.53)

Petitioner last saw Dr. Fletcher on March 3, 2020. She testified that Dr. Fletcher performed a comprehensive examination of both shoulders, spending a total of 45 minutes. Petitioner has not returned to Dr. Fletcher after the functional capacity evaluation (FCE) to discuss the results or additional treatment options. (T. 54- 55)

Diane Westfall's Testimony

Ms. Westfall testified that she is a registered nurse and the branch manager at the Pittsfield office. She has been employed as the branch manager since September of 2017. (T. 69)

Ms. Westfall identified RX12 as the transitional duty offer. She noted that it was an offer to Petitioner to come into the office in Pittsfield to do light duty work. She testified that Petitioner worked around 20 hours per week and the light duty offer was made for Petitioner to do those hours at the Pittsfield location. (T. 71) Ms. Westfall testified that there were three offers for light duty work that were sent to Petitioner, on January 10, 2019, February 14, 2019 and March 22, 2019. (T. 72)

Ms. Westfall then testified to her conversation with Petitioner about the light duty job offer on January 10, 2019. She reported that she spoke with Petitioner on the phone and told her that she could come in to the office to work. Petitioner provided several reasons as to why she could not return to work including needing to lay down because of her headaches, her car was repossessed,

and she had a doctor's appointment the following week. (T. 74) According to Ms. Westfall, Petitioner called back later and advised she could not go to work the next day because she did not have a way to get there. (T. 75, 77-78)

Medical Records

On October 26, 2017, Petitioner saw her primary care physician, Dr. Tawny Allen, at the Quincy Medical Group on March 6, 2018, for an evaluation for depression. Her symptoms had been going on for months, noted to be situational. Her symptoms included depressed mood, difficulty concentrating, hopelessness, insomnia, and possible panic attacks. She was prescribed Zoloft and it was noted that she was an everyday smoker. (RX5, p. 1) Following that visit, Petitioner saw Dr Tawny again on November 28, 2017, and again on February 6, 2018, for a follow-up for her depression. There was no mention of a work accident that would have occurred on or about November 4, 2016, in any of these office visit notes.

On January 30, 2018, Petitioner sought treatment at Vance Chiropractic and saw chiropractor Mark Sprague. (PX6) Petitioner complained of frequent (75%-50%) tingling, burning and shooting discomfort in the back of the neck. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement and applied pressure.

The subjective complaints document that Petitioner hurt herself at work over a year ago. She reported she was having headaches and sleeping poorly. She was diagnosed with cervicalgia and headache. (PX6, p. 1)

Petitioner returned to the chiropractor on February 24, 2018, complaining of constant (100%-75%) sharp, aching, burning, numbing, tingling and shooting discomfort in the back of the neck. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe.

The discomfort was reported to increase with prolonged sitting, movement and applied pressure. Petitioner also complained of frequent (75%-50%) aching, tightness and throbbing discomfort inthe upper back. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of1to10, with 10 being the most severe. The discomfort was reported to increase with movement and prolonged sitting.

Petitioner also complained of frequent (75%-50) aching, tightness and throbbing discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement and prolonged sitting.

Petitioner stated that she had been feeling worse since her last visit. She was having headaches and reported that she had not been sleeping well since her last visit. She was diagnosed with cervicalgia, pain in the thoracic spine and low back pain. (PX6, pp. 2-3)

Petitioner returned to her primary care physician, Dr. Tawny Allen, for another follow-up

for depression on March 6, 2018. (RX5, p. 18) She reported that she had neck pain and went to the chiropractor two times. The notes document, "Injury 1 year ago at work-encouraged WC appointment." (RX5, p. 18)

Petitioner returned to the chiropractor on April 18, 2018, 17 days before the second reported accident, and saw chiropractor Ryan Miller. She complained of frequent (75%-50%), sharp, shooting, numbing, tingling, and burning discomfort in the back of the neck. She rated the intensity ofdiscomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with applied pressure and movement. The discomfort was reported to decrease with rest.

Petitioner also complained of frequent (75%-50%) aching and tingling discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement.

Petitioner reported that she was having a headache that day, no leg pain. She said that it hurts worse if she is bent over too long and she was sleeping okay. Objective examination revealed areas of spasm, hypomobility and end point tenderness indicative of subluxation at C1 and LS. Palpation of the muscles revealed spasm in the following areas: cervical and lumbar. The diagnosis was cervicalgia and low back pain. (PX6, p. 4)

Petitioner reported a second accident occurred arising out of and in the course of her employment on May 9, 2018, approximately two weeks after her last chiropractor visit, however, she had no medical consult as a result of that accident until more than three months later, on August 23, 2018, when she saw Dr. Allen again at the Quincy Medical Group. Petitioner reported that she believed her neck pain and headaches with dizziness was work-related because of the two reported incidents; however, Petitioner saw the nurse practitioner at Quincy Medical Group on June 1, 2018, only weeks after the May 9, 2018, incident for left wrist pain with no mention of the work accident, or neck or shoulder issues at that time. (RX5, pp. 49-52)

On June 27, 2018, Petitioner met with Dr. Eric Flynn-Thompson for a left wrist ganglion cyst. Petitioner reported that about three months prior, she developed a cyst around the volar radial aspect of her left wrist that lasted about a week. She had pain with it for about a week and then the cyst eventually resolved as did her pain. She reported about three weeks prior, she started to have increased pain in her left volar radial wrist and the dorsal radial wrist. The splint that she started wearing about three days ago helped some of her symptoms, but not completely. She complained of pressure and tingling in the fingers for the past couple of weeks including the index, middle and ring fingers. She also complained of left hand weakness and pain with wrist motion. All other systems were reviewed and were negative. Dr. Flynn-Thompson advised that Petitioner's several week history of left wrist pain appeared to be related to deQuervain's tendinitis and flexor carpi radialis tendinitis. He opined that it was unusual for Petitioner to have tendinitis in 2 locations at the same time. He recommended initial rigid immobilization with work restrictions of no use of the left hand. (RX 5, p. 36) There was no mention of a May 9, 2018, work accident.

Petitioner saw Dr. Allen on August 23, 2018. She complained of neck pain, increased frequency and severity of headaches. She reported "no specific injuries --- years ago 1995 car

wreck." The notes continue, "Thinks work related because a few years ago a client was trying to get up and patient put arm out and it strained neck-in May similar situation and re-aggravated it. Has not been seen except a chiropractor which did not help." (RX5, p. 49) Petitioner was positive for nausea with headaches, photophobia and phonophobia. Dr. Allen noted tender vertebrae at C6-C7 tight muscles. Dr. Allen diagnosed Petitioner with neck pain, increased frequency of headaches, and increased severity of headaches. "With stretching from side to side-feels electric shock down spine." She prescribed Zanaflex and a Medrol Dosepak. A cervical spine x- ray and an MRI of the brain were ordered. (RX5, pp. 49-50)

On August 23, 2018, Petitioner underwent a cervical spine x-ray at Quincy Medical Group. Neck pain for two years was listed as the reason for the study. The results of the scan were read to reveal no acute findings and a congenital fusion of C2-C3. (RX5, p. 29)

On September 7, 2018, Petitioner underwent an MRI brain scan at Quincy Medical Group Imaging as ordered by Dr. Allen. The results of the scan were read to reveal multiple small scattered areas of T2 hyperintensity cannot completely exclude demyelinating process. (RX 5, pp. 54, 125)

Petitioner returned to Dr. Allen on September 11, 2018. She advised that medication has not helped, and she complained of neck pain with "zinger feeling" in neck down spine. In addition, recent MRI brain scan returned abnormal, (cannot completely exclude demyelinating process). She was diagnosed with depressive disorder, abnormal finding on MRI of brain, increased severity of headaches, neck pain, cervical radiculopathy, and fusion of spine of cervical region. Dr. Allen recommended a cervical spine MRI and a referral to neurology. She started Petitioner on Topamax for headache prevention as she had a history of probably migraines. (RX5, pp. 54-55)

On September 21, 2018, Petitioner underwent a cervical spine MRI at Quincy Medical Group Imaging as ordered by Dr. Allen. The reason for the study was listed as neck pain and cervical radiculopathy. Issues were existing 3-5 years with history of "MVA over 20 years ago and recent strain helping someone stand in May." She reported posterior headaches and dizziness. The results of the scan were read to reveal multilevel cervical spondylosis, most significant at C5-C6 with mild to moderate spinal canal stenosis and mild bilateral neural foraminal narrowing. (RX5, pp. 126-127)

On September 24, 2018, Petitioner presented to Dr. Daniel Kimple at Quincy Medical Group Department of Neurology on referral from Dr. Allen and due to an abnormal MRI. Petitioner reported a daily headache for two hours at a time. She further reported that she had frequent headaches and a pinched nerve that occurred for the first time in approximately 2016 when she injured herself assisting a patient who was about to fall. Symptoms began with a sudden onset. Petitioner noted headaches that are occipital bilaterally. She reported a typical duration of symptoms lasting 4-8 hours in length occurring almost every day. Dr. Kimple noted the abnormal brain MRI and the MRI of the cervical spine which exhibited spondylosis at multiple levels prominent at C4 through C6 with associated mild to moderate spinal canal stenosis and mild bilateral neuroforaminal narrowing at C5-C6, but there was no abnormal signal change of the spinal cord. (RX5, pp. 131-132)

Dr. Kimple documented Petitioner's history of abnormal MRI with T2 lesion, tobacco abuse, chronic daily headache, and history of cervicalgia. There was concern for chronic tension headache with associated peri-cranial tenderness. Trial medications of Xanax, Zoloft, Topamax, Cymbalta, and Gabapentin and Ibuprofen have not provided relief. Dr. Kimple requested authorization for Botox and to continue Topamax and Zanaflex. He advised that for the cervicalgia (myofascial pain, cervical disc disease with radiculopathy) there was no evidence of cord edema on MRI cervical spine. He recommended continued monitoring. Finally, as for the abnormal MRI, Dr. Kimple's notes that in the setting of chronic tobacco abuse and history of migraines when she was younger, these are nonspecific, and they were to be followed with clinical correlation. (RX 5, p. 135)

On September 24, 2018, Petitioner underwent a trigger point injection in the upper and lower trapezius, occipital ridge/upper cervical paraspinal, and levator scapula performed by Dr. Kimple. (RX5)

The October 3, 2018, work status from Dr. Allen documents light duty work restrictions were assigned. The diagnosis was listed as cervical spine stenosis secondary to bulging disc. (RX5)

An October 16, 2018, Call Documentation, confirms Petitioner called Dr. Kimple's office and requested a letter stating her injuries and pain to her neck "could possibly be due to her slipped disc in her back, due to her patient falling and trying to catch himself with her hands." Dr. Kimple advised that she could bring in a Questionnaire for "workman's comp" and he would answer questions, but he was unable to write a letter stating patient's injuries were due to an incident with patient's resident. (RX 5, p. 77)

On October 24, 2018, Petitioner presented to Dr. Hayan Dayoub at the referral of Dr. Tawny Allen. Petitioner reported that she was having headaches daily with neck and arm pain. She noted a work injury a couple of years ago with pain that never really went away and came back in May. She rated her pain as 10/10. She complained of neck pain into both arms that radiated into all of her fingers. Everything was an exacerbating factor and nothing helped for relief. He also noted numbness and tingling in her hands. Petitioner reported that she had a history of migraines in the last few years and had an injection in the occipital area as well as the neck with modest improvement. Petitioner was convinced that her injuries were the result of a work injury. (RX5, p. 161)

Dr. Dayoub reviewed the MRI scans and opined that it revealed mild to moderate degenerative changes at C4-C5 and C5-C6 with mild bilateral foraminal stenosis at C5-C6. Treatment recommendations were discussed including conservative management versus surgery. Dr. Dayoub recommended against surgical intervention given her young age and relative diffuse nature of her degenerative changes. He recommended physical therapy and pain management. (RX14, p. 162)

On November 1, 2018, Petitioner presented to Dr. Fletcher at SafeWorks Illinois. She presented for evaluation and treatment of headaches and bilateral, neck and back pain. She reported that that she reached out to help support her patient from falling and her patient pulled her left arm

with their whole weight of 350 lbs. She reported pain in her left shoulder, right shoulder, and upper thoracic region and severe headaches with a stabbing pain on top of the shoulders, and pain in the middle of her upper back. Her left finger will go intermittently numb. Dr. Fletcher diagnosed Petitioner with radiculopathy, cervical region and noted a left brachial plexus injury. He recommended Lyrica, Tens unit, electrical, EMG studies with Professor Trudeau, to consider a surgical consult, and physical therapy (P.T.) with cervical traction. He opined that it was related to the work activities and authorized Petitioner off work. The date of injury and illness was listed as both November 1, 2018 and May 9, 2018. (PX3)

On December 4, 2018, QMG called Petitioner to advise that Botox injections were approved. (RX5)

Petitioner presented to Dr. Trudeau for nerve conduction studies on December 17, 2018. His interpretation of the NCS were as follows:

1. Left brachial plexopathy, medial cord lesion, moderately severe in electroneurophysiologic testing characterization, consistent with the quite correct clinical assessment of Dr. Fletcher.
2. No current evidence of cervical radiculopathy, particularly C6 or C7 on either side.
3. No current evidence of entrapment neuropathy, particularly ulnar neuropathy.
4. No current evidence of left long thoracic neuropathy, left spinal accessory neuropathy, or other peripheral nerve compromised.
5. No current evidence of mononeuritis multiplex.

The diagnosis was of left brachial plexopathy, medial cord lesion, moderate to severe. No entrapment neuropathy. No peripheral nerve compromised. No evidence of cervical radiculopathy. (PX9)

Petitioner returned to Dr. Fletcher on December 27, 2018. Dr. Fletcher noted that the electrical studies confirmed a diagnosis of left brachial plexus injury. He diagnosed Petitioner with cervical radiculopathy, left side injury of brachial artery, and injury of brachial plexus. He placed Petitioner on light duty work restrictions, and recommended Lyrica, Topamax, a Tens unit, a surgical consult with Dr. Kube, and physical therapy. The work status was for the period December 27, 2018, through January 17, 2019. (PX 3)

On January 15, 2019, Petitioner consulted Andrew Kitterman, PA at Prairie Spine Institute and complained of neck pain, numbness, weakness bilaterally. Objective tests found a positive Spurling's and positive Tinel's in her ulnar nerve. Apparently, a Botox injection helped in her neck with headaches. She was diagnosed with ulnar tunnel syndrome.

A cervical spine motion x-ray was recommended with follow up with Dr. Kube to discuss surgery versus conservative treatment. (PX16)

Petitioner had a surgical consult with Dr. Kube on February 5, 2019. They reviewed her MRI scans and her history. Dr. Kube opined that he did not think surgical intervention would reliably improve her. He advised that she could entertain a dorsal column stimulator placement.

(PX 16)

Petitioner saw Dr. Fletcher on February 8, 2019. She reported an allergic reaction to medications. It was noted that Petitioner saw Dr. Kube who advised that she was not a surgical candidate. His diagnosis remained the same. He recommended Lyrica, a Tens unit, pain consult with Dr. Benyamin, physical therapy, and Toradol injection. Light duty work restrictions were continued. The next appointment was scheduled for March 1, 2019. (PX3)

On February 14, 2019, Petitioner had a physical therapy initial evaluation at First Choice Physical Therapy. (PX8) Petitioner's primary complaint was neck pain and headaches (occipital) with pain that travels into both upper extremities with tingling in her left hand, her fourth and fifth digits and her thumb.

Petitioner presented to Blessing Hospital ER via private vehicle with complaints of neck pain and experiencing hot and cold from her spine to the right arm. She also complained of nausea and headaches. Petitioner reported that the pain started after completing her physical therapy session. Petitioner reported that she had a history of a bulging disc and a pinched nerve. She was diagnosed with neck pain. She was discharged with four tablets of hydrocodone.

On February 20, 2019, Petitioner returned to ExamWorks. According to the Patient Visit Summary and Instructions, Petitioner was diagnosed with cervical radiculopathy, left side injury of brachial artery, and injury of brachial plexus. Petitioner was authorized off work from February 20, 2019, until March 20, 2019. Dr. Fletcher noted she had to go to the ER due to increased pain and he recommended Lyrica, a Tens unit, physical therapy, hold on the Dr. Benyamin pain consult, and Toradol injection. The follow up appointment was scheduled for March 20, 2019. Dr. Fletcher noted that she was not a surgical candidate and that cervical disc pathology and cervical radiculopathy have been ruled out. He noted that the electrical studies confirmed diagnoses of left brachial plexus injury and was concerned with thoracic outlet syndrome. (PX3)

Petitioner returned to Dr. Fletcher on March 3, 2020. Dr. Fletcher noted that Petitioner had left shoulder swelling and was unable to lift above shoulder level. He refilled prescriptions and noted Dr. Trudeau's electrical studies that exhibited persistent long thoracic neuropathy. He diagnosed Petitioner with injury of the brachial plexus, brachial plexus disorders, injury of the nerve root of thoracic spine, and adhesive capsulitis of left shoulder. He recommended an FCE for permanent work restrictions. (PX3)

Petitioner had an appointment with Dr. Tawny on March 19, 2019, for blisters on her feet. (RX5)

Petitioner returned to Dr. Fletcher on March 20, 2019. She was diagnosed with brachial plexus injury. Dr. Fletcher noted that she was much improved; the best he has seen her. He noted that Petitioner saw Dr. Salvacion for an assessment of a dorsal column nerve stimulator, but Petitioner decided to wait. Petitioner was placed on light duty work restrictions which included no long distance driving. (PX3) Dr. Fletcher testified that the restrictions were due to the sedating nature of her medication. (PX13, p. 60) The work status was for the period of four weeks, through April 19, 2019. (PX3)

Petitioner presented to Dr. O'Leary on March 28, 2019, for the first §12 evaluation at Respondent's request. She reported that she hurt both arms. She advised the first one happened in November of 2016 with a client that weighed about 350 pounds. The second incident occurred on May 9, 2018, with a client who weighed about 200 pounds. She reported that her client was going to fall and she pulled on Petitioner's arms which pulled her down. Petitioner said that she gets headaches as a result of this every day. She gets an electric shock going down her spine. She gets pins and needles. She has been to a primary care, to a neurologist and seen a surgeon and a physiatrist. She sees Dr. Fletcher with occupational medicine in Champaign, although she is from Quincy. She sees Dr. Salvacion right now for pain management.. She told Dr. O'Leary that she has lesions on her brain, approximately seven lesions. She was worried about what is to come of the headaches and dizziness. She did not want a spinal cord stimulator. (RX1; RX4, DepX2)

Dr. O'Leary documented that on her intake form that she filled out, she noted that treatment has not helped. She reported that treatment to date included a TENS unit and therapy, that made her condition worse. In fact, she reported ending up in the ER from therapy. She reported injections, and medications did not help. She reported numbness and tingling on the ulnar border of her left forearm and into the small and ring fingers. She also noted burning on the bottoms of her feet as well as burning, clicking and popping in the right shoulder and midline. She has headaches. She did mention something about a history of cluster headaches, but she says the headaches since the accident are different. She describes dizziness, electric shocks, pins and needles. Current level of pain is "seven or eight, neck, headaches, and electric shocks." She says she has all of the symptoms every day. (RX1, pp. 1-2)

During the examination, Dr. O'Leary noted an antalgic gait pattern. Her examination findings included pain with range of motion of her neck, exquisite tenderness to even the lightest touch at the base of her neck near the vertebral prominence. She advised that touching her neck elicits an electric shock going down her neck. Dr. O'Leary notes that this electrical show is not reproduced when she voluntarily flexes her chin to touch her chest. He found shoulder impingement signs are equivocal because she did not have much voluntary activity in terms of ranging (sic) her arms over her head.

After the examination and review of the medical records, Dr. O'Leary diagnosed Petitioner with cervical spondylosis without myelopathy, neck pain, ill-defined upper extremity complaints, and history of headaches. He opined that her subjective complaints were not consistent with the objective findings. He noted that there were no reproducing objective tests on exam, and he did not feel that she had findings consistent with Lhermitte's sign. He further noted that Petitioner had exaggeration of symptom complaints as she had exquisite tingling with the slightest sensation of touch to the posterior aspect of the neck. He opined that Petitioner did not need any more treatment with regard to any reported work injury. He stated that he was not certain that an actual work injury caused the current state of ill-being as there was nothing to explain her ongoing headaches from the mechanism of injury. He further reported that the clinical exam did not present with a medial cord brachial plexopathy.

As for her return to work, he opined that based upon his questioning, the medical causation as well as the symptom magnification and severe amount of disability with

relatively minimal exam findings, he had no reason to restrict her from her duties as a home visiting nurse. He placed her at MMI and opined that no further treatment was necessary. (RXl; RX4, DepX2))

Thereafter, Petitioner met with Dr. Fletcher on April 19, 2019. There were no changes from the prior medical appointment. He again advised that this was the best that he has seen her and she was much improved. Work restrictions were continued. (PX3)

Petitioner had a pain consultation with Dr. Salvacion at Memorial Medical Center on April 25, 2019. Petitioner underwent a cervical epidural steroid injection on May 2, 2019. She underwent a second injection on May 23, 2019. (PX 9)

Petitioner underwent a new nerve conduction study on May 16, 2019. The results, interpreted by Dr. Trudeau, revealed left brachial plexopathy, medical cord lesion, mild to moderately severe in electroneurophysiologic testing terms, improved in comparison to previous study of December 17, 2018. Dr. Trudeau did not find any evidence of entrapment neuropathy, no evidence of right brachial plexopathy, no current evidence of cervical radiculopathy, no current evidence of mononeuritis multiplex, no current evidence of radiculoplexus neuropathy, although Dr. Fletcher noted that she developed right sided thoracic outlet syndrome type presentation. (PX 11)

Petitioner returned to Dr. Fletcher on May 17, 2019. Work restrictions were continued and there were no changes to her diagnoses. Dr. Fletcher noted that follow up electrical studies showed improvement. He advised that today was the best he has seen her and she was much improved. He opined that she is nearly at MMI and needs to find a job. (PX 3)

Petitioner had an appointment with Dr. Fletcher on June 18, 2019. Petitioner was diagnosed with injury of her brachial plexus and brachial plexus disorders. Permanent work restrictions of no lifting more than 10 pounds, no overhead activities, and no driving long distances due to sedating nature of medication were provided. Petitioner was discharged from care. The following After Care Instructions were listed:

> -No lifting more than 10 pounds, no overhead activities. She needs to find a job.
> - Toperamine/Nuyncia/Flexeril
> -Released from care. She is MMI. Electrical studies showed improvement.
> -Home exercise program.
> -The patient verbalizes agreement and understanding of these plans and instructions and had no further questions or concerns. (PX 3)

On July 2, 2019, Petitioner was referred to Dr. Hazlerigg for consultation regarding thoracic outlet syndrome. (PX 3)

On August 5, 2019, Petitioner presented to Dr. Hazlerigg at SIU for an evaluation and possible thoracic outlet syndrome. Petitioner reported that she was a home care worker who initially injured her back in 2016 catching a patient and had another episode less than a year

ago that exacerbated it. He reviewed the treatment to date which included several epidural injections, evaluation with Dr. Fletcher, EMG by Dr. Trudeau, MRI of the neck, and two spine surgeons who did not recommend surgical interventions. She complained of paresthesias that extended down into her left fourth and fifth digits. She also complained of shoulder and neck pain as well as what Petitioner described at cluster headaches. Petitioner noted that she has started on treatment for the cluster headaches with some mild improvement.

Dr. Hazlerigg noted full range of motion of all joints with 5/5 muscle strength throughout, normal radial pulses with mildly positive decrement with head turning, and developed numbness in the left fourth and fifth fingers. He diagnosed Petitioner with numbness and tingling in the left hand. Dr. Hazlerigg advised that Petitioner had an injury related neurological issue. He opined that she might have thoracic outlet syndrome, worse on the left side, and her symptoms of numbness down the ulnar distribution appeared to be appropriate. He notes that Petitioner has "more neck and headache related issues than might be attributed to thoracic outlet syndrome." He opined and noted Petitioner probably does have thoracic outlet syndrome and might benefit from a first rib resection. He did not think that the rib resection would relieve her headaches or improve her neck conditions as he thought there were multiple etiologies for her issues. (PX 10, PX5, p. 166)

Petitioner met with Dr. Fletcher on August 16, 2019, for evaluation and treatment of headaches and bilateral shoulder, neck, and back pain. Dr. Fletcher diagnosed Petitioner with injury of brachial plexus and brachial plexus disorder. Petitioner complained of terrible headaches and numbness on the left with pain on the right side. She reported that nothing was helping with the pain. Petitioner advised that she decided to proceed with bilateral rib resection with Dr. Hazelrigg. (PX3)

On September 11, 2019, Petitioner underwent a left first rib resection, transaxillary at Memorial Medical Center as performed by Dr. Hazlerigg. The operative diagnosis was listed as left thoracic outlet syndrome. (PX9) In the Indications section, it was noted that Petitioner was evaluated by Dr. Fletcher extensively and he felt that she had signs and symptoms consistent with thoracic outlet syndrome. (PX10 PX5, p. 170)

Petitioner had a return appointment with Dr. Hazlerigg on October 14, 2019. Petitioner reported she had a lot of discomfort without relief of symptoms since she went home. Petitioner was not moving her shoulder very much and Dr. Hazlerigg gave her instructions to prevent her from getting frozen left shoulder. He advised that though it did not appear to be optimistic, he would give her several more weeks for improvement. He opined that her symptoms were dominated by her discomfort. (PX10)

Petitioner continued treatment with Dr. Fletcher on December 20, 2019, and February 10, 2020. Petitioner had continued complaints without much improvement. Work restrictions were continued, and Dr. Fletcher recommended updated electrical studies. (PX3)

Petitioner was discharged from physical therapy on January 23, 2020. She underwent a total of 14 therapy visits between November 1, 2019 and January 23, 2020. (PX8)

Dr. O' Leary authored a record review report dated February 6, 2020. After review of the medical records, his opinion regarding Petitioner's diagnosis was unchanged. He opined that "putting together the understanding of the EMG and her subjective complaints, one could try to isolate this to something like thoracic outlet syndrome," but Petitioner gave him no indication that this was present on the day that he evaluated her on March 28, 2019. He wrote that Petitioner did not have consistent findings when he evaluated her on March 28, 2019, to suggest that this was a specific clinical syndrome, either cervical radiculopathy, brachial plexopathy, or TOS, or other type of mimicking cervical radicular-type syndromes.

He again questioned whether any of the significant findings and subjective complaints were caused or aggravated by the alleged work injury. He noted that there were multiple complaints that were not consistent throughout the record. He found no conclusive evidence when he evaluated her to pinpoint these diagnoses and her condition on a work related event. He confirmed his opinion that further treatment was not necessary for the following reasons:

- Inconsistent physical exam findings related to subjective complaints;
- Delayed report of a work injury without any significant intervening medical workup from May 2018 through August 2018;
- Magnifying and exaggerating type of behaviors on physical examination make the history provided by the claimant potentially unreliable in this case. (RX2; RX4, DepX3)

Petitioner followed up with Dr. Fletcher on February 10, 2020. It was reported that Petitioner had left shoulder swelling and was unable to lift above her shoulder level. Dr. Fletcher refilled her Nucynta, Topamax, Flexeril, and Cymbalta. He recommended electrical studies but discontinued therapy as she was no better. He continued work restrictions. (PX3)

On February 25, 2020, Petitioner underwent updated electroneurophysiologic studies performed by Dr. Trudeau. The results of the testing revealed the following:

- Left long thoracic neuropathy moderately severe in electroneurophysiologic testing characterization consistent with the quite correct clinical assessment of Dr. Fletcher;
- Left brachial plexopathy, medial cord lesion, mild in electroneurophysiologic testing terms, improved in comparison to previous study of May 16, 2019;
- No current evidence of cervical radiculopathy;
- No current evidence of ulnar neuropathy at left elbow or wrist;
- No current evidence of mononeuritis multiplex or cervical radicular plexus neuropathy. (PX11)

On May 11, 2020, Petitioner underwent an FCE at ATI Physical Therapy. (PX12) As part of the evaluation, Petitioner underwent a medical intake interview, unilateral static shoulder strength testing, grip strength testing, pinch grip strength testing, real time isometric strength testing, dynamic lifting assessment, positional tolerance testing, and an assessment of symptom magnification on written instruments. The results of the evaluation reflected a consistent, maximal effort with some abnormal test behaviors and indicators of symptom magnification were very minimal. Except for Petitioner' s left-banded static grip strength testing results, her FCE results were considered to be a valid representation of her functional abilities. Petitioner was released to

work within the sedentary physical demand level with the following restrictions of occasional 15 pound lifting limit from floor to waist height; occasional 15 pound carrying limit; occasional 10 pound lifting limit from waist to overhead with right hand only; occasional two pound lifting limit from waist to shoulder height with left hand only.

Petitioner's primary physical and functional deficits included significant left shoulder weakness, very poor left shoulder mobility, poor left arm strength, poor left hand grip strength, bilateral pinch grip weakness, and overall physical de-conditioning. Two sections of symptom magnification were noted (Oswestry Low Back Inventory and Waddell Questionnaire). She passed all aspects of Legitimacy of Effort but failed on validity criteria (on the basis of excessive variation between tests trials during left-handed static grip strength testing). (PX12)

In an email between Dr. Fletcher and Petitioner's attorney, Dr. Fletcher placed Petitioner at MMI with permanent work restrictions consistent with the FCE. (PX3)

On August 6, 2020, Petitioner presented to Dr. O' Leary for a repeat §12 evaluation. Petitioner complained of tingling and numbness and he noted that she would not lift her arm above shoulder height. She reported that she needs help putting on her shirt and pulling up certain pairs of pants. She advised that she cuts her hair short because she can no longer brush her hair. On a symptoms drawing, Petitioner noted pain and symptoms from the posterior aspect of her neck, scapula down the back of her arm towards the small, ring, and long fingers, and medial aspect of her anteriorly, ulnar sided digits as well. Dr. O'Leary noted that he would "state unequivocally that there is a clear behavioral change this time compared to the last time when I had seen her when she was much more dramatic and verbal. Today, she appeared very calm, answered all questions with a calm demeanor and was not combative or excited in the office at all." His examination findings note a normal gait pattern; Romberg sign is normal; Spurling maneuver is negative; Lhermitte sign is negative; Excellent range of motion of her cervical spine today with near full extension and lateral rotation; Right upper extremity: deltoid biceps, triceps, wrist extensor, grip and interossei are basically all normal tested manually. (RX3)

Dr. O'Leary noted a limited examination. He noted that she does not really fire her shoulder muscles very much voluntarily and it was difficult to assess the triceps and biceps function. She appeared to have diminished grip strength. As for the scapula winging, Dr. O'Leary did not observe any obvious scapular winging. He requested that Petitioner put her palms flat against the wall in the examination room. Petitioner could not do it on her left side and gave the impression of having a difficult time moving the arm and the hand. She could not extend the elbow completely. (RX3)

After review of updated medical records and examination, Dr. O' Leary opined that nothing in the medical records and his examination changed his diagnosis or medical causation opinion. No opinions from his prior reports had changed. Dr. O'Leary found the medical records to be inconsistent. (RX3)

As for work restrictions, Dr. O'Leary advised that a weight restriction for the right arm did not make sense as her right arm was normal and nothing during the examination provided any basis for work restrictions. As for the left arm, he questioned the validity of a two-pound limit from waist to shoulder. He noted that the surveillance video indicated that Petitioner

used her arm " fairly freely." Dr. O'Leary noted the following:

> While the surveillance video was limited and at times she appeared to be holding the arm, it was seen that she was holding the arm in different postures, elbow flexed and at the side versus elbow extended and the hand at the side and then occasionally carrying a purse or other groceries, multiple bags at one time hold them in the left arm, and opening and closing a door with her left arm. To me reviewing the bulk of the 30 minute surveillance, it appeared that she uses the arm much more normally than what I observed in the office today. (RX 3)

Dr. Patrick O'Leary's Testimony

Dr. O'Leary testified via evidence deposition that he went to Loyola Medical School. He completed a 5-year orthopedic surgery residency training program and completed a year of spinal advanced training program at Washington University in St. Louis before becoming board certified in 2010. He is board certified through 2030. He currently works at Midwest Orthopedic Center in Peoria. His focus is treating patients with spinal disorders, the large majority of which are non-operative, in both children and adults. He performs 300-350 spinal surgeries a year on children and adults. In his practice, he sees a range of individuals who do not have a spinal problem, be it a shoulder or a knee, and refers that patient to the right person. (RX 4)

Dr. O'Leary advised that his normal process for doing a §12 evaluation is to examine the Petitioner first to try and figure what is wrong, and then review the medical records to see if the history matches up before recommending the next step in treatment. He testified that he does it this way to prevent the introduction of bias from reading the medical records from other treatment providers. (RX 4)

Dr. O'Leary noted that Petitioner had exquisite tenderness to even the lightest touch at the base of her neck, near the vertebral prominence (prominens). (RX4, p. 15) He opined that this was evidence of symptom magnification. He also noted that she complained of "electric shock going down her neck," for which he noted that there was no neurological explanation for that. (RX4, p. 16) He disagreed with Dr. Fletcher's examination finding that the Petitioner had positive Lhermitte's sign. Dr. O'Leary opined that the cervical spine MRI explained why she would not have a positive Lhermitte's sign, noting that there were no spinal cord abnormalities, no large disk herniations, no spinal cord compression, and no cord signal change. (RX 4, pp. 16-17))

Dr. O'Leary also testified as follows:

> I was at this time somewhat skeptical about the entire presentation... Well, I mean, obviously, she comes with some findings. This EMG, some of her complaints might match up. She had seen another spine surgeon already who I think kind of said, you know, this isn't anything that you need surgery for sort of thing. And I didn't find her examination reliable. I mean, I just thought that it was very hard for me to say that there were what I would call reproducible objective tests. And she has a myriad of complaints, some findings that really don't fit one type of clinical scenario. And if you ask me to say which scenario they fit, I wouldn't be able to tell you. So kind

> of non-dermatomal, nonorganic type of subjective complaints. You know, examination doesn't match those. Findings on the MRI which don't necessary support these findings. She has some stenosis at C5-6, but if she had that problem and that was this problem, she would have thumb symptoms or index finger symptoms, not ring and small finger.
>
> So, in other words, I'm conflicted trying to evaluate her because, you, I don't really see anything adding up to this type of, you know, problem. (RX 4, pp. 22-24)

Dr. O'Leary further questioned if she had two injuries, which injury caused her condition or whether it really happened. He advised that if he thought that she was reliable and her exam was straightforward, it would be different. (RX 4, pp. 24)

Dr. O'Leary did not have any treatment recommendations as he could not imagine what further treatment would be indicated. In making this opinion, he noted that the Petitioner had a high self-reported severe disability, imaging that was not consistent, exaggeration and magnification findings during his examination, and nothing seemed to help her thus far. He placed the Petitioner at maximum medical improvement (MMI) as it related to the alleged work accident. (RX4)

Dr. O'Leary further testified that he does not formally treat thoracic outlet syndrome but was generally familiar with the diagnosis. He opined that it was an unusual and controversial diagnosis. RX1, p. 29) He noted that the "causes, etiologies of thoracic outlet syndrome are kind of largely not widely agreed upon." He advised that it could be a mimicker of a pinched nerve in the neck. His experience was that it was rare for someone to have true thoracic outlet syndrome and the results from the surgery were a "mixed bag." Dr. O'Leary further testified:

> Q. Okay. And based on - again based on your examination and review of medical records, it was tough for you to find a clinical assessment of that (thoracic outlet syndrome)?
>
> A. Well, number one, as I testified to already, this is - this diagnosis is not necessarily straightforward. I would say far from straightforward. I feel it's a diagnosis largely of exclusion.
>
> If you can't find anything else wrong with someone and there are very clearly some signs on examination that point to this being a possible diagnosis, then I would refer them to a thoracic surgeon or a special center to evaluate this. I' II be honest with you, the time when I saw her on March, what date was it, March 28, there is no way this diagnosis crept into my field of view. (RX4, pp. 33-34)

Dr. O' Leary noted that she had so many complaints, only a few of which are related to a potential medial cord plexopathy or thoracic outlet syndrome. He noted that she has a history of her arm being tugged, but he was not the first doctor who evaluated her. (RX4, p. 34)

Later, after review of the operative report and updated medical, when asked if any

conditions of ill-being were caused or aggravated by the alleged work injury, Dr. O'Leary testified, reading from his report, that he had no conclusive evidence to pinpoint these diagnoses or conditions and a work related event. (RX4, p. 56)

Dr. David Fletcher's Testimony

Dr. Fletcher testified via evidence deposition that he went to medical school in Chicago at Rush University and did a residency in Occupational and Preventive Medicine. He earned a master's degree in Public Health and Epidemiology and was Board certified in both Preventative and Occupational Medicine and has practiced in that field continuously since then. Governor Pritzker appointed him to the Illinois Workers' Compensation Medical Fee Advisory Board in January 2020. This is his second term of office. He was appointed in 2016 by Governor Rauner and served for three years. (RX13, pp. 7-9) Dr. Fletcher defined his role as an occupation medicine doctor as a "sort of primary care gatekeeper for an injured worker, make an assessment for the diagnosis," with appropriate treatment. If surgery is required, send the person to the surgeon and then, after the surgery, work with the surgeon or often times the surgeon will defer to him for the rehab and return to work decision. (RX13, p. 10) Besides injury care, he does drug and alcohol testing and onsite consulting for employers at the work site. (PX13, pp. 7-9, DepX2)

Dr. Fletcher testified that Petitioner came under his care under the direction of Mr. John Boshardy, her former attorney or current attorney. Boshardy recommended that she see Dr. Fletcher because of his experience with these types of injuries. (RX13, p. 49) His understanding at the initial visit, on the advice of Boshardy, her former legal counsel, now retired, was that this was an accepted claim. (PX13, p. 17) Dr. Fletcher first saw Petitioner in November 2018. (PX13, p. 11) Dr. Fletcher testified that when he began seeing her he requested records, however, he never received her prior medial records. (PX13, p. 50) Dr. Fletcher testified that he reviewed the records from Quincy Medical Group from October 2018 and the MRI from September 21, 2018. (PX13, pp. 14-15) He knew that Petitioner had seen Dr. Tawny Allen and there was talk about going to a neurosurgeon. (PX13, p. 16) Those were all the records he reviewed in their entirety. He never saw the neurosurgeon's records from Quincy Medical Group. (PX13, p. 52) Dr. Fletcher testified that Petitioner "was not pleased with what they were doing." (PX13, p. 16)

Dr. Fletcher testified that after electrical studies were performed by Dr. Trudeau on December 17, 2018, he reviewed the results with Petitioner and they objectively confirmed a brachial plexus injury and in his opinion ruled out that she would be a candidate for any cervical spine surgery. (PX13, p. 18) He also sent Petitioner to orthopedic spine surgeon Dr. Kube in Peoria for confirmation regarding her cervical spine condition. (RX13, p. 20) Dr. Fleming's understanding was that Dr. Kube did not feel there was any surgical intervention that was going to help Petitioner. (PX13, p. 22)

When Dr. Fletcher next saw Petitioner, he was concerned that, along with the brachial plexopathy, that her presentation "kind of fit a picture of the term traumatic thoracic outlet syndrome." He was focused on the fact that she was not improving. (RX13, p. 23) He prescribed physical therapy. Dr. Fletcher saw Petitioner 13 times. (RX13, p. 57) In the summer of 2019, Dr. Fletcher was at the end of what he could do for her. She had not had any satisfaction with what

Dr. Salvacion had done. At the eighth visit, he brought up the consultation with Dr. Hazelrigg. She had improvement on her EMG with Dr. Trudeau up to that point, but not complete resolution. (RX13, p. 59)

On February 20, 2019, she reported an increase in her pain. She had to go to the ER in Quincy. Her subjective complaints were reportedly worse. This was the first time Dr. Fletcher was concerned that, along with brachial plexopathy, that this kind of fit a picture of the term traumatic thoracic outlet syndrome (TOS). (PX13, 23) She tried conservative treatment.

On March 20, 2019, she reported no improvement with therapy. For the first time she reported contralateral symptoms as well. She had right upper extremity symptomatology as reflected in her pain drawing. Again, in a very classic C7-C8 distribution, that she had bilateral type of complaints. Dr. Fletcher talked to her about trying to do some interventional pain management with Dr. Salvacion who runs Memorial Medical Center Pain Clinic. He was running out of options - she was not benefitting with therapy. (PX13, 25) Dr. Salvacion performed an epidural steroid injection to her cervical spine on May 2, 2019.

She next saw Dr. Fletcher on April 19, 2010. With no change in symptoms, he released her with restrictions. (PX13, p. 26)

Dr. Fletcher testified that Petitioner always had good effort. She wanted to get back to work. Dr. Fletcher testified that Petitioner's life was somewhat in disarray because he believed around this time she couldn't get any further care authorized from workers' compensation. She had to use personal insurance. She was separated from her husband. He testified that "[a]pparently they got back together and she was able to access his health insurance. (PX13, 28)

Dr. Fletcher further testified Petitioner was traveling to come to Champaign from Quincy to see him. He testified that he would hear from her sometimes in between visits. (PX13, 29). Updated electrical studies at that time showed she objectively had a problem. There was some improvement in her brachial plexopathy. It did not show any evidence of any cervical radiculopathy, but it did document objectively that she had an abnormality consistent with her subjective complaints. There was no change in her overall presentation or exam. Dr. Fletcher kept her trying to do modified duty and put her on Topamax for some pain control as opposed to Lyrica. She was approaching MMI. (PX13, 31)

At the eighth visit on June 18, 2019, she was the same. Dr. Fletcher felt she had a positive Adson's sign consistent with thoracic outlet syndrome. He would try one last consultation, have her see a cardiovascular surgeon for consideration for a rib resection or anterior scalenectomy. He kept her on restricted activities-10 pounds, basically sedentary light work level. (PX13, p. 32)

She did not want surgery in June 2019. She returned in August and wanted to reconsider surgery. (PX13, 33) Dr. Hazelrigg is a cardiovascular thoracic surgeon at SIU School of Medicine. He's also a professor. Dr. Fletcher worked with him for more than 25 years. He's probably operated on 15 or 20 of his patients. She saw him about a week and a half before the August 16, 2019, visit. Dr. Fletcher testified that he had oral communication with Dr. Hazelrigg and he agreed with Dr. Fletcher's diagnosis. (PX13, p. 34)

Dr. Hazelrigg was planning to do a more traditional thoracic outlet surgery, basically a rib resection on the left side. She was also complaining of headaches. She had complaints of headaches since the beginning. (PX13, 35)

Dr. Fletcher testified that he probably had, in his career, probably 50 of his patients had thoracic outlet surgery. He testified that the surgery still has controversy in medicine. He further stated, "I've done everything for this lady absent her having a breast reduction." (PX13, p. 36)

Petitioner did ultimately undergo the surgery at Memorial Medical Center on September 11, 2019. Dr. Hazelrigg saw her for one post-operative visit then referred her back to Dr. Fletcher. (PX13, 37) Dr. Fletcher took her off work postoperatively. He had her go back to therapy. She followed-up with Dr. Fletcher on November 25, 2019. (PX13, 39)

Dr. Fletcher testified that Petitioner had some depression because she was still in chronic pain. She did have some improvement in shoulder girdle strength. On December 20, 2019, she reported benefit with surgery but reported left shoulder pain and more issues with weakness in her left shoulder; scapular winging had returned. (PX13, 40)

At the time of the deposition, Dr. Fletcher testified that he just saw her that week on February 10, 2020; there was no change in presentation. Scapular winging was really significant but there was not much more he could do for her. The scapular winging could affect her in the fact that if she doesn't move her upper extremity she could develop a frozen shoulder and that could cause her more complications, more pain and discomfort. He opined that she would have to get back to some pain control, using the TENS unit, taking more medications. Some of these injuries could take up to two years to get better. (PX13, 41-45)

Dr. Fletcher opined that all her conditions, cervical spine, brachial plexus and winging scapula are causally related to the workplace injury she reported on May 9, 2018. The mechanism of injury she described, a wrenching type of injury of her left upper extremity, will cause a traction injury to the brachial plexus and to the anterior scalene muscles that can cause a traumatic thoracic outlet and an associated brachial plexopathy. All the treatment he recommended was reasonable and necessary including with Dr. Hazelrigg. If the electrical studies don't really show any major change then he will have to give her options. There is not any further surgical solution. (PX13, 46-47)

Conclusions of Law

The Commission finds that Petitioner failed to sustain her burden of proving her condition of ill-being is related to either accident for the following reasons.

Petitioner did not seek medical treatment after the first accident for more than a year, when, on January 30, 2018, she told a chiropractor that she believed her neck and head pain complaints were from the November 2016 incident. Petitioner saw her primary care physician, Dr. Tawny Allen, at the Quincy Medical Group on March 6, 2018, for a follow-up for depression. She reported that she had neck pain and went to the chiropractor two times. The notes document, "Injury 1 year ago at work-encouraged WC appointment." (RX5)

On April 18, 2018, 17 days before the second reported accident, Petitioner returned to the chiropractor and complained of frequent (75%-50%) sharp, shooting, numbing, tingling and burning discomfort in the back of the neck. She rated the intensity ofdiscomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with applied pressure and movement. The discomfort was reported to decrease with rest.

Petitioner also complained of frequent (75%-50%) aching and tingling discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement. Petitioner also reported that she was having a headache that day.

Petitioner then reported an accident at work on May 9, 2018, despite no mention of a new work accident at an appointment with her primary care group at Quincy Medical Center on June 1, 2018. Petitioner reported the new work accident to her primary care physician, Dr. Tawny Allen in August 2018.

The Commission notes that prior to presenting to Dr. Fletcher, Petitioner was evaluated by Dr. Kimple from the Quincy Medical Group. (RX5) Neither Dr. Kimple, nor Dr. Dayoub, diagnosed thoracic outlet syndrome or provided a causation opinion or imposed work restrictions. In fact the records confirm that Dr. Kimple was specifically asked by Petitioner telephonically to provide a causation opinion on her behalf and he responded by stating that Petitioner could bring in a questionnaire, but he was unable to write a letter stating patient's injuries were due to an incident with patient's resident. (RX 5, p. 77)

The Commission notes that Petitioner testified that she was not satisfied with the level of care at Quincy Medical Group and that is the reason she consulted Dr. Fletcher in Urbana starting on November 1, 2018. (T. 16, 18) The Commission finds that testimony to be disingenuous.

Dr. Fletcher, a board certified doctor in Preventative and Occupational Medicine, was the fourth medical provider that Petitioner consulted after the May 2018 accident date and the first to causally relate her symptoms to work. (T, p. 51) Dr. Fletcher testified that he reviewed the records from Dr. Tawny Allen from October 2018 and the MRI from September 21, 2018. Those were all the records he reviewed in their entirety. He never saw Dr. Tawny's notes regarding the Petitioner's earlier complaints, the two neurosurgeon's records from Quincy Medical Group or the chiropractor's records from February through April 2018. (RX13, p. 52)

Dr. Fletcher testified that Petitioner provided him a history of a specific work injury from May 2018. She described where she was reaching out her hand and helped support a patient from falling and the patient pulled her left arm with her whole weight, sort of like a traction type of injury to her left upper extremity, and that was the history of the mechanism of injury. (RX13, p. 12) Dr. Fletcher testified that when he first saw her on November 1, 2018, he causally related her problems to work activities. He was not told there was an accident dispute when Petitioner was referred to him, thus, he made that opinion based on the mechanism of injury that she reported to

him in her presentation and what was in the subjective history in the records from Quincy Medical Group regarding her injury in May 2018. To clarify, Dr. Fletcher testified he had the records from October 2018 and the MRI from September 21, 2018. Dr. Fletcher based his initial causal connection opinion on what Petitioner told him and the limited records he reviewed from Quincy Medical Group and the MRI. (RX13, pp. 51-52)

Next, the Commission finds Petitioner's testimony is called into question, refusing to admit her attorney sent her to Dr. Fletcher despite the fact that she traveled to Urbana to see him. Dr. Fletcher was very candid regarding the fact that attorney Boshardy referred Petitioner to him for treatment. Dr. Fletcher testified that Boshardy recommended that she see Dr. Fletcher because of his experience with these type of injuries. (RX13, p. 49) His understanding at the initial visit, on the advice of Boshardy, her former legal counsel, refutes Petitioner's testimony that she found Dr. Fletcher on the internet and was referred to him by Dr. Allen, located in Quincy. Petitioner also admitted that to see Dr. Fletcher in Urbana, it is more than a six hour round trip drive from Quincy. (T. 51, 63)

The Commission finds it telling that Dr. Fletcher diagnosed thoracic outlet syndrome and referred Petitioner to Dr. Hazelrigg for surgery, then Dr. Fletcher, not Dr. Hazelrigg provided the causal connection opinion, and the testimony regarding causation. Dr. Hazelrigg's note at Petitioner's consultation on August 5, 2019, states that Petitioner has "more neck and headache related issues than might be attributed to thoracic outlet syndrome." He opined Petitioner "probably" does have thoracic outlet syndrome and might benefit from a first rib resection. He did not think that the rib resection would relieve her headaches or improve her neck condition as he thought there were multiple etiologies for her issues. (PX 10)

Dr. Fletcher testified that thoracic outlet surgery has controversy in medicine. (PX13, p. 36) Dr. O'Leary, a Board certified doctor in orthopedic spine surgery, also testified that thoracic outlet surgery is a controversial diagnosis. (RX1, p. 29)

During the time period between November 4, 2016, and August 23, 2018, Petitioner worked multiple positions without missing any time from work due to issues related to the work accidents. (T. 45) Respondent's exhibit 11 is "call documentation" of Petitioner refusing hours due to work obligations with her other position. Petitioner did this on multiple occasions since the November 4, 2016, work accident. Petitioner called off additional hours due to other work obligations on May 11, 2018, July 3, 2018, August 9, 2018, and August 15, 2018, after the alleged accident. This is consistent with her presentation at the June appointments and infers that Petitioner did not have new acute symptoms and was able to work both jobs.

Dr. O' Leary performed two §12 evaluations and prepared a third records' review report. Dr. O'Leary reviewed all pertinent medical records. When he evaluated Petitioner, he noted that she had exquisite tenderness to even the lightest touch at the base of her neck, near the vertebral prominence. He opined that this was evidence of symptom magnification. He also noted that she complained of electric shock going down her neck, for which he noted that there was no neurological explanation for that. He disagreed with Dr. Fletcher's examination finding that Petitioner had positive Lhermitte's sign. After he reviewed the cervical spine MRI, he noted that

there were no spinal cord abnormalities, no large disk herniations, no spinal cord compression, and no cord signal change.

Dr. O'Leary further testified that he did not see anything that added up in Petitioner's symptoms. Dr. O'Leary did not have any treatment recommendations as he could not imagine what further treatment would be indicated. In making this opinion, he noted that Petitioner had a high self-reported severe disability, imaging that was not consistent, exaggeration and magnification findings during his examination, and nothing seemed to help her thus far. He placed Petitioner at MMI as it related to the work accident. After reviewing additional reports and performing a second examination, Dr. O'Leary's opinions did not change.

> Expert evidence is legal and competent evidence and is to be received, treated and weighed precisely as other evidence by triers of fact in this character of cases. The weight of such testimony must be determined by the character, capacity, skill and opportunities for observation and apparent state of mind of the experts themselves as seen and heard and estimated by the triers of fact and by the nature of the case and its developed facts. (Peabody Coal Co. v. Industrial Com. 289 Ill. 449.)

Madison County Mining Co. v. Industrial Comm'n., 306 Ill. 591, 594, 138 N.E. 211, 212, 1923 Ill. LEXIS 1124, *5

In the subject case, the Commission finds that Dr. O'Leary's opinions and testimony regarding causal connection are more persuasive that Dr. Fletcher's opinions and testimony casually relating the Petitioner's conditions to the work accident of either November 4, 2016 or May 9, 2018. The Commission further finds that Petitioner's now retired attorney referred Petitioner to Dr. Fletcher and that Petitioner's testimony in this regard was not credible.

The Commission further finds that Petitioner was having the same or similar symptoms January 30, 2018, through April 18, 2018, before Petitioner alleged that she had a second work accident on May 9, 2018, evidenced by the medical records from Vance Chiropractic. (PX6) Dr. Fletcher never reviewed those records. Thus, the Commission finds the basis for Dr. Fletcher's opinion is flawed.

Although Petitioner related her complaints to a work accident more than one year prior when she saw Dr. Tawny in August 2018, the medical records also document that Petitioner was in a "car wreck" in 1995. Petitioner's delayed medical treatment after the reported accidents until more than one year in the first instance and several months later after the May 9, 2018, accident, casts further aspersion on the causal relationship between the two alleged work accidents and Petitioner's current conditions of ill-being. Further, the medical records from Quincy Group are replete with documentation that Petitioner was depressed with personal issues since well before this occurrence including evidence that her sleep was disrupted as a result of depression and anxiety. The Commission notes Petitioner has an ongoing headache syndrome, with a brain MRI documenting lesions that worried Petitioner, however, the Commission does not find Petitioner's headaches causally related to the work accidents based upon Dr. Kimple's records that he was concerned Petitioner had a chronic tension headache with associated peri-cranial tenderness. (RX5, p. 135)

Further, Petitioner alleges that she had no final resolution of her pain complaints after the thoracic outlet surgery. The Petitioner had reported mostly left sided symptoms throughout her treatment although she told Dr. O'Leary that she hurt both arms, which was years after the accidents occurred and contrary to her testimony. Her medical and body part histories are thus inconsistent. Petitioner further testified that not only did she have right sided similar symptoms, but "[t]hey wanted to do surgery on both sides at one point in time." (T. p. 53) The Commission finds that Petitioner's testimony is confusing at minimum and is further evidence that her condition is unrelated to the work accidents on either November 4, 2016, or May 9, 2018. There is no mention of right side pain complaints in the medical records for the majority of her course of treatment following either accident and Petitioner specifically testified that both accidents involved her left arm. (T, pp. 10, 113-14)

Finally, the Commission notes that Dr. Hazelrigg, the cardiovascular surgeon who performed the left-side thoracic outlet syndrome surgery, did not testify. At best, his notes from the August 5, 2019 consultation, indicate that his opinion of whether or not Petitioner she needed the surgery recommended by Dr. Fletcher, was equivocal, stating Petitioner, "probably does have thoracic outlet syndrome and might benefit from a first rib resection." He did not think that the rib resection would relieve her headaches or improve her neck conditions as he thought there were multiple etiologies for her issues. (PX 10, PX5, p. 166)

Therefore, the Commission finds that Petitioner has failed to prove a causal connection to thoracic outlet syndrome and her work accidents.

Finally, the Commission agrees with Dr. O'Leary's assessment of the video surveillance of Petitioner. Dr. O'Leary opined, "To me reviewing the bulk of the 30 minute surveillance, it appeared that she uses the arm much more normally than what I observed in the office today." (RX 3) The Commission finds the video surveillance belies Petitioner's testimony regarding her disability.

For the reasons enunciated above, the Commission reverses the Arbitrator's Decision regarding causal connection and vacates the Arbitrator's awards of temporary total disability, the TTD underpayment, maintenance, medical expenses, permanent partial disability and §19(k) and §19(l) penalties and §16 attorneys' fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on October 26, 2020, is hereby modified and causation is reversed for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability, and the temporary total disability underpayment, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of maintenance is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical services and related expenses is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of penalties under §19(k) and §19(l), and attorney's fees under §16, is vacated.

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

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(1) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 13, 2021

KAD/bsd
O071321
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/s/*Kathryn A. Doerries*
Kathryn A. Doerries

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

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

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

21IWCC0462

UNGLESBEE, CHRISTY
Employee/Petitioner

Case# **18WC031608**
18WC031609

HELP AT HOME
Employer/Respondent

On 10/26/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW A BREWER
1610 S 6TH ST
SPRINGFIELD, IL 62703

0000 INMAN & FITZGIBBONS LTD
FRANK JOHNSTON
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Christy Unglesbee
Employee/Petitioner

v.

Help at Home
Employer/Respondent

Case # **18** WC **31608**

Consolidated cases: **18 WC 31609**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **8/27/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **11/4/16 and 5/9/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,669.96**; the average weekly wage was **$482.74**.

On the date of accident, Petitioner was **38; 39** years of age, ***married*** with **1** dependent children.

ORDER

- The Arbitrator finds that the Petitioner met her burden of proof regarding the issue of accident on both the 11/4/16 and 5/9/18 work injuries.

- The Arbitrator finds that the Petitioner's current condition of ill being is causally related to the Petitioner's work injury of 5/9/18.

- The Arbitrator finds that the Petitioner's correct average weekly wage pursuant to Section 10 of the Act is $482.74.

- The Respondent shall all reasonable and necessary medical services as set forth in Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act.

- The Respondent shall pay the Petitioner temporary total disability benefits of $321.83 a week for 85 weeks, commencing October 3, 2018 through May 19, 2020, as provided in Section 8(b) of the Act. The Arbitrator notes that the Respondent did pay a total of $5,740.92 in TTD covering the period of October 9, 2018 to April 22, 2019. However, a TTD underpayment is owed as described below.

- The Respondent shall pay the Petitioner maintenance benefits of $321.83 a week for 14 and 2/7 weeks, commencing May 20, 2020 through the date of trial August 27, 2020, as provided in Section 8(a) of the Act.

- The Arbitrator finds that the Respondent paid TTD at a rate of $220.00 a week for 26 and 6/7 weeks covering October 9, 2018 through April 22, 2019 for a total of $5,740.92. The Petitioner's correct TTD rate is $321.83. As such, the total of TTD benefits owed during this time frame would be $8,643.43. For this reason the Arbitrator orders the Respondent to pay $2,902.51 representing the TTD underpayment covering the period of October 9, 2018 through April 22, 2019.

- The Arbitrator notes that while accident was put in dispute the Respondent presented zero evidence of any real controversy on the issue of accident. Furthermore, the Respondent's Section 12 examiner, Dr. O'Leary, testified that he had no opinion one way or another regarding causation on the Petitioner's diagnosis and treatment for thoracic outlet syndrome. As such, the Respondent does not present a real controversy on the issue of causation. Lastly, even if the Arbitrator were to have found that the Petitioner's average weekly wage was $416.73 as alleged by the Respondent, the minimum TTD rate for

the Petitioner's May 9, 2018 date of accident would be $286.00 given the fact that she was married with one dependent at the time of the May 9, 2018 accident. Again, the Respondent did not present any evidence as to why there was this intentional underpayment of compensation. As such, the Arbitrator awards penalties and fees as follows: the Arbitrator awards $12,602.26 in attorney's fees under Section 16 of the Act as the compensation payable under the Act at the time of trial totaled $63,01 1.32. It is noted the outstanding medical bills at the time of trial were $36,799.12. In addition after subtracting the previously paid TTD of $5,740.92 the Petitioner was also TTD and maintenance benefits of $26,212.20. This makes the total compensation owed at trial $63,011.72. As such, penalties are awarded in the amount of $31,505.66 under Section 19(k) of the Act. The Arbitrator awards $10,000.00 in penalties under Section 19(l).

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.

Edward Lee
Signature of Arbitrator

10/24/20
Date

ICArbDec19(b)

OCT 26 2020

FINDINGS OF FACT

At the time of the trial the Petitioner was 41 years old. The Petitioner has a high school education with some college. The Petitioner was married with zero dependents under the age of 18. However, at the time of her 11/4/16 and 5/9/18 accidents she was married with one dependent under the age of 18. The Petitioner has lived in Quincy, IL for the past 2 years.

The Petitioner was employed by the Respondent on 11/4/16 as a home care worker. The Petitioner's job included traveling to clients' homes and helping them with their day to day activities. The Petitioner testified that she would see between 3 and 4 client's a day.

The Petitioner testified on 11/4/16 she was helping a client out of their chair when the client grabbed the Petitioner's left arm and then fell back into the chair pulling on the Petitioner's left arm. The Petitioner was at the client's house and on the clock when this happened. The Petitioner noticed pain to the left side of her neck radiating down to her arms and to her small and ring finger.

The Petitioner notified her employer of the 11/4/16 accident. The Petitioner completed an accident report on 11/7/16. (PX 17)

The Petitioner testified that she did improve after the accident, which was part of the reason, she did not seek care. The Petitioner initially did not seek care after her 11/4/16 accident until early 2018 when she saw Chiropractor Vance. The accident of 11/4/16 was minor and the Petitioner was able to continue to work her job with the Respondent and her concurrently held position with the Illinois Department of Human Services full duty after the 11/4/16 accident.

The Petitioner sustained a second accident while working for the Respondent on 5/9/18. The Petitioner was still employed by the Respondent in the same position as a home care helper and had the same job duties as she did in November of 2016. The Petitioner described essentially the same accident that had occurred on 11/4/16 as occurring again on 5/9/18. The Petitioner testified that she was assisting a client as they were getting out of their chair at which time the client fell back into the chair and pulled on the Petitioner's left arm. The Petitioner described the client on 5/9/18 as a female weighing over 200 lbs. Again, the Petitioner was at the client's house and was on the clock when this happened. The Petitioner again described complaints of pain from her neck shooting down into her left arm into her fingers on her left hand.

The Petitioner did provide notice to her employer and filled out an accident report on the day of the accident 5/9/18. The Petitioner was able to finish her shift on this day.

Again, the Petitioner did not immediately seek medical care after the 5/9/18 accident. The Petitioner testified that due to the fact she was able to continue working full duty after her 11/4/16 accident which was essentially the same mechanism she was hopeful that her symptoms following the 5/9/18 accident would go away or allow her to continue to work full duty as she had previously. The Petitioner also testified that she was concerned that may she lose her job if she filed a workers' compensation claim.

However, the Petitioner's complaints became severe enough after the 5/9/18 accident that she did seek medical care. The Petitioner was initially seen by Quincy Medical Group on 8/23/18 complaining of neck pain radiating down the left upper extremity. The Petitioner followed up with Quincy Medical Group on 9/11/18 and described a "zinger feeling." At that time, a recommendation was made for the Petitioner to undergo a cervical spine MRI. (PX 2)

The MRI of the cervical spine taken on 9/21/18 showed multi-level cervical spondylosis most significant at C5-6 with mild to moderate spinal canal stenosis and mild bilateral neural foraminal narrowing. (PX 2)

The Petitioner testified that she was not satisfied with her care at Quincy Medical Group. The Petitioner testified that the physicians at Quincy Medical Group in her opinion did not listen to her symptoms and the specific issues that she was having. Despite that the Petitioner was placed on light duty work on 10/3/18. The Petitioner testified that her employer was unable to accommodate the restrictions at that time.

Furthermore, the Petitioner testified that despite her delay in seeking medical care after the 5/9/18 accident, the Respondent authorized and paid for her initial medical treatment.

The Petitioner then subsequently came under the care of Dr. David Fletcher. The Petitioner initially saw Dr. Fletcher on 11/1/18. Dr. Fletcher took an examination and reviewed the cervical spine MRI from 9/21/18. Dr. Fletcher diagnosed the Petitioner with left C6-7 radiculopathy and a left brachial plexus injury. Dr. Fletcher prescribed medication recommended the Petitioner have an EMG study with Dr. Trudeau in Springfield. Dr. Fletcher took the Petitioner off of work entirely at this time. (PX 3)

The Petitioner underwent the recommended EMG with Dr. Trudeau on 12/17/18. The results of Dr. Trudeau's EMG were a left brachial plexopathy, medical cord lesion, moderately severe in electroneurophysiologic testing characterization, consistent with the clinical assessment of Dr. Fletcher. There was no evidence of cervical radiculopathy at C6 or C7 on either side.

The Petitioner returned to see Dr. Fletcher on 12/27/18. At which time Dr. Fletcher reviewed the results of the EMG study with the Petitioner. At that time, Dr. Fletcher continued to diagnose cervical radiculopathy as well as an injury of the brachial artery on the left side and injury of the brachial plexus. Dr. Fletcher instituted work restrictions of no lifting more than 10 pounds and no overhead activity. The Petitioner was also referred to Dr. Richard Kube for further consultation regarding the cervical spine. (PX 3)

The Petitioner testified that she was off work as of 10/3/18. The Petitioner was not paid temporary total disability benefits in October, November, or December of 2018. RX 9 which is the TTD benefit ledger reveals that the Petitioner's first TTD check was not issued until 12/28/18 and covered only 10/19/18 through 11/15/18. The Petitioner testified that she did not even receive this check until January of 2019. The Petitioner testified that due to the fact that she was not paid TTD benefits her car was repossessed on 1/3/2019. As such the Petitioner did not have any mode of transportation and had no way of getting around. The Petitioner confirmed that PX 19 contained an accurate copy of the notice that she received from the creditor on her vehicle. In order to "redeem her vehicle" the Petitioner owed the creditor $2,046.19. The Petitioner confirmed that the initial TTD check issued on 12/28/18 covering the dates of 10/9/18 through 11/15/18 was for a total of $1,194.29. As such this would account for only half of the money she needed to pay the creditor to get her vehicle back.

The Respondent admitted into evidence as RX 12 three light duty job offers. The Petitioner recalled communication with the Respondent and receiving the contents of RX 12. The first is dated 1/10/19 where the Petitioner was offered a light duty position. The Petitioner testified that this was for an office support position at the Respondent's Pittsfield location. The Petitioner confirmed at the time of this offer she was living in Quincy, IL. The Arbitrator takes judicial notice that from the Petitioner's address in Quincy to Pittsfield and back is approximately 95 miles round trip. The Petitioner confirmed that she had no car at the time this light duty job was offered and therefore did not have a way to get to and from Pittsfield every day. The Petitioner testified that if she did in fact have transportation she would have worked the light duty job offered.

The Petitioner was ultimately seen by Dr. Richard Kube's office on 1/5/19. Following an examination and review of the September 2018 cervical spine MRI it was recommended for the Petitioner to have a cervical

spine motion analysis x-ray scan. This scan was taken on 1/25/19. Dr. Kube reviewed the motion x-ray scan with the Petitioner on 2/5/19 and indicated the Petitioner was not a cervical candidate. Dr. Kube instead recommended the Petitioner participate in pain management for her cervical spine. (PX 16)

The Petitioner followed up with Dr. Fletcher on 2/8/19. Dr. Fletcher recommended the Petitioner begin physical therapy at that time and continued her on light duty no lifting more than 10 pounds and no overhead activity. (PX 3)

The Petitioner described a second light duty job offer made by the Respondent on 2/14/19. This job offer was the same as the first in that it was for the office support position in the Respondent's Pittsfield office. The Petitioner testified that she still had no car at this time and had no transportation or way of getting to the light duty position.

The Petitioner testified that she did begin physical therapy around this time at ATI in Quincy.

The Petitioner continued to follow up with Dr. Fletcher next seeing him on 2/20/19. The Petitioner continued to have significant subjective complaints of pain. At this time Dr. Fletcher took the Petitioner off work entirely. The Petitioner was to continue with physical therapy to see if she could obtain any improvement with her symptomatology. (PX 3)

The Petitioner followed up with Dr. Fletcher on 3/20/19. At this time the Petitioner was placed back on light duty restrictions of no lifting more than 10 pounds, no overhead activities and the Petitioner was to avoid driving long distances due to the sedating nature of the medication which was being prescribed. The Petitioner was prescribed Nucynta as well as Flexeril. Additionally, Dr. Fletcher recommended the Petitioner be seen by Dr. Salvacion, a pain management doctor in Springfield. (PX 3)

On 3/22/19 the Respondent made its third and final light duty offer. This was again the same position as was originally offered in January of 2019, that being an office support position at the Respondent's Pittsfield location. The Petitioner testified that she still did not have her car back and in fact has not had a car since it was repossessed in January of 2019. The Petitioner testified that not only did she fall behind on her car payments, but on all of her personal bills and expenses due to the fact that the Respondent did not pay TTD in October, November or December of 2018.

The Petitioner followed up with Dr. Fletcher on 4/9/19. Again, the Petitioner was recommended to continue physical therapy and was set to see Dr. Salvacion. The Petitioner maintained on her same work restrictions of no lifting more than 10 pounds, no overhead activities and no driving long distances. (PX 3)

The Petitioner did get to see Dr. Salvacion at Memorial Medical Center in Springfield. Dr. Salvacion performed a series of cervical epidural steroid injections which took place on 4/25/19, 5/2/19 and 5/23/19. (PX 9)

The Petitioner was also sent for an updated EMG study with Dr. Edward Trudeau. The Petitioner underwent the second EMG with Dr. Trudeau on 5/16/19. The results of this study again showed a left brachial plexopathy, medial cord lesion, mild to moderately severe in electroneurophysiologic testing terms, improved in comparison the previous study of 12/17/18 consistent with the clinical assessment of Dr. Fletcher. (PX 9)

The Petitioner followed up with Dr. Fletcher on 5/17/19. The Petitioner testified that she did not obtain any significant relief from the epidural steroid injections. At that time Dr. Fletcher maintained the Petitioner on light duty work restrictions of no lifting more than 10 pounds, no overhead activities and not driving long

distances. Dr. Fletcher also noted that the Petitioner was improved and was nearing maximum medical improvement. (PX 3)

The Petitioner followed up with Dr. Fletcher on 6/18/19. The Petitioner continued to have significant subjective complaints. Dr. Fletcher indicated that the Petitioner had continued to present with features of a brachial plexopathy and thoracic outlet syndrome. A discussion was had to refer the Petitioner to Dr. Hazelrigg at SIU in Springfield for a thoracic outlet evaluation which the Petitioner did not wish to do. The Petitioner did not wish to undergo any potential thoracic outlet surgery at that time. As such Dr. Fletcher placed the Petitioner at maximum medical improvement as of 6/18/19. The Petitioner was also issued permanent restrictions at that time of no lifting more than 10 pounds and no overhead activities. (PX 3)

The Petitioner testified that following the June 2019 visit with Dr. Fletcher she did not fare well. The Petitioner continued to have significant issues and as a result elected to see Dr. Hazelrigg for further evaluation.

The Petitioner initially saw Dr. Hazelrigg on 8/5/19. Dr. Hazelrigg reviewed the prior diagnostic studies and performed an extensive examination. Dr. Hazelrigg diagnosed the Petitioner with thoracic outlet syndrome worse on the left side. Dr. Hazelrigg indicated that based upon the diagnosis and her presentation that she may benefit from a first rib resection procedure. (PX 10)

The Petitioner did elect to undergo this procedure on 9/11/19 Dr. Hazelrigg performed a transaxillary first rib resection. Pre and post-operative diagnosis was thoracic outlet syndrome. The Petitioner was taken off work after the surgery. Subsequently the Petitioner was sent back to Dr. Fletcher for post-surgical follow up care. (PX 9)

The Petitioner followed up with Dr. Fletcher on 10/28/19. The Petitioner did have some initial relief after the surgery, but her symptoms returned. The Petitioner was continuing to complain of numbness and weakness in the left upper extremity. Dr. Fletcher recommended physical therapy start back up at this time and kept the Petitioner off of work. (PX 3)

The Petitioner again participated in physical therapy starting on 11/1/19.

Follow up visits with Dr. Fletcher on 11/25/19 and 12/20/19 indicate the Petitioner was to continue physical therapy and was maintained on restrictions of no lifting more than 10 lbs, no overhead activities and not driving long distances due to her medication. (PX 3)

As of 2/10/20 Dr. Fletcher recommended the Petitioner have a third and final EMG study. (PX 3)

On 2/25/20 the Petitioner underwent her third EMG study with Dr. Trudeau. This study revealed left long thoracic neuropathy, moderately severe in electroneurophysiologic testing characterization consistent with the clinical assessment of Dr. Fletcher, as well as left brachial plexopathy medial cord lesion, mild in electroneurophysiologic testing terms improved in comparison to the previous study of 5/16/19. (PX 11)

Dr. Fletcher saw the Petitioner in follow up on 3/3/20. This was the last time Dr. Fletcher actually saw the Petitioner. At this time, it was recommended that the Petitioner undergo a Functional Capacity Evaluation following review of the most recent EMG from February of 2020. (PX 3)

The Petitioner underwent a Functional Capacity Evaluation at ATI Physical Therapy on 5/11/20. This was a valid study the Petitioner gave consistent effort. Physical demand level demonstrated by the Petitioner was sedentary. The physical demand level of her previous job with the Respondent was medium to heavy. Recommended restrictions were issued for occasional 15 pound lifting from floor to waist, occasional 15 pound

carrying, occasional 10 pound lifting from waist to overhead with the right hand only, and occasional 2 pound lifting from the waist to shoulder height with the left hand. (PX 12)

Dr. Fletcher subsequently placed the Petitioner at maximum medical improvement with permanent restrictions per the Functional Capacity Evaluation on 5/20/20. The Petitioner testified that she did not see Dr. Fletcher on 5/20/20. However, as of the last time she saw Dr. Fletcher on 3/3/20, Dr. Fletcher indicated to the Petitioner that if the FCE was valid that she would be placed at maximum medical improvement and permanent restrictions issued consistent subsequent to the FCE.

The Petitioner testified as of the time of trial she was not offered a position by the Respondent within her permanent restrictions. The Petitioner then began participating in a self-directed job search once she was placed at maximum medical improvement. Job search logs were admitted as PX 15. The Petitioner confirmed that per her job search logs she had applied for roughly 90 different jobs between May and August of 2020.

The Petitioner testified just prior to trial she was offered a position with Blessing Hospital. The Petitioner testified that this position would be approximately 24 hours a week and she would be making $12.68 an hour.

The Petitioner confirmed that as of the time of her May of 2018 accident she did have concurrent employment. The Petitioner was concurrently employed at that time as a personal assistant with the Illinois Department of Human Services Home Services program. The Petitioner testified given her residual condition and her permanent restrictions she is unable to return to that position.

As of the time of trial the Petitioner testified that she still experiences symptomatology stemming from the left side of her cervical spine down her left arm. The Petitioner still has weakness and experiences numbness going into the fingers. The Petitioner testified that she does not believe she can return to work with the Respondent in her prior position.

The Petitioner testified that after Dr. O'Leary's Independent Medical Examination that some of her bills were paid by her husband's group health insurance which was Blue Cross Blue Shield.

The Respondent called Diane Westfall at the time of trial as its witness. Ms. Westfall works for the Respondent as a Registered Nurse and a branch manager at their Pittsfield location.

Ms. Westfall confirmed that the Respondent made light duty job offers to the Petitioner on three separate occasions. These offers were admitted as RX 12. The initial light duty offer was made on 1/10/19 for an office support position at the Respondent's Pittsfield location. This same position was later offered on 2/14/19 and again on 3/22/19. All three light duty job offers were for the office support position and were located at the Respondent's Pittsfield location.

Ms. Westfall confirmed on cross examination that the Petitioner lived in Quincy at the time these light duty job offers were made. She also confirmed that it was approximately 95 miles round trip from Quincy to the Pittsfield location and back.

Ms. Westfall also confirmed the email communications that she had with other members of the Respondent admitted as RX 13. Ms. Westfall confirmed that she was made aware at the time each light duty offer was made to the Petitioner that the Petitioner did not have a vehicle as it had been repossessed at the time when the Respondent failed to pay the Petitioner TTD benefits which caused Petitioner to become delinquent on her car payments and therefore could not get a ride all the way to and from Pittsfield every day. Ms. Westfall confirmed that the light duty position in Pittsfield would be four to five days a week.

The Arbitrator finds that although the Respondent did offer the Petitioner light duty work, it was reasonable for the Petitioner not to be able to attend as her car has been repossessed due to the fact that the Respondent failed to pay TTD benefits. As such the Arbitrator finds that the Petitioner had no way of getting to and from Pittsfield which was approximately 95 miles round trip each day for the light duty work, and therefore the Petitioners failure to work the light duty position was justified and not a refusal to work. The Arbitrator also notes that the Petitioner testified if she had transportation and a way to get to a from the light duty position that she would have worked it.

The evidence deposition of Dr. Fletcher was conducted on 2/14/2020. Dr. Fletcher is board certified in both preventative and occupational medicine. Dr. Fletcher has testified many times in the past regarding issues of causation, work restrictions, permanent partial disability, as well as maximum medical improvement in Illinois Workers' Compensation cases. Dr. Fletcher has also been appointed to the Illinois Workers' Compensation Medical Fee Advisory Board.

Dr. Fletcher confirmed that the Petitioner provided a history regarding her accident of 5/9/18. Dr. Fletcher treated the Petitioner from November of 2018 through May of 2020. Dr. Fletcher testified at the time of his evidence deposition that he believed based upon the history that the Petitioner provided, which he felt was consistent with the medical records, that the mechanism of injury described by the Petitioner from her 5/9/18 work accident was the cause of her conditions relative to her cervical spine, brachial plexus, winging scapula and thoracic outlet syndrome. Dr. Fletcher believed that the Petitioner's current condition of ill being is causally related to her accident of 5/9/18. Dr. Fletcher specifically described the mechanism which was a wrenching type of injury to the left upper extremity which is the type of mechanism that can cause a traction injury to the brachial plexus and to the anterior scaling muscles that can cause a traumatic thoracic outlet syndrome and associated brachial plexopathy. Dr. Fletcher believed that all the Petitioner's medical care for her conditions including the surgery performed by Dr. Hazelrigg as well as the need for her permanent restrictions are causally related to her 5/9/18 accident. The Arbitrator also notes that the photographs admitted as Exhibit 3 to Dr. Fletcher's evidence deposition show clearly the winging scapula condition that was noted and diagnosed by Dr. Fletcher.

The Respondent obtained an Independent Medical Examination from Dr. Patrick O'Leary. Dr. O'Leary's examination took place on 3/29/19. Dr. O'Leary's evidence deposition was taken on 2/27/20. Dr. O'Leary is a board certified orthopedic surgeon focusing on spinal care. Dr. O'Leary practices at Midwest Orthopedic Center in Peoria. After taking a history and performing an examination, Dr. O'Leary diagnosed cervical spondylosis without myelopathy as well as neck pain. Dr. O'Leary described "ill defined extremity complaints with a history and headaches and questionable history of brain lesions". Dr. O'Leary did not believe that any of his diagnoses were related to the work accident.

Dr. O'Leary confirmed on cross-examination that he performed between 300-350 surgeries a year. Dr. O'Leary confirmed that he does not perform and has never performed surgery for thoracic outlet syndrome including the rib re-section performed by Dr. Hazelrigg in this case. (RX 4, p 35-36)

Dr. O'Leary confirmed that the mechanism on injury described by the Petitioner could case a cervical spine injury, a brachial plexus injury or even a shoulder injury. (RX 4, p 44) Dr. O'Leary was not provided any evidence to dispute that the accidents in this case did in fact occur. (RX 4, p 44) Dr. O'Leary did confirm that in March of 2019 when he saw the Petitioner for an IME she did have subjective complaints that would be consistent with a medial cord lesion and/or thoracic outlet syndrome. (RX 4, p 44) Dr. O'Leary at his examination did not perform specific testing for thoracic syndrome for example an Addison's Test. (RX 4, p 47) Dr. O'Leary confirmed that the EMG performed on 12/27/18 did show a left a left brachial plexopathy, medical cord lesion which was moderately severe in testing characterization. (RX 4, p 48-49) Dr. O'Leary had no evidence and was not provided any documentation that showed any issues the Petitioner had with her cervical

spine, brachial plexus, or thoracic outlet syndrome prior to either of her work accidents. (RX 4, p 52) **Lastly, the Arbitrator notes that the final question asked on cross-examination to Dr. O'Leary by Petitioner's counsel:**

> **Q. Doctor, have you – maybe I am missing it because we are talking about several issues here today. Have you given an opinion as to whether or not within a reasonable degree of medical certainty the ultimate diagnosis and procedure that she had relative to the thoracic outlet syndrome has any correlation to her work accident?**
>
> **A. No.**

Subsequent to Dr. O'Leary's testimony the Respondent obtained an additional addendum report from Dr. O'Leary dated 8/6/2020. Dr. O'Leary reviewed additional records at that time but stated he did not find anything in the medical records which changed his initial opinions based upon his initial evaluation. The Arbitrator finds that given Dr. O'Leary's testimony on cross-examination and the fact that he had no change in opinion at the time of his addendum report, the Respondent presented no causation defense or opinion relative to the Petitioner's thoracic outlet syndrome which is the key diagnosis in this case. Dr. O'Leary's opinions do provide a basis for a defense regarding the Petitioner's cervical spine condition which the evidence showed was not a surgical issue. However, the focus of the Petitioner's treatment has been thoracic outlet syndrome and the Respondent did not present any opinion in evidence to dispute Dr. Fletcher's causation opinion in favor of the Petitioner on thoracic outlet syndrome.

ARBITRATOR'S FINDINGS

Accident

The Arbitrator finds the Petitioner met her burden of proof regarding issue of accident on both the 11/4/16 and 5/9/18 work injuries. The Respondent did not provide any defense to dispute the issue of accident.

Causal Connection

The Arbitrator finds the Petitioner's current condition of ill-being is causally related to the Petitioner's work injury of 5/9/18. The Arbitrator finds that the 11/4/16 accident caused a minor aggravation to the Petitioner's condition, but the accident of 5/9/18 is the cause of her condition of ill-being. In support of this the Arbitrator notes that Dr. Fletcher, the Petitioner's treating physician, provided a clear and credible causation opinion in favor of the Petitioner relative to all of her conditions including her thoracic outlet syndrome. The Arbitrator further notes that although the Respondent's IME physician Dr. O'Leary disputed causation of the Petitioner's cervical spine condition, he at no time gave an opinion to dispute causation relative to the Petitioner's thoracic outlet syndrome which was surgically treated in this case. Despite Dr. O'Leary's opinion regarding the cervical spine condition the Arbitrator finds the opinions of Dr. Fletcher to be controlling on all of the Petitioner's conditions of ill-being.

Average Weekly Wage

The Arbitrator finds the correct average weekly wage pursuant to Section 10 of the Act to be $482.74. The Arbitrator notes that the wage statement was admitted as RX 15. That document shows the Petitioner in the 52 weeks prior to the accident worked a total of 1766.45 hours. These hours divided by 40 shows the Petitioner had earnings in 44.16 weeks and parts thereof. The total earnings of the Petitioner in the 52 weeks before the

accident with the Respondent was $16,811.03. The total earnings divided over 44.16 (representing the weeks and parts thereof where Petitioner had earnings) gives an average weekly wage of $380.68.

Additionally, admitted as PX 7 were the earnings the Petitioner had in her concurrent employment as a personal assistant with the Illinois Department of Human Services – Home Services Program. In the Petitioner's concurrent employment she earned $2,857.79 over a period of 28 weeks for an additional average weekly wage of $102.06.

Combining the Petitioner's earnings that she made with the Respondent as well as her concurrent employer, the Arbitrator finds that the average weekly wage in this case is $482.74.

Medical Bills

The Respondent shall all reasonable and necessary medical services as set forth in Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act. In support of this, the Arbitrator refers his decision regarding causal connection in favor of the Petitioner.

Temporary Total Disability

The Respondent shall pay the Petitioner temporary total disability benefits of $321.83 a week for 85 weeks, commencing October 3, 2018 through May 19, 2020, as provided in Section 8(b) of the Act.

Maintenance Benefits

The Respondent shall pay the Petitioner maintenance benefits of $321.83 a week for 14 and 2/7 weeks, commencing May 20, 2020 (the date of MMI) through the date of trial August 27, 2020, as provided in Section 8(a) of the Act.

TTD Underpayment

The Arbitrator finds that the Respondent paid TTD at a rate of $220.00 a week for 26 and 6/7 weeks covering October 9, 2018 through April 22, 2019 for a total of $5,740.92. The Petitioner's correct TTD rate is $321.83. As such, the total of TTD benefits owed during this time frame would be $8,643.43. For this reason the Arbitrator orders the Respondent to pay $2,902.51 representing the TTD underpayment covering the period of October 9, 2018 through April 22, 2019.

Penalties and Fees

The Arbitrator notes that while accident was put in dispute the Respondent presented zero evidence of any real controversy on the issue of accident. Furthermore, the Respondent's Section 12 examiner, Dr. O'Leary, testified that he had no opinion one way or another regarding causation on the Petitioner's diagnosis and treatment for thoracic outlet syndrome. The evidence as presented shows the focus of Petitioner's treatment and her advanced and invasive care was directed toward curing her thoracic outlet syndrome.

As such, the Respondent did not present a real controversy on the issue of causation. Lastly, even if the Arbitrator were to have found that the Petitioner's average weekly wage was $416.73 as alleged by the Respondent, the minimum TTD rate for the Petitioner's May 9, 2018 date of accident would be $286.00 given the fact that she was married with one dependent at the time which is clearly stated on the Application for Adjustment of Claim and not disputed by the Respondent at trial. Again, the Respondent did not present any evidence as to why there was this intentional underpayment of compensation.

As such, the Arbitrator awards penalties and fees as follows:

Section 16 Attorney Fees: The Arbitrator awards $12,602.26 in attorney's fees under Section 16 of the Act as the compensation payable under the Act at the time of trial totaled $63,011.32.

Section 19(k) Penalties: It is noted the outstanding medical bills at the time of trial were $36,799.12. In addition, after subtracting the previously paid TTD of $5,740.92 the Petitioner was also TTD and maintenance benefits of $26,212.20. This makes the total compensation owed at trial $63,011.72. As such, penalties are awarded in the amount of $31,505.66 under Section 19(k) of the Act.

Section 19(l) Penalties: The Arbitrator awards $10,000.00 in penalties under Section 19(l).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031609
Case Name	UNGLESBEE, CHRISTY A v. HELP AT HOME
Consolidated Cases	18wc031608
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0463
Number of Pages of Decision	39
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Frank Johnston

DATE FILED: 9/13/2021

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0463

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTY UNGLESBEE,

Petitioner,

vs. NO: 18 WC 31609

HELP AT HOME,

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, average weekly wage, causal connection, medical expenses, temporary total disability, maintenance, permanent disability, penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, and reverses on the threshold issue of causal connection, 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 partial disability, if any, pursuant to *Thomas v. Industrial Comm'n.* 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission affirms and adopts that part of the Arbitrator's Decision finding that Petitioner sustained an accident arising out of and in the course of her employment on May 9, 2018, and regarding the calculation of Petitioner's average weekly wage, however, the Commission reverses the Arbitrator's Decision finding that Petitioner's current condition of ill-being including, but not limited to, headaches, her cervical spine, brachial plexopathy or thoracic outlet syndrome is causally related to the May 9, 2018, accident and vacates the Arbitrator's award of temporary total disability, maintenance, medical expenses and penalties under §19(k) and §19(l) and attorney's fees under §16, for the reasons explained below. Therefore, the Commission strikes all portions of the Arbitrator's Findings of Fact and Conclusions of Law except the paragraphs under Accident and Average Weekly Wage.

Findings of Fact

Petitioner alleges that she sustained an accident on May 9, 2018, that arose out of and in the course of her employment with Respondent. She had no contemporaneous medical treatment as a result of this alleged injury.

Petitioner's Testimony

Petitioner testified that on May 9, 2018, she was employed with Respondent as home care. She worked for Respondent since 2009. Her responsibilities with Respondent included helping clients with whatever was needed, including cleaning, errands, laundry, bathing, and dressing. (T. 8-9)

She testified that on November 4, 2016, she had a client that was going to stand up and she put her arm out for him to steady himself. He pulled her left arm with his whole weight and they both fell. She experienced numbness in her fingers (ring and pinky), pain going down her left shoulder and arm area, her neck hurt, and she has headaches. She testified that she reported the accident but did not seek any medical care for her symptoms. She was able to continue to work for Respondent. (T. 9-10)

Petitioner testified that a similar accident occurred on May 9, 2018. She put out her left arm to help steady the client and the client pulled her left arm back as she fell. She experienced the same symptoms as before but noted that the pain was even sharper going down her left arm, shoulder, neck and headaches. (T. 13) She later presented to Quincy Medical Group, but because she was not satisfied with the level of care, saw Dr. Fletcher in Urbana starting on November 1, 2018. (T. 16, 18)

Dr. Fletcher managed Petitioner's care starting on November 1, 2018, including her work restrictions. She advised that she had a light duty offer for work at the Respondent's Pittsfield office, but could not make it as her car was repossessed in early January 2019. Petitioner testified about her course of treatment. (T. 25-40)

Petitioner testified that she was placed at MMI on May 20, 2020, with permanent work restrictions of occasional 15 pound lifting floor to waist, 15 pound carrying, 10 pounds lifting waist to overhead with the right hand only and two pounds lifting from the waist to shoulder with her left hand. (T. 39)

Petitioner advised that she had a second job at the time of the May 2018 work accident as a personal assistant with the Illinois Department of Human Services. (T. 42)

She next testified that she has symptoms of tingling and numbness, sharp pain, and her shoulder blade sticking out all the time causing pain on the left side. The sharp pain goes down her arm. She noted occasional headaches and neck pain as well. (T. 43)

Petitioner testified on cross-examination that she did not seek any treatment for the November 2016 accident in 2016 or 2017. During this time frame, she held multiple jobs at the

same time. Petitioner was able to continue working her multiple jobs through October of 2018. (T. 45) She did not recall if she was ever contacted to work additional hours and she did not recall if she refused those hours due to obligations with her other job. (T. 46)

Petitioner testified that Dr. Allen was her primary care physician, who she saw on August 23, 2018, for symptoms related to the work accident. Petitioner could not recall her presentation of symptoms when she presented to Dr. Allen on June 1, 2018, nor could she recall if she reported any symptoms related to the neck or shoulder. (T. 47) She later testified that she rated her symptoms as severe during the summer of 2018. (T. 60)

Petitioner saw both Dr. Kimple and Dr. Dayoub for her pain complaints. She testified that she did not discuss work restrictions with either physician. When asked about the October 16, 2018, phone call requesting a medical causation opinion from Dr. Kimple, she did not have a recollection. (T. 49-50)

Petitioner testified that Dr. Fletcher was the fourth physician that she saw and the first one to provide a medical causation opinion. He was also the first one to authorize the Petitioner off work. Petitioner testified that she found Dr. Fletcher's information online and was referred to him by Dr. Allen. She admitted that to see Dr. Fletcher in Urbana, it is more than a six hour round trip drive from Quincy. (T. 51, 63)

Petitioner advised that it was fair to say that the majority of treatment was for the left side. She testified that she had symptoms on her right side. She testified that both Dr. Fletcher and Dr. Hazelrigg recommended a surgery for the right side that she decided to not undergo. (T.53)

Petitioner last saw Dr. Fletcher on March 3, 2020. She testified that Dr. Fletcher performed a comprehensive examination of both shoulders, spending a total of 45 minutes. Petitioner has not returned to Dr. Fletcher after the functional capacity evaluation (FCE) to discuss the results or additional treatment options. (T. 54- 55)

Diane Westfall's Testimony

Ms. Westfall testified that she is a registered nurse and the branch manager at the Pittsfield office. She has been employed as the branch manager since September of 2017. (T. 69)

Ms. Westfall identified RX12 as the transitional duty offer. She noted that it was an offer to Petitioner to come into the office in Pittsfield to do light duty work. She testified that Petitioner worked around 20 hours per week and the light duty offer was made for Petitioner to do those hours at the Pittsfield location. (T. 71) Ms. Westfall testified that there were three offers for light duty work that were sent to Petitioner, on January 10, 2019, February 14, 2019, and March 22, 2019. (T. 72)

Ms. Westfall then testified to her conversation with Petitioner about the light duty job offer on January 10, 2019. She reported that she spoke with Petitioner on the phone and told her that she could come in to the office to work. Petitioner provided several reasons as to why she could not return to work including needing to lay down because of her headaches, her car was repossessed,

and she had a doctor's appointment the following week. (T. 74) According to Ms. Westfall, Petitioner called back later and advised she could not go to work the next day because she did not have a way to get there. (T. 75, 77-78)

Medical Records

On October 26, 2017, Petitioner saw her primary care physician, Dr. Tawny Allen, at the Quincy Medical Group on March 6, 2018, for an evaluation for depression. Her symptoms had been going on for months, noted to be situational. Her symptoms included depressed mood, difficulty concentrating, hopelessness, insomnia, and possible panic attacks. She was prescribed Zoloft and it was noted that she was an everyday smoker. (RX5, p. 1) Following that visit, Petitioner saw Dr Tawny again on November 28, 2017, and again on February 6, 2018, for a follow-up for depression. There was no mention of a work accident that would have occurred on or about November 4, 2016, in any of these office visit notes.

On January 30, 2018, Petitioner sought treatment at Vance Chiropractic and saw chiropractor Mark Sprague. (PX6) Petitioner complained of frequent (75%-50%) tingling, burning and shooting discomfort in the back of the neck. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement and applied pressure.

The subjective complaints document that Petitioner hurt herself at work over a year ago. She reported she was having headaches and sleeping poorly. She was diagnosed with cervicalgia and headache. (PX6, p. 1)

Petitioner returned to the chiropractor on February 24, 2018, complaining of constant (100%-75%) sharp, aching, burning, numbing, tingling and shooting discomfort in the back of the neck. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe.

The discomfort was reported to increase with prolonged sitting, movement and applied pressure. Petitioner also complained of frequent (75%-50%) aching, tightness and throbbing discomfort inthe upper back. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of1to10, with 10 being the most severe. The discomfort was reported to increase with movement and prolonged sitting.

Petitioner also complained of frequent (75%-50) aching, tightness and throbbing discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement and prolonged sitting.

Petitioner stated that she had been feeling worse since her last visit. She was having headaches and reported that she had not been sleeping well since her last visit. She was diagnosed with cervicalgia, pain in the thoracic spine and low back pain. (PX6, pp. 2-3)

Petitioner returned to her primary care physician, Dr. Tawny Allen, for another follow-up

for depression on March 6, 2018. (RX5, p. 18) She reported that she had neck pain and went to the chiropractor two times. The notes document, "Injury 1 year ago at work-encouraged WC appointment." (RX5, p. 18)

Petitioner returned to the chiropractor on April 18, 2018, 17 days before the second reported accident, and saw chiropractor Ryan Miller. She complained of frequent (75%-50%), sharp, shooting, numbing, tingling, and burning discomfort in the back of the neck. She rated the intensity of discomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with applied pressure and movement. The discomfort was reported to decrease with rest.

Petitioner also complained of frequent (75%-50%) aching and tingling discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement.

Petitioner reported that she was having a headache that day, no leg pain. She said that it hurts worse if she is bent over too long and she was sleeping okay. Objective examination revealed areas of spasm, hypomobility and end point tenderness indicative of subluxation at C1 and LS. Palpation of the muscles revealed spasm in the following areas: cervical and lumbar. The diagnosis was cervicalgia and low back pain. (PX6, p. 4)

Petitioner reported a second accident occurred arising out of and in the course of her employment on May 9, 2018, approximately two weeks after her last chiropractor visit, however, she had no medical consult as a result of that accident until more than three months later, on August 23, 2018, when she saw Dr. Allen again at the Quincy Medical Group. Petitioner reported that she believed her neck pain and headaches with dizziness was work-related because of the two reported incidents; however, Petitioner saw the nurse practitioner at Quincy Medical Group on June 1, 2018, only weeks after the May 9, 2018, incident for left wrist pain with no mention of the work accident, or neck or shoulder issues at that time. (RX5, pp. 49-52)

On June 27, 2018, Petitioner met with Dr. Eric Flynn-Thompson for a left wrist ganglion cyst. Petitioner reported that about three months prior, she developed a cyst around the volar radial aspect of her left wrist that lasted about a week. She had pain with it for about a week and then the cyst eventually resolved as did her pain. She reported about three weeks prior, she started to have increased pain in her left volar radial wrist and the dorsal radial wrist. The splint that she started wearing about three days ago helped some of her symptoms, but not completely. She complained of pressure and tingling in the fingers for the past couple of weeks including the index, middle and ring fingers. She also complained of left hand weakness and pain with wrist motion. All other systems were reviewed and were negative. Dr. Flynn-Thompson advised that Petitioner's several week history of left wrist pain appeared to be related to deQuervain's tendinitis and flexor carpi radialis tendinitis. He opined that it was unusual for Petitioner to have tendinitis in 2 locations at the same time. He recommended initial rigid immobilization with work restrictions of no use of the left hand. (RX 5, p. 36) There was no mention of a May 9, 2018, work accident.

Petitioner saw Dr. Allen on August 23, 2018. She complained of neck pain, increased frequency and severity of headaches. She reported "no specific injuries --- years ago 1995 car

wreck." The notes continue, "Thinks work related because a few years ago a client was trying to get up and patient put arm out and it strained neck-in May similar situation and re-aggravated it. Has not been seen except a chiropractor which did not help." (RX5, p. 49) Petitioner was positive for nausea with headaches, photophobia and phonophobia. Dr. Allen noted tender vertebrae at C6-C7 tight muscles. Dr. Allen diagnosed Petitioner with neck pain, increased frequency of headaches, and increased severity of headaches. "With stretching from side to side-feels electric shock down spine." She prescribed Zanaflex and a Medrol Dosepak. A cervical spine x- ray and an MRI of the brain were ordered. (RX5, pp. 49-50)

On August 23, 2018, Petitioner underwent a cervical spine x-ray at Quincy Medical Group. Neck pain for two years was listed as the reason for the study. The results of the scan were read to reveal no acute findings and a congenital fusion of C2-C3. (RX5, p. 29)

On September 7, 2018, Petitioner underwent an MRI brain scan at Quincy Medical Group Imaging as ordered by Dr. Allen. The results of the scan were read to reveal multiple small scattered areas of T2 hyperintensity cannot completely exclude demyelinating process. (RX 5, pp. 54, 125)

Petitioner returned to Dr. Allen on September 11, 2018. She advised that medication has not helped, and she complained of neck pain with "zinger feeling" in neck down spine. In addition, recent MRI brain scan returned abnormal, (cannot completely exclude demyelinating process). She was diagnosed with depressive disorder, abnormal finding on MRI of brain, increased severity of headaches, neck pain, cervical radiculopathy, and fusion of spine of cervical region. Dr. Allen recommended a cervical spine MRI and a referral to neurology. She started Petitioner on Topamax for headache prevention as she had a history of probably migraines. (RX5, pp. 54-55)

On September 21, 2018, Petitioner underwent a cervical spine MRI at Quincy Medical Group Imaging as ordered by Dr. Allen. The reason for the study was listed as neck pain and cervical radiculopathy. Issues were existing 3-5 years with history of "MVA over 20 years ago and recent strain helping someone stand in May." She reported posterior headaches and dizziness. The results of the scan were read to reveal multilevel cervical spondylosis, most significant at C5-C6 with mild to moderate spinal canal stenosis and mild bilateral neural foraminal narrowing. (RX5, pp. 126-127)

On September 24, 2018, Petitioner presented to Dr. Daniel Kimple at Quincy Medical Group Department of Neurology on referral from Dr. Allen and due to an abnormal MRI. Petitioner reported a daily headache for two hours at a time. She further reported that she had frequent headaches and a pinched nerve that occurred for the first time in approximately 2016 when she injured herself assisting a patient who was about to fall. Symptoms began with a sudden onset. Petitioner noted headaches that are occipital bilaterally. She reported a typical duration of symptoms lasting 4-8 hours in length occurring almost every day. Dr. Kimple noted the abnormal brain MRI and the MRI of the cervical spine which exhibited spondylosis at multiple levels prominent at C4 through C6 with associated mild to moderate spinal canal stenosis and mild bilateral neuroforaminal narrowing at C5-C6, but there was no abnormal signal change of the spinal cord. (RX5, pp. 131-132)

Dr. Kimple documented Petitioner's history of abnormal MRI with T2 lesion, tobacco abuse, chronic daily headache, and history of cervicalgia. There was concern for chronic tension headache with associated peri-cranial tenderness. Trial medications of Xanax, Zoloft, Topamax, Cymbalta, and Gabapentin and Ibuprofen have not provided relief. Dr. Kimple requested authorization for Botox and to continue Topamax and Zanaflex. He advised that for the cervicalgia (myofascial pain, cervical disc disease with radiculopathy) there was no evidence of cord edema on MRI cervical spine. He recommended continued monitoring. Finally, as for the abnormal MRI, Dr. Kimple's notes that in the setting of chronic tobacco abuse and history of migraines when she was younger, these are nonspecific, and they were to be followed with clinical correlation. (RX 5, p. 135)

On September 24, 2018, Petitioner underwent a trigger point injection in the upper and lower trapezius, occipital ridge/upper cervical paraspinal, and levator scapula performed by Dr. Kimple. (RX5)

The October 3, 2018, work status from Dr. Allen documents light duty work restrictions were assigned. The diagnosis was listed as cervical spine stenosis secondary to bulging disc. (RX5)

An October 16, 2018, Call Documentation, confirms Petitioner called Dr. Kimple's office and requested a letter stating her injuries and pain to her neck "could possibly be due to her slipped disc in her back, due to her patient falling and trying to catch himself with her hands." Dr. Kimple advised that she could bring in a Questionnaire for "workman's comp" and he would answer questions, but he was unable to write a letter stating patient's injuries were due to an incident with patient's resident. (RX 5, p. 77)

On October 24, 2018, Petitioner presented to Dr. Hayan Dayoub at the referral of Dr. Tawny Allen. Petitioner reported that she was having headaches daily with neck and arm pain. She noted a work injury a couple of years ago with pain that never really went away and came back in May. She rated her pain as 10/10. She complained of neck pain into both arms that radiated into all of her fingers. Everything was an exacerbating factor and nothing helped for relief. He also noted numbness and tingling in her hands. Petitioner reported that she had a history of migraines in the last few years and had an injection in the occipital area as well as the neck with modest improvement. Petitioner was convinced that her injuries were the result of a work injury. (RX5, p. 161)

Dr. Dayoub reviewed the MRI scans and opined that it revealed mild to moderate degenerative changes at C4-C5 and C5-C6 with mild bilateral foraminal stenosis at C5-C6. Treatment recommendations were discussed including conservative management versus surgery. Dr. Dayoub recommended against surgical intervention given her young age and relative diffuse nature of her degenerative changes. He recommended physical therapy and pain management. (RX14, p. 162)

On November 1, 2018, Petitioner presented to Dr. Fletcher at SafeWorks Illinois. She presented for evaluation and treatment of headaches and bilateral, neck and back pain. She reported that that she reached out to help support her patient from falling and her patient pulled her left arm

with their whole weight of 350 lbs. She reported pain in her left shoulder, right shoulder, and upper thoracic region and severe headaches with a stabbing pain on top of the shoulders, and pain in the middle of her upper back. Her left finger will go intermittently numb. Dr. Fletcher diagnosed Petitioner with radiculopathy, cervical region and noted a left brachial plexus injury. He recommended Lyrica, Tens unit, electrical, EMG studies with Professor Trudeau, to consider a surgical consult, and physical therapy (P.T.) with cervical traction. He opined that it was related to the work activities and authorized Petitioner off work. The date of injury and illness was listed as both November 1, 2018 and May 9, 2018. (PX3)

On December 4, 2018, QMG called Petitioner to advise that Botox injections were approved. (RX5)

Petitioner presented to Dr. Trudeau for nerve conduction studies on December 17, 2018. His interpretation of the NCS were as follows:

1. Left brachial plexopathy, medial cord lesion, moderately severe in electroneurophysiologic testing characterization, consistent with the quite correct clinical assessment of Dr. Fletcher.
2. No current evidence of cervical radiculopathy, particularly C6 or C7 on either side.
3. No current evidence of entrapment neuropathy, particularly ulnar neuropathy.
4. No current evidence of left long thoracic neuropathy, left spinal accessory neuropathy, or other peripheral nerve compromised.
5. No current evidence of mononeuritis multiplex.

The diagnosis was of left brachial plexopathy, medial cord lesion, moderate to severe. No entrapment neuropathy. No peripheral nerve compromised. No evidence of cervical radiculopathy. (PX9)

Petitioner returned to Dr. Fletcher on December 27, 2018. Dr. Fletcher noted that the electrical studies confirmed a diagnosis of left brachial plexus injury. He diagnosed Petitioner with cervical radiculopathy, left side injury of brachial artery, and injury of brachial plexus. He placed Petitioner on light duty work restrictions, and recommended Lyrica, Topamax, a Tens unit, a surgical consult with Dr. Kube, and physical therapy. The work status was for the period December 27, 2018, through January 17, 2019. (PX 3)

On January 15, 2019, Petitioner consulted Andrew Kitterman, PA at Prairie Spine Institute and complained of neck pain, numbness, weakness bilaterally. Objective tests found a positive Spurling's and positive Tinel's in her ulnar nerve. Apparently, a Botox injection helped in her neck with headaches. She was diagnosed with ulnar tunnel syndrome.

A cervical spine motion x-ray was recommended with follow up with Dr. Kube to discuss surgery versus conservative treatment. (PX16)

Petitioner had a surgical consult with Dr. Kube on February 5, 2019. They reviewed her MRI scans and her history. Dr. Kube opined that he did not think surgical intervention would reliably improve her. He advised that she could entertain a dorsal column stimulator placement.

(PX 16)

Petitioner saw Dr. Fletcher on February 8, 2019. She reported an allergic reaction to medications. It was noted that Petitioner saw Dr. Kube who advised that she was not a surgical candidate. His diagnosis remained the same. He recommended Lyrica, a Tens unit, pain consult with Dr. Benyamin, physical therapy, and Toradol injection. Light duty work restrictions were continued. The next appointment was scheduled for March 1, 2019. (PX3)

On February 14, 2019, Petitioner had a physical therapy initial evaluation at First Choice Physical Therapy. (PX8) Petitioner's primary complaint was neck pain and headaches (occipital) with pain that travels into both upper extremities with tingling in her left hand, her fourth and fifth digits and her thumb.

Petitioner presented to Blessing Hospital ER via private vehicle with complaints of neck pain and experiencing hot and cold from her spine to the right arm. She also complained of nausea and headaches. Petitioner reported that the pain started after completing her physical therapy session. Petitioner reported that she had a history of a bulging disc and a pinched nerve. She was diagnosed with neck pain. She was discharged with four tablets of hydrocodone.

On February 20, 2019, Petitioner returned to ExamWorks. According to the Patient Visit Summary and Instructions, Petitioner was diagnosed with cervical radiculopathy, left side injury of brachial artery, and injury of brachial plexus. Petitioner was authorized off work from February 20, 2019, until March 20, 2019. Dr. Fletcher noted she had to go to the ER due to increased pain and he recommended Lyrica, a Tens unit, physical therapy, hold on the Dr. Benyamin pain consult, and Toradol injection. The follow up appointment was scheduled for March 20, 2019. Dr. Fletcher noted that she was not a surgical candidate and that cervical disc pathology and cervical radiculopathy have been ruled out. He noted that the electrical studies confirmed diagnoses of left brachial plexus injury and was concerned with thoracic outlet syndrome. (PX3)

Petitioner returned to Dr. Fletcher on March 3, 2020. Dr. Fletcher noted that Petitioner had left shoulder swelling and was unable to lift above shoulder level. He refilled prescriptions and noted Dr. Trudeau's electrical studies that exhibited persistent long thoracic neuropathy. He diagnosed Petitioner with injury of the brachial plexus, brachial plexus disorders, injury of the nerve root of thoracic spine, and adhesive capsulitis of left shoulder. He recommended an FCE for permanent work restrictions. (PX3)

Petitioner had an appointment with Dr. Tawny on March 19, 2019, for blisters on her feet. (RX5)

Petitioner returned to Dr. Fletcher on March 20, 2019. She was diagnosed with brachial plexus injury. Dr. Fletcher noted that she was much improved; the best he has seen her. He noted that Petitioner saw Dr. Salvacion for an assessment of a dorsal column nerve stimulator, but Petitioner decided to wait. Petitioner was placed on light duty work restrictions which included no long distance driving. (PX3) Dr. Fletcher testified that the restrictions were due to the sedating nature of her medication. (PX13, p. 60) The work status was for the period of four weeks, through April 19, 2019. (PX3)

Petitioner presented to Dr. O'Leary on March 28, 2019, for the first §12 evaluation at Respondent's request. She reported that she hurt both arms. She advised the first one happened in November of 2016 with a client that weighed about 350 pounds. The second incident occurred on May 9, 2018, with a client who weighed about 200 pounds. She reported that her client was going to fall and she pulled on Petitioner's arms which pulled her down. Petitioner said that she gets headaches as a result of this every day. She gets an electric shock going down her spine. She gets pins and needles. She has been to a primary care, to a neurologist and seen a surgeon and a physiatrist. She sees Dr. Fletcher with occupational medicine in Champaign, although she is from Quincy. She sees Dr. Salvacion right now for pain management.. She told Dr. O'Leary that she has lesions on her brain, approximately seven lesions. She was worried about what is to come of the headaches and dizziness. She did not want a spinal cord stimulator. (RX1; RX4, DepX2)

Dr. O'Leary documented that on her intake form that she filled out, she noted that treatment has not helped. She reported that treatment to date included a TENS unit and therapy, that made her condition worse. In fact, she reported ending up in the ER from therapy. She reported injections, and medications did not help. She reported numbness and tingling on the ulnar border of her left forearm and into the small and ring fingers. She also noted burning on the bottoms of her feet as well as burning, clicking and popping in the right shoulder and midline. She has headaches. She did mention something about a history of cluster headaches, but she says the headaches since the accident are different. She describes dizziness, electric shocks, pins and needles. Current level of pain is "seven or eight, neck, headaches, and electric shocks." She says she has all of the symptoms every day. (RX1, pp. 1-2)

During the examination, Dr. O'Leary noted an antalgic gait pattern. Her examination findings included pain with range of motion of her neck, exquisite tenderness to even the lightest touch at the base of her neck near the vertebral prominence. She advised that touching her neck elicits an electric shock going down her neck. Dr. O'Leary notes that this electrical show is not reproduced when she voluntarily flexes her chin to touch her chest. He found shoulder impingement signs are equivocal because she did not have much voluntary activity in terms of ranging (sic) her arms over her head.

After the examination and review of the medical records, Dr. O'Leary diagnosed Petitioner with cervical spondylosis without myelopathy, neck pain, ill-defined upper extremity complaints, and history of headaches. He opined that her subjective complaints were not consistent with the objective findings. He noted that there were no reproducing objective tests on exam, and he did not feel that she had findings consistent with Lhermitte's sign. He further noted that Petitioner had exaggeration of symptom complaints as she had exquisite tingling with the slightest sensation of touch to the posterior aspect of the neck. He opined that Petitioner did not need any more treatment with regard to any reported work injury. He stated that he was not certain that an actual work injury caused the current state of ill-being as there was nothing to explain her ongoing headaches from the mechanism of injury. He further reported that the clinical exam did not present with a medial cord brachial plexopathy.

As for her return to work, he opined that based upon his questioning, the medical causation as well as the symptom magnification and severe amount of disability with

relatively minimal exam findings, he had no reason to restrict her from her duties as a home visiting nurse. He placed her at MMI and opined that no further treatment was necessary. (RXl; RX4, DepX2))

Thereafter, Petitioner met with Dr. Fletcher on April 19, 2019. There were no changes from the prior medical appointment. He again advised that this was the best that he has seen her and she was much improved. Work restrictions were continued. (PX3)

Petitioner had a pain consultation with Dr. Salvacion at Memorial Medical Center on April 25, 2019. Petitioner underwent a cervical epidural steroid injection on May 2, 2019. She underwent a second injection on May 23, 2019. (PX 9)

Petitioner underwent a new nerve conduction study on May 16, 2019. The results, interpreted by Dr. Trudeau, revealed left brachial plexopathy, medical cord lesion, mild to moderately severe in electroneurophysiologic testing terms, improved in comparison to previous study of December 17, 2018. Dr. Trudeau did not find any evidence of entrapment neuropathy, no evidence of right brachial plexopathy, no current evidence of cervical radiculopathy, no current evidence of mononeuritis multiplex, no current evidence of radiculoplexus neuropathy, although Dr. Fletcher noted that she developed right sided thoracic outlet syndrome type presentation. (PX 11)

Petitioner returned to Dr. Fletcher on May 17, 2019. Work restrictions were continued and there were no changes to her diagnoses. Dr. Fletcher noted that follow up electrical studies showed improvement. He advised that today was the best he has seen her and she was much improved. He opined that she is nearly at MMI and needs to find a job. (PX 3)

Petitioner had an appointment with Dr. Fletcher on June 18, 2019. Petitioner was diagnosed with injury of her brachial plexus and brachial plexus disorders. Permanent work restrictions of no lifting more than 10 pounds, no overhead activities, and no driving long distances due to sedating nature of medication were provided. Petitioner was discharged from care. The following After Care Instructions were listed:

> -No lifting more than 10 pounds, no overhead activities. She needs to find a job.
> - Toperamine/Nuyncia/Flexeril
> -Released from care. She is MMI. Electrical studies showed improvement.
> -Home exercise program.
> -The patient verbalizes agreement and understanding of these plans and instructions and had no further questions or concerns. (PX 3)

On July 2, 2019, Petitioner was referred to Dr. Hazlerigg for consultation regarding thoracic outlet syndrome. (PX 3)

On August 5, 2019, Petitioner presented to Dr. Hazlerigg at SIU for an evaluation and possible thoracic outlet syndrome. Petitioner reported that she was a home care worker who initially injured her back in 2016 catching a patient and had another episode less than a year

ago that exacerbated it. He reviewed the treatment to date which included several epidural injections, evaluation with Dr. Fletcher, EMG by Dr. Trudeau, MRI of the neck, and two spine surgeons who did not recommend surgical interventions. She complained of paresthesias that extended down into her left fourth and fifth digits. She also complained of shoulder and neck pain as well as what Petitioner described at cluster headaches. Petitioner noted that she has started on treatment for the cluster headaches with some mild improvement.

Dr. Hazlerigg noted full range of motion of all joints with 5/5 muscle strength throughout, normal radial pulses with mildly positive decrement with head turning, and developed numbness in the left fourth and fifth fingers. He diagnosed Petitioner with numbness and tingling in the left hand. Dr. Hazlerigg advised that Petitioner had an injury related neurological issue. He opined that she might have thoracic outlet syndrome, worse on the left side, and her symptoms of numbness down the ulnar distribution appeared to be appropriate. He notes that Petitioner has "more neck and headache related issues than might be attributed to thoracic outlet syndrome." He opined and noted Petitioner probably does have thoracic outlet syndrome and might benefit from a first rib resection. He did not think that the rib resection would relieve her headaches or improve her neck conditions as he thought there were multiple etiologies for her issues. (PX 10, PX5, p. 166)

Petitioner met with Dr. Fletcher on August 16, 2019, for evaluation and treatment of headaches and bilateral shoulder, neck, and back pain. Dr. Fletcher diagnosed Petitioner with injury of brachial plexus and brachial plexus disorder. Petitioner complained of terrible headaches and numbness on the left with pain on the right side. She reported that nothing was helping with the pain. Petitioner advised that she decided to proceed with bilateral rib resection with Dr. Hazelrigg. (PX3)

On September 11, 2019, Petitioner underwent a left first rib resection, transaxillary at Memorial Medical Center as performed by Dr. Hazlerigg. The operative diagnosis was listed as left thoracic outlet syndrome. (PX9) In the Indications section, it was noted that Petitioner was evaluated by Dr. Fletcher extensively and he felt that she had signs and symptoms consistent with thoracic outlet syndrome. (PX10 PX5, p. 170)

Petitioner had a return appointment with Dr. Hazlerigg on October 14, 2019. Petitioner reported she had a lot of discomfort without relief of symptoms since she went home. Petitioner was not moving her shoulder very much and Dr. Hazlerigg gave her instructions to prevent her from getting frozen left shoulder. He advised that though it did not appear to be optimistic, he would give her several more weeks for improvement. He opined that her symptoms were dominated by her discomfort. (PX10)

Petitioner continued treatment with Dr. Fletcher on December 20, 2019, and February 10, 2020. Petitioner had continued complaints without much improvement. Work restrictions were continued, and Dr. Fletcher recommended updated electrical studies. (PX3)

Petitioner was discharged from physical therapy on January 23, 2020. She underwent a total of 14 therapy visits between November 1, 2019 and January 23, 2020. (PX8)

Dr. O' Leary authored a record review report dated February 6, 2020. After review of the medical records, his opinion regarding Petitioner's diagnosis was unchanged. He opined that "putting together the understanding of the EMG and her subjective complaints, one could try to isolate this to something like thoracic outlet syndrome," but Petitioner gave him no indication that this was present on the day that he evaluated her on March 28, 2019. He wrote that Petitioner did not have consistent findings when he evaluated her on March 28, 2019, to suggest that this was a specific clinical syndrome, either cervical radiculopathy, brachial plexopathy, or TOS, or other type of mimicking cervical radicular-type syndromes.

He again questioned whether any of the significant findings and subjective complaints were caused or aggravated by the alleged work injury. He noted that there were multiple complaints that were not consistent throughout the record. He found no conclusive evidence when he evaluated her to pinpoint these diagnoses and her condition on a work related event. He confirmed his opinion that further treatment was not necessary for the following reasons:

- Inconsistent physical exam findings related to subjective complaints;
- Delayed report of a work injury without any significant intervening medical workup from May 2018 through August 2018;
- Magnifying and exaggerating type of behaviors on physical examination make the history provided by the claimant potentially unreliable in this case. (RX2; RX4, DepX3)

Petitioner followed up with Dr. Fletcher on February 10, 2020. It was reported that Petitioner had left shoulder swelling and was unable to lift above her shoulder level. Dr. Fletcher refilled her Nucynta, Topamax, Flexeril, and Cymbalta. He recommended electrical studies but discontinued therapy as she was no better. He continued work restrictions. (PX3)

On February 25, 2020, Petitioner underwent updated electroneurophysiologic studies performed by Dr. Trudeau. The results of the testing revealed the following:

- Left long thoracic neuropathy moderately severe in electroneurophysiologic testing characterization consistent with the quite correct clinical assessment of Dr. Fletcher;
- Left brachial plexopathy, medial cord lesion, mild in electroneurophysiologic testing terms, improved in comparison to previous study of May 16, 2019;
- No current evidence of cervical radiculopathy;
- No current evidence of ulnar neuropathy at left elbow or wrist;
- No current evidence of mononeuritis multiplex or cervical radicular plexus neuropathy. (PX11)

On May 11, 2020, Petitioner underwent an FCE at ATI Physical Therapy. (PX12) As part of the evaluation, Petitioner underwent a medical intake interview, unilateral static shoulder strength testing, grip strength testing, pinch grip strength testing, real time isometric strength testing, dynamic lifting assessment, positional tolerance testing, and an assessment of symptom magnification on written instruments. The results of the evaluation reflected a consistent, maximal effort with some abnormal test behaviors and indicators of symptom magnification were very minimal. Except for Petitioner' s left-banded static grip strength testing results, her FCE results were considered to be a valid representation of her functional abilities. Petitioner was released to

work within the sedentary physical demand level with the following restrictions of occasional 15 pound lifting limit from floor to waist height; occasional 15 pound carrying limit; occasional 10 pound lifting limit from waist to overhead with right hand only; occasional two pound lifting limit from waist to shoulder height with left hand only.

Petitioner's primary physical and functional deficits included significant left shoulder weakness, very poor left shoulder mobility, poor left arm strength, poor left hand grip strength, bilateral pinch grip weakness, and overall physical de-conditioning. Two sections of symptom magnification were noted (Oswestry Low Back Inventory and Waddell Questionnaire). She passed all aspects of Legitimacy of Effort but failed on validity criteria (on the basis of excessive variation between tests trials during left-handed static grip strength testing). (PX12)

In an email between Dr. Fletcher and Petitioner's attorney, Dr. Fletcher placed Petitioner at MMI with permanent work restrictions consistent with the FCE. (PX3)

On August 6, 2020, Petitioner presented to Dr. O' Leary for a repeat §12 evaluation. Petitioner complained of tingling and numbness and he noted that she would not lift her arm above shoulder height. She reported that she needs help putting on her shirt and pulling up certain pairs of pants. She advised that she cuts her hair short because she can no longer brush her hair. On a symptoms drawing, Petitioner noted pain and symptoms from the posterior aspect of her neck, scapula down the back of her arm towards the small, ring, and long fingers, and medial aspect of her anteriorly, ulnar sided digits as well. Dr. O'Leary noted that he would "state unequivocally that there is a clear behavioral change this time compared to the last time when I had seen her when she was much more dramatic and verbal. Today, she appeared very calm, answered all questions with a calm demeanor and was not combative or excited in the office at all." His examination findings note a normal gait pattern; Romberg sign is normal; Spurling maneuver is negative; Lhermitte sign is negative; Excellent range of motion of her cervical spine today with near full extension and lateral rotation; Right upper extremity: deltoid biceps, triceps, wrist extensor, grip and interossei are basically all normal tested manually. (RX3)

Dr. O'Leary noted a limited examination. He noted that she does not really fire her shoulder muscles very much voluntarily and it was difficult to assess the triceps and biceps function. She appeared to have diminished grip strength. As for the scapula winging, Dr. O'Leary did not observe any obvious scapular winging. He requested that Petitioner put her palms flat against the wall in the examination room. Petitioner could not do it on her left side and gave the impression of having a difficult time moving the arm and the hand. She could not extend the elbow completely. (RX3)

After review of updated medical records and examination, Dr. O' Leary opined that nothing in the medical records and his examination changed his diagnosis or medical causation opinion. No opinions from his prior reports had changed. Dr. O'Leary found the medical records to be inconsistent. (RX3)

As for work restrictions, Dr. O'Leary advised that a weight restriction for the right arm did not make sense as her right arm was normal and nothing during the examination provided any basis for work restrictions. As for the left arm, he questioned the validity of a two-pound limit from waist to shoulder. He noted that the surveillance video indicated that Petitioner

used her arm " fairly freely." Dr. O'Leary noted the following:

> While the surveillance video was limited and at times she appeared to be holding the arm, it was seen that she was holding the arm in different postures, elbow flexed and at the side versus elbow extended and the hand at the side and then occasionally carrying a purse or other groceries, multiple bags at one time hold them in the left arm, and opening and closing a door with her left arm. To me reviewing the bulk of the 30 minute surveillance, it appeared that she uses the arm much more normally than what I observed in the office today. (RX 3)

Dr. Patrick O'Leary's Testimony

Dr. O'Leary testified via evidence deposition that he went to Loyola Medical School. He completed a 5-year orthopedic surgery residency training program and completed a year of spinal advanced training program at Washington University in St. Louis before becoming board certified in 2010. He is board certified through 2030. He currently works at Midwest Orthopedic Center in Peoria. His focus is treating patients with spinal disorders, the large majority of which are non-operative, in both children and adults. He performs 300-350 spinal surgeries a year on children and adults. In his practice, he sees a range of individuals who do not have a spinal problem, be it a shoulder or a knee, and refers that patient to the right person. (RX 4)

Dr. O'Leary advised that his normal process for doing a §12 evaluation is to examine the Petitioner first to try and figure what is wrong, and then review the medical records to see if the history matches up before recommending the next step in treatment. He testified that he does it this way to prevent the introduction of bias from reading the medical records from other treatment providers. (RX 4)

Dr. O'Leary noted that Petitioner had exquisite tenderness to even the lightest touch at the base of her neck, near the vertebral prominence (prominens). (RX4, p. 15) He opined that this was evidence of symptom magnification. He also noted that she complained of "electric shock going down her neck," for which he noted that there was no neurological explanation for that. (RX4, p. 16) He disagreed with Dr. Fletcher's examination finding that the Petitioner had positive Lhermitte's sign. Dr. O'Leary opined that the cervical spine MRI explained why she would not have a positive Lhermitte's sign, noting that there were no spinal cord abnormalities, no large disk herniations, no spinal cord compression, and no cord signal change. (RX 4, pp. 16-17))

Dr. O'Leary also testified as follows:

> I was at this time somewhat skeptical about the entire presentation... Well, I mean, obviously, she comes with some findings. This EMG, some of her complaints might match up. She had seen another spine surgeon already who I think kind of said, you know, this isn't anything that you need surgery for sort of thing. And I didn't find her examination reliable. I mean, I just thought that it was very hard for me to say that there were what I would call reproducible objective tests. And she has a myriad of complaints, some findings that really don't fit one type of clinical scenario. And if you ask me to say which scenario they fit, I wouldn't be able to tell you. So kind

> of non-dermatomal, nonorganic type of subjective complaints. You know, examination doesn't match those. Findings on the MRI which don't necessary support these findings. She has some stenosis at C5-6, but if she had that problem and that was this problem, she would have thumb symptoms or index finger symptoms, not ring and small finger.
>
> So, in other words, I'm conflicted trying to evaluate her because, you, I don't really see anything adding up to this type of, you know, problem. (RX 4, pp. 22-24)

Dr. O'Leary further questioned if she had two injuries, which injury caused her condition or whether it really happened. He advised that if he thought that she was reliable and her exam was straightforward, it would be different. (RX 4, pp. 24)

Dr. O'Leary did not have any treatment recommendations as he could not imagine what further treatment would be indicated. In making this opinion, he noted that the Petitioner had a high self-reported severe disability, imaging that was not consistent, exaggeration and magnification findings during his examination, and nothing seemed to help her thus far. He placed the Petitioner at maximum medical improvement (MMI) as it related to the alleged work accident. (RX4)

Dr. O'Leary further testified that he does not formally treat thoracic outlet syndrome but was generally familiar with the diagnosis. He opined that it was an unusual and controversial diagnosis. RX1, p. 29) He noted that the "causes, etiologies of thoracic outlet syndrome are kind of largely not widely agreed upon." He advised that it could be a mimicker of a pinched nerve in the neck. His experience was that it was rare for someone to have true thoracic outlet syndrome and the results from the surgery were a "mixed bag." Dr. O'Leary further testified:

> Q. Okay. And based on - again based on your examination and review of medical records, it was tough for you to find a clinical assessment of that (thoracic outlet syndrome)?
>
> A. Well, number one, as I testified to already, this is - this diagnosis is not necessarily straightforward. I would say far from straightforward. I feel it's a diagnosis largely of exclusion.
>
> If you can't find anything else wrong with someone and there are very clearly some signs on examination that point to this being a possible diagnosis, then I would refer them to a thoracic surgeon or a special center to evaluate this. I' II be honest with you, the time when I saw her on March, what date was it, March 28, there is no way this diagnosis crept into my field of view. (RX4, pp. 33-34)

Dr. O' Leary noted that she had so many complaints, only a few of which are related to a potential medial cord plexopathy or thoracic outlet syndrome. He noted that she has a history of her arm being tugged, but he was not the first doctor who evaluated her. (RX4, p. 34)

Later, after review of the operative report and updated medical, when asked if any

conditions of ill-being were caused or aggravated by the alleged work injury, Dr. O'Leary testified, reading from his report, that he had no conclusive evidence to pinpoint these diagnoses or conditions and a work related event. (RX4, p. 56)

Dr. David Fletcher's Testimony

Dr. Fletcher testified via evidence deposition that he went to medical school in Chicago at Rush University and did a residency in Occupational and Preventive Medicine. He earned a master's degree in Public Health and Epidemiology and was Board certified in both Preventative and Occupational Medicine and has practiced in that field continuously since then. Governor Pritzker appointed him to the Illinois Workers' Compensation Medical Fee Advisory Board in January 2020. This is his second term of office. He was appointed in 2016 by Governor Rauner and served for three years. (RX13, pp. 7-9) Dr. Fletcher defined his role as an occupation medicine doctor as a "sort of primary care gatekeeper for an injured worker, make an assessment for the diagnosis," with appropriate treatment. If surgery is required, send the person to the surgeon and then, after the surgery, work with the surgeon or often times the surgeon will defer to him for the rehab and return to work decision. (RX13, p. 10) Besides injury care, he does drug and alcohol testing and onsite consulting for employers at the work site. (PX13, pp. 7-9, DepX2)

Dr. Fletcher testified that Petitioner came under his care under the direction of Mr. John Boshardy, her former attorney or current attorney. Boshardy recommended that she see Dr. Fletcher because of his experience with these types of injuries. (RX13, p. 49) His understanding at the initial visit, on the advice of Boshardy, her former legal counsel, now retired, was that this was an accepted claim. (PX13, p. 17) Dr. Fletcher first saw Petitioner in November 2018. (PX13, p. 11) Dr. Fletcher testified that when he began seeing her he requested records, however, he never received her prior medial records. (PX13, p. 50) Dr. Fletcher testified that he reviewed the records from Quincy Medical Group from October 2018 and the MRI from September 21, 2018. (PX13, pp. 14-15) He knew that Petitioner had seen Dr. Tawny Allen and there was talk about going to a neurosurgeon. (PX13, p. 16) Those were all the records he reviewed in their entirety. He never saw the neurosurgeon's records from Quincy Medical Group. (PX13, p. 52) Dr. Fletcher testified that Petitioner "was not pleased with what they were doing." (PX13, p. 16)

Dr. Fletcher testified that after electrical studies were performed by Dr. Trudeau on December 17, 2018, he reviewed the results with Petitioner and they objectively confirmed a brachial plexus injury and in his opinion ruled out that she would be a candidate for any cervical spine surgery. (PX13, p. 18) He also sent Petitioner to orthopedic spine surgeon Dr. Kube in Peoria for confirmation regarding her cervical spine condition. (RX13, p. 20) Dr. Fleming's understanding was that Dr. Kube did not feel there was any surgical intervention that was going to help Petitioner. (PX13, p. 22)

When Dr. Fletcher next saw Petitioner, he was concerned that, along with the brachial plexopathy, that her presentation "kind of fit a picture of the term traumatic thoracic outlet syndrome." He was focused on the fact that she was not improving. (RX13, p. 23) He prescribed physical therapy. Dr. Fletcher saw Petitioner 13 times. (RX13, p. 57) In the summer of 2019, Dr. Fletcher was at the end of what he could do for her. She had not had any satisfaction with what

Dr. Salvacion had done. At the eighth visit, he brought up the consultation with Dr. Hazelrigg. She had improvement on her EMG with Dr. Trudeau up to that point, but not complete resolution. (RX13, p. 59)

On February 20, 2019, she reported an increase in her pain. She had to go to the ER in Quincy. Her subjective complaints were reportedly worse. This was the first time Dr. Fletcher was concerned that, along with brachial plexopathy, that this kind of fit a picture of the term traumatic thoracic outlet syndrome (TOS). (PX13, 23) She tried conservative treatment.

On March 20, 2019, she reported no improvement with therapy. For the first time she reported contralateral symptoms as well. She had right upper extremity symptomatology as reflected in her pain drawing. Again, in a very classic C7-C8 distribution, that she had bilateral type of complaints. Dr. Fletcher talked to her about trying to do some interventional pain management with Dr. Salvacion who runs Memorial Medical Center Pain Clinic. He was running out of options - she was not benefitting with therapy. (PX13, 25) Dr. Salvacion performed an epidural steroid injection to her cervical spine on May 2, 2019.

She next saw Dr. Fletcher on April 19, 2010. With no change in symptoms, he released her with restrictions. (PX13, p. 26)

Dr. Fletcher testified that Petitioner always had good effort. She wanted to get back to work. Dr. Fletcher testified that Petitioner's life was somewhat in disarray because he believed around this time she couldn't get any further care authorized from workers' compensation. She had to use personal insurance. She was separated from her husband. He testified that "[a]pparently they got back together and she was able to access his health insurance. (PX13, 28)

Dr. Fletcher further testified Petitioner was traveling to come to Champaign from Quincy to see him. He testified that he would hear from her sometimes in between visits. (PX13, 29). Updated electrical studies at that time showed she objectively had a problem. There was some improvement in her brachial plexopathy. It did not show any evidence of any cervical radiculopathy, but it did document objectively that she had an abnormality consistent with her subjective complaints. There was no change in her overall presentation or exam. Dr. Fletcher kept her trying to do modified duty and put her on Topamax for some pain control as opposed to Lyrica. She was approaching MMI. (PX13, 31)

At the eighth visit on June 18, 2019, she was the same. Dr. Fletcher felt she had a positive Adson's sign consistent with thoracic outlet syndrome. He would try one last consultation, have her see a cardiovascular surgeon for consideration for a rib resection or anterior scalenectomy. He kept her on restricted activities-10 pounds, basically sedentary light work level. (PX13, p. 32)

She did not want surgery in June 2019. She returned in August and wanted to reconsider surgery. (PX13, 33) Dr. Hazelrigg is a cardiovascular thoracic surgeon at SIU School of Medicine. He's also a professor. Dr. Fletcher worked with him for more than 25 years. He's probably operated on 15 or 20 of his patients. She saw him about a week and a half before the August 16, 2019, visit. Dr. Fletcher testified that he had oral communication with Dr. Hazelrigg and he agreed with Dr. Fletcher's diagnosis. (PX13, p. 34)

Dr. Hazelrigg was planning to do a more traditional thoracic outlet surgery, basically a rib resection on the left side. She was also complaining of headaches. She had complaints of headaches since the beginning. (PX13, 35)

Dr. Fletcher testified that he probably had, in his career, probably 50 of his patients had thoracic outlet surgery. He testified that the surgery still has controversy in medicine. He further stated, "I've done everything for this lady absent her having a breast reduction." (PX13, p. 36)

Petitioner did ultimately undergo the surgery at Memorial Medical Center on September 11, 2019. Dr. Hazelrigg saw her for one post-operative visit then referred her back to Dr. Fletcher. (PX13, 37) Dr. Fletcher took her off work postoperatively. He had her go back to therapy. She followed-up with Dr. Fletcher on November 25, 2019. (PX13, 39)

Dr. Fletcher testified that Petitioner had some depression because she was still in chronic pain. She did have some improvement in shoulder girdle strength. On December 20, 2019, she reported benefit with surgery but reported left shoulder pain and more issues with weakness in her left shoulder; scapular winging had returned. (PX13, 40)

At the time of the deposition, Dr. Fletcher testified that he just saw her that week on February 10, 2020; there was no change in presentation. Scapular winging was really significant but there was not much more he could do for her. The scapular winging could affect her in the fact that if she doesn't move her upper extremity she could develop a frozen shoulder and that could cause her more complications, more pain and discomfort. He opined that she would have to get back to some pain control, using the TENS unit, taking more medications. Some of these injuries could take up to two years to get better. (PX13, 41-45)

Dr. Fletcher opined that all her conditions, cervical spine, brachial plexus and winging scapula are causally related to the workplace injury she reported on May 9, 2018. The mechanism of injury she described, a wrenching type of injury of her left upper extremity, will cause a traction injury to the brachial plexus and to the anterior scalene muscles that can cause a traumatic thoracic outlet and an associated brachial plexopathy. All the treatment he recommended was reasonable and necessary including with Dr. Hazelrigg. If the electrical studies don't really show any major change then he will have to give her options. There is not any further surgical solution. (PX13, 46-47)

Conclusions of Law

The Commission finds that Petitioner failed to sustain her burden of proving her condition of ill-being is related to either accident for the following reasons.

Petitioner did not seek medical treatment after the first accident for more than a year, when, on January 30, 2018, she told a chiropractor that she believed her neck and head pain complaints were from the November 2016 incident. Petitioner saw her primary care physician, Dr. Tawny Allen, at the Quincy Medical Group on March 6, 2018, for a follow-up for depression. She reported that she had neck pain and went to the chiropractor two times. The notes document, "Injury 1 year ago at work-encouraged WC appointment." (RX5)

On April 18, 2018, 17 days before the second reported accident, Petitioner returned to the chiropractor and complained of frequent (75%-50%) sharp, shooting, numbing, tingling and burning discomfort in the back of the neck. She rated the intensity ofdiscomfort, using a VAS, as a level 8 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with applied pressure and movement. The discomfort was reported to decrease with rest.

Petitioner also complained of frequent (75%-50%) aching and tingling discomfort in the low back. She rated the intensity of discomfort, using a VAS, as a level 6 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement. Petitioner also reported that she was having a headache that day.

Petitioner then reported an accident at work on May 9, 2018, despite no mention of a new work accident at an appointment with her primary care group at Quincy Medical Center on June 1, 2018. Petitioner reported the new work accident to her primary care physician, Dr. Tawny Allen in August 2018.

The Commission notes that prior to presenting to Dr. Fletcher, Petitioner was evaluated by Dr. Kimple from the Quincy Medical Group. (RX5) Neither Dr. Kimple, nor Dr. Dayoub, diagnosed thoracic outlet syndrome or provided a causation opinion or imposed work restrictions. In fact the records confirm that Dr. Kimple was specifically asked by Petitioner telephonically to provide a causation opinion on her behalf and he responded by stating that Petitioner could bring in a questionnaire, but he was unable to write a letter stating patient's injuries were due to an incident with patient's resident. (RX 5, p. 77)

The Commission notes that Petitioner testified that she was not satisfied with the level of care at Quincy Medical Group and that is the reason she consulted Dr. Fletcher in Urbana starting on November 1, 2018. (T. 16, 18) The Commission finds that testimony to be disingenuous.

Dr. Fletcher, a board certified doctor in Preventative and Occupational Medicine, was the fourth medical provider that Petitioner consulted after the May 2018 accident date and the first to causally relate her symptoms to work. (T, p. 51) Dr. Fletcher testified that he reviewed the records from Dr. Tawny Allen from October 2018 and the MRI from September 21, 2018. Those were all the records he reviewed in their entirety. He never saw Dr. Tawny's notes regarding the Petitioner's earlier complaints, the two neurosurgeon's records from Quincy Medical Group or the chiropractor's records from February through April 2018. (RX13, p. 52)

Dr. Fletcher testified that Petitioner provided him a history of a specific work injury from May 2018. She described where she was reaching out her hand and helped support a patient from falling and the patient pulled her left arm with her whole weight, sort of like a traction type of injury to her left upper extremity, and that was the history of the mechanism of injury. (RX13, p. 12) Dr. Fletcher testified that when he first saw her on November 1, 2018, he causally related her problems to work activities. He was not told there was an accident dispute when Petitioner was referred to him, thus, he made that opinion based on the mechanism of injury that she reported to him in her presentation and what was in the subjective history in the records from Quincy Medical

Group regarding her injury in May 2018. To clarify, Dr. Fletcher testified he had the records from October 2018 and the MRI from September 21, 2018. Dr. Fletcher based his initial causal connection opinion on what Petitioner told him and the limited records he reviewed from Quincy Medical Group and the MRI. (RX13, pp. 51-52)

Next, the Commission finds Petitioner's testimony is called into question, refusing to admit her attorney sent her to Dr. Fletcher despite the fact that she traveled to Urbana to see him. Dr. Fletcher was very candid regarding the fact that attorney Boshardy referred Petitioner to him for treatment. Dr. Fletcher testified that Boshardy recommended that she see Dr. Fletcher because of his experience with these type of injuries. (RX13, p. 49) His understanding at the initial visit, on the advice of Boshardy, her former legal counsel, refutes Petitioner's testimony that she found Dr. Fletcher on the internet and was referred to him by Dr. Allen, located in Quincy. Petitioner also admitted that to see Dr. Fletcher in Urbana, it is more than a six hour round trip drive from Quincy. (T. 51, 63)

The Commission finds it telling that Dr. Fletcher diagnosed thoracic outlet syndrome and referred Petitioner to Dr. Hazelrigg for surgery, then Dr. Fletcher, not Dr. Hazelrigg provided the causal connection opinion, and the testimony regarding causation. Dr. Hazelrigg's note at Petitioner's consultation on August 5, 2019, states that Petitioner has "more neck and headache related issues than might be attributed to thoracic outlet syndrome." He opined Petitioner "probably" does have thoracic outlet syndrome and might benefit from a first rib resection. He did not think that the rib resection would relieve her headaches or improve her neck condition as he thought there were multiple etiologies for her issues. (PX 10)

Dr. Fletcher testified that thoracic outlet surgery has controversy in medicine. (PX13, p. 36) Dr. O'Leary, a Board certified doctor in orthopedic spine surgery, also testified that thoracic outlet surgery is a controversial diagnosis. (RX1, p. 29)

During the time period between November 4, 2016, and August 23, 2018, Petitioner worked multiple positions without missing any time from work due to issues related to the work accidents. (T. 45) Respondent's exhibit 11 is "call documentation" of Petitioner refusing hours due to work obligations with her other position. Petitioner did this on multiple occasions since the November 4, 2016, work accident. Petitioner called off additional hours due to other work obligations on May 11, 2018, July 3, 2018, August 9, 2018, and August 15, 2018, after the alleged second accident. This is consistent with her presentation at the June appointments and infers that Petitioner did not have new acute symptoms and was able to work both jobs.

Dr. O' Leary performed two §12 evaluations and prepared a third records' review report. Dr. O'Leary reviewed all pertinent medical records. When he evaluated Petitioner, he noted that she had exquisite tenderness to even the lightest touch at the base of her neck, near the vertebral prominence. He opined that this was evidence of symptom magnification. He also noted that she complained of electric shock going down her neck, for which he noted that there was no neurological explanation for that. He disagreed with Dr. Fletcher's examination finding that Petitioner had positive Lhermitte's sign. After he reviewed the cervical spine MRI, he noted that there were no spinal cord abnormalities, no large disk herniations, no spinal cord compression,

and no cord signal change.

Dr. O'Leary further testified that he did not see anything that added up in Petitioner's symptoms. Dr. O'Leary did not have any treatment recommendations as he could not imagine what further treatment would be indicated. In making this opinion, he noted that Petitioner had a high self-reported severe disability, imaging that was not consistent, exaggeration and magnification findings during his examination, and nothing seemed to help her thus far. He placed Petitioner at MMI as it related to the work accident. After reviewing additional reports and performing a second examination, Dr. O'Leary's opinions did not change.

> Expert evidence is legal and competent evidence and is to be received, treated and weighed precisely as other evidence by triers of fact in this character of cases. The weight of such testimony must be determined by the character, capacity, skill and opportunities for observation and apparent state of mind of the experts themselves as seen and heard and estimated by the triers of fact and by the nature of the case and its developed facts. (Peabody Coal Co. v. Industrial Com. 289 Ill. 449.)

Madison County Mining Co. v. Industrial Comm'n., 306 Ill. 591, 594, 138 N.E. 211, 212, 1923 Ill. LEXIS 1124, *5

In the subject case, the Commission finds that Dr. O'Leary's opinions and testimony regarding causal connection are more persuasive that Dr. Fletcher's opinions and testimony casually relating the Petitioner's conditions to the work accident of either November 4, 2016 or May 9, 2018. The Commission further finds that Petitioner's now retired attorney referred Petitioner to Dr. Fletcher and that Petitioner's testimony in this regard was not credible.

The Commission further finds that Petitioner was having the same or similar symptoms January 30, 2018, through April 18, 2018, before Petitioner alleged that she had a second work accident on May 9, 2018, evidenced by the medical records from Vance Chiropractic. (PX6) Dr. Fletcher never reviewed those records. Thus, the Commission finds the basis for Dr. Fletcher's opinion is flawed.

Although Petitioner related her complaints to a work accident more than one year prior when she saw Dr. Tawny in August 2018, the medical records also document that Petitioner was in a "car wreck" in 1995. Petitioner's delayed medical treatment after the reported accidents until more than one year in the first instance and several months later after the May 9, 2018, accident, casts further aspersion on the causal relationship between the two alleged work accidents and Petitioner's current conditions of ill-being. Further, the medical records from Quincy Group are replete with documentation that Petitioner was depressed with personal issues since well before this occurrence including evidence that her sleep was disrupted as a result of depression and anxiety. The Commission notes Petitioner has an ongoing headache syndrome, with a brain MRI documenting lesions that worried Petitioner, however, the Commission does not find Petitioner's headaches causally related to the work accidents based upon Dr. Kimple's records that he was concerned Petitioner had a chronic tension headache with associated peri-cranial tenderness. (RX5, p. 135)

Further, Petitioner alleges that she had no final resolution of her pain complaints after the thoracic outlet surgery. The Petitioner had reported mostly left sided symptoms throughout her treatment although she told Dr. O'Leary that she hurt both arms, which was years after the accidents occurred and contrary to her testimony. Her medical and body part histories are thus inconsistent. Petitioner further testified that not only did she have right sided similar symptoms, but "[t]hey wanted to do surgery on both sides at one point in time." (T. p. 53) The Commission finds that Petitioner's testimony is confusing at minimum and is further evidence that her condition is unrelated to the work accidents on either November 4, 2016, or May 9, 2018. There is no mention of right side pain complaints in the medical records for the majority of her course of treatment following either accident and Petitioner specifically testified that both accidents involved her left arm. (T, pp. 10, 113-14)

Finally, the Commission notes that Dr. Hazelrigg, the cardiovascular surgeon who performed the left-side thoracic outlet syndrome surgery, did not testify. At best, his notes from the August 5, 2019 consultation, indicate that his opinion of whether or not Petitioner she needed the surgery recommended by Dr. Fletcher, was equivocal, stating Petitioner, "probably does have thoracic outlet syndrome and might benefit from a first rib resection." He did not think that the rib resection would relieve her headaches or improve her neck conditions as he thought there were multiple etiologies for her issues. (PX 10, PX5, p. 166)

Therefore, the Commission finds that Petitioner has failed to prove a causal connection to thoracic outlet syndrome and her work accidents.

Finally, the Commission agrees with Dr. O'Leary's assessment of the video surveillance of Petitioner. Dr. O'Leary opined, "To me reviewing the bulk of the 30 minute surveillance, it appeared that she uses the arm much more normally than what I observed in the office today." (RX 3) The Commission finds the video surveillance belies Petitioner's testimony regarding her disability.

For the reasons enunciated above, the Commission reverses the Arbitrator's Decision regarding causal connection and vacates the Arbitrator's awards of temporary total disability, the TTD underpayment, maintenance, medical expenses, permanent partial disability and §19(k) and §19(l) penalties and §16 attorneys' fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on October 26, 2020, is hereby modified and causation is reversed for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability, and the temporary total disability underpayment, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of maintenance is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical services and related expenses is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of penalties under §19(k) and §19(l), and attorney's fees under §16, is vacated.

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

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(1) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 13, 2021

KAD/bsd
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/s/*Kathryn A. Doerries*
Kathryn A. Doerries

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

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

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

21IWCC0463

UNGLESBEE, CHRISTY
Employee/Petitioner

Case# **18WC031608**
18WC031609

HELP AT HOME
Employer/Respondent

On 10/26/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW A BREWER
1610 S 6TH ST
SPRINGFIELD, IL 62703

0000 INMAN & FITZGIBBONS LTD
FRANK JOHNSTON
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Christy Unglesbee
Employee/Petitioner

v.

Help at Home
Employer/Respondent

Case # **18** WC **31608**

Consolidated cases: **18 WC 31609**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **8/27/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **11/4/16 and 5/9/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,669.96**; the average weekly wage was **$482.74**.

On the date of accident, Petitioner was **38; 39** years of age, ***married*** with **1** dependent children.

ORDER

- The Arbitrator finds that the Petitioner met her burden of proof regarding the issue of accident on both the 11/4/16 and 5/9/18 work injuries.

- The Arbitrator finds that the Petitioner's current condition of ill being is causally related to the Petitioner's work injury of 5/9/18.

- The Arbitrator finds that the Petitioner's correct average weekly wage pursuant to Section 10 of the Act is $482.74.

- The Respondent shall all reasonable and necessary medical services as set forth in Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act.

- The Respondent shall pay the Petitioner temporary total disability benefits of $321.83 a week for 85 weeks, commencing October 3, 2018 through May 19, 2020, as provided in Section 8(b) of the Act. The Arbitrator notes that the Respondent did pay a total of $5,740.92 in TTD covering the period of October 9, 2018 to April 22, 2019. However, a TTD underpayment is owed as described below.

- The Respondent shall pay the Petitioner maintenance benefits of $321.83 a week for 14 and 2/7 weeks, commencing May 20, 2020 through the date of trial August 27, 2020, as provided in Section 8(a) of the Act.

- The Arbitrator finds that the Respondent paid TTD at a rate of $220.00 a week for 26 and 6/7 weeks covering October 9, 2018 through April 22, 2019 for a total of $5,740.92. The Petitioner's correct TTD rate is $321.83. As such, the total of TTD benefits owed during this time frame would be $8,643.43. For this reason the Arbitrator orders the Respondent to pay $2,902.51 representing the TTD underpayment covering the period of October 9, 2018 through April 22, 2019.

- The Arbitrator notes that while accident was put in dispute the Respondent presented zero evidence of any real controversy on the issue of accident. Furthermore, the Respondent's Section 12 examiner, Dr. O'Leary, testified that he had no opinion one way or another regarding causation on the Petitioner's diagnosis and treatment for thoracic outlet syndrome. As such, the Respondent does not present a real controversy on the issue of causation. Lastly, even if the Arbitrator were to have found that the Petitioner's average weekly wage was $416.73 as alleged by the Respondent, the minimum TTD rate for

the Petitioner's May 9, 2018 date of accident would be $286.00 given the fact that she was married with one dependent at the time of the May 9, 2018 accident. Again, the Respondent did not present any evidence as to why there was this intentional underpayment of compensation. As such, the Arbitrator awards penalties and fees as follows: the Arbitrator awards $12,602.26 in attorney's fees under Section 16 of the Act as the compensation payable under the Act at the time of trial totaled $63,01 1.32. It is noted the outstanding medical bills at the time of trial were $36,799.12. In addition after subtracting the previously paid TTD of $5,740.92 the Petitioner was also TTD and maintenance benefits of $26,212.20. This makes the total compensation owed at trial $63,011.72. As such, penalties are awarded in the amount of $31,505.66 under Section 19(k) of the Act. The Arbitrator awards $10,000.00 in penalties under Section 19(l).

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.

Edward Lee
Signature of Arbitrator

10/24/20
Date

ICArbDec19(b)

OCT 26 2020

FINDINGS OF FACT

At the time of the trial the Petitioner was 41 years old. The Petitioner has a high school education with some college. The Petitioner was married with zero dependents under the age of 18. However, at the time of her 11/4/16 and 5/9/18 accidents she was married with one dependent under the age of 18. The Petitioner has lived in Quincy, IL for the past 2 years.

The Petitioner was employed by the Respondent on 11/4/16 as a home care worker. The Petitioner's job included traveling to clients' homes and helping them with their day to day activities. The Petitioner testified that she would see between 3 and 4 client's a day.

The Petitioner testified on 11/4/16 she was helping a client out of their chair when the client grabbed the Petitioner's left arm and then fell back into the chair pulling on the Petitioner's left arm. The Petitioner was at the client's house and on the clock when this happened. The Petitioner noticed pain to the left side of her neck radiating down to her arms and to her small and ring finger.

The Petitioner notified her employer of the 11/4/16 accident. The Petitioner completed an accident report on 11/7/16. (PX 17)

The Petitioner testified that she did improve after the accident, which was part of the reason, she did not seek care. The Petitioner initially did not seek care after her 11/4/16 accident until early 2018 when she saw Chiropractor Vance. The accident of 11/4/16 was minor and the Petitioner was able to continue to work her job with the Respondent and her concurrently held position with the Illinois Department of Human Services full duty after the 11/4/16 accident.

The Petitioner sustained a second accident while working for the Respondent on 5/9/18. The Petitioner was still employed by the Respondent in the same position as a home care helper and had the same job duties as she did in November of 2016. The Petitioner described essentially the same accident that had occurred on 11/4/16 as occurring again on 5/9/18. The Petitioner testified that she was assisting a client as they were getting out of their chair at which time the client fell back into the chair and pulled on the Petitioner's left arm. The Petitioner described the client on 5/9/18 as a female weighing over 200 lbs. Again, the Petitioner was at the client's house and was on the clock when this happened. The Petitioner again described complaints of pain from her neck shooting down into her left arm into her fingers on her left hand.

The Petitioner did provide notice to her employer and filled out an accident report on the day of the accident 5/9/18. The Petitioner was able to finish her shift on this day.

Again, the Petitioner did not immediately seek medical care after the 5/9/18 accident. The Petitioner testified that due to the fact she was able to continue working full duty after her 11/4/16 accident which was essentially the same mechanism she was hopeful that her symptoms following the 5/9/18 accident would go away or allow her to continue to work full duty as she had previously. The Petitioner also testified that she was concerned that may she lose her job if she filed a workers' compensation claim.

However, the Petitioner's complaints became severe enough after the 5/9/18 accident that she did seek medical care. The Petitioner was initially seen by Quincy Medical Group on 8/23/18 complaining of neck pain radiating down the left upper extremity. The Petitioner followed up with Quincy Medical Group on 9/11/18 and described a "zinger feeling." At that time, a recommendation was made for the Petitioner to undergo a cervical spine MRI. (PX 2)

The MRI of the cervical spine taken on 9/21/18 showed multi-level cervical spondylosis most significant at C5-6 with mild to moderate spinal canal stenosis and mild bilateral neural foraminal narrowing. (PX 2)

The Petitioner testified that she was not satisfied with her care at Quincy Medical Group. The Petitioner testified that the physicians at Quincy Medical Group in her opinion did not listen to her symptoms and the specific issues that she was having. Despite that the Petitioner was placed on light duty work on 10/3/18. The Petitioner testified that her employer was unable to accommodate the restrictions at that time.

Furthermore, the Petitioner testified that despite her delay in seeking medical care after the 5/9/18 accident, the Respondent authorized and paid for her initial medical treatment.

The Petitioner then subsequently came under the care of Dr. David Fletcher. The Petitioner initially saw Dr. Fletcher on 11/1/18. Dr. Fletcher took an examination and reviewed the cervical spine MRI from 9/21/18. Dr. Fletcher diagnosed the Petitioner with left C6-7 radiculopathy and a left brachial plexus injury. Dr. Fletcher prescribed medication recommended the Petitioner have an EMG study with Dr. Trudeau in Springfield. Dr. Fletcher took the Petitioner off of work entirely at this time. (PX 3)

The Petitioner underwent the recommended EMG with Dr. Trudeau on 12/17/18. The results of Dr. Trudeau's EMG were a left brachial plexopathy, medical cord lesion, moderately severe in electroneurophysiologic testing characterization, consistent with the clinical assessment of Dr. Fletcher. There was no evidence of cervical radiculopathy at C6 or C7 on either side.

The Petitioner returned to see Dr. Fletcher on 12/27/18. At which time Dr. Fletcher reviewed the results of the EMG study with the Petitioner. At that time, Dr. Fletcher continued to diagnose cervical radiculopathy as well as an injury of the brachial artery on the left side and injury of the brachial plexus. Dr. Fletcher instituted work restrictions of no lifting more than 10 pounds and no overhead activity. The Petitioner was also referred to Dr. Richard Kube for further consultation regarding the cervical spine. (PX 3)

The Petitioner testified that she was off work as of 10/3/18. The Petitioner was not paid temporary total disability benefits in October, November, or December of 2018. RX 9 which is the TTD benefit ledger reveals that the Petitioner's first TTD check was not issued until 12/28/18 and covered only 10/19/18 through 11/15/18. The Petitioner testified that she did not even receive this check until January of 2019. The Petitioner testified that due to the fact that she was not paid TTD benefits her car was repossessed on 1/3/2019. As such the Petitioner did not have any mode of transportation and had no way of getting around. The Petitioner confirmed that PX 19 contained an accurate copy of the notice that she received from the creditor on her vehicle. In order to "redeem her vehicle" the Petitioner owed the creditor $2,046.19. The Petitioner confirmed that the initial TTD check issued on 12/28/18 covering the dates of 10/9/18 through 11/15/18 was for a total of $1,194.29. As such this would account for only half of the money she needed to pay the creditor to get her vehicle back.

The Respondent admitted into evidence as RX 12 three light duty job offers. The Petitioner recalled communication with the Respondent and receiving the contents of RX 12. The first is dated 1/10/19 where the Petitioner was offered a light duty position. The Petitioner testified that this was for an office support position at the Respondent's Pittsfield location. The Petitioner confirmed at the time of this offer she was living in Quincy, IL. The Arbitrator takes judicial notice that from the Petitioner's address in Quincy to Pittsfield and back is approximately 95 miles round trip. The Petitioner confirmed that she had no car at the time this light duty job was offered and therefore did not have a way to get to and from Pittsfield every day. The Petitioner testified that if she did in fact have transportation she would have worked the light duty job offered.

The Petitioner was ultimately seen by Dr. Richard Kube's office on 1/5/19. Following an examination and review of the September 2018 cervical spine MRI it was recommended for the Petitioner to have a cervical

spine motion analysis x-ray scan. This scan was taken on 1/25/19. Dr. Kube reviewed the motion x-ray scan with the Petitioner on 2/5/19 and indicated the Petitioner was not a cervical candidate. Dr. Kube instead recommended the Petitioner participate in pain management for her cervical spine. (PX 16)

The Petitioner followed up with Dr. Fletcher on 2/8/19. Dr. Fletcher recommended the Petitioner begin physical therapy at that time and continued her on light duty no lifting more than 10 pounds and no overhead activity. (PX 3)

The Petitioner described a second light duty job offer made by the Respondent on 2/14/19. This job offer was the same as the first in that it was for the office support position in the Respondent's Pittsfield office. The Petitioner testified that she still had no car at this time and had no transportation or way of getting to the light duty position.

The Petitioner testified that she did begin physical therapy around this time at ATI in Quincy.

The Petitioner continued to follow up with Dr. Fletcher next seeing him on 2/20/19. The Petitioner continued to have significant subjective complaints of pain. At this time Dr. Fletcher took the Petitioner off work entirely. The Petitioner was to continue with physical therapy to see if she could obtain any improvement with her symptomatology. (PX 3)

The Petitioner followed up with Dr. Fletcher on 3/20/19. At this time the Petitioner was placed back on light duty restrictions of no lifting more than 10 pounds, no overhead activities and the Petitioner was to avoid driving long distances due to the sedating nature of the medication which was being prescribed. The Petitioner was prescribed Nucynta as well as Flexeril. Additionally, Dr. Fletcher recommended the Petitioner be seen by Dr. Salvacion, a pain management doctor in Springfield. (PX 3)

On 3/22/19 the Respondent made its third and final light duty offer. This was again the same position as was originally offered in January of 2019, that being an office support position at the Respondent's Pittsfield location. The Petitioner testified that she still did not have her car back and in fact has not had a car since it was repossessed in January of 2019. The Petitioner testified that not only did she fall behind on her car payments, but on all of her personal bills and expenses due to the fact that the Respondent did not pay TTD in October, November or December of 2018.

The Petitioner followed up with Dr. Fletcher on 4/9/19. Again, the Petitioner was recommended to continue physical therapy and was set to see Dr. Salvacion. The Petitioner maintained on her same work restrictions of no lifting more than 10 pounds, no overhead activities and no driving long distances. (PX 3)

The Petitioner did get to see Dr. Salvacion at Memorial Medical Center in Springfield. Dr. Salvacion performed a series of cervical epidural steroid injections which took place on 4/25/19, 5/2/19 and 5/23/19. (PX 9)

The Petitioner was also sent for an updated EMG study with Dr. Edward Trudeau. The Petitioner underwent the second EMG with Dr. Trudeau on 5/16/19. The results of this study again showed a left brachial plexopathy, medial cord lesion, mild to moderately severe in electroneurophysiologic testing terms, improved in comparison the previous study of 12/17/18 consistent with the clinical assessment of Dr. Fletcher. (PX 9)

The Petitioner followed up with Dr. Fletcher on 5/17/19. The Petitioner testified that she did not obtain any significant relief from the epidural steroid injections. At that time Dr. Fletcher maintained the Petitioner on light duty work restrictions of no lifting more than 10 pounds, no overhead activities and not driving long

distances. Dr. Fletcher also noted that the Petitioner was improved and was nearing maximum medical improvement. (PX 3)

The Petitioner followed up with Dr. Fletcher on 6/18/19. The Petitioner continued to have significant subjective complaints. Dr. Fletcher indicated that the Petitioner had continued to present with features of a brachial plexopathy and thoracic outlet syndrome. A discussion was had to refer the Petitioner to Dr. Hazelrigg at SIU in Springfield for a thoracic outlet evaluation which the Petitioner did not wish to do. The Petitioner did not wish to undergo any potential thoracic outlet surgery at that time. As such Dr. Fletcher placed the Petitioner at maximum medical improvement as of 6/18/19. The Petitioner was also issued permanent restrictions at that time of no lifting more than 10 pounds and no overhead activities. (PX 3)

The Petitioner testified that following the June 2019 visit with Dr. Fletcher she did not fare well. The Petitioner continued to have significant issues and as a result elected to see Dr. Hazelrigg for further evaluation.

The Petitioner initially saw Dr. Hazelrigg on 8/5/19. Dr. Hazelrigg reviewed the prior diagnostic studies and performed an extensive examination. Dr. Hazelrigg diagnosed the Petitioner with thoracic outlet syndrome worse on the left side. Dr. Hazelrigg indicated that based upon the diagnosis and her presentation that she may benefit from a first rib resection procedure. (PX 10)

The Petitioner did elect to undergo this procedure on 9/11/19 Dr. Hazelrigg performed a transaxillary first rib resection. Pre and post-operative diagnosis was thoracic outlet syndrome. The Petitioner was taken off work after the surgery. Subsequently the Petitioner was sent back to Dr. Fletcher for post-surgical follow up care. (PX 9)

The Petitioner followed up with Dr. Fletcher on 10/28/19. The Petitioner did have some initial relief after the surgery, but her symptoms returned. The Petitioner was continuing to complain of numbness and weakness in the left upper extremity. Dr. Fletcher recommended physical therapy start back up at this time and kept the Petitioner off of work. (PX 3)

The Petitioner again participated in physical therapy starting on 11/1/19.

Follow up visits with Dr. Fletcher on 11/25/19 and 12/20/19 indicate the Petitioner was to continue physical therapy and was maintained on restrictions of no lifting more than 10 lbs, no overhead activities and not driving long distances due to her medication. (PX 3)

As of 2/10/20 Dr. Fletcher recommended the Petitioner have a third and final EMG study. (PX 3)

On 2/25/20 the Petitioner underwent her third EMG study with Dr. Trudeau. This study revealed left long thoracic neuropathy, moderately severe in electroneurophysiologic testing characterization consistent with the clinical assessment of Dr. Fletcher, as well as left brachial plexopathy medial cord lesion, mild in electroneurophysiologic testing terms improved in comparison to the previous study of 5/16/19. (PX 11)

Dr. Fletcher saw the Petitioner in follow up on 3/3/20. This was the last time Dr. Fletcher actually saw the Petitioner. At this time, it was recommended that the Petitioner undergo a Functional Capacity Evaluation following review of the most recent EMG from February of 2020. (PX 3)

The Petitioner underwent a Functional Capacity Evaluation at ATI Physical Therapy on 5/11/20. This was a valid study the Petitioner gave consistent effort. Physical demand level demonstrated by the Petitioner was sedentary. The physical demand level of her previous job with the Respondent was medium to heavy. Recommended restrictions were issued for occasional 15 pound lifting from floor to waist, occasional 15 pound

carrying, occasional 10 pound lifting from waist to overhead with the right hand only, and occasional 2 pound lifting from the waist to shoulder height with the left hand. (PX 12)

Dr. Fletcher subsequently placed the Petitioner at maximum medical improvement with permanent restrictions per the Functional Capacity Evaluation on 5/20/20. The Petitioner testified that she did not see Dr. Fletcher on 5/20/20. However, as of the last time she saw Dr. Fletcher on 3/3/20, Dr. Fletcher indicated to the Petitioner that if the FCE was valid that she would be placed at maximum medical improvement and permanent restrictions issued consistent subsequent to the FCE.

The Petitioner testified as of the time of trial she was not offered a position by the Respondent within her permanent restrictions. The Petitioner then began participating in a self-directed job search once she was placed at maximum medical improvement. Job search logs were admitted as PX 15. The Petitioner confirmed that per her job search logs she had applied for roughly 90 different jobs between May and August of 2020.

The Petitioner testified just prior to trial she was offered a position with Blessing Hospital. The Petitioner testified that this position would be approximately 24 hours a week and she would be making $12.68 an hour.

The Petitioner confirmed that as of the time of her May of 2018 accident she did have concurrent employment. The Petitioner was concurrently employed at that time as a personal assistant with the Illinois Department of Human Services Home Services program. The Petitioner testified given her residual condition and her permanent restrictions she is unable to return to that position.

As of the time of trial the Petitioner testified that she still experiences symptomatology stemming from the left side of her cervical spine down her left arm. The Petitioner still has weakness and experiences numbness going into the fingers. The Petitioner testified that she does not believe she can return to work with the Respondent in her prior position.

The Petitioner testified that after Dr. O'Leary's Independent Medical Examination that some of her bills were paid by her husband's group health insurance which was Blue Cross Blue Shield.

The Respondent called Diane Westfall at the time of trial as its witness. Ms. Westfall works for the Respondent as a Registered Nurse and a branch manager at their Pittsfield location.

Ms. Westfall confirmed that the Respondent made light duty job offers to the Petitioner on three separate occasions. These offers were admitted as RX 12. The initial light duty offer was made on 1/10/19 for an office support position at the Respondent's Pittsfield location. This same position was later offered on 2/14/19 and again on 3/22/19. All three light duty job offers were for the office support position and were located at the Respondent's Pittsfield location.

Ms. Westfall confirmed on cross examination that the Petitioner lived in Quincy at the time these light duty job offers were made. She also confirmed that it was approximately 95 miles round trip from Quincy to the Pittsfield location and back.

Ms. Westfall also confirmed the email communications that she had with other members of the Respondent admitted as RX 13. Ms. Westfall confirmed that she was made aware at the time each light duty offer was made to the Petitioner that the Petitioner did not have a vehicle as it had been repossessed at the time when the Respondent failed to pay the Petitioner TTD benefits which caused Petitioner to become delinquent on her car payments and therefore could not get a ride all the way to and from Pittsfield every day. Ms. Westfall confirmed that the light duty position in Pittsfield would be four to five days a week.

The Arbitrator finds that although the Respondent did offer the Petitioner light duty work, it was reasonable for the Petitioner not to be able to attend as her car has been repossessed due to the fact that the Respondent failed to pay TTD benefits. As such the Arbitrator finds that the Petitioner had no way of getting to and from Pittsfield which was approximately 95 miles round trip each day for the light duty work, and therefore the Petitioners failure to work the light duty position was justified and not a refusal to work. The Arbitrator also notes that the Petitioner testified if she had transportation and a way to get to a from the light duty position that she would have worked it.

The evidence deposition of Dr. Fletcher was conducted on 2/14/2020. Dr. Fletcher is board certified in both preventative and occupational medicine. Dr. Fletcher has testified many times in the past regarding issues of causation, work restrictions, permanent partial disability, as well as maximum medical improvement in Illinois Workers' Compensation cases. Dr. Fletcher has also been appointed to the Illinois Workers' Compensation Medical Fee Advisory Board.

Dr. Fletcher confirmed that the Petitioner provided a history regarding her accident of 5/9/18. Dr. Fletcher treated the Petitioner from November of 2018 through May of 2020. Dr. Fletcher testified at the time of his evidence deposition that he believed based upon the history that the Petitioner provided, which he felt was consistent with the medical records, that the mechanism of injury described by the Petitioner from her 5/9/18 work accident was the cause of her conditions relative to her cervical spine, brachial plexus, winging scapula and thoracic outlet syndrome. Dr. Fletcher believed that the Petitioner's current condition of ill being is causally related to her accident of 5/9/18. Dr. Fletcher specifically described the mechanism which was a wrenching type of injury to the left upper extremity which is the type of mechanism that can cause a traction injury to the brachial plexus and to the anterior scaling muscles that can cause a traumatic thoracic outlet syndrome and associated brachial plexopathy. Dr. Fletcher believed that all the Petitioner's medical care for her conditions including the surgery performed by Dr. Hazelrigg as well as the need for her permanent restrictions are causally related to her 5/9/18 accident. The Arbitrator also notes that the photographs admitted as Exhibit 3 to Dr. Fletcher's evidence deposition show clearly the winging scapula condition that was noted and diagnosed by Dr. Fletcher.

The Respondent obtained an Independent Medical Examination from Dr. Patrick O'Leary. Dr. O'Leary's examination took place on 3/29/19. Dr. O'Leary's evidence deposition was taken on 2/27/20. Dr. O'Leary is a board certified orthopedic surgeon focusing on spinal care. Dr. O'Leary practices at Midwest Orthopedic Center in Peoria. After taking a history and performing an examination, Dr. O'Leary diagnosed cervical spondylosis without myelopathy as well as neck pain. Dr. O'Leary described "ill defined extremity complaints with a history and headaches and questionable history of brain lesions". Dr. O'Leary did not believe that any of his diagnoses were related to the work accident.

Dr. O'Leary confirmed on cross-examination that he performed between 300-350 surgeries a year. Dr. O'Leary confirmed that he does not perform and has never performed surgery for thoracic outlet syndrome including the rib re-section performed by Dr. Hazelrigg in this case. (RX 4, p 35-36)

Dr. O'Leary confirmed that the mechanism on injury described by the Petitioner could case a cervical spine injury, a brachial plexus injury or even a shoulder injury. (RX 4, p 44) Dr. O'Leary was not provided any evidence to dispute that the accidents in this case did in fact occur. (RX 4, p 44) Dr. O'Leary did confirm that in March of 2019 when he saw the Petitioner for an IME she did have subjective complaints that would be consistent with a medial cord lesion and/or thoracic outlet syndrome. (RX 4, p 44) Dr. O'Leary at his examination did not perform specific testing for thoracic syndrome for example an Addison's Test. (RX 4, p 47) Dr. O'Leary confirmed that the EMG performed on 12/27/18 did show a left a left brachial plexopathy, medical cord lesion which was moderately severe in testing characterization. (RX 4, p 48-49) Dr. O'Leary had no evidence and was not provided any documentation that showed any issues the Petitioner had with her cervical

spine, brachial plexus, or thoracic outlet syndrome prior to either of her work accidents. (RX 4, p 52) **Lastly, the Arbitrator notes that the final question asked on cross-examination to Dr. O'Leary by Petitioner's counsel:**

> **Q. Doctor, have you – maybe I am missing it because we are talking about several issues here today. Have you given an opinion as to whether or not within a reasonable degree of medical certainty the ultimate diagnosis and procedure that she had relative to the thoracic outlet syndrome has any correlation to her work accident?**
>
> **A. No.**

Subsequent to Dr. O'Leary's testimony the Respondent obtained an additional addendum report from Dr. O'Leary dated 8/6/2020. Dr. O'Leary reviewed additional records at that time but stated he did not find anything in the medical records which changed his initial opinions based upon his initial evaluation. The Arbitrator finds that given Dr. O'Leary's testimony on cross-examination and the fact that he had no change in opinion at the time of his addendum report, the Respondent presented no causation defense or opinion relative to the Petitioner's thoracic outlet syndrome which is the key diagnosis in this case. Dr. O'Leary's opinions do provide a basis for a defense regarding the Petitioner's cervical spine condition which the evidence showed was not a surgical issue. However, the focus of the Petitioner's treatment has been thoracic outlet syndrome and the Respondent did not present any opinion in evidence to dispute Dr. Fletcher's causation opinion in favor of the Petitioner on thoracic outlet syndrome.

ARBITRATOR'S FINDINGS

Accident

The Arbitrator finds the Petitioner met her burden of proof regarding issue of accident on both the 11/4/16 and 5/9/18 work injuries. The Respondent did not provide any defense to dispute the issue of accident.

Causal Connection

The Arbitrator finds the Petitioner's current condition of ill-being is causally related to the Petitioner's work injury of 5/9/18. The Arbitrator finds that the 11/4/16 accident caused a minor aggravation to the Petitioner's condition, but the accident of 5/9/18 is the cause of her condition of ill-being. In support of this the Arbitrator notes that Dr. Fletcher, the Petitioner's treating physician, provided a clear and credible causation opinion in favor of the Petitioner relative to all of her conditions including her thoracic outlet syndrome. The Arbitrator further notes that although the Respondent's IME physician Dr. O'Leary disputed causation of the Petitioner's cervical spine condition, he at no time gave an opinion to dispute causation relative to the Petitioner's thoracic outlet syndrome which was surgically treated in this case. Despite Dr. O'Leary's opinion regarding the cervical spine condition the Arbitrator finds the opinions of Dr. Fletcher to be controlling on all of the Petitioner's conditions of ill-being.

Average Weekly Wage

The Arbitrator finds the correct average weekly wage pursuant to Section 10 of the Act to be $482.74. The Arbitrator notes that the wage statement was admitted as RX 15. That document shows the Petitioner in the 52 weeks prior to the accident worked a total of 1766.45 hours. These hours divided by 40 shows the Petitioner had earnings in 44.16 weeks and parts thereof. The total earnings of the Petitioner in the 52 weeks before the

accident with the Respondent was $16,811.03. The total earnings divided over 44.16 (representing the weeks and parts thereof where Petitioner had earnings) gives an average weekly wage of $380.68.

Additionally, admitted as PX 7 were the earnings the Petitioner had in her concurrent employment as a personal assistant with the Illinois Department of Human Services – Home Services Program. In the Petitioner's concurrent employment she earned $2,857.79 over a period of 28 weeks for an additional average weekly wage of $102.06.

Combining the Petitioner's earnings that she made with the Respondent as well as her concurrent employer, the Arbitrator finds that the average weekly wage in this case is $482.74.

Medical Bills

The Respondent shall all reasonable and necessary medical services as set forth in Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act. In support of this, the Arbitrator refers his decision regarding causal connection in favor of the Petitioner.

Temporary Total Disability

The Respondent shall pay the Petitioner temporary total disability benefits of $321.83 a week for 85 weeks, commencing October 3, 2018 through May 19, 2020, as provided in Section 8(b) of the Act.

Maintenance Benefits

The Respondent shall pay the Petitioner maintenance benefits of $321.83 a week for 14 and 2/7 weeks, commencing May 20, 2020 (the date of MMI) through the date of trial August 27, 2020, as provided in Section 8(a) of the Act.

TTD Underpayment

The Arbitrator finds that the Respondent paid TTD at a rate of $220.00 a week for 26 and 6/7 weeks covering October 9, 2018 through April 22, 2019 for a total of $5,740.92. The Petitioner's correct TTD rate is $321.83. As such, the total of TTD benefits owed during this time frame would be $8,643.43. For this reason the Arbitrator orders the Respondent to pay $2,902.51 representing the TTD underpayment covering the period of October 9, 2018 through April 22, 2019.

Penalties and Fees

The Arbitrator notes that while accident was put in dispute the Respondent presented zero evidence of any real controversy on the issue of accident. Furthermore, the Respondent's Section 12 examiner, Dr. O'Leary, testified that he had no opinion one way or another regarding causation on the Petitioner's diagnosis and treatment for thoracic outlet syndrome. The evidence as presented shows the focus of Petitioner's treatment and her advanced and invasive care was directed toward curing her thoracic outlet syndrome.

As such, the Respondent did not present a real controversy on the issue of causation. Lastly, even if the Arbitrator were to have found that the Petitioner's average weekly wage was $416.73 as alleged by the Respondent, the minimum TTD rate for the Petitioner's May 9, 2018 date of accident would be $286.00 given the fact that she was married with one dependent at the time which is clearly stated on the Application for Adjustment of Claim and not disputed by the Respondent at trial. Again, the Respondent did not present any evidence as to why there was this intentional underpayment of compensation.

As such, the Arbitrator awards penalties and fees as follows:

Section 16 Attorney Fees: The Arbitrator awards $12,602.26 in attorney's fees under Section 16 of the Act as the compensation payable under the Act at the time of trial totaled $63,011.32.

Section 19(k) Penalties: It is noted the outstanding medical bills at the time of trial were $36,799.12. In addition, after subtracting the previously paid TTD of $5,740.92 the Petitioner was also TTD and maintenance benefits of $26,212.20. This makes the total compensation owed at trial $63,011.72. As such, penalties are awarded in the amount of $31,505.66 under Section 19(k) of the Act.

Section 19(l) Penalties: The Arbitrator awards $10,000.00 in penalties under Section 19(l).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC026343
Case Name	POPOVIC, PETER v. WAL-MART INC.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0464
Number of Pages of Decision	11
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	William Wimmer
Respondent Attorney	Khristopher Dunard

DATE FILED: 9/14/2021

/s/Thomas Tyrrell, 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

Peter Popovic,

Petitioner,

vs. NO: 16 WC 26343

Wal Mart, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 13, 2020, is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $64,350.00. 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.

September 14, 2021

o: 9/7/21
TJT/jds
51

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0464
NOTICE OF ARBITRATOR DECISION

POPOVIC, PETER Case# **16WC026343**
Employee/Petitioner

WAL MART INC
Employer/Respondent

On 10/13/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0368 WIMMER STIEHL & McCARTHY
WILLIAM L WIMMER
2 PARK PLACE PROFESSIONAL CTR
BELLEVILLE, IL 62226

0000 WIEDNER & McAULIFFE LTD
KHRISTOPHER S DUNARD
101 S HANLEY SUITE 1450
ST LOIUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Peter Popovic
Employee/Petitioner

v.

Wal Mart, Inc.
Employer/Respondent

Case # 16 WC 26343

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 27, 2020. By stipulation, the parties agree:

On the date of accident, August 8, 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 $19,733.48; the average weekly wage was $379.49.

At the time of injury, Petitioner was 70 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $21,288.14 for TTD, $0.00 for TPD, $0.00 for maintenance, and $3,795.00 for other benefits (advance on permanency), for a total credit of $25,083.14. The parties stipulated TTD benefits were paid in full.

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

ORDER

Respondent shall pay Petitioner permanent total disability benefits of $535.79 per week for life, commencing March 22, 2018, as provided in Section 8(f) of the Act. Respondent shall receive a credit of $3,795.00 for advance payment on permanency.

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.

William R. Gallagher, Arbitrator

September 27, 2020
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on August 8, 2016. According to the Application, "Employee was lifting boxes of produce and injured back" and sustained an injury to his "Lower back" (Arbitrator's Exhibit 2).

At trial Petitioner and Respondent stipulated that the only disputed issue was the nature and extent of disability. Further, Petitioner and Respondent stipulated Petitioner was temporarily totally disabled for 84 weeks, commencing August 9, 2016, through March 21, 2018, and that Petitioner was paid temporary total disability benefits during that period of time. Petitioner and Respondent also stipulated Respondent paid Petitioner $3,795.00 and this amount would be a credit against the permanency award (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a maintenance worker. Petitioner's job duties included cleaning shelves/racks in the dairy/meat departments, restocking coolers, mopping floors, cleaning bathrooms, etc.

On August 8, 2016, Petitioner moved a crate which contained bags of grapes. Petitioner estimated the crate weighed approximately 45 to 50 pounds. The crate was in the back of a shelf and Petitioner reached in to move it and, when he did so, he experienced a sharp pain in his middle/lower back. The accident was reported to Respondent the same day it occurred.

Petitioner was 70 years old at the time of the accident, and 74 years old when the case was tried. Petitioner became employed by Respondent in November, 2011, and usually worked 38 to 40 hours per week.

Petitioner testified that, following the accident, Respondent directed him to go to Dr. James Hitchcock, a family physician. Dr. Hitchcock evaluated Petitioner on August 9, 2016. At that time, Petitioner complained of low back pain with radiation into both buttocks/legs. Dr. Hitchcock opined Petitioner had low back pain. He prescribed medication and recommended Petitioner undergo an MRI scan (Petitioner's Exhibit 4).

Dr. Hitchcock saw Petitioner on September 21, 2016, and Petitioner was doing physical therapy. Dr. Hitchcock opined Petitioner had low back pain and lumbar radiculopathy. He referred Petitioner to pain management (Petitioner's Exhibit 4).

Petitioner sought treatment from Dr. Alfred Johnson, his family physician, on August 16, 2016. At that time, Petitioner informed Dr. Johnson he had injured his back at work while lifting boxes. Petitioner complained of low back pain with radiating pain into his buttocks. Dr. Johnson noted Petitioner had undergone a prior back surgery. Dr. Johnson opined Petitioner had an unspecified injury of the low back and prescribed medication (Petitioner's Exhibit 5).

The MRI of Petitioner's lumbar spine was performed on August 22, 2016, but the report of the radiologist was not tendered into evidence. However, the MRI was subsequently reviewed by Dr. Donald deGrange, an orthopedic surgeon (who examined Petitioner at Respondent's request on

April 3, 2017). Dr. deGrange opined the MRI revealed a prior laminectomy and fusion at L4-L5 and L5-S1 as well as a grade 1 degenerative spondylolisthesis with moderately severe spinal stenosis at L3-L4 (Petitioner's Exhibit 6).

Petitioner was seen at Memorial Pain Management on November 14, 2016, by Dr. Anthony Anderson. At that time, Petitioner informed Dr. Anderson he had undergone a lumbar fusion at L4-L5 and L5-S1 in 1975 and had done well afterward until he sustained the accident on August 8, 2016. Dr. Anderson administered epidural steroid injections at L3-L4 on January 3, January 24, and February 21, 2017 (Petitioner's Exhibit 10). At trial, Petitioner testified the injections did not help.

Petitioner continued to be treated by Dr. Johnson for his low back symptoms as well as other health issues. When Dr. Johnson saw Petitioner on March 14, 2017, Petitioner advised the injections did not work (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon, on April 3, 2017. In connection with his examination of Petitioner, Dr. deGrange reviewed medical records and, as previously noted herein, the MRI. Dr. deGrange opined Petitioner had an anatomic stenosis at L3-L4 which he opined was aggravated by the accident of August 8, 2016. Dr. deGrange recommended Petitioner undergo a decompressive laminectomy at L3-L4 (Petitioner's Exhibit 6).

Dr. deGrange performed surgery on June 8, 2017. The procedure consisted of a laminectomy at L3-L4 with decompression of spinal nerve roots (Petitioner's Exhibit 7).

Following surgery, Petitioner continued to be treated by Dr. deGrange. When Dr. deGrange saw Petitioner on June 21, 2017, he ordered physical therapy and authorized Petitioner to remain off work (Petitioner's Exhibit 6).

Petitioner received physical therapy from September 2, 2016, through February 23, 2018. He also received work hardening from October 5, 2017, through February 13, 2018 (Petitioner's Exhibit 9).

Dr. deGrange saw Petitioner periodically while Petitioner was in physical therapy and work hardening. Dr. deGrange noted Petitioner's condition improved, but his progress was slow. When Dr. deGrange saw Petitioner on February 16, 2018, he noted Petitioner had to stop a physical therapy session because of back pain (Petitioner's Exhibit 6).

When Dr. deGrange last saw Petitioner on March 21, 2018, Petitioner continued to complain of pain/weakness in the low back. Dr. deGrange noted tenderness on palpation throughout the lumbar area. He opined Petitioner's condition had stabilized and Petitioner was at MMI. Dr. deGrange opined Petitioner had a permanent restriction of a 50 pound lifting limit (Petitioner's Exhibit 6).

Petitioner continued to be treated by Dr. Johnson following the back surgery. Dr. Johnson treated Petitioner for his back as well as other health issues. When he saw Petitioner on March 11, 2019, Petitioner continued to complain of low back pain (Petitioner's Exhibit 5).

In a medical report dated June 19, 2019, Dr. Johnson noted Petitioner had been his patient for over 15 years. In addition to Petitioner's low back injury, Dr. Johnson noted he treated Petitioner for other medical conditions including hypertension, cerebral vascular accident, prostatic hyperplasia and cervical radiculopathy. Dr. Johnson opined Petitioner could only safely lift and carry approximately 10 pounds for a short period of time and that Petitioner had difficulties standing or sitting for a prolonged period of time as well as difficulties reaching, bending, twisting, stooping or any movement that included movement of his low back (Petitioner's Exhibit 11).

At the direction of his attorney, Petitioner was evaluated by Dolores Gonzalez, a vocational rehabilitation/employment expert on November 20, 2018. In connection with her evaluation of Petitioner, Gonzalez interviewed Petitioner and obtained a history of his education and work background. She noted Petitioner attended high school through the ninth grade, but did not graduate or obtain a GED. With the exception of one job where Petitioner worked as a telemarketer, Petitioner's work history was limited to manual labor type jobs. Gonzalez reviewed medical records provided to her by Petitioner's counsel and noted the opinion of Dr. deGrange of March 21, 2018, wherein he opined Petitioner could return to work with a 50 pound lifting restriction (Petitioner's Exhibit 3 – Report attached to Deposition).

Gonzalez also administered tests to Petitioner to determine his skills in reading, spelling and math. Overall, Petitioner tested within in the "average" range of achievement (Petitioner's Exhibit 3; Report attached to Deposition).

Gonzalez concluded Petitioner could not return to work at his prior job with Respondent even with accepting Dr. deGrange's 50 pound lifting restriction. Gonzalez noted Petitioner continued to take narcotic and non-narcotic pain medications which significantly impaired his attention and concentration. She opined Petitioner lacked transferable skills and secondary education, had a limited work history as well as a limited functional capacity. Based on the preceding, Gonzalez opined Petitioner was not a candidate for vocational rehabilitation and was not capable of any work for which there was a reasonably stable job market (Petitioner's Exhibit 3; Report attached to Deposition).

Dolores Gonzalez was deposed on February 20, 2019, and her deposition testimony was received into evidence at trial. On direct examination, her testimony was consistent with her report of November 20, 2018, and she reaffirmed the opinions contained therein. Specifically, Gonzalez testified that, considering Petitioner's age, limited education, residual functional capacity and lack of transferable skills, Petitioner was not a candidate for vocational rehabilitation and not capable of any competitive work for which there was a stable job market (Petitioner's Exhibit 3; pp 33-34).

Dr. Johnson was deposed on August 29, 2019, and his deposition testimony was received into evidence at trial. Dr. Johnson testified he had been Petitioner's primary care physician for over 21 years. He did not testify regarding all of his prior treatment of Petitioner; however, he saw Petitioner in 2009 after Petitioner had sustained a stroke (Petitioner's Exhibit 2; pp 7-8).

Dr. Johnson testified he treated Petitioner following the work accident of August 8, 2016, through May 13, 2019. Dr. Johnson treated Petitioner for his low back injury as well as various other health issues. He noted Petitioner continued to complain of low back pain, difficulties in sitting, standing, walking, reaching, bending and twisting as well as any other movement which required movement of his low back. He opined these difficulties were caused by the accident of August 8, 2016. He testified Petitioner was not capable of lifting 50 pounds and could lift no more than 10 pounds (Petitioner's Exhibit 2; pp 32-36).

On cross-examination, Dr. Johnson agreed Petitioner had other conditions unrelated to his back injury which contributed to his recommendation for work restrictions. These included the prior stroke, cervical spine pain, feet/leg swelling and atherosclerosis. Dr. Johnson was also not certain of Petitioner's exact work duties when employed by Respondent. He also agreed his 10 pound lifting restriction was because of both the lumbar and cervical spine conditions (Petitioner's Exhibit 2; pp 54-62).

Dr. deGrange was deposed on February 11, 2020, and his deposition testimony was received into evidence at trial. On direct examination, Dr. deGrange's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, he testified that on March 21, 2018, Petitioner was at MMI and Petitioner could return to work with a 50 pound lifting restriction (Petitioner's Exhibit 1; pp 20-21).

On cross-examination, Dr. deGrange agreed Petitioner was not a malingerer. In regard to the 50 pound lifting restriction, Dr. deGrange stated that, mechanically, his spine was capable of lifting 50 pounds; however, he agreed that other factors which contributed to Petitioner's "overall condition and health" would prevent him from lifting 50 pounds (Petitioner's Exhibit 1; pp 27, 45-46).

Shortly after Petitioner was found to be at MMI by Dr. deGrange, Respondent offered Petitioner a job which conformed to the 50 pound lifting restriction. Petitioner declined Respondent's offer on the basis he believed he could not perform the job.

On February 21, 2019, Respondent tendered a written offer of a job which conformed to the 50 pound lifting restriction (Respondent's Exhibit 4). This job offer was also declined by Petitioner for the same reason he gave previously.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained a permanent and total disability as a result of the accident of August 8, 2016, and became so disabled at that time he was determined to be at MMI on March 21, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent agreed Petitioner was at MMI as of March 21, 2018.

Dr. deGrange initially evaluated Petitioner at the direction of Respondent, but subsequently became the treating physician and performed surgery on Petitioner's low back.

Dr. deGrange opined Petitioner could return to work with a permanent 50 pound lifting restriction; however, this was based solely on his opinion that, mechanically, Petitioner's spine was capable of lifting 50 pounds. He did not consider other factors which contributed to Petitioner's "overall condition and health."

Dr. Johnson has been Petitioner's primary treating physician in excess of 21 years and has treated Petitioner for a variety of health issues. Dr. Johnson opined Petitioner was subject to a 10 pound lifting restriction and noted Petitioner had difficulties performing a number of activities of daily living, all of which he attributed to the accident.

As noted herein, Petitioner had a significant number of other medical conditions which pre-existed the accident

Based on the preceding, the Arbitrator finds Dr. Johnson to be more knowledgeable of Petitioner's overall condition and health than Dr. deGrange.

The opinion of Petitioner's vocational rehabilitation/employment expert, Dolores Gonzalez, was unrebutted.

William R. Gallagher, Arbitrator

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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028771
Case Name	GARCIA, ADOLFO v. SUNSET POOL & SPA
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0468
Number of Pages of Decision	29
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Christopher Williams
Respondent Attorney	John Maciorowski

DATE FILED: 9/15/2021

/s/Stephen Mathis, 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Adolfo Garcia,

Petitioner,

vs. No. 18 WC 28771

Sunset Pool & Spa,

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 the issues of causal connection, medical expenses, prospective medical care, temporary disability, average weekly wage/benefit rates and an evidentiary ruling, and being advised of the facts and law, corrects, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Commission agrees with Respondent that Dr. Novoseletsky's "Rebuttal to Independent Medical Evaluation" report dated September 16, 2019 was prepared for the purposes of litigation. Accordingly, the Commission excludes the report from the evidence. However, the Commission finds Dr. Pelinkovic's opinion is a sufficient basis for causal connection.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2020, is hereby corrected, 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.

September 15, 2021

SJM/sk
o-07/28/2021
44

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

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

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

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

21IWCC0468

GARCIA, ADOLFO
Employee/Petitioner

Case# **18WC028771**

SUNSET POOLS & SPAS
Employer/Respondent

On 2/11/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP LLC
CHRIS M WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ADOLFO GARCIA
Employee/Petitioner

v.

SUNSET POOLS & SPAS
Employer/Respondent

Case # **18** WC **28771**

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 **Soto**, Arbitrator of the Commission, in the city of **Wheaton**, on **10/22/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/9/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,920;** the average weekly wage was **$876.36**.

On the date of accident, Petitioner was **53** 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 **$7,225.74** for TTD, **$0** for TPD, **$0** for maintenance, and **$13,472.30** for other benefits, for a total credit of **$20,698.04**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $23,050.00 to RNS Physical Therapy, $14,712.49 to Suburban Orthopaedics, $75,544.00 to Ashton Surgery Center, $845.88 to ADCO, and $5,628.86 to Persistent Rx, as provided in Sections 8(a) and 8.2 of the Act, as set forth in the attached Conclusions of Law;

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $524.24/week for 63.1 weeks, commencing 7/17/18 through 7/22/18, 8/3/18 through 10/28/18, and 11/8/18 through 10/22/19 as provided in Section 8(b) of the Act, as set forth in the attached Conclusions of Law;

Prospective Medical Treatment

Respondent shall pay for Petitioner to return to treatment with Dr. Pelinkovic, obtain a lumbar MRI so that Dr. Pelinkovic could determine whether he recommends surgery and, if so, the type of surgery recommended. Respondent shall also pay for Petitioner to receive the C7-T1 cervical injections recommended by Dr. Novoseletsky, as set forth I the attached 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

2/6/2020
Date

FEB 11 2020

Procedural History

This matter was tried on October 22, 2019 pursuant to Sections 19(b) and 8(a) of the Act. The issues in dispute are whether an accident occurred that arose out of and in the course of Petitioner's employment, date of accident, whether Petitioner's current condition of ill-being is causally related to the injury, whether Respondent is liable for reasonable and related medical services, whether Respondent is liable for prospective medical care, and whether Petitioner is entitled to TTD benefits. At trial, Petitioner offered into evidence a report authored by treating physician entitled "Rebuttal to Independent Medical Evaluation" which the Arbitrator deferred ruling upon the admissibility of the report until the issuance of the Decision.

Findings of Fact

Adolfo Garcia (hereafter referred to as "Petitioner") testified that he has been employed by Sunset Pools & Spas (hereafter referred to as "Respondent") as a laborer for the past 8 years. Petitioner testified that his employment is seasonal, and he works 8 months a year beginning in March and ending in December. Petitioner testified that he works 6 days a week and that he works 10 hours a day, from 7:00 A.M. until 5:50 P.M. Petitioner testified that he has never been allowed to leave work before 5:30 P.M. Petitioner testified that working Saturdays was not required. Respondent submitted into evidence a Report of Employee's Wages for 36 weeks which indicated that Petitioner's hourly rate of pay was $23.00 for 17 out of 36 weeks and $21.00 for 19 out of 36 weeks. The Repot of Employee's Wage also showed that Petitioner worked overtime on a regular basis. (RX 1).

Petitioner testified that part of his job duties including moving rocks and boulders, placing rods, excavating and installing plumbing. Petitioner testified that on July 9, 2018, he was setting stones for a patio when he and three co-workers were lifting boulders weighing between 600-700 pounds. Petitioner testified that to move a boulder a strap would be placed around the builder and around the back of his neck. He would lift the boulder by pulling up on the straps. Petitioner testified that while lifting a large boulder with several of his coworkers he felt pain in his neck and low back. Petitioner testified that he reported the incident to his supervisor, John, and continued to work but with difficulties. Petitioner testified that he for a few more days before seeking medical treatment with Dr. Rivera at RNS Physical Therapy.

Medical Records

Petitioner first sought treatment with Dr. Gabriel Rivera, of RNS Physical Therapy, on July 17, 2018 (PX1 p. 104). Petitioner reported that he injured is neck and low back while carrying an extremely heavy stone with several coworkers on July 9, 2018. (PX1 p. 104). Petitioner was diagnosed with sprain/strain of the cervical, thoracic, and lumbar spine and prescribed physical therapy, chiropractic treatment and he was taken off work. (PX1 p. 109-110).

On July 27, 2018, Dr. Rivera released Petitioner to return to work light duty with no lifting over 20-25 pounds, no pushing or pulling over 25-30 pounds and no repetitive movements such as bending, twisting, or squatting (PX1 p. 133-134). On August 3, 2018, Petitioner returned to Dr. Rivera who noted that Petitioner's pain had become severe from work and he took Petitioner off work. (PX1 p. 142-143). Dr. Rivera referred Petitioner to an orthopedic specialist and ordered MRIs of the cervical and lumbar spines (PX1 p. 151-152).

On August 15, 2018, Petitioner underwent a cervical and lumbar spine MRI at Fox Valley Imaging. (PX4). The lumbar MRI identified an annular tear and broad-based central disc herniation at L4-5 with mild abutment of the exiting L4 nerve roots and an annular tear and broad-based disc herniation at L5-S1 (PX4 p. 1). The cervical MRI identified an annular tear and broad-based disc herniation at C5-6 and a disc protrusion at C6-7. (PX4 p. 2).

On August 17, 2018, Dr. Rivera referred Petitioner to Dr. Novoseletsky, a pain specialist at Suburban Orthopaedics. (PX1 p. 168-170). On August 23, 2018, Petitioner presented to Dr. Novoseletsky. At that time, Petitioner reported that he was injured carrying 80-pound rocks on his left shoulder and, a few days later, moving a rock weighing 600 pounds and by the end of the day he was experiencing severe low back pain. (PX2 p. 118). At that visit, Petitioner complained of left sided pain and pain radiating from neck to left arm and from low back to left foot. (PX2 p. 118). Dr. Novoseletsky diagnosed low back pain and neck pain, ordered an EMG, injections, and continuing with physical therapy. Dr. Novoseletsky continued to keep Petitioner off work. (PX2 p. 116, 120-121).

Petitioner continued physical therapy at RNS Physical Therapy. (PX1 p. 176 – 214). On September 20, 2018, Petitioner returned to Dr. Novoseletsky reporting pain from the left side of the neck into his left arm and left side of his low back into his left leg. (PX2 p. 112). Dr. Novoseletsky recommended injection and he referred Petitioner to Dr. Pelinkovic. (PX2 p. 115).

On October 10, 2018, Petitioner underwent the EMG of the upper extremities which found: (1) muscle fiber membrane electrical instability in the left biceps brachii and cervical paraspinal muscles which should be correlated with left C5/6 left cervical radiculopathy, (2) evidence of mild right median sensorimotor mononeuropathy in its wrist segment as seen in carpal tunnel syndrome, (3) mild left ulnar neuropathy without findings to clearly discern focal neuropathy at the elbow vs. lower trunk brachial plexopathy, (5) no electrodiagnostic evidence of focal right ulnar neuropathy in the elbow, wrist or upper limbs. (PX2 p. 130-134). On October 11, 2018, Petitioner returned to Dr. Novoseletsky who prescribed topical pain medicine, cervical injections and continued to keep Petitioner off work. (PX2 p. 103-108).

On October 12, 2018, Petitioner was examined by Dr. Pelinkovic also at Suburban Orthopaedics. (PX2 p. 93-101). Dr. Pelinkovic noted that Petitioner was having persistent L5 pain and left C6 dermatomal pain and subjective weakness. (PX2 p. 93). Dr. Pelinkovic diagnosed Petitioner with a left L4-5 disc herniation and recommended either injections or microdiscectomy at L4-5 (PX2 p. 95-100).

On November 8, 2018, Petitioner sought a second opinion with Dr. Lorenz of Hinsdale Orthopaedics. (RX2 exhibit 6). Petitioner reported being injured after lifting a 600-pound rock with multiple coworkers when he felt a pop in his lumbar spine and increased neck pain and pain that radiated into the left leg and toe. (RX2 exhibit 6). Dr. Lorenz diagnosed Petitioner with an L4-5 annular tear and left sided disc herniation with radiculopathy secondary to his work-related injury and cervicalgia with left upper extremity radiculopathy. (RX2 exhibit 6). Dr. Lorenz recommended an epidural steroid injection at L4-5. (RX2 exhibit 6).

Petitioner continued with physical therapy at RNS Physical Therapy. On November 15, 2018, Petitioner returned to Dr. Novoseletsky. (PX2 p. 82-87). At this visit, Petitioner reported that his condition remained unchanged. (PX2 p. 82). Dr. Novoseletsky recommended lumbar and cervical epidural steroid injections and continue therapy. (PX2 p. 86). Dr. Novoseletsky continued to keep Petitioner off work. (PX2 p. 87).

On December 19, 2018, Petitioner underwent a lumbar epidural steroid injection at L5-S1 with Dr. Novoseletsky. (PX2 p. 128). On January 3, 2019, Petitioner followed up with Dr. Novoseletsky reporting that after the injection he his left leg radicular symptoms completely resolved and that he experienced 65% improvement in pain. (PX2 p. 75). Dr. Novoseletsky recommended left medial branch blocks at L2, L3, L4, and L5. (PX2 p. 79).

On January 15, 2019, Petitioner underwent prognostic lumbar medial branch blocks. (PX2 p. 126-127). On Janurary 17, 2019, Petitioner followed up with Dr. Novoseletsky reporting greater than 75% relief within 30 minutes of the procedure and the pain relief lasted more than 8 hours. (PX2 p. 70). Dr. Novoseletsky recommended a second round of blocks. Dr. Novoseletsky also kept Petitioner off work. (PX2 p. 74).

On February 19, 2019, Petitioner underwent the second round of blocks. (PX2 p. 124-125). On February 22, 2019, Petitioner followed up with Dr. Novoseletsky reporting 80% pain relief following the injections but that his pain returned to the pre-injection levels. (PX2 p. 61). Dr. Novoseletsky recommended medial branch radiofrequency neurotomy. (PX2 p. 65).

On March 12, 2019, Petitioner underwent the radiofrequency neurotomy. After the procedure Petitioner reported 50% relief of pain. (PX2 p. 56, 122-23). Petitioner continued to complain of pain and stiffness in his neck radiating down to his left shoulder. (PX2 p. 56). Dr. Novoseletsky recommended continuing with therapy and he recommended cervical injections. Dr. Novoseletsky continued to keep Petitioner off work. (PX2 p. 59-60).

On April 25, 2019, Petitioner returned to Dr. Novoseletsky reporting that his neck and back pain level was 3 out of 10. (PX2 p. 47). Dr. Novoseletsky kept Petitioner off work and recommended continuing physical therapy (PX2 p. 50-51). Petitioner continued to follow up with Dr. Novoseletsky on May 23, 2019, June 27, 2019, July 25, 2019, August 22, 2019, and September 19, 2019. At that time, Dr. Novoseletsky recommended cervical injections, a left shoulder MRI and continued to keep Petitioner off work. (PX2 p. 10-46).

Testimony of Dr. Wehner the Section 12 Examiner

Dr. Wehner, an orthopedic surgeon, examined Petitioner on October 15, 2018, pursuant to Section 12 of the Act. Dr. Wehner testified that Petitioner was lifting stones weighting up to 600 pounds with 3 others when he developed an onset of neck pain that went down to his low back. Petitioner continued working and sought treatment with Dr. Rivera, a chiropractor, on July 17, 2018. (RX2).

Dr. Wehner testified that she examined Petitioner without an interpreter present but that she has a telephonic service available, which she did not use. (RX2 p. 24-25). Dr. Wehner testified that she experience some trouble communicating with Petitioner and that some of the information was provided by Petitioner's wife. (RX2).

Dr. Wehner testified that she reviewed Petitioner's MRIs. Dr. Wehner testified that the MRIs were not normal, but all the MRI findings were due to degeneration. Dr. Wehner opined that no causal relationship between the MRI findings and Petitioner's work accident.

Dr. Wehner testified the lumbar MRI findings showed an annular fissure and a 2.5-disc herniation at L4-5 which she opined was a disc protrusion not a herniation. Dr. Wehner further testified that the MRI also showed an annual fissure and a broad-based right centric disc herniation at L5-S1 which she opined was a disc protrusion with spurring. Dr. Wehner opined that the MRI findings were degenerative, and the MRI did not show any impingement on the nerve roots. (RX2).

Dr. Wehner testified the cervical MRI showed mild stenosis at C3-4 and moderate bilateral foraminal stenosis at C4-5 with severe right and moderate left foraminal stenosis. Dr. Wehner opined that the cervical MRI findings were degenerative. Dr. Wehner testified that there was no evidence of nerve root impingement on the cervical MRI. Dr. Wehner opined there was no causal relationship between the cervical MRI findings and Petitioner's work accident. (RX2).

Dr. Wehner testified that she examined Petitioner and noted pain with light palpation at L5-S1 and pain in the left shoulder with axial compression. Petitioner's upper extremity strength was 4 out of 5 and he had decreased sensation in the left arm to light touch, which did not follow any radicular pattern. Dr. Wehner also noted pain in the bottom of Petitioner's foot with movement of the big toe and pain with compression in the calf. Petitioner's knee and ankle reflexes were one plus, and his motor examination showed giving way at 4 out of 5 in both lower extremities. (RX2).

Dr. Wehner found evidence of symptom magnification and diagnosed non-specific pain of the low back and non-specific pain of the neck. Dr. Wehner opined that Petitioner was a maximum medical improvement, could return to work full duty, and surgical intervention was not warranted. (RX2).

Dr. Wehner testified that epidural injections at L4-5 were recommended and they could be beneficial if Petitioner had a radicular component to his pain. Dr. Wehner opined that Petitioner's pain was not radicular and that Petitioner's straight leg raise test was negative. Dr. Wehner testified the test was negative based upon Petitioner's non-specific pain that did not follow a radicular pattern of pain. Dr. Wehner testified that she found no impingement on the nerve root and the finding of mild abutment of the exiting L4 nerve roots, as found on the MRI,

means "almost nothing, and abutment means coming close. It doesn't mean it's impinging on it, displacing it, compressing it". Dr. Wehner opined that Petitioner would not benefit from an epidural steroid injection and that 50% of all injection recipients have a placebo effect. (RX2).

Dr. Wehner testified that she did not review any of the records from Suburban Orthopedics including the records of Dr. Novoseletsky. Dr. Wehner testified that it was possible that Petitioner suffered a cervical and lumbar strain based upon his history of lifting a heavy rock. (RX2).

Testimony of Dr. Pelinkovic, a treating physician

Dr. Pelinkovic testified that Petitioner was referred to him by Dr. Novoseletsky and that he first saw Petitioner on October 12, 2018. At that time, Petitioner complained of low back pain, left lower extremity pain at the L5 dermatomal, neck pain, neck pain at the left C6 dermatomal and pain between the shoulder blades. Petitioner reported that he was carrying rocks over his left shoulder on July 9, 2018 and, a couple of days later, he was moving a 600-pound rock when he began to have severe low back pain. (PX3).

Dr. Pelinkovic examined Petitioner and noted tenderness along the cervical spine, positive Spuling's sign on the left and positive straight leg raise test on the left. Dr. Pelinkovic testified that he reviewed the lumbar MRI which showed a left disc herniation which, he said, correlated with Petitioner's left extremity symptoms. Dr. Pelinkovic also testified that he reviewed the cervical MRI which showed a left disc herniation at C4-5 which, he said, correlated with Petitioner's radiculopathy and neck injury. Dr. Pelinkovic testified that he diagnosed left L4-5 disc herniation and a neck injury with an annular tear at C5-6. (PX3).

Dr. Pelinkovic testified that recommended epidural steroid injections and he referred Petitioner back to the pain doctor for injections. Dr. Pelinkovic testified that Petitioner underwent steroid injections and medial branch block injections reporting a 65% pain improvement and Petitioner's radicular symptoms resolved which, he said, supports his diagnosis. Dr. Pelinkovic testified that if the injections helped, even for a short period of time, confirms that the pain generator was the left L5 dermatomal. (PX3).

Dr. Pelinkovic testified that Petitioner was able to perform his work duties prior to his work accident. Dr. Pelinkovic opined that Petitioner's lumbar disc herniation at L4-5 and leg pain is directly related to Petitioner's work accident. Dr. Pelikovic testified that the annular tear at C5-6 was also causally related to his accident because lifting with upper extremities places

stress on cervical vertebrae (PX3). Dr. Pelinkovic testified that lifting the with the upper extremities causes stress on the cervical vertebras, specifically at C5-6 and C6-7, and the axial load, turning, and twisting could lead to a disc disruption. (PX3).

Dr. Pelinkovic testified that Petitioner may need a lumbar microdiscectomy which would involve taking out the disc causing the pain. (PX3 p. 17-18). Dr. Pelinkovic testified that assuming Petitioner still has the same left leg symptoms correlating with his MRI and has not improved, a microdiscectomy is a good treatment option. (PX3, p. 23). He testified that he had not seen Petitioner since October 15, 2018, but that if he continued to have the same left leg symptoms and difficulty being gainfully employed, he would recommend the microdiscectomy (PX3 p. 23). Dr. Pelinkovic testified that he is not recommending any type of surgery for the cervical spine (PX3 p. 48).

Dr. Pelinkovic testified that he did not review records of Dr. Rivera or of any family physician and that he was unaware that Petitioner had any pre-existing back problems (PX3 p. 28-29). Dr. Pelinkovic testified that a 53-year-old would have some disc degeneration as it starts at age 16. (PX3 p. 33-34). Dr. Pelinkovic testified that a herniation is where the disc comes out while a protrusion where the envelope is still intact. (PX3 p. 36).

In his report dated February 12, 2019, which was admitted as an exhibit to his evidence deposition without objection, Dr. Pelinkovic opined that Petitioner has been unable to work since his accident. (PX3 exhibit 2). In the report, Dr. Pelinkovic also indicated that he disagreed with the independent medical evaluation dated October 15, 2018. Dr. Pelinkovic indicated that disc herniations and disruptions may cause pain through receptors in the posterior longitudinal ligament of the spine and through chemical irritation by the epidural space being exposed to the collagen 2 from herniations. Dr. Pelinkovic further indicated that it is well known that in addition to cord impingement, nerve root irritation and irritation of the sinuvertebral nerve and stretch on the posterior longitudinal ligament could also result in axial back pain and that not all pain produced in dermatomal in the distribution of the spinal nerve and could be myotomal pain distribution from musculoskeletal pain generators. (PX3, exhibit 2).

Testimony of Nick Luisi

Respondent called Nick Luisi as a witness. Mr. Luisi is the owner of Respondent. He testified that Respondent builds pools and patios. He testified that he is familiar with Petitioner. He testified that Petitioner worked for him for years. He testified that he considered Petitioner a

good employee. He testified that Petitioner had never called off work due to an injury prior to July 9, 2018. Her testified that Petitioner's work was heavy depending on the work they were doing at any particular time. He testified that there are various tools that employees can use to lift including wheelbarrows, straps, heavy machines, and pry bars. He testified that he assumes the heaviest item anyone would need to lift would be 100 pounds.

Mr. Luisi testified that on July 9, 2018, the company was involved in a project in Wayne, Illinois setting blue stone steps on a patio. He testified that he learned of Petitioner's injury in a text message on July 17, 2018. He testified that he was telling Petitioner about a job in Ann Arbor, Michigan when Petitioner told him he hurt himself lifting the rock. Mr. Luisi testified that Petitioner would routinely travel out of state on these jobs when asked prior to the injury.

Mr. Luisi testified that he communicated with Petitioner via text message, phone calls, or in person communication at a job site. He testified that he was able to communicate with Petitioner in English. He testified that he has approximately 38 employees and they are required to work only 8 hours per day. He testified that if the employee does not wish to work overtime, he need not.

Mr. Luisi testified that he received various text messages from Petitioner attaching medical notes regarding Petitioner's work restrictions, the first of which coming on July 17, 2018. He testified that Petitioner told him he hurt himself lifting the rock. He testified that whenever Petitioner presented him with work restrictions, the restrictions were accommodated by Respondent. He testified that he would meet with the foreman at the jobsite to go over the restrictions. He testified that he did not stay to witness whether the restrictions were being followed but trusted that the foreman would follow them. He testified that he received messages from Petitioner that took him off work.

Mr. Luisi testified that he appeared at a jobsite that Petitioner was working, and Petitioner said that he was doing well. He testified that Petitioner informed him that he would be going to Mexico for a month in December. He testified that the last communication with Petitioner was on January 3, 2019 wherein he asked Petitioner if he would be returning to work on the following Monday for an indoor job. He testified that Petitioner responded with an off work slip from his doctor. Mr. Luisi testified that light duty and full duty work has been available for Petitioner since November 2018.

Surveillance

Respondent introduced various videos and photographs of Petitioner. Three investigators testified on behalf of Respondent.

Ian Mellott testified for Respondent. He is a licensed investigator who took videos of Petitioner on October 5 and October 8, 2018. He testified that he began surveillance at the Petitioner's home and then to a dog park. He testified that he witnessed Petitioner lifting various items with both arms, stepping over a dog leash, and squatting down for one minute. He testified that Petitioner showed no signs of pain as he made these movements.

Mr. Mellott testified that he is not a physiatrist or body mechanics expert. He testified that he does not know the weight of any of the items that Petitioner lifted.

The arbitrator viewed the surveillance videos and made the following observations.

October 5, 2018 video

At 11:17:04 AM, Petitioner is seen carrying what appear to be shopping bags from a car to the house.

At 1:35:35 PM, Petitioner is seen walking slowly in his driveway. Petitioner enters his vehicle at 1:36:50 PM.

At 2:45:00 PM, Petitioner is seen exiting a chiropractor's office.

At 2:54:00 PM, Petitioner is seen leaving a store and carrying bags with both hands and entering his vehicle.

At 2:59:10 PM, Petitioner returns home and carries bags from his vehicle to the house.

October 8, 2018 video

At 9:35:50 AM, Petitioner is seen carrying a small dog and placing it in a vehicle before entering himself.

At 9:47:50 AM, Petitioner is seen sitting in the drivers' seat of a vehicle and going through a drive thru window and accepting cups of coffee.

At 9:55:55, Petitioner is seen walking around a dog park, holding a cup of coffee. He proceeds to stand in the dog park for approximately 15 minutes. He then proceeds to walk around before sitting at a picnic table at 10:09:50 AM. At 10:13:31 AM, Petitioner squats down and appears to pet his dog. He rises up at 10:17:43 AM. He bent down slowly and rose slowly and was squatting for a total of 12 seconds. The Petitioner takes two small dogs' leashes at 10:16:36 AM and lifts his legs over these leashes as they tangled around his legs. He then walks with the dogs around the dog park. At 10:22:37 AM, Petitioner returns to his car

and again steps over the leashes. He then bends down to lift each of the dogs, one at a time, into the back of his vehicle.

At 1:45:36 PM, Petitioner is seen walking and getting into his vehicle.

At 1:51:54 PM, Petitioner is seen entering a chiropractor's office.

At 2:52:50 PM, Petitioner is seen leaving a chiropractor's office.

Justin Contreras testified on behalf of Respondent. Mr. Contreras is a licensed investigator who took videos of Petitioner on November 19 and November 20, 2018. He testified that he witnessed Petitioner loading various items onto a truck in front of his home in Aurora on November 19, 2019 and then driving that truck to a storage unit and then to another home in Rockford on November 20, 2019. He testified that he did not witness Petitioner driving from Rockford to Aurora. He testified that he saw Petitioner lift heavy boxes, bend, and lift items over his head. He testified that he did not notice Petitioner displaying any signs of pain or distress. He testified that he was 75-100 yards away from Petitioner when he watched Petitioner and that he could see facial expressions from that distance. He testified that he believed one box contained tile because it looked like a tile box and he knows what that looks like. He testified that it could have been filled with something else. He testified that he does not actually know how much any of the items that Petitioner lifted weighed. He testified that he is not medically trained and not a body mechanics expert. He testified that part of his view on November 20, 2019 was obscured by the ground.

The arbitrator viewed the surveillance videos and made the following observations.

November 19, 2018 video

At 8:38:39 AM, Petitioner is seen entering his vehicle and carrying a tray of coffee cups in his right hand and a bag in his left hand.

At 8:43:23 AM, Petitioner is seen carrying the coffee into his house.

At 9:24:13 AM, Petitioner is seen entering a red truck with J&A Landscaping on the door. He drives the truck around the corner and exits the vehicle and walks back into his house.

At 10:36:54 AM, Petitioner is seen standing in front of his house. The view of Petitioner is obstructed by a tree and other items.

At 10:37:45 AM, Petitioner is walking in front of his house and entering his house.

At 10:45:50 AM, Petitioner is seen standing in front of his house while other individuals move items on a trailer. Petitioner opens the red truck's door and appears to retrieve rope. Petitioner appears to be tying items down with a rope at 10:48:00 AM. To do this he bends slightly at the waist. At 10:50:00 AM, Petitioner lifts a white box out of the trailer with both hands and carries it into a building.

At 10:52:48 AM, Petitioner carries a large cardboard box from his house to the trailer with both hands. At 10:53:22 AM, Petitioner carries another similar box from his house to the trailer with both hands. At 10:54:13 AM, Petitioner carries another similar box from his house to the trailer with both hands. At 10:55:30 AM, Petitioner carries a small item from the house to the trailer. At 10:56:23 AM, Petitioner carries what looks like rope from his house to the trailer with his left hand.

At 11:03:19 AM, Petitioner carries a TV tray to the trailer.

At 11:41:44 AM, Petitioner is seen standing up on the red truck's running board looking into the truck with the door open. He then appears to retrieve a tarp and drop it near the trailer.

At 1:28:26 PM, Petitioner walks to the trailer and removes a paint roller and then drops it back in the trailer.

At 1:40:50 PM, Petitioner is seen looking through items in the trailer with another individual while standing straight up.

At 1:43:15 PM, Petitioner is carrying what appears to be a light fixture in his left hand below the waist.

At 1:48:52 PM, Petitioner is seen carrying white bags in both hands from his house to the truck.

At 1:52:39 PM, Petitioner is seen carrying a small box from the house to the truck with both hands and moving it to his right hand to place it into the truck.

At 1:59:01 PM, Petitioner is seen carrying three bottles of laundry detergent and a bag in his left arm and a bottle of fabric softener in his right hand. He places these items in the red truck while standing.

At 2:01:20 PM, Petitioner pulls an item out of the trailer with his right arm and moves it into a building.

At 2:05:36 PM, Petitioner carries a white bag in both hands and places it in the red truck by stepping onto the running board and bending at the waist. Other individuals are seen loading the truck and trailer.

November 20, 2018 video

At 7:38:39 AM, Petitioner is seen entering the red truck.

At 10:11:42 AM, Petitioner is seen walking near the truck at a storage facility. The Arbitrator notes that Petitioner is joined by other individuals who are unloading the truck. The Arbitrator further notes that the view is obstructed by trees, and grass. The view of Petitioner while standing is approximately from mid-torso and up.

At 10:18:46 AM, Petitioner is seen carrying what appear to be two couch cushions into a storage unit with both arms.

At 10:19:43 AM, Petitioner is seen bending slightly at the waist, and then is seen lifting a box with both arms and carrying it into the storage container.

At 10:21:43 AM, Petitioner is seen carrying a couch cushion into the storage container.

At 10:22:40 AM, Petitioner carries an unknown item into the storage unit.

At 10:25:40 AM, Petitioner appears to carry another item into the storage unit, but the view of the item is obstructed.

At 10:28:15 AM, Petitioner is viewed moving around the drivers' side of the red truck, but what he is doing is obstructed. At 10:28:43 AM, Petitioner appears to carry an item in his left arm into the storage unit.

At 10:33:55 AM, a mattress is removed from the trailer and carried into the storage unit. Petitioner is not participating in the carrying of the mattress.

At 10:34:32 AM, Petitioner is reaching overhead into the back of the truck with his right arm and pulling an unknown item out of the truck with both arms.

At 10:36:40 AM, an individual standing in the back of the truck hands a single dining room chair to Petitioner over the side of the truck. Petitioner accepts the chair and carries it into the storage unit with both arms. Petitioner accepts another unknown item in the same manner shortly thereafter.

At 10:39:56 AM, Petitioner tosses an unknown item into the back of the truck with his right arm. He then enters the truck's driver's seat.

At 2:26:13 PM, Petitioner is seen walking near the red truck.

Allison Levison testified for Respondent. Ms. Levison is a licensed investigator who took videos and photos of Petitioner on May 4, 2019. She testified that the video was inaccessible, but that the photographs presented by Respondent are an adequate representation of the video. She testified that she took video of Petitioner when he was in Rockford. She testified that he was carrying 1-2 bags of laundry to load a vehicle. She testified that two women left with the items and returned in 90 minutes. She testified that she knew it was laundry because it looked like laundry and she saw clothes. She testified that she believed the women had completed the laundry and returned in 90 minutes. Ms. Levison testified that she did not know how much the items that Petitioner lifted weighed.

The Arbitrator viewed the surveillance photos and made the following observations. Petitioner is seen lifting a white bag with his left arm and placing the bag into the back of his vehicle. He is seen closing the back hatch by reaching overhead with his left arm. Petitioner is seen bending slightly at the waist to pet a dog. He does not appear to lift the dog. Petitioner is seen taking a white bag from another individual with two hands and carrying it away.

Additional testimony from Petitioner

Petitioner testified about the surveillance videos and photos. He testified that on November 19th and November 20th, he was moving from Aurora to Rockford because his house had just sold. He testified that the red truck in the video belonged to his brother who operates a landscaping company and was assisting in the moving of items. He testified that the other people seen in the videos were there to help him move and that they handled the heavier items. He testified that he never lifted anything weighing more than 20 pounds.

Petitioner testified that the small dogs in the videos weigh 8 pounds. He testified that the box identified as a tile box contained sponges. He testified that the large brown boxes he was lifting on November 19 contained plastic kitchen items like Tupperware. He testified that after moving the items into the storage unit, they were moved out and into his home approximately one month later by friends from Texas.

Petitioner testified that after his move to Rockford, he was planning on commuting to his job with Respondent in Schaumburg once he was released to work.

Petitioner testified that he was taken off work and placed on light duty at various times by his treating doctors. He testified that when he was placed on light duty, he attempted to return to

work each time. He testified that he was not always allowed to work within his restrictions as he was required to carry multiple heavy rods at a time. He testified that he worked light duty from July 23, 2018 through August 2, 2018 and from October 29, 2018 through November 7, 2018.

Petitioner testified that he has continued to treat with RNS Physical Therapy and was referred to Suburban Orthopaedics and is currently treating there. He testified that he has received injections, but that they did not provide much relief. He testified that he was given a therapeutic belt by Suburban Orthopaedics. He testified that he does not wear it all the time because sometimes it causes him discomfort.

Petitioner testified that since he stopped working for Respondent in November of 2018 and that he has not worked anywhere else. He testified that he has not traveled to Mexico since this accident but before the accident he would take a yearly trip to Mexico. He testified that he has difficulty standing or sitting for long periods of time and squatting down. He testified that he can reach overhead with his right arm, but not his left. He testified that he still drives, but it causes him discomfort. He testified that he has driven for 2-3 hours at a time. He testified that he continues to lift simple things around the house, but nothing more than 10 pounds. He testified that he continues to struggle with daily activities.

Petitioner testified that he has not applied for unemployment benefits and that he is supporting himself through his wife and daughter. He testified that he did not tell his boss, Nick, that he was feeling fine. He testified that Nick may visit a jobsite once every week or two and would stay for 10-20 minutes.

The Arbitrator found the testimony of the Petitioner and Mr. Luisi to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

In support of the Arbitrator's decision 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 as follows:

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his injury "arose out of" and "in the course of" his employment. 820 *ILCS* 305/1(d) (West 2014). Both elements must be present to justify

compensation. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill.App.3d 102, 105, 853 N.E.2d. 799, 803 (2006).

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

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that his injury arose out of and in the course of his employment with Respondent. Petitioner testified that he was working when he attempted to lift a 600 boulder with several co-workers when he experienced pain in his neck and lower back. Petitioner reported the same history to the various medical providers. Respondent did not proffer testimony which conflicted with Petitioner's testimony.

In support of the Arbitrator's decision relating to issues "D" the date of accident, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that he was injured at work on July 9, 2018. Petitioner testified that he was injured on July 9, 2018 while lifting a 600 boulder with 3 co-workers. Petitioner testified that when he was hurt, he was working on a project was located in Wayne and Mr. Luisi testified that Petitioner was working on a on a project in Wayne setting blue stones on July 9, 2018. The initial medical record from Dr. Rivera, dated July 17, 2017, indicates that Petitioner was injured on July 9, 2018 while carrying an extremely heavy stone with his co-workers. The Arbitrator notes that the history provided to Dr. Wehner identifies a different date of accident but Dr. Wehner testified that she did not use an interpreter and part of the history was provided by Petitioner's wife who accompanied Petitioner. The Arbitrator finds that Petitioner's testimony and the initial medical records support that the accident of July 9, 2018.

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 finds as follows:

Accidental injuries need not be the sole cause of the Petitioner's current condition of ill-being as long as the accidental injuries are a causative factor resulting in the current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003).

The Arbitrator finds that Petitioner proved by the preponderance of the evidence that his current lumbar and cervical condition are causally related to his injury of July 9, 2018.

Petitioner testified that he injured is neck and low back when he was lifting a 600-pound stone while working for Respondent. The testimony by Petitioner and Mr. Luisi show that Petitioner was able to work and lift heavy objects prior to his work accident of July 9, 2018. Mr. Luisi testified that Petitioner never complained of or missed work for injuries prior to July 9, 2018 and that Petitioner performed heavy and labor-intensive. Respondent proffered no evidence that Petitioner experienced prior low back or neck symptoms or received any medical treatment for neck or back conditions.

The Arbitrator finds the medical records and opinions of Drs. Novoseletsky and Pelinkovic to be persuasive. The Arbitrator accepts Dr. Pelinkovic's opinion that lifting heavy objects placed stress on the cervical and lumbar spine and could have caused disc disruptions as evident in Petitioner's MRIs. The Arbitrator further notes that Dr. Rivera, Dr. Novoseletsky, and Dr. Lorenz all opined that Petitioner's condition of ill-being is causally related to the work accident.

The Arbitrator does not find the opinions of Dr. Wehner to be persuasive. The Arbitrator notes that Dr. Wehner did not review the medical records of Suburban Orthopedics which included the records of Dr. Novoseletsky. The Arbitrator further notes that Dr. Wehner's opinions were based, in part, upon her finding that Petitioner had no radicular symptoms and the straight leg test was negative. Dr. Wehner testified that Petitioner expressed pain during the straight leg test, but she determined the test was negative because Petitioner's pain was non-specific and did not follow a radicular pattern. The Arbitrator notes that Dr. Wehner did not cite to any medical authority supporting her interpretation of the test result. The Arbitrator notes that both Drs. Novoseletsky and Pelinkovic found the straight leg test to be positive and Dr. Lorenz diagnosed Petitioner with an L4-5 annular tear and left sided disc herniation with radiculopathy secondary to a work-related injury with cervicalgia and left upper extremity radiculopathy. The

Arbitrator notes that Dr. Wehner did not review the medical records from Suburban Orthopedics and she was not aware of that several other physicians found a positive straight leg test. The Arbitrator further notes that Dr. Wehner did not know that Petitioner experienced significant pain relief and that his radicular symptoms temporally resolved after the injections. Dr. Pelinkovic testified that Petitioner underwent steroid injections and medial branch block injections reporting a 65% pain improvement and the radicular symptoms resolved which, he said, supports his diagnosis. Dr. Pelinkovic testified that if the injections helped, even for a short period of time, confirms that the pain generator was the left L5 dermatomal. (PX3). Dr. Wehner opined that Petitioner was not experiencing any radicular symptoms but she did not have the medical records showing the results from the steroid injections and medial branch block injections when she rendered her opinion. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-515 (Frist Dist. 2000).

As to the issue of non-specific pain that does not follow a radicular pattern, Dr. Pelinkovic stated, in his report, that disc herniations and disruptions may cause pain through receptors in the posterior longitudinal ligament of the spine and through chemical irritation by the epidural space being exposed to the collagen 2 from herniations. Dr. Pelinkovic further indicated it was well known that in addition to cord impingement, nerve root irritation, irritation of the sinuvertebral nerve and stretch on the posterior longitudinal ligament could cause axial back pain and that not all of the pain is produced in dermatomal in the distribution of the spinal nerve but there is also myotomal pain distribution from musculoskeletal pain generators. (PX3, exhibit 2).

The Arbitrator further notes that taken as a whole, Petitioner's complaints began immediately following his work accident. He had no prior back or neck complaints. All of Petitioner's treating medical providers opined that his injuries were caused by his work accident. As such, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident in July 9, 2018.

In support of the Arbitrator's decision relating to "G," what were Petitioner's earnings, the Arbitrator finds as follows:

Evidence presented at trial indicates that Petitioner worked an average of 50 to 60 hours per week. Both Petitioner and Mr. Luisi testified that Petitioner was only required to work 8 hours per day 5 days per week. Despite Petitioner working significant overtime, the testimony showed that overtime was not required and, thus, not includable into the average weekly wage calculation.

Respondent offered an unsigned wage statement that purports to list the hours that Petitioner worked in the year preceding the injury (RX1). The Arbitrator notes the wage statement shows that Petitioner's hourly rate was $23.00 for 15 of the 33[1] weeks worked and $21.00 per hour for 18 of the 33 weeks worked as listed on the wage statement. As such Petitioner's average weekly wage is $876.36. [i.e. ($23.00 per hour x 40 hours = $920.00 x 15 weeks = $13,800.00), ($21.00 per hour x 40 hours = $840.00 x 18 weeks = $15,120.00). $13,800.00 + $15,150.00 = $28,920.00 divided by 33 weeks = $876.36].

In support of the Arbitrator's decision related to issue "J" were the medical services 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:

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

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that the medical treatment Petitioner received was reasonable and necessary to diagnose, relieve or cure the effects of his injury. As such the Respondent shall pay the following medical expenses, pursuant to fee schedule and subject to Sections 8(a) and 8.2 of the Act:

Petitioner's reasonable medical expenses (pre-fee schedule) are as follows:

1)	RNS Physical Therapy (PX1)	$23,050.00
2)	Suburban Orthopaedics (PX8)	$14,712.49
3)	Ashton Surgery Center (PX5)	$76,544.00

[1] The wage statement shows 33 weeks worked not 34 because the week of 4/1 appears twice showing an adjustment in pay for a pay raise Petitioner received.

4) ADCO (PX6)	$845.88
5) Persistent Rx (PX7)	$5,628.86

The Arbitrator also finds that Respondent is entitled to a credit for all amounts previously pain totaling $13,472.30.

In support of the Arbitrator's decision related to issue "K" is Petitioner entitled to prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner has failed to prove by the preponderance of the evidence that he is entitled to a lumbar microdiscectomy at this time. Dr. Pelinkovic testified that he has not seen Petitioner since October 15, 2018. Dr. Pelinkovic testified that a microdiscectomy would be a good treatment option assuming Petitioner still has the same left leg symptoms which correlate to MRI findings and Petitioner's condition had not improved. (PX3, p. 23).

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that Petitioner is entitled to return to treatment with Dr. Pelinkovic for an additional examination, lumbar MRI and determination of a course of treatment, if any. As such, the Respondent shall approve and pay for Petitioner to return to treatment with Dr. Pelinkovic and obtain a lumbar MRI such that Dr. Pelinkovic could determine whether he recommends surgery and, if so, the type of surgery recommended. The Arbitrator further finds that Petitioner is also entitled to receive the C7-T1 cervical injections recommended by Dr. Novoseletsky. (PX2). Based upon the medical evidence, Petitioner requires additional medical care and his condition has not stabilized. As such, the Arbitrator finds that Petitioner is entitled to prospective medical care as outlined above and as recommended by his treating physicians, Dr. Novoseletsky and Dr. Pelinkovic.

In support of the Arbitrator's decision related to issue "L" whether Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, *i.e.*, until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, *i.e.*, reached MM.I. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at 28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial*

Comm'n, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *Gallentine*, 201 Ill. App. 3d at 887; *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The Arbitrator's findings and conclusions relating to the issues of accident and causal connection are incorporated herein. As stated above, the Arbitrator found that Petitioner's condition as not stabilized.

Petitioner claims to be entitled to temporary total disability benefits from July 17, 2018 through July 22, 2018 and from August 3, 2018 through October 28, 2018 and from November 8, 2018 through October 22, 2019, the date of trial.

Petitioner was taken off work from July 17, 2018 – July 23, 2018 by Dr. Rivera. (PX1 p. 110). On July 27, 2018, Dr. Rivera issued light duty work restrictions of no lifting over 20-25 pounds, not pushing or pulling over 25-30 pounds, no repetitive movements such as bending, twisting, or squatting (PX1 p. 133-134). On August 3, 2018, Petitioner returned to Dr. Rivera who noted that Petitioner's pain from work had become more severe and he took Petitioner off work at that time (PX1 p. 142-143). Dr. Rivera referred Petitioner to an orthopedic specialist (PX1 p. 143). From August 3, 2018 through October 22, 2019, Petitioner has been taken off work by his treating physicians. Petitioner testified that he worked light duty for Respondent from July 23, 2018 through August 2, 2018. Petitioner testified that he remained of off work until he attempted to return to light duty following Dr. Wehner's restrictions of October 29, 2018. Petitioner testified that he stopped working and has not worked since November 8, 2018.

The Arbitrator notes that Respondent presented evidence that light duty work was always available for Petitioner. After August 3, 2018, Dr. Wehner is the only physician who issued light duty restrictions. Dr. Wehner later indicated that Petitioner could return to work full duty without restrictions. Throughout treatment, except as otherwise noted above, Petitioner's treating physicians kept him off work.

The Arbitrator reviewed the surveillance video and photographs and notes that Petitioner is not seen doing any heavy-type work that he would be required to do with Respondent. The most damning piece of footage is Petitioner lifting a large box into the back of a truck. The only evidence presented as to what was in the box came from Petitioner who testified the box contained plastic kitchen items that weighed very little. Petitioner testified that he needed to

move his home and is seen moving items to a storage unit in Rockford. It is noteworthy that Petitioner has assistance from other individuals and that Petitioner is not seen lifting any heavy items. As such the Arbitrator finds that Petitioner was temporarily totally disabled from July 17, 2018 through July 22, 2018 and from August 3, 2018 through October 28, 2018 and from November 8, 2018 through October 22, 2019, a total period of 63 1/7 weeks.

In support of the Arbitrator's decision related to issue "O" the admissibility of a document entitled "Rebuttal to Independent Medical Evaluation" authored by Dr. Novoseletsky, the Arbitrator finds as follows:

Petitioner sought to admit a report entitled "Rebuttal to Independent Medical Evaluation" authored by Dr. Novoseletsky on September 16, 2019. The report was included in Petitioner's medical records, which were secured by a subpoena and contained a certification that the record are true and complete reproductions of the original records and kept in the regular course of business. (PX 2, p. 2, 3). Respondent did not object to the sufficiently of the certification or assert that the report was not produced pursuant to a properly executed subpoena. Respondent asserts a hearsay objected to the report claiming the report was created in anticipation of litigation.

The Arbitrator notes that the report was not addressed to Petitioner's attorney and no request for the report was contained in the subpoenaed medical records. The report was addressed to "To whom it may concern" and the report, in addition to disagreeing with the conclusion of the IME, recommends C7-T1 cervical epidural steroid injection via an interlaminar approach. The report asserts that the interlaminar approach is the safest and easiest level to access the epidural space. (PX 2, p. 17-18). The Arbitrator notes that no evidence was proffered showing that Petitioner or his attorney requested the report. Despite the title of the report, the report appears to be an attempt to secure approval for proposed medical treatment.

Section 16 states that the records of treating physicians shall be admissible without any further proof so long as they are certified. The exception to Section 16 is reports prepared by treating providers for use in litigation. Dr. Novoseletsky is a treating physician and the report dated September 16, 2019 was contained in his treatment records. The Arbitrator finds that there was no evidence proffered indicating that the report was prepared in anticipation of litigation such as a request made by Petitioner's attorney or any other indicia the report was prepared in anticipation of litigation.

Treating records will likely contain medical opinions relating to a variety of aspects of the patient's care and treatment. *RG Constr. Servs. V. Ill. Workers' Comp. Comm'n,* 24 N.E.3d 923, 934, 388 Ill. Dec. 643, 654 (1st Dist. 2014). Offering no basis to support a claim that a report was created for use in litigation can render that argument waived. *Id.* Respondent offered no evidence to support the claim that this report was created in anticipation of litigation. The Arbitrator notes that Dr. Novoseletsky's report was recommending treatment for the cervical spine which was not approved. Dr. Novoseletsky could have generated the report attempting to secure authorization for the treatment. For the above reasons, the Arbitrator finds that the report entitled "Rebuttal to Independent Medical Evaluation Report" contained in Petitioner's Exhibit 2 is admissible under Section 16.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC032789
Case Name	BLACK, TANYA v. CITY OF CHICAGO DEPT OF STREETS & SANITATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0469
Number of Pages of Decision	23
Decision Issued By	Kathryn Doerries, Commisioner

Petitioner Attorney	Arnold Rubin
Respondent Attorney	Gerald F. Cooper, Jr.

DATE FILED: 9/17/2021

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TANYA BLACK,

Petitioner,

vs. NO: 09 WC 032789

CITY OF CHICAGO DEPARTMENT OF
STREETS AND SANITATION,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS*

305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 17, 2021

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

KAD/bsd
007/27/21
42

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BLACK, TANYA
Employee/Petitioner

Case# **09WC032789**

CITY OF CHICAGO DEPT OF STREETS & SANITATION
Employer/Respondent

On 8/22/2019, 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 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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1401 SCOPELITIS GARVIN LIGHT ET AL
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CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tanya Black
Employee/Petitioner

v.

City of Chicago Dept. of Streets & Sanitation
Employer/Respondent

Case # **09 WC 32789**

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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 15, 2019**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/25/2009, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned $**60,486.40** ; the average weekly wage was **$1,163.20**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **3** 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 $**360,925.92** for TTD/maintenance, $**-0-** for TPD and $**24,305.64** for other benefits (PPD advance), for a total credit of $**385,231.56**.

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

ORDER

- Respondent shall pay Petitioner temporary total disability/maintenance benefits in the amount of $775.47/week for 537-4/7 weeks, for the period of **3/26/2009 through 7/14/2019**, which is the period for which temporary total disability/maintenances benefits are due.

- Respondent shall pay Petitioner the sum of $660.27/week for the further period commencing 7/15/2019 for the duration of the disability as provided in Section 8(d)1 of the Act because the injuries sustained by Petitioner caused her inability to pursue her usual and customary line of employment and resulted in an impairment of earnings.

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

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

Molly C Mason

Signature of Arbitrator

Date 8/22/19

Arbitrator Decision Paragraphs

AUG 22 2019

Tanya Black v. City of Chicago
09 WC 32789

Summary of Disputed Issues

The parties agree that Petitioner injured her low back while working as a sanitation laborer for Respondent on March 25, 2009. Petitioner initially saw Dr. Diadula at MercyWorks, Respondent's occupational medicine clinic. Petitioner later saw Drs. Wehner and Phillips, at the direction of Dr. Diadula. She underwent a lumbar fusion on October 28, 2009, following a course of conservative care. She continued seeing Dr. Phillips, her surgeon, and Dr. Diadula thereafter, with both physicians noting persistent symptoms. On September 29, 2010, Dr. Diadula imposed restrictions of no lifting more than 40 pounds, no continuous standing, no sitting more than 20 minutes and no prolonged walking more than 10 minutes. He also indicated Petitioner "should be allowed to vary positions."

On October 14, 2010, Dr. Phillips noted Petitioner had developed severe symptoms after attempting to resume a job that involved extensive walking. He made the decision to defer to the significant restrictions imposed by Dr. Diadula. PX 3, p. 10. On December 1, 2011, Dr. Diadula continued these restrictions and added restrictions of no driving more than 20 minutes and no machine operation. PX 8, p. 3. Respondent does not dispute the need for these restrictions. Petitioner testified to making a second attempt to resume working In August 2013. She tried to return to work in Respondent's rodent control department. She testified this job involved walking in alleys for periods exceeding her restrictions. After two days, she reported symptoms to her supervisor and returned to MercyWorks, where she was placed on duty disability.

Petitioner began a very lengthy, self-directed job search in late October 2010. PX 16.

At the request of her attorney, Petitioner met with Steven Blumenthal, a certified vocational rehabilitation counselor, in June 2015. Blumenthal conducted vocational testing a few months later. He recommended computer office training and suggested Petitioner undergo this training at Triton Community College. On her own, Petitioner took some classes at Olive Harvey in the fall of 2017. She testified she attempted to enroll at Triton but never received authorization to attend classes there.

Respondent offered the opinions of Gary Wilhelm, a certified vocational counselor affiliated with Independent Rehab Services, Inc. Wilhelm never met with Petitioner. He issued two reports, in December 2018 and January 2019. He agreed with Blumenthal's recommendation of computer office training but targeted a different vendor that offered such training online. Petitioner never underwent the recommended training. Respondent also offered a report and labor market survey prepared by Lisa Helma, a third certified vocational counselor.

At the hearing, Respondent stipulated to two periods of temporary total disability in exchange for Petitioner withdrawing a penalties petition.

The sole disputed issue is nature and extent. Arb Exh 1. Petitioner seeks a wage differential award while Respondent argues that permanency should be awarded under Section 8(d)2.

Arbitrator's Findings of Fact

Petitioner testified she is currently 47 years old. She is a high school graduate. In 1995, she took some courses at a business college for eight months but did not obtain a certificate. Before being hired by Respondent, she worked for Segun Services, a non-profit organization, addressing the needs of disabled adults. Her duties included lifting and transferring patients, administering medication and taking patients on outings. She did not need to have a certificate to work at Segun Services.

Petitioner testified she began working for Respondent about six years before her accident of March 25, 2009. She worked as a sanitation laborer in Respondent's Department of Streets and Sanitation. She worked behind a garbage truck in the 11th Ward, pulling cans of garbage to a truck. She testified each can was about 4 feet high. A can could weigh between 10 and 100 pounds, depending on the contents. Some cans had dirt or construction debris on the bottom and bags of garbage on the top.

Petitioner testified she worked 8 hours a day from Monday through Friday. She was a member of a union and was paid by the hour, at union scale.

Petitioner denied injuring her low back or undergoing any low back treatment prior to the accident. Immediately before the accident, she grabbed a cart, tilted it onto its two wheels and turned it about 45 degrees so that she could pull it toward the truck. As she turned it, she felt a sharp pain in her lower back. This pain traveled down the back of her legs into both feet. She later had an opportunity to view the contents of the can. There were rocks and cement at the bottom and garbage on the top. She estimated that the cart weighed over 100 pounds.

Petitioner testified she initially underwent care at MercyWorks. Her supervisor sent her to his facility.

Records in PX 1 reflect that Petitioner saw Dr. Diadula at MercyWorks on March 25, 2009. In his note of that date, the doctor recorded a consistent history of the accident. He described Petitioner as pulling her lower back when turning a cart toward a garbage truck. He noted that Petitioner complained of 8/10 low back pain radiating to both thighs. He indicated that Petitioner denied any past similar conditions.

On initial examination, Dr. Diadula noted forward flexion to 2 degrees, extension to 10 degrees, difficulty with heel walking and pain at 90 degrees with bilateral seated straight leg raising. He noted that Petitioner declined to allow straight leg raising while lying down. He obtained X-rays and diagnosed a lumbar strain. He prescribed Ibuprofen, Amrix, ice applications followed by heat and home exercises. He took Petitioner off work. PX 1, pp. 1-2.

Petitioner returned to MercyWorks on March 30, 2009 and again saw Dr. Diadula. The doctor noted ongoing 8/10 low back pain radiating to both thighs, along with a new complaint of a "little bit of tingling in the toes." He continued the medication and home exercises. He directed Petitioner to remain off work. PX 1, p. 2.

Petitioner underwent an initial evaluation at Chatham Physical Therapy on April 1, 2009. PX 7, pp. 1-3. After several sessions, she returned to Dr. Diadula on April 13, 2009. Her complaints were unchanged. The doctor again noted difficulty with heel walking and lying flat. He added Vicodin to the medication. He prescribed a lumbar spine MRI and continued therapy. He continued to keep Petitioner off work. PX 1, p. 3.

The lumbar spine MRI, performed without contrast on April 17, 2009, showed a subligamentous disc herniation at L5-S1, with no evidence of nerve root compression, and facet arthrosis. PX 6.

On April 23, 2009, Dr. Diadula reviewed the MRI and noted persistent complaints, including a complaint of numbness in the toes of the left foot. He referred Petitioner to Dr. Wehner and directed her to remain off work. PX 1, p. 3.

Petitioner first saw Dr. Wehner, a spine surgeon, on April 29, 2009. The doctor recorded a consistent history of the work accident and subsequent care. She indicated that Petitioner complained of low back pain radiating down the back of both thighs and both calves. She noted that Petitioner denied any pre-accident back problems.

Dr. Wehner described Petitioner's gait pattern as normal. She indicated Petitioner was able to walk on her heels and toes but could only bend to the mid-tibia level with her fingertips. On examination, she noted negative straight leg raising, no pain with hip range of motion and 5/5 strength. She reviewed the MRI report. She diagnosed "low back pain/strain based on the mechanism of injury." She recommended that Petitioner wean herself off the Vicodin and progress to work conditioning for the next two weeks. PX 2, pp. 1-2.

Petitioner also saw Dr. Diadula on April 29, 2009, with the doctor noting Dr. Wehner's recommendation of two weeks of work conditioning. He described Petitioner's gait as normal but noted some discomfort with toe and heel walking. He directed Petitioner to remain off work. PX 1, p. 4.

Petitioner underwent several work conditioning sessions at Michigan Occupational Therapy thereafter. Her therapist described her as reporting high pain levels but making gains. PX 7.

On May 13, 2009, Petitioner returned to Dr. Diadula. Petitioner complained of 8/10 low back pain radiating to both feet with associated numbness and tingling. Petitioner also reported difficulty walking and bending over along with occasional buckling of her legs. On re-examination, the doctor noted bilateral straight leg raising to 2 degrees. He recommended that Petitioner remain off work, continue therapy and return to Dr. Wehner. PX 1, p. 4.

On May 22, 2009, Petitioner saw both Dr. Wehner and Dr. Diadula, with Dr. Wehner recommending she remain off work and continue work conditioning for another two to three weeks. PX 1, p. 5. PX 2, p. 3.

On June 5, 2009, Petitioner again saw both physicians. Dr. Wehner noted that Petitioner was performing home exercises and that no additional work conditioning had been authorized. She released Petitioner to light duty with no lifting over 25 pounds. PX 3, p. 8. Dr. Diadula noted that Dr. Wehner had recommended additional work conditioning but that Dr. Sebby of Coventry was unable to authorize this. Dr. Diadula also noted that Petitioner was requesting a second opinion. He released Petitioner to light duty, with no lifting over 25 pounds, and directed her to return to MercyWorks on June 19, 2009, "or after Dr. Phillips." PX 1, p. 6.

Petitioner first saw Dr. Phillips, a spine surgeon, on June 16, 2009. Dr. Phillips wrote to Dr. Diadula the same day, outlining his examination findings and recommendations. He described Petitioner as having a normal gait and being able to walk on her heels and toes. He indicated that Petitioner displayed no Waddell's signs. He described straight leg raise as negative bilaterally. He

interpreted the MRI as showing some disc desiccation and a tiny central non-compressive bulge at L5-S1. Given Petitioner's radicular complaints and failure to respond to therapy, he recommended one or two epidural steroid injections along with four weeks of therapy/work conditioning. He found Petitioner capable of modified duty. PX 3, p. 1.

Petitioner underwent another physical therapy evaluation on June 26, 2009. The therapist noted that Petitioner remained symptomatic despite previous therapy and work conditioning. She indicated that Petitioner complained of 7-10/10 pain and numbness "over both feet." PX 7, p. 13.

Dr. Cupic administered the first transforaminal epidural steroid injection, at L5-S1 on the right, on July 15, 2009. PX 5, pp. 1-2.

Dr. Cupic administered a second injection, again at L5-S1 on the right, on August 20, 2009. PX 5, pp. 3-4.

Petitioner testified that the injections provided no relief.

Petitioner returned to Dr. Phillips on September 8, 2009. She reported no lasting relief from the injections. She complained of disabling low back pain and radicular symptoms into her right leg. On re-examination, the doctor noted positive straight leg raising at 60 degrees. He re-reviewed the MRI and recommended an L5-S1 decompression with a fusion. PX 3, p. 2.

Dr. Phillips operated on October 28, 2009, performing a lumbar fusion at L5-S1. PX 4.

On November 17, 2009, Petitioner returned to Dr. Phillips and reported some back and thigh discomfort. On re-examination, the doctor described straight leg raising as negative bilaterally. He obtained X-rays which showed good positioning of the surgical hardware. He recommended that Petitioner return to him in two months. PX 3, p. 6.

Petitioner also saw Dr. Diadula on November 17, 2009. The doctor described the surgical incision as healing. He noted that Petitioner was using a cane and remained off work per Dr. Phillips. PX 1, p. 9.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Butler on November 19, 2009. In his report of the same date, Dr. Butler recorded a consistent history of the work accident and subsequent care. He described Petitioner as having made good progress since the October 28, 2009 fusion. He noted that Petitioner was still experiencing some back spasming and leg weakness. He indicated Petitioner was continuing to take Norco and Flexeril

Dr. Butler interpreted the MRI as showing disc dehydration at L5-S1 "aggravated by a work-related lifting injury." On examination, he noted some mild local swelling, normal strength and reflexes and negative straight leg raising.

Dr. Butler found a causal relationship between the work accident and Petitioner's condition, noting that Petitioner denied having any back pain or injury before the accident. He viewed the injections as "somewhat questionable" but otherwise described Petitioner's treatment to date as reasonable and necessary. He noted that Petitioner would need to start physical therapy about six weeks out from the fusion. He found Petitioner capable of normal daily activities but recommended she

stay off work. He anticipated she would reach maximum medical improvement within about seven months of the fusion. He described Petitioner's subjective complaints as "supported by objective medical evidence." RX 17.

On January 12, 2010, Petitioner saw both Dr. Phillips and Dr. Diadula. Dr. Phillips described Petitioner as "doing reasonably well." He prescribed therapy. PX 3, p. 7. Dr. Diadula noted that Petitioner was scheduled to begin physical therapy on February 12, 2010, per Dr. Phillips. He also noted that Petitioner remained off work. PX 1, p. 10.

Petitioner began another course of care at Chatham Physical Therapy on February 17, 2010. PX 1, p. 10.

On April 13, 2010, Dr. Phillips noted that Petitioner had completed two months of therapy but was still experiencing low back achiness as well as bilateral buttock and thigh discomfort. He obtained new X-rays. On review of the films, he indicated it was difficult to tell whether the fusion was healing. He switched Petitioner from Vicodin to Ultram and Ibuprofen. He recommended that Petitioner start work conditioning in six weeks. PX 3, p. 8.

Petitioner returned to Dr. Phillips on July 13, 2010. She reported a flare-up during work conditioning. The doctor obtained new X-rays. He interpreted the films as showing good bridging bone across the disc space. He placed work conditioning on hold due to the recent setback. He directed Petitioner to take it easy for a month or so "to let the acute flare-up calm down." He prescribed Flexeril and indicated Petitioner would be able to resume restricted duty after the rest period. PX 3, p. 9.

On August 5, 2010, Dr. Diadula noted Dr. Phillips' most recent recommendations. He directed Petitioner to remain off work. PX 1, p. 14.

On August 25, 2010, Petitioner returned to Dr. Diadula and complained of 8/10 low back pain radiating to both legs, with associated numbness in her feet. The doctor noted that Dr. Phillips had imposed a 40-pound lifting restriction. He directed Petitioner to return on September 29, 2010. PX 1, p. 14.

Petitioner saw Dr. Diadula again on September 29, 2010. The doctor noted that "continuous standing, sitting and walking aggravates the low back pain, which is now 8/10." He also noted that the numbness in the legs and feet had returned. He recommended that Petitioner follow up with Dr. Phillips. After examining Petitioner, he imposed the following restrictions:

> "No lifting more than 40 lbs., no continuous standing, sitting more than 20 minutes, should be allowed to vary positions. No prolonged walking more than 10 minutes."

Dr. Diadula directed Petitioner to continue taking Meloxicam, Cyclobenzaprine and Lyrica. He advised Petitioner to return to MercyWorks after seeing Dr. Phillips or on October 20, 2010, "whichever comes first." PX 1, p. 14. PX 8, p. 1.

Petitioner last saw Dr. Phillips on October 14, 2010. The doctor wrote to Dr. Diadula the same day. He noted that while Petitioner "initially did reasonably," she "now has more and more symptoms."

He did not suspect a pseudoarthrosis because Petitioner primarily complained of bilateral buttock pain, worse on the right. He also noted a complaint of numbness in both feet with prolonged sitting.

On examination, Dr. Phillips noted a good lumbar range of motion. He described repeat X-rays as confirming the L5-S1 fusion construct and showing good positioning of the pedicle screws and interbody device.

Dr. Phillips indicated that Petitioner had probably reached maximum medical improvement. He noted that she had attempted to return to a job that involved extensive walking and had developed severe back pain within a few days. He indicated that, given the fusion, it was "not unexpected that she will have some limitations." After noting that Petitioner felt she could function within the lifting- and walking-related restrictions placed by Dr. Diadula, he indicated he would "go ahead with" those restrictions. He directed Petitioner to return to him annually unless she had problems. PX 3, p. 10.

On October 21, 2010, Dr. Diadula reviewed Dr. Phillips' note of October 14, 2010. He noted that Dr. Phillips was deferring to the restrictions he had previously placed on Petitioner. He continued those restrictions and found Petitioner to be at maximum medical improvement. PX 1, p. 15.

Petitioner testified she began a self-directed job search in late October 2010. She identified PX 16 as a collection of the 2,000 plus contacts she made between late October 2010 and July 2019. The Arbitrator has reviewed the documents in PX 16. They include one reference to a job interview. [See page 1 of PX 16.] Petitioner indicated this interview took place on November 3, 2010 and involved a job as an insurance sales agent. The information Petitioner recorded appears to correlate with the "100% commission based" insurance job interview referenced in Steve Blumenthal's initial report. See page 8 of this decision.

Petitioner acknowledged receiving a letter from Respondent dated August 18, 2011 concerning the availability of a watchman job paying $19.24 per hour. The author of the letter described this job as within Petitioner's restrictions, with no further elaboration. The author advised Petitioner her ability to secure this job was contingent on "the successful completion of a 'willing and able questionnaire'." PX 10. Petitioner testified that, after she received this letter, she reported to Respondent's personnel office on South State Street and completed a questionnaire concerning her restrictions. She testified Respondent never offered her a watchman position.

On August 26, 2011, Petitioner's counsel wrote to Respondent's counsel, enclosing the letter of August 18, 2011 and advising that Petitioner completed the requisite questionnaire on August 22nd. [The questionnaire is not in evidence. In the August 26, 2011 letter, Petitioner's counsel described it as calling for responses as to what activities Petitioner felt she was capable of performing. He questioned why Petitioner needed to complete the questionnaire when the original communication described the watchman job as within Petitioner's restrictions.] Petitioner's counsel indicated Petitioner was waiting to hear back from Respondent. He also enclosed Petitioner's job search log for the week of August 15, 2011. He asked Respondent to continue paying weekly benefits. PX 10.

Petitioner returned to Dr. Diadula on December 1, 2011 and October 29, 2012. On both occasions, the doctor noted a complaint of 8/10 low back pain radiating to the feet with associated numbness and tingling. He re-examined Petitioner, continued the previous restrictions and added the following restrictions: no driving more than 20 minutes and no operation of machinery. PX 8, p. 3.

At Respondent's request, Dr. Ross, a neurosurgeon, conducted a Section 12 examination of Petitioner on March 19, 2013. In his report of the same date, Dr. Ross recorded a history of the March 25, 2009 accident and subsequent care. He noted that Petitioner denied obtaining any relief from the lumbar fusion and complained of lower back pain extending into both buttocks and thighs along with numbness and tingling in both feet. He described Petitioner's surgical history as notable only for the fusion. He indicated he reviewed records from MercyWorks, Dr. Wehner and Dr. Phillips along with a CD of the April 17, 2009 MRI and Dr. Butler's report.

After examining Petitioner and reviewing the aforementioned records, Dr. Ross opined that the initial diagnosis of a lumbar strain was "likely correct." He disagreed with Dr. Butler's conclusion that the work accident aggravated an underlying degenerative condition at L5-S1. Although he noted symptom magnification and described several Waddell's tests as positive, he recommended additional care, including a cortisone injection to address right trochanteric bursitis, testing to confirm whether the fusion had healed properly and a repeat functional capacity evaluation, to be performed "after the bursitis has been addressed." He indicated that, if the repeat evaluation was valid, Petitioner would require permanent restrictions per the evaluation but that she could resume full duty if the evaluation was invalid. He went on to express belief that an earlier evaluation had been performed but noted he did not have access to the results. [The Arbitrator notes that no functional capacity evaluation is in evidence.]

With the exception of the fusion, Dr. Ross characterized the treatment to date as reasonable and necessary. He described the decision to proceed with the fusion as "controversial at best," noting that Petitioner did not undergo confirmatory testing to verify that the L5-S1 disc was symptomatic.

Dr. Ross found Petitioner's ongoing back symptoms to be causally related to the work accident. He noted there was "no intervening period of recovery", "no history of subsequent back injury or accident that would be considered contributing factors" and no indication that Petitioner was symptomatic before the accident. RX 14.

Petitioner acknowledged receiving a letter from Respondent dated June 21, 2013 directing her to take a "skills assessment test" to determine her qualification for a potential traffic enforcement technician job. Petitioner testified she took this test on July 10, 2013, at a Respondent facility located at 1869 Pershing. Via a letter dated July 26, 2013, Respondent notified her she had passed the test. The letter states, in relevant part: "please be advised that this . . . does not constitute an offer of employment." PX 11, p. 2. Petitioner testified Respondent never offered her a traffic enforcement technician job.

Petitioner testified Respondent contacted her again in August 2013 concerning a potential rodent control job. On August 19, 2013, she completed a number of employment-related forms, including background checks. PX 12. She testified she attempted to perform the rodent control job for two days, starting on August 19, 2013. The job required her to walk for several blocks over a 25- to 30-minute period, with no breaks. She testified this exceeded her walking-related restrictions. She experienced significant low back pain during the two days she tried to perform the job. After the second day, she talked to her supervisor about her restrictions and returned to MercyWorks.

On September 27, 2013, Dr. Diadula noted that Petitioner had lost 51 pounds since the previous visit but remained symptomatic. After re-examining Petitioner, he continued the previous restrictions. PX 1, p. 16.

Petitioner testified that Respondent suspended her temporary total disability benefits on May 2, 2014 but subsequently resumed paying her.

On July 15, 2014, Respondent's counsel sent Petitioner's counsel a copy of Dr. Ross's report. In his cover letter, Respondent's counsel indicated that Respondent "has a job they believe is within [Petitioner's] restrictions." This job is not further described. RX 14.

On September 8, 2014, Dr. Diadula noted that Petitioner complained of 8/10 low back pain radiating to her feet with associated numbness and tingling. He recommended that Petitioner take Ibuprofen. He found Petitioner to be at maximum medical improvement and continued the previous restrictions. PX 1, pp. 16, 32.

At the request of her attorney, Petitioner met with Steven Blumenthal, MS, CRC, a certified rehabilitation counselor, on June 4, 2015. In his report of June 25, 2015, Blumenthal described Petitioner as cooperative throughout the interview. He indicated he reviewed records from Drs. Phillips along with Dr. Ross's report, Petitioner's job search logs and correspondence between Respondent and Petitioner.

Blumenthal noted that Petitioner never underwent a functional capacity evaluation and that Dr. Diadula imposed restrictions of no lifting over 40 pounds, no standing, sitting or driving more than 20 minutes and no walking more than 10 minutes in approximately October 2010. He further noted that Petitioner was no longer seeing Dr. Phillips but was seeing Dr. Diadula once a year. He indicated that Petitioner was taking an anti-depressant related to the loss of her mother in November 2014.

Blumenthal noted that Petitioner reported constant, 7/10 pain in her low back radiating down both buttocks and legs to her feet. He indicated that Petitioner was attempting to deal with this pain by taking Ibuprofen and using a TENS unit twice a day. He noted that Petitioner was able to provide self-care but regularly obtained assistance with tasks such as cleaning and carrying groceries.

Blumenthal indicated that Petitioner had been looking for work since October 2014 but had attended only one job interview to date. He noted that this interview took place in 2011 and that it involved a job that was "100% commission based, selling insurance."

With respect to Petitioner's educational background, Blumenthal noted that Petitioner reported graduating from Englewood High School in 1991 and attending Taylor Business Institute "for nine months out of a 1.5 year program." He indicated that Petitioner denied any other formal education. He noted that Petitioner described herself as a "two handed typist looking at the keyboard," having taken a typing class in high school, but denied completing any software training. He indicated that Petitioner denied owning a computer.

With respect to Petitioner's post-accident interactions with Respondent, Blumenthal noted that Petitioner passed a mandatory test for a prospective traffic technician position "she was asked to apply for" but denied being informed of the duties associated with this job. Blumenthal also noted that Petitioner had attempted to perform a rodent control job for three days in 2013 but "could not physically handle the continuous walking." Finally, Blumenthal noted that Petitioner completed a questionnaire for a prospective watchman job but was never offered this job.

Blumenthal obtained a job history from Petitioner. He noted that she reported working as a casher or bagger at various establishments between 1989 and 1997, performing a commissary job at Cook County Jail between 1997 and 1998 and working with disabled adults at several social service agencies between 1998 and 2003.

Blumenthal noted that Petitioner had last received temporary total disability benefits from Respondent in early May 2014 and had not applied for SSDI benefits.

Based on the most recent MercyWorks work status note of September 8, 2014, and noting that Dr. Phillips allowed Petitioner to use restrictions imposed by Dr. Diadula, Blumenthal concluded that Petitioner "will require a work setting that is sedentary to light in nature with the performance of job tasks that will allow for alternating physical positioning and, if needed, the ability to sit." Blumenthal found Petitioner to be an "excellent candidate for vocational rehabilitation." He noted that Petitioner was no longer able to work as a laborer and would sustain a significant loss of wages if she returned to work as a cashier or developmental trainer, "assuming her physical abilities could be accommodated" in either of those jobs. He recommended that Petitioner complete achievement, aptitude and interest training, along with an evaluation of her ability to sit, using an ergonomic chair, and use a conventional versus standing desk. He also indicated Petitioner would benefit from job readiness training and job placement assistance. PX 15, pp. 1-11.

Petitioner returned to MercyWorks on July 17, 2015. The examining physician noted ongoing complaints of "everyday" 7/10 low back pain radiating down both legs to the feet. The physician also noted that Petitioner described her feet as "going numb" after sitting for ten minutes. The physician continued the previous restrictions. PX 1, pp. 33-34.

On August 13, 2015, Respondent's counsel wrote to Steven Blumenthal, indicating the communication "should serve as authorization to begin any further work you need on the rehabilitation plan." RX 11.

On August 14, 2015, Sharon Zajac, Vice President of Case Management at Vocamotive, wrote to Petitioner's counsel, noting a referral from Altina Ford-Hunter of Respondent and seeking permission to contact Petitioner and set up an interview with Lisa Helma. RX 10.

On August 24, 2015, a paralegal at Respondent's counsel's office wrote to Sharon Zajac of Vocamotive, clarifying that Altina Ford-Hunter of Respondent was authorizing an initial interview and labor market survey and that "any job search will be done by Steven Blumenthal." The paralegal informed Zajac that her report would be a "second opinion requested by" Respondent. RX 9.

On September 8, 2015, Petitioner underwent vocational testing at Steven Blumenthal's office. In his report of September 10, 2015, Blumenthal described Petitioner as cooperative throughout the testing. He found the results to be a valid representation of Petitioner's abilities. He noted that Petitioner sat in an ergonomic chair with lumbar support during the testing. He also noted that Petitioner reported she had purchased a car and had obtained a laptop computer from her sons.

With respect to the Gates-MacGinitie reading test, Blumenthal noted that Petitioner "demonstrated average reading vocabulary with below average reading comprehension in comparison to entering community college students." He described Petitioner as a "slow but literate reader who was unable to complete the reading comprehension section in the allotted time to obtain a higher

score." Overall, he found Petitioner's reading performance "consistent with a high school level education." As for the Wide Range Achievement Test [WRAT], he noted that Petitioner's spelling and math computational abilities were below average in comparison to her age peers and below her attained level of education. He indicated, however, that Petitioner's skills might have deteriorated since she had been out of school for a number of years and was not required to use those skills while working for Respondent. He found Petitioner's Beta IQ to be 84, indicating "low average nonverbal reasoning ability." With respect to the Career Ability Placement Survey [CAPS], he noted stanines of 2/9 (low) on mechanical reasoning, spatial relations and verbal reasoning, 3/9 on numerical ability and word knowledge, 4/9 on language usage, 5/9 on perceptual speed and accuracy and 8/9 on manual speed and dexterity. He indicated that Petitioner fell into the 21st percentile on the oral directions test, with this score denoting "below average auditory discrimination and problem solving ability." The results of interest inventory testing showed that Petitioner demonstrated highest interest for the occupational cluster of clerical with secondary interest in skilled science and much below average interest across all other occupational clusters. The results of the transferable skills analysis [TSA] showed that Petitioner "has the necessary aptitudes and physical ability to perform work related to" social service aide, cashier, clerk and receptionist duties. Blumenthal noted that, "for clerical/clerk job titles, [Petitioner] would need to acquire computer literacy skills to include keyboarding data entry and use of Microsoft Office Word, Excel and Outlook."

Blumenthal indicated he contacted Vocamotive in Hinsdale to obtain a proposal for an open entry/open exit clerical training program, to be completed in four months. He noted this would cost $2,145. He indicated Petitioner could initiate training at Vocamotive within several weeks of authorization by Respondent. PX 15, pp. 12-25.

On October 15, 2015, Petitioner met with Lisa Helma, CRC, a certified vocational counselor affiliated with Vocamotive. In her report of November 13, 2015, Helma described Petitioner as "fully cooperative with all aspects of the interviewing process." Helma recorded a history of the work accident, fusion and subsequent care. She indicated that Petitioner denied undergoing a functional capacity evaluation. She noted that Petitioner described herself as independent with respect to self-care but needing help with food preparation and driving less than she used to due to becoming uncomfortable after prolonged sitting. She also noted that Petitioner reported having difficulties sleeping and walking more than ½ to 1 block. She documented the permanent restrictions imposed by Dr. Diadula.

Helma indicated that Petitioner reported graduating from high school in 1991 and being an honor roll student while in high school. She noted that Petitioner also reported attending Taylor Business Institute in 1994 but failing to complete a 12-month program in computer repair. She noted that Petitioner owned a computer and reported being able to type so long as she could look at the keyboard. She indicated that Petitioner denied having any software skills but expressed interest in data entry, office or clerical occupations "as she enjoys working on the computer and working with people."

Helma described Petitioner, at age 43, as a "younger person" based on Social Security criteria. She went on to state that age is not generally considered to affect a "younger person's" ability to adjust to other work. She recommended that Petitioner undergo a typing test to determine her proficiency, adding that keyboard training might be beneficial, depending on the results of the test. Based on Petitioner's work history and the Dictionary of Occupational Titles, she found that Petitioner's job experience most closely resembled the following occupations: garbage collector, mental retardation aide, commissary agent, sales clerk and fast food worker.

Helma concluded that Petitioner "does have some transferable skills" but that she would need accommodations in many of the jobs available to her based on Dr. Diadula's restrictions with regard to sitting, standing, walking and machine operation. She indicated Petitioner would primarily qualify for sedentary jobs so that she could change position as needed. She stated that positions available to Petitioner included receptionist, administrative clerk, office clerk, data entry clerk and concierge. She opined that Petitioner's "most probable wage earning potential is between $9 and $13 hourly." She found Petitioner to be a viable candidate for rehabilitation services and recommended that such services be provided.

Attached to Helma's report is an undated labor market survey. In this survey, Helma identified a number of full-time and part-time receptionist and clerk job openings. With respect to some of these openings, Helma was unable to determine the wage being offered. One receptionist position required "sitting for extended periods." Another receptionist position required proficiency with Microsoft Word and Outlook. An administrative assistant position required proficiency with Microsoft Office Suite and internet and E-mail applications. A data entry clerk job required "minimum 6000 keystrokes per hour with a high degree of accuracy" and "excellent PC skills, including Microsoft Office." A concierge job required "experience in MS Office." RX 8, pp. 11-17.

On September 17, 2015, Petitioner's counsel wrote to Respondent's counsel, enclosing Petitioner's recent job logs and the results of the vocational testing. Petitioner's counsel requested authorization of the Vocamotive training program recommended by Steven Blumenthal. PX 1, p. 27.

On June 2, 2016, another physician at MercyWorks evaluated Petitioner and continued the previous restrictions. PX 1, pp. 35-36.

On April 27, 2017, Dr. Anderson of MercyWorks evaluated Petitioner and continued the previous restrictions. PX 1, pp. 37-38.

Petitioner testified she took classes in African-American studies and English at Olive Harvey in the fall of 2017. Respondent did not pay for these classes. She then registered at Triton Community College. She never attended classes there because the classes were not paid for.

Steven Blumenthal met with Petitioner on January 29, 2018 "to assess [her] progress." Blumenthal wrote to Petitioner's counsel on April 23, 2018, indicating that Petitioner reported having completed classes in African-American studies, business and English at Olive Harvey based on a representative of that college having told her these courses were required after completing the entrance examination. Blumenthal went on to state that, according to Petitioner, this representative indicated the college did not offer any office-based clerical training classes. Blumenthal noted that "the City of Chicago college system does not offer a formal clerical office skills certificate program," with that system's website stating that, as of the summer of 2016, "they were no longer accepting students into their Basic Certificate Program." Blumenthal again recommended that Petitioner complete formal, classroom-based computer office skills training. He identified a two-semester office assistant certificate program offered by Triton Community College, indicating this would cost $1,845, assuming Petitioner could obtain an in-district rate. He stated Petitioner would have to obtain a waiver from her local community college, stating they do not offer such training, in order for Petitioner to be admitted to Triton. PX 15, pp. 28-29.

Petitioner returned to MercyWorks on March 27, 2018 and February 21, 2019. On both occasions, Dr. Anderson continued the previous restrictions. PX 1, pp. 39-40.

On September 11, 2018, Maria Estrada, a Respondent claims examiner, sent Petitioner a letter identifying her as a workers' compensation recipient subject to temporary or permanent restrictions. Estrada indicated that the Committee on Finance had arranged for Petitioner to participate in an orientation at City Hall on September 26, 2018 to help her meet her job search/vocational rehabilitation requirements. Estrada indicated that Petitioner would meet with a human resources representative at this meeting who would help her create a profile for Respondent's online job screening system. Estrada noted that a "documented job search is a [Respondent] employment requirement and failure to comply may affect your entitlement to workers' compensation benefits." She directed Petitioner to bring a current resume, E-mail address, Illinois driver's license and copies of any certifications or licenses indicating a specialized skill or training. She warned that failure to attend the orientation could jeopardize Petitioner's continued receipt of benefits. PX 13.

Petitioner testified she attended the requisite meeting at City Hall thereafter. More than ten individuals were present. A representative of Respondent's Streets and Sanitation department attended this meeting and directed the attendees to continue looking for work and turning in their job search sheets on a weekly basis. The meeting lasted about two hours. Petitioner testified she brought her resume (PX 14) to the meeting but no one reviewed it or asked her to turn it in.

On November 5, 2018, Steven Blumenthal issued an addendum in which he addressed Petitioner's earning capacity. Noting that Petitioner lacks formal office-based clerical work experience, and assuming she successfully completed a computer office skills training program, she could earn "in the range of $12.00 to perhaps $13.00 an hour on an entry level basis." He indicated he based this on his review of the state's Department of Employment Security wage data for Petitioner's geographic area, the current minimum wage for the City of Chicago ($12/hour as of July 1, 2018) and his experience in placing entry level clerical workers back into the labor market post computer office skills training. PX 15, p. 30.

On December 14, 2018, Gary Wilhelm, MS, CRC, a certified vocational counselor affiliated with Independent Rehab Services, Inc., sent an initial vocational assessment report to Maria Estrada of Respondent. In his report, Wilhelm indicated he reviewed records from Dr. Phillips, Dr. Ross's report, Blumenthal's reports of June 25, 2015, September 10, 2015, April 23, 2018 and November 5, 2018, information concerning the current wage of Respondent sanitation laborers, Petitioner's resume and Petitioner's job search logs from October to November 2018. He noted that the job search logs revealed Petitioner was primarily applying for data entry clerk jobs. He indicated this "suggested [Petitioner] has acquired some level of keyboarding skills, either on her own or through other more formal training sources." He also indicated that, since Petitioner had recently acquired a laptop, she could "practice and acquire software skills in Microsoft office products, Outlook and other office-related software." After noting Blumenthal's recommendation of the Triton program, he indicated that Petitioner might not qualify for the in-district rate of $1,845, based on her address, and that she might have to pay the out-of-district rate of $4,800, along with the expenses associated with textbooks and commuting. Wilhelm suggested a "similar" 15-week program, "run through Donka," noting that this business was now offering a computer fundamentals course that provided one-on-one training "either in person or by internet instruction." He indicated the cost of this course would be $3,000 plus an $86 initial assessment fee and $200 for books.

After noting the results of the testing conducted by Blumenthal, Wilhelm identified a number of jobs Petitioner could perform, while simultaneously noting that Petitioner might need additional clerical/computer skills to perform some of these jobs. The entry level hourly wage associated with the targeted jobs ranged from $8.91 (store cashier) to $16.09 (residence counselor). Wilhelm indicated that these wages were likely to increase since the minimum wage in Chicago was scheduled to rise from $12 to $13 per hour as of July 1, 2019.

Wilhelm opined that Petitioner "is capable of returning to work with or without training as she could transfer her previous skills in counseling and social services to positions that would compensate more in the $12 to $15 per hour range."

On December 18, 2018, Steven Blumenthal issued another addendum in response to Wilhelm's report. Blumenthal indicated that Wilhelm appeared to agree with him that Petitioner would benefit from computer office skills training but was recommending a "Donka" program that could be completed in person or online. Blumenthal noted that he reviewed the computer fundamentals program on the "Donka" website after reading Wilhelm's report and that he did not see any computer keyboarding offered as a component of this program. He reiterated his previous recommendation of Triton's program. Based on the testing he conducted, he indicated Petitioner "would very clearly benefit from a training program where she is on-site with the instructor as opposed to any internet-based training program." He went on to state that participating in a program that does not have a focus on keyboarding, much less office business practices, "will not provide [Petitioner] with the level of training required to access employment in a stable labor market." PX 15, pp. 31-32.

On January 16, 2019, Wilhelm wrote to Respondent's counsel, responding to Blumenthal's report of December 18, 2018. Wilhelm again recommended that Petitioner undergo training via "Donka." He noted that he had referred other claimants to this provider in the past and that "Donka" provided one-on-one training, either in person or online, versus the traditional classroom setting offered at Triton. He also noted that Triton's program was longer and more costly and that the "Donka" program allowed for open admission. He responded to the concerns voiced by Blumenthal by stating that "Donka" did include keyboarding training in its program. Citing Petitioner's job search contacts from late 2018, which showed that 25 out of the 30 contacts related to data entry positions, Wilhelm concluded that Petitioner "has confidence already in her ability to be competitive when it comes to keyboarding." He recommended that Petitioner arrange for her initial assessment at "Donka," noting she could complete its program by June 2019 instead of having to wait until August 2019 to begin a more traditional one-year classroom program. RX 1.

Steven Blumenthal issued two other reports on April 16 and July 2, 2019. In the April 16th report, he noted that the minimum wage in Chicago would increase to $13.00 per hour as of July 1, 2019. He also noted that the "Donka" Microsoft Office Suite computer training program would cost $5,000 to $8,000 per student, based on information obtained from the "Donka" website. He opined that the "Donka" program would not provide the level of training or certificate that the Triton program would provide. He again recommended that Petitioner attend the Triton program. He also recommended that Petitioner concurrently take classes in Excel and Outlook offered by Daley College, with the cost of those two classes projected at less than $500. In his July 2nd report, Blumenthal revisited his previous opinion as to Petitioner's earning capacity. Based on the new minimum wage in effect in Chicago, he revised that opinion and indicated Petitioner could earn "$13.oo to perhaps $14.00 per hour," assuming she completed the training he previously recommended. PX 15, pp. 36-37.

Petitioner testified she received no additional guidance from Respondent after the September 11, 2018 meeting but was told she could go on Respondent's website to see whether she was qualified for any available Respondent positions. Petitioner testified she checked this website but was not qualified for the jobs she saw posted there. She received no job offers from Respondent between the meeting and July 2019. She continued looking for work and turning in the job search sheets during that time. She looked for jobs online, using Career Builders. She targeted entry level data entry positions.

Petitioner testified she stopped receiving weekly checks from Respondent on June 7, 2019.

Petitioner testified she would currently be earning $37.76 per hour if she were able to perform her union laborer job. [See PX 17, a May 28, 2019 letter from Victor Roa, Secretary-Treasurer of LiUNA Local 1001, confirming that the current rate of pay for sanitation laborers is $37.76 per hour based on 2080 hours per year.]

Petitioner denied sustaining any new low back injuries after the accident of March 25, 2009. She continues to experience constant, throbbing pain in the middle of her lower back. Her feet become numb when she sits. She does not have leg pain. She takes three Extra Strength Tylenol 500 pills every four hours, every day. She experiences constant pain when she stands or walks. She tries to stretch. She is able to use an elliptical machine for about ten minutes but gets stiff afterward.

Under cross-examination, Petitioner testified she graduated from Englewood High School, where she was on the honor roll. She received As and Bs in high school and was the editor of the school newspaper. She attended Taylor Business Institute and later took classes at Olive Harvey. She did not take any data entry classes at Olive Harvey. She has never served in the military. At the time of the accident, she did not have a home computer. Her son later bought a laptop for her. She could not recall when he made this purchase. She uses the laptop every day. Her Apple usage reports reflect she uses the computer a maximum of three hours per day. She met with Steven Blumenthal twice. He interviewed her and later conducted testing at his office. She also met with a woman whose name she cannot recall. She started her job search in late October 2010. She would agree the economy was bad at that time and it was difficult to find work. She identified her handwriting on RX 3, a job search sheet dated November 13, 2010. The companies listed on this sheet never contacted her. She applied for cashier and front desk agent jobs. She also identified her handwriting on RX 4, a job search sheet dated January 7, 2019. She applied for office clerk and several data entry jobs but received no response from the companies she contacted. Over the period she looked for work, most of the jobs she applied for were in data entry. She last met with Blumenthal last year.

On redirect, Petitioner testified she initially met with Blumenfeld in June 2015. She underwent testing at Blumenfeld's office. He then recommended she undergo retraining. She met with him again on January 29, 2018. She met with him to clarify what had happened at Olive Harvey in 2017. When she met with a counselor at Olive Harvey, she requested data entry classes. The counselor told her the three classes she ended up taking would "lead up to data entry." She disagreed but took the classes. After she took them, she realized Olive Harvey did not offer data entry classes. She then met with Blumenthal, who recommended she attend Triton. She also met with a woman whose name she cannot recall. She met with this woman once, at her attorney's office. She is not sure how old her home laptop is. She uses the laptop to practice typing. She practices by using a free instructional program. She applied for data entry jobs with the hope of undergoing "on the job" training. She would expect to earn $13 per hour. She is not an economist. She is motivated to return to work. She did not receive any job offers from the 2,000 contacts she made. She never met with Wilhelm. On the morning of the hearing,

she updated her job search records to bring them forward through July 12, 2019. She last applied for work on July 12, 2019. Careerbuilders is the source she uses when looking for work.

Under re-cross, Petitioner reiterated that the economy was bad when she started looking for work in 2010.

Arbitrator's Credibility Assessment

It is to Petitioner's credit that she attempted to return to work on two occasions. Dr. Phillips' note of October 14, 2010 shows she developed severe back pain after the first attempt, due to having to walk extensively. It was at this point that Dr. Phillips made the decision to defer to the significant restrictions that Dr. Diadula, a treating physician of Respondent's selection, had imposed about two weeks earlier. PX 1, p. 14. PX 3, p. 10. Additional restrictions came into play in 2011. Petitioner testified the second attempt, in 2013, failed for the same reason. She tried to perform a rodent control job for several days but indicated this job involved walking exceeding her restrictions. Respondent did not call any witness to refute this testimony.

Petitioner abided by Respondent's requirement that she look for work and turn in job search records weekly. She handed in these records for more than a decade. Respondent now criticizes her methodology but did not offer job search assistance. Petitioner also abided by Respondent's requirement that she attend a meeting, with the goal of creating an online job profile, in September 2018. Petitioner testified she brought her resume to this meeting, as directed, but no one asked to see it. The irony of this is not lost on the Arbitrator.

Respondent's first Section 12 examiner, Dr. Butler, noted no inconsistencies on examination. He described Petitioner's subjective complaints as "supported by objective medical evidence." RX 17. Respondent's second examiner, Dr. Ross, did note inconsistencies, including several positive Waddell's signs, but nevertheless recommended more treatment. He questioned the need for the fusion but attributed Petitioner's post-operative complaints to the work accident, noting the absence of any post-accident reinjuries.

Three certified vocational counselors evaluated Petitioner's marketability. The two who actually met with Petitioner, Steven Blumenthal and Lisa Helma, described her as cooperative. [Of these two, only Helma specifically addressed the effect of the additional restrictions of no driving more than 20 minutes and no machine operation imposed in 2011. RX 8.] Respondent has elected to primarily rely on the third, Gary Wilhelm. The opinions of Blumenthal and Wilhelm overlap to the extent that both recommended training in computer office skills. They disagreed as to which vendor should provide such training. In the Arbitrator's view, Blumenthal's personal interaction with Petitioner provided a rational basis for his conclusion that she would obtain greater benefit from "in person" instruction than the online option endorsed by Wilhelm. Wilhelm lost credence when he concluded that, "with or without training," Petitioner could earn "more in the $12 to $15 per hour range" simply by transferring her "previous skills in counseling and social services." While Petitioner did work for social services agencies, she did so in the remote past, between 1998 and 2003. She then collected garbage for Respondent between 2003 and the accident of March 2009. As of the 2019 hearing, she had not worked in any capacity (save for her two brief attempts to resume working for Respondent) for ten years and had not worked in a social services setting for sixteen years. The Arbitrator lacks Wilhelm's confidence that Petitioner's social service skills remain transferable, particularly in this era of electronic record keeping.

Arbitrator's Conclusions of Law

What is the nature and extent of the injury? Did Petitioner establish entitlement to wage differential benefits?

Petitioner seeks a wage differential award. Respondent maintains Petitioner failed to establish entitlement to such an award. Respondent contends permanency should be awarded under Section 8(d)2.

To qualify for a wage differential award under Section 8(d)(1) of the Act, a claimant must prove (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) an impairment of earnings. Gallianetti v. Industrial Commission, 315 Ill.App.3d 721, 730 (2000). In the instant case, there is no real dispute that the work accident resulted in injuries that prevent Petitioner from resuming her former garbage collection job. As of the hearing, Petitioner was still subject to a battery of restrictions imposed in 2010 and 2011 by Dr. Diadula, a physician affiliated with MercyWorks, a medical facility of Respondent's selection. Respondent's first examiner, Dr. Butler, saw Petitioner shortly after the fusion, well before the subject of restrictions arose. Respondent's second examiner, Dr. Ross, conceded Petitioner could require permanent restrictions based on a valid functional capacity evaluation. There is no evidence indicating Petitioner ever underwent a functional capacity evaluation. Dr. Phillips decided not to prescribe one after Petitioner told him she felt she could function within the restrictions imposed by Dr. Diadula.

The Arbitrator, having reviewed the reports generated by Blumenthal, Helma and Wilhelm, finds there is also no real dispute that Petitioner's injuries resulted in an impairment of earnings. All three of these consultants concluded that Petitioner has lost access to her former occupation but has wage earning potential, although only Helma factored in the 2011 restrictions relating to driving and machine operation. RX 8. They also agree that training could enhance that potential. Although Respondent now criticizes Petitioner's approach to job hunting, arguing Petitioner submitted only resumes and failed to follow up with potential employers, Wilhelm did not level such criticism and Respondent did not intervene, except to the extent it targeted three jobs at various points in time. Of these jobs, one was beyond Petitioner's restrictions, another was never offered, despite Petitioner having passed a requisite examination, and the third was "contingent," with Petitioner meeting that contingency by completing a questionnaire. [The Arbitrator notes that, even if the questionnaire had passed muster, and Respondent had offered Petitioner a watchman job, that job paid significantly less per hour ($19.24) than the amount Petitioner would be earning if she were still working as a garbage collector. PX 10. The Arbitrator also notes that, on most of the job contact sheets Petitioner completed, she indicated she submitted an application (or completed an online application) as well as a resume. PX 16.]

Although Respondent questions Petitioner's entitlement to wage differential benefits, it joins Petitioner in citing Crittenden v. IWCC, 2017 IL App (1st) 160002WC. Crittenden is a case of first impression involving a claimant who, like Petitioner, was not working as of the hearing but sought a wage differential award. The Arbitrator finds that the real question in this case, as in Crittenden, is the method to be used in determining "the average amount which [Petitioner] is able to earn in some suitable employment or business after the accident." The Court defined "suitable employment" as "employment in which the claimant is both able and qualified to perform." The Arbitrator finds that, as of the hearing, at which point the parties set aside the training-related dispute and placed permanency at issue, a clerk position would be "suitable employment" for Petitioner. When Petitioner met with Helma, she admitted to having some typing proficiency, contingent on being able to look at the

keyboard, but denied having any software skills. RX 8, p. 7. At the hearing, she acknowledged using her laptop on a daily basis to practice typing via a free online course. Helma, who considered all of the relevant restrictions, concluded that Petitioner could perform a sedentary clerical job, so long as she could alternate positions. She projected hourly earnings ranging between $9 and $13. In her labor market survey, she listed several clerk jobs, a couple of which involved driving and/or sitting/standing for extended periods. Of the jobs that did not involve these activities, or require applicants to have proficiency with computer software, several full-time positions paid between $10 and $14 per hour.

The Arbitrator, having considered the vocational evidence, including the results of the aptitude and interest testing conducted by Blumenthal, selects $13.00 per hour as a reasonable wage. This amount is on the high end of the range projected by Helma and within the ranges projected by Blumenthal and Wilhelm. The Arbitrator notes that Blumenthal based his projected range of $13 to "perhaps" $14 per hour on the assumption of additional training. This training did not take place. Wilhelm opined that Petitioner could earn "more like" $12 to $15 per hour, with or without additional training, but he based that opinion on the assumption of transferable skills from social service jobs Petitioner performed long ago.

The parties agree that, as of the hearing, Petitioner would be earning $37.76 per hour, or $1,510.40 per week, if she were still able to work as a garbage collector. Petitioner would earn $520.00 per week if she worked 40 hours per week earning $13 per hour. $1,510.40 minus $520.00 equals $990.40. Two-thirds of $990.40 equals $660.27. The Arbitrator awards Petitioner wage differential benefits in the amount of $660.27 per week beginning July 15, 2019, the date of the hearing, for the duration of her disability.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC012472
Case Name	JANIAK, ANGELA v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0470
Number of Pages of Decision	11
Decision Issued By	Kathryn Doerries, Commisioner

Petitioner Attorney	Michael Casey
Respondent Attorney	Stephanie Lipman

DATE FILED: 9/17/2021

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANGELA JANIAK,

Petitioner,

vs. NO: 13 WC 012472

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 17, 2021

KAD/bsd 009/07/21 42

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JANIAK, ANGELA
Employee/Petitioner

Case# **13WC012472**
14WC001142

CITY OF CHICAGO
Employer/Respondent

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

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

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

2221 VRDOLYAK LAW GROUP LLC
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CHICAGO, IL 60606

0113 CITY OF CHICAGO DEPT OF LAW
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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

Angela Janiak
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **12472**

Consolidated cases:
14 WC **1142**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **7/12/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/10/13**, 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 $**63,678.54**; the average weekly wage was $**1224.59**.

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

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

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

Respondent shall be given a credit of $**14,695.74** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**14,695.74**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 50 weeks, because the injuries sustained caused the 5% loss of the person as a whole for the neck injury and 5% loss of the person as a whole for the low back injury, 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

04/15/2020
Date

ICArbDec p. 2

APR 30 2020

PROCEDURAL HISTORY

This matter was consolidated with cases 14WC1142 and 14WC1231. The Petitioner presented a motion to voluntarily dismiss case 14WC1231 as is was a duplicative filing. This motion was granted by Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on July 12, 2019.

This matter was heard before Arbitrator Kay on July 12, 2019 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator.

The parties proceeded to hearing with the following issues in dispute: whether Ms. Angela Janiak's (hereinafter "Petitioner") current condition of ill-being is causally connected to her injury on April 10, 2013 while working for the City of Chicago (hereinafter "Respondent") and the nature and extent of her injury. (Arb.X1)

The parties stipulated that on April 10, 2013, Petitioner and Respondent were operating under the Illinois Workers' Act (hereinafter "Act"), that their relationship was one of employee and employer, and that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. (Arb.X1) In addition, the parties stipulated that Petitioner provided notice to the Respondent of the accident within the time limits stated in the Act, the calculated average weekly wage pursuant to Section 10 of the Act was $1224.59, Petitioner was 64 years of age at the time of the accident, married and had 0 dependent children. (Arb.X1)

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that on April 10, 2013 she was supervisor of ticketing for city stickers with the City of Chicago, however she could not recall her job title. She testified that she had done the job for approximately 9 years prior to the accident. (T.10) Petitioner's job duties included checking cars to see if the sticker was valid and current. If the car did not have a current sticker she issued a ticket. Petitioner testified that before the date of accident she had no problems with her mid back and low back that required medical attention. (P.X8-9)

On the April 10, 2013, she was in the process of ticketing a car when she went around the car to look for an expired city sticker. She testified that there was a big hole in the street and that she fell. (T.11 & 12) She does not recall how she fell. (T.20- 21) Specifically, whether she fell forward, backward, left or right. Petitioner testified that after she fell the next thing she remembers is being in the ambulance. Petitioner alleges that she lost consciousness after she tripped. (T.20) She was transported to Resurrection Healthcare by ambulance after she tripped. She underwent x-rays of her back, neck and pelvis. (T.21 & 22) Petitioner was diagnosed with back strain; strain of thoracic region; strain of neck muscle. X-rays were performed of the pelvis, left hip, thoracic spine, lumbosacral spine, cervical spine. Medications including diazepam, Norco and ibuprofen were ordered. (PX 3, p 4) In addition, Petitioner was given orders to return to work without restriction on April 15, 2013 and follow-up with physician for re-evaluation. (PX 3, p 3).

Petitioner testified that on April 12, 2013, she reported to MercyWorks. (P.X4, T.22) The medical history stated that Petitioner "presents for evaluation of multiple injuries to her back, left hip, left rib cage and cervical spine occurred on 4/11/13 (sic); states she was inspecting a car with no sticker; piece of sidewalk missing, she tripped and fell backwards and injured her left side, leg, hip underarm and neck; she was seen at Resurrection Hospital emergency room; x-rays were done; was told nothing was broken; she describes falling backwards hitting her head; she saw stars with questionable loss of consciousness for 30 seconds; today her pain is in her neck, left rib cage, left hip and lower back, all between a 7 to 9/10 level."(PX 4, p.4) Petitioner was diagnosed with contusion of the back and left rib cage; strain to cervical spine and left hip. Her orders were: medications; referred to orthopedic specialist at Midland Orthopedics; ordered off duty; discharged from Mercy Works. (PX 4, p.5)

Petitioner testified that she followed up with her primary care physician, Dr. Mohammed Alawad (hereinafter "Dr. Alawad") at Alawad Medical Center. (T.23) She testified that first saw him on April 22, 2013 (T.23) Dr. Alawad's records state Petitioner fell at work; left arm and neck and left leg pain; left hip pain; left LS spine pain. Examination revealed: neck spasm; cervical spine tenderness; left shoulder range of motion limited abduction; tenderness left LS spine area; SLR positive pain 90°; Physical therapy was ordered. (PX 5, p.5, P.X6)

On May 17, 2013, Petitioner had a follow-up with Dr. Alawad where she complained of pain, she was also complaining of depression and an inability to sleep. He ordered an MRI which resulted in spondylosis C6-7, C5-6, bulge C4-5; off work; medication. He diagnosed her discogenic neck pain, depression. (PX 5, p.7-8)

On May 28, 2013, Petitioner had another follow-up with Dr. Alawad where the doctor's records indicate that she was depressed and sad because she lost her husband. She was crying and unable to eat. She was complaining of left leg pain.

On June 5, 2013, Petitioner had a follow-up with Dr. Alawad where she complained of left ankle swelling. She was diagnosed with left ankle pain, and a discogenic low back pain. (P.X5,p.9)

On June 12, 2013, Petitioner returned to see Dr. Alawad, where the records indicated she was positive for swelling of her left ankle; discogenic low back pain; diagnosed with left ankle sprain and a plan to continue physical therapy. (P.X5, p.10)

On June 12, 2013, Petitioner was seen at Chicago Ridge Radiology for an X-ray of her left ankle. (P.X5, p.24) The X-ray revealed early degenerative changes at tibial lateral articulation with tiny spur formation from the medial malleolus and talus; otherwise no radiological evidence of acute fracture or dislocation. She was told to follow-up may be suggested if clinical concern persists. (PX 5, p.24)

On August 20, 2013, Petitioner was examined by Respondent's Section 12 Examiner, Dr. Daniel A. Troy (hereinafter "Dr. Troy"). (R.X1) Dr. Troy opined the claimant has subjective complaints only regarding her neck and back with no objective findings; the claimant's current subjective complaints of pain to the neck and low back are not related to the work accident; claimant cervical spine MRI demonstrates profound degenerative changes throughout the cervical

spine, these having been long-standing and pre-existing; the claimant has been treated appropriately and extensively for the underlying questionable cervical and lumbar strains that she suffered; the claimant requires no further care; the claimant can return to work full duty without restrictions. (R.X1)

Specifically, his report stated, in part, that she "*has only self-limiting behaviors on my examination. I would go one step further and sate that the claimant's symptoms appear to be magnified during the examination. I felt that her subjective complaints appeared to be out of proportion to the degree of the examination.*" He opined that there were no objective findings to support her subjective complaints. He noted that she was able to return to work full duty and at maximum medical improvement. (R.X1,p.6-7)

In a supplemental letter directed to respondent dated October 12, 2013 admitted in evidence as Respondent Exhibit 2, Dr. Troy opined: "Ms. Angela Janiak had no complaints of groin pain on the evaluation of August 20, 2013; she had no complaints of pain to the inner thigh; complaints of pain were to left gluteal region; it is this left gluteal region that has been referred to as "hip"; claimant never suffered any injury to her hip; claimant suffered a lumbosacral strain with secondary symptoms going into the left upper gluteal area; claimant was found to be in maximum medical improvement; claimant had no discrete objective findings on examination; claimant had advanced arthritic changes noted to her cervical spine, which could account for some of her subjective complaints of discomfort." (RX.2)

Petitioner agreed that she returned to her regular job on August 20, 2013. (T.27 & 49) Petitioner testified that now she takes medication to "solve her pain and sleep" which she didn't take prior to the work incident. (T.37) She stated that her neck was in "discomfort". (T.37) She complained that standing, sitting or driving too long causes her neck to be in pain. (T.38) She cannot drive more than 3 to 4 hours. (T.40) She takes medication 4 - 5 times a month. (T.39)

Petitioner alleged that her physician provided her with various restrictions. She claimed he gave her restrictions "right after my return to work and that she took them to her employer." (T .54) She further alleged that she has restrictions with respect to standing and driving. (T 54) Later she testified that "No, I didn't say driving restrictions". (T 56) When questioned further about her restrictions she answered that she did not recall and referred the court to Dr. Alawad's records. (T 57) When questioned about treating with Dr. Alawad for depression Petitioner initially responded sometimes (T.42) and then repeatedly answered that she did not recall treating for depression. (T.44 & 45)

CONCLUSIONS OF LAW

With respect to issue (F), whether Petitioner's current condition of ill-being causally connected to his injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The evidence in the record demonstrates that prior to the accident date of April 10, 2013, Petitioner had no problem with her neck, mid back or low back that required any medical treatment. (T.8-9) Petitioner was taken by ambulance from the scene of the accident to Resurrection Hospital. Records from Resurrection Hospital document complaints of low back,

mid-back and neck pain. (PX 3, p3-4) Medical history given to all medical providers including Mercy Works, Dr. Alawad, and Mid-America Physical Therapy documents onset of the back and neck pain with the accident. No evidence was provided that Petitioner injured her neck and back in any subsequent accidents. (T.41) The onset of pain in her low back, mid back and neck were immediate with the accident.

Dr. Troy, Respondent's IME, opined that based upon MRI of the cervical spine on May 10, 2013 Petitioner had a profound, pre-existing, long-standing, degenerative changes at C4-5, C5 and C6-7. He opined that claimant continues with subjective complaints of pain to the neck and low back with no objective findings and that claimant's current subjective complaints of pain to the neck and low back are not related to the work accident. In the supplemental report, Dr. Troy opined that Petitioner had advanced arthritic changes to her cervical spine which could account for some of her subjective complaints of discomfort. (R.X2) The evidence in this record demonstrates that Petitioner had no problems or complaints with her neck or low back prior to the date of the accident. Petitioner's testimony and the medical records demonstrate that the complaints of neck and back pain continued from the date of accident through the last date of medical treatment and up to the date of the hearing. There is no evidence of any accident or injury to the neck or back subsequent to the date of the work accident of April 10, 2013. (T.41)

Under a chain of events analysis, and considering all of the evidence in the record, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that the work accident of April 10, 2013 made a previously asymptomatic degenerative condition of Petitioner's neck and low back symptomatic. The Arbitrator finds that petitioner's current condition of ill-being regarding her neck and low back are causally related to the work accident of April 10, 2013. The arbitrator notes that Respondent Exhibits 5, 6 and 7 are EOB, Explanation of Benefits, for bill payments made by respondent to medical providers. These are not IME reports from a Section 12 examining physician or from any physician, nor are they Utilization Review consistent with the requirements of Section 8.7 of the Worker's Compensation Act. Additionally, Section 8.7 (i) (5) of the Act limits Utilization Review to addressing the reasonableness and necessity of the medical bills or treatment, not the causal connection of the injury to the work accident. The Arbitrator gives these EOB's no weight in the determination of the issue of causal connection.

With respect to issue (L), what is the Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the Section §8.1b of the Illinois Workers' Compensation Act. Here, the accident occurred on April 10, 2013, making section §8.1b applicable.

With regard to (i) the reported level of impairment, neither party submitted an AMA impairment rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to (ii) of §8.1b(b), the occupation of the employee, Petitioner worked as a supervisor in the City Clerk Office issuing tickets to vehicles that did not display current city

stickers. Petitioner was released to work full duty, back to her prior position, with Respondent. Therefore, the Arbitrator gives less weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 64 years of age at the time of the accident. With Petitioner being an older employee, it may be more difficult for her to live and work with the residual issues from her hip as opposed to a younger worker. Therefore, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, there was no evidence or testimony presented that Petitioner has incurred a loss of earnings. Therefore, the Arbitrator gives less weight to this factor.

With regard to subsection (v) of§8.1b(b), evidence of disability corroborated by the treating medical records, Dr. Alawad documents continuing complaints of neck and back pain from the date of initial treatment through the date Petitioner returned to work on August 20, 2013. However, the Arbitrator notes that in Dr. Troy's IME report he opined that Petitioner could return to work full duty and respondent directed her to return full duty to her job. (R.X2) Dr. Troy's IME report opined that Petitioner's advanced arthritic changes noted in her cervical spine could account for some of her subjective complaints of discomfort. (RX 2) The Arbitrator having found that the Petitioner had no complaints of cervical or lumbar pain prior to the date of the accident and having found that Petitioner's current condition of ill being is causally related to the work accident, finds that the medical records document and substantiate Petitioner's ongoing complaints of neck and low back pain.

At hearing, Petitioner testified that she has difficulty sitting for extended periods of time or standing for extended periods of time. She has avoided activities which exacerbate the pain in her neck and back. The Arbitrator finds that the medical records evidence disability consistent with Petitioner's testimony at hearing and find that this increases the level of disability and gives this factor more weight.

Based on the above, the record taken as a whole and testimony, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10 % Man as a whole.

Signature of Arbitrator

4/15/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC001142
Case Name	JANIAK, ANGELA v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0471
Number of Pages of Decision	10
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Michael Casey
Respondent Attorney	Stephanie Lipman

DATE FILED: 9/17/2021

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANGELA JANIAK,

Petitioner,

vs. NO: 14 WC 001142

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 17, 2021

KAD/bsd 009/07/21 42

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

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

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

21IWCC0471

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JANIAK, ANGELA
Employee/Petitioner

Case# **14WC001142**
13WC012472

CITY OF CHICAGO
Employer/Respondent

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

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

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
100 N RIVERSIDE PLZ 24TH FL
CHICAGO, IL 60606

0113 CITY OF CHICAGO DEPT OF LAW
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angela Janiak
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **1142**

Consolidated cases: **13 WC 12472**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **7/12/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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. [ ] Other _____

FINDINGS

On **11/26/13**, 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 $**63,678.54**; the average weekly wage was $**1224.59**.

On the date of accident, Petitioner was **65** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as indicated in the attached Addendum as provided in Sections 8(a) and 8.2 of the Act. Respondent is given credit for all bills paid.

Respondent shall pay petitioner permanent partial disability of $721.66/week for 7.6 weeks, because the injuries sustained caused the 10 % loss of the right thumb as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

04/15/2020
Date

APR 30 2020

PROCEDURAL HISTORY

This matter was consolidated with cases 13WC12472 and 14WC1231. The Petitioner presented a motion to voluntarily dismiss case 14WC1231 as is was a duplicative filing. This motion was granted by Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on July 12, 2019.

This matter was heard before Arbitrator Kay on July 12, 2019 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator.

The parties proceeded to hearing with the following issues in dispute: whether the City of Chicago (hereinafter "Respondent") is liable for unpaid medical bills and the nature and extent Ms. Angel Janiak's (hereinafter "Petitioner") injury. (Arb.X2)

The parties stipulated that on November 26, 2013, Petitioner and Respondent were operating under the Illinois Workers' Act (hereinafter "Act"), that their relationship was one of employee and employer, that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent and that Petitioner's current condition of ill-being is casually connected to her injury while working for Respondent. (Arb.X2) In addition, the parties stipulated that Petitioner provided notice to the Respondent of the accident within the time limits stated in the Act, the calculated average weekly wage pursuant to Section 10 of the Act was $1224.59, Petitioner was 65 years of age at the time of the accident, married and had 0 dependent children. (Arb.X2)

STATEMENT OF FACTS AND EVIDENCE

On November 26, 2013, Petitioner testified that her supervisor closed the computer down on her right thumb. (T.29,31,32) Petitioner testified that it hurt and began to swell. (T.32) The accident is not in dispute. (Arb.X2)

On November 26, 2013, Petitioner reported to MercyWorks. (T.33) The medical records state that Petitioner complained of an 8/10 level of pain at the site of trauma on the distal right thumb along the fingernails; currently on hormone replacement therapy for menopause since hysterectomy in 1989; in mild distress secondary to right thumb pain; examination of right thumb revealed a 2x3 millimeter abrasion with scant bleeding at the radial side of the proximal cuticle with local tenderness; erethma and soft tissue swelling; thumb had normal range of motion and distal neurovascular was intact. Abrasion was cleaned; tetanus booster given in the left arm." Petitioner was diagnosed with an contusion with abrasion right thumb. The treatment plan was: medication; thumb guard; return to Mercy Works for evaluation. Petitioner was ordered Off-duty. (PX 7, p 4) An X-ray of Petitioner's right thumb was taken; impression was: unremarkable right thumb. (PX 7, p 8).

Petitioner returned for care with Dr. Mohammed Alawad (hereinafter "Dr. Alwad") at the Alawad Medical Center. (T.34) Petitioner was referred to physical therapy. (T.34) She was also referred for an EMG/NCV.

Petitioner returned for a follow-up with Dr. Alawad on December 12, 2013. The records indicate that Petitioner complained of thumb numbness, crying and still mourning the loss of her husband. (P.X5,p.14) Petitioner saw Dr. Alawad again on December 17, 2013 where she was diagnosed right thumb contusion, depression, insomnia. Petitioner was ordered off work (PX.5, p 15).

Admitted in evidence as Petitioner Exhibit 8 are the medical records/bill of Mid-America Physical Therapy for treatment rendered from December 31, 2013 through June 2, 2014.

On December 31, 2013 and continuing through June 2, 2014 Mid-America Physical Therapy records document: work related contusion of the right thumb; right thumb pain & sensory loss; pain scale 8-4/10; pain description numbness and tingling. (PX.8, p.19)

On January 7, 2014, Petitioner returned for a follow-up with Dr. Alawad. He indicated that Petitioner was depressed and afraid to go back to work because of what happened with her boss; crying and still morning her husband; thumb numbness secondary to contusion; right thumb still swollen. (PX.5, p.17)

On January 7, 2014, Dr. Alawad's records documented a follow-up right thumb numbness; having problems at night sleeping during the day; still has no feeling in right thumb since got hit on it; still going to therapy. The diagnosis: right thumb nerve contusion; anxiety; depression; insomnia. (PX.5, p.18)

On February 13, 2014, Petitioner followed-up with Dr. Alawad. His records document complaining of depression and crying; stressed concerning her husband's death; right arm and right-hand pain same; still going to therapy. (PX.5, p.19)

On March 13, 2014, Petitioner followed-up with Dr. Alawad. His records document that Petitioner still had pain in the arm and right thumb; muscle weakness in the right arm; can't sleep. Petitioner was diagnosed with a nerve contusion secondary to trauma. An EMG was ordered. (PX.5, p.20).

On March 13, 2014, Petitioner was seen at Chicago Ridge Radiology by Dr. Timothy Putnam (hereinafter "Dr. Putnam"). His records noted: 66-year-old female presents for a 2 limb EMG/NCS because of pain (grade 10), numbness and tingling in the right thumb, ulnar hand, wrist, forearm and elbow since November 2013 following a work-related trauma to the right thumb stretch injury to the right upper limb; she states that she is globally impaired in all self-care activities using the right upper limb. (PX 9, p 5) Petitioner had a nerve conduction & EMG that was interpreted as 1. The upper limb NCS is normal; 2. The needle EMG examination of muscles innervated by the right medial cord innervated muscles, reveals neurogenic findings and large motor unit potentials, reduced number of motor units at maximal effort. Dr. Putnam concluded that the above electrical findings and clinical presentation are consistent with the right medial cord brachial plexopathy/plexitis as seen with neurovascular stretch injuries of the upper limb. (PX 5, p 21-22, PX 9, p 6).

On April 15, 2014 Petitioner was seen back at Mid-America Physical Therapy. The medical records document that Petitioner improved superficial sensation of the right thumb to normal, patient has decreased lateral grip strength with pain at the medial aspect of the forearm that interferes. (PX 8, p 83)

On June 2, 2014, Petitioner had a follow-up at Mid-America Physical Therapy. The records document: contusion of finger; 45 visits; pain in joint, hand. Petitioner reported the following problems: poor grip, limited work ability. (PX 8, p 113-114).

Petitioner testified her last medical treatment of the right thumb was at Mid America Physical Therapy on June 2, 2014. (T.35). Petitioner testified that he did not injure her right thumb in any accident other than the accident of November 26, 2013. (T.36)

Petitioner did not lose time from work subsequent to the accident and kept working.

CONCLUSIONS OF LAW

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 Parties stipulated that Petitioner's current condition of ill-being regarding Petitioner's right thumb is causally related to the work accident of November 26, 2013. Petitioner's Exhibit 10 are the unpaid medical bills claimed by Petitioner to treat the work injury. The Arbitrator notes the bills which are summarized in Petitioner's Exhibit 10 are in response to a Commission Subpoena and are therefore rebuttably presumed to be true and correct pursuant to Section 16 of the Act. (PX 7, PX 8, PX 9) Additionally, Petitioner stipulated that for any of the awarded bills that have been paid by Respondent a credit will be given to respondent. (T.71)

The bill of Mercy Works Occupational Medicine for treatment rendered on November 26, 2013 is in the amount of $299.75. (PX 10, p 2) The bill of Mercy Works for treatment rendered on December 2, 2013, in the amount of $131.87. (PX 10, p 3) The Bill of Mercy Works for services rendered on December 3, 2013, is in the amount of $119.53. (PX 10, p 4) The bill of Mercy Works for services rendered on December 5, 2013, is in the amount of $63.34. (PX 10, p 5) The bill of Mercy Works Occupational Medicine in the amount of $96.20 for services rendered on December 9, 2013 is in the amount of $96.20. (PX 10, p 6) The Arbitrator has reviewed the identification of services in these bills and they are consistent with the treatment rendered to Petitioner for the injury to the right thumb as documented in Petitioner Exhibit 7, the records of Mercy Works, which demonstrate treatment of the right thumb on 11/26/13, 12/2/13, 12/3/13, 12/5/13. The Arbitrator finds that these bill for the services rendered at Mercy Works are reasonable and necessary and therefore respondent is ordered to pay them at the fee schedule. Respondent is given credit for any payment made.

The bill of Mid-America Physical Therapy documents treatment rendered to Angela Janiak beginning 12/31/13 through 1/13/15. PX 10, p 7-21. The arbitrator notes that on 12/26/2013 Dr. Alawad ordered physical therapy for the thumb. PX 5, p 26. On 1/17/14 Dr. Alawad noted: petitioner follow-up for right thumb numbness; still in physical therapy; orders continuing physical therapy for the right thumb; petitioner has no feeling in the right thumb. PX 5, p 18. On 2/13/14 Dr. Alawad noted: petitioner complaining of right-hand pain the same and still going to physical therapy. (PX 5, p 19) On March 13, 2014 Dr. Alawad noted: Petitioner continues to have pain in the right thumb with diagnosis of nerve contusion secondary to trauma. EMG was ordered. (PX 5, p 20) The Arbitrator has reviewed the records of Mid-America Physical Therapy for treatment rendered from 12/31/13 through 1/13/15, Petitioner Exhibit 8, which document: the physical therapy that was rendered to petitioner was directed to the work related contusion injury of the right thumb with description of numbness/tingling; that the referring physician was Mohammed Alawad, MD. (PX 8) A total of 45 sessions of physical therapy to the right thumb on referral from Mohammed Alawad, MD are documented. (PX 8, p 113) The Arbitrator finds that the therapy directed to petitioner's right thumb was reasonable and necessary and therefore respondent is ordered to pay the bill of Mid-America Physical Therapy subject to the fee schedule. Respondent a given credit for any payment made.

The bill of all Alawad Medical Center in the amount of $1054 is for treatment rendered from 6/16/ 2012 through 7/24/2013. This bill is for treatment prior to the work accident of 11/26/2013. The Arbitrator finds that the bill is not reasonable, necessary and causally related to treatment of the petitioner's work injury to her right thumb from the accident of 11/26/13.

The bill of Timothy Putnam MD in the amount of $725 is for services rendered on 3/13/14 for an EMG NCV performed on that date. Dr. Alawad ordered EMG/NCV on 3/13/14. (PX 5, p 20) A copy of the

EMG/NCV report for EMG performed on 3/13/14 is in Dr.Alawad's records and is part of the evidence as petitioner Exhibit 9. The Arbitrator finds that this is reasonable and necessary medical treatment of the right thumb injury and Respondent is ordered to pay the bill of Dr. Putnam subject to the fee schedule. Respondent is given credit for any payment made.

With respect to issue (L), what is the Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the Section §8.1b of the Illinois Workers' Compensation Act. Here, the accident occurred on April 10, 2013, making section §8.1b applicable.

With regard to (i) there is Neither party submitted an AMA impairment rating and therefore the arbitrator gives this factor no weight.

With regard to (ii) of §8.1b(b), the occupation of the employee, Petitioner was a supervisor of ticketing for city stickers for the City of Chicago. Following this injury, she lost no time from work and continued to work her usual and customary position with the respondent. Therefore, the Arbitrator gives little weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 65 years of age at the time of the accident. Petitioner returned to work full duty in her customary position. Therefore, the Arbitrator gives little weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, nothing in the record, including Petitioner's testimony, suggests that her future earning capacity has been affected by the injury sustained. Therefore, the Arbitrator gives little weight to this factor.

With regard to subsection (v) of§8.1b(b), evidence of disability corroborated by the treating medical records, on December 17, 2019 Dr. Alawad diagnosed Petitioner with a "right thumb contusion". She complained of numbness but was able to continue working. It is known that the petitioner did not lose time from work for this injury. It falls to reason that either she was off for something else of the doctors' notes are incorrect. Petitioner treated for her right arm, which is not part of this claim. She is claiming an injury to her right thumb, only. She lost no time from work.

Based on the above, the record taken as a whole and testimony, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10 % loss of use of the right thumb.

Signature of Arbitrator

4/15/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC037025
Case Name	HRNJIC, NIHAD v. MERCEDES BENZ-WESTMONT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0472
Number of Pages of Decision	49
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Ian Elfenbaum
Respondent Attorney	William A. Lowry, Sr.

DATE FILED: 9/17/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0472

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

Nihad Hrnjic,

Petitioner,

vs. NO: 13 WC 037025

Mercedes-Benz of Westmont,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical treatment, temporary total disability ("TTD"), and multiple evidentiary issues, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Decision of the Arbitrator on the issues of accident, causation, medical expenses, prospective medical treatment, TTD, and multiple evidentiary issues.

As it pertains to permanent disability ("PPD"), the record reflects that Petitioner suffered a work-related accident on March 5, 2013. Accordingly, a determination of permanent disability under § 8.1b of the Act must follow. Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b. Specifically, § 8.1b states:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria.

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

measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

The Commission modifies the findings of the Arbitrator to include an analysis of these factors as indicated below.

With regard to subsection (i) of Section 8.1b(b), the reported level of impairment pursuant to Section 8.1b(a), the Commission notes that neither party entered into evidence an impairment rating. Therefore, the Commission gives no weight to this factor in determining PPD.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the injured employee, Petitioner was not medically restricted from returning to his prior occupation as a porter. The Commission gives moderate weight to this factor in determining PPD.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, Petitioner was 34 years old at the time of his work injury. Petitioner therefore has more work years in which he may experience the lingering effects of his injury than an older employee. The Commission gives moderate weight to this factor in determining PPD.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, no evidence was presented that Petitioner's future earnings capacity was diminished due to his work injury. The Commission gives lesser weight to this factor in determining PPD.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, Petitioner sustained a blow to the head, a minor traumatic brain injury that resulted in a mild concussion, as well as a low back strain, as a result of the accident. Petitioner had symptoms of headache, confusion, dizziness, and nausea, as well as low back pain after the accident. He underwent physical therapy and speech therapy. His post-concussive care lasted about a year. The Commission gives greater weight to this factor in determining PPD.

In consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is

conclusive on the issue of permanency and after considering all of the evidence adduced, the Commission finds that, as a result of the injuries sustained, Petitioner suffered permanent partial disability to the person as a whole to the extent of 6% loss of use thereof, pursuant to Section 8(d)2 of the Act.

The Commission corrects a scrivener's error in the Arbitrator's Decision on page 40, the last sentence of the first paragraph (carried over from page 39), should read as follows, "The fact that Petitioner could work at full duty for three years following an incident and only after the lay-off became totally unable to work is not credible."

The Commission corrects a scrivener's error in the Arbitrator's Decision on page 41, in the third sentence of the first full paragraph, which should read as follows, "Petitioner also attributes Dr. Landre's findings against Petitioner to her bias."

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 3, 2018, is modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Petitioner's conditions of ill-being regarding his head, low back, and wrist are causally related to the March 5, 2013, work accident. Petitioner's complaints regarding mental/psychological illness are not causally related to the work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $540.00 per week for a period of 30 weeks, as provided in § 8(d)2 of the Act, for the reason that the injury sustained to the cervical spine caused the loss of use of 6% of the person as a whole.

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.

September 17, 2021

o: 8/24/21
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
NOTICE OF ARBITRATOR DECISION

HRNJIC, NIHAD
Employee/Petitioner

Case# **13WC037025**

MERCEDES-BENZ OF WESTMONT
Employer/Respondent

On 12/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% 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:

0307 ELFENBAUM EVERS & AMARILIO
JOSEPH D AMARILIO
900 W JACKSON BLVD SUITE 3-E
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF)

☐ 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

NIHAD HRNJIC,
Employee/Petitioner

Case # **13 WC 37025**

v.

Consolidated cases: ___

MERCEDES-BENZ OF WESTMONT,
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 **KETKI STEFFEN**, Arbitrator of the Commission, in the city of **WHEATON**, on **August 9, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/5/2013**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$46,800.00**; the average weekly wage was $**900.00**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, of $540.00/week for 30 weeks, because the injuries sustained caused permanent disability to the person to the extent of 6% thereof, 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.

KSSteffen

Signature of Arbitrator

November 30, 2018

Date

DEC 3 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NIHAD HRNJIC,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 13 WC 37025
	)	
MERCEDES-BENZ OF WESTMONT,	)	
	)	
Respondent.	)	

PROCEDURAL HISTORY

The matter was heard before Arbitrator Ketki Steffen in Geneva, Illinois on August 9, 2018. The parties stipulated to the occurrence of an accident on May 20, 2013 and further stipulated to an average weekly wage of $900.00 in the year prior to the accident. Disputed issues were causation, TTD, payment of medical bills and prospective medical care; Respondent disputed accident as to the psychiatric condition. Tr. 13. Respondent waived its objection to proceeding under Section 19(b) and the hearing proceeded on that basis, as Petitioner was still in treatment. The Arbitrator reserved the right to rule on the nature and extent of Petitioner's disability, if appropriate. Tr. 7-8.

EVIDENCIARY RULINGS

Dr. McManus Depostion Testimony: Dr. McManus testified by evidence deposition on July 12, 2018. Petitioner's Exhibit 1, the transcript of Dr. McManus' testimony, indicates that his curriculum vitae (CV) was tendered to the court reporter at the start of his testimony and marked as Exhibit 1. A copy of this CV is attached to the transcript and marked as "Exhibit #1 Dr. McManus, 7/12/18." *Id.* No objection from Respondent was recorded.

At trial, however, Respondent moved to exclude Dr. McManus' testimony on the grounds that his CV had not been "offered into evidence" on the day of the deposition, and that Petitioner had therefore failed to qualify him as an expert witness. Tr. 229. The Arbitrator finds that this question can be resolved by the record above, as well as Dr. McManus' subsequent testimony as to the qualifications listed in Petitioner's Exhibit 1.

These indicate that both documentary evidence and oral testimony were duly presented on the date of deposition which are sufficient to qualify Petitioner's examiner as an expert witness. The Arbitrator allows for the entry of these documents at trial and therefore finds that Petitioner has presented a sufficient basis to qualify their expert, Dr. McManus. The Arbitrator allows for his deposition testimony and overrules any objection to his qualifications as an expert.

Bosnian War Photograpsh

Petitioner Exhibit 18 included a copy of his Bosnian passport with residences in Cerska and Srebrenica (180001); photos of Petitioner at the graves of his uncle and brother-in-law, taken by a nephew in 2012 (180002-3); photos of the Srebrenica massacre memorial site, taken in 2015 (180004); photos of Petitioner outside the UN compound and with UN soldiers, taken in 1995 (180005-6); and a document dated June 5, 2000, confirming his acceptance in a resettlement program under U.S. State Department auspices (180007).

Respondent objected to this testimony and to Petitioner's Exhibit 18 on grounds of relevance. Tr. 83, 88. The Arbitrator ruled that limited testimony could be admitted, but rejected Px 18 on several grounds including weighing the probative value against the harm and sympathy that such pictures can arouse, particularly ones of the graves and massacre memorials. Tr. 90; Tr. 250-51.

FACTUAL HISTORY

The Petitioner was hired by Respondent on February 14, 2001, as a porter who would drive, wash cars, and sweep around. (98-99). He would also pick up parts for vehicles and greet customers. (100). He testified that on March 5, 2013, he was head porter on the service side of the dealership. (100-101) . He would "tell the porters what to do," and would have to make sure "everything is flowing." (101-102). He stated also that he was the rental car manager whose job required that rental vehicles were prepared for customer use; this job also involved preparing the appropriate paperwork for the rentals.

(101-102). Petitioner had a business card which stated his role as "Customer Care Specialist." (105). Petitioner also claimed that he was assigned work in relation to impounded vehicles. (108-109). Petitioner testified that he never had the job title of janitor. (111). Christine Brady, Human Resource Director for Respondent testified that Petitioner was a porter, both before and after the accident. (See below, Christine L. Brady Testimony).

The Petitioner testified that after accident of March 5, 2013, he returned to work on March 9, 2013, and worked for the rest of the year of 2013. He also worked the entirety of 2014 and 2015 for Mercedes Benz of Westmont. He was eventually terminated on April 1, 2016 due to a lay off. (187-188). When he had returned to work after the accident, it was on a full-time basis. He had been awarded disability. The Social Security Decision noted that his condition was expected to improve with treatment and that it would be reviewed in 18 months. (191-192).

The Petitioner testified that his wages prior to the accident were $1,950.00/bi-monthly. (The Parties stipulated to an average weekly wage of $900.)

The Petitioner testified that he was demoted after the accident and received lower pay, $18.95 per hour. (120-121). He identified Petitioner's Exhibit 21, a paystub, which reflected 78.88 regular hours and 8.63 overtime hours plus 8 hours holiday pay, all at a rate of $18.95 per hour. (120; 189-190). Christine Brady testified Petitioner's rate of pay was $18.95 per hour both before and after the accident. (215). The last pay stub available from June 2015 shows gross earnings of $1,958.64. (PX 21, p. 11).

The Parties stipulated that Petitioner was involved in an accident on March 5, 2013, while spreading salt on the premises. Petitioner testified regarding the accident. He was

walking in the garage to obtain additional salt and while standing in the truck bed, he struck his head on a pipe and fell. Petitioner indicated an indentation in the left temple area which he described as approximately one-inch in length.

During the hearing the Arbitrator examined the area of the injury. The Arbitrator noted that the other side, the right side, of Petitioner's head looked the same. (124-127). Petitioner referred to a scar on the left side of his head that was "very hard to see." The Arbitrator observed that there seemed to be an indentation on the left forehead by the temple but that there was an almost identical indentation on the other side. (128-129).

Petitioner testified further that he felt dizzy, and while attempting to get off the truck he fell on his butt and back (130). When assistance came, he was sitting on the concrete. He noticed blood on his hand and the left side of his forehead. (134). He also felt dizzy and felt back and wrist pain – the wrist pain did not persist. (136). He was taken to Concentra where he was treated and released and sent to Hinsdale Hospital. (137; PX2).

Petitioner testified that he could not recall if he lost consciousness – he did not remember much of what transpired at Hinsdale. He followed up at Concentra the next day. (139-140), and called his family physician, Dr. Sharif. Dr. Sharif prescribed Norco and Valium. (140-141; PX4).

Petitioner testified that he did not have dizziness or headaches before March 5, 2013. However, he appeared at Adventist Bolingbrook Hospital on August 3, 2012, complaining of headaches and dizziness and underwent a CT scan of the head on that date. He spoke with Dr. Childs on March 5, 2013 when he described the accident and told Dr. Childs that he did not lose consciousness. (192-194; RX1-4).

Dr. Sharif referred Petitioner to Dr. Frank who he saw on April 5, 2013. He complained of confusion, dizziness, and nausea as well as a loss of consciousness. (142-143; PX4, 5). Petitioner also saw Dr. Brown who also referred him to Dr. Frank as well as prescribing physical therapy at ATI. (143-144; PX5, 6, 9).

Petitioner saw Dr. Hill, a neuropsychologist, who undertook vision and hearing tests at Hinsdale Hospital on October 21, 2013, and also saw Dr. Pilcher at Dr. Frank's office on October 14, 2013; Dr. Frank had retired. (144-145; PX3, 5). He was referred to Adventist Bolingbrook Hospital for speech therapy during the period December 27, 2013 to February 20, 2014. (145; PX8).

Petitioner then came under the care of Gail West-Hooper, a social worker, on January 29, 2014. He continued to see Dr. Pilcher – he last saw her two weeks prior to the trial. (146-147; PX5, 12). Petitioner also saw Dr. Diwan, a psychiatrist, on March 20, 2014 who prescribed Wellbutrin to which Petitioner testified he did not have a "good reaction." (148-149; PX10). He then saw a new psychiatrist, Dr. Ahsan, as Dr. Diwan had moved out of state. (150; PX11).

Petitioner saw Dr. Hill on January 26, 2016, for her neuropsych evaluation. After he left the employ of Mercedes Benz of Westmont, he also saw Dr. Ashan who increased his medication. (152; PX7, 11). He was admitted to Silver Cross Hospital Outpatient Program on July 19, 2017. He was discharged on September 14, 2017. (153-154; PX 14). He remains under the care of Dr. Ashan and Dr. Pilcher. His current family physician is Dr. Khan. He also sees Gail West-Hooper. (155-156; PX5, 11, 12).

Petitioner testified that after he returned to work after the accident his manager was different towards him. He was assigned to be a janitor to clean bathrooms after he

"messed up" twice while picking up parts. Christine Brady testified that Petitioner remained a porter after he returned to work in March 2013. (215).

Gail West-Hooper Testimony

Gail West-Hooper is a licensed clinical social worker, and a psychotherapist practicing at West Suburban Counseling Associates. Her specialty is working with women with trauma with related difficulties such as anxiety and depression. She also does couple counseling and works with adolescents. (16-18). She first saw Petitioner on January 29, 2014 and continues to see him on a weekly basis, the last visit being August 7, 2018. (19-20). Upon being asked for a medical legal opinion regarding whether Petitioner is suffering from a major depressive disorder, the Arbitrator sustained an objection from counsel for Respondent that Ms. West-Hooper was not qualified to render such an opinion. Ms. West-Hooper testified further that she was trained to render a diagnosis – this was part of her licensing requirement. She renders diagnoses on a daily basis. (22-23). Counsel for Respondent again objected to Ms. West-Hooper's offering an expert medical opinion which the Arbitrator again sustained. However, the Arbitrator permitted her to offer a diagnostic opinion. (23-24).

Ms. West-Hooper testified that she conferred with Petitioner's treating doctors, including the neurologist, psychiatrist, primary care doctor, and the neuropsychologist. She stated that she shared their diagnosis. She agreed with the Arbitrator that she relied on the medical reports and diagnoses of other physicians. (28). Ms. West-Hooper's opinion was that Petitioner had a post-concussive syndrome called TBI and that he had post-traumatic stress disorder with anxiety and depression. Counsel for Respondent objected to Ms. West-Hooper testifying to opinions and conclusions held by a qualified medical expert

which the Arbitrator sustained: Although qualified as a licensed clinical social worker to give treatment, she was not a medical expert.

Ms. West-Hooper testified that Petitioner's experiences in Bosnia when he was 11 or 12 years old were a significant factor in rendering her diagnosis. (42). She also stated that: After Petitioner was laid off, he felt shame because he couldn't support his family; after the layoff his medications increased; after the layoff, Petitioner told her that he couldn't concentrate. During their sessions Petitioner would become agitated and move from side-to-side. (45-46). Ms. West-Hooper stated the Petitioner could work but not consistently due to difficulty with concentration. (47). On cross-examination, upon being asked by counsel if she had observed Petitioner sitting still, Ms. West-Hooper stated that Petitioner had not. Petitioner's attorney noted for the record that Petitioner had been "swaying back and forth." The Arbitrator observed that this behavior started only after counsel for Respondent asked Ms. West-Hooper the question. (51-52).

Ms. West-Hooper is not a psychologist or a psychiatrist; she does not have a PhD. She did not perform any testing. Among the tests she did not perform were the back anxiety/back depression inventories, booklet category, California verbal learning, fingertip tapping, Nova University Concussion Symptom Checklist, the Ray 15-Item Test, and the structured inventory of malingered symptomatology and memory malingering tests. She also did not perform the Wechsler Adult Intelligence Scale or word memory tests or the MMPI Second Edition. (54-55). She did not perform symptom validity or performance validity testing. The Arbitrator ruled that a clinical social worker was attempting to give a medical opinion without performing those tests which were appropriate for diagnosing post-concussion or post-traumatic stress disorder. (56-57).

Ms. West-Hooper testified that the head trauma at work in March 2013 was significant because of exacerbated symptoms, whereas the Petitioner could cope and hold back previous memories before the head trauma, he was no longer able to do that after. (50). Petitioner did have post-traumatic stress disorder prior to the accident at work and had been treated for depression. She had reviewed records from Dr. Sharif which reflected this history. (61). He had been depressed and anxious in relation to his experience in Bosnia which was a post-traumatic stress disorder. (69-70). According to Ms. West-Hooper, Petitioner's experiences in Bosnia did not come out in the first counseling sessions which commenced in January 2014. She was dealing with the "present issues" at that time. The experiences in Bosnia "did not come out until later." (71-72).

Christine L. Brady Testimony

Christine Lynn Brady is employed by Auto Nation Central Region Management, LLC as the Market Human Resources Manager. She was working in this capacity on March 5, 2013 and had known Petitioner for approximately seven years. Prior to March 5, 2013, he was employed as a porter at Mercedes Benz of Westmont which was the same position he returned to after the accident at work. After Petitioner returned to work on March 9, 2013, he was not asked to clean toilets or bathrooms. Ms. Brady was shown Petitioner's Exhibit 17 (Job Status Documents) and identified a PTO request form on page 7 of said exhibit. On this document the term janitor appeared. Ms. Brady testified that Mercedes Benz of Westmont did not have a janitor position. The PTO application, a request for paid time off, is submitted to an employee's manager for approval to take time off work, in this case from September 16 through September 30 when Petitioner was requesting two weeks' vacation. (208). Regarding cleaning washrooms at the Mercedes Benz of Westmont facility, there is

an outside cleaning crew that maintains the entire building, including bathrooms. The outside cleaning crew would have been performing this work after March 5, 2015. (208-209).

After Petitioner returned to work in March 2015, she had general conversations with him in passing. She was aware of a workers' compensation claim and discussed questions regarding that issue as well as benefit issues. Per Ms. Brady, Petitioner did not express any grievances, only questions regarding the workers' compensation claim. (210-211). If there are grievances, company policy was to address this with the employee's manager. If they are not satisfied with the outcome, employees can discuss the issue with Human Resources or go to another manager. The company does have an anonymous hotline as well; Petitioner apparently did not utilize the hotline . (211-212, 214). No employee of Mercedes Benz of Westmont was disciplined relative to unfair treatment of Petitioner upon his return to work. (211). If Petitioner had come to Ms. Brady with a grievance about how he was being treated, she would have investigated the complaint and "would have gotten to the bottom of it and addressed it." (215). Petitioner's wages before and after the incident at work in March 2013 were the same. (215). Petitioner worked in the porter position from the day Ms. Brady started in 2011 until the day he was laid off. (217). Mercedes Benz of Westmont does not have a "Customer Care Specialist" role. When shown the business card with this term, she did not recognize it. (218-219). Porters do certain work such as restocking the coffee area, filling water bottles, and sweeping floors, if these things become necessary. All porters engage in those types of activities. Porters did not clean bathrooms. Bathrooms were cleaned by the outside service in the evenings. If there was an incident

during the day the dealership would need somebody to clean up but this did not occur on an every-day basis. (122-124).

Dr. Hill Reports (PX 7)

Erin K. Hill, Psy.D., ABPP, is a Board-certified neuropsychologist who evaluated Petitioner and conducted neuropsychological tests on August 29, 2013. Her diagnostic impressions at that time were post-concussive syndrome and anxiety disorder with panic attacks and symptoms of depression. She found Petitioner's intellect reading ability average, but his performance on cognitive testing was questionable. His responses to the comprehensive personality inventory, among other tests, were invalid. Except for planning skills required to draw a clock, all other performances were in the significantly impaired range. Petitioner demonstrated significantly impaired performances on tasks of visual construction and reasoning ans well as visual processing speed. (PX 7, 43-45).

Ms. Hill considered the validity of the cognitive test results questionable and of poor validity, making it difficult to determine whether the low scores represented suboptimal effort or cognitive impairment. When inquiring into background information, Petitioner mentioned that he was born in Bosnia and moved to the United States in 2002. He had seen dead people there, but his medical history did not include treatment for PTSD; his history was unremarkable except for hypertension. Ms. Hill did not diagnose post-traumatic stress syndrome. (PX 7, p. 43-45).

Ms. Hill administered a second set of neuropsychological tests on January 26, 2016. Petitioner reported having driven to the evaluation. Her diagnostic impressions were post-concussive syndrome, agitated depression, generalized anxiety disorder, and PTSD, based on Petitioner's psychiatrist. She recommended follow-up with a neurologist and with a

primary care physician. She indicated that Petitioner should continue with psychiatric consultation. She considered his injury to be mild but that his reported physical symptoms and medical records were consistent with a mild brain injury. She disagreed with Ms. West-Hooper who stated that the Petitioner had a severe head injury. (PX 7, p. 9-10, 12)

Regarding the neuropsychiatric testing, Dr. Hill stated that Petitioner performed below cutoff range which suggested suboptimal effort on cognitive testing. Dr. Hill stated that the test results needed to be "interpreted with caution." She found it difficult to determine the extent of true impairment versus factors affecting validity. Petitioner reported having driven to the evaluation. (PX 7, p. 12-13).

Dr. Hill stated a connection between the accident and her diagnoses. Dr. Hill did not mention a pre-existing post-traumatic stress disorder or pre-existing anxiety and depression. Dr. Hill also did not comment on the effects of Petitioner's layoff in 2016. The report states that Petitioner was not working "at the moment," that Petitioner met the criteria for disability and that return to work should be gradual. Petitioner was working full time as a porter at Mercedes Benz of Westmont at the time of Dr. Hill's examination and the date of her report. (PX 7).

Dr. McManus Testimony (PX 1)

The Petitioner offered the testimony of Timothy D. McManus, Psy.D. Dr. McManus is Board-certified in rehabilitation psychology and neuropsychology and is licensed to practice clinical psychology in the State of Illinois. His curriculum vitae was marked and offered as Petitioner's Exhibit 1 during the deposition. (PX1, 5-6). As part of his practice, Dr. McManus consults with a variety of medical professionals, including psychiatrists. He is trained to review medical records of neurologists and psychologists and integrates their

conclusions and information into his assessment and treatment plan. (PX1, 8). Dr. McManus authored a report which summarized his evaluation on September 9, 2016. (PX1, 10).

Dr. McManus testified that he has performed research and given presentations on post-concussion injuries. He is knowledgeable on the subject of how post-closed head injury and post-concussion injuries may affect post-traumatic stress disorder (PTSD). Whether there were preexisting conditions before a concussion is an important question. (PX1, 12-13). He had reviewed certain medical records as well as the evaluation performed by Dr. Landre on March 25, 2014. This included the raw data from her testing. (PX1, 14-16). The Petitioner reported a history of anxiety and nightmares as a child growing up in Bosnia; these were longstanding as well as current symptoms which included depression, irritability and panic. He had had nightmares and sleep disruption as a result of his life in Bosnia. Dr. McManus testified that Petitioner copes with his problems through isolation and withdrawal. (PX1, 18-19).

Dr. McManus considered Petitioner's current symptoms consistent with PTSD. Petitioner reported work-related stressors associated with his return to work after the accident; he indicated the work incident resulted in changes in his assignments in that he was demoted and had his salary changed. He felt harassed and demeaned and reported negative comments from coworkers. (PX1, 21-22).

Based on his clinical interview and test results, Dr. McManus was of the opinion that Petitioner had a post-traumatic stress disorder, chronic, as well as a major depressive disorder and an illness and anxiety disorder. He testified that these diagnoses were causally related to the accident; the work accident exacerbated these conditions. (PX1, 56-

57). He disagreed with Dr. Landre that the Petitioner was malingering or magnifying symptoms. (PX1, 58). Dr. McManus stated that the event was threatening on multiple levels and noted that Petitioner had lost money and been demoted and humiliated and called names. These would be enough to reactivate or stimulate memories of what occurred in Bosnia. His long-term prognosis without treatment was poor but he had the capacity for recovery. (PX1, 62-63). Dr. McManus also stated that Petitioner's condition was not permanent because he made progress once before and should be able to progress again. (PX1, 63). He agreed with Dr. Landre that going back to work would be good for Petitioner. (PX1, 65).

Dr. McManus further testified that it is possible that a mild 'second' event will not aggravate a preexisting post-traumatic stress disorder. A subsequent mild event may only temporarily aggravate the pre-existing PTSD. (PX1, 70-71). It is possible that the more inconsistencies there are on testing, the more likely it is an individual is malingering. (PX1, 79-82). Dr. McManus agreed that it would be significant if the Petitioner had returned to work after the accident at work and worked in the same position as he had pre-accident until April 1, 2016. It would be important or significant if Petitioner had remained in the same position under the same salary, with the same work conditions, and in the same environment. (PX1, 83-85).

In discussing the records of Dr. Hill, Dr. McManus stated that 29 unrelated responses on neuropsychological testing was highly unusual. He considered it significant because the Petitioner could be afraid of what might happen if he answered truthfully or honestly; therefore, he gave the answers he believed Dr. Hill wanted to hear. (PX1, 93-94). Dr. McManus also considered it significant that on August 29, 2013, Dr. Hill noted

Petitioner's responses to a comprehensive personality inventory were generally invalid. It was significant because a language issue could be involved or Petitioner was paying inadequate attention. But it was also possible that the "Big M word" (malingering) was involved as well. (PX1, 94).

Dr. McManus also considered it significant if the Petitioner was not made to clean bathrooms when he returned to work but instead was placed in his old position at the same level and same rate of pay. (PX1, 97). In addition, if Petitioner asked about a past history of psychological trauma and he did not mention Bosnia, this would be a matter of concern. (PX1, 98). Dr. McManus did not perform a Nova University Concussion Symptom Checklist because he thought it was not necessary. He was focusing on psychological issues. It was not the actual physiological event of the concussion that was creating difficultly, in his opinion. (PX1, 102). Dr. McManus testified throughout that he did not perform neuropsychological tests. (PX1, 99-103).

Dr. McManus had no personal knowledge of Petitioner's ability to perform gainful employment or whether or not Petitioner sustained any permanent partial disability. (PX1, 106).

Dr. Zelby Testimony (RX 1)

Dr. Zelby is a Board-certified neurosurgeon who evaluated the Petitioner on September 6, 2013. (RX1, 4, 7). Dr. Zelby prepared a report in relation to this examination which contained a history of the incident at work wherein the Petitioner claimed a loss of consciousness followed by a fall off the truck when he landed on his back. He described headaches, dizziness and blurry vision. He also described other symptoms – wrist, neck, and shoulder pain – which had resolved. He still had headaches, bifrontally and occipital,

as well as dizziness, blurry vision and problems with memory and mood changes. He also described constant low back pain, exacerbated by anything. He was able to drive. (RX10, 7-9).

He described his work at Mercedes Benz of Westmont as a supervisor and rental fleet manager which required physical labor. He stated that he returned to work with restrictions of lifting no more than 15 pounds and no driving company cars; he reported to Dr. Zelby that he was still working with those restrictions. (RX10, 9-10).

Petitioner described his pain as being 8 on a scale of 10. However, Dr. Zelby noted that during the exam he rested and moved comfortably with no pain behaviors. The doctor stated that any person would be able to tell if someone were in pain at an 8 on a scale of 10 – no semblance of medical training would be necessary. Dr. Zelby considered this inconsistent. (RX10, 10-11). The cranial nerve exam was normal except for trigeminal sensation on the left side of the face and head and vibratory sensation exclusively in the forehead and occiput. Dr. Zelby testified that this was a completely non-anatomic presentation as there was no condition affecting the brain or nerves that could result in this finding. (PX10, 12-13). Exam of the cervical and lumbar spines was also normal except for tenderness with deep palpation in the lower lumbar spine with "little" diminished forward flexion. Straight leg raising was positive lying but was negative in the sitting position. (RX10, 13-14). This also was inconsistent. The complaint of back pain suggested no neural impingement. (RX10, 14-16). Dr. Zelby also considered the sensory exam of both the upper and lower extremities to be nonanatomic: Petitioner described diminished sensation circumferentially in both hands and the left lower extremity, inconsistent with any condition of the spine, peripheral nervous system, or brain. (RX 10, 16-17). Dr. Zelby considered the

diminished sensation complaints "a constellation of complaints without an unidentifiable medical basis."

Dr. Zelby reviewed medical records from the date of the accident as well as records from Hinsdale Hospital, Bolingbrook Hospital, Dr. Sharif, and Dr. Brown. The lumbar MRI was normal for a person of Petitioner's age. (RX10, 18-19). Diagnostic studies of the brain were negative. Dr. Zelby concluded that Petitioner had a mild cerebral concussion with a mild post-concussion syndrome. He also sustained a lumbar strain. Whether Petitioner lost consciousness or not, Dr. Zelby considered this to be inconsequential, considering there were no traumatic findings on the CT. Also, Dr. Zelby noted a note in the margin of Dr. Brown's records indicating that there was no evidence for closed head injury on EEG. Also, the hospital records indicated that the Petitioner did not think he lost consciousness. Nonetheless, he did suffer a mild concussion, symptoms from which typically resolve within three to four months and should be completely gone within six months after the occurrence. (RX10, 19-21).

Dr. Zelby stated that Petitioner's subjective complaints could be consistent with a post-concussion syndrome but that he sustained no injury that should result in persistent symptoms. The low back injury was a soft tissue lumbar sprain. (RX10, 21-22). The doctor opined that the Petitioner reported no additional diagnostic studies or further treatment for the spinal nervous system after the September 2013 exam. He considered the Petitioner's subjective complaints not causally related to the incident. He opined that Petitioner was qualified to safely return to his prior activities. Regarding whether Petitioner's reported systems were false or exaggerated, the doctor stated that this was a reasonable assumption to make based on the disparity between the Petitioner's subjective complaints

and the objective medical findings. (RX10, 23-24). An unremarkable brain MRI does not necessarily rule out all injuries stemming from a concussion; however, it shows that whatever injury was sustained was minor. The same could be said for a negative neurological exam. (RX10, 40).

Dr. Landre Testimony (RX 11)

Dr. Nancy Landre is a clinical psychologist who has been licensed and certified to practice in Illinois for 27 years. Her specialty is Neuropsychology wherein she evaluates and makes treatment recommendations for people with known or suspected cognitive or psychological problems. She has published articles in the *Archives of Clinical Neuropsychology, The Journal of Nervous and Mental Disease*, and *The Journal of Neuropsychology, Neuropsychology,* and *Behavioral Neurology*. Her published titles have included "Cognitive Functioning and Post-Concussive Symptoms in Trauma Patients with and without Mild TBI." She also published an article in behavioral management strategies for working with persons with brain injury: a manual (2nd Edition) titled "Addressing Cognitive Changes Following Brain Injury." In addition, Dr. Landre has made numerous presentations in relation to cognitive functioning and post-concussion symptoms, neuropsychological performance in patients with mild traumatic brain injury, minor head and traumatic brain injuries, and cognitive and behavioral deficits following head injury. (RX 11, 5-6; Exhibit 1 on Deposition).

Dr. Landre evaluated Petitioner on March 25, 2014, and prepared a narrative report regarding that encounter. Petitioner was referred to her to investigate potential changes in cognitive and emotional functioning following the accident at work on March 5, 2013. (RX 11, 7-9). Petitioner presented with a history of an accident while working as a Supervisor

or a Rental Fleet Manager for Mercedes Benz in Westmont. He suffered an injury to his head when, while standing in the back of a salt truck, he struck his head on an overhead sprinkler pipe and stepped off the vehicle, falling backwards and allegedly hurting his back and left wrist. (RX 11, 9-10). Petitioner's history continued with his being taken to Concentra Occupational Health where he denied loss of consciousness but complained of headache, dizziness and pain as well as neck, low back and left wrist pain. The diagnosis at Concentra was a left frontal face/scalp contusion, concussion without loss of consciousness, and cervical, lumbar and left wrist sprains. He was referred to a local ER for a CT scan. (RX 11, 9-10). Dr. Landre stated that with no loss of consciousness, the accident was likely a "pretty minor injury" if the blow was insufficient to render him unconscious. There was a negative CT scan of the brain which, with the other injury characteristics, indicated that at worst Petitioner had a mild, uncomplicated concussion. (RX 11, 11).

Dr. Landre's history continued with Petitioner's report that he followed up with Occupational Health the day after the accident when the wrist and back were improving but the headaches and dizziness continued. He denied nausea, vomiting or other symptoms suggestive of increased intracranial pressure at the March 6, 2013 follow-up visit. His exam was normal at that time except for stiffness in the cervical spine and low back and left wrist tenderness. The diagnosis at Occupational Health was low back pain, forehead contusion, and left wrist sprain. He was released to return to work with a restriction of no lifting over 20 pounds and no climbing. Despite the modified release, Petitioner complained of nausea, blurry vision, forgetfulness, fever, ear pain, a sore throat, insomnia, photophobia, and depression. An MRI of the lumbar spine revealed mild degenerative

disease and bulging at L3-4; a brain MRI was negative. He was treated with medication and referred for physical and vestibular therapy, with limited improvement. (RX 11, 11-12).

Petitioner continued working and reported having been advised to refrain from work-related driving and to avoid lifting more than 15 pounds. By July, 2013 Petitioner claimed he was limited by low back pain and was unable to push or pull or to perform prolonged standing and walking. He continued to complain of headache, memory issues, dizziness, nausea and vision changes. He was taking different medications, including psychotropic medications. (RX 11, 12-13). He underwent a neuropsychological evaluation with Dr. Hill on August 29, 2013, when his complaints were similar to those described above and included problems with concentration. In addition, he felt out of sorts, sad, tearful, worthless, and scared about the future. Dr. Hill's examination included an assessment of response bias which was abnormal, suggesting suboptimal effort. Dr. Landre noted that Dr. Hill advised that the neuropsych test results needed to be interpreted with caution. (RX 11, 13-14). The test results were such that Dr. Landre opined that he was actively suppressing his own performance. This was significant because one cannot interpret tests which result in these types of findings. Dr. Hill found Petitioner to be depressed and anxious. However, a comprehensive personality test was deemed invalid due to inconsistent responding. This testing has built-in validity checks to ensure that a person responds purposefully and genuinely. Dr. Landre stated that Dr. Hill's test results in this regard were invalid as they were not interpretable. The comprehensive personality test results called into question Petitioner's credibility regarding his symptoms. Dr. Landre appeared to agree with Dr. Hill's conclusions that the cognitive test results were questionable due to a number of factors. Nonetheless, Dr. Hill diagnosed post-concussive

syndrome and generalized anxiety disorder with panic attacks and symptoms of depression. (RX 11, 14-17).

Dr. Landre had also reviewed the Dr. Zelby report from the September 6, 2013, evaluation. Dr. Zelby was of the opinion that Petitioner's subjective complaints were completely inconsistent with the objective medical evidence and that he was able to resume all pre-injury activities without restriction. (RX 11, 17-19). With regard to the treatment the Petitioner received with the social worker, Ms. West-Hooper, Dr. Landre described no significance to her opinions. (RX 11, 22).

When Petitioner presented to Dr. Landre, his affect was stable but constricted. His mood was distressed but in a dramatic, non-credible manner. Dr. Landre performed multiple tests, including psychological tests during which Petitioner's performance was markedly abnormal. He failed three of the stand-alone measures and five out of five imbedded validity measures. One test, developed to detect malingering, was markedly elevated, indicating that it was unlike that of patients with genuine cognitive psychological and/or neurological problems and highly consistent with malingering. (RX 11, 26-27). In addition, Petitioner's responses to one of the standard psychological assessments yielded an invalid profile secondary to marked over-reporting of somatic, cognitive and psychiatric symptoms. Collectively, the findings of these tests indicated that Petitioner's cognitive and emotional results were not valid for interpretation as they portrayed him as much more impaired than he actually was. The same resulted with motor functioning tests and language function. (RX 11, 27-28). Visuospatial functioning and attention processing were moderately impaired. But his performance on a simple measure of psychomotor speed was profoundly impaired, as was executive functioning. Petitioner demonstrated

moderately impaired performance on certain parts of learning and memory capability testing; his memory for designs immediately following their presentation and following a delay of three minutes were severely impaired and borderline impaired, respectively. Total recall was mildly impaired; delayed recall ranged from moderately to severely impaired. The recognition component of recall on verbal material was also severely impaired. (RX 11, 28-30).

Dr. Landre considered Petitioner's pre-morbid intellectual functioning to have been within the low average to average range of ability whereas his current performance was markedly discrepant from that, with IQ tests placing him in the moderately impaired range of functioning. Regarding emotional functioning, scores were markedly elevated which would normally indicate a severe, clinically significant mood disorder. (RX 11, 30). Dr. Landre administered the MMPI-2-RF profile, the Minnesota Multiphase of Personality Inventory, 2nd Edition. This test is a very comprehensive measure of emotional or psychological functioning. The results of this test were not capable of interpretation because they were invalid due to an excessive number of infrequent responses. The Petitioner's level of infrequent responding during the test would be uncommon even in individuals with genuine severe psychopathology. Further, Petitioner reported a considerably larger than average number of physical symptoms that are rarely described by individuals with genuine medical conditions. The overall results were a very unusual combination of responses that had been shown to be associated with non-credible reporting of physical and cognitive symptoms. Dr. Landre described that the test developers considered this pattern uncommon even in individuals with substantial medical problems and severe emotional dysfunction who report credible symptoms. Dr. Landre

considered it of interest that Petitioner clearly understood item content and was not confused: There are two scales which measure this and on these he had normal scores. The most common diagnostic consideration for an individual with Petitioner's profile according to the test developers, is malingering. (RX 11, 31-32).

Dr. Landre was of the opinion that Petitioner had sustained, at worst, an uncomplicated concussion and that his workup was essentially unremarkable. He nonetheless complained of a variety of post-concussion and other symptoms which failed to improve as expected, despite time and an extensive course of treatment. Although he was working at the time of the evaluation, he reported severe physical, cognitive, and psychiatric problems. The results of her evaluation reflected highly abnormal cognitive functioning with markedly abnormal performance on nearly all neuropsychological assessment measures. These results were felt to be invalid because Petitioner failed multiple performance validity indicators. (RX 11, 33). Petitioner's level of performance was improbably low for someone with Petitioner's injury characteristics; his complaints and course of recovery were highly inconsistent with his injury characteristics. The available evidence suggested that factors other than the injury were driving Petitioner's complaints. Dr. Landre concluded that the available evidence strongly supported the conclusion of probable malingering. (RX 11, 34).

Dr. Landre reviewed the Dr. Ahsan May 28, 2015 report wherein Dr. Ahsan diagnosed agitated depression, generalized anxiety disorder, post-concussion syndrome and PTSD. Dr. Landre was of the opinion that Petitioner did not have any of these conditions. She was of the opinion that

Petitioner did not have a neuropsychological condition related to the accident at work on

March 5, 2013. As regards the relationship between Petitioner's complaints and his alleged post-concussion syndrome and the alleged injury at work, Dr. Landre stated that they were unrelated. (RX 11, 35-36). Dr. Landre felt Petitioner was capable of driving and was not in need of additional treatment. She was of the opinion that he could perform full-duty work, no restrictions; he was at maximum medical improvement. She felt the treatment he had received prior to her evaluation was not reasonable and necessary because it was apparent that factors other than his injury were driving Petitioner's symptom complaints and therefore, treatment after the September 20, 2013 evaluation demonstrated that factors other than Petitioner's injury were driving his symptom complaints. (RX 11, 36-38).

Dr. Landre reviewed a report from the neuropsychologist, Dr. Hill, who performed repeat neuropsychological testing on February 12, 2016. The findings from those tests were similar to her previous examination and that of Dr. Landre. The findings were markedly abnormal and, if taken at face value, would suggest severe problems with cognitive and emotional functioning. Dr. Landre felt that those results were uninterpretable due to the fact that Petitioner again failed multiple performance validity tests and that the level of his performance was implausibly low for someone with his injury characteristics. She testified that Dr. Hill acknowledged problems with the validity of the tests. She stated that Petitioner had "performed below cutoff on a test of response bias, suggesting suboptimal effort on cognitive testing." Notwithstanding this statement, Dr. Hill considered Petitioner's complaints consistent with a post-concussive syndrome. She then diagnosed multiple conditions of post-concussion syndrome, agitated depression, generalized anxiety disorder and PTSD, per Petitioner's psychiatrist. (RX 11, 38-40). Dr. Landre stated that

Dr. Hill's updated testing did not support her diagnoses but rather provided additional evidence of malingering. Specifically, Petitioner had by then demonstrated problems with the validity of his test performance and credibility of his self-report on three separate occasions. His course of recovery and complaints were highly inconsistent with his injury. (RX 11, 39-40).

Dr. Landre also reviewed the evaluation report of Dr. McManus. This stated that Petitioner had been terminated and had not resumed work in any capacity secondary to cognitive and psychological symptoms. Dr. McManus administered what Dr. Landre considered a very limited evaluation which consisted of review of select medical records, a clinical interview and a single psychological assessment test from which Dr. McManus opined that Petitioner suffered from PTSD, a major depressive disorder, and generalized anxiety disorder which he attributed in part to the accident. (RX 11, 41-42).

Dr. Landre testified that Dr. McManus' opinion was based solely upon Petitioner's self-report with regard to his pre-injury experiences in Bosnia for which there is no corroborating evidence. Because information from other sources indicated Petitioner's self-report was of low validity, she considered this conclusion unfounded and unsupported. Also, Petitioner did not report PTSD symptoms at the time of her evaluation, only physical and cognitive complaints. Further, Petitioner specifically denied any history of psychiatric problems. However, even if Petitioner had experienced significant trauma in Bosnia and, in fact, suffered from PTSD prior to the accident at work, that would not explain his failure on multiple performance in symptom validity tests. Those measures were developed specifically so that they could be easily passed even by people with significant mental health or medical disorders. Therefore, his invalidating scores on multiple performance

and symptom validity tests could not be interpreted as reflecting anything other than intentional poor performance and exaggeration or feigning of injury relating symptoms. (RX 11, 43-44).

Dr. Landre disagreed with the opinion that Petitioner's symptoms were an exacerbation of a pre-existing PTSD. His medical records clearly indicated that he had no more than a bump on his head after walking into a pipe. More important, there was no indication that he was distressed at the time of the injury and the early medical records indicated that his psychiatric and neurological exams were unremarkable. Dr. Landre found it difficult to construe how a relatively minor injury could exacerbate pre-existing PTSD, particularly to the degree Petitioner demonstrated. And, also important is that the incident did not satisfy criteria for PTSD: The triggering incident must involve exposure to actual or threatened death, serious injury or sexual violence. Petitioner's presentation and extreme unremitting symptoms were highly uncommon even among patients with legitimate PTSD. (RX 11, 44-45).

Dr. Landre also disputed Dr. McManus on the question of Petitioner being pressured to return to work when he had not been medically cleared to do so. She testified that that assertion was not consistent with recent evidence regarding the management of post-concussion symptoms. Research has shown that brain rest is ineffective and frequently counter-productive following an injury of that nature. (PX 23). Even if Petitioner had been pressured to return to work, this had no impact on his symptoms or recovery. (RX 11, 45). And, even though Dr. McManus opined that Petitioner was not malingering, he acknowledged that Petitioner's MMPI-2 results and his scores on the performance validity testing were well within the invalid range. Dr. McManus attributed this to the pre-morbid

PTSD and his lack of fluency in English. Dr. Landre stated that Dr. McManus lacked understanding with regard to the psychometric properties of and the published literature regarding the reliability and validity of these indices. There is a large volume of research which demonstrates that symptom and performance validity measures are easily passed even by individuals with significant genuine psychiatric medical and/or neurological condition. (RX 11, 46).

In addition, Petitioner's test results clearly indicate that his ESL (English as a Second Language) status had no impact on the test results. Specifically, there are two validity scales on the MMPI that were developed to ensure that test takers clearly understand the item content and are responding in a reliable manner. Petitioner obtained normal scores on both these scales, indicating that he indeed clearly understood and responded purposefully to the test items on the basis of their content. The assertion that ESL status could have accounted for the failure on performance and symptom validity testing is unsupported. (RX 11, 46-47).

The large body of peer-reviewed literature suggests that failing multiple performance validity testing is highly unlikely among credible individuals who provide genuine effort. More specifically, research demonstrates that 30% of credible individuals will fail one performance validity test when administered a comprehensive battery of tests. Failure on two or more has shown to be associated with a high probability, between .94 and .99, of performance invalidity. Petitioner failed eight out of eight PVT indexes as well as both symptom validity tests. These results indicated he was non-credible and did not provide genuine effort. The low performance on cognitive indices was lower than among individuals with severe brain injury, dementia and other serious neurological conditions.

(RX 11, 47-48).

Dr. McManus did not administer cognitive testing. He administered only the personality assessment inventory. Research regarding that particular test has shown that its sensitivity or ability to detect malingering is quite poor. A published survey of practicing neuropsychologists indicates that that test does not appear on a list of 29 measures used by neuropsychologists for that purpose. The test she administered, the MMPI-2-RF, is supported by a very large body of peer-reviewed literature and is the second most commonly used measure for detecting malingering. (RX 11, 48-49).

Dr. Landre was of the opinion that administering a single symptom validity measure in the context of a forensic evaluation is inconsistent with long-established professional practice guidelines for neuropsychologists. The National Academy of Neuropsychology recommends that psychologists employ a number of techniques and interpretation guidelines when seeing patients in a forensic context. Professional practice guidelines state that multi-method, multi-test approaches should be given substantially greater weight than subjective indicators of suboptimal efforts such as examinees' statements and examiners' observations. (RX 11, 49-50).

Dr. McManus' conclusion was based solely on very limited test results and his "reinterpretation" of previous test results. He explained the test results away as due to PTSD or ESL issues but did not explain Petitioner's failure on the other symptom validity tests on which Petitioner obtained exceptionally high score: a total of 48 on a test where a score of 14 is considered suspicious for malingering. The likelihood of a credible Claimant obtaining a score of more than 24 on this instrument is less than 1%. Finally, Dr. McManus did not address Petitioner's failure on the eight performance validity tests which is

essentially never observed; Petitioner failed one of those indices at a near-chance level which is strong evidence of an intentionally poor effort. (RX 11, 50-51).

Dr. Landre opined that the conclusion of malingering was not made lightly but rather was based on widely accepted published criteria, specifically The Slick Criteria published in 1999. This is a set of established criteria which, Dr. Landre stated, showed clear evidence of exaggeration or fabrication with psychological dysfunction: His self-report was discrepant with information contained in the medical records, his symptoms were discrepant with known patterns of brain functioning, and his symptoms were discrepant with behavioral observations. Finally, published research indicates that there is a very high rate of malingering, 40% or higher among traumatic brain injury litigants. This clearly provides unequivocal support for a conclusion of malingering. Dr. Landre disagreed with the proposition that Petitioner's emotional difficulties were aggravated by the accident. She considered Dr. McManus' opinion defective because he based his opinion solely on based on Petitioner's self-report. (RX 11, 51-52).

Petitioner's current condition

Petitioner testified that he is still under the care of his neurologist, Dr. Pilcher and psychiatrist Dr. Ahsan. From July to September 2017 he was treated for depression at Silver Cross Hospital's outpatient program. Petitioner reviewed the list of medications in (PX 22, 1-2) and agreed that he was currently taking all of them except for amoxicillin and diazepam. Tr. 154. Petitioner testified that he continues to experience headaches, nausea and dizziness, and takes Meclozine for dizziness. Tr. 184. He still has hallucinations, flashbacks, nightmares, including in the past month. Petitioner testified that prior to his accident he did experience some nightmares and flashbacks related to his past in Bosnia. However, these did not keep him from going to work, and he did not seek treatment prior to his accident. Tr. 184.

FINDINGS/ANALYSIS

WITH REGARD TO ISSUE C.: DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IT THE COURSE OF PETITONER'S EMPLOYMENT BY RESPONDENT, AND ISSUE F.: IS PETITIONER'S CURRENT CONDITION OF ILL-BEING AUSALLY RELATED TO THE INJURY, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS:

Initially the Arbitrator notes the Petitioner, a 34 year old Bosnian immigrant, was working for the Respondent car dealership since 2001. Regardless of title, Petitioner worked as a porter and gave customer care or service to the clients of Mercedes-Benz. The facts surrounding the March 5, 2013 accident are not in dispute. Petitioner was injured during the course of his employment when he stuck the left side of his head on a pipe and subsequently also slipped and fell hurting his back, buttocks and wrist. Although there is disagreement and factual disparity regarding whether the Petitioner suffered a LOC, there is no disagreement that Petitioner suffered physical injury to his temple and his back. (Wrist or buttocks injury is minimal by all accounts) The greater and more complex issue in this case related to Petitioner' claim of mental injury. Without attempting to untangle the knots within this argument, briefly, the Petitioner claims that his childhood in Bosnia during the Bosnian civil war had subjected him to great mental harm. Essentially, he suffered PTSD and depression. He alleges that the physical injury of March 5, 2013 and the resulting medical issues caused his work life to suffer, that he was ridiculed and demoted and eventually laid-off. In essence, the physical injury and the subsequent sequence of events have caused him to suffer a great mental health injury that are causally connected to his work accident.

The hearing in this case was vigorous, the medical records prolific and plentiful. There were several complicated issues regarding admissibility of Bosnia war photographs

as well as whether Petitioner's clinical social worker, Ms. Gail West-Hooper, can give **expert** opinion on Petitioner's medical condition.

Prior to rendering her opinion, the Arbitrator notes that this opinion is not meant to disregard the real atrocities of the Bosnian crisis and the terrible human toll that it has extracted from all who suffered from it. The Arbitrator also notes the complexity and difficulty in assessing mental health claims that can very well persist long after the physical injury has healed. The Arbitrator also notes that while it is difficult to find conclusive physical evidence in psychological/mental injury cases; that undue and sole reliance on self-reporting of symptoms, without a keen examination and critical evaluation of all the material facts can lead to disparate results.

Upon evaluating the totality of all the medical records, opinions, evidence and testimony presented in the case, the Arbitrator concludes that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on March 5, 2013, when he struck his head on a pipe and also injured his low back. The is some evidence that the Petitioner landed on buttock and uses his wrist to brace himself, however those injuries were de minimis. The Arbitrator finds that the Petitioner injured the left side of his forehead and suffered a concussion and also suffered a low back sprain from his subsequent fall. The Arbitrator finds that Petitioner returned back to work on March 9, 2013 and worked at his usual job for almost three years, until his economic layoff in February 2016. The Arbitrator finds that the Petitioner received minimal conservative medical treatment after his injury that included PT and speech therapy. As to his back injury, there are no current on-going medical issues. The Arbitrator finds that the Petitioner did suffer a back sprain that arose from his work accident, but he is at MMI for this injury.

As to mental health injury claim, Petitioner alleges that currently suffers from severe impairments of post-concussive syndrome, PTSD, mood disorder, anxiety and somatoform disorder that are all related to his work accident. Although sympathetic to Petitioner's history, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his current condition of mental ill-being is causally connected to the incident at work on March 5, 2013.

Prior to delving into the details of the medical and testimonial evidence in support of her position, the Arbitrator notes the following compelling/obvious deficiencies in Petitioner's position:

- There is conflicting evidence, at best, that Petitioner suffered a LOC. Although this is just one of many elements to indicate a serious injury, the Arbitrator notes that the Petitioner initially does not report a LOC.
- Petitioner returned to full-time, regular duty soon after the accident and continued to until February 2016. His own doctors as well as the IMEs believe this to be a significant aspect of the case. The escalation of his symptoms and his claim after the layoff may be coincidental or related to his layoff, but it is also suspect due to the timing. The Arbitrator finds this long three-year work continuation period (following the injury) to be one of the most significant fact that weakens Petitioner's position.
- Petitioner's claim that he was demoted to janitor is unsubstantiated, at best, and aimed for personal gain or sympathy. It is wholly without support.
- Petitioner's claim that his co-workers harassed him and contributed to the deterioration of his mental ill-health is not credible as there are no supporting

complains by him in this regard. Even if taken as partially true, there needs to be strong and medically certain support that this contributed to his original injury or is a secondary injury in and of itself.

- The testimony of Gail West-Hopper is not credible and in the Arbitrator's estimate, her testimony is not objective. Ms. West-Hopper gives divergent testimony of her own financial interest in rendering her voluntary services for the Petitioner. Her insistence and belief that as a clinical social worker she is authorized to give an expert medical opinion as to Petitioner's medical diagnosis is note-worthy. She lacks medical credentials, has performed no independent testing in support of her diagnosis. Although the Arbitrator has allowed her to forward her diagnosis, the Arbitrator gives little to no value to her opinion based on her lack of proper credentials and her seeming personal self interest in Petitioner's case outcome.

- Petitioner's prior medical history has no mention of PTSD or prior psychiatric treatment from his experience in Bosnia that he claims was aggravated by his work injury. This is significant. It is the Arbitrators opinion that this medical theory evolved and went in search of support rather then rising reasonably or organically as a logical conclusion based on Petitioner's prior recorded medical history. This stretch to reasoning that a Petitioner with no prior reported medical PTSD history suddenly became mentally disabled from a relatively minor injury to his head causes the causation argument to fail.

- Petitioner's testing by Ms. Erin Hill is of poor validity.

- The Petitioner did not display fidgety behavior in court until his attorney directly asked a witness a question in this regard. On cue, Petitioner then started to fidget.

- Petitioner insisted that there is a scar or a mark of a severe injury on his left lobe but there does not appear to be a distinct mark there. Both left and right side seem to have a very slight, similar dent/marking that does not resemble scarring.
- Dr. Mcmann does not discount that Petitioner may be malingering and acknowledges that 29 unrelated responses on the neuropsychological evaluation are 'highly unusual'.
- A significant, if not singular, aspect of Petitioner's treating physician opinions is based on Petitioner's self-reported symptoms. There is paucity of objective medical tests that would support Petitioner's subjective complaints. Rather, the lumber MRI, the diagnostic brain studies, the CT and the closed head study on EEG all indicate normal findings.
- The accident and physical injury are not serious enough to account for the extremely long period of ill-being claimed by Petitioner. Additionally, Petitioner's claim that his ill-treatment by his co-workers caused his deterioration is not credible. Specially in an allegation of mental or psychological injury, it is paramount that the fact-finder look towards the severity of the original physical accident and gauge that against the length and breath of time that it took the Petitioner/injured party to recover from the after-effects. In this case, there is a great disproportionality between the relatively minor accident (that did not require lengthy over-night hospitalization or give positive MRI results) and the long term temporary total disability claimed by the Petitioner
- The work accident was not of a nature similar to war trauma. (Compare that, for example, to a case where someone with a prior childhood trauma may have been held at gunpoint in a work-related robbery) Dr. Landre notes the American Psychiatric

Association criteria for PTSD require "exposure to actual or threatened death, serious injury or sexual violence". In this case, Petitioner suffered an honest accident, not one caused by events outside of his control where he was subjugated to the atrocities or war. Although Petitioner tried to relate the alleged mis-treatment by his co-workers as a similar causal trigger, this testimony is weak, over-stretched and unsupported by any extrinsic evidence. It appears to be created to find some weak link or commonality with the events in Bosnia. This shows a recognition and acknowledgement that the work-accident needs to be a sufficiently similar and/or of an intensity and gravity to warrant a re-opening of old wounds. The Arbitrator find this to be absent in Petitioner's case.

The Arbitrator notes the above points as a bold reference in evaluating the Petitioner's claim. Although the majority of the Arbitrator's decision is based on the medical findings, the above points are poignant in assessing the diverging medical opinions. The Arbitrator further elaborates on her opinion based on the medical evidence as follows:

The Arbitrator finds the testimony of Respondent's witnesses Christine L. Brady and Dr. Nancy Landre more credible, both generally and specifically, with regard to two important issues: The allegations Petitioner made regarding an alleged demotion he received after the accident; and the results of neuropsychological testing and the diagnoses made by Petitioner's treating physicians and his expert, Dr. McManus. The Arbitrator also gives weight to the report and testimony of Dr. Zelby who evaluated Petitioner in September 2013, for his low back condition as well as the head injury.

The Arbitrator has reviewed the medical records introduced into evidence, including those from Concentra Hospital, Hinsdale Hospital, the social worker, Gail West-Hooper, who also testified, Dr. Frank, Dr. Sharif, Adventist Bolingbrook Hospital, Dr. Brown, Dr. Hill, a

neuropsychologist, Dr. Diwan and Dr. Ashan, psychiatrists, and Dr. Pilcher. The Arbitrator notes the treatment Petitioner has received from his various treating physicians, his social worker, and the neuropsychologist and concludes that the treatment Petitioner received for psychological problems following his return to work on March 9, 2013, was not causally connected to the accident at work in March, 2013.

The Arbitrator finds more credible the testimony of Dr. Landre and Dr. Zelby as well as the conclusions of Dr. Hill, the neuropsychologist, that Petitioner had sustained a minor injury the symptoms of which should have resolved within a short amount of time. The Arbitrator understands that there are instances where individuals will report persistent problems following head injuries, even minor ones, but cannot conclude that these symptoms relate to the accident at work in this case. The testimony of Dr. Landre is compelling in this regard. Dr. Landre reviewed medical records and performed a full battery of 24 psychological and neuropsychological tests and procedures, which reflected incongruent results reflective of symptom magnification. Dr. McManus tested Petitioner only for psychological difficulties and did not perform neuropsychological testing. Only Dr. Landre and Dr. Hill performed such tests and both Dr. Landre and Dr. Hill found the results of the tests invalid. These tests were invalid, according to both Dr. Hill and Dr. Landre, because Petitioner was reporting symptoms which were far beyond what individuals with profound psychological and neuropsychological defects report on testing.

Dr. Hill felt that notwithstanding the invalid results that Petitioner suffered from post-traumatic stress disorder; however, Dr. Landre testified very specifically to each area of testing and how the results of each test reflected incongruent results; Dr. Hill did not. Also, the Arbitrator notes that Dr. Hill's opinion in this regard was rendered only after her *second*

evaluation in 2016. In August 2013 this was not part of her diagnosis. The Arbitrator thus places greater weight on the opinions and testimony of Dr. Landre who elucidated with great specificity on the tests she performed as well as those performed by Dr. Hill. The Arbitrator places far less weight on the testimony and opinions of Dr. McManus because Dr. McManus performed only psychological testing and based his diagnosis solely on one psychological test and Petitioner's self-reporting. Dr. Landre stated that formulating a diagnosis on such limited and self-serving information does not comport with the protocols of their profession.

In addition to the results of neuropsychological testing, Petitioner's testimony regarding his work at Mercedes Benz of Westmont is troubling. First, Petitioner claimed to be the "head"' porter and that he also was the rental car manager. However, his business card stated he was a "Customer Care Specialist." This suggests that Ms. Brady's testimony with regard to Petitioner's job duties was

more correct: he was a porter, both before and after the accident. It is clear Petitioner was never a janitor, either before or after the occurrence. The Respondent used an outside janitorial service to clean bathrooms on a daily basis. Porters were sometimes asked to clean around the coffee machine or, in unusual circumstances, perhaps perform cleaning; however, this was not part of Petitioner's regular duties.

The Arbitrator also finds Petitioner's testimony with regard to his duties at the Respondent incongruent with Petitioner's allegation that he performed poorly on neuropsychological testing due to having English as a second language. His attorney made much of the fact that the MMPI-2 was not given in Petitioner's language, but the Petitioner testified in English with no apparent difficulty and spoke English with all providers as well

as the expert examiners. None of the expert examiners (Hill, Landre, Zelby, and McManus) made note of difficulties in communication due to language problems. Indeed, Dr. Landre pointed out a major incongruity in the testing in that Petitioner tested normal on content whereas all other phases of testing were abnormal, which supported her opinion that Petitioner was malingering. Dr. Landre made clear that Petitioner had no difficulty whatsoever understanding the content of the questions being posed. This causes the Arbitrator to rule out any facet of communication difficulty as the source of the abnormal testing. Rather, the Arbitrator concludes that Dr. Landre's opinions are the most consistent with the test results which include the two neuropsychological tests, both invalid, performed by Dr. Hill.

Petitioner claims that his experiences in Bosnia when a young boy caused a post-traumatic stress disorder which was aggravated by the head injury in March, 2013. However, the record does not reflect a history of treatment for post-traumatic stress disorder. Petitioner testified to his experiences visiting Bosnia, but when seen by Dr. Landre denied a history of post-traumatic stress disorder resulting from his prior experience in Bosnia. Rather, the PTSD claim seems to have been a developing concept after the occurrence, a self-reported phenomenon, which by Ms. West-Hooper's testimony increased after Petitioner's layoff, a non-work related event.

The Petitioner returned to work performing the full duties of a porter four days after the accident. He performed these same duties for three years until an economic layoff. Following the layoff, he claimed that he could no longer work at all. The Arbitrator finds this claim to be inconsistent with the fact that he was able to work at full duty for three consecutive years with no apparent disturbance. No grievance was reported, nor any

complaint made to Petitioner's managers or Human Resources. This is also inconsistent with the opinions of Dr. Zelby who examined Petitioner before the layoff and Dr. Landre as well. Even Dr. McManus could not state that Petitioner had sustained any permanent disability as a result of the accident. As of the time of the layoff, Petitioner was earning more than the weekly wage to which the parties stipulated. The Social Security decision indicates that the disability award would be reviewed in 18 months. The Arbitrator concludes that there is little to support the claim for total disability or a claim for ongoing temporary total disability at this time. The fact that Petitioner could work at full duty for three years following an incident and only after the incident became totally unable to work is not credible.

The Arbitrator agrees that the incident was minor based on her observations of the alleged location of the blow to the head on the left side in the temple area. The Arbitrator observed that there was an indentation on the right side of the head which looked the same as that on the left. This observation also impacts on and supports the testimony of Dr. Landre who considered Petitioner to be exaggerating. It also impacts on Petitioner's credibility on the issues of his alleged demotion after the accident and his inability to work after an economic layoff.

In sum, the Petitioner sustained a blow to the head, a minor traumatic brain injury that resulted in a mild concussion. He also sustained a back strain per his initial report of injury. Most of Petitioner's symptoms resolved but, over time, his symptoms seemed to increase, especially after the economic layoff. The Arbitrator cannot conclude that the symptoms which increased after the economic layoff and of which Petitioner complained at the time of trial are causally connected to the accident at work in March, 2013. The

Arbitrator places greater weight on the opinions of Dr. Landre who opined that Petitioner was magnifying symptoms or malingering. The Arbitrator considers Dr. Landre's testimony compelling in this regard as her testing and testimony were the most comprehensive. The evidence introduced is insufficient to support a theory of total disability or that Petitioner has been temporarily totally unable to work since the economic layoff in 2016, before which he was performing his customary work duties.

Additionally, in discounting the arguments and opinions of Petitioner and his medical experts the Arbitrator notes as follows: Both sides propose and the medical records show that all of the neuropsychological testing administered by all three doctors (Dr. Landre, Dr. McManus and Dr. Hill) clearly shows that Petitioner's scores on tests of cognitive abilities were outside the norms of validity set by the test developers, and lower than would be expected for the type of head injury he had sustained. The Petitioner urges that this is due to Petitioner cultural and language limitations, his medications and due to his fidgety behavior caused by his mental illness. Petitioner also contributes Dr. Landre's findings against Petitioner to her bias. Respondent's expert, Dr. Landre, discounts these causes as she points out that tests themselves are embedded with safeguards for these types of conditions and issues and that Petitioner language and cultural makeup was insufficient to account for the test results. In disagreeing with Petitioner arguments, the Arbitrator finds that Dr. Landre's findings, opinions and deposition testimony appear to be free of any obvious or implied personal or professional bias. Dr. Landre's tests and exams appear to be conducted in a professional manner. Secondly, as to the argument that Petitioner's language, culture or illness caused the results to be disfavorable, there is little sufficient scientific support for this explanation by Dr. Hill and Dr McManus. Initially, Petitioner

presented himself before the Arbitrator for a trial that lasted the majority of the day. The Arbitrator observed him; he communicated and clearly expressed and advocated for himself. In our diverse state, specially at the Commission, people from all walks of life and from diverse national and culture backgrounds present themselves before the court. Such diversity can sometimes be both a blessing and a hardship for the litigants and the fact-finder. However, as a finder of fact, the Arbitrator must account and accommodate for people whose cultural, educational and intellectual framework is diverse. The Petitioner, in this case, was pleasant and while occasionally upset and passionate about what had happened to him (in Bosnia and at work), was able to understand his environment and zealously advocate for himself by answering the questions in court. What his doctors state caused his tests to be skewed, was not present or obvious in court which also presents a stressful environment for witnesses. Secondly, it defies logic and reason, that well developed, accepted neuropsychological tests whose very purpose is to test a wide diversity of people who suffer from mental issues, do not have built in safeguards to counter issues and challenges that testing mentally ill patients presents. For such tests to be invalid if they test a subject with cultural or psychological challenges, means that such tests are not appropriate for use in testing people with mental health challenges. The very function of these tests is to work with people with psychological issues. Petitioner's arguments that his results are affected and inaccurate due to his cultural, language or psychological challenges is circular reasoning and insufficient to overcome his burden of proof.

Therefore, the Arbitrator finds that the Petitioner did suffer an injury to his head, back and wrist but that he has recovered from these injuries. The Arbitrator finds that his

current condition of ill-being, in regards to his claim of mental/psychological illness, is not related to his work accident.

WITH REGARD TO ISSUE J: WERE THE MEDICAL SERVICES THAT WERE PROVIDED PETITIONER REASONABLE AND NECESSARY/HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL EXPENSES, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS:

Based on the Arbitrator's findings and conclusions with regard to the issue of causal connection, the Arbitrator denies the claim for additional medical services. Petitioner failed to prove that his condition of ill-being, other than the minor head injury and low back sprain, was causally connected to the accident at work in March 2013.

WITH REGARD TO ISSUE K: WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS:

Based on the Arbitrator's findings and conclusions with regard to the issue of causal connection, the Arbitrator denies the claim for temporary total disability benefits. The Petitioner failed to prove that the layoff at work was caused by his then condition of ill-being or that his current condition of ill-being is causally connected to the accident at work in March 2013.

WITH REGARD TO ISSUE L.: WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS:

This matter was heard under Section 19(b) of the Act. However, the parties stipulated that the Arbitrator could make findings with regard to permanent disability if the Arbitrator concluded that the evidence warranted an award for disability. In light of the

Arbitrator's findings on the issue of causal connection, the Arbitrator has concluded that the evidence warrants an award for permanent partial disability.

To that end, the Arbitrator finds that Petitioner has sustained permanent partial disability to the extent of 6% as provided by Section 8(d)2 of the Act. The basis for this finding is that Petitioner sustained a mild concussion and low back sprain as a result of the accident of March 5, 2013. He received appropriate treatment for these injuries at Concentra Occupational Health and Hinsdale Hospital. He testified to a multitude of symptoms which the Arbitrator has found not related to the accident. However, the Arbitrator notes that he had symptoms of headache and low back pain after the accident which would warrant an award for permanent partial disability.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC005559
Case Name	ISSLER, GARY v. THE AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0473
Number of Pages of Decision	16
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Kenneth Werts

DATE FILED: 9/17/2021

/s/Maria Portela, Commissioner

Signature

21IWCC0473

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY ISSLER,

Petitioner,

vs. NO: 16 WC 5559

THE AMERICAN COAL CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causation and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of occupational disease but attaches the Decision for the Findings of Fact, which is made a part hereof, with the modifications noted below.

The Commission finds that Petitioner failed to prove he suffers from the occupational disease of coal workers' pneumoconiosis (CWP) and we strike the Arbitrator's Conclusions of Law in their entirety. However, we specifically address a few of the Arbitrator's findings.

First, the Arbitrator incorrectly found that "Dr. Castle's report made no reference to Petitioner's work as a coal miner…." *Dec. 7*. Dr. Castle's report does contain references to Petitioner's work as a coal miner in his discussion of the records from Southern Orthopedic and those of Dr. Paul. Dr. Castle included in his conclusion that Petitioner "apparently worked in the mining industry for about 30 years and most of that time was spent as a service man. This is sufficient enough exposure history to have possibly caused him to develop [CWP] if he were a susceptible host." *Rx2-DepRxC at 4*. Therefore, in contrast to the Arbitrator's finding, Dr. Castle's report does specifically reference Petitioner's work as a coal miner. In addition, the Arbitrator found that Dr. Castle's review was "neither thorough nor based on the preponderance of the treatment citations." *Dec. 7*. However, we note that none of Petitioner's experts reviewed any medical records at all. *Px1 at 41; Px2*.

Second, the Arbitrator's statement that "Respondent provided no direct patient history, no physical examination, no pulmonary function testing, and no chest x-ray of its own" (*Dec. 6*) is completely irrelevant to the question of whether Petitioner suffers from CWP. We find that it was unnecessary for Respondent to have its own expert directly obtain Petitioner's history because "exposure" was not disputed. Furthermore, Petitioner's medical expert, Dr. Paul, took Petitioner's history and testified that Petitioner had no symptoms and was taking no breathing medication. *Px1 at 40*. In addition, Dr. Paul testified that Petitioner had normal pulmonary function testing and physical examination. *Px1 at 12, 41*. We find there was nothing in Dr. Paul's history, testing or examination of Petitioner which required that Respondent obtain a contrary opinion. We also disagree with the Arbitrator's finding that "an examination would provide a superior dataset than a mere records review." *Dec. 7*. Even though Dr. Paul performed a physical examination, his opinion that Petitioner has CWP was based solely on his interpretation of Petitioner's chest x-ray and his history of exposure to coal dust and the "coal mine environment." *Px1 at 12, 43*. Although Dr. Castle testified that, in general, doing an examination in addition to the records review would "help me make the most accurate assessment," (*Rx2 at 43*), we find that the examination was irrelevant in this case. There is no medical opinion in evidence indicating that Petitioner's examination results support a finding of CWP.

Third, the Arbitrator's finding, regarding the Logan Primary Care records, that "the almost 100 medical citations give rise to the rational presumption that Petitioner does have pulmonary and airway problems" (*Dec. 7*) both exaggerates the extent of Petitioner's alleged complaints and is also irrelevant to the issue before us. Those "100 medical citations" to various symptoms and diagnoses are contained in only a handful of records over fifteen years. Furthermore, Petitioner testified, "I never noticed much of a breathing problem." *T.16*. It wasn't until Petitioner was pressed further by his attorney that he testified that he noticed himself coughing more "in the morning" at the end of his career. *Id*. He testified that it got "slightly worse" from the time he noticed it until he left the mine and had "stayed about the same" since he had left the mine. *T.17*. When asked if he ever talked to Dr. Korte about any breathing difficulties, Petitioner testified, "You know, really, I didn't." *T.19*. Although some of the records reflect sinus, upper respiratory and bronchial issues, the examinations were nearly all normal and, for the most part, reflect that Petitioner's lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales and with normal inspiratory and expiratory phases. Ultimately, however, it does not matter how many references to pulmonary symptoms, diagnoses or medications are contained in Petitioner's records because there is no medical opinion to causally relate these to CWP or Petitioner's exposure to the coal mine environment. We point out that Dr. Paul's sole diagnosis was CWP, which is the only occupational disease at issue before us. *Px1 at 43*. He did not diagnose any other pulmonary problems causally related to Petitioner's alleged occupational exposures. Again, as discussed above, Dr. Paul's diagnosis of CWP was based solely on his interpretation of Petitioners' chest x-ray and his history of exposure. None of Petitioner's alleged symptoms, physical examination findings or pulmonary testing results were relied upon by his medical experts.

Chest X-ray Interpretations

Therefore, the only relevant question in this case is whether Petitioner has proven that he has CWP. Of the medical experts, only Respondent's Dr. Meyers provided evidence that he was a certified B-reader at the time of his x-ray review. Dr. Meyers performed his B-reading on November 9, 2017. His B-reader certificate in evidence was valid from January 1, 2019 through December 31, 2022. *Rx1-DepRxB*. Therefore, there is no documentary evidence that his B-reader certificate was valid at the time he reviewed the x-ray. Nevertheless, he testified that he became a B-reader in 1999. *Rx1 at 19*. Although he failed the B-reader test the first time (*Rx1 at 74*), he passed it in 1999 and has passed the recertification every time since then. *Id. at 94*. Based on the above testimony and documentary evidence, we find that Dr. Meyers *was* a certified B-reader at the time he reviewed Petitioner's x-rays.

In contrast, Petitioner's examiner, Dr. Paul, was never a B-reader. Petitioner's "B-reader," Dr. Smith, reviewed Petitioner's x-ray on February 15, 2017, but his B-Reader certificate in evidence was only valid through July 31, 2015. *Px2*. Although it is possible that Dr. Smith had it renewed, based solely on what is in evidence, his certification had expired at the time of his review. Similarly, Respondent's Dr. Castle was formerly a B-reader for 32 years, but he let his certificate expire in June 2017. *Rx2 at 13-14*; *Rx2-DepRxC*. Therefore, he interpreted Petitioner's x-ray as an "A-Reader" only.

Regarding the persuasiveness of the experts, we do not find Dr. Paul to be persuasive because he is not a B-reader. *Px1 at 43*. Dr. Smith's report indicates that Petitioner had simple CWP with small opacities, primary p, secondary p, all lung zones involved bilaterally, profusion 1/0. However, he did not testify to explain his opinion. In addition, there is the question of whether he was a certified B-reader at the time of his review. Dr. Meyers testified that Petitioner's chest x-ray showed "no radiographic findings" of CWP. *Rx1 at 40*. Similarly, Dr. Castle testified that the x-ray showed "no changes of pneumoconiosis." *Rx2 at 28*. After thorough consideration of the evidence, we find the opinions of Dr. Meyers and Dr. Castle most persuasive that Petitioner's chest x-ray did not show findings of CWP.

Radiographic versus Pathologic CWP

Nevertheless, Dr. Paul testified that it is possible to have CWP despite having a normal x-ray. *Px1 at 14*. Dr. Meyers and Dr. Castle also admitted that a person can have CWP even though it is not apparent on x-rays. *Rx1 at 71, 76, 85-86, 88; Rx2 at 41*.

Dr. Paul testified that studies show that 50% or more of long-term coal miners will be found to have CWP at autopsy even though it was not detected radiographically during their lives. *Px1 at 14*.

Dr. Meyers admitted "there is an old study that shows a much higher incidence of finding coal macules in coal workers that haven't reached the degree of severity to be seen at x-ray." *Rx1 at 86*. He admitted there are studies that showed at autopsy as much as 50 percent of coal miners are found to have abnormalities of CWP when they might not have been apparent radiographically during their life. *Id. at 87-88*. He also testified that all long-time coal miners are going to come out with some dust deposit trapped in their lungs; however, the majority of those will not have changes in their lungs that qualify for CWP, which is defined pathologically

by the presence of the coal macule (conglomerate of white blood cells with coal in it). *Id. at 53-54*.

Dr. Castle also admitted that there are studies that show that as many as 50% of long-term coal miners have pathological CWP that was not appreciated by a radiographic study during their life. *Rx2 at 42*. However, on redirect examination, Dr. Castle gave the following testimony:

> Q: In regard to the correlation of chest x-ray to pathology and detection of pneumoconiosis, are you aware of any study that has shown that half or more of the individuals in the study had pathologic evidence of pneumoconiosis, and of that same group, half or more had absolutely no evidence of pneumoconiosis on their chest x-ray?
>
> A: No, not aware of any evidence to that effect. I am aware of the pathologic study done by Vallyathan and so on, that Green and Hatfield were on that where, actually, the majority, I think was 69 percent, had an abnormal x-ray if they had pathologic evidence.

Rx2 at 66-67. We are intrigued by Dr. Castle's reference to a study that showed that 69% of the individuals who had pathologic evidence of CWP also had an abnormal x-ray. However, without actually reviewing these studies, it is difficult to know what they indicate. It is even more difficult to base a factual finding, in Petitioner's particular case, on a general study with unknown details. Nevertheless, even if we were to accept that 50% or more of coal miners may be found at autopsy to have pathologic evidence of CWP that was not appreciated radiographically during their lives, we find this would be insufficient to prove that Petitioner has CWP.

The Arbitrator wrote he "is not speculating nor engaging in conjecture that Petitioner has pathologically significant CWP; however, the Arbitrator does take note of the studies cited by Respondent's expert in finding that 50% or more of long-term coal miners will have CWP diagnosed pathologically if an autopsy is performed at the time of their death. That testimony, combined with the other evidence establishes that Petitioner has met his burden." *Dec. 8*.

It appears to us that the Arbitrator used the "50% or more" study "combined with the other evidence" to find that Petitioner has CWP. Despite his denial to the contrary, we believe the Arbitrator did engage in speculation and conjecture regarding this evidence. Although Dr. Meyers admitted that it is possible that an autopsy might show coal macules in Petitioner's lungs even with a negative chest x-ray (*Rx1 at 76*), Petitioner has the burden of proof.

Here, there is no medical opinion that Petitioner's examination, pulmonary function testing or medical records support a finding of CWP. There are conflicting opinions regarding whether the x-ray shows CWP. The only thing remaining is the "speculation" and "conjecture" that 50% or more of long-term coal miners will have pathologic CWP at autopsy. We find it inappropriate to infer Petitioner has CWP based on these studies. Therefore, since Respondent's experts are more persuasive that Petitioner does not have CWP, based on his chest x-ray, we find that Petitioner failed to prove that he has CWP. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, dated October 24, 2019, is hereby reversed and all awards vacated.

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

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

September 17, 2021

/s/ *Maria E. Portela*

SE/
O: 8/10/21
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ISSLER, GARY
Employee/Petitioner

Case# **16WC005559**

THE AMERICAN COAL CO
Employer/Respondent

On 10/24/2019, 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 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gary Issler
Employee/Petitioner

v.

The American Coal Co.
Employer/Respondent

Case # **16** WC **05559**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **9/13/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/30/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**40,164.80**; the average weekly wage was $**772.40**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Respondent shall pay Petitioner permanent partial disability benefits of $463.44/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Michael K. Nowak, Arbitrator

10/17/19
Date

OCT 24 2019

FINDINGS OF FACT

Petitioner, Gary Issler, of Herrin, Illinois was 65 years of age at the time of arbitration with a date of birth of March 20, 1954. He is married to Liz Issler and has no dependent children. He did not graduate high school but went to the tenth grade at Alton High. He did receive his GED. He did one year of welding courses at John A. Logan Junior College. He worked 31 years in the coal mining industry, all of those on the surface. During that time, besides coal dust he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

His last day of work in the coal mines was May 30, 2015. He was working for American Coal at their Galatia Mine. He was 61 years of age with a job classification of yardman. He testified that on that date he was exposed to and breathed coal dust.

Petitioner began his mining career in April of 1986 when he was hired in at Kerr-McGee, which later became American Coal. He worked in the same mine for his entire mining career. He started as a clerk in the warehouse above ground and did that job for approximately five years. He then was reclassified as a yardman and stayed in that position for the rest of his career. A yardman handled all of the material that came into the mines. This included fuel, rocks, or anything that had to be loaded onto the slope cars that had to be taken into the mines. Any equipment that would be taken into the mine would be taken off and loaded by the yardmen. Petitioner described loading rock onto rock bins that were shipped out into the mine. He testified that this created quite a bit of dust. When equipment would be brought up from the mine it would have to be loaded onto vehicles. Petitioner described there being so much dust on the equipment that it could not be hosed off with a hose but instead had to be shoveled. Petitioner also operated a crane, which was used to drop supplies into twelve foot holes.

Petitioner testified that in the last ten years he noticed a little more breathing difficulty. He noticed himself coughing more in the morning when he would get up. From the first time he started noticing breathing problems until the time he left the mine they became slightly worse. Since the time he has left the mine up until the time of trial they have stayed approximately the same. Petitioner can walk approximately half a mile before becoming short of breath and can climb approximately forty stairs before having to rest. Petitioner has noticed that his breathing has affected his everyday living. He does not play basketball or softball anymore. When he bikes or hikes, he has to slow his pace down.

Petitioner's family doctor is Dr. Korte. Petitioner is a non-smoker and only smoked briefly when he was around 18 years old. Other than breathing difficulties Petitioner has no other medical conditions and takes no medications.

An office note dated 6/3/03 reflects sinus congestion. Patient complained of sinus symptoms x 10 days, including congestion, headache, facial pressure, and post nasal drainage. Low grade fever. (rx 3, p 111)

The note corresponding to an office visit of 12/23/06 reflects a 52 year old male who presented with nasal discharge, cough, face pain, fever-chills, maxillary toothache, and sore throat with pnd. Duration of symptoms was 2 days. Past history noted allergic rhinitis, and sinusitis. (rx 3, p 97) The assessment was sinusitis. (rx 3, p 98)

On an office note dated 12/20/07 under, subjective, it indicates 54 year old male presents with nasal discharge, purulent nasal discharge, cough, face pain behind right eye, maxillary toothache, duration of symptoms was 4 days. Under past history it reflects allergic rhinitis, and sinusitis. (rx 3, p 93) The assessment was sinusitis. (rx 3, p 94)

On 3/29/08 the notes reflect 54 year old male with URI symptoms. Runny nose, congestion, mucopurulent nasal discharge, and cough. (rx 3, p 90) Under assessment: acute sinusitis. (rx 3, p 91)

On an office note dated 5/29/08 indicates that Petitioner presented with upper/lower respiratory symptoms of 2 days duration including runny nose, congestion, post nasal drip, sore throat, headache, sinus pressure, and cough. (rx 3, p 86) The assessment was URI, cough. (rx 3, p 87)

On 12/18/08 Petitioner complained of sinus pressure. He presented with upper/lower respiratory symptoms including runny nose, congestion, post nasal drip, sore throat, headache, sinus pressure, and cough. The assessment was URI, acute unspec site. (rx 3, p 80)

On 2/4/09 Petitioner presented with sore throat, runny nose, cough and congestion. He complained of nasal discharge, purulent nasal discharge, cough, face pain, for 1 week. (rx 3, p 76) The assessment was sinusitis, acute, unspecified. (rx 3, p 77)

On 10/21/10 Petitioners chief complaint was congestion. He presented with URI symptoms including runny nose, congestion, purulent nasal discharge, cough, and sneezing. Review of symptoms indicated sinus pressure, sore throat and pressure in ears. (rx 3, p 63) The assessment was acute sinusitis. (rx 3, p 64)

An office note dated 3/9/12 reflects symptoms of coughing all the time, and was unable to get anything up. He had No dyspnea. It was noted that he works in the coal mines. The assessment was acute bronchitis. (rx 3, p 51)

An office note dated 2/1/13, indicates cough, congestion, and drainage. Under associated signs and symptoms it lists body aches, runny nose, nasal congestion, post nasal drip, sore throat, headache, sinus pressure, ear pain, and cough. (rx 3, p 40) Under past medical history notes allergic rhinitis, and sinusitis. (rx 3, p 41) The assessment on that date was acute sinusitis. (rx 3, p 41)

An office note dated 1/3/15 reveals chief complaints of cough, congestion, and sore throat. Petitioner presented with nasal discharge, purulent nasal discharge, cough, and face pain. (rx 3, p 28) The assessment on that date was acute sinusitis, cough. (rx 3, p 29)

On an office note dated 10/22/15 under subjective the note indicates "... also having sinus drainage and pressure. Nasal congestion. History of sinus problems in the past." (rx 3, p 18) the assessment indicates sinusitis. (rx 3, p 19)

At Petitioner's attorney's request, Petitioner was examined by Dr. Glennon Paul. He was the senior physician at the Central Illinois Allergy and Respiratory Clinic. He was also the medical director of St. John's respiratory therapy and clinical assistant professor of medicine at SIU Medical School for approximately 35 years until he retired. (px 1, p 6) Dr. Paul testified on physical examination, Petitioner's PFTs were within the normal range. His x-rays were abnormal and showed fibronodular lesions, both lungs, more in his lower lung

fields. Based on this examination, Dr. Paul gave an opinion within a reasonable degree of medical certainty that Petitioner has coal worker's pneumoconiosis which was caused by coal dust and the coal mine environment. (px 1, p 12) In light of his CWP, he could have no further exposures to the environment of the coal mine without endangering his health. (px 1, p 12 & 13) Based on his opinion, Petitioner was permanently medically precluded from being in the coal mines. (px 1, p 13) By definition, if a person has CWP it is true that they necessarily have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (px 1, p 16) A person can have shortness of breath despite having normal pulmonary function tests. A person can have CWP that is radiographically significant but not have shortness of breath. (px 1, p 19) They can even have radiographically significant CWP and have normal pulmonary function testing, normal blood gases, and normal physical examination of the chest. CWP is considered a progressive disease. (px 1, p 20) There is no cure for CWP and even if a coal worker ends his exposure to the coal mine dust it can still progress. (px 1, p 20 & 21) When a miner leaves the coal mine after twenty years or more, they will have coal mine dust that stays trapped in their lungs that they cannot get out. It will remain with them for the rest of their life. (px 1, p 32 & 33) A person can have CWP and have a normal chest x-ray. It can be found both on pathology and autopsy and not show up on the x-ray. (px 1, p 33)

At Petitioner's request, b-reader, Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated February 7, 2017. Dr. Smith found interstitial fibrosis of classification p/p, all lung zones involved bilaterally, of a profusion 1/0. There are no chest wall plaques, calcifications or large opacities. There are linear streaky density changes in the posterolateral left lung base related to parenchymal scarring and/or mild subsegmental atelectasis. The heart size is within normal limits, There is calcified thoracic aorta. There is mild mid to lower dorsal spondylosis. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary p, all lung zones involved bilaterally, profusion 1/0.

At Respondent's request, Dr. Meyer reviewed a PA and lateral chest radiograph dated February 7, 2017 from Central Illinois Allergy and Respiratory. (rx 1, p 40) It was a quality 2 due to over-exposure. Dr. Meyer interpreted the film as the lungs were well expanded without small or large opacities. There was a single linear parenchymal band at the left lung base. His interpretation was that there were no radiographic findings of CWP. (rx 1, p 40) On cross-examination, Dr. Meyer testified that when you want to determine the existence of lung disease, pathologic review of the tissue itself rather than radiology is the gold standard. (rx 1, p 46 & 47) The macule of CWP is a permanent abnormality. (rx 1, p 56) Once there is CWP that is progressing, there is no medicine or anything modern medical science can do to stop or reverse the progression. Removing the worker from the exposure, is the best response. (rx 1, p 57) CWP can be considered a chronic progressive disease. If a person has CWP at any time in their life, inasmuch as the only thing that causes CWP is coal mining exposure, it would be true that they probably had the CWP at some level when they left the coal mine. (rx 1, p 58) When a coal worker has CWP that progresses, it is true that the rate of progression can vary from miner to miner rather than be exactly the same in all miners. (rx 1, p 61) It would be fair to say that a miner who has 1/0 pneumoconiosis, probably won't even know he has it, probably won't complain to his doctor until he has a b-reading that tells him he has it. (rx 1, p 66) It is possible that a miner could work 30-40 years in the coal mine, develop radiographically significant CWP but not have it manifest itself on the x-ray until the last year, or even the first year, after they leave the coal mine. (rx 1, p 75)

At Respondent's request, Dr. James R. Castle performed a records review. Dr. Castle testified to a reasonable degree of medical certainty that Petitioner does not suffer from any pulmonary disease or

impairment occurring as a result of his occupational exposure to coal mine dust. (rx 2, p 35) Dr. Castle testified under cross-examination that he would always want to do his own examination if possible, to make the most accurate assessment of a person's condition. (rx 2, p 43 & 44) The abnormality of CWP is basically trapped coal dust in part of the lung, which ends up wrapped in scar tissue and can be accompanied by emphysema around it. (rx 2, p 45 & 46) The affected tissue of the scarring and emphysema cannot perform the function of normal healthy lung tissue. Therefore, by definition if a person has CWP they would have an impairment in the function of the lungs at the site of the scarring and emphysema. (rx 2, p 46) A person can have radiographically significant CWP, yet have normal spirometry, normal pulmonary function in all areas, normal blood gases, normal physical exam of the chest, and maybe even no complaints. (rx 2, p 47) If they do have any complaints, shortness of breath is the most likely. (rx 2, p 47) With CWP from just coal dust or mixed dust, either one, inasmuch as trapped dust will never be removed from the lungs, essentially their exposure to that insult never ends, it will always be there. (rx 2, p 52) Therefore the lung tissue would be exposed to that trapped dust which would be there for the rest of their lives. (rx 2, p 52) It would be true the PFTs within the range of normal does not mean that your lungs are free from any lung damage injury or disease. (rx 2, p 62)

CONCLUSIONS

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (O): Was disablement timely under the Occupational Diseases Act?

The Arbitrator resolves the issue of occupational disease and causation in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from coal worker's pneumoconiosis (CWP), which was caused by his exposures as a coal miner. He worked as a coal miner for 31 years. He has a minimal smoking history, smoking cigarettes for only one year at age 18. The Arbitrator found Petitioner to be a candid and sincere witness.

Dr. Paul examined Petitioner on 1/10/17 at Petitioner's request. Dr. Paul is Board Certified in Internal Medicine, Allergy and Immunology, and he has authored a book on asthma. He served as the Medical Director of Respiratory Therapy at St. John's Hospital in Springfield for 40 years and concurrently as Medical Director of Respiratory Therapy at Memorial Hospital in Springfield for the first 10 of those years. Dr. Paul has performed black lung examinations for 40 years as often at the request of Respondents as Petitioners. He also examines miners at the request of the Department of Labor (DOL). He finds the majority of x-rays sent to him by Petitioner's counsel to be negative for CWP. Dr. Paul diagnosed CWP based on his independent medical examination, which included a patient history, physical examination, pulmonary function testing (PFT), and chest x-ray. His physical examination of the chest and pulmonary function testing were not remarkable. Dr. Smith, b-reader/radiologist reviewed chest films of 2/7/17 at the request of Petitioner, and in addition to finding interstitial fibrosis, p/p bilaterally in all zones at a profusion of 1/0, he also found linear streak density changes in the left lung base related to parenchymal scarring and/or mild subsegmental atelectasis.

While Respondent was entitled to a full examination, it determined to only obtain a review of treatment records and the other medical data developed by the parties for this claim. In deciding to do this, Respondent provided no direct patient history, no physical examination, no pulmonary function testing, and no chest x-ray of its own. Dr. Castle, who performed the records review, has been retired for over a decade, and currently his

practice consists of records reviews and depositions such as he did in this case. He did not examine, speak to, nor see Petitioner. The Arbitrator notes that an examination would provide a superior dataset than a mere records review.

The Arbitrator testimony and opinions of Dr. Paul more persuasive in this case.

The Arbitrator notes that in his report, Dr. Castle mentioned only nine treatment record entries by Dr. Korte of Logan Primary Care. None of the nine referenced pulmonary medicines. Only three referenced pulmonary symptoms, two of cough and one of nasal discharge. And six referenced pulmonary diagnoses. Dr. Castle did not cite any record entries referring to Petitioner's work as a coal miner.

The Arbitrator further notes that the Logan Primary Care records included approximately 32 references to symptoms, including 11 of cough, six of congestion, four of postnasal drip, three of drainage or sinus drainage, three of nasal discharge, two of sinus congestion, and one each of sputum, sinus headache, and sinus infection. The Logan records also included approximately 30 pulmonary or airways diagnoses, including 11 of sinusitis, eight of acute sinusitis, four of allergic rhinitis, six of upper respiratory infections, and one of acute bronchitis. While Dr. Castle's report made no citations to prescription medications, the records contain approximately 34 entries, including seven of Depomedrol, four of Zithromax, three of Prednisone, three of Augmentin, three of Nasacort, two of Medrol, two of Robitussin, two of over-the-counter decongestant/antihistamine, and one each of Tussive, Penicillin, Tessalon Perles, Phenergan/codeine, Allegra, Ceftin, Flonase, and Z-pak. In addition, while Dr. Castle's report made no reference to Petitioner's work as a coal miner, the Logan records list Petitioner as working for American Coal on 12/20/07 and "works in a coal mine" on 3/9/12.

The Arbitrator notes that the actual treatment records paint a significantly different picture of Petitioner than Dr. Castle's report. The almost 100 medical citations give rise to the rational presumption that Petitioner does have pulmonary and airways problems, and in this Petitioner with 31 years of mining and just one year of teenage cigarette smoking, there is further reason to give the greatest weight to the opinions of Dr. Paul. Most importantly, Dr. Castle's review is neither thorough nor based on the preponderance of the treatment citations.

The Arbitrator also notes that the medical records conflict with parts of Petitioner's testimony at arbitration; however, in each discrepancy, Petitioner understates rather than exaggerates his position. Petitioner testified that he did not talk to Dr. Korte about his breathing problems. In light of the Logan Primary Care records, this obviously cannot be true. Petitioner testified that he does not take breathing medications. While he may not have been taking medications on the day of the arbitration, it is obvious from the records that he has taken numerous medications over the years. The Arbitrator notes that Petitioner tended to understate his position on some issues, but that he was a candid and sincere witness.

The Arbitrator notes that the issue of "disease" is whether Petitioner suffers from "CWP," not "radiographic" CWP, "clinically significant" CWP, or "physiologically significant" CWP. CWP in any form is compensable. Our Appellate Court has noted that CWP is a slowly progressive disease which is composed of abnormalities consisting of coal mine dust wrapped in scar tissue and surrounded by emphysema. There is no cure for it; it results in an impairment in the function of the lung at the site of the scarring, whether such can be measured by testing or not; and the sufferer cannot return to the environment of a coal mine without endangering his health.

The Arbitrator notes that Respondent's b-reader/radiologist, Dr. Meyer, described CWP. He cited studies showing that at autopsy, 50% or more of long-term coal miners are diagnosed with CWP that was not diagnosed radiographically during life. He also testified that there are older studies that show a much higher incidence than that. Therefore, by Respondent's witness, it would be more likely than not that this Petitioner would have CWP if an autopsy were performed at his death. Petitioner worked as a coal miner for 31 years, which qualifies him as a long-term coal miner. Further, Dr. Meyer testified that it is possible for a miner to have CWP despite having a negative chest x-ray.

With regard to his negative b-reading in this case, Dr. Meyer testified that such would not rule out the possibility that Petitioner could still have CWP. "It's possible to find coal macules with a negative x-ray." He also testified that notwithstanding his negative x-ray reading, Petitioner could still have CWP. Regarding the nature of pathologic CWP, he testified that the abnormalities of CWP which are found pathologically, not radiographically, would have the same constitution as the macules or nodules that would be apparent on x-ray, just perhaps smaller. They would still be subject to potential progression as any other CWP abnormality might be. He further testified that when a miner has CWP that progresses, the rate of that progression would vary from miner to miner, as would the exact shape, size, and location of the macules, and that these things would also vary within an individual miner.

In terms of the miner's awareness of his CWP, Dr. Meyer said that a miner with 1/0 CWP probably won't know he has it, and won't complain to his doctor about it. He said it is similar to prostate cancer or colon cancer: most people won't have any idea that they have it until they take the appropriate test and get the diagnosis. As to the specific nature of the exposure of a coal miner, Dr. Meyer testified that the body's ability to clear the dust is important, but that the amount of dust in the lung can be as much as one-half the total weight of the lung itself. He added that with mixed dust exposure, including silica, there is much more toxicity. The Arbitrator notes that Petitioner's unrebutted testimony is that he was exposed to silica in his coal mining work.

Regarding the value of treatment records, Dr. Meyer testified that if he reads the x-ray positive, entries in treatment records of clear lungs wouldn't change his diagnosis; pulmonary function tests, be they good or bad, wouldn't have a bearing; and complaints of shortness of breath or a failure to find shortness of breath would have no effect on the reading of the x-ray. Again, he said that reading an x-ray as negative does not rule out the possibility that CWP exists. Dr. Castle, Respondent's other witness, did not disagree with Dr. Meyer.

In weighing the evidence, the Arbitrator finds the preponderance of the evidence in Petitioner's favor. Respondent's experts were equivocal, admitting that their negative readings did not rule out CWP. The Arbitrator is not speculating nor engaging in conjecture that Petitioner has pathologically significant CWP; however, the Arbitrator does take note of the studies cited by Respondent's expert in finding that 50% or more of long-term coal miners will have CWP diagnosed pathologically if an autopsy is performed at the time of their death. That testimony, combined with the other evidence establishes that Petitioner has met his burden.

As noted above, the Appellate Court has settled the issue. When a miner has proven the existence of CWP, he has also proven disablement by both an impairment in the function of the lungs and by a medical contraindication of further coal mine exposure. The universal testimony in this record agrees with the Court.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Petitioner's pulmonary function testing was within the range of normal. 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 coal mining involves daily exposure to coal mine dust, and that the unrebutted testimony of Petitioner was that he was regularly exposed to silica. The clear preponderance of the evidence, as well as a ruling of the Appellate Court establish that when a miner has CWP, he has an impairment in the function of his lungs whether such can be measured or not. It also establishes that there is no safe level of coal mine exposure for a miner who has been diagnosed with CWP. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner testified that he was 61 years of age when he was laid off by Respondent. The Arbitrator recognizes that Petitioner's mining career was cut short by Respondent's lay-off and Petitioner's subsequent recognition that he had CWP. 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 Petitioner's lay-off and subsequent recognition that he suffers from CWP caused a reduction of his earning capacity The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. that the treatment records from Logan Primary Care establish that Petitioner has a number of pulmonary or airways diagnoses, has had symptoms related to such, and has been given numerous prescriptions for such problems, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	05WC013055
Case Name	REYES, RAMON v. CITY OF CHICAGO-SANITATION
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0474
Number of Pages of Decision	21
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mark Weiner
Respondent Attorney	Lucy Huang

DATE FILED: 9/20/2021

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ramon Reyes,

Petitioner,

vs. NO. 05WC 13055

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 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.

No bond is required for the 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.

September 20, 2021

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

/s/ *Marc Parker*
Marc Parker

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

SJM/sj
o-9/2/2021
44

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0474
NOTICE OF ARBITRATOR DECISION

REYES, RAMON Case# **05WC013055**
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

On 7/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1927 HUGHES SOCOL PIERS RESNICK & D
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ramon Reyes
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **05** WC **13055**

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 **05/14/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **03/11/2005**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to his current right shoulder, spinal and right foot/ankle conditions but failed to establish causation as to his claimed current left shoulder condition.

In the year preceding the injury, Petitioner earned $**51,236.64**; the average weekly wage was $**985.32**.

On the date of accident, Petitioner was **42** 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 $**140,332.97** for TTD, $ for TPD, $**292,495.76** for maintenance, and $ for other benefits, for a total credit of $**432,828.73**.

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

ORDER

Respondent stipulated Petitioner was entitled to maintenance from April 16, 2009 through October 27, 2017. The Arbitrator declines to award additional maintenance from October 28, 2017 through the hearing of May 14, 2019. Respondent is given credit for the $292,495.76 in maintenance benefits it paid. Arb Exh 1.

Petitioner is entitled to have and receive from Respondent 250 weeks at the applicable maximum permanency rate of $567.87 per week because he sustained a 50% loss of use of the person as a whole under Section 8(d)2.

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

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

Molly C Mason

Signature of Arbitrator

6/28/19
Date

JUL 1 - 2019

Ramon Reyes v. City of Chicago
05 WC 13055

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on March 11, 2005 while working as a sanitation laborer for Respondent. Petitioner testified he was pulling a garbage cart in icy weather conditions that day when the cart "went airborne," causing him to fall backward. The contents of the cart, including about 400 pounds of concrete, fell on top of him. He underwent a lumbar fusion later the same year, a cervical fusion the following year and a right shoulder arthroscopy in February 2007. He testified he never returned to work following the accident.

The parties agree Petitioner was temporarily totally disabled from March 12, 2005 through April 15, 2009 and entitled to maintenance from April 16, 2009 through October 27, 2017. They also agree Respondent paid $140,332.97 in temporary total disability benefits and $292,495.76 in maintenance benefits prior to trial. The disputed issues include causal connection, whether Petitioner is entitled to additional maintenance from October 28, 2017 through the hearing of May 14, 2019 and nature and extent. Petitioner seeks an award of "odd lot" permanent total disability benefits while Respondent maintains permanency should be awarded under Section 8(d)2.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent in approximately 1990. His sanitation laborer duties included collecting garbage. T. 5/14/19, p. 10.

Petitioner testified the weather was icy on March 11, 2005. Prior to the accident, he was working near 107th and Ewing, pulling a garbage cart toward a truck. The cart was heavy and covered with bags. He later determined it contained about 400 pounds of concrete. The cart "went airborne," causing him to fall backward. He landed on his back, twisting his right leg in the process. As he fell, he could see rocks and other debris coming toward his head. As he covered his face, his right shoulder "went back." He "felt something pop but didn't know what it was at the time." He lost consciousness. He was eventually transported to the Emergency Room at Advocate Trinity Hospital.

The very limited Advocate Trinity Hospital Emergency Room records (PX 1) include a paramedic run sheet but this document is not legible. The bill (PX 1, p. 2) includes charges for hip, lumbar spine and right shoulder X-rays. The X-ray reports are not in evidence. Petitioner was given Toradol for pain. PX 1, p. 5. At discharge, Petitioner was instructed to rest, seek follow-up care and take Ibuprofen, Robaxin and Vicodin. PX 1, p. 6.

Later the same day, Petitioner went to the Emergency Room at Mercy Hospital. Petitioner reported the work accident and indicated he had been seen at Trinity but was still experiencing pain in his anterior chest and abdomen. At discharge, he was directed to take Motrin and follow up at MercyWorks on Monday, March 14, 2005. PX 3, p. 6.

Petitioner saw Dr. Ali at MercyWorks on March 14, 2005. The doctor recorded a history of the work accident and subsequent Emergency Room visits. He noted complaints of pain in the right shoulder, low back and right foot. He ordered lumbar spine and right hip X-rays, which were negative for fracture. PX 6, p. 26. He diagnosed multiple contusions and kept Petitioner off work. He directed

Petitioner to return on March 17, 2005. On that date, Dr. Ali prescribed physical therapy and a right shoulder MRI. PX 6, pp. 176-177. The MRI, performed without contrast on March 22, 2005, showed mild degenerative changes of acromioclavicular joint, a tiny amount of fluid in the subacromial bursa, irregularity and increased signal intensity near the greater tuberosity of the humeral head and slightly increased signal intensity at the undersurface of the supraspinatus tendon. PX 6, pp. 21-22.

Petitioner underwent an initial physical therapy evaluation at Mercy Medical Center on March 23, 2005. The evaluating therapist recorded the following history of the March 11, 2005 work accident:

> "He was moving a garbage cart away from a house. Reports his L lower extremity slipped and R lower extremity went under cart & cart tipped & fell onto his R lower extremity/pelvic region. + pushing with R shoulder = pain on entire R side of body."

The therapist also noted that Petitioner reported difficulty sleeping, sitting and walking.

Petitioner continued attending therapy thereafter, with the therapist documenting multiple complaints and consultations. PX 6, pp. 30-32.

On March 24, 2005, Dr. Ali referred Petitioner to Dr. Heller for evaluation of his right shoulder and right foot/leg complaints. PX 6, p. 177.

Petitioner saw Dr. Heller of Midland Orthopedics on March 28, 2005. The doctor recorded a history of the work fall and noted that, of all of his injuries, Petitioner described his right shoulder and low back as the most severe.

Dr. Heller described Petitioner as right-handed. On examination, he noted slight scapular winging, pain in the trapezius as well as the shoulder, a limited range of motion, markedly positive Hawkins maneuver, positive drop arm testing and positive cross arm adduction. He indicated that, while the MRI report documented a slight undersurface tear, he believed there was a "full-thickness rotator cuff tear." He administered an injection and prescribed therapy. He directed Petitioner to remain off work. PX 6, p. 1.

Dr. Sheth of MercyWorks also saw Petitioner on March 28, 2005. On examination, he noted "resolving ecchymosis both shoulder blade area" as well as positive impingement testing and lumbar tenderness. He directed Petitioner to remain off work, continue therapy and follow up with Dr. Heller. PX 6, p. 178.

On April 8, 2005, Dr. Heller noted that Petitioner had come in to see him a week early due to persistent right shoulder complaints as well as pain in his upper and lower back and burning and tingling in his feet. He also noted that Petitioner had seen his primary care physician, with this doctor recommending spinal MRI imaging. On right shoulder re-examination, he again noted positive impingement testing and slightly positive drop arm testing. He indicated that Petitioner was going to need an arthroscopy. He contacted Dr. Sheth to inform him of Petitioner's other symptoms and recommended that Petitioner undergo cervical and lumbar spine MRIs. He directed Petitioner to remain off work. PX 6, p. 3.

Petitioner returned to Dr. Heller on April 22, 2005. The doctor noted that Petitioner was still experiencing spinal pain, as well as lower extremity numbness and tingling and right shoulder pain. He described the intervening cervical and lumbar spine MRIs as unremarkable but recommended that Petitioner see a spine specialist before undergoing any right shoulder surgery. He communicated this to Dr. Sheth and directed Petitioner to remain off work. PX 6, p. 5.

A thoracic spine MRI, performed without contrast on April 15, 2005, showed minor degenerative changes and no significant disc bulging. A lumbar spine MRI, performed the same day, showed no evident herniations and degenerative changes at L4-L5, highlighted by a degenerative anterolisthesis. PX 6, pp. 109-116.

A cervical spine MRI, performed without contrast on April 22, 2005, showed bulges at C2-C3 and C4-C5 along with a herniation at C5-C6 "lateralized to the right side and proximal right neural foramen, superimposed upon disc bulging." PX 6, pp. 104-105.

At the recommendation of Dr. Arnold of MercyWorks, Petitioner saw Dr. Mirkovic on May 4, 2005. Dr. Mirkovic wrote to Dr. Arnold the same day, summarizing the work accident and treatment to date. He noted that Petitioner described his spinal pain as starting at about mid-buttock and radiating down his right leg into his foot. He also noted that Petitioner described his right foot as "dragging." He described Petitioner's past history as positive for a tonsillectomy and appendectomy. He also noted that Petitioner had been hospitalized for chest pain at age 39.

On examination, Dr. Mirkovic noted 4/5 right tibialis anterior and dorsiflexion weakness, sensory changes in the L5 distribution on the right versus the left, mildly positive straight leg raising on the right and no tenderness to palpation of the back. After reviewing the lumbar spine MRI and obtaining X-rays, he diagnosed lumbar spondylosis and right lumbar radiculopathy. He recommended that Petitioner continue taking Vicodin and Mobic, continue therapy and undergo epidural steroid injections. He expressed concern that Petitioner "is experiencing anxiety symptoms." He indicated this "may require treatment." He noted that such treatment "would assist in [Petitioner's] overall care." PX 6, p. 302.

Petitioner saw Dr. Heller again on May 6, 2005, with the doctor noting Dr. Mirkovic's recommendation of spinal injections. Dr. Heller indicated that, "at this point, it is time to start treating [the] shoulder." He again recommended an arthroscopic rotator cuff repair. PX 6, p. 7.

On May 11, 2005, Dr. Mirkovic requested authorization for an epidural steroid injection and directed Petitioner to remain off work. PX 6, p. 183. Petitioner saw Dr. Sheth of MercyWorks the same day. Dr. Sheth noted that Petitioner wanted a second opinion concerning his shoulder and planned to see Dr. Kalainov. He also noted that Petitioner was scheduled to see Dr. Cupic for the lumbar injection on May 17th. He continued to keep Petitioner off work. PX 6, p. 179.

At the recommendation of Dr. Arnold of MercyWorks, Petitioner saw Dr. Perns, a podiatrist, on May 23, 2005. Dr. Perns noted that, at the time of the work accident, Petitioner fell onto his right side, twisting his right foot. He also noted that Petitioner was finding it difficult to walk. He described Petitioner's gait as antalgic. He also noted complaints of shoulder and back pain as well as tingling in the leg.

On right ankle examination, Dr. Perns noted no edema or ecchymosis, pain to the lateral gutter, ATF ligament and peroneal tendons and pain with range of motion. He obtained right foot and ankle X-

rays. He interpreted the films as showing no frank fractures or dislocations. He noted that Petitioner had undergone an MRI but that the images were not available. He diagnosed a lateral right ankle sprain with possible osteochondral lesion. He recommended that Petitioner begin ankle therapy and continue therapy for his shoulder and back. He also recommended that Petitioner keep his right foot elevated, apply ice and return in one week with his MRI films. PX 6, p. 9.

Petitioner first saw Dr. Kalainov on May 24, 2005. In his note of that date, the doctor recorded a history of the work accident and subsequent care. He noted that Dr. Heller had recommended right shoulder surgery and that Petitioner had seen Dr. Mirkovic for his lumbar spine.

Dr. Kalainov described Petitioner as complaining of pain in the anterosuperior aspect of his right shoulder with intermittent radiation toward the right lateral aspect of the neck and "only infrequent pain radiating distally into" the right arm. He noted that Petitioner denied any right hand numbness or tingling.

On initial examination, Dr. Kalainov noted marked limitations with neck flexion, extension and lateral rotation. He indicated that Spurling's maneuver toward the right shoulder produced right shoulder pain. He noted positive Neer and Hawkins impingement maneuvers on the right and pain with deep finger pressure over the long head of the biceps tendon. He obtained right shoulder X-rays and reviewed the MRIs. He diagnosed cervical radiculopathy and right shoulder impingement syndrome. He injected the right shoulder subacromial space, with Petitioner reporting only 10% improvement after five to ten minutes. He indicated it would be reasonable for Petitioner to return to Dr. Mirkovic for his cervical spine issues. He did not recommend right shoulder surgery but indicated an operative approach could be considered later if Petitioner's pain localized primarily to his shoulder. PX 6, pp. 245-246.

Petitioner returned to Dr. Perns on June 1, 2005 and reported having attended one therapy session to date. He complained of pain from his neck down to his right ankle. Dr. Perns noted what appeared to be right-sided weakness in Petitioner's right upper extremity. His right ankle examination findings were unchanged. He directed Petitioner to continue attending therapy and bring in his MRI films in one month. PX 6, p. 11.

On July 6, 2005, Dr. Perns noted that Petitioner's right ankle was still symptomatic, particularly with stair usage, but that he was primarily complaining of pain from his hips and buttocks down to his legs. He noted that Petitioner was scheduled to undergo a lumbar fusion. He put the ankle-related care on hold and directed Petitioner to follow up with him following the fusion. PX 6, p. 13.

On September 1, 2005, Dr. Mirkovic performed a posterior lateral fusion at L4-L5, using a bone graft and screws. T. 12. Petitioner was transferred to the Rehabilitation Institute of Chicago a week later. PX 6, p. 190.

On September 14, 2005, Dr. Mirkovic's assistant noted that Petitioner was due to be discharged from the Rehabilitation Institute of Chicago in a few days. The assistant also noted that Petitioner's endurance had improved and that he was "very pleased with his surgical outcome." She removed the sutures and staples. She directed Petitioner to remain off work and alternate Tylenol and Norco as needed. PX 6, p. 297.

On October 26, 2005, Dr. Mirkovic recommended that Petitioner advance his walking program and begin weaning himself out of his brace in three weeks. PX 6, p. 241.

On December 21, 2005, Dr. Mirkovic noted that Petitioner had weaned himself out of his brace and was experiencing minimal low back pain. He indicated Petitioner's right foot remained symptomatic. On cervical spine examination, he noted positive Spurling testing. Lumbar spine X-rays showed a solid fusion at L4-L5.

Dr. Mirkovic described Petitioner as doing "exceptionally well" with respect to his lumbar spine. He recommended six to eight weeks of therapy to be followed by work hardening. He indicated that Petitioner was still complaining of right neck pain radiating to his right shoulder. He noted that Petitioner was still seeing Dr. Kalainov for the shoulder. He recommended a repeat cervical spine MRI. He indicated Petitioner would require an anterior discectomy and fusion at C5-C6 if the repeat MRI showed a herniation at this level. PX 6, pp. 238-239.

The repeat cervical spine MRI, performed without contrast on March 20, 2006, showed degenerative/dehydrational decreased disc signal intensity between C2-C3 and T3-T4, with the radiologist suggesting a CT study directed at T4, along with a posterior broad-based herniation at C5-C6 with associated annular tearing. PX 6, pp. 101-103.

A thoracic spine CT scan, performed on April 21, 2006, showed no significant abnormality and "specifically no abnormality at the T4 level." PX 6, pp. 96-97.

On May 4, 2006, Dr. Mirkovic performed an anterior cervical discectomy and fusion at C5-C6. PX 6, pp. 185-186. Petitioner was discharged from the hospital two days later. At discharge, Dr. Mirkovic recommended that Petitioner wear an Aspen collar at all times and take Norco. PX 6, p. 188.

Petitioner testified he underwent additional therapy following the cervical spine surgery. The therapy did not provide relief. T. 13.

A Mercy therapy discharge note dated August 22, 2006 reflects that Petitioner was still experiencing mild dizziness and had met one out of three of his therapy goals. PX 6, p. 282.

The following day, August 23, 2006, Dr. Mirkovic found Petitioner to be at maximum medical improvement and capable of full duty from a spinal perspective. He noted that Petitioner was still undergoing right shoulder and right ankle care. He directed Petitioner to return to him in three months. PX 6, p. 333.

Dr. Kalainov recommended additional right shoulder therapy on September 20 and November 1, 2006. PX 6, p. 313.

On November 29, 2006, Dr. Kalainov noted that Petitioner's right shoulder felt "looser," secondary to therapy, but that Petitioner was still experiencing pain deep in the superolateral aspect. He recommended a repeat right shoulder MRI, noting that the original study dated back to March 2005. PX 6, p. 289.

Petitioner returned to Dr. Kalainov on December 20, 2006, having undergone the repeat MRI on December 6th. Dr. Kalainov interpreted the MRI as "suggestive for a tiny partial articular surface tear at the distal margin of the supraspinatus tendon." PX 6, pp. 63-64. On right shoulder re-examination, he noted pain with impingement maneuvers and with finger pressure over the AC joint and proximal biceps

tendon. He again recommended a right shoulder arthroscopy and rotator cuff debridement or repair. PX 6, pp. 65-66.

Dr. Kalainov operated on February 12, 2007, performing a right shoulder arthroscopy with extensive debridement of the glenohumeral joint space, subacromial decompression, including partial coracoacromial ligament release and anterior acromioplasty, and a distal claviculectomy. In his operative report, he documented partial articular surface tearing of the supraspinatus tendon and absence of the long head of the biceps tendon. PX 6, pp. 20-22.

At Dr. Kalainov's direction, Petitioner underwent right shoulder therapy following the surgery. On February 22, 2007, Petitioner reported improvement to the doctor's assistant. The assistant removed the surgical sutures and directed Petitioner to continue therapy. PX 6, p. 10.

On March 15, 2007, Dr. Kalainov noted that Petitioner's pain was "calming down" and that he had reduced his Norco intake to one per day. He recommended that Petitioner discontinue the Norco and continue attending therapy. PX 6, p. 8.

Dr. Kalainov again noted progress on April 25, 2007. He indicated that Petitioner described his right shoulder as having improved 75% since the surgery. He prescribed additional therapy. PX 6, p. 4.

On May 23, 2007, Dr. Kalainov noted that Petitioner "described only transient shoulder discomfort when throwing with his right arm." On examination, he noted forward flexion to 145 degrees and active external rotation with the arm adducted to 75 degrees. He described strength measurements as "normal for all major muscle groups around the right shoulder." He anticipated that Petitioner would reach maximum medical improvement in four more weeks. PX 2, pp. 25-26. He released Petitioner to full duty, indicating the release "pertains to right upper extremity only." PX 2, p. 21.

On June 12, 2007, Petitioner saw Dr. Pinzur at Loyola. The doctor recorded a history of the March 11, 2005 work accident. He noted a complaint of right ankle pain since the accident. He also noted that Petitioner had a mass in his right knee.

Dr. Pinzur described Petitioner's gait as antalgic. On right ankle examination, he noted a virtually full range of motion but a palpable click anteriorly. He suspected a loose body. He prescribed a right ankle MRI and directed Petitioner to see Dr. Evans for his knee. PX 2, pp. 4-5.

On June 27, 2007, Dr. Mirkovic described Petitioner as "doing exceptionally well" and experiencing "only occasional low back symptoms with sitting." On examination, he noted an excellent range of motion of the cervical and lumbar spine. He found Petitioner to be at maximum medical improvement from a spinal perspective. He released Petitioner to full duty but noted that Petitioner indicated he was still undergoing evaluation of his right foot at Loyola. He directed Petitioner to return to him as needed. PX 2, p. 23.

A right ankle MRI, performed without contrast on June 27, 2007, showed no ligament or tendon abnormalities and an osteochondral lesion in the lateral talar dome "with no significant surrounding bone marrow edema." The radiologist indicated the lesion "may be related to prior injury." PX 2, p. 27.

On July 3, 2007, Dr. Pinzur described the recent right ankle MRI as "unremarkable." He did not believe the osteochondral lesion was responsible for Petitioner's current symptoms. He recommended that Petitioner wear an Aircast air support and do a course of therapy and work hardening, followed by a functional capacity evaluation. He directed Petitioner to return to him in one month. PX 2, pp. 3-4.

Ghulam Panawala, a therapist at Mercy Medical, conducted a neuromuscular evaluation of Petitioner on July 12, 2007. Panawala described Petitioner as walking slowly, "limping on rt leg." She also noted that Petitioner "passed Waddell's testing." PX 10, p. 23.

Between July 19, 2007 and August 13, 2007, Petitioner underwent work hardening at Mercy Hospital. Several of the daily notes reflect complaints of bilateral hip, lower back, right knee and right ankle pain, especially while lifting boxes. Petitioner was unable to complete a functional capacity evaluation on August 13, 2007 "due to [an] incident that required initiating EMS." The therapist noted that, prior to this incident, Petitioner was able to occasionally lift 25 pounds from floor to waist "with great effort" and occasionally lift 15 pounds from waist to above shoulder level "with strain noted." The therapist indicated that Petitioner was not able to pull a sled due to low back pain and complained of hip and lower back pain after walking for 30 minutes at 450-foot intervals. She described Petitioner as performing all of the tasks asked of him and exhibiting consistent pain behaviors with "gait deviation to right leg and low back." She recommended discharge, indicating "it does not appear that [Petitioner] will be able to increase his lifting to 50 pounds," as required "based on employer's job description." PX 10, pp.

Petitioner testified he underwent treatment for suicidal ideation at Michael Reese Hospital in August 2007. T. 14. The Michael Reese Hospital records, which consist primarily of forms, reflect Petitioner was admitted on August 13, 2007 and discharged three days later, with prescriptions for Lexapro and another medication. PX 5.

On August 21, 2007, Dr. Pinzur noted that, while Petitioner was still complaining of a good bit of right ankle pain, his examination was relatively unremarkable. He had no explanation for the pain. He recommended that Petitioner either return to MercyWorks or discuss his situation with his attorney. He indicated that a chronic pain management program would be appropriate. He released Petitioner from care on a PRN basis. PX 2, pp. 2-3.

A MercyWorks work status discharge note dated September 20, 2007 reflects that Petitioner was found to be at maximum medical improvement and capable of sedentary duty. The note also states: "to f/u with F.P. for rt ankle and leg problem." The Arbitrator concludes that "F.P.", as used in this context, refers to "family practitioner." There is no evidence indicating Petitioner underwent additional ankle or leg care after September 20, 2007.

Petitioner testified he was discharged from right shoulder therapy in September 2007. At that point, his right shoulder felt better but he was still symptomatic. His right shoulder symptoms have never gone away. He has difficulty lying on his right side at night. He believes he now has left shoulder problems as well. He fell in a parking lot while throwing out garbage one day and injured his left shoulder. He is not a doctor but believes he might have a tear in his left shoulder. T. 15. He feels there is not much he can do, activity-wise. He has never returned to work. There are days when he does not want to get out of bed. He takes over-the-counter medication because he no longer wants to take "hard" medicine. He is able to cook, clean and dress himself. T. 15-16.

On October 15, 2007, Robert Serafin of Respondent's Committee on Finance [hereafter "Serafin"] wrote to Petitioner, directing him to meet with Russell Baggett of Respondent's Department of Personnel on October 24, 2007. Serafin informed Petitioner that failure to attend this interview "may jeopardize" his temporary total disability benefits. PX 12, p. 6.

On May 20, 2008, Serafin wrote to Petitioner again, directing him to attend a career development workshop on June 3, 2008. Serafin again warned Petitioner that failure to attend might result in suspension or termination of his benefits. PX 12, p. 5.

On June 17, 2008, Serafin sent another letter to Petitioner, instructing him to attend an interview with Theresa Hill on July 2, 2008. Serafin advised Petitioner that Hill would work with him to create a profile for Respondent's "new online job application" so that Respondent could identify potential jobs for him. Serafin again warned Petitioner that failure to attend could jeopardize his benefits. PX 12, p. 4.

On March 11, 2010, Ellen Bell, director of Respondent's workers' compensation division, wrote to Petitioner, directing him to attend a meeting with the human resources department on March 19, 2010. Bell informed that a human resources recruiter would interview him and help him create a profile for Respondent's online job application system. She warned Petitioner that failure to attend could jeopardize his continued receipt of benefits. PX 12, p. 1.

On May 6, 2010, Angie Matos of Respondent wrote to Petitioner. Matos noted that Petitioner had reached maximum medical improvement. She indicated he might be able to return to work "in [his] title" within his restrictions. She directed him to attend an appointment on May 13, 2010 to explore this possibility. She indicated that, if Petitioner was not able to return to his original job, he would be required to look for work and "complete at least 10 job searches each week." She provided him with job log forms and indicated he had to submit a log in person to Room 701 of City Hall on a weekly basis. PX 12, p. 3.

Petitioner "vaguely" recalled undergoing an evaluation by Genex Services in September 2012. T. 16. The records from Genex Services reflect that Patrick Conway, BA, CDMS, met with Petitioner at his attorney's office on September 11, 2012, to obtain his work history and complete a vocational assessment. Conway sent an initial report to Respondent's Committee on Finance on September 28, 2012. In this report, he noted that Petitioner had undergone two fusions and a right shoulder surgery. He also noted that Petitioner reported having difficulty with bending, twisting, kneeling, stooping, reaching, standing or sitting for long periods, driving for more than an hour and walking for more than half an hour. He indicated that Petitioner reported being able to perform activities of daily living. He described Petitioner as taking some computer classes after high school and being able to send text messages. He indicated that Petitioner "knows some Spanish but very little" and has a valid driver's license.

With respect to Petitioner's work history, Conway noted that Petitioner worked in a warehouse for five years, starting in high school, subsequently worked as a concrete laborer for the Chicago Housing Authority and then began working for Respondent. He indicated that, at Respondent, Petitioner started out as an acting laborer foreman, supervising up to 7 individuals, and later worked as a sanitation laborer.

With respect to Petitioner's educational history, Conway noted that Petitioner reported attending Bowen High School for three years, leaving in 1980 without a degree, and later attending extension computer courses at Olive Harvey for six months. He indicated that Petitioner described the computers at Olive Harvey as "very old."

Conway described Petitioner as having "good presentation and communication skills." He noted that Petitioner denied performing any job search and had "not given much thought to what work he would like to perform." He identified 5 directly transferable, 26 generally transferable and 183 directly related occupations at the sedentary level. RX 1.

Included in the Genex records is a three-page sanitation laborer job description. Physical requirements listed at the bottom of the second page include "extremely heavy lifting and carrying ranging from 75 to 100 pounds," standing, walking and bending for extended or continuous periods, the ability to move one's hands and arms to grasp or manipulate objects, the ability to climb and the ability to operate certain hand tools and equipment. In an attached "transferable skills analysis," Conway characterized the garbage collector job as at the "very heavy" level of exertion. PX 13.

On June 2, 2016, Lisa Helma, CRC, a certified vocational rehabilitation counselor affiliated with Vocamotive, met with Petitioner at his attorney's office. In her report of June 21, 2016 (RX 2), Helma described Petitioner as "fully cooperative with all aspects of the interviewing process." Helma described Petitioner as a 53-year-old, left-handed male most recently employed as a laborer by Respondent. She recorded a history of the work accident and noted current complaints of pain in the neck, right leg, ankle and hips. She indicated that Petitioner described the right leg condition as disputed. She also indicated that Petitioner described himself as "unable to walk" and characterized a trip to the grocery store as a "big task." He reported difficulty sleeping, turning his head and driving for any significant period. Petitioner denied undergoing any psychological treatment as of the interview. He acknowledged using Oxycontin for pain on an occasional basis and over the counter pain medication on a daily basis.

According to Helma, Petitioner reported graduating from Bowen High School in 1980. He also denied knowing any other languages. He reported having acquired mechanical skills from his father.

Helma noted that Petitioner stated he was looking for work daily, using the Yellow Pages and contacting hardware and roofing companies.

Helma stated that "testing would be beneficial" in determining Petitioner's interests and abilities. She concluded that Petitioner lacked transferable skills and needed training, consisting of computer training and possibly an internship. She noted that she had not been provided with any mental health records. She stated "it is unknown as to how [Petitioner's] mental health may impact his ability to participate in vocational rehabilitation activities."

Helma found that Petitioner had lost access to his usual laborer occupation but that he remained employable. She stated that occupations available to Petitioner included customer service representative, office clerk, front desk clerk and dispatcher, "along with other occupations." With respect to earning potential, she opined that Petitioner could probably earn between $10 and $13 per hour. Attached to Helma's report is a labor market survey listing various receptionist, customer service representative, dispatcher and clerical positions. Some of the listed employers required a high school diploma and/or computer proficiency.

Petitioner did not testify to contacting any of the potential employers identified in the labor market survey.

On November 13, 2017, Sharon Zajac of Vocamotive wrote to Petitioner, via regular and certified mail, scheduling him to begin vocational rehabilitation services at Vocamotive's office in Hinsdale on Monday, November 20th. In the letter, Zajac asked Petitioner to call her upon receipt to confirm the appointment. RX 3.

Respondent offered into evidence a "progress report" dated January 25, 2018 directed to Tomika Conner of Respondent's Committee on Finance. Helma and Zajac authored this report. In it, they detailed their unsuccessful efforts to contact Petitioner, as well as the efforts they made to involve a member of Petitioner's attorney's staff. They noted that Petitioner failed to appear for the November 20, 2017 meeting, that they advised Petitioner's attorney of this and that Petitioner still had not contacted them. They recommended closing the file. RX 4.

On February 4, 2019, about three months before the hearing, Petitioner met with Thomas A. Grzesik, MS, CRC, a certified vocational rehabilitation counselor affiliated with Grzesik & Associates. On that date, Grzesik interviewed Petitioner and administered vocational tests to him. Grzesik issued a report on March 12, 2019. In this report, he described Petitioner as periodically grimacing, alternating between sitting, standing and walking and having a flat affect. He indicated that Petitioner "remained cooperative throughout the interview." He noted that Petitioner denied being bilingual and reported living with his brother. He indicated that Petitioner reported experiencing constant pain in his neck, low back, hips, shoulders and right foot but denied taking any medication. He also indicated that Petitioner reported feeling depressed, sometimes to the point where he would isolate himself and not eat. He noted that Petitioner reported engaging in various hobbies, including bicycle riding and working on cars, before the accident but "no longer has hobbies."

With respect to Petitioner's pre-Respondent work history, Grzesik noted that Petitioner reported working as a printer helper for a paper company for eight to nine years, during which time he loaded paper into printing machines, and working as a laborer at a warehouse for one to two years. Grzesik expressed criticism of the conclusions Conway of Genex reached in 2012, indicating Conway incorrectly assumed Petitioner worked as a warehouse manager. Grzesik also expressed criticism of Vocamotive's methodology, indicating that Vocamotive recommended but did not conduct any vocational testing. Grzesik described the labor market survey conducted by Vocamotive as "premature."

Grzesik indicated he administered various tests to Petitioner. He found the results of the MAB-II test to be indicative of a "below average verbal learning potential and a low average performance (perceptive skills) learning potential." He found the results of the WRAT-5 test to be indicative of an average word reading ability, a very low ability in spelling and math computation and a low average ability in sentence comprehension. He noted that Petitioner scored at the 3rd percentile on the Bennett Mechanical Comprehension Test, suggesting he has "a very poor mechanical aptitude." He indicated that the DAT results suggested Petitioner "has a poor aptitude in abstract reasoning, space relations and language usage." Based on the available test results, he concluded that Petitioner "is not a feasible candidate for participation in a formal academic or vocational training program."

Grzesik did not mention Dr. Mirkovic's and Dr. Kalainov's full duty releases in his report. Citing the MercyWorks sedentary duty release of September 20, 2007, he concluded that Petitioner is not able

to work as a sanitation laborer for Respondent. Based on Petitioner's overall profile, including his age (56 as of Grzesik's evaluation), educational and work history, test results and years away from the workplace, Grzesik reiterated that Petitioner "is not a feasible candidate for participation in a a vocational rehabilitation program." He found Petitioner to be "not employable" and recommended he be "evaluated for odd lot permanent total disability." PX 15.

Under cross-examination, Petitioner testified he fell and injured his left shoulder about three or four months before the hearing. He was not working at that time. He was at a McDonald's. He went to put garbage in a can and lost his balance "because [his] body mechanics don't work as well." T. 18-19.

Petitioner identified his current mailing address in Chicago. He then looked at a collection of letters that Respondent sent to him. RX 12. He did not recall receiving a letter from Respondent's personnel department in October 2007. The letter directed him to attend an appointment on October 24, 2007. If he was told to attend, he is sure he did so but the letter is dated twelve years ago. T. 20. He "kind of remembers" being told at the meeting that he would be placed on an eligibility list for various positions at Respondent. He thinks that Respondent "sent [him] for a night watchman's job or something" after this meeting. He did not want to accept a watchman position because he has trouble sitting and walking and continues experiencing problems with his back and leg. Respondent told him they were going to send him to some pain management program for his leg but this never happened. T. 22-23. He did not contact Respondent about the watchman position or request more information. T. 23. He does not remember whether he received a letter dated May 20, 2008, directing him to attend a career development workshop. He does not recall attending such a workshop. T. 23-24. He also does not recall receiving another letter dated June 17, 2008, directing him to attend another workshop to develop a profile for Respondent's career website. He did not attend a workshop on July 2, 2008. T. 24-25. He did not complete any ADA paperwork seeking reasonable accommodation of his restrictions. T. 25. He recalls receiving a letter dated May 6, 2010, directing him to look for work and submit at least ten job contacts per week. He turned in his job logs to Respondent. T. 26-27. He did not attend a career workshop on March 19, 2010. T. 27. He met with Conway of Genex in 2010 but does not recall Conway finding him capable of performing several jobs at a sedentary level. T. 27. He recalls meeting with Helma of Vocamotive in 2016. He also recalls Helma concluding that he is employable. T. 28. He does not recall Helma finding him to be a good candidate for vocational rehabilitation. T. 28. Nor does he recall Helma finding him capable of working as a customer service representative, office clerk, front desk clerk or dispatcher. T. 28-29. He remembers Vocamotive attempting to contact him in November 2017 so that vocational rehabilitation could start. A Vocamotive representative left multiple messages for him. He did not respond because he "felt like they wanted [him] to go somewhere in Westchester or something like that and [he] can barely get out of bed some days, let alone go to Westchester." T. 29-30. He did not call Vocamotive back. T. 30. He "must have" received Vocamotive's letter directing him to attend an appointment on November 20, 2017 but he did not attend this appointment. He has not applied for any jobs since November 2017. He has not applied for any jobs on Respondent's career website. He does not have access to a computer. He has always worked with his hands and does not know how to operate a computer. He did work as a warehouse manager in the past, before being hired by Respondent. In that job, he dealt with customers and supervised employees. T. 32. He also worked as a foreman during some of his tenure with Respondent. He supervised but did not hire. T. 32. He completed and turned in job logs between September 2007 and November 22, 2017. He did not bring any of these logs to the hearing. T. 33. He might still have some at home. T. 34. During the period he completed the logs, he would look for work by checking the telephone book, calling places and asking if the places were hiring. He conducted all of his job search via telephone. T. 34. He did not follow up with the businesses he contacted. If someone told him the business was not hiring, "that was it." T. 35.

After the accident, he did not apply for other jobs at Respondent. He felt as if he "couldn't do anymore." His body was "shot." T. 36. During his tenure as a sanitation laborer, he worked 40 hours per week. T. 37. During the period when he was turning in job search logs, he "made an effort" and occasionally made more than ten contacts per week. It took him "a couple minutes, calling on the phone" to make one contact. T. 38. He did not make all of the calls on a single day. T. 39.

On redirect, Petitioner testified he was "in good shape" and "very active" before the accident. He was able to run, bike and do mechanical work. T. 39. He believes he slipped at McDonald's because his back does not allow him to move like a normal person. This is due to the surgery. When he fell at McDonald's, he put out his left hand as a protective measure because he knows his left hand is stronger than his right. When he landed, he felt something "snap" in his left shoulder. He has had left shoulder pain ever since. The leg treatment that was never provided was for his right leg, which was injured in the accident. T. 40. He turned in job logs to Respondent for ten years. Respondent searched for work for him within its ranks. T. 41.

No witnesses testified on behalf of Respondent. In addition to the exhibits previously described, Respondent offered into evidence a print-out of the weekly benefits it paid to Petitioner from March 12, 2005 through October 27, 2017 and various medical and case management expenses it paid during the pendency of the claim. RX 5.

Arbitrator's Credibility Assessment

Petitioner was subdued and occasionally querulous. As Lisa Helma observed, "it is unknown as to how [Petitioner's] mental health may impact his ability to participate in vocational rehabilitation activities." Thomas Grzesik, another certified vocational rehabilitation counselor who evaluated Petitioner in February 2019, noted that Petitioner reported being depressed and anxious, isolating himself and occasionally having "fleeting suicidal ideation without a plan." PX 15, pp. 9-10. The only medical records in evidence bearing on Petitioner's mental health are some brief notes from Michael Reese dating back twelve years. PX 5. Petitioner ignored and resisted rehabilitation-related efforts but, In the absence of more current information, it is difficult to determine whether this inaction stems from lack of motivation, psychological issues or a combination thereof.

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise, as does the fact he sometimes performed supervisory duties.

There is a discrepancy between Petitioner's testimony concerning the nature of his pre-Respondent employment and the information Petitioner provided to Thomas Grzesik in 2019. At the hearing, Petitioner acknowledged working as a manager at a warehouse and as a foreman at the Department of Transportation. He also acknowledged that both of these jobs involved supervising other people. T. 32. When he met with Grzesik, however, he described the warehouse job as physical and unskilled and apparently did not mention the Department of Transportation position. It was this reporting that prompted Grzesik to conclude that Lisa Helma of Vocamotive relied on an "inaccurate" job history in finding Petitioner to be employable.

There is also a discrepancy between Petitioner's testimony concerning the extent of his education and the information he provided to Lisa Helma in 2016. Helma described him as telling her he graduated from Bowen High School in 1980. She relied on this reporting in identifying potential employers. At the hearing, Petitioner testified he attended high school for three years. T. 17. This is

the same information that Conway recorded in 2012. Conway identified the lack of a high school diploma as one of several barriers to employment. RX 1.

Respondent directed Petitioner's medical care, for the most part. Of the treating physicians, only one, Dr. Pinzur, indicated he had no explanation for Petitioner's pain. Regardless, Dr. Pinzur recommended a chronic pain management program to address Petitioner's right ankle complaints. Petitioner testified this program was never authorized. The therapist who conducted a neuromuscular evaluation in 2007 noted no positive Waddell's findings.

Petitioner professed to have difficulty recalling whether he responded to Respondent's written communications. He did, however, acknowledge that he did not pursue a night watchman job with Respondent or go to Vocamotive's offices. He testified he felt physically unable to work as a watchman or get himself to Vocamotive. He recalled submitting completed job logs to Respondent on a weekly basis between 2007 and 2017 but did not produce any of these logs. He acknowledged he stopped looking for work in November 2017, at which point Respondent stopped issuing maintenance benefits.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of March 11, 2005 and his various claimed conditions of ill-being?

The Arbitrator finds that Petitioner established causation as to his spinal, right shoulder and right ankle conditions of ill-being. In so finding, the Arbitrator relies on Petitioner's credible testimony concerning his pre-accident state of health and the fact that he successfully performed physical work for Respondent for a number of years before the accident. The Arbitrator also relies on the treatment records. Respondent did not introduce any evidence suggesting that the spinal and shoulder surgeries were unrelated to the accident.

The Arbitrator further finds that Petitioner failed to establish causation as to his claimed left shoulder condition. Petitioner testified he injured his left shoulder three or four months before the hearing, when he moved awkwardly and fell while discarding garbage at or outside a McDonald's restaurant. He claimed his back condition adversely affects his body mechanics, making him prone to falling, but did not offer any medical opinion linking his left shoulder condition to his work-related spinal condition.

Insofar as Petitioner's restrictions are concerned, the Arbitrator notes a significant discrepancy between the full duty releases of Petitioner's spine and shoulder surgeons, Drs. Mirkovic and Kalainov, and the sedentary work restriction documented in the MercyWorks work status note of September 20, 2007. PX 4, p. 99. The surgeons' 2006 and 2007 releases were tempered by notations that Petitioner remained under care for other body parts, but, with respect to the last of those parts, the right ankle, Dr. Pinzur described the MRI as "unremarkable" and Petitioner's persistent pain as "unexplainable." The work hardening notes of 2007 speak to a greater level of function than sedentary. Petitioner was unable to complete a functional capacity evaluation, apparently due to an incident that required emergency medical intervention, but the work hardening therapist indicated that, prior to the attempted evaluation, Petitioner was able to perform some lifting, albeit not at the level required of a laborer.

The basis for the conclusion that Petitioner is capable of only sedentary work remains unclear. As of the hearing, that conclusion was twelve years old.

Is Petitioner entitled to additional maintenance benefits from October 28, 2017 through the hearing of May 14, 2019?

Respondent agrees Petitioner was entitled to maintenance benefits from April 16, 2009 through October 27, 2017. Arb Exh 1. Petitioner claims an additional period of benefits extending from October 28, 2017 through the hearing.

The Arbitrator, having considered the full duty releases of Petitioner's spine and shoulder surgeons, along with the Vocamotive records and testimony elicited under cross-examination, declines to award additional maintenance benefits. Petitioner acknowledged that he stopped looking for work in November 2017. He also acknowledged that he failed to respond to Vocamotive the same month. He claimed he ignored Vocamotive because he has difficulty even getting out of bed but offered no convincing medical evidence that he is as incapacitated as he claims.

What is the nature and extent of the injury?

This is a pre-amendatory case, since the accident occurred before September 1, 2011.

Petitioner claims he falls into the "odd lot" category. He seeks an award of permanent total disability benefits. It has long been held that a claimant seeking such an award must initially establish, by a preponderance of the evidence, that he falls into the "odd lot" category before the burden shifts to the employer to show the availability of work.

The medical evidence, taken as a whole, does not support an award of permanent total disability. Petitioner underwent three significant surgeries, years back, but the physicians who performed those surgeries ultimately found him capable of full duty, subject to ongoing care for other body parts. Dr. Pinzur, the physician who addressed the last of those body parts, the right ankle, recommended pain management but did not find Petitioner unable to work. As indicated earlier, the basis for the subsequent MercyWorks sedentary duty restriction remains unclear. The restriction is not accompanied by any dictated note. Nor is it supported by the results of a functional capacity evaluation. It is simply a form completed by a physician (perhaps Dr. Sheth) whose signature is illegible. PX 4, p. 99. Another complicating factor is that, at the hearing, Petitioner tended to focus on recent difficulties with his left shoulder, a body part the Arbitrator has found to be unrelated to the 2005 work accident.

The Arbitrator acknowledges that Petitioner, unlike the claimant in Westin Hotel v. Industrial Commission, 373 Ill.App.3d 1080 (2007), does not rely on medical evidence alone in claiming "odd lot" benefits. He offered an opinion from a certified vocational rehabilitation counselor that he is not employable. While this counselor, Thomas Grzesik, CRC, did conduct testing, unlike Lisa Helma, he failed to acknowledge the full duty releases and factored in some inaccurate information, i.e., that all of Petitioner's pre-Respondent jobs were physical and unskilled in nature. The Arbitrator finds his opinion less than persuasive.

The Arbitrator, having considered the evidence as a whole, finds that Petitioner failed to meet his burden of proving he falls into the "odd lot" category of permanent total disability. The Arbitrator

finds that Petitioner established permanency equivalent to 50% loss of use of the person as a whole, representing 250 weeks of benefits, under Section 8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC007801
Case Name	ROMERO, SERGIO v. ATKORE INTERNATIONAL GROUP
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0475
Number of Pages of Decision	21
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Joseph Higgins

DATE FILED: 9/20/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sergio Romero,

Petitioner,

vs. NO: 20 WC 7801

Atkore International Group,

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, 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 December 20, 2020, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,100.00. 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.

September 20, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 9/16/21
68

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

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

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

21IWCC0475

ROMERO, SERGIO
Employee/Petitioner

Case# **20WC007801**

ATKORE INTERNATIONAL GROUP
Employer/Respondent

On 12/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH J HIGGINS
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)/8(A)

Sergio Romero
Employee/Petitioner

v.

Atkore International Group
Employer/Respondent

Case # **20** WC **7801**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 17, 2020**. The parties opted to bifurcate the hearing so that Respondent could obtain a Section 12 examination. Due to the pandemic and resulting Commission shutdown, they later agreed, via a written stipulation, to supplement the existing record with two Section 12 reports (RX 7) and close proofs on November 27, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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 2, 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 sustained an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**43,680.00**; the average weekly wage was $**840.00**.

On the date of accident, Petitioner was **62** years of age, **married,** with **1** dependent child.

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

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

Respondent did not claim Section 8(j) credit at the hearing. Arb Exh 1.

ORDER

Temporary Total Disability

Respondent shall pay temporary total disability benefits at the rate of $560.00 per week from March 3, 2020, through July 17, 2020, a period of 19 4/7 weeks, as provided in Section 8(b) of the Act.

Medical Benefits

With the exception of a $200.00 non-emergency transportation charge claimed by Illinois Orthopedic Network (PX 2), Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of Franciscan Health Hammond, Midwest Anesthesia Consultants, Midwest Specialty Pharmacy, Total Rehab, P.C., Illinois Orthopedic Network and Premium Healthcare Solutions. PX 1-6. As noted in the attached decision, the bill from Franciscan Health Hammond (PX 1) reflects a $7,019.95 payment by Blue Cross Illinois. Petitioner did not testify to this payment and it is not clear whether Blue Cross Illinois is a Section 8(j) carrier. The Arbitrator leaves it to the parties to sort out whether Respondent is entitled to Section 8(j) credit for this payment.

Prospective Medical

Respondent shall authorize and pay for the recommended lower extremity EMG and post-EMG care, including but not limited to the lumbar spine surgery contemplated by Respondent's examiner, Dr. Phillips. RX 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.

Molly C Mason

Signature of Arbitrator

Date 12/17/20

ICArbDec19(b)

DEC 21 2020

Sergio Romero v. Atcorp
20 WC 7801

Summary of Disputed Issues

Petitioner, a loader who worked in a dock area, claims head, neck and back injuries occurring on March 2, 2020 (as amended, PX 7). Petitioner testified that, prior to being injured, he and an outside truck driver, who he had never previously encountered, were on opposite sides of the driver's 18-wheeler, working to cover the load with a tarp. The driver was experiencing difficulty with the tarping process and, according to Petitioner, sounded irritated. Petitioner testified the driver used profanity. Petitioner acknowledged he also used profanity, saying "can you fucking do that?" to the driver. Petitioner testified he then went over to the driver's side, with the intention of providing assistance. He denied threatening the driver in any way. The driver pushed him down with sufficient force to cause his hard hat to fly off. Respondent offered a video of the incident. The video (RX 1) has no accompanying audio. It does not provide a close-up view of the incident. Respondent's first witness, Mark Elliott, who testified he was initially 25 to 35 feet away from the two men, acknowledged that outside truck drivers often have difficulty applying tarps. Elliott asserted that Petitioner came into the truck driver's personal space and that the driver acted defensively when he pushed Petitioner down. He conceded, however, that Petitioner did not say anything to the driver after he came over to where the driver was working. Respondent's second witness, Dallas Wilson, admitted he was not present when the incident occurred. He reviewed the video and other investigatory materials. Respondent suspended Petitioner shortly after the incident and subsequently terminated him.

The disputed issues include accident, causal connection, medical expenses, temporary total disability benefits and prospective care.

Arbitrator's Findings of Fact

Petitioner testified via a Spanish-speaking interpreter but clarified that the conversations that occurred at work, prior to the incident of March 2, 2020, took place in English. T. 14.

Petitioner testified he began working for Respondent about eight months before his claimed accident of March 2, 2020. T. 15. He worked in the warehouse, filling orders, and in the dock area, loading trucks, using a forklift. He also applied tarps to loads. T. 16-17.

Petitioner acknowledged having lower back problems about five years before the accident. He underwent three or three and a half months of physical therapy at that time and improved. He denied undergoing any other back treatment between that time and the accident of March 2, 2020.

Petitioner testified he was scheduled to work his usual shift, from 3 PM to 11 PM, on March 2, 2020. T. 17-18. When he started his shift that day he was not experiencing any back or foot problems. T. 46-47. The incident occurred in the late afternoon. The dock where he works has twenty-eight doors. During his shift, twenty-eight trucks from different companies drive in to be loaded. T. 18.

During the hearing, the Arbitrator and parties watched RX 1, a video of the occurrence. The video has no accompanying audible audio. An individual wearing a yellow hard hat can be seen in the lower right hand portion of this video. Petitioner identified this individual as the truck driver who pushed him to the ground. T. 20, 27. Petitioner testified he had never previously encountered this individual and does not know his name. T. 21. The driver is on one side of an 18-wheeler, attempting to work with a tarp. Petitioner then appears on the right side of the screen. He is wearing an orange hard hat. T. 27. He is on the opposite side of the truck, also working with a tarp. T. 22. Tarping is the last step in the process of readying a truck to leave. Petitioner testified he had frequently applied tarps to loads. He was familiar with the process. Once a load was tarped, the driver would stop in the office to pick up paperwork and then drive away. T. 23.

Petitioner testified that, shortly before the incident, he was working on a different truck. At that point, his supervisor, who was a relatively new employee, was talking with the driver who subsequently pushed him down. His supervisor then came over to him and asked him to help that driver. Petitioner approached the driver and asked whether he was ready to work with the tarp. The driver said "no" because he was "doing some strapping." The driver seemed irritated and spoke with a "strong voice." T. 28. Ten or fifteen seconds later, the driver said "kind of a bad word" and then said, "yeah, I'm fine, I'm ready." T. 28-29. Petitioner then told the driver to bring the tarps. The driver "continued with the same vocabulary because the tarps are heavy." Petitioner testified the tarps weigh between 150 and 180 pounds. He told the driver to put the tarps on the floor but the driver put them on the edge of the trailer. Petitioner again told the driver to put them on the floor. The driver, using "bad words," transferred the tarps to the floor, indicating this was not his job. Petitioner and the driver then opened the tarps. Petitioner tried to explain to the driver how to apply the tarp. This is when Petitioner went over to the side of the truck where the driver was, so that he could help the driver. T. 29-30.

Petitioner testified that the dock is somewhat noisy but people do not have to speak up a lot. During the time he interacted with the driver, he and the driver only discussed the task at hand. Petitioner denied threatening the driver or making any threatening gestures but acknowledged using profanity, asking the driver, "can you fucking do that?" [referring to the tarping process] before he and the driver were face to face. Once he and the driver were face to face, he did not repeat the "F" word. T. 32. The driver had been waiting at the dock for some period of time. Drivers normally wait two to ten hours for their trucks to get loaded and tarped. The loading process takes one to four hours, depending on the load. T. 33.

Petitioner testified that, once he and the driver were face to face, the driver pushed him backward, causing him to fall to the ground and strike his head, neck and back. His hard hat came off, despite being "well fastened." T. 35. Petitioner testified he would have hit his head hard had the helmet not been well fastened. The video shows Petitioner being pushed and flying backward quite a distance before landing.

Petitioner testified that, after he landed, he felt dazed and was experiencing pain in his head, neck and back. He asked his supervisor if he could go home. The supervisor said no but told him he could sit and rest until 11 PM, the end of his shift. T. 37. As Petitioner sat, he felt pain in his head and low back. He went home at 11 PM. The following morning, he felt a little more pain in his head, neck and low back. T. 38. He went to the Emergency Room at Franciscan Health Hammond, where he underwent X-rays. T. 38.

The Emergency Room triage notes reflect that Petitioner reported being assaulted at work the previous night. Petitioner indicated he was pushed by another person and fell backwards, hitting his head. He denied losing consciousness. He complained of headaches and lower back pain. PX 1, p. 7. The examining physician, Dr. Lyons, noted tenderness, pain and a normal range of motion in the cervical, thoracic and lumbar areas. He ordered CT scans of the brain and cervical spine. The brain CT scan showed no abnormalities. The cervical spine CT scan showed moderate multi-level spondylosis. PX 1, pp. 12-13. Lumbar and thoracic spine X-rays showed no acute abnormalities. PX 1, p. 14. Dr. Lyons diagnosed a head contusion, cervical and lumbar sprains and a thoracic strain. He prescribed Hydrocodone and Flexeril. He directed Petitioner to seek follow-up care. PX 1, p. 43.

Petitioner testified he was suspended and terminated following the incident. He has not worked anywhere since March 2, 2020. T. 40.

Petitioner testified he began experiencing a strange pain, "like tingling and needles," in his left leg about two weeks after the incident. T. 39.

On March 24, 2020, Petitioner saw Dr. Lipov, a pain management physician affiliated with Illinois Orthopedic Network [ION]. The doctor recorded a history of the incident, noting that Petitioner "was putting a tarp over a trailer with a remote crane when he was confronted and pushed by another worker," causing him to "fall backwards onto concrete." The doctor noted complaints of headaches, upper and lower back pain, neck pain and left thigh numbness and tingling. He also noted that Petitioner had been off work for two weeks. He indicated he had access to the Emergency Room records. On initial examination, he noted mildly positive tenderness and hypertonicity over the cervical paraspinal musculature extending into the trapezius muscles bilaterally, positive tenderness and hypertonicity over the lumbosacral paraspinal musculature and lumbar spinous processes, mildly positive straight leg raising on the left, negative Spurling compression bilaterally and 5/5 strength. He prescribed physical therapy along with Celebrex, Lidocaine patches and Flexeril. He directed Petitioner to remain off work. PX 2. T. 41.

Petitioner underwent an initial physical therapy evaluation at Total Rehab, P.C. on March 31, 2020. The evaluating therapist recorded a consistent history of the incident and subsequent care. He noted complaints of low back pain, upper back soreness and tingling in the lower leg/lateral thigh radiating down to the left foot. PX 4.

Petitioner continued attending therapy on a regular basis after the initial evaluation. PX 4. Petitioner testified his pain began to get better after attending therapy for a month or two. T. 41.

The ION bill (PX 2) reflects that Petitioner had a telephonic consultation with Dr. Lipov on April 15, 2020. The doctor's office note of that date is not in evidence. The doctor recommended additional therapy, along with Lyrica. He continued to keep Petitioner off work. PX 3.

Petitioner had another telephonic consultation with Dr. Lipov on May 13, 2020. T. 41. The doctor noted that Petitioner's neck, trapezius and head pain had resolved but that he was still experiencing 3-4/10 low back pain and numbness in the top of his left foot. He also noted that he had started Petitioner on Lyrica at the previous visit. He increased the Lyrica dosage and prescribed a lumbar spine MRI to evaluate Petitioner's radicular symptoms. PX 2.

The lumbar spine MRI, performed without contrast on May 20, 2020, showed spastic paraspinal muscles, spondylodegenerative lumbar disc disease, a 4.4 mm annular bulge at L4-L5, a 2.4 mm annular bulge at L5-S1 and stenosis at the L4-L5 level. PX 2, PX 6. T. 42.

A physical therapy progress note dated June 4, 2020 reflects that Petitioner's neck pain had improved but that he was still experiencing low back pain. PX 4.

On June 8, 2020, Petitioner saw Dr. Mohiuddin, another pain management physician affiliated with ION. T. 42-43. The doctor noted that Petitioner was still experiencing low back pain radiating down his left leg associated with numbness and tingling. He reviewed the MRI results with Petitioner and recommended a left L4-L5, L5-S1 lumbar epidural steroid injection. He continued the medication and directed Petitioner to continue therapy and remain off work. PX 2.

On June 22, 2020, Dr. Mohiuddin administered a left L4-L5, L5-S1 lumbar transforaminal epidural steroid injection. He directed Petitioner to remain off work. PX 2.

Petitioner testified that the injection did not help. T. 43.

On July 6, 2020, Dr. Mohiuddin noted that Petitioner reported "essentially 0% improvement of his symptoms" following the injection. He recommended an EMG of the lower extremities along with continued therapy. He directed Petitioner to remain off work and return following the EMG. PX 2. T. 43.

The last therapy note in evidence is dated July 8, 2020. PX 4.

On July 28, 2020, Dr. Mohiuddin again recommended a lower extremity EMG, noting complaints of numbness and tingling in the left leg. RX 7.

At Respondent's request, Dr. Phillips, a spine surgeon, conducted a Section 12 examination of Petitioner on September 24, 2020. In his report of the same date, Dr. Phillips indicated he reviewed various treatment records, along with the lumbar spine MRI images of May 20, 2020, in connection with his examination. Dr. Phillips interpreted the MRI as showing advanced degenerative changes at L4-L5 with disc space narrowing and desiccation. He found no evidence of stenosis at L5-S1 on the axial views. He noted facet arthropathy with a central disc osteophyte complex with moderately severe stenosis at L4-L5.

Dr. Phillips noted that Petitioner described experiencing neck, low back and radicular left leg pain after being pushed to the floor at work. He indicated that Petitioner's neck was "much improved" but that he was still experiencing mild low back pain and numbness and weakness around his left foot and ankle. He described the foot and ankle complaints as Petitioner's "dominant" problem. He noted that Petitioner had not worked since the incident.

On examination, Dr. Phillips noted a normal gait, the ability to heel and toe walk, no positive Waddell's signs, a full range of neck motion with some right-sided discomfort, 5/5 upper extremity strength, a good range of lumbar spine motion with some mild end range discomfort, 5/5 lower extremity strength, trace EHL weakness on the left, intact sensation on the right, fairly diffusely diminished sensation in the left foot in a non-classic dermatomal pattern and negative straight leg raising bilaterally.

Dr. Phillips opined that the work incident directly caused a cervical strain which had since resolved. He further opined that the work incident aggravated an underlying lumbar spine condition which had "mostly resolved aside from subjective weakness and numbness" in Petitioner's left foot. He indicated that, if Petitioner felt his foot and ankle symptoms to be disabling, he "would potentially be a candidate for decompressive surgery." He opined that the need for this surgery related, in part, to the work incident. He described the surgery as "not absolutely indicated," finding that Petitioner could resume full duty. He found Petitioner to be at maximum medical improvement absent the surgery. RX 7.

On October 29, 2020, Dr. Phillips issued an addendum after reviewing a video of the work incident (RX 1). He indicated that the video did not prompt him to alter any of the opinions he expressed in his report of September 24, 2020. RX 7.

At the hearing held on July 13, 2020, Petitioner testified he remains off work at Dr. Mohiuddin's direction. He feels the same as he did a month ago. He is still experiencing mild low back pain and mild left leg pain. His left leg symptoms improved but he is still experiencing constant numbness and pain in the front of his left foot, near the toes. He is also experiencing

numbness down his left leg but that has improved. He wants to undergo the EMG that Dr. Mohiuddin recommended. T. 44.

Petitioner testified he is currently 63 years old. He was 62 at the time of the incident. He is 5 feet, 7 inches tall and weighs 150 pounds. T. 47.

Under cross-examination, Petitioner testified he was in the process of tarping a load when the incident occurred. The tarp is hooked onto a crane bar. The crane then lifts the tarp over the load. T. 51. The incident occurred at around 4:50 PM, not 6:00 PM. Following the incident, after everything calmed down, he wrote out a statement. He identified RX 2 as this statement. The statement reads as follows:

> "I, Sergio Romero, testified what happen [sic] in this incident. I was in a process of tarping this driver. This man, having problem to open his tarp and eventually having problem hooking up [illegible] at one side of the truck, myself at the other. I start talking to the guy after 2 minutes he trying. I explain him how to do it and he couldn't get it. And he began scriming [sic], yelling. My mistake go around to help him hooking the tarp at that moment. He already [sic] irritated. I try one time. He said "you not going to do it," "help him." I try second time. I bent to grab it. Then he just stop in front of me, without waiting his reaction, he push me hart [sic]. I almost flip over on the floor."

RX 2. Petitioner testified he wrote exactly what occurred when he completed RX 2. T. 52-53. Petitioner testified that, when he realized that the driver was struggling and offered to help, he was on one side of the truck and the driver was on the other. He and the driver were about six to seven feet apart, with the width of the truck between them. He tried to explain the process of hooking the tarp to the bar. After two minutes, the driver "couldn't get it" and started yelling. At that point, he and the driver were still six to seven feet apart. The driver was irritated. He said, "fuck this, I can fucking do this." T. 56. It was at this point that Petitioner went over to the driver. The driver never explained why he was upset. T. 57. Once he and the driver were on the same side, he (Petitioner) tried to hook up the tarp. Petitioner said, "let me help you" but the driver did not allow him to help. T. 58. Petitioner tried a second time. He bent to try to grab the tarp, to do the driver's job for him. He had no time to bend, however, because it was at this point that the driver grabbed him and pushed him. T. 60. Petitioner testified that the tarp was on the ground. [The tarp can be seen on the bottom right side of the video.] The driver was near the hook and did not let Petitioner bend.

Petitioner acknowledged that, right before he came around the truck to help the driver, he said "can you fucking do that?" but maintained he was not irritated. His tone of voice "never changed." T. 71. It was common to use bad language while working in the dock area. Workers used bad language even when they were not mad. T. 70.

Respondent offered into evidence, with no objection from Petitioner, an "employee reprimand" form dated March 3, 2020. RX 3. Petitioner denied being written up on the night of the incident or on March 6th. T. 73. He also denied signing this form. He testified he never saw the form at any point prior to the hearing. The words "refused to sign" appear in the box marked "employee signature." Petitioner's seniority date is designated as July 29, 2019. The discipline consisted of a five-day suspension pending discharge. The explanation of the violation reads as follows:

> "This violation is intentionally attempting to or actually causing bodily injury to another, fighting or instigating a fight on company property or attempting to abuse, coerce, intimidate or threaten any person on company property.
>
> On the evening of March 2nd, you were observed getting into an altercation with a driver in the RDC. Witnesses stated that you were using inappropriate language directed toward the driver and when things escalated, you aggressively confronted him resulting in a further heated exchange which resulted in your being shoved backwards."

RX 3. Also in evidence is a letter that Respondent sent to Petitioner on March 24, 2020, informing him that his five-day suspension pending discharge had been converted to a discharge. The author indicated that a copy of the letter would be provided to Petitioner's union representative. RX 4. Petitioner acknowledged receiving RX 4. He also acknowledged having previous write-ups. T. 75. He acknowledged attending a meeting a couple of days after the incident. At the meeting, he was informed he was being suspended. T. 76.

On redirect, Petitioner testified that it is impossible for RX 3 to say he refused to sign because he was never shown RX 3. T. 79. It was after he tried to bend a second time that the driver pushed him. T. 80. The tarp was behind the driver. The driver was blocking him. T. 81-82. He never put his hands on the driver. T. 81. He is not a mind reader but he saw the driver's hands and perceived that the driver was irritated. The driver was struggling with the tarping process. He has no idea how long the driver had been waiting to get back on the road. T. 84.

Under re-cross, Petitioner testified that Dallas Wilson was Respondent's general manager as of March 2, 2020. Wilson was not present when the incident occurred. Nor was Wilson present the following day. T. 86. He (Petitioner) talked with Wilson at the meeting. T. 87.

Mark Elliott testified on behalf of Respondent. Elliott testified he has worked for Respondent for more than twenty-six years. He is a forklift driver. T. 90. He knows Petitioner and has worked near him. He and Petitioner had a good working relationship. T. 91. He and Petitioner worked on March 2, 2020. T. 91. He witnessed the altercation, which took place

sometime between 5:30 PM and 6:00 PM. He (Elliott) was off to the side, about twenty-five to thirty-five feet away, when the altercation took place but he was able to see Petitioner and the truck driver. T. 91-92.

Elliott identified RX 5 as a witness statement he signed on either the night of March 2nd or the morning of March 3rd. T. 92. In the first sentence, he indicated he was by the battery charger, about twenty-five or thirty feet away from the truck, when he heard someone yelling. He saw Petitioner yelling at a truck driver and "got closer." Petitioner was at the back of the truck, kind of on the east side. T. 95. Petitioner and the driver were about six to eight feet away from one another. T. 95. He heard Petitioner cursing at the driver. He was close enough to hear. T. 96. Petitioner told the driver he was "fucking stupid." He is not sure why Petitioner was yelling. Petitioner never offered to help the driver. T. 96. The driver did not say anything at first but then said "stop cursing at me, I'm not going to have....." T. 97. At that point, Petitioner and the driver were still six to eight feet apart. Petitioner then "rushed" the driver, moving quickly into the driver's personal space. T. 97. Petitioner went east and then right up to the driver. It never appeared as if Petitioner was attempting to help the driver or pick up the tarp. T. 98. Petitioner was no longer yelling. Petitioner and the driver were inches away from one another. The driver never cursed at Petitioner. Nor did the driver wave his arms or otherwise threaten Petitioner. Petitioner walked right up to the driver and came within inches of him. At that point, Petitioner was not saying anything. T. 99. The driver "defensively put his hands up and pushed." T. 99. At no time did the driver curse at Petitioner, wave his arms at Petitioner or threaten Petitioner. T. 100. [At this point in the hearing, the Arbitrator and parties watched the video again.] Elliott testified that Petitioner "walked right up to" the driver. T. 107. The only thing the driver said to Petitioner was "stop cursing at me." The driver did not say anything else before he pushed Petitioner. It was after the driver told Petitioner to stop cursing that Petitioner "walked right up to" the driver. T. 108. The Arbitrator sustained Petitioner's hearsay objection to statements the driver made after he pushed Petitioner, with Respondent's counsel making an offer of proof as to those statements. Elliott testified that, after the driver pushed Petitioner, he (the driver) very loudly said, "I just defended myself. I did not hit this man." T. 108-109.

Under cross-examination, Elliott testified he heard Petitioner yell "are you fucking stupid?" He did not hear Petitioner say anything else. T. 111. The driver said nothing other than "stop cursing at me." T. 111. He (Elliott) started observing Petitioner and the driver about two to three minutes before the altercation. He watched the tarping process and did not overhear either Petitioner or the driver say anything at that time. He was twenty-five to thirty feet away when he heard Petitioner say "are you fucking stupid?" He does not know the driver. T. 112. His only interaction with the driver took place that day. He did not observe the driver earlier that day. Both Petitioner and the driver were trying to tarp. The process was not going well. Elliott acknowledged that "most truck drivers have a hard time doing it." T. 113. It is possible the two men were not seeing eye to eye on how the tarping should be done. T. 114. He did not hear Petitioner offer to help with the tarp. T. 114. The driver was on the other side. There was a bar between Petitioner and the driver. Either man could have accessed the bar to connect it. T. 115-116.

On redirect, Elliott testified that, when the two men were face to face, the bar was off to the side, on Petitioner's right side. Petitioner could have used his right hand to grab the bar. He (Elliott) did not see Petitioner try to grab the bar. T. 118-119.

Under re-cross, Elliott testified that when the two men were face to face, he was approximately 20 or 25 feet away from them. He had gotten "a little closer." T. 119.

On further redirect, Elliott testified that, at a distance of 20 to 25 feet, he could clearly see the two men and the bar. T. 119.

Dallas Wilson also testified on behalf of Respondent. Wilson testified he has worked for Respondent for a little less than three years. T. 123. His job title is regional distribution manager. He manages approximately 120 employees. Respondent has a half million square foot warehouse in Harvey that ships electrical and mechanical steel products. T. 123. He is familiar with Petitioner. He was not in Respondent's facility at the time of the altercation. He learned of the altercation the following morning, via an Email from his director, Mike Blatzer and a summary of an Email written by Ronald Herzog, the second shift supervisor. T. 124. Herzog was Petitioner's supervisor as of that time. Herzog no longer works for Respondent. T. 125. He (Wilson) was involved in the investigation of the altercation. An investigation typically consists of interviewing witnesses, reviewing any closed circuit video footage, obtaining statements from any outside vendors and partnering with Respondent's human resources department. T. 125-126. Petitioner provided him with a written statement. RX 2. He (Wilson) did not speak directly with the truck driver, Zane Vailes. Vailes is not appearing at the workers' compensation hearing. He is "stuck in Louisiana on a different job." Vailes did provide Respondent with a statement. RX 6. Vailes wrote out RX 6 and signed it on the evening of the incident. T. 129. [At this point in the hearing, the Arbitrator sustained Petitioner's hearsay objection to RX 6. Respondent then made an offer of proof. T. 130-131.]

Wilson testified he is familiar with Mark Elliott. T. 131. He identified RX 5 as the statement that Elliott provided and signed. Wilson also testified he watched the video (RX 1) of the incident. T. 132. Vailes can be seen in this video. He is wearing a white hard hat. He was working with Respondent's tarping crane system. A ceiling-mounted crane comes down, grabs the tarp on both ends and applies it to the top of the load to protect the steel material. T. 133. Vailes can be seen attempting to connect the crane arm to the driver's side of the tarp. Then Petitioner can be seen coming into the frame from right to left. Petitioner is wearing an orange hard hat. Wilson testified that "through [his] witness," he saw Petitioner in the video walk toward the driver's side of the truck and approach Vailes face to face. Petitioner came within inches of Vailes. T. 134. Vailes then took two to three steps back, to create space. Petitioner "continued to encroach" and Vailes then pushed Petitioner out of his space. T. 135. Wilson testified he watched the video several times and compared it to Petitioner's statement. Petitioner had admitted he had a problem with Vailes and used some foul language toward him. Petitioner also acknowledged Vailes was having difficulty connecting the tarp. T. 135. Wilson testified he spoke with Petitioner about the incident during the investigation and at the

union hearing. T. 136. When he (Wilson) watched the video, he realized it did not substantiate Petitioner's claim that he was going to help Vailes. T. 137. The video shows Petitioner walking "with intent" and going "nose to nose" with Vailes, "not reaching for the work." T. 138. At the end of the investigation, Respondent filed a suspension with intent to terminate after five days. RX 3. Petitioner saw RX 3. RX 3 states that Petitioner "refused to sign" the document. It was Wilson, not Petitioner, who wrote the words "refused to sign." It was during the union hearing that Wilson learned Petitioner was refusing to sign RX 3. T. 140. The five days following a suspension allows Respondent time to double check the statements and the thoroughness of the investigation. T. 141. Ultimately, Respondent terminated Petitioner's employment. T. 142. Wilson identified RX 4 as a letter that Respondent sent to Petitioner via certified mail, telling him the suspension was converted to a termination. T. 142.

Under cross-examination, Wilson reiterated he was not present when the altercation occurred. T. 143. In terms of video footage, he only reviewed RX 1. He did not review any other video. RX 1 is not accompanied by audio. T. 144. RX 1 is the only video that exists. T. 144. The oral statements Petitioner made to him were consistent with his written statement. T. 145. He (Wilson) does not know whether Vailes has repeatedly visited Respondent's facility. Vailes works for E. W. Wylie. E. W. Wylie is a regular carrier of Respondent's products. Revenue is frequently generated as a result of Respondent's relationship with E. W. Wylie. T. 146. Petitioner worked for Respondent for eight months before the incident. At the union hearing, Petitioner mentioned that he had sought medical treatment. T. 146-147. It was Respondent's human resources division that dealt with the issue of treatment. T. 148.

Petitioner was recalled in rebuttal. Petitioner testified he knows Mark Elliott by sight. During the time he worked for Respondent, he would walk in to work at the point at which Elliott was leaving. T. 150. Elliott worked the morning shift. Petitioner testified he did not see Elliott at the time of the incident. He does not know whether Elliott was there.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working, deferential individual. His testimony concerning the incident of March 2, 2020 is completely consistent with the written statement he prepared at work. RX 2. His testimony that he never saw RX 3, a suspension-related document he purportedly "refused to sign," is plausible, given Dallas Wilson's admission that it was he, not Petitioner, who wrote the words "refused to sign." T. 140. His testimony that the truck driver prevented him from bending over to grab the tarp (T. 66-68) is also plausible, given the level of frustration the driver was experiencing. Overall, the Arbitrator found Petitioner credible.

Respondent's examiner, Dr. Phillips, noted no positive Waddell's signs. RX 7.

The Arbitrator found Dr. Phillips persuasive, insofar as his causation opinions are concerned, but the doctor became less believable when he indicated Petitioner was capable of resuming his laborer job despite being a candidate for lumbar spine surgery.

The Arbitrator had problems with aspects of Elliott's testimony. Elliott has worked for Respondent for many years. He readily acknowledged he was 25 to 35 feet away and "off to the side" when he first heard someone yelling. T. 91, 94. He contradicted himself on direct examination, initially stating that Petitioner "rushed" at the truck driver and then stating that Petitioner "walked" up to the driver. He acknowledged that Petitioner was not saying anything when he approached the driver yet he claimed that the driver acted "defensively." T. 99.

Dallas Wilson, who also testified on behalf of Respondent, admitted he was not present when the incident occurred. He also admitted that the truck driver's employer is a carrier that regularly transports Respondent's products, generating revenue for Respondent. T. 146. He described Vailes as backing away from Petitioner, to "create space." T. 135. Elliott, who was at the scene, never mentioned this.

Arbitrator's Conclusions of Law

Did Petitioner sustain accidental injuries on March 2, 2020 arising out of and in the course of his employment?

The Arbitrator finds that Petitioner sustained a compensable work accident on March 2, 2020. Initially, the Arbitrator finds that the confrontation of that date was clearly work-related. Petitioner credibly testified he first interacted with the truck driver only minutes before the confrontation. He also credibly testified the truck driver was having difficulty tarping the truck and seemed frustrated. Respondent offered no evidence suggesting that the two men knew one another or that the incident stemmed from some personal animosity. The Arbitrator further finds that Petitioner was not the initial aggressor. Franklin v. Industrial Commission, 341 Ill.App.3d 128 (1st Dist. 2003). While Petitioner may have become annoyed, due to the driver's ineptitude and the need to get the truck on its way, and while Petitioner acknowledged using profanity within earshot of the driver, his conduct must be examined in context, considering the totality of the circumstances. Ford Motor Company v. Industrial Commission, 78 Ill.2d 260, 263 (1980). Petitioner credibly testified that he was attempting to come to the driver's aid, in furtherance of their mutual goal, i.e., hooking the tarp to the crane so that they could cover the load, immediately before the driver pushed him to the floor. Petitioner had to come to the side of the truck where the driver was positioned to access the tarp and hook. The Arbitrator does not find credible Elliott's testimony that Petitioner "rushed" at the driver with the intent of making contact, particularly because Elliott went on to describe Petitioner as "walking" toward the driver. Petitioner was 62 years old as of the incident. At 5 feet, 7 inches tall and 150 pounds, he is not a physically imposing individual. The Arbitrator also takes issue with Elliott's suggestion that the driver acted "defensively" when he pushed Petitioner. Elliott acknowledged that, as Petitioner approached the driver, he was not saying anything. The precise movements of the two men are somewhat difficult to discern but the video clearly shows Petitioner flying backward, with his hard hat coming off in the process. As Respondent's examining physician noted, Petitioner landed "a considerable distance" from the driver. Principles of physical force are incompatible with Elliott's description. If one person "rushes" at

another, intending to do harm, is it likely he would end up being violently propelled backward? Wilson's testimony further complicates Respondent's proposed scenario. Wilson described the truck driver as taking two to three steps back as Petitioner approached yet it is Petitioner who ends up flying backward.

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established a causal connection between the accident of March 2, 2020 and his current condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony concerning the relatively minor nature of the back problems he experienced five years before the accident (T. 45-46); 2) the fact that Petitioner successfully performed a laborer-type job for Respondent for eight months prior to the accident; 3) Petitioner's credible account of the accident; 4) the video (RX 1), which shows Petitioner being violently propelled backward and landing on a hard surface; 5) the histories and causation opinions set forth in the treatment records; and 6) the causation opinions expressed by Dr. Phillips, Respondent's Section 12 examiner.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses relating to his Emergency Room care and subsequent treatment. PX 1-6. [The Arbitrator notes that, while Petitioner claims $7,219.95 in charges from the Emergency Room, the itemized bill (PX 1) reflects a Blue Cross Illinois payment of $7,019.95 and a balance of $200.00. Petitioner did not testify to the payment and Respondent did not claim any Section 8(j) credit. Arb Exh 1.] Respondent disputes this claim based on its accident defense. The Arbitrator has previously found in Petitioner's favor on the issue of accident. With the exception of one $200.00 charge from Illinois Orthopedic Network for non-emergency transportation provided on June 8, 2020 (see last page of PX 2), the Arbitrator finds the treatment underlying the claimed charges to be reasonable and necessary, as well as causally related to the accident. The Arbitrator does not view the $200.00 charge as reasonable since Petitioner did not establish the need for transportation to an office visit of June 8, 2020. The Illinois Orthopedic Network records reflect Petitioner benefited from therapy in that it helped his neck symptoms. Respondent's examiner, Dr. Phillips, did not criticize any aspect of the treatment Petitioner underwent, although he felt that Petitioner had plateaued with conservative care. RX 7.

With the exception of the $200.00 transportation-related charge from Illinois Orthopedic Network (PX 2), the Arbitrator awards the claimed medical expenses, subject to the fee schedule. The Arbitrator leaves it to the parties to sort out whether Respondent is entitled to Section 8(j) credit for the payment Blue Cross Illinois made to Franciscan Health Hammond. PX 1.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from March 3, 2020 through the initial hearing of July 17, 2020. Respondent disputes this claim based on its accident and causation defenses. Arb Exh 1. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Respondent did not obtain a Section 12 examination until several months after the hearing. Respondent's examiner, Dr. Phillips, found Petitioner capable of returning to his laborer job but simultaneously conceded that Petitioner could benefit from spinal surgery. Dr. Phillips did not suggest that Petitioner would have been capable of resuming full duty at some earlier date. RX 7.

The Arbitrator finds that Petitioner was temporarily totally disabled from March 3, 2020 through July 17, 2020, a period of 19 4/7 weeks. Based on the stipulated average weekly wage of $840.00, the Arbitrator awards benefits at the rate of $560.00 per week.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the lower extremity EMG prescribed by Dr. Mohiuddin. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Respondent's examiner, Dr. Phillips, did not specifically comment on the EMG recommendation but conceded that Petitioner would be a candidate for lumbar spine surgery if he felt his left foot and ankle symptoms were disabling. Petitioner credibly testified he continues to be bothered by those symptoms. Dr. Phillips also conceded that the accident aggravated Petitioner's underlying lumbar spine condition and that the need for surgery was related, at least in part, to the accident. RX 7.

The Arbitrator awards prospective care in the form of the lower extremity EMG and post-EMG treatment, including but not limited to the lumbar spine surgery contemplated by Dr. Phillips.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC003319
Case Name	RUIZ, JOSE v. MIRACLE PRESS
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0476
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Kevin Veugeler
Respondent Attorney	Richard Sledz

DATE FILED: 9/20/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Ruiz,

Petitioner,

vs. NO: 08 WC 3319

Miracle Press,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, 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 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.

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.

September 20, 2021

MP:yl
o 9/16/21
68

/s/ *Marc Parker*
Marc Parker

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0476

RUIZ, JOSE
Employee/Petitioner

Case# **08WC003319**

MIRACLE PRESS
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:

0391 HEALY SCANLON
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1596 MEACHUM BOYD TRAFMAN ET AL
RICHARD SLEDZ
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

Jose Ruiz
Employee/Petitioner
v.
Miracle Press
Employer/Respondent

Case # **08** WC **003319**

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 **November 13, 2019** and **January 15, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 16, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,240.00**; the average weekly wage was **$1,120.00**.

On the date of accident, Petitioner was **49** years of age, married, with no 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 **$0** under Section 8(j) of the Act.

ORDER

Medical benefits
Respondent shall pay reasonable and necessary vocational services of **$1,326.85**.

Permanent Partial Disability: Wage differential
Respondent shall pay Petitioner permanent partial disability benefits, commencing August 1, 2010, of **$626.80/week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

April 11, 2020
Date

APR 14 2020

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Ruiz,	)	
Petitioner,	)	
	)	
vs.	)	**NO. 08 WC 003319**
	)	**Arbitrator Charles Watts**
Miracle Press,	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

Findings of Fact

Petitioner was employed as a pressman for Respondent, Miracle Press, a printing company that prints labels for cans. (11/13/19 Tr. P. 8-9). Pressman are responsible to put printing plates and ink on the press, and then operate the press. (11/13/19 Tr. P. 10, 11-12). On January 16, 2008, Petitioner's hourly wage was $33.50. (11/13/19 Tr. P. 43). On January 16, 2008, the Petitioner sustained accidental injuries that arose out of and in the course of employment to his left hand when his hand was crushed in the rollers of a printing press. (11/13/19 Tr. P. 16-17). Petitioner was extricated from the printing press by the Chicago Fire Department and taken to Cook County Hospital where he came under the care of Dr. Alfonso Mejia. (11/13/19 Tr. P. 16-17, PX1, PX2). Dr. Mejia diagnosed a crush injury, degloving, and near amputation of Petitioner's non-dominate left hand. (11/13/19 Tr. P. 16-17, PX1, PX2).

On the day of the accident, Dr. Mejia performed surgery to reattach Petitioner's left thumb with pins. (11/13/19 Tr. P. 18, PX1). Over the course of the next 28 days, Petitioner remained an inpatient at Cook County Hospital and had two additional surgeries. (11/13/19 Tr. P. 17-19, PX1). On January 22, 2008, Dr. Mejia performed an amputation of the left-hand thumb due to necrosis and gangrene. (11/13/19 Tr. P. 18, PX1). On January 29, 2008, Dr. Mejia performed another surgery to debride necrotic tissue. (11/13/19 Tr. P. 18-19, PX1).

After discharge from the hospital, Petitioner continued occupational therapy with a home health nurse and remained off work and under Dr. Mejia's care. (11/13/19 Tr. P. 20-21, PX2).

In an October 1, 2008 §12 report obtained by Respondent, Dr. Charles Carroll confirmed that Petitioner continued to have significant decreased range of motion, grip strength and sensation to the left hand. (PX10). Dr. Carroll noted Petitioner's loss of thumb had resulted in impairment to the left hand. Dr. Carroll recommended a return to work, one handed work only, and discussed long-term restrictions in the light category. (PX10).

Petitioner returned to Dr. Mejia on November 20, 2008, and discussed Dr. Carroll's return to work recommendations. (11/13/19 Tr. P. 18-19, PX2). Dr. Mejia recommended a functional capacity exam. (11/13/19 Tr. P. 18-19, PX2). Respondent denied the FCE recommendation. (11/13/19 Tr. P. 22, PX2).

Petitioner returned to work on December 15, 2008 on a light duty basis performing one handed work. (11/13/19 Tr. P. 22-23, PX2). On December 8, 2008, Petitioner began working with Scheck and Siress at

University of Illinois at Chicago Hospital to try and develop a functional prosthetic device to allow Petitioner improved hand function and perform two handed work. (11/13/19 Tr. P. 23-25, PX3). Unfortunately, several attempts to fashion a prosthetic device were unsuccessful due to skin breakdowns. (11/13/19 Tr. P. 24-25, 35).

Petitioner testified that Respondent's rehabilitation nurse referred him to the amputation clinic at Northwestern Hospital and the Rehabilitation Institute of Chicago. (11/13/19 Tr. P. 25-26, PX4). Petitioner came under the care of Dr. Todd Kuiken. (11/13/19 Tr. P. 26, PX4). Dr. Kuiken's 12/30/09 note reveals he took a history of a left hand compression injury and degloving at work on 1/16/08 resulting in three surgeries and three attempted prosthetics with skin breakdowns. (PX4). Petitioner complained of residual pain, especially with cold weather, and an examination was significant for decreased wrist and finger range of motion. (PX4). Dr. Kuiken referred Petitioner to Dr. Gregory Dumanian, a hand/plastic surgeon, for consideration of additional surgery. (11/13/19 Tr. P. 26-27, PX4).

On January 20, 2010, Dr. Dumanian performed an examination of Petitioner and recommended an additional surgery to release scar tissue and do a skin graft. (11/13/19 Tr. P. 27-28, PX6). On May 27, 2010, Dr. Dumanian performed a release of scar tissue in the hand web along with a skin graft where the hand was attached to the groin. (11/13/19 Tr. P. 27-28, PX5). Petitioner remained an inpatient for three days. (11/13/19 Tr. P. 28, PX5). On June 15, 2010, a subsequent surgery separated Petitioner's hand from his groin. (11/13/19 Tr. P. 28, PX5).

After wound care, Petitioner was discharged from Dr. Dumanian's care on July 28, 2010, and released back to one handed work on August 1, 2010. (11/13/19 Tr. P. 29, PX6).

Petitioner testified since that time he has continued working for Respondent performing light duty one handed work. (11/13/19 Tr. P. 29-30,46-47). Petitioner testified that his employer created a position as a post-production binder and stocker. (11/13/19 Tr. P. 30-31,48). Prior to his injury, his employer did not have the position that was created for him and he is currently paid $35.50/hr. (11/13/19 Tr. P. 30-31).

At the time of trial, Petitioner testified he continues to have pain and weather sensitivity in his left hand, along with locking of his fingers. (11/13/19 Tr. P. 31-32). He has difficulty with everyday activities such as putting on clothes and household chores. (11/13/19 P. 31-32).

Petitioner also testified concerning his background. He was born in Mexico, however he never graduated high school and learned English on his own. (11/13/19 Tr. P. 32-34).

Petitioner presented the testimony of Lisa Byrne, a nationally certified rehabilitation counselor and vocational evaluator. (11/13/19 Tr. P. 49-50, 57). She has a Master's degree in Rehabilitation Counseling and has published articles in her field. (11/13/19 Tr. P. 56-57). Ms. Byrne testified she works for a variety of clients, including the Illinois Department of Rehabilitation Services, performing vocational evaluations and placement services, including in the Illinois Workers' Compensation Commission. (11/13/19 Tr. P. 50-52, 58). Ms. Byrne testified that she performed a vocational assessment of Jose Ruiz after his hand injury. (11/13/19 Tr. P. 52, PX7). The Arbitrator finds she is highly qualified in her field.

Ms. Byrne reviewed medical records, conducted vocational testing of Jose Ruiz, and reviewed vocational reports of Respondent's vocational counselor. (11/13/19 Tr. P. 59-60, 76-77). As identified by Ms. Byrne, Petitioner's vocational challenges include his lack of a high school diploma or GED equivalent, his injury to his left hand and limitations identified in his dexterity testing, and limitations in spelling and math. (11/13/19 Tr. P. 60-62, 71-73). Respondent's vocational evaluator acknowledged that Petitioner could not

perform the duties of a pressman with Respondent. (11/13/19 Tr. P. 77, 88-89). Ms. Byrne confirmed that his current wage at Miracle Press does not accurately reflect his accurate earning capacity. (11/13/19 Tr. P. 62-63). Given his injury, education, and vocational background, Petitioner's earning capacity in a competitive labor market is $10.00/hr. (11/13/19 Tr. P. 63-64). The Arbitrator finds that Petitioner's current wage of $35.50, in a created position, does not accurately reflect the wage loss suffered by Petitioner as a result of his work related crush injury to his left hand.

Petitioner's wife, Juanita, also testified. (11/13/19 Tr. P. 90). She confirmed that Jose has issues and problems with everyday activities of daily life. (11/13/19 Tr. P. 90-92, 94-95).

Petitioner submitted the following vocational rehabilitation expenses without objection concerning reasonableness and necessity:

PX9 The Eval Center - $1,326.85

Respondent presented the testimony of Respondent's owner and representative, Bruce Novak. (11/13/19 Tr. P. 97). Mr. Novak confirmed that Petitioner previously worked as a pressman prior to his crush injury to his hand. (11/13/19 Tr. P. 98). He described Petitioner as a hardworking, honest employee. (11/13/19 Tr. P. 99, 106-107). Mr. Novak confirmed that after his injury, Petitioner's restrictions were accommodated and he returned to work as a post-production packer and binder supervisor. (11/13/19 Tr. P. 99-100). Respondent created this position for Petitioner and paid him $35/hr, despite the fact that this is an entry level position that normally pays $12/hr. (11/13/19 Tr. P. 104-105). Mr. Novak also confirmed that because of the injury to his hand, Petitioner has not returned as a pressman. (11/13/19 Tr. P. 111-112).

Respondent failed to present any testimony of its own vocational rehabilitation counselors, Julie Bose and Jacqueline Bethell, although both indicated that Petitioner could not return to work as a pressman, as the position is considered skilled in nature and medium in physical demand level. (PX11, P. 4).

Subsequent to the November 13, 2019 hearing, proofs were reopened and Petitioner was recalled to testify. (1/15/20 Tr. P. 4). Petitioner recounted a conversation with Mr. Novak after the November 13, 2019 hearing. (1/15/20 Tr. P. 11). Specifically, Petitioner asked Mr. Novak why he was excluded from receiving a raise like his co-workers and was told that he would no longer receive raises, because he has reached the top of the salary bracket for his created position in the warehouse. (1/15/20 Tr. P. 11-15). Respondent chose not to put forth any evidence to refute Petitioner's testimony.

The Arbitrator finds the testimony of Petitioner to be credible. It is clear that the Petitioner's created position of warehouse supervisor artificially inflates the wage loss suffered by Petitioner. Petitioner is married to this position, as if the owner chose to close the company, or the company was sold to new owners, Petitioner would not be able to replicate his $35.50/hr. wage given his hand injury. Further, as an at-will employee, if Petitioner was fired from this position, a similar position could not be found at the same rate of pay.

Conclusions of Law

(J) Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner submitted into evidence a medical bill in the amount of $1,326.85 from The Eval Center for vocational services. (PX9). Respondent is ordered to pay Petitioner $1,326.85 for these expenses.

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

Pursuant to §8(d)1, if an employee has become partially incapacitated from pursuing his usual and customary line of employment, he shall receive 66-2/3% of the difference between what he could earn in the ***full performance*** of his duties in the occupation in which he was engaged ***at the time of his accident*** and the amount he is earning or is ***able to earn*** in some ***suitable employment*** after the accident. 820 ILCS 305/8(d)1, emphasis added.

The purpose of a wage differential award under §8(d)1 is to compensate an injured employee for reduced earning capacity. Dawson v. Illinois Workers' Compensation Commission, 382 Ill. App. 3d 581, 888 N. E.2d 135 (5th Dis. 2008). The Illinois Supreme Court has expressed a preference for the entry of wage differential awards under §8(d)1. Gallianetti v. Illinois Industrial Commission, 315 Ill. App. 3d 721, 734 N.E.2d 482, (3rd Dist. 2000).

The proper inquiry for the entry of a wage differential award is whether or not a petitioner has suffered an impairment of earning capacity as a result of his accident injuries. Jackson Park Hospital v. Illinois Workers' Compensation Commission, 2016 IL App (1st) 142431 WC (2016). However, whether a petitioner has sustained an impairment of earning capacity cannot be determined by simply comparing pre- and post-injury income. Id, Cisarik v. Northwest Building Material, 08 IL.W.C. 33526, 2017 WL 7658135. The analysis requires consideration of other factors, including the nature of the post-injury employment in comparison to wages the claimant can earn in a competitive job market. Id.

In Jackson Park Hospital, petitioner, a stationary engineer, sustained injuries to her low back and knee that resulted in permanent restrictions. Her employer accommodated her restrictions, returned her back to work in light duty capacity, and paid her full wages commiserate with other stationary engineers employed by respondent at $23/hr. 2016 IL App (1st) 142431 WC (2016). The Arbitrator determined that while petitioner was no longer able to engage in the full performance of her usual and customary line of employment, she did not suffer lost income because her pre-injury and post injury wages were the same, precluding an award for a wage differential. Id. While the case was on appeal to the Commission, the employer terminated the employee. Subsequently, the Commission affirmed the Arbitrator's award of a specific scheduled loss under §8(d)2 person as a whole. The Circuit Court vacated the Commission decision and remanded the case for the entry of a wage differential under §8(d)1. In affirming the entry of a wage differential, the Workers' Compensation panel of the Illinois Appellate Court noted earning capacity is not synonymous with post-injury earnings. Instead, the proper inquiry is whether petitioner's post-injury wages reflected one's true earning capacity in a competitive job market, based on the injury, restrictions, transferable skills, and the wages one would expect in a competitive job market. Id. In that case, the unrebutted testimony of a vocational counselor was that petitioner's true earning capacity as a result of her injury was $8-9/hr., far less than the $23/hr. she was being paid by respondent. The Appellate Court also dismissed respondent's contention that awarding a wage differential based on earning capacity and not simply post-injury wages could present the danger of a claimant receiving both wage differential benefits while still earning the same wage, as the Act specifically provides that a claimant is entitled to a wage differential award if there is an impairment in earning capacity, and that is not synonymous with income. Finally, the Appellate Court admonished that if other employers would not hire an employee with restrictions at a comparable wage level, post-injury wages cannot be an accurate reflection of petitioner's earning capacity and the failure to award wage differential benefits undermines the purpose of the Act. Id.

In this case, Petitioner is clearly precluded from working in the full performance of his occupation as a pressman. It is undisputed that Petitioner cannot return to full duty work as a pressman. Respondent has created a new position for Petitioner and accommodated one handed restrictions since Petitioner has returned to work.

It is also unrebutted that Petitioner has suffered a reduced earning capacity as a result of his injuries. Ms. Byrne testified that Petitioner would not be able to be placed for work as a pressman in a competitive labor marker given his restrictions. Respondent's owner, Mr. Novak, also testified that Petitioner could not perform the full functions of a pressman.

Ms. Byrne credibly testified that given Petitioner's age, work history, education, and left hand function, Petitioner's earning capacity as a result of his left hand injury is around $10/hour in a stable labor market. Respondent did not offer any vocational testimony to rebut Ms. Byrne's vocational analysis. In fact, Respondent did retain Medvoc to perform vocational services, nevertheless, Respondent failed to offer those opinions.

The Arbitrator also notes that Respondent declined to offer testimony from Petitioner's co-workers to refute Petitioner's testimony of his job activities or physical condition. Respondent did not attempt to provide any evidence contradicting Ms. Byrne's testimony concerning Petitioner's earning capacity. It is well settled that the failure of a party to produce testimony or evidence within its control creates a presumption that the evidence, if produced, would be adverse or unfavorable. Reo Movers v. Industrial Commission, 226 Ill.App.3d 216, 589 N.E.2d 704, 168 Ill.Dec. 304, (1st Dist.), Stypula v. City of Chicago, 03 IIC 833.

The Arbitrator finds that Petitioner's earning capacity has been diminished as a result of his work-related injury to his left hand such that Respondent is ordered to pay Petitioner wage differential benefits pursuant to §8(d)1 in the amount of $626.800/week commencing on August 1, 2010, when Petitioner was released to return to restricted work, based on 66 2/3% difference of the wage of a pressman with Miracle Press on the date of accident of $33.50/hr., and Petitioner's earning potential of $10.00/hr determined by Petitioner's expert, Ms. Byrne.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC000742
Case Name	WALKER, CARL v. JARVIS HANDY
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0477
Number of Pages of Decision	29
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	RAYMOND M. SIMARD
Respondent Attorney	David Christensen

DATE FILED: 9/20/2021

/s/Kathryn Doerries, Commissioner

Signature

21IWCC0477

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

CARL WALKER,

Petitioner,

vs. NO: 15 WC 000742

JARVIS HANDY and THE ILLINOIS STATE TREASURER, as *ex officio* CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, employment relationship, jurisdiction, causal connection, medical expenses, temporary disability, permanent disability, and evidentiary rulings, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's Decision in its entirety, however, in the Conclusions of Law section, strikes paragraphs C through O, beginning on page 14 through page 22. The Commission further modifies the Decision after paragraph B on page 14 by adding the sentence, "All other issues are moot."

IT IS THEREFORE ORDERED BY THE COMMISSION that workers' compensation benefits are denied as Petitioner failed to prove the existence of an employee-employer relationship.

The Illinois State Treasurer, as *ex officio* custodian of the Injured Workers' Benefit Fund (IWBF) was named as a co-respondent in this matter. The Treasurer was represented by the Office

of the Illinois Attorney General. This finding and Order is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act, however, no party shall seek or have a right to any recovery from the IWBF. Should any recovery by Petitioner occur, Respondent/Employer/Owner/Officer shall reimburse the IWBF for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the IWBF, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Respondent/Employer/Owner/Officer's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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)(1) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 20, 2021

KAD/bsd
0082421
42

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0477

WALKER, CARL
Employee/Petitioner

Case# **15WC000742**

JARVIS HANDY AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 1/29/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% 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

0000 JARVIS HANDY
PO BOX 7
SHARON, MS 39103

5604 ASSISTANT ATTORNEY GENERAL
DAVID CHRISTENSEN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Carl Walker
Employee/Petitioner

v.

Jarvis Handy and the Illinois State Treasurer as custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **15 WC 742**

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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, 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. ☒ 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 **The liability of the Injured Workers' Benefit Fund**

FINDINGS

On **October 6, 2014**, Respondent-employer ***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-employer.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$13,000.00** the year proceeding the injury and the average weekly wage was **$250.00**.

On the date of accident, Petitioner was 62 years of age, **single** with no dependent children.

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

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

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

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

ORDER

DENIAL OF BENEFITS

Workers' compensation benefits are denied as Petitioner failed to prove the existence of an employee-employer relationship.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund ("IWBF") was named as a co-Respondent in this matter. The Treasurer was represented by the Office of the Illinois Attorney General. This finding is hereby entered as to the IWBF to the extent permitted and allowed under §4(d) of the Act, no party shall seek or have a right to any recovery from the IWBF. Should any recovery by the Petitioner occur, Respondent-Employer shall reimburse the IWBF for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the IWBF, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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.

David A. Kane
Signature of Arbitrator

January 29, 2020
Date

JAN 29 2020

STATE OF ILLINOIS)
)
COUNTY OF DUPAGE)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Carl Walker
Petitioner/Employee

V.

Case # 15 WC 742
Chicago – Arb. David Kane

Jarvis Handy and the Illinois State Treasurer as custodian of the Injured Workers' Benefit Fund
Respondent/Employer

RIDER TO ARBITRATOR'S DECISION
FINDINGS OF FACT AND CONCLUSIONS OF LAW

This action was pursued under the Illinois Workers' Compensation Act ("Act") by Petitioner-Employee, Carl Walker ("Petitioner"), and sought relief from the Respondent-Employer, Jarvis Handy ("Handy"). The Illinois State Treasurer as *ex-offico* custodian of the State of Illinois, Injured Workers' Benefit Fund ("IWBF") was named as a Respondent.

On January 16, 2020, a hearing was held and proofs were closed before Arbitrator David Kane in Chicago, Illinois. Attorney Raymond M. Simard, P.C. represented Petitioner. Jarvis Handy did not appear and was

not represented. The Illinois Attorney General's Office represented the IWBF.

Statement of Facts

On October 6, 2014, Petitioner was 62 years old and single with no dependent children. [AX.1]. The Petitioner testified that on October 6, 2014, he resided at 5435 S. Damen Street in Chicago, Illinois. Petitioner testified that he lived at 5435 S. Damen for 19 years prior to his injury and moved on July 21, 2018.

Petitioner has known Respondent Handy for 14 to 15 years. He knew Handy for five to six years prior to the date of injury. During cross-examination, Petitioner testified that he knew Handy for nine years prior to his injury but does not know if Handy is Jarvis Handy Sr. or Jarvis Handy Jr. and has never met his family.

Petitioner testified that Handy lived at 5429 S. Damen, two doors down. During cross-examination, Petitioner testified that he does not know how long Handy lived at 5429 S. Damen and that he assumed that Handy lived there. Petitioner has seen Handy in that area but that Petitioner has never gone into 5429 S. Damen. Petitioner knows that a woman lived at 5429 S. Damen. Petitioner does not know if Handy has relationship with the woman. On re-direct, Petitioner testified that the woman was Petitioner's girlfriend's sister and that the sister was Handy's girlfriend. Petitioner does not know if Handy had a corporation and does not know where Handy's business was located.

Petitioner testified that Handy was an electrician and had logos on his car. Petitioner later testified that he drove Handy to worksites in a truck neither of them owned and that had no logos on it. They spoke at 5435 S. Damen and Handy asked Petitioner to assist him with driving and electrical

work. Petitioner assisted Handy for a number of years. Petitioner usually assisted Handy three days a week but it depended on the job. Handy paid him $100 a day in cash. Petitioner assisted Handy replacing service boxes and bringing electrical lines to residential buildings. This involved climbing a ladder. Petitioner made use of an electric power drill, a pliers like cutting tool, and a ladder. Handy provided the tools and obtained the customers. Handy told him what to do.

Petitioner did not fill out any paperwork when he was hired by Handy. In the first conversation, they discussed the amount he would be paid but not the hours. There were no set hours and his hours were not tracked. They did not work regular hours or meet at a regular time. Handy would call or see Petitioner and tell him when they would next work. While the number of hours varied, the pay did not. Petitioner would complete the task and then could leave. Petitioner was paid at the end of the job, not the end of the day. The length of the jobs varied. Handy did not withhold taxes or provide a W2 or 1099. Petitioner was not given a uniform. Petitioner had performed electrical work own his before but never for pay. Handy trained him but just told him to drag the line. On Re-direct, Petitioner confirmed that he was not trained as an electrician and when asked by his attorney agreed he was an electrician's helper. Petitioner never refused work that was offered by Handy and did not know what would happen if he had. No one else worked with Petitioner and Handy. There was no rule book. The Petitioner owned the ladder they used. They did not use any materials. While working with Handy there would sometimes be a week between jobs. Handy did work jobs without Petitioner. Petitioner also worked other jobs. While working for Handy Petitioner also worked at an adult day care center for a year.

The truck Petitioner used to drive Handy was parked at 5429 S. Damen. Petitioner does not know who owns the truck. On re-direct, Petitioner testified that the truck was owned by Petitioner's girlfriend's sister. There was no logo on the truck. Petitioner drove, but did not own, the truck.

On October 6, 2014, Petitioner was assisting with electrical work at a residence on 103rd Street in Chicago. Petitioner was on a ladder cutting a "steel hanger." Handy was talking to the Petitioner from the base of the ladder. The wire "snapped" causing Petitioner to fall off the ladder. Petitioner fell 15-20 ft. Handy saw him fall.

After Petitioner fell, Handy stated he did not have insurance. Petitioner did not ask Handy if he had insurance. Handy called the ambulance.

Petitioner next saw Handy a week after his surgery but they did not speak. After the injury, Handy never called him for work. Petitioner saw Handy a month ago near where he lived. They said "hi" and Handy asked if Petitioner wanted to work again. Petitioner told him no due to the pain. Petitioner has seen Handy four to five times since the injury in that same area. Each time they have simply said "hi." These four to five times he spoke with Handy are the only conversations they had after the accident.

Petitioner was transported by the Chicago Fire Department. [Px4p26 of 48]. It notes that Petitioner resides at 5435 S. Damen Ave. It also notes that he fell 11 to 15 feet off of a 10 foot ladder at a residence at 1033 W. 103rd St. [Px4 p26 of 48].

Petitioner was transported to Metro South Medical Center (Metro). [Px4] It is noted that "The location where the incident occurred was at home and fell off ladder PTA." [Px4 p5 of 48]. The Petitioner now reported a 20

foot fall [Px4 p7 of 48]. Petitioner underwent x-rays showing comminuted mildly displaced and mildly angulated fractures of the distal tibia and fibula. [Px4 p28 of 48]. Petitioner was diagnosed with closed fractures of the distal end of the right fibula and tibia. [Px4 p10 of 48].

Petitioner sought follow up treatment at Stroger Hospital ("Stroger"). [Px5]. Petitioner was first seen on October 8, 2014 and reported that "He was helping hang wire outside on a ladder 2 days ago when he fell about 20 feet, landing on his right foot and left heel." [Px5 p11 of 47]. Petitioner underwent x-rays with consistent results. Petitioner was diagnosed with tricompartmental degenerative changes in his right knee.

On October 17, 2014, Petitioner underwent surgery, a right ankle distal tibia and fibular open reduction and internal fixation. [Px5 p59 of 186].

Petitioner continued post-surgical care and physical therapy at Stroger. On January 22, 2015, Petitioner stated "I fell off a ladder at work. I'm retired... No workers' comp insurance b/c I'm collecting unemployment." [Px5 p2 of 17]. In March of 2015, the records note that Petitioner suffered a heart attack. [Px5 p2 of 12]. On April 15, 2015, the records note that two of the screws in his right ankle had broken. The records also note that Petitioner had degenerative conditions in both knees. [Px5 p2 of 6]. On April 20, 2015, Petitioner reported that "The last MD visit she said I have 2 broken screws but that they weren't going to take them out unless it was causing a problem." Petitioner also reported that he had pain when walking two blocks. [Px5 p9 of 20]. On May 11, 2015, Petitioner reported that he was "good," had returned to work and "I have no issues at work." [Px5 p8 f 19]. On June 9, 2015, it was noted that he was able to walk and ride a bike. [Px5 p3 of 13]. On August 26, 2015, it was noted that he had returned to work on May 1, 2015 and that he had pain when

kneeling. Surgery to remove the screws was scheduled. [Px5b p15 of 157]. On September 28, 2015, the records noted that Petitioner could walk without pain, had no healing problems but "while on his knees he does feel prominence of the two proximal medial screws." [Px5b p2 of 157]. The records also note that "He is able to stand on his right leg in isolation without pain. He has some difficulty performing a single leg toe raise but has no pain when he tries to do this." [Px5b p3 of 157]. The records also note that "The patient continues to work as a carpenter." [Px5b p3 of 157] and that "Pt works as a carpenter and is frequently on his knees." [Px5b p4 of 157]. Petitioner did report that he had pain if he was on his knees. [Px5b p4 of 157]. On September 28, 2015, Petitioner underwent surgery to remove two screws. [Px5b p56 of 157]. On November 11, 2015, Petitioner returned for treatment to have his sutures removed. [Px5b p19 of 157].

Petitioner testified that he did not work from the date of injury until November 17, 2015. Petitioner has worked at the Solo Cup Company for a year in 2017 and at Fresh Express for a year in 2018. From November 4, 2018 to October 24, 2019, he worked at Fresh Express as a forklift operator. He does not spend time on his feet and is seated. He is now retired. Petitioner testified that he worked as a carpenter prior to the injury but did not work as a carpenter in 2015.

Petitioner's right leg hurts most of the time and it is hard to walk a distance. He testified that he also limped on the right side. Petitioner cannot stand on one leg.

CONCLUSIONS OF LAW

The Arbitrator adopts the Findings of Facts in support of the Conclusions of Law:

Preliminary Matter: Notice:

Section 9030.20(c) of the Illinois Administrative Code requires notice to all parties 15 days prior to the hearing date and that a completed Request for Hearing form be included.

Section 9020.70(a) of the Illinois Administrative Code requires that all motions be accompanied by a Notice of Motion and Order and must set for the date on which the party will present the motion, the type of motion and the nature of relief sought. If a motion is not included it may be stricken. Subsection (b)(1)(C) requires proof of service either by (i) written acceptance of service, (ii) affidavit of the person delivering the papers, or (iii) if mailed by affidavit of the person mailing the papers.

Section 9020.70(b)(1)(D) of the Illinois Administrative Code allows service at the last known address if a party has failed to appear or has failed to designate a place for service.

The Commission has held that

> failure to provide proper notice to the Respondents rendered the arbitrator's decision void. As the Supreme Court noted in *Interstate Contractors v. Industrial Commission*, ... "the Industrial Commission and the circuit court are vested with the power to examine the validity of the decisions entered in the proceedings below and empowered to determine whether they are void for lack of jurisdictions over the parties." The purpose of providing notice and requiring a notice procedure to be followed is to allow both parties an equal opportunity to be made aware of an impending trial date so they may be able to present their respective side of the case on said date prior to a determination by the arbitrator. Further, the Commission finds requiring notice ensures due process under the law. The

Commission finds due to lack of proper notice, there was no jurisdiction to conduct an ex parte hearing. *Byron Rene Donis, Petitioner v. Claudio L. Radu/juan Carlos Hernandez & Illinois Workers Benefit Fund, Respondent*, 08 IL. W.C. 00798 (Ill. Indus. Com'n May 21, 2018)

In *Donis,* correspondence sent by Petitioner to the Respondent was returned noting "Return to Sender, Attempted - Not Known, Unable to Forward." *Id.* The correspondence failed to include a completed Request for Hearing form. The Commission held that there was "no evidence Petitioner made any attempt to prepare and/or file a Motion for Trial Date nor any evidence a completed Request for Hearing form was prepared and provided to the Respondents." *Id.*

In the instant case, Respondent-Employer was not and is not an incorporated entity. There are no Secretary of State records setting forth an address of a registered agent or a business address.

Petitioner issued most of his service attempts to 5429 S. Damen Chicago IL, 60609. This is based on Petitioner's testimony on direct that Handy resided at that address. However, during cross-examination, Petitioner admitted he "assumed" Handy lived at that address. Petitioner testified that while he has known Handy for 14 to 15 years, he did not know how long Handy may have lived at that address. Petitioner testified that in the five or six years after the injury, 2014 to 2020, he saw Handy in that neighborhood only four or five times. Petitioner admitted that a woman, he did not know, lived in the house at 5429 S. Damen. Petitioner later admitted that the woman was the Petitioner's girlfriend's sister. Petitioner did not know if Handy had a relationship with the woman. Petitioner admitted he

"assumed" Handy lived at that address but had never been inside the house and only seen Handy in that area less than once a year, only four or five times in six years. The majority of Petitioner's attempts at service were to this address.

Petitioner's Exhibit 1 contains Petitioner's attempts at service for previous hearing dates.

Petitioner's Exhibit 1A is certified mail containing a notice of motion and order and request for hearing, dated February 27, 2019, for a hearing date of March 13, 2019 sent to 5429 S. Damen Ave. Chicago IL 60609. It was returned as "refused".

Petitioner's Exhibit 1B was a certified letter dated September 24, 2019, with no notice of hearing or request for hearing, for a hearing date in October 24, 2019, sent to 3660 Newcastle Drive SE, Grand Rapids, MI 49508. It was returned "attempted – not known". There is no evidence in the record that Handy ever resided or did business at this address.

Petitioner's Exhibit 1C was a certified letter dated September 24, 2019, with no notice of hearing or request for hearing, for a hearing date in October 24, 2019, sent to 5429 S. Damen. It was returned marked as "Moved" return to sender unable to forward.

Petitioner's Exhibit 1D was a certified letter dated December 6, 2019, with no notice of hearing or request for hearing, for a hearing date of December 12, 2019, sent to 5429 S. Damen. The tracking information reports that "Your item was returned to the sender … because the address was vacant or the business was no longer operating at the location..."

Petitioner's last attempt to serve the Handy, and only attempt for the actual hearing date, was via 9020.70(c)(ii), service by delivery supported by affidavit. Petitioner served a one page letter on an unknown female on

December 24, 2019 at 9:00 a.m. at 5429 S. Damen Ave. Chicago, IL 60609.

All but the first attempt at service, fail to comply with the notice requirements of 9020.70(a), which requires a Notice of Motion and Order to be served on all parties, and 9030.20(B) which requires that a completed Request for Hearing form be provided.

Petitioner's attempts at service paint a clear picture. Petitioner assumed that Handy lived at 5429 S. Damen, despite knowing an unknown woman with no known relationship to Handy lived there. In February 2019, notice to 5429 S. Damen was refused. In September 2019, it was marked as "Moved." In December 2019, the address was vacant. Finally, in late December 2019 an unknown woman refused to accept service. Neither the attempts at service nor the testimony at trial support that Handy resided at that address at any time. Further, even had Handy lived at the 5429 address at some point, it is clear that in September of 2019 someone had moved from the property and it was then vacant until an unknown woman lived there. There is no basis to believe that the served unknown woman, was the same unknown woman Petitioner testified lived there previously. Finally, there is no evidence to support the affiant's assertions, in Petitioner's Exhibit 8, that this unknown woman was "a member of the family" of Handy. [Px8].

None of the attempts at service comply with the Administrative Codes Requirements or due process. Service that fails to comply with 9020.70 or 9030.20 of the Illinois Administrative Code is not sufficient. Service that is refused, undeliverable, vacant, moved or to an unknown address is not sufficient. *Byron Rene Donis, Petitioner v. Claudio L. Radu/juan Carlos Hernandez & Illinois Workers Benefit Fund, Respondent*, 08 IL. W.C. 00798

(Ill. Indus. Com'n May 21, 2018). Service on an unknown woman, even if it were the same unknown woman Petitioner himself admitted had no known relationship with Handy, is not sufficient. Service at an address Petitioner admitted he did not know that Handy lived at, is not sufficient. Service at an address in a neighborhood that Petitioner testified he had seen Handy in less than once a year (only four or five times) in the last six years, is not sufficient. Service that does not provide notice to the Respondent of the proceedings is not sufficient.

A. In support of the Arbitrator's decision with regard to whether Petitioner and Respondent were operating under and subject to the Act, the Arbitrator makes the following conclusions of law:

The Act defines those businesses that are considered "employers" and, thus, come under its jurisdiction. Under Section 3 of the Act, various types of businesses automatically come under the Act's jurisdiction due to their business activities. 820 ILCS 305/3. The Respondent-employer is subject to the automatic coverage provisions as Respondent-Employer was engaged in work that involved; Section 3(1), altering a structure; Section 3(2) electrical work; and Section 3(8) an enterprise using sharp edged cutting tools. Therefore there is automatic coverage under the Act.

B. In support of the Arbitrator's decision with regard to whether there existed an Employee and Employer relationship, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the evidence presented shows that there did not exist an employee-employer relationship.

The law in Illinois provides no specific litmus test for determining whether an employer-employee relationship exists. Rather, such a relationship, if one exists, must be inferred from the conduct of the parties,

the right to control work being the primary factor in determining an employment relationship. There are multiple factors to consider in assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122, (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with the needed instrumentalities; and (7) whether the employer's general business encompasses the person's work. *Roberson v. Indus. Comm'n*, 225 Ill. 2d 159, 175 (2000). Other relevant factors include: (8) the label the parties place on their relationship; and (9) whether the parties' relationship was "long, continuous, and exclusive." *Ware,* 318 Ill. App. 3d at 1122, 1126. "The single most important factor determining whether a party is an employee or an independent contractor is the right to control the manner in which one's work is done ... an independent contractor is one who undertakes to produce a given result, without being controlled as to the method by which he attains the result." *Bryant v. Fox,* 162 Ill. App. 3d 46 (1st Dist. 1987). "No single factor is determinative, and the significance of these factors will change depending on the work involved." The determination rests on the totality of the circumstances. *Roberson*, 225 Ill. 2d at 175.

The evidence introduced at hearing shows that Petitioner was not an employee of Handy's. As to the first factor, right to control the manner in which the work is performed, Petitioner's testimony was Handy would tell

him what to do. However, it was unclear whether Petitioner meant that Handy gave him general instructions regarding the overall work, i.e. replace an electrical box at a particular home, or specific instructions such as cutting a specific wire; or doing work a particular way. It is unclear if Handy told him what job to do or told him how to do the job. As to the second factor, whether the alleged employer dictates the Petitioner's schedule, the Petitioner's testimony is clear that there were no set hours. He did not clock in or out. His hours were not tracked. They did not meet at a regular time. He could leave when he finished the job. He was paid at the completion of a job $100 a day for each day the job took, regardless of hours required to complete it. As to the third factor, whether the Petitioner was paid hourly, Petitioner's testimony is clear he was paid $100 for each day it took to complete a job, once a job was completed. As to the fourth factor, whether taxes were withheld, Petitioner testified that they were not. As to the fifth factor, whether the alleged employer could discharge the Petitioner at any time, the Petitioner's testimony was clear that he worked only specific jobs. If Handy did not ask him to work, he did not. Handy worked some jobs without Petitioner. There was no expectation of a next job. In short, Petitioner was "hired" for each job with no guarantee of being brought in on the next job or ongoing employment. As to the sixth factor, whether the alleged employer provided the tools used, Petitioner's testimony was clear that Handy provided some tools (a power drill and pliers) but that Petitioner provided other tools (the ladder). As to the seventh factor, whether Handy's general business involved the Petitioner's work. Petitioner was clear that Handy worked jobs without him. Petitioner did not know Handy's business location or corporate status. The evidence shows that Handy performed electrical work, some of which with the Petitioner. However, the full scope

of Handy's business is unknown. As to the eighth factor it is unclear what, if any, label the parties put on their relationship as only the Petitioner testified and there were no documents or correspondence from Handy indicating how he would have referred to their relationship. As the ninth and final factor, whether the relationship was long, continuous and exclusive, the Petitioner's testimony is that at the time of the injury he had worked for the Handy off and on for an unknown period of time. Further, Petitioner testified that it was not an exclusive working relationship as both Petitioner and Handy worked jobs without the other. Petitioner worked at an adult day care center while also working with Handy. There was no testimony that Handy was aware of Petitioner's other employment.

Based upon the evidence presented, this Arbitrator finds that an employee-employer relationship did not exist between Handy and Petitioner at the time of the alleged injury.

C. In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of an in the course of his employment with Respondent-Employer, the Arbitrator makes the following conclusions of law:

Petitioner testified that he injured his right foot on October 6, 2014, when he fell off a ladder while working at a job site for Respondent-Employer. The Arbitrator finds sufficient evidence was submitted that an accidental injury occurred on that date. However, based upon the Arbitrator's findings above the Arbitrator finds that as there was no employee-employer relationship the accidental injury did not arise out of or during the course of Petitioner's employment.

D. In support of the Arbitrator's decision as to the date of the accident, the Arbitrator makes the following conclusions of law:

Based upon the Arbitrator's findings above, the Arbitrator finds that Petitioner provided sufficient evidence to support that an accidental injury occurred on October 6, 2014. Such evidence includes, but is not limited to, the Petitioner's testimony and the medical records reflecting a consistent date of injury.

E. In support of the Arbitrator's decision with regard to whether Petitioner gave Respondent-Employer notice of the accident within the time limits stated in the Act, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner's testimony regarding the circumstances surrounding his injury are sufficient to show that Respondent-Employer was present at the time of the injury and witnessed same. The Arbitrator finds that the Petitioner provided sufficient evidence that the Respondent-Employer had notice of the injury. The Arbitrator finds that Petitioner proved timely notice was provided to Respondent-Employer.

F. In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner's current condition is not causally related to the alleged work injury.

Petitioner testified that he did not work from the date of injury until November 17, 2015. Petitioner testified that he did not work as a carpenter in 2015. However, Petitioner's medical records directly contradict Petitioner's testimony. The records note that on May 11, 2015, Petitioner reported that he was "good," and had returned to work and stated "I have no issues at work." [Px5 p8 of 19]. On August 26, 2015, it was noted that he had returned to work on May 1, 2015. [Px5b p15 of 157]. On September

28, 2015, the records noted that "The patient continues to work as a carpenter." [Px5b p3 of 157].

Petitioner testified that currently his right leg hurts most of the time and it is hard to walk a distance. He testified that he also limped on the right side. Petitioner testified that he cannot stand on one leg. However, again Petitioner's medical records directly contradict his testimony. On May 11, 2015, Petitioner reported that he was "good," had returned to work and "I have no issues at work." [Px5 p 8 f 19]. On June 9, 2015, it was noted that he was able to walk and ride a bike. [Px5 p 3 of 13]. In August 2015, it was noted that while he had returned to work he now had pain when kneeling. [Px5bp15 of 157]. On September 28, 2015, the records noted that Petitioner could walk without pain, had no healing problems but "while on his knees he does feel prominence of the two proximal medial screws." [Px5b p2 of 157]. The records also noted that "He is able to stand on his right leg in isolation without pain. He has some difficulty performing a single leg toe raise but has no pain when he tries to do this." [Px5b p3 of 157]. On September 28, 2015, Petitioner underwent surgery to remove two screws. [Px5bp56 of 157]. On November 11, 2015, Petitioner returned for treatment to have his sutures removed. [Px5bp19 of 157]. Petitioner has not sought additional treatment in the subsequent five years.

Based upon the above, it is clear that Petitioner's testimony regarding his physical condition is not consistent with what is noted in the medical records. Petitioner testified that he limped, his leg hurts most of the time, it was hard to walk and he limped. The records show he had no limitations at work other than feeling the prominence of the screws when he kneeled. He could stand on his right leg with no issues and could single leg toe raise with no pain. Petitioner had those screws removed and has not sought

treatment since. The Arbitrator finds that the only reported post injury discomfort, feeling the screws, resolved after the second surgery and that Petitioner sought no treatment after that date clearly indicating that there were no residual symptoms.

Based upon the above the Arbitrator finds that no current symptoms or conditions of the Petitioner are related to the alleged work injury.

G. In support of the Arbitrator's decision with regard to what the Petitioner's earnings were in the year preceding the Accident and what the Petitioner's average weekly wage was calculated pursuant to Section 10 of the Act, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner did submit sufficient evidence to support the alleged annual earnings of $13,000.00 and an average weekly wage of $250.00. Petitioner testified that he usually worked three days a week for Handy. However, Petitioner also testified that there were times when there was no work and there would be a week between jobs. While the Petitioner sought to amend that application during the hearing, based upon the evidence the Arbitrator finds that original allegation of a $250.00 AWW to be more credible.

H. In support of the Arbitrator's decision with regard to the Petitioner's age, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner submitted sufficient evidence that at the time of the alleged injury Petitioner was 62 years old.

I. In support of the Arbitrator's decision with regard to the Petitioner's marital status and dependents at the time of the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner submitted sufficient evidence that at the time of the alleged injury Petitioner was single with no dependent children.

J. In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent-Employer paid all the appropriate charges, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that while Petitioner did incur bills related to medical treatment arising from this injury, Petitioner's testimony was clear that these bills were never submitted to and Handy was never aware of the claimed amounts. Petitioner testified that, after his injury, he next saw Handy a week after his surgery but they did not speak. Petitioner has seen Handy four to five times since the injury. They have simply said "hi". Petitioner has had only four or five conversations with Handy since the injury and in none of them has he mentioned, provided or asked for bills to be paid. This Arbitrator will not find an alleged employer liable for bills that they were never made aware of five years after the last of same was incurred.

Further, based upon the Arbitrator's findings above the Arbitrator finds that as there was no employee-employer relationship any reasonable or related medical treatment is not compensable.

K. In support of the Arbitrator's decision with regard to temporary total and temporary partial disability, the Arbitrator makes the following conclusions of law:

Based upon the Arbitrator's findings above, the Arbitrator finds that Petitioner did not suffer a compensable injury. Further, the Arbitrator finds

that Petitioner did not present sufficient, credible evidence that he was unable to work from October 7, 2014 to November 17,2015, as alleged in the Request for Hearing [Ax1].

Petitioner testified that he did not work from the date of injury until November 17, 2015. However, again Petitioner's medical records directly contradict his testimony. On May 11, 2015, Petitioner reported that he had returned to work. [Px5 p 8 f 19]. In August 2015, it was noted that had returned to work. [Px5bp15 of 157]. On September 28, 2015, the records noted that "The patient continues to work as a carpenter." [Px5b p3 of 157]. It is clear, based upon the medical records that Petitioner returned to work at least by May of 2015.

Further, Petitioner's testimony was clear that no light duty, modified duty or off work notes were ever submitted to and Handy. Petitioner testified that, after his injury, he next saw Handy a week after his surgery but they did not speak. Petitioner has seen Handy four to five times since the injury. They have simply said "hi". Petitioner has had only four or five conversations with Handy since the injury and in none of them has he mentioned or provided documentation of work restrictions nor asked to be returned to work in any capacity. "To be entitled to temporary total disability (TTD) benefits, a workers' compensation claimant must prove not only that he did not work, but that he was unable to work..." *Freeman United Coal Min. Co. v. Indus. Comm'n*, 318 Ill. App. 3d 170, 741 N.E.2d 1144 (5th Dist. 2000). There is no evidence that Petitioner was unable to work for Handy in any capacity as Handy was never provided the opportunity to accommodate any medical restrictions.

Therefore, the Arbitrator denies any award of TTD benefits as: Petitioner's testimony regarding his work history is not credible, the

Petitioner did not show the was unable to work as he never provided Handy the opportunity to accommodate or provide light duty, and finally as based upon the Arbitrator's findings above, there was no employee-employer relationship.

L. In support of the Arbitrator's findings regarding the nature and extent of the Petitioner's injury, the Arbitrator makes the following conclusions of law:

Based upon the Arbitrator's findings above, Petitioner did not suffer a compensable work injury.

However, Section 8.1(b) of the Act requires the Arbitrator consider certain factors. Section 8.1b states "In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b

The Arbitrator finds that Petitioner presented sufficient, credible evidence that he suffered a 20% loss of use of the right foot.

The Arbitrator notes that Petitioner was employed as a self titled "electrician's helper" at the time of the accident and that he was able to return to work as a carpenter by May of 2015.. The Arbitrator notes that Petitioner was 62 years old at the time of the accident. The Arbitrator notes that, regarding the future earnings capacity of the Petitioner, the testimony showed the Petitioner was able to return to work but no evidence was introduced as to his subsequent or current wages. No evidence was

introduced regarding Petitioner's potential earning capacity at this time five years after the injury. The Arbitrator notes the reasonable nature of medical treatment sought and received by the Petitioner, consisting of two surgeries and physical therapy and no further treatment for over five years. As to Petitioner's current condition, the Arbitrator discounts Petitioner's testimony, as it is directly contradicted by the medical records. The Arbitrator notes the following; On May 11, 2015, Petitioner reported that he was "good," had returned to work and "I have no issues at work." [Px5 p 8 f 19]. On June 9, 2015, it was noted that he was able to walk and ride a bike. [Px5 p 3 of 13]. On September 28, 2015, the records noted that Petitioner could walk without pain, had no healing problems but "while on his knees he does feel prominence of the two proximal medial screws." [Px5b p2 of 157]. The records also note that "He is able to stand on his right leg in isolation without pain. He has some difficulty performing a single leg toe raise but has no pain when he tries to do this." [Px5b p3 of 157]. The records noted Petitioner's work as a carpenter. [Px5b p3 of 157] and that Petitioner did report that he had pain if he was on his knees. [Px5bp4 of 157]. On September 28, 2015, Petitioner underwent surgery to remove two screws. [Px5bp56 of 157]. On November 11, 2015, Petitioner returned for treatment to have his sutures removed. [Px5bp19 of 157]. Petitioner then sought no further treatment.

Due to Petitioner's AWW of $240.00 the minimum rate of $220, as set forth in Section 8(b)(2) of the Act applies. Based upon the above this Arbitrator finds that the Petitioner suffered a 20% loss of the right foot, a total award of $7,348.67 (33.40 weeks x $220.00 = $7,348.67). Howeverr, based upon the Arbitrator's findings above the Arbitrator finds that as there was no employee-employer relationship and the injury is not compensable.

O. The Injured Workers' Benefit Fund is Not Liable.

The IWBF was named as a party respondent in this matter. Petitioner submitted sufficient credible evidence that Respondent-Employer was not insured at the time of the injury. Such evidence consists of the National Council on Compensation Insurance Certificate. [Px2].

This finding is hereby entered as to the IWBF to the extent permitted and allowed under §4(d) of the Act. Should any recovery by the Petitioner occur, Respondent-Employer shall reimburse the IWBF for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the IWBF, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC011148
Case Name	SIMPSON, DANIEL v. ADVANCED ASPHALT CO
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0478
Number of Pages of Decision	19
Decision Issued By	Barbara Flores, Commisioner

Petitioner Attorney	Patrick Serowka
Respondent Attorney	James Kelly

DATE FILED: 9/21/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIEL SIMPSON,

Petitioner,

vs. Nos: 20 WC 11148

ADVANCED ASPHALT COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b-1) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, temporary total disability, and the Arbitrator's exclusion of Petitioner's Exhibit 11, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the changes made below. The Commission further remands this case to the Arbitrator for further proceedings including a determination of permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Commission writes additionally on the issues of accident and causal connection.

1. Accident

The Arbitrator found that Petitioner proved by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment which resulted in a disabling injury. To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 194 (2002). An injury "arises out of" one's employment if it originated from a risk connected with, or incidental to, the employment and involved a causal connection between the employment and the accidental injury. *Id.* "In the course of" refers to the time, place, and circumstances of the

accident. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). Both elements must be present at the time of the claimant's injury to justify compensation under the Act. *Id.*

Petitioner alleges an injury based on repetitive trauma. In a repetitive trauma case, the employee must allege and prove a single, definable accident. *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d 907, 911 (2007). The date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury "manifests itself." *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 531 (1987). The phrase "manifests itself" signifies "the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Id.*

However, our supreme court later ruled that "'[t]o always require an employee suffering from a repetitive-trauma injury to fix, as the date of accident, the date the employee became aware of the physical condition, presumably through medical consultation, and its clear relationship to the employment is unrealistic and unwarranted.'" *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006) (quoting *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (1988)). "'An employee who continues to work on a regular basis despite his own progressive ill-being should not be punished merely for trying to perform his duties without complaint.'" *Durand*, 224 Ill. 2d at 70 (quoting *Three "D" Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 49 (1989)). Reviewing the case law, the *Durand* court concluded: "In short, courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities." *Durand*, 224 Ill. 2d at 72.

Respondent argues on review that Petitioner's injury manifested prior to a complete collapse of his condition, observing in particular that Dr. Edward Pegg had opined that Petitioner's condition was work-related due to his job duties during the four years prior to February 28, 2020. Respondent also argues that no evidence corroborated Petitioner's arbitration testimony that his right ring and small fingers went limp while working for Respondent on April 24, 2020, and that Petitioner's testimony generally was not credible.

In this case, while a repetitive trauma injury may manifest prior to a complete collapse of an employee's condition, Petitioner testified that he previously experienced numbness or tingling in his hands which tended to appear during or after working but receded after periods of rest, particularly during his "off-season." Petitioner sought treatment in January 2020 after a swimming incident which included "seeing stars" which seems unrelated to carpal or cubital tunnel syndrome. Petitioner testified that he sought treatment because he believed the right-handed symptoms could be a prelude to a heart attack or stroke, rather than a chronic condition related to his job. After conducting an EMG, Dr. Pegg opined in February 2020 that Petitioner displayed signs of severe bilateral carpal tunnel syndrome or median nerve entrapment at the wrist. However, the record is silent as to whether Dr. Pegg informed Petitioner of these impressions. Petitioner did not follow up with Dr. Pegg or otherwise seek further treatment.

Instead, Petitioner continued to work as a concrete laborer until April 24, 2020, the date on which his right ring and small fingers went limp while working for Respondent. Michael

Pyszka, Respondent's project superintendent, testified that he did not see anything unusual regarding Petitioner and that Petitioner reported no symptoms or work injury to him. However, the fact that Mr. Pyszka did not observe Petitioner's condition does not directly contradict Petitioner's testimony either. Petitioner's text exchanges with John Becker, Respondent's operations manager, did not expressly refer to a work injury. Yet the fact that Petitioner did not return to work lends support to his testimony. In addition, Petitioner testified that he thought he had inflammation which could be remedied by diet or stretching and that he would be able to return to work, whereas if he complained about his condition, he might have lost the job.

The Arbitrator explicitly found that Petitioner's testimony regarding his job duties was credible and detailed. The Arbitrator also found that Petitioner's testimony regarding his condition in January and February 2020 was consistent with the medical records, corroborating his testimony that he was capable of working full duty prior to April 24, 2020.

Respondent identifies various inconsistencies in Petitioner's testimony beyond Respondent's reliance on the testimony from Mr. Pyszka and Mr. Becker discussed above. However, these discrepancies do not result in the legal conclusion that Petitioner's condition had manifested as the sole result of some non-occupational cause or work with another employer. Similarly, Petitioner's confusion of his first date of treatment as May 4, 2020 instead of June 4, 2020 does not cast significant doubt on the testimony regarding his symptoms on April 24, 2020. It is not lost on the Commission that Petitioner's length of work for Respondent on the project at the time of the manifestation of his injury was two days. However, Petitioner's testimony regarding the manifestation of his symptoms is corroborated overall by the record, which shows that Petitioner did not return to work, provided notice to Respondent (albeit defective notice as stated in the Decision of the Arbitrator), and sought treatment for his condition after an onset of symptoms that required treatment and interrupted his ability to work without restriction.

Given the record as a whole, the Commission concludes that Petitioner continued to work on a regular basis despite his own progressive ill-being and should not be punished merely for trying to perform his duties without complaint. Petitioner's injury manifested on April 24, 2020, which in this case was both the date on which Petitioner required medical treatment and the date on which he could no longer perform work activities. The decision of the Arbitrator finding an accident as of April 24, 2020 is supported by the preponderance of the evidence.

2. Causal Connection

The Arbitrator found a causal connection between Petitioner's accident and his current condition of ill-being. An employee who alleges an injury based upon repetitive trauma must "show [] that the injury is work-related and not the result of a normal degenerative aging process." *Peoria County Bellwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 530 (1987); *Glister Mary Lee Corp. v. Industrial Comm'n*, 326 Ill. App. 3d 177, 182 (2001). "It is axiomatic that employers take their employees as they find them." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). When an employee has a preexisting condition, "recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a

normal degenerative process of the preexisting condition." *Id*. at 204-05. A claimant need only prove that his work for the employer "was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id*. at 205.

Respondent argues that the Commission should accept the opinions of its Section 12 examiner, Dr. Michael Vender, over those of the treating surgeon, Dr. Blair Rhode. Petitioner replies that Respondent's reliance on the fact that Petitioner had only worked 42 days for Respondent misapprehends the burden of proof that such work was a causally related factor to his current condition.

In this case, Dr. Vender's core opinion was that Petitioner could not prove causation where he had worked for Respondent only 42 days over the prior 52 weeks. This core opinion is contrary to the rule that employers take employees as they find them. As the Arbitrator noted, Dr. Pegg's impressions of severe bilateral carpal tunnel syndrome or median nerve entrapment at the wrist support the finding of a causal connection rather than negate it. The record indicates that Petitioner's work for Respondent in April 2020, using a jackhammer, plate compactor, and flat shovel to move concrete, involved the same job duties which led Dr. Pegg to opine that Petitioner's condition was work-related. In contrast, Dr. Vender professed to be unaware of Petitioner's job duties in his deposition testimony and offered no opinion regarding Petitioner's right upper extremity. Petitioner's work for Respondent aggravated his condition to the point where Petitioner could no longer work and required treatment, as evidenced by Dr. Rhode's treatment records concluding that Petitioner's bilateral carpal and cubital tunnel syndromes were secondary to Petitioner's work. Dr. Rhode did not directly refer to Petitioner's work for Respondent, but the record indicates that it was this work which caused the manifestation of Petitioner's condition. Given the record on review, the decision of the Arbitrator finding a causal connection between the current condition of his bilateral hands and arms and the manifestation of that condition on April 24, 2020 is supported by the preponderance of the evidence.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner sustained an accident on April 24, 2020 that arose out of and occurred in the course of employment.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner's current condition of ill-being is causally related to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical bills pursuant to the fee schedule and §§8(a) and 8.2 of the Act, for the services provided by: Orland Park Orthopedics representing $22,326.73; South Chicago Surgical Solutions representing $13,193.90; ATI representing $8,728.59; RX Development representing $7,484.92; Bob Rady, Inc., representing $1,150.63; Persistent Labs, representing $1,808.80; and Infinite Strategic Innovations, representing $100.78.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $806.67 per week for the periods from June 4, 2020 through November 19, 2020 and

from December 22, 2020 through February 23, 2021, for a period of 33 and 2/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit for any benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 5, 2019 is hereby affirmed and adopted with the changes stated herein.

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

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

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

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

September 21, 2021

o: 9/16/21
BNF/kcb
045

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

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC011148
Case Name	SIMPSON, DANIEL v. ADVANCED ASPHALT COMPANY
Consolidated Cases	
Proceeding Type	19(b-1) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Jessica Hegarty, Arbitrator

Petitioner Attorney	Patrick Serowka
Respondent Attorney	James Kelly

DATE FILED: 5/25/2021

THE INTEREST RATE FOR THE WEEK OF MAY 18, 2021 0.04%

/s/ Jessica Hegarty, 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-1)

Daniel Simpson
Employee/Petitioner
v.

Case # **20** WC **11148**

Consolidated cases: _____

Advanced Asphalt Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on 1/4/2021. Respondent filed a *Response* on 1/19/2021. The Honorable **Jessica Hegarty**, Arbitrator of the Commission, held a pretrial conference on 2/16/2021, and a trial on 2/23/2021, in the city of **Chicago**. 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 **Evidentiary issue.**

FINDINGS

- On the date of accident, **4/24/2020**, 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 $**32,670.00**; the average weekly wage was $**1,210.00**.
- 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.

Medical Bills

Respondent shall pay the following reasonable and necessary medical services as provided in Sections 8(a) and determined under 8.2 of the Act:

$22,326.73	Orland Park Orthopedics
$13,193.90	South Chicago Surgical Solutions
$8,728.59	ATI
$7,484.92	RX Development
$1,150.63	Bob Rady Inc.
$1,808.80	Persistent Labs
$100.78	Infinite Strategic Innovations

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits, as provided in Section 8(b) of the Act, of $**806.67**/week for the following periods:

- June 4, 2020 through November 19, 2020
- December 22, 2020 through February 23, 2021

Petitioner's claim for "prospective" TTD is denied.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $693.00 or the Estimated cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Jason C. Knotts

_____

MAY 25, 2021

Signature of Arbitrator

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ADDENDUM TO THE DECISION OF THE ARBITRATOR

Petitioner, a 46-year-old, left-handed, union concrete laborer for the last 21 years, alleges repetitive injuries to his bilateral hands /wrists manifested while working for Respondent on April 24, 2020. (Arb. Ex 1).

Testimony of Petitioner

Petitioner, a concrete laborer in good standing since 1999, worked out of Laborer's Local 393. (Transcript "T" 9).

On the alleged manifestation date, Petitioner was a long-term smoker and had a thyroid condition for which he took prescription medication. (Id. 87).

Petitioner's usual and customary duties as a concrete ground preparation worker for the last 21 years involved the following:

1. Demolishing existing concrete surfaces and structures with a jackhammer, sledgehammer and shovel (Id. 9);

2. Lifting broken, 40 to 50 lb., concrete chunks, with a shovel placing them in a bucket (Id. 16-17);

3. Packing down gravel subgrade using a hand-guided, vibrating plate compactor machine (Id. 17-18);

4. Assembling concrete forms by nailing wooden boards together with a hammer (Id. 19);

5. Setting the wooden forms in the ground by pounding 3-foot-long steel stakes into the ground with a sledgehammer (Id. 20);

6. As the wet concrete flows from a truck, a flat shovel is used to push, pull and shape the wet concrete into the forms (Id. 21-22);

7. On flat surfaces, a concrete rake is used to smooth the concrete. (Id. 23).

Between 2016 and 2020, Petitioner worked the following jobs for Respondent, performing the above described duties:

- In July 2016, a roadwork job along Interstate 80 and 26 (Id., 25);

- Beginning in May of 2017 and lasting most of the summer, a job in downtown Ottawa involving handicap ramps and curbs (Id., 27);
- In 2018 a job along 4H Road in Ottawa that lasted about 2 months;
- In 2018 a job in downtown Ottawa involving curbs and gutters (Id., 28);
- In 2019 Petitioner worked two jobs for Respondent. One in downtown Ottawa, the other involved 6 blocks of Euclid Avenue in Princeton. He recalled the subgrade on the Princeton job was very hard when driving the pins (iron stakes). Typically, Petitioner could drive a pin in 3 to 5 strikes with a sledgehammer but the Princeton job required Petitioner to swing 15 to 20 times per pin. On this job, set a pin every 4 feet for six blocks. He installed forms for gutters on this job. He noticed his hands and arms were really tired and sore during this job, keeping him up at night (Id., 31-32);

During and after the Princeton job, Petitioner noticed his hands and arms were tired and sore. Although these symptoms kept him up at night, he kept working after the Princeton job.

Later in the summer of 2019, he worked on several jobs for companies other than Respondent:

- In August of 2019 he worked at the training center for the Operating Engineers running backhoes, Bobcats and heavy equipment. He was doing this work because it was easier on his body;
- From August 25 through August 31, 2019, a job for Dirt Works in which he worked 32 hours (Rx. 10, Px.10). Petitioner described this as an easy job where he held a stick to make sure the hole was deep enough;
- From September 5, 2019 through October 9, 2019, a job for the Illinois Civil Contractors, involving a storm septic system at a hospital (Id.);
- A one-day job for Forrestal concrete unloading trucks (Px. 10);
- On October 16th, 2019 a job sweeping out containers (Id.).

Petitioner testified that concrete construction in the Midwest is weather dependent as the material will not cure beyond a certain, low temperature (Id., 24). The State of Illinois mandates that concrete not be poured once the weather has reached a specific temperature. (Id., 24). During these long off-season winter breaks, the symptoms in Petitioner's bilateral hands/wrists would decrease, allowing him to work the next season. (Id.).

Petitioner testified that he rested between November 2019 and January 2020. (Id., 35-36).

In January of 2020 Petitioner went to St. Margaret's Hospital with a history of feeling light-headed, dizzy and "seeing stars" after swimming. (Id., 38). Worried he might have a heart condition, he sought medical treatment. Although he did not visit the doctor specifically for hand-related complaints, he did report that his hands were bothering him. (Id.).

From January 15, 2020 through February 3, 2020, Petitioner worked for Getz Concrete on a job involving flat, concrete warehouse floors. He rested after that job. (Id., 37).

On April 23, 2020 Petitioner began a job for Respondent requiring the demolition and construction of 2 concrete medians on Route 178 and Route 50 in Utica, Illinois. (Id., 41-42. Petitioner first "saw cut" the existing concrete medians. A machine then excavated the structures. Petitioner then, using a jackhammer, went around the edges of the structures picking up small concrete piles with a shovel, placing them into the bucket. (Id., 42-43). Petitioner returned to the job the following day, April 24, 2020 (the alleged manifestation date) for the construction of 2 concrete islands. (Id. 43). Petitioner used a sledgehammer to set 25-30 pins (3-foot-long steel stakes) that day. He testified his hands were numb and tingling performing this task. He then assembled wooden forms with a regular hammer. Next, concrete was poured while Petitioner used a shovel to push, pull and shape the wet concrete into the forms. (Id., 45). Towards the end of the day while performing this task, Petitioner's pinkie and ring finger on his right hand went limp. Petitioner testified his right pinkie and ring fingers "were just kind of hanging" and he could not make a fist or grab things. (Id., 46).

On Tuesday, April 28, 2020 John Becker, on behalf of Respondent, texted Petitioner asking if Petitioner could return to work. (Px.3, Rx. 20). Petitioner responded that he would not be available until the next Monday. John Becker replied, "no problem." (Id.). The Petitioner testified he was hoping he could rest and self-rehabilitate his right hand and return to work for Respondent. When asked why he didn't tell Mr. Becker that his hand had gone limp the previous Friday, the Petitioner testified he was hoping his hand would heal and he could come back to work. (T. 47-49; Px. 3).

On Monday, May 6. 2020 John Becker texted asking if he could return to work for Respondent. (Px. 3, Rx. 20). Petitioner texted Becker back that Petitioner would be out of commission for at least the next month, that he would be having emergency surgery on his wrist. John Becker texted back indicating Petitioner's hand situation was "not good", asking Petitioner what happened. Petitioner texted back that he had carpal tunnel and his hand went limp. (Id). Petitioner indicated he would call when he was healed. (Id.).

Regarding Petitioner's text to Becker that he was having "emergency surgery" despite the fact that no surgical recommendation had, in fact, been rendered, Petitioner testified he

based this statement on conversations he had with co-workers regarding their experiences.

Testimony of Mike Pyszka

Respondent's employee, Mike Pyszka was the project superintendent for Respondent on April 24, 2020 at County Highway 43 and Illinois 178 in Waltham Township, LaSalle County, where Petitioner was working. (Id., 112). Petitioner was there to remove and replace a concrete island that was approximately 8' by 16'. (Id.). Pyszka testified that it was a wet spring and there was at least a 3-hour rain delay on one day. (Id.). During a rain delay, Petitioner would have sat in his vehicle or company truck to be out of the weather. Petitioner was part of a crew of 2 to 6 people. Petitioner's duties were forming concrete, curb and gutter, compacting gravel, sand gravel, pounding form pins, and stacking lumber. (Id., 114). Petitioner's job duties would have varied throughout the 2 days there would have been a chance Petitioner would have run a jackhammer during those 2 days and also a small vibrating plate compactor. The plate compactor is an 18" by 12" compactor that runs on a vibratory motor and compacts the gravel. (Id.). Petitioner did not report any kind of injury, symptoms, or incident on the job. (Id.).

Pyszka testified that Petitioner worked for Respondent for 2 days in April of 2020.

Medical Records

The January 2020 records of St. Margaret's Hospital reflect Petitioner's complaints of tenderness in his cervical, upper posterior shoulder area as well as his right arm and wrist with numbness and tingling. Petitioner reportedly was "seeing stars" and had been swimming for several hours prior to the onset of symptoms. Petitioner reported a history of right-handed numbness and tingling for the last 5 to 10 years, worse over the past month. Petitioner denied any recent injury and reported working in concrete construction. Petitioner stated he was likely dehydrated at the time and that his condition resolved after sitting. Petitioner was told to call the office if he had any concerns or recurrence of feelings are lightheadedness. The assessment reflected a discussion of the possible causes of right upper extremity symptoms and a referral to neurology for an EMG. (Rx. 2).

On February 28, 2020 Petitioner underwent an EMG performed by Dr. Edward Pegg at St. Margaret's Hospital, Neurology Center. (Px. 7; Rx. 3). Dr. Pegg noted the following:

> *Daniel presents with a four-year history of numbness and occasional pain in his hands bilaterally. He would notice this when he was at work using tools or vibrating equipment. He also would awaken with it at night bothering him. He did think it involves most of the fingers of both hands but felt that it was worse on the right than the left. (Id).*

Dr. Pegg noted the following impression:

> *This EMG shows evidence of severe bilateral carpal tunnel syndrome or median nerve entrapment at the wrist. This is a work-related injury and clearly would be related to the type of activity that Dan would have been doing over the last four years. (Id.).*

On June 4, 2020 Petitioner presented to Dr. Blair Rhode, an orthopedic surgeon at Orland Park Orthopedics. (Px. 4). Dr. Rhode noted the left-handed Petitioner's complaints of bilateral hand numbness and tingling, worse while working. Petitioner reported his symptomology had progressively worsened over the course of the last 4 years. Petitioner reportedly worked as a concrete laborer for his current company for 5 years. The doctor noted Petitioner was exposed to a significant amount of force, repetition, and vibration. Petitioner had performed the same job activities over the course of 25 years. Petitioner reported a history of hypothyroidism and smoking. Dr. Rhode noted a February 28, 2020, EMG demonstrated severe bilateral carpal tunnel syndrome. On exam, positive Phalen's and Tinel's were noted on Petitioner's bilateral wrists. Dr. Rhode noted a diagnosis of bilateral carpal tunnel and bilateral ulnar nerve lesions. An injection of Kenalog and Lidocaine was administered to Petitioner's right wrist. Petitioner was taken off work and was to follow up in 2 weeks.

On June 18, 2020 Dr. Rhode noted Petitioner's report that his symptoms in the right ring and pinkie finger were greater than in his other right digits. Dr. Rhode discussed treatment options and Petitioner indicated he wished to proceed with right carpal and cubital tunnel release. Petitioner was released to modified light-medium work. Petitioner underwent right carpal and cubital tunnel surgery, performed by Dr. Rhode, on August 18, 2020. (Px.5).

On September 15, 2020, Petitioner underwent left carpal and cubital tunnel syndrome surgery, performed by Dr. Rhode. (Id.).

On November 19, 2020 Dr. Rhode released Petitioner to full-duty work and instructed him to follow up in 4 weeks to consider MMI. (Id.).

Petitioner testified he did not contact Respondent regarding light duty work because it was the end of the work year. (Id.). Instead, Petitioner "tested" his hands by painting his basement and hanging some shelves. (Id., 58-59). After performing these "easy tasks" Petitioner concluded he was not ready to go back into the concrete field. (Id., 58). Petitioner noticed his hands were sore and tight. His left hand was still sore from surgery, but he could use it. (Id., 59).

On December 22, 2020, Petitioner reported to Dr. Rhode that he was not accommodated by his employer. (Px. 4). Petitioner told the doctor he attempted to perform work-like activities at his house and experienced worsening symptomology. Dr. Rhode released Petitioner to modified work restrictions and told him to follow up in 4 weeks for re-evaluation.

Petitioner was supposed to follow up with Dr. Rhode on January 26, 2021 but Petitioner missed the appointment due to a separation with his lady. (T. 60).

On February 19, 2021 Petitioner returned to Dr. Rhode with increased symptoms to the left upper extremity. (Px. 4). Petitioner did not feel capable of duty. On exam, Petitioner had positive Tinel's sign on the right and positive Tinel's on the left. Petitioner had positive cubital tunnel sign in the left. Dr. Rhode took Petitioner off work. (Id.).

Dr. Vender, a board-certified orthopedic hand surgeon. performed a Section 12 exam of Petitioner on August 24, 2020 and testified via evidence deposition on November 20, 2020. (Rx.1).

CONCLUSIONS OF LAW

ACCIDENT AND CAUSAL CONNECTION

Based on a preponderance of the credible evidence contained in the record, the Arbitrator finds that Petitioner sustained his burden with respect to accident and causal connection.

Petitioner, a union cement worker for the last 21 years, testified he had symptoms in his bilateral hands for four years leading up to April 24, 2020 when, while using a shovel to push, pull and shape wet concrete, his right pinkie and ring finger went limp and he was unable to make a fist or grab an object with his right hand.

The job for Respondent involved the demolition and construction of 2 concrete medians along Route 178 and Route 50 in Utica, Illinois. The job involved the usual and customary duties of a concrete laborer. Petitioner used a saw, jackhammer, and shovel (the day prior to the accident) to demo the existing concrete medians. On the manifestation day, his hands were numb and tingling as he pounded 25 to 30, 3-foot-long, steel stakes into the ground using a sledgehammer. Petitioner kept working. Using a hammer, he assembled wooden the forms. It was during the last step, at the end of the day, while using a flat shovel to push, pull, and shape wet concrete, his right pinkie and ring finger went limp. Petitioner testified the digits "were just kind of hanging" and he could not make a fist or grab things.

The Arbitrator found Petitioner's testimony credible and detailed regarding the specific

jobs he performed for the Respondent from 2016 through 2020. This testimony stands unrebutted. The duties performed for Respondent on the two-day job that includes the manifestation date, were corroborated by Respondent's witness.

Respondents' exhibits reflecting Petitioner worked as a concrete laborer in varying capacities for Respondent and other employers is consistent with the Petitioner's testimony that he worked as a concrete laborer until the April 24, 2020 date of accident.

On direct examination Petitioner testified he saw a doctor at St. Margaret's in January of 2020; however, the purpose of his visit was not regarding the condition of his hands. Petitioner had been swimming and had an episode of "lightheadedness, dizziness, seeing stars" and was concerned he had a heart condition. He agreed his hands were hurting as well. (T. 37-38). The January 23, 2020 records of St. Margaret's reflect pain in the right arm/ wrist with numbness and tingling chronic back pain; he's a concrete worker. The January 12, 2020 history reflects right arm numbness and he was "seeing stars". Further, he had been swimming for several hours prior to onset of symptoms. The details of the exam reflect cervical tenderness, upper posterior shoulder tenderness and slight tenderness along right arm, wrist. He complained of chronic right-handed numbness and tingling for the last 5 to 10 years, worse over the past month, and approximately three to four times his whole arm felt that way. He denied any recent injury and reportedly worked in concrete construction. The assessment reflected a discussion of the possible causes of right upper extremity symptoms, a referral to neurology for EMG, and Petitioner's report that he was likely dehydrated at the time. The Petitioner also reported his condition resolved after sitting and he had not had any episode since. Petitioner was told to call the office if he had any concerns or recurrence of feelings are lightheadedness. (Rx. 2).

The Arbitrator finds these records are consistent with the Petitioners testimony as to the reason for the visit, consistent with this testimony that he had some symptoms in his hands and arms prior to April 24, 2020 and consistent with a general condition of well-being prior to the manifestation date. This record does not controvert the facts corroborating Petitioners' testimony he was capable of working full duty prior to April 24, 2020.

The records of St. Margaret's neurology center of February 28, 2020 reflected that Petitioner presents with a four-year history of numbness and occasional pain in his hands bilaterally. Petitioner reported using tools and vibrating equipment at work. On examination he had good strength in the APB and intrinsic hand muscles were full strength. Sensory examination noted a deficit involving the median distribution and noted splitting of the ring finger on both hands consistent with median nerve deficit.

The February 28, 2020 EMG showed evidence of severe bilateral carpal tunnel syndrome or median nerve entrapment at the wrist. Dr. Edward Pegg opined, "This is a work-

related injury and clearly would be related to the type of activity that Dan would have been doing over the last 4 years"(Px.7, Rx. 3).

The Arbitrator finds the opinions of Dr. Pegg are supportive of a causal relationship as to the general work activities of the Petitioner, but an injury or disablement was not manifest at this time. The Arbitrator finds the evidence corroborates Petitioners' testimony that, following the EMG results, he did not see a surgeon or other doctor for treatment. Petitioner explained it was his regular practice to let his hands rest before returning to work and he was able to perform his duties. The Arbitrator finds this explanation reasonable in light of the evidence suggesting Petitioner typically rested in the offseason and this recuperative period enabled him to return to full duty concrete work the prior several seasons. The Petitioner rested during the remainder of January, February, March and up to April 22, 2020. This was the offseason for pouring concrete. (T.38-40)(Px.10).

The medical records of Dr. Rhode reflect a disabling condition of ill-being in Petitioner's bilateral hands/arms. Dr. Rhode opined Petitioners bilateral hands and wrists were causally related to the work activities for Respondent. Petitioner was restricted from work as of June 4, 2020. Dr. Rhode's basis for this opinion are well-supported by a detailed recorded understanding of Petitioner's work duties as a concrete laborer and notations that these exposures were significantly forceful, repetitious and vibratory as to be causal. The causation opinions of Dr. Rhode's are more credible than Dr. Vender as supported by a history of progressively worsening symptoms over the last 4 years. The January 28, 2020 opinions of Dr. Pegg are supportive of causal connection to his repetitive work activities which manifested on the April 24, 2020 date of disablement. Further, Dr. Rhode's diagnosis of bilateral carpal tunnel and bilateral cubital tunnel syndrome are well-supported by the findings on EMG, ultrasound, correlative clinical findings of bilateral carpal and cubital tunnel syndromes, diagnostic clinical confirmation post-injections and relief of symptoms post-surgery.
Dr. Vender refrained from opining on causation regarding Petitioner's right hand/wrist as he could not examine Petitioner's right upper extremity (because Petitioner had recently had surgery).

The Arbitrator notes Dr. Vender hadn't reviewed any job description and had no knowledge of the Petitioner's specific duties for Respondent. Dr. Vender agreed he made findings consistent with the presence of ulnar neuropathy in Petitioner's left arm. Dr. Vender's denial of the presence of cubital tunnel syndrome was based upon exam findings of which he had no recollection of at the time of his testimony and failed to specify in his report.

Based upon the foregoing the Arbitrator finds that Petitioner met his burden of proof that regarding "accident" and whether his employment with Respondent was 'a' causative factor in the current condition of his bilateral hands and arms.

NOTICE

The Arbitrator finds that on May 6, 2020 Petitioner provided defective notice via text messages to Respondent's employee, however, the Arbitrator finds Respondent was not prejudiced by such defective notice to Respondent as Mike Pyszka was available to investigate the allegations. Therefore, notice was given to Respondent.
Further, any alleged defect in notice existing prior to May 6, 2020 was cured by service of the filed application for adjustment on Respondent on or about May 13, 2020 within the 45-day notice provision of the Act. As such, the Arbitrator finds Petitioner provided notice to the respondent within the 45-day period.

MEDICAL BILLS

Regarding Respondent's Exhibit #17, the Arbitrator finds the contents of the exhibit difficult to discern and unclear if said review or figures are of the type allowed by the Act as they don't describe utilization review, URAC standards under Section 8.7 of the Act or reference to the "WCUM" guide. To be relevant (to the reasonableness and necessity of charges) the utilization review criteria set forth in the "WCUM" guide must be followed. The Arbitrator notes other aspects of this exhibit appear to be fee schedule reductions.

Respondent's Exhibit 17 contains no reference to any type of substantive review of the medical services or criteria for their decision to enable review or appeal. Further, there is an absence of named medical professionals or evidence of their credential to discern whether they health care professionals or whether they possess the required certification in the specialty as required by URAC Guidelines.

Petitioner's Exhibit #8 reflects unpaid bills which correlate to the treatment records as reflected in Petitioner's Exhibits 4, 5 and 6. The Arbitrator finds an adequate evidentiary foundation for admission of these exhibits as they were received in response to Commission subpoena and contain signed documents from records' custodians

The Arbitrator finds Respondent is liable for the following medical bills:

South Chicago Surgical Solutions	$13,193.90
Orland Park Orthopedics	$22,326.73
Bob Rady Inc.	$1,150.63
RX development	$7,484.92
Persistent Labs	$1,808.80
Infinite Strategic Innovations	$100.78.

No fee schedule calculation was provided for the bills of ATI. The Arbitrator awards this medical expense per the fee schedule of Section 8.2 of the Act.

PROSPECTIVE MEDICAL TREATMENT

No prospective medical care or services was prescribed by Dr. Rhode on his last medical note, dated February 19, 202. The Arbitrator questions why Petitioner listed this issue on the stipulation sheet at all as it clearly is not at issue in this case.

TTD

Based on a preponderance of the credible evidence, the Arbitrator finds Petitioner is entitled to TTD for the following periods:

- June 4, 2020 through November 19, 2020 (when Dr. Rhode released Petitioner to full-duty work);

- December 22, 2020 through February 23, 2021.

Petitioner's claim for "prospective" TTD is denied.,

OTHER ISSUES

The parties took the evidence deposition of Dr. Vender, Respondent's IME, on November 20, 2020. During that evidence deposition, Petitioner's attorney referred to a paper, Occupational biomechanical risk factors for surgically treated ulnar nerve entrapment in a prospective study of male construction workers ("paper"). Petitioner failed to offer the paper into evidence in Dr. Vender's evidence deposition, which renders the issue of admissibility of the paper moot. *Walski v. Tiesenga,* 72 Ill. 2d 249, 381 N.E. 2d 279 (1978); *Roach v. Springfield Clinic*, 157 Ill. 2d 29, 623 N.E. 2d 246 (Ill. 1993).

Accordingly, the paper is inadmissible and was not considered by the Arbitrator.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC034636
Case Name	BERG, BRUCE v. STATE OF ILLINOIS-ILLINOIS DEPARTMENT OF TRANSPORTATION
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0479
Number of Pages of Decision	32
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	EDWARD CZAPLA
Respondent Attorney	Danielle Curtiss

DATE FILED: 9/21/2021

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRUCE BERG,

Petitioner,

vs. NO: 15 WC 34636

STATE OF ILLINOIS-ILLINOIS
DEPARTMENT OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, and penalties and attorney's fees, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator for the reasons outlined below, and finds that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment by Respondent on September 22, 2015. The Commission further finds in favor of Petitioner on the issues of causal connection, medical expenses, TTD benefits, and PPD benefits. However, the Commission does not find that Petitioner is entitled to an award of penalties or attorney's fees.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner's counsel confirmed on the record that the only claim being made on the date of arbitration pertained to Petitioner's alleged left knee injury. The Commission therefore makes the following findings as it relates to the left knee:

1) Petitioner worked full-time as a highway maintainer for Respondent as of October 2002. (T.13-14). His job duties included cutting grass, trimming trees, asphalt work, running a jackhammer, using a backhoe and front-end loader, working with plows, minor maintenance on trucks, and supervising individuals as an acting foreman. Petitioner also did concrete work, rebuilt sewers and sewer frames, cleaned storm drains, cleaned garbage and debris on the highway, and cleaned up after a roadway accident. (T.14). During the snow season, Petitioner would plow snow and spread salt. (T.18-19). Petitioner identified

Petitioner's Exhibit 15 – Respondent's job description for a highway maintainer. (T.14-15; PX15). Petitioner classified the nature of his work as very heavy duty and physical. (T.16).

2) Prior to his alleged injury on September 22, 2015, Petitioner stated that he was working without restriction for Respondent. (T.16-17). Petitioner confirmed that he was able to perform his duties as a highway maintainer before September 22, 2015. (T.23).

3) Petitioner testified that he did not have any problems, treatment or complaints related to the left knee prior to September 22, 2015. (T.22-23).

4) Petitioner, 68 years old on the date of accident, testified that he was supervising at work on September 22, 2015. He was walking along the roadway in an area with uncut, tall grass. Petitioner described it as a "washout." He confirmed that he encountered a depression or "that washed out area in the median." (T.23). "I went into a – stepped into a sinkhole that was covered over, and twisted my knee and fell and was in pain." (T.23-24). Petitioner injured his left knee. He had "twisted and turned and fell to the side." (T.24). He fell in the grassy area and not on the pavement. (T.24). Petitioner clarified that his crew had been working on a median cutting and trimming. (T.24).

5) Petitioner identified Petitioner's Exhibit 13; a copy of the Workers' Compensation Employee's Notice of Injury dated September 22, 2015. (T.25; PX13). He confirmed that he had filled out and signed the form, and that the report accurately depicted the mechanism of injury on September 22, 2015. (T.25). The report stated that on September 22, 2015, Petitioner sustained injuries to his left knee, middle leg, lower right back, butt and leg. The report also described: "Where there were holes, rutts and water/mud plus a large log sticking out of ground. I stepped into a rut covered by grass and twisted and jerked my left knee. I, also, have pain in my right lower back around my butt and down my right leg." (PX13; RX1). During cross-examination, Petitioner identified Respondent's Exhibit 1 which was the same document as Petitioner's Exhibit 13. (T.49-50; RX1; PX13). "It says holes, ruts, holes and ruts." (T.50). Petitioner explained: "A sinkhole, hole, a rut, it's all the same." (T.50).

6) Petitioner sought emergency treatment at Adventist La Grange Memorial Hospital on September 22, 2015. (T.27; PX1). The history noted that Petitioner had onset of left knee pain and swelling just prior to arrival. The record indicated that Petitioner had a falling and twisting injury. Range of motion in the left knee was restricted by pain. X-rays of the left knee revealed mild-to-moderate degenerative arthritic changes with mild narrowing of the medial joint space compartment. There was a degenerative spur arising from the superior patella. There was no evidence of a fracture or bony destructive lesion. Petitioner was diagnosed with a left knee sprain. He was prescribed Norco and restricted from work until further evaluation by an orthopedic doctor. (T.28; PX1).

7) Petitioner followed-up with Dr. Joshua Blomgren at Midwest Orthopaedics at Rush on October 2, 2015. (T.28; PX3, Vol. II). The history recorded stated that Petitioner was a highway maintainer for Respondent who presented for an acute injury to the left knee. "On 09/22/2015, he was walking when he stepped on a rock that was covered by grass. He

twisted and fell on the knee and felt as if it buckled underneath him." Dr. Blomgren noted that Petitioner went to the emergency room where x-rays were taken, his knee was placed in an immobilizer, and he was given crutches. Petitioner reported having a stabbing pain when he moved his leg and swelling. Petitioner denied any previous injury, treatment or trauma to the left knee. (PX3, Vol. II).

8) Dr. Blomgren's examination of the left knee revealed swelling, weakness, trace effusion, and range of motion was five to 105 degrees with pain. Petitioner exhibited tenderness to palpation of the medial and lateral joint line, lateral femoral and tibial condyles. Dr. Blomgren noted relative immobility of the patella, as well as tenderness to palpation of the patella. McMurray's testing was positive. Dr. Blomgren reviewed the x-rays from September 22, 2015 and noted some medial compartment joint space narrowing, bony spurring of the medial femoral and tibial condyle. There was lucency adjacent to the lateral femoral condyle and there was an anvil osteophyte noted on lateral projection. Dr. Blomgren diagnosed Petitioner with a traumatic left knee injury with suspected internal derangement and/or occult fracture. Dr. Blomgren recommended an immobilizer for the left knee and that Petitioner limit any weightbearing. Dr. Blomgren also ordered an MRI of the left knee and gave Petitioner a prescription for Norco. (T.29; PX3, Vol. II).

9) Petitioner completed the MRI of the left knee on October 2, 2015. The impression indicated a degenerative complex tear in the posterior horn extending to the body of the medial meniscus. A small meniscal fragment was seen in the medial joint gutter. There was also moderate-to-severe cartilaginous loss with osteophytosis in the patellofemoral compartment and medial compartment. Complete cartilaginous loss was noted over the medial femoral condyle and adjacent medial tibial plateau with associated subchondral marrow edema. Focal areas of fissuring and cartilaginous loss were noted over the lateral femoral condyle and lateral tibial plateau. Mild semimembranosus tendinosis was also noted. (PX2; PX3, Vol. II; RX7).

10) Dr. Blomgren reviewed the MRI results on October 8, 2015, and noted a degenerative appearance of the medial compartment and patellofemoral joint. There was a tear of the posterior horn of the medial meniscus which appeared degenerative in nature. There was also extrusion of the meniscus as well as a fragment in the medial joint gutter. Petitioner's diagnosis was now medial meniscal tear of the left knee. Dr. Blomgren stated in the office visit note, "Despite the degenerative quality in appearance of it on the MRI, the patient sustained this in the work-related event. He had noted no prior injury, treatment or trauma . . ." (PX3, Vol. II). Dr. Blomgren kept Petitioner off work and referred him to Dr. Charles Bush-Joseph for a surgical consultation. (T.30; PX2; PX3, Vol. II).

11) Petitioner consulted with Dr. Bush-Joseph at Midwest Orthopaedics at Rush on November 3, 2015. Dr. Bush-Joseph noted Petitioner's job position with Respondent and "on 09/22/2015 was walking on site and stepped into a hole on the side of the road. At that time his left knee 'jerked' with the knee moving outward and buckling." (T.30; PX3, Vol. II). Dr. Bush-Joseph noted Petitioner's treatment to date and that he had never injured his knee in the past. Physical examination revealed that Petitioner walked with an antalgic gait favoring the affected left side. "He does have, at baseline, valgus deformity bilaterally at

the knee." Dr. Bush-Joseph removed the knee immobilizer and noted no swelling, bruising or atrophy. Petitioner had restricted patellar mobility and was unable to extend the knee past approximately 10 degrees. Forced extension and flexion were painful but there was no effusion on examination. Petitioner also had mild medial joint line tenderness but no lateral joint line tenderness. (PX3, Vol. II).

12) Additional examination of Petitioner's left knee demonstrated that Petitioner had pain with McMurray's testing and he showed significant quad atrophy when compared to the unaffected right side. Petitioner was able to complete a straight leg raise. Dr. Bush-Joseph reviewed x-rays and the MRI results. He noted tricompartmental arthritic changes on the x-rays and a medial meniscal extrusion with degenerative changes on the MRI. There was no lateral meniscal damage or any ligamentous damage or loose bodies. Dr. Bush-Joseph diagnosed Petitioner with a medial meniscal tear with extrusion of the left knee, tricompartmental arthritis of the left knee, and post-traumatic stiffness. (PX3, Vol. II).

13) Dr. Bush-Joseph stated in his November 3, 2015 office visit note that Petitioner's medial meniscus extrusion was likely related to the work injury. "However, based on the use of the immobilizer and the stiffness that he is showing today, it is difficult to determine if the meniscus is causing his symptoms." Dr. Bush-Joseph first recommended a corticosteroid injection and physical therapy before considering surgery. (T.30-32; PX2; PX3, Vol. II). He administered the injection at the appointment. Petitioner reported immediate relief from his symptoms, but continued to have difficulties with range of motion. Dr. Bush-Joseph wanted Petitioner to use his left leg as much as possible without using the immobilizer or crutches. Petitioner was to remain off work. (T.32; PX3, Vol. II).

14) Petitioner returned to Dr. Bush-Joseph on November 17, 2015. Dr. Bush-Joseph noted that the injection did not provide lasting relief and physical therapy also provided minimal benefit. Physical examination demonstrated that Petitioner had a varus gait. He was not wearing the immobilizer and was able to weight-bear without issue. Petitioner had no signs of swelling, bruising or atrophy. He continued to have resisted patellar mobility but his extension had improved. Flexion was approximately 110 degrees with pain along the lateral side of the knee. Petitioner had medial and joint line tenderness. He also had a stable ligamentous exam. McMurray's testing was negative. (T.32; PX3, Vol. II).

15) X-rays were taken at the November 17, 2015 appointment and revealed significant tricompartmental arthritis with medial joint space narrowing bilaterally right worse than left. There were no signs of any bony fractures or masses. Petitioner's diagnoses were degenerative medial meniscal tear with extrusion of the left knee, tricompartmental arthritis of the bilateral knees and improving post-traumatic stiffness. The office visit note stated that Dr. Bush-Joseph believed that "he had likely exacerbated his pre-existing arthritis with the addition of the meniscus tear." Dr. Bush-Joseph opined that arthroscopic surgery of the left knee would make Petitioner's condition worse with possible increased stiffness and risks. He wanted Petitioner to continue with physical therapy, pain relievers, and he ordered a medial unloader brace for Petitioner. (PX3, Vol. II). Petitioner was also given work restrictions of no lifting more than 20 pounds maximum and a 10-pound limit of frequent lifting or carrying. Petitioner was also restricted from prolonged sitting with a degree of

pushing/pulling arm and/or leg controls, and restricted from significant walking or standing. (PX2; PX3, Vol. II).

16) On December 8, 2015, Dr. Bush-Joseph evaluated Petitioner. Petitioner continued to complain of left knee pain that was diffuse throughout the knee despite the corticosteroid and viscosupplementation injection and physical therapy. Physical examination demonstrated range of motion lacking approximately 5-10 degrees. Petitioner continued to have varus alignment, non-localizing tenderness to palpation of his medial and lateral joint lines, and small effusion. Petitioner exhibited patellofemoral crepitation with flexion and extension of the knee. He had a stable ligamentous exam. Dr. Bush-Joseph also examined the right knee and diagnosed Petitioner with bilateral knee osteoarthritis. Dr. Bush-Joseph recommended a left knee replacement. He referred Petitioner to Dr. Scott Sporer for a surgical consultation. (T.33; PX2; PX3, Vol. II).

17) Petitioner had been in physical therapy at ATI Physical Therapy from November 4, 2015 through January 28, 2016. (T.31; PX4, Vol. III and IV). Petitioner testified that physical therapy did not improve his left knee condition. (T.31). The January 21, 2016 Progress Note stated that Petitioner reported a 50% improvement since starting therapy. His flexion range of motion in the left knee had improved slightly but everything else remained the same. The report also indicated that Petitioner was non-compliant with his home exercises as he had reported that he had been busy taking care of his grandchildren. Petitioner apparently refused to be progressed in therapy secondary to pain and time constraints. "Due to continued non-compliance of the patient he reports that he does not wish to continue to a work conditioning/work hardening program. Petitioner was discharged on January 28, 2016. (PX4, Vol. III).

18) Petitioner next consulted with Dr. Scott Sporer on February 17, 2016. Dr. Sporer evaluated Petitioner's bilateral knee osteoarthritis. Dr. Sporer noted Petitioner's treatment to date and that Petitioner had complaints of swelling and clicking in his knees. He did not have specific catching. The office visit note stated, "The pain has been progressive over the last many years. However, he had recent trauma in fall of last year that caused him to become acutely worse." (T.33; PX3, Vol. II).

19) Dr. Sporer examined Petitioner's back, hip area and both knees. He noted that Petitioner walked without assistive device or limp. Petitioner had no tension signs of the lumbar spine with straight leg raise. There was varus deformity of both knees. The left knee had a 10-degree flexion contracture. Petitioner could flex to 115 degrees before feeling stiff and pain. He also had tenderness along the lateral joint line and posterior joint line. Petitioner had pain with patellofemoral grind test. The right knee had similar findings. X-rays taken at the appointment revealed medial compartment disease of both knees with left worse than right. There was narrowing of the medial joint space, sclerosis, and osteophyte formation. There was also chondrocalcinosis within the lateral joint space of the left knee. There was osteophyte formation laterally and around the patellofemoral joint. Dr. Sporer diagnosed Petitioner with bilateral knee osteoarthritis, left worse than right. Dr. Sporer recommended total knee arthroplasty for both knees, starting with the left. (T.33; PX3, Vol. II).

20) Petitioner proceeded with the left cemented total knee arthroplasty with Dr. Sporer on March 17, 2016 at Central DuPage Hospital. (T.33-34; PX3, Vol. II; PX5, Vol. I). Post-surgery, Petitioner remained off work and continued to follow-up with Dr. Sporer's office. (T.34-35; PX3, Vol. II). By April 29, 2016, Petitioner reported to Dr. Sporer that he was doing very well regarding the left knee. "He states his pain is markedly improved from preoperative state." Petitioner did have residual stiffness, but his biggest complaint involved the right knee. Petitioner was scheduled for the right total knee arthroplasty on June 2, 2016. (PX3, Vol. II).

21) Petitioner had been undergoing post-op physical therapy for the left knee at ATI Physical Therapy as of April 1, 2016 through May 26, 2016. (T.34; PX4, Vol. II and III). The last Daily Note dated May 25, 2016 indicated that Petitioner had difficulty sleeping due to left knee pain. However, his right knee pain was greater on that date due to osteoarthritis. Petitioner was discharged from therapy because he was proceeding with a right total knee arthroplasty the following week. (PX4, Vol. II).

22) Petitioner saw Physician Assistant Lauren Opila on May 25, 2016, but that office visit pertained to his pre-operative evaluation for the upcoming right total knee arthroplasty. (T.35; PX3, Vol. II). The medical records thereafter from Dr. Sporer's office and colleagues were not related to the left knee; the medical records primarily pertained to treatment for the right knee and lumbar spine. (PX3, Vol. I and II).

23) On June 7, 2017, Dr. Sporer evaluated Petitioner's knees. He noted that Petitioner had no complaints of pain and no functional limitations. He recommended that Petitioner continue with activity as tolerated including a home exercise maintenance program. Petitioner testified that he only had to return for his "[a]nnual visit, follow-up, yes, only come in if you have pain or difficulty." (T.36; PX3, Vol. I).

24) Petitioner stated that Respondent did not accommodate work restrictions. "Highway maintainers have to be 100 percent or not at all." (T.36). Petitioner confirmed that he was off work from September 23, 2015 through June 1, 2016. (T.36-37). He did not receive TTD benefits during this time period. (T.37).

25) Respondent sent Petitioner for a Section 12 examination with Dr. G. Klaud Miller. (T.37-38). Petitioner was sent home because Dr. Miller would not examine him unless he filled out paperwork. (T.39). "He wanted me to fill out a bunch of paperwork like a new patient, information and I wasn't his patient, so I really – so I didn't fill it out." (T.39; 52-53). Respondent's Exhibit 9, Deposition Exhibit 3 was the paperwork that Petitioner allegedly did not complete, but Petitioner testified that the paperwork did not look familiar. (T.54-55; RX9). Petitioner confirmed that Dr. Miller did not see him when Petitioner returned to his office on June 3, 2020. (T.40).

26) Dr. Miller instead completed a records review and provided his Section 12 report dated June 18, 2020. (RX9; RX10, pgs. 14-15). Dr. Miller's evidence deposition was taken on August 10, 2020. (RX10). Dr. Miller confirmed that he was a board-certified orthopedic surgeon. (RX10, pg. 5).

27) Dr. Miller explained that Petitioner "didn't show for the examination. He canceled twice, so I never actually physically examined him." (RX10, pg. 14). Dr. Miller stated that Petitioner had been scheduled for an IME on April 1, 2020 and June 17, 2020. (RX10, pg. 19). With respect to the paperwork his office asks Petitioners and patients to complete: "[W]e ask for permission to do the examination. We ask for a medical history, and we ask for a history of the specific injuries alleged, as well as the functional and – functional components and their complaints on the day of the examination." (RX10, pgs. 15-17). Dr. Miller testified that without the paperwork describing an individual's medical history, current symptoms and condition, and history of treatment, he could not perform an adequate examination. (RX10, pg. 17).

28) Dr. Miller reviewed the medical records and diagnostic images, which included information for the unrelated lumbar spine and right knee injuries, as well as a job description. "He was a supervisor of a – for a highway maintenance crew. There were no specific physical demands, but he was repairing structures on the road and driving trucks." (RX9, RX10, pg. 21). Dr. Miller's understanding of how Petitioner was injured was: "The accident report simply said that he twisted his left knee as he was supervising. Some of the other details from some of the other medical records stated that he stepped on a rock and twisted his knee." (RX10, pg. 21).

29) Dr. Miller diagnosed Petitioner with pre-existing arthritis of the left knee. (RX10, pg. 22). "They [the pre-existing conditions] could not possibly have occurred in the short period of time between the accident in question and when they were first documented." (RX10, pg. 22). Dr. Miller opined that Petitioner's left knee condition was unrelated to the alleged September 22, 2015 work injury. (RX10, pg. 26). He also testified, "You cannot aggravate arthritis by twisting it." (RX10, pg. 27).

30) Notwithstanding causation, Dr. Miller found Petitioner's treatment to be reasonable and necessary, Petitioner did not need further treatment for the left knee, and did not require work restrictions. (RX9, RX10, pgs. 27-28).

31) During cross-examination, Dr. Miller confirmed that he did not have any pre-accident medical records. (RX10, pg. 36). "I had no medical records referencing the knee prior to the accident in question." (RX10, pg. 37). Dr. Miller conceded that a twisting of the knee was a competent cause for a meniscal tear, but not an extrusion of the meniscus. "That does not occur in a traumatic injury. That's a degenerative process. It takes months and months to develop." (RX10, pgs. 48-49). During further cross-examination, Dr. Miller clarified:

> I absolutely disagree that that aggravated the underlying condition. It may have aggravated his symptoms, yes. Anybody with arthritis who walks too far gets a painful knee. You twist an arthritic knee, it's painful, but it does not aggravate, accelerate, or affect the underlying condition in any way. It's painful, yes, but it does not aggravate the arthritis. (RX10, pgs. 64-65).

32) As of the date of arbitration, Petitioner stated: "I have pain that wakes me up in the middle of the night. I still have aches now and then, it kind of makes it difficult for me to go up and down stairs or to ride a bike as much as I used to." (T.40). Petitioner testified that before the accident, he would ride his bike recreationally. He now also had difficulty walking, balancing, and using stairs. (T.41-43).

33) Petitioner confirmed that the total knee replacement surgery helped relieve the initial pain he was experiencing in 2015. (T.41). His current pain level fluctuated between three and ten. (T.41-42). He experienced left knee pain every other day or so. (T.45-46).

34) Petitioner retired from working for Respondent in December 2018. (T.45; RX5).

> I was still off of Workmen's Comp and I was still – I had the time so I decided why should I – it doesn't look like I'm going to be back 100 percent, so if you're not 100 percent you can't be a highway maintainer and there is no if and/or buts about that. (T.45).

During cross-examination, Petitioner clarified that his actual last date working for Respondent was November 30, 2018. (T.56; RX5).

35) The last medical record was dated July 24, 2019 from Midwest Orthopaedics at Rush. Dr. Sporer evaluated Petitioner and noted that Petitioner had no complaints of pain and no functional limitations. Petitioner had been experiencing bilateral knee pain a few months prior, but was given new orthotics and was feeling much better. Dr. Sporer recommended that Petitioner return in five years or sooner, if needed. (RX7).

36) Respondent's Exhibit 4 is a screen printout of the IWCC's website indicating that Petitioner had a prior settlement of 3% loss of use (LOU) of the left leg and 7.5% LOU of the left foot. The settlement contract was approved in June 2009. (RX4).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A.O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972). The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

The Arbitrator found that Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment by Respondent. The Arbitrator also found that Petitioner failed to prove that his current condition of ill-being with respect to his left knee was causally related to the September 22, 2015 work injury. The Arbitrator denied all benefits.

The Commission hereby reverses the Arbitrator's findings of no accident and no causal connection. Petitioner testified that during his work shift on September 22, 2015, he had been

walking along the roadway in an area of uncut, tall grass. There was no evidence to rebut or dispute Petitioner's testimony that he was at work on September 22, 2015 working with a crew near a roadway cutting and trimming tall grass. Petitioner testified that there had been a depression, he stepped into a sinkhole, and twisted his knee and fell. The various injury/accident reports and the medical records in evidence specified the September 22, 2015 date of accident and that Petitioner was at work when he injured his left knee. Whether the testimony, reports and records indicated that Petitioner fell due to a depression, a sinkhole, a rut, rock or hole, the preponderance of the evidence demonstrated that Petitioner encountered something in the area where he and his crew were working that caused him to injure his left knee. Petitioner explained that a sinkhole and a rut meant the same thing to him. The Commission finds sufficient evidence that Petitioner was at work performing his job duties when he sustained an injury to this left knee.

With respect to causal connection, the Commission notes that Petitioner was 68 years old on September 22, 2015. Petitioner described his job duties as heavy duty and physical, but he testified that he was capable of carrying out his work for Respondent prior to September 22, 2015. Petitioner was also asymptomatic and not receiving any active medical treatment for his left knee.

Following the September 22, 2015 work injury, Petitioner sought immediate treatment for his left knee and was either taken off work or given work restrictions. The medical records indicated that Petitioner complained of pain in his left knee, it was swollen, and McMurray's test was positive for a meniscal tear. Petitioner was prescribed medication; x-rays and an MRI were ordered; he was provided with a knee immobilizer, crutches, and a medial unloader brace; Petitioner underwent an injection, physical therapy and a left total knee replacement.

The Arbitrator had stated in his Decision that Petitioner testified that he never had problems with his left knee prior to the date of accident, but that "evidence submitted at trial proves that Petitioner had been suffering from left knee pain for many years leading up to the date of accident"; the Arbitrator had relied on Dr. Sporer's statement. Notwithstanding, Dr. Sporer was the only physician who indicated any pre-existing pain in Petitioner's left knee, but he still concluded, "However, he had recent trauma in fall of last year [2015] that caused him to become acutely worse." (T.33; PX3, Vol. I). The Arbitrator also stated that Petitioner had end-stage bilateral arthritis as of the accident date of September 22, 2015, and that Petitioner's condition already warranted a left total knee replacement. The Commission finds no evidence indicating any such recommendation prior to September 22, 2015.

The Commission instead finds that despite any pre-existing degenerative findings in Petitioner's left knee, the chain of events support Petitioner's position and supports that the mechanism of injury, the twisting and falling that was noted by nearly every medical provider, including the Section 12 examiner, Dr. Miller, was a cause in Petitioner's deteriorating left knee condition. Further,

> [I]f a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the

> previous condition had been. *Schroeder v. Ill. Workers' Comp. Comm'n*, 2017 IL App (4th) 160192WC, ¶ 26.

Dr. Blomgren diagnosed Petitioner with a medial meniscal tear of the left knee. Dr. Blomgren stated in the office visit note, "Despite the degenerative quality in appearance of it on the MRI, the patient sustained this in the work-related event. He had noted no prior injury, treatment or trauma . . ." (PX3, Vol. II). Dr. Blomgren referred Petitioner to Dr. Bush-Joseph who also diagnosed Petitioner with a medial meniscal tear. Dr. Bush-Joseph opined that Petitioner "does have extrusion of the medial meniscus, which is likely related to the injury." Dr. Bush-Joseph further opined that, "the injury that he had likely exacerbated his pre-existing arthritis with the addition of the meniscus tear." (PX3, Vol. II). Dr. Bush-Joseph additionally indicated that Petitioner had no pre-existing complaints related to the left knee. Again, Dr. Sporer examined Petitioner and diagnosed him with bilateral knee osteoarthritis and recommended left total knee arthroplasty surgery. Dr. Sporer opined, "[t]he pain has been progressive over the last many years. However, he had recent trauma in the fall of last year that caused him to become acutely worse." (PX3, Vol. II).

The Commission additionally addresses Petitioner's alleged non-compliance with completing paperwork for his Section 12 examination with Dr. Miller. Petitioner argued in his Brief that the paperwork was required by a treating physician and not a Section 12 medical examiner. (Petitioner's Brief, pgs. 15-16). Petitioner relied on the Commission case of *Rokocz v. Simplex Grinnell/LP Tyco*, 2006 Ill. Wrk. Comp. LEXIS 1235 *, 6 IWCC 1093, in support of his position that Section 12 of the Act provided that Petitioner shall "submit himself, at the expense of the employer, for examination." Section 12 of the Act also states that: "If the employee refuses so to submit himself to examination or unnecessarily obstructs the same, his right to compensation payments shall be temporarily suspended until such examination shall have taken place, and no compensation shall be payable under this Act for such period." *820 ILCS 305/12*. *Rokocz* discussed the claimant's entitlement to TTD benefits after the claimant used profanity in the Section 12 examiner's office and refused to complete the pre-examination questionnaire. The Section 12 examiner proceeded to examine the claimant despite the claimant's behavior. The Arbitrator in *Rokocz* found that the claimant did not obstruct the examination and had made himself available for examination. The Arbitrator awarded TTD. *Rokocz v. Simplex Grinnell/LP Tyco*, 2006 Ill. Wrk. Comp. LEXIS 1235 *19.

In the case at bar, Petitioner's refusal to complete paperwork at the Section 12 examination does not preclude a finding of causal connection and in turn an award of benefits. The Petitioner in this case did avail himself to Dr. Miller for a physical examination. The Commission finds that Dr. Miller could have easily interviewed Petitioner and asked the very same questions with respect to permission to evaluate him, Petitioner's medical history, his injuries, functional components and current complaints. Notwithstanding, Dr. Miller provided his opinions based on a records review and testified at his evidence deposition within a reasonable degree of medical and scientific certainty as a board-certified orthopedic surgeon. The Arbitrator in fact found Dr. Miller's opinions persuasive. The Commission finds no merit to this argument as raised by the parties.

With that said, the Commission finds the medical evidence submitted by Petitioner more persuasive than Respondent's evidence, including Dr. Miller's testimony. Dr. Miller had no

evidence that Petitioner had any prior left knee treatment, injury or pain. Dr. Miller also admitted that he had no prior medical records documenting Petitioner's pre-existing left knee condition. Further, Dr. Miller acknowledged that a twisting injury was a competent cause of a meniscus tear. Dr. Miller testified that the twisting injury may have aggravated Petitioner's left knee symptoms. "All I can say is that the twisting injury is going to cause pain in an arthritic knee." (RX10, pg. 64; 68).

The preponderance of the evidence demonstrated that despite any pre-existing left knee issues, Petitioner was asymptomatic. The chain of events following the September 22, 2015 twist and fall at work supports Petitioner's position. The medical evidence demonstrated that the mechanism of injury was a competent cause for Petitioner's symptoms, complaints, deteriorating condition, and eventual need for the left knee replacement. The Commission finds that Petitioner's left knee condition is causally related to the September 22, 2015 work accident.

Having found that Petitioner sustained a work-related accident and that his current condition of ill-being is causally related to the September 22, 2015 work injury, the Commission awards the following worker's compensation benefits. Neither Petitioner nor Respondent addressed these issues specifically or in detail in their Briefs; their Briefs focused on the issues of accident and causal connection.

The Commission awards the reasonable and necessary medical bills related to the left knee, and as evidenced in PX1 through PX4 and PX7 through PX12. Notwithstanding causation, Dr. Miller found Petitioner's treatment to be reasonable and necessary. The Arbitrator had awarded Respondent a credit of $1,785.14 for medical bills previously paid even though the Arbitrator found no accident or causal connection. The Commission finds that that amount does not correspond with Respondent's ledger in its Exhibit 2. As the Commission finds in favor of Petitioner, the Commission further finds that Respondent is entitled to a credit totaling $1,381.05, and based on the following:

-$75.86 for payment to Midwest Orthopaedics at Rush (10/8/2015)
-$21.89 for payment towards prescription medication (10/12/2015)
-$425.98 for payment to ATI Physical Therapy (4/22/2016)
-$48.75 for payment to Total Home Health (9/22/2015)
-$808.57 for payment to Adventist La Grange Hospital (9/22/2015)

The Commission further awards TTD benefits from September 23, 2015 through June 1, 2016 or 36 1/7 weeks. The evidence demonstrated that Petitioner was either taken off work by his treating physicians or was given work restrictions during this period. There is no evidence that Respondent offered to accommodate Petitioner's restrictions, and by the Request for Hearing, Respondent disputed liability for TTD based on no compensable accident.

The Commission next awards PPD benefits of 45% LOU of the left leg pursuant to Section 8(e) of the Act, less credit for the previous award of 3% LOU of the left leg (RX4). The Commission has considered the five factors under Section 8.1b of the Act:

(i) Impairment Rating: The parties did not offer any impairment rating into evidence. The Commission gives this factor no weight.

(ii) Occupation of Injured Employee: Petitioner retired on November 30, 2018. The panel gives this factor minimal weight.

(iii) Petitioner's Age: Petitioner was 68 years old on the accident date; neither party submitted evidence into the record which would indicate the impact of Petitioner's age on any permanent disability resulting from the September 22, 2015 accident. Nonetheless, the panel Commission finds that Petitioner must still live with his disability and gives this factor minimal weight.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: Evidence of Petitioner's disability is corroborated by the treating medical records. Following the twist and fall injury to his left knee at work on September 22, 2015, Petitioner was prescribed medication; x-rays and an MRI were ordered; he was provided with a knee immobilizer, crutches, and a medial unloader brace; Petitioner underwent an injection, physical therapy and a left total knee replacement. Petitioner confirmed that the total knee replacement surgery helped relieve the initial pain he was experiencing in 2015. His current pain level fluctuated between three and ten and he experienced left knee pain every other day or so. "I have pain that wakes me up in the middle of the night. I still have aches now and then, it kind of makes it difficult for me to go up and down stairs or to ride a bike as much as I used to." (T.40). Petitioner testified that before the accident, he would ride his bike recreationally. He now also had difficulty walking, balancing, and using stairs.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission awards Petitioner 45% LOU of the left leg pursuant to Section 8(e) of the Act, less credit for the previous award of 3% LOU of the left leg (RX4).

Finally, the Commission finds no basis or documentation evidence to support an award of penalties and attorney's fees. The parties made no arguments relative to this issue in their Briefs. The Commission further finds that reasonable grounds existed for challenging liability. The parties' evidence and their physicians presented conflicting positions with respect to accident and causal connection. The Commission therefore denies Petitioner's request for Section 19(k) and 19(l) penalties as well as Section 16 attorney's fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on December 7, 2020, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills as evidenced in PX1 through PX4 and PX7 through PX12 pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $1,381.05 for medical bills previously paid and as evidenced in RX2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit pursuant to Section 8(j) of the Act for those bills paid by its group medical plan. Respondent shall hold Petitioner harmless for any claims for reimbursement from any health insurance provider.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $944.64 per week for 36 1/7 weeks, from September 23, 2015 through June 1, 2016, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week for 96.75 weeks because the injuries sustained caused forty-five percent (45%) loss of use of the left leg, as provided in Section 8(e) of the Act. Respondent is entitled to a credit for the previous award of three-percent (3%) loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for Section 19(k) and 19(l) penalties as well as Section 16 attorney's fees is hereby denied.

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

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

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.

September 21, 2021

Christopher A. Harris
Christopher A. Harris

CAH/pm
O: 9/16/2021
052

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0479

BERG, BRUCE
Employee/Petitioner

Case# **15WC034636**

IL DEPT OF TRANSPORTATION
Employer/Respondent

On 12/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% 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:

1876 CZAPLA LAW
EDWARD ADAM CZAPLA
1834 WALDEN OFFICE SQ STE 500
SCHAUMBURG, IL 60173

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 BUREAU OF RISK MANAGEMENT
801 S 7TH ST
6TH FL
SPRINGFIELD, IL 62794

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

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

DEC -7 2020

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bruce Berg
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 15 WC 34636

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **October 26, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **September 22, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**73,682.03**; the average weekly wage was $**1,416.96**

On the date of accident, Petitioner was **6** 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 $**79.85** for other benefits, for a total credit of $**79.85.**

ORDER

- The Petitioner failed to meet the threshold burden of establishing his injury arose out of his employment. Therefore all benefits are denied.
- The Petitioner failed to meet the threshold burden of establishing his current condition of ill-being is causally-related to the work accident. Therefore all benefits are denied.

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

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

David A. Kane
Signature of Arbitrator

D?ecember 1, 2020
Date

DEC 7 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Bruce Berg	)	
	)	
Employee/Petitioner	)	
v.	)	
	)	Case No. 15 WC 34636
State of Illinois, Illinois Department of Transportation	)	
	)	
	)	**Chicago, IL**
Employer/Respondent	)	

Findings of Facts and Conclusions of Law

I. FINDINGS OF FACT

Petitioner pursued this action under the Workers' Compensation Act and sought relief from the Respondent-Employer Illinois Department of Transportation (hereinafter "IDOT"). On October 26, 2020, the parties appeared at a hearing before Arbitrator David Kane. Edward Czapla of Czapla Law appeared on behalf of Petitioner. Assistant Attorney General Danielle Curtiss of the Illinois Attorney General's Office appeared on behalf of Respondent. At hearing, Petitioner's Exhibits 1-9, and Respondent's Exhibits 1-13 were admitted into evidence. Respondent objected to Petitioner's Exhibits 7, 9, and 10 on the basis that they lacked CPT codes for purposes of payment pursuant to the applicable fee schedule. The Arbitrator admitted these exhibits over Respondent's objection. The issues at hearing were accident, causation, average weekly wage, unpaid

medical, outstanding temporary total disability benefits, nature and extent, and penalties and fees. After hearing the proofs and reviewing the evidence presented, the Arbitrator makes the following findings on the disputed issues.

Testimony of Petitioner

Petitioner testified that he began employment with IDOT in October 2002, when he was hired as a highway maintainer. In this role, he was responsible for the maintenance, repair, and upkeep of roads, bridges, and other related structures and features in Illinois. (Petitioner's Exhibit "PX" 15). Maintenance of the roadway included plowing snow, repairing the roadway with the use of jack hammers and other equipment, and clearing the roadway of trash and other debris when necessary.

Petitioner testified that on September 22, 2015, he was working at the 31st Street Eastbound exit of the 290 Expressway. He was walking on an area of the median that contained uncut tall grass, and he twisted his knee when stepping into a sinkhole. Petitioner fell in the grass on the median, and experienced pain in his right lower back around the buttocks, which radiated down to his right leg. (RX 1). Petitioner testified that prior to this alleged accident, he did not have knee pain.

Petitioner sought treatment on the date of the alleged accident at Lagrange Memorial Hospital. (PX 1). He underwent a left knee total arthroscopy, followed by physical therapy. (PX 2; PX 3; PX 4). Petitioner was off work following the accident. He retired from IDOT on November 30, 2018. (RX 5).

Petitioner testified that he still experiences pain and swelling in his left knee while running or walking. He experiences pain while golfing and biking. He experiences pain while climbing the 28 steps into his home. He

admitted on cross examination that he uses both legs to partake in all of the above activities, and his right leg also experiences pain. Petitioner testified that he is only claiming a work-related injury for his left knee.

Regarding average weekly wage, Petitioner testified that overtime at IDOT is not mandatory during the spring or summer months. However, overtime is mandatory during the fall and winter months. All employees are required to complete overtime from the last Sunday in October through the third Sunday in April. If an employee does not complete the overtime, they would be written up. Petitioner testified on cross examination that he never refused overtime during this time period. He admitted that he was unsure as to whether there was a progressive write-up policy if overtime was refused or missed.

Testimony of Dan Scandiff

Dan Scandiff ("Scandiff") testified that he is employed as an Operations Manager at IDOT. In this role, he is responsible for supervising Operations Supervisors and Highway Maintainers, which includes overseeing overtime. Scandiff testified that overtime at IDOT is defined as hours worked outside of an employees' scheduled hours. Highway maintainers work from 6:30 a.m. to 3:00 p.m.

Scandiff testified that there are two different types of overtime at IDOT: summer and winter. Winter overtime is given between the last Sunday in October through the third Sunday in April. Summer overtime is the overtime during the remainder of the year.

During summer overtime, an employee can decide whether they want to work. If they refuse the overtime, they are assigned equalization hours. Equalization hours are defined as the actual hours the employee missed working multiplied by the appropriate overtime factor (RX 13). Scandiff

testified that equalization hours effectively push an employee's name lower down on the list of potential employees to call when offering overtime. Employees are not written up and can freely refuse overtime during the summer months.

During winter overtime, when a snow or ice event occurs which requires the roads to be plowed, all IDOT highway maintainers are called in to work overtime. If an employee has a pre-scheduled event that they know will potentially occur during a snow or ice event, they can request advance approval to pass on overtime. (RX 11, RX 12). If an employee obtains advance approval to pass, they will not be written up for refusing overtime.

If an employee refuses winter overtime without prior approval, they will be written up by a supervisor. The write-up procedure is graduated. After being written up once, the second refusal results in a 1-day suspension. The third refusal results in a 3-day suspension. A fourth winter overtime refusal results in a 5-day suspension. A fifth winter overtime refusal results in a 10-day suspension. If an employee refuses winter overtime for the sixth time, this results in a 15-day suspension. Finally, only after refusing overtime seven times does an employee face a 30-day suspension pending release. Scandiff testified that even after an employee has refused seven winter overtimes, the union would still hold a hearing to determine whether dismissal is appropriate.

Notice of Injury

Petitioner completed a notice of injury on September 22, 2015. (RX 1). On the notice of injury, he reported that he was "walking on shoulder of road, supervising other highway maintainers in an area where there were holes ruts, and water/mud plus a large log sticking out of ground. I stepped

into a rut covered by grass and twisted and jerked my left knee. I also have pain in my right lower back around my butt, and down my right leg." *Id.*

Summary of Petitioner's Medical Treatment

Petitioner presented to Lagrange Memorial Hospital on September 22, 2015 with left knee pain and complained that he fell and twisted his knee. (PX 1). *Id.* He underwent an x-ray which revealed mild degenerative changes with medial joint line narrowing and spurring of the patella. *Id.* He was discharged with a diagnosis of left knee sprain. *Id.*

Petitioner saw Dr. Blomgren on October 2, 2015 at Midwest Orthopedics. (PX 2). He reported that he stepped on a rock covered by grass and twisted and fell on his left knee. *Id.* He underwent an MRI of the left knee at Midwest Orthopedic on October 2, 2015, which revealed degenerative complex tear in the posterior horn, extending to the body of the medial meniscus. There was a small meniscal fragment is seen in the medial joint gutter. *Id.* Moderate to severe cartilaginous loss with ostephytosis in the patellofemoral compartment and medial compartment existed. *Id.* Mild cartilaginous loss and fissuring over the lateral compartment was present. *Id.*

Petitioner followed up with Dr. Blomgren on October 8, 2015 to discuss the MRI results. *Id.* Dr. Blomgren noted that there was a tear of the posterior medial meniscus which was degenerative in nature along with the extrusion of the meniscus. *Id.*

On November 3, 2015, Petitioner followed up at Midwest Orthopedics, and continued to complain of pain. (PX 3). Petitioner underwent an injection and physical therapy was ordered. *Id.* Dr. Bush-

Joseph opined that it was difficult to determine if the meniscus was causing Petitioner's symptoms. *Id.*

Petitioner followed up with Midwest Orthopedic on November 17, 2015. *Id.* He underwent another injection. *Id.* Petitioner was diagnosed with a degenerative medial meniscus tear with extrusion of the left knee, tri-compartmental arthritis of bilateral knees, and improving post-traumatic stiffness. Dr. Bush-Joseph opined that the injury likely exacerbated Petitioner's pre-existing arthritis with the addition of the meniscus tear. *Id.*

After failing conservative treatment, Petitioner was referred to Dr. Sporer at Midwest Orthopedic for a total knee replacement consultation on February 17, 2016. *Id.* Dr. Sporer noted that Petitioner has had progressive pain over many years, but he had recent trauma last year that caused the pain to become acutely worse. *Id.*

On March 17, 2016, Petitioner underwent a left total knee arthroscopy with Dr. Sporer. *Id.* On this date, he also complained of low back pain. *Id.* Following surgery, Petitioner underwent physical therapy at ATI from April 1, 2016 through May 26, 2016. (PX 4).

On April 29, 2016, Petitioner followed up with Dr. Sporer after the left total knee arthroscopy. (PX 3). Petitioner also scheduled a right knee replacement on this date. *Id.* Petitioner was last seen for left knee complaints on May 25, 2016. *Id.*

Following treatment on the left knee, Petitioner sought extensive treatment on the right knee and back. Petitioner has not submitted any medical records past May 26, 2016 reflecting treatment on the left knee. The Arbitrator notes that Petitioner testified that he is claiming a work-related injury for neither his right knee nor his back.

On April 3, 2018, Petitioner saw Dr. Lopez at Midwest Orthopedic, complaining of right lower extremity pain. Dr. Lopez noted that Petitioner traveled to Rome two weeks ago, and he walked seven or eight miles per day with no significant exacerbation or pain to his right ankle. *Id.* There is no mention of any pain or swelling to the left knee.

Summary of Examination with Dr. Miller

Petitioner was scheduled for two Independent Medical Examinations ("IMEs") with Dr. Klaud Miller, on April 1, 2020 and June 17, 2020. (RX 9). *Id.* The deposition of Dr. Miller was taken by the parties on August 10, 2020. Dr. Miller requires that all individuals he examines complete paperwork prior to an IME. *Id.* Petitioner refused to complete this paperwork. (RX 9, Respondent's Deposition Exhibit 3). Dr. Miller testified that this paperwork needs to be completed for safety reasons, to determine where an individual is experiencing pain and provides consent for Dr. Miller to examine the individual. *Id.*

As Petitioner refused to complete the paperwork, Dr. Miller was unable to examine him. *Id.* Dr. Miller therefore completed an IME report on June 18, 2020 which did not include a physical examination of Petitioner. *Id.*

Following a review of Petitioner's medical records, Dr. Miller diagnosed Petitioner's left knee with persistent pain status post bilateral total knees and a lumbosacral spine fusion. (RX 10). He opined that Petitioner suffered from pre-existing bilateral knee arthritis, lumbosacral spine stenosis and degenerative disc disease. Dr. Miller noted that Dr. Sporoer had confirmed that Petitioner's knees were symptomatic prior to the accident in question. *Id.*

Dr. Miller further opined that the current condition of Petitioner's bilateral knees was not causally related to the accident in question following a review of the October 2, 2015 MRI. *Id.* Dr. Miller noted at the deposition that Petitioner's arthritis was noted in the emergency room on the date of the alleged accident. (RX 9). He further explained that all of the orthopedic surgeons, within a couple of months of the date of injury, documented that Petitioner had end-stage arthritis, and they recommended a total knee replacement. *Id.* Dr. Miller stated that an individual cannot develop arthritis in eight weeks. *Id.*

II. CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

The Arbitrator finds that no accident occurred that arose out of and in the course of Petitioner's employment because Petitioner failed to present credible evidence of an accident.

To establish that Petitioner's injury arose out of and in the course of his employment, Petitioner bears the burden of proving by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. *Metro. Water Reclamation Dist. of Greater Chicago v. Illinois Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011). To satisfy that burden the Petitioner must show that the cause of the injury is a risk that is "connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* The Court recognizes three

types of risks. First, risks that are distinctly associated with the employment; second, risks that are personal to the employee; and third, neutral risks that do not have any particular employment or personal characteristics. *Id.* For an injury resulting from a neutral risk to be compensable a petitioner must show that they were "exposed to the risk to a greater degree than the general public ... Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Id.* An injury resulting from a neutral risk to which the general public is equally exposed does not arise out of Petitioner's employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 59 (1989).

The Courts have addressed the increased quantitative risks faced by traveling employees. An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable. *Kertis v. Illinois Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, ¶ 16. Conduct is reasonable and foreseeable by the employer when it might normally be anticipated or foreseen by the employer. *Id. U.S. Indus., Prod. Mach. Div. v. Indus. Comm'n*, 40 Ill. 2d 469, 474 (1968).

Petitioner attempted to prove that an accident occurred through his testimony and other evidence presented, but his testimony the other evidence. Petitioner testified that he was walking on an area of the median that contained uncut tall grass, and he twisted his knee when stepping into a sinkhole. (RX 1). However, on September 22, 2015, Petitioner's Notice of Injury does not mention a sinkhole. (RX 1). Rather, Petitioner reported that

he stepped into a rut covered by grass and twisted and jerked his left knee. *Id.*

Further, on October 2, 2015, Petitioner saw Dr. Blomgren for the first time after the accident. On this date, Petitioner reported that he stepped on a rock covered by grass and twisted and fell on his left knee. (RX 7).

Therefore, Petitioner has clearly told at least three different versions of how the accident occurred. Petitioner did not submit photos or other evidence of the grass, the hole, or the rock. No testimony was presented as to the size of the rut or sinkhole or any other condition that allegedly existed in the grass or roadway. Medical records clearly indicate that Petitioner had end-stage bilateral arthritis on the date of accident, which already warranted a left total knee replacement within six weeks of the accident.

This Arbitrator finds that Petitioner has presented no credible evidence that an accident occurred, let alone that one occurred which arose out of an in the course of his employment for Respondent and Petitioner is not entitled to compensation.

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

The Arbitrator finds Petitioner failed to meet his threshold burden of showing his injury arose out of his employment and therefore need not address causal connection.

Additionally, even if the Arbitrator found that Petitioner's injury arose out of his employment, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the September 22, 2015 accident because Petitioner was suffering from end-stage bilateral knee arthritis on the date of accident.

Petitioner presented inconsistent evidence of pre-existing knee pain. He testified at trial that he never had problems with his left knee prior to the date of accident. However, the evidence submitted at trial proves that Petitioner had been suffering from left knee pain for many years leading up to the date of accident. As Petitioner's testimony is inconsistent with the medical records he submitted at trial, it is not credible and therefore not given any weight.

Petitioner underwent an MRI ten days after the accident, on October 2, 2015. (PX 2). The MRI revealed a degenerative complex tear in the posterior horn, extending to the body of the medial meniscus. (PX 2) There was a small meniscal fragment is seen in the medial joint gutter. *Id.* Moderate to severe cartilaginous loss with ostephytosis in the patellofemoral compartment and medial compartment existed. *Id.* Mild cartilaginous loss and fissuring over the lateral compartment was present. *Id.* Dr. Blomgren noted that the tear of the posterior medial meniscus was degenerative in nature along with the extrusion of the meniscus. *Id.*

Petitioner next saw Dr. Bush-Joseph on November 3, 2015, who opined that it was difficult to determine if the meniscus was causing Petitioner's symptoms. *Id.* Petitioner once again saw Dr. Bush-Joseph on November 17, 2015. *Id.* Dr. Bush-Joseph opined that the injury likely exacerbated Petitioner's pre-existing arthritis with the addition of the meniscus tear. *Id.*

Most notably, on February 17, 2017, Petitioner saw Dr. Sporer on who noted that Petitioner had progressive left knee pain for many years. (PX 2).

Clearly, Petitioner's fall did not cause his degenerative, pre-existing condition. The Arbitrator finds Dr. Miller's IME assists in providing a full

picture of Petitioner's condition. It should be noted that Petitioner refused to complete the necessary paperwork to undergo a physical examination with Dr. Klaud Miller on June 17, 2020. (RX 9). Dr. Miller was therefore forced to complete a record review without a complete physical examination. (RX 10). The Petitioner's lack of willingness to provide Dr. Miller, and in turn this Arbitrator, with a complete history of his knee pain in order to complete the IME would suggest that Petitioner is not credible.

Despite the lack of a physical examination, Dr. Miller was confident in his opinion that Petitioner's left knee condition was not causally related to any work accident. Dr. Miller diagnosed Petitioner's left knee with persistent pain status post bilateral total knees and a lumbosacral spine fusion. (RX 10). He opined that Petitioner suffered from a pre-existing injury of bilateral knee arthritis, lumbosacral spine stenosis and degenerative disc disease. Dr. Miller noted that Dr. Sporer had confirmed that Petitioner's knees were symptomatic prior to the accident in question. *Id.*

Dr. Miller further opined that the current condition of Petitioner's bilateral knees was not causally related to the accident in question following a review of the October 2, 2015 MRI. *Id.* Dr. Miller noted at the deposition that Petitioner's arthritis was noted in the emergency room on the date of the alleged accident. (RX 9). He further explained that all of the orthopedic surgeons, within a couple of months of the date of injury, documented that Petitioner had end-stage arthritis, and they recommended a total knee replacement. *Id.* Dr. Miller stated that an individual cannot develop arthritis in eight weeks. *Id.*

Based upon the testimony and evidence presented by Petitioner, as well as Dr. Miller's IME, the Arbitrator finds that the Petitioner has not established by a preponderance of the evidence that the condition of ill

being as described above is causally related to the accidental injury sustained on September 22, 2015. All compensation is therefore denied.

N. Is Respondent due any credit?

Respondent submitted a payment ledger, which indicates that a total of $1,785.14 was paid in medical bills. (RX 2). Respondent paid $79.86 to Midwest Orthopedics at Rush on January 29, 2016. *Id.* Total Home Health was paid $48.75 on June 19, 2017. *Id.* Adventist Lagrange Hospital was paid $808.57 on January 29, 2016. Athletic & Therapeutic Institute was paid $425.98 on June 23, 2016. The Arbitrator finds that Respondent is entitled to a credit for $1,785.14.

Based upon the foregoing, all other issues are rendered moot. Compensation is hereby denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC002924
Case Name	ROSENDO, CLAUDIO v. JD NEW CON & REMODELING
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0480
Number of Pages of Decision	20
Decision Issued By	Marc Parker, Commissioner, Christopher Harris, Commissioner

Petitioner Attorney	John Castaneda
Respondent Attorney	Dan Kallio

DATE FILED: 9/22/2021

/s/Marc Parker, Commissioner
Signature

DISSENT

/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

Claudio Rosendo,

Petitioner,

vs. No. 18 WC 2924

JJD New Construction & Remodeling LLC,
and the Illinois State Treasurer as Custodian
of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein, Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund, and notice given to all parties, the Commission, after considering the issues of benefit rates, wage calculation, causal connection, 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 March 5, 2020, is hereby affirmed and adopted.

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

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

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

September 22, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-08/05/21
068

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

DISSENT

I respectfully dissent as I find the award of permanent partial disability (PPD) benefits to be excessive. While the Commission has broad discretion to award a percentage loss of the foot or leg for ankle injuries and hand or arm for wrist injuries, historically, as discussed below, an injury is given one award to a specific body part unless there are distinct injuries or evidence of disability that would merit an award for both the foot and leg or hand and arm.

The Petitioner herein sustained two primary injuries as a result of the December 18, 2017 work accident: a closed, left comminuted, intra-articular distal radius fracture and a closed pilon fracture of the left ankle. For the pilon fracture, Petitioner first underwent external fixation on December 19, 2017 to address the significant swelling and blisters in his left lower extremity. The operative report stated that the procedure would allow the soft tissues to calm down before proceeding with the definitive treatment. This treatment involved an open reduction internal fixation (ORIF) of the left intra-articular distal tibia for the pilon facture, which was completed on December 27, 2017. Petitioner's left distal radius fracture was treated by way of an ORIF with iliac crest bone grafting performed on January 16, 2018. (PX1; PX2).

With respect to the permanent effects of his injuries, Petitioner testified that his leg swells and he has pain every day. (T.25). Petitioner also testified that he no longer played soccer with his son due to his left ankle and foot condition. (T.25-26). As to his left arm and left hand, Petitioner simply testified that he could not move it well. (T.26). Petitioner confirmed that he is right-hand dominant. (T.26). Petitioner continued to take Advil and Tylenol but did not wear any kind of brace or support for any of the body parts. (T.25-26).

The Arbitrator's award of 20% loss of use (LOU) of the left foot, 30% LOU of the left leg, 35% LOU of the left arm and 25% LOU of the left hand appears to award at or near full value for a closed pilon fracture of the left ankle and closed, left-comminuted, intra-articular distal radius

fracture. This award to both sets of body parts for injuries principally to the wrist and ankle is excessive. I instead find that an award of 35% LOU of the left hand and 45% LOU of the left foot conforms with the evidence and testimony in the record and aligns doctrinally with the case law relative to such injuries.

The parties cite several Commission decisions in support of their respective positions. Petitioner argued that the Arbitrator's PPD award should be affirmed, but additionally cited to cases with the award being placed on the arm for the distal radius injury and the leg for the pilon fracture. See *Dolan v. Ameritech SBC*, 2007 Ill. Wrk. Comp. LEXIS 26, 7 IWCC 0097 (the Commission awarded 50% LOU of the left leg and 45% LOU of the left foot for an open comminuted tibial Plafond fracture (pilon fracture) along with a fracture of the distal tibia of the left ankle); *Sebens v. Dewey, Combined Schilli Co.*, 2008 Ill. Wrk. Comp. LEXIS 359, 8 IWCC 337 (the Commission affirmed and adopted the Arbitrator's award of 40% LOU of the right arm for a distal radius fracture); *Wallace v. National Maintenance & Repair*, 2011 Ill. Wrk. Comp. LEXIS 126, 11 IWCC 0112 (the Commission affirmed and adopted the Arbitrator's PPD award of 35% LOU of the left arm for a comminuted distal left radius fracture and a left ulnar styloid fracture. The claimant underwent an ORIF for the left distal radius fracture).

It is notable that in both *Sebens* and *Wallace*, the Commission's awards were not applied to both the arm and the hand. Whereas, in *Dolan*, the PPD award comprised the loss of use of the leg and foot. In *Dolan*, there were complications with the ORIF surgery related to the claimant's pilon fracture which led to further injury, additional surgeries, and debilitating damage from his calf to his toes – this is in excess of the Petitioner here. *Dolan v. Ameritech SBC*, 2007 Ill. Wrk. Comp. LEXIS 26 *5-7.

I believe that the Respondent was correct in asserting that the Arbitrator erred in making an award for the left arm in addition to the left hand, as well as making an award for the left leg in addition to the left foot. See *Ortega v. Fresh Express, Inc*., 2010 Ill. Wrk. Comp. Lexis 636 (the Commission affirmed the Arbitrator's award of 40% LOU of the left hand for a moderately comminuted fracture of her left distal radius which was intra-articular and somewhat displaced. The claimant underwent an ORIF); *Thomas v. SOI Department of Human Services*, 2016 Ill. Wrk. Comp. LEXIS 649, 16 IWCC 717 (the Commission affirmed the Arbitrator's award of 22.5% LOU of the right hand for a non-displaced fracture of the distal radius, an avulsion fracture of the dorsal pole of the triquetrum, and mild osteoarthritis of the 1st metacarpal joint. The distal radius fracture eventually necessitated a right carpal tunnel release); *Reiman v. St. Joseph Memorial Hospital*, 2019 Ill. Wrk. Comp. LEXIS 1314, 19 IWCC 0700 (the Commission affirmed the Arbitrator's award of 35% LOU of the right hand and 20% LOU of the left hand for bilateral wrist fractures. All of the claimant's complaints, findings, and treatment were related to the wrists); *Orozco v. Innophos, Inc.*, 2014 Ill. Wrk. Comp. LEXIS 188, 14 IWCC 216 (30% LOU of the right hand for a right distal radius fracture with a subsequent ORIF); *Garcia, et. al. v. Clarida d/b/a Northwest Design and Country Mutual Insurance Company*, 2017 Ill. Wrk. Comp. LEXIS 516, 17 IWCC 528 (30% LOU of the right foot for an oblique and displaced fracture of the distal tibia, an avulsion fracture of the distal fibula with displacement, and fractures of the metatarsals. The claimant

required an ORIF). Respondent's cases uniformly issue awards for similar injuries in this case to the hand or the foot – but similar to Petitioner's cited cases – not to both the arm and the hand, and the leg and the foot.

With regard to the pilon fracture, I believe that the present case is factually similar to the claimant in *DeLeon v. Kinnard Realty & Management LLC and the Illinois State Treasurer, as Ex Officio Custodian of the Illinois Injured Workers' Benefit Fund*, 2016 Ill. Wrk. Comp. LEXIS 529, 16 IWCC 825. In *DeLeon,* the claimant sustained an injury after a stove he was carrying with a co-worker fell on his right ankle. He reported complaints of severe right ankle and leg pain. *Id.* at 8. The claimant later underwent an application of a right ankle spanning external fixator. His post-operative diagnoses were right ankle pilon fracture with distal tibia and fibular fractures extending intra-articularly. *Id.* The claimant had another procedure, namely: (1) open treatment of the pilon fracture of the tibia only; (2) removal of the external fixation device of the right leg under general anesthesia; and (3) irrigation and debridement of a full-thickness fracture blister on the right leg. The pre-operative and post-operative diagnosis remained a right ankle pilon fracture. *Id.* at 10. The claimant in *DeLeon* testified that he returned to his regular duties for the Respondent. He continued to experience pain and swelling in his right foot and ankle, and he took ibuprofen and aspirin for the pain and swelling. The claimant could no longer jog or play soccer. *Id.* at 12. The Arbitrator awarded 45% LOU of the right foot, and the Commission affirmed and adopted the Arbitrator's Decision. *Id.* at 1.

While I do not dispute the factual underpinnings of the case before the Panel, and acknowledge the broad discretion afforded to the Commission in issuance of permanency awards, I nevertheless believe that the award affirmed by the Panel is excessive. I would therefore award 35% LOU of the left hand and 45% LOU of the left foot.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0480

ROSENDO, CLAUDIO
Employee/Petitioner

Case# **18WC002924**

JJD NEW CONSTRUCTION & REMODELING LLC AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 3/5/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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.

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CLAUDIO ROSENDO
Employee/Petitioner

v.

JJD NEW CONSTRUCTION & REMODELING, LLC and the ILLINOIS STATE TREASURER as custodian of the INJURED WORKERS' BENEFIT FUND.
Employer/Respondent

Case # **18 WC 002924**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **December 6, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 18, 2017**, Respondent-Employer **was** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's earned $42,432.00 and the average weekly wage was $ 816.00.

On the date of accident, Petitioner was **35** years of age, **married** with **4** dependent children.

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

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

Respondents shall not be given a credit.

Respondents are not entitled to a credit under Section 8(j) of the Act.

ORDER

TEMPORARY TOTAL DISABILITY

Respondent shall pay to Petitioner temporary total disability benefits of $544.00/week for 18.429 weeks, commencing from 12-19-17 through 04-26-18, as provided in Section 8(b) of the Act.

MEDICAL BENEFITS

Respondent shall pay to Petitioner reasonable and necessary medical services of $129,461.61 in accordance with Sections 8(a) and 8.2 of the Act.

PERMANENT PARTIAL DISABILITY

Respondent shall pay to Petitioner permanent partial disability benefits of $ 489.60/week for 33.4 weeks, because the injuries sustained caused 20% loss of the left foot, as provided in Section 8(e) of the Act.

Respondent shall pay to Petitioner permanent partial disability benefits of $ 489.60/week for 64.5 weeks, because the injuries sustained caused 30% loss of the left leg, as provided in Section 8(e) of the Act.

ORDER - CONTINUED

Respondent shall pay to Petitioner permanent partial disability benefits of $ 489.60/week for 88.55 weeks, because the injuries sustained caused 35% loss of the left arm, as provided in Section 8(e) of the Act.

Respondent shall pay to Petitioner permanent partial disability benefits of $ 489.60/week for 51.25 weeks, because the injuries sustained caused 25% loss of the left hand, as provided in Section 8(e) of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund ("IWBF") was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. The award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act, in the event of the failure of Respondent-Employer to pay benefits due and owing to the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

RULES REGARDING APPEALS

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

STATEMENT OF INTEREST RATE

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

Signature of Arbitrator

3.5.20
Date

MAR 5 - 2020

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Claudio Rosendo, Employee/Petitioner, v. JJD New Construction & Remodeling and State Treasurer & ex-officio custodian of Injured Workers' Benefit Fund Employer/Respondents.	Case# 18 WC 002924 Arbitrator: Kurt Carlson

ADDENDUM TO DECISION OF THE ARBITRATOR

All issues were in dispute. This claim involved an alleged uninsured respondent for which petitioner claimed to work as an employee at the time of the disputed accident. Neither respondent JJD New Construction & Remodeling, LLC's owner Mr. David Munoz Valente, nor counsel for that respondent appeared at the arbitration hearing. The Arbitrator heard arguments from co-respondent's counsel, the Illinois Attorney General's Office, on whether JJD New Construction & Remodeling and Mr. Valente had sufficient notice of the arbitration hearing scheduled for December 6, 2019. The Arbitrator reviewed documentation from petitioner's counsel including copies of letters sent regular and certified mail to Mr. Valente's registered agent address and respondent JJD New Construction & Remodeling's address on the Secretary of State's website advising both of the hearing scheduled for December 6, 2019 and that the matter would proceed even if they failed to appear. The Arbitrator finds that both respondent JJD New Construction & Remodeling and Mr. David Munoz Valente had sufficient notice to meet due process requirements.

FINDINGS OF FACT

Petitioner, Claudio Rosendo, was the sole witness and testified via a Spanish interpreter. Petitioner was born on October 16, 1982 and came in contact with the respondent, JJD New Construction & Remodeling via social media. Petitioner indicated he contacted the company and spoke to the owner, David Munoz Valente and scheduled an interview. Petitioner met Mr. Valente at a job site in Berwyn, Illinois. At this interview in June of 2016, Mr. Valente inquired of petitioner as to his experience in various aspects of construction. Mr. Valente advised petitioner he needed him to perform work such as installing drywall, working with plaster, and demolition work. Mr. Valente informed petitioner he would earn $15/hour but at the time of the alleged accident, petitioner was earning $17/hour. Mr. Valente also advised petitioner he would work Monday through Saturday working from approximately 8:00 a.m. to 5:30 p.m.

Petitioner indicated after that meeting he began to do work for Mr. Valente. Mr. Valente would send a text or call petitioner every day to inform him of where he had to be present, what time to be present, and what work had to be done. Petitioner submitted copies of the payments made to him by Mr. Valente. (PX5).

On December 18, 2017, Mr. Valente instructed petitioner to go to 2636 North Nordica in Chicago to do demolition work. Petitioner arrived at the location of this address at approximately 8:00 a.m. Petitioner's work duties that day required him to cut the roof to make a new addition. At approximately 11:45 a.m. his co-workers descended from the roof to begin their lunchtime. While petitioner descended the ladder from the roof the ladder toppled and petitioner fell from the second floor to the first floor. When petitioner fell to the floor he struck his left hand, left arm and left leg. Petitioner's co-employees attempted to help him up but he

couldn't get up. After one of the co-workers contacted Mr. Valente, the co-worker transported petitioner to Stroger Cook County Hospital. Petitioner claimed he was in the hospital for about a week. After petitioner was discharged from the hospital Mr. Valente contacted him by telephone. At that time petitioner explained to Mr. Valente how the accident occurred. Mr. Valente advised petitioner he would help him but he never did.

Petitioner treated at Stroger Cook County Hospital from December 18, 2017 through May 30, 2018. (PX1). Petitioner underwent three surgeries at Stroger Cook County Hospital including a left ankle external fixation for closed pilon fracture on December 19, 2017 (PX1: 243-244); open reduction internal fixation of a left intra-articular distal tibia fracture on December 27, 2017 (PX1: 245-247); and open reduction internal fixation of a left distal radius fracture with iliac crest auto graft on January 16, 2018. (PX1: 247-248). Petitioner also underwent physical therapy at Provident Hospital from January 26, 2018 through June 1, 2018. (PX2).

Petitioner returned to similar work of construction/remodeling by August of 2018 doing ceramics and earning approximately $800-$1000/week. Petitioner no longer works for the respondent. Petitioner takes Tylenol or Advil for pain in his left foot and ankle and left arm. Petitioner has difficulty doing his normal daily activities because of his left ankle and difficulty moving his left arm.

On cross-examination by counsel for the co-respondent, Injured Workers' Benefit Fund, petitioner discovered JJD New Construction & Remodeling, LLC on Facebook. Petitioner confirmed that he was doing demolition work during his injury and that his supervisor was Mr. David Munoz Valente. Petitioner confirmed there were other employees working for the

respondent JJD New Construction & Remodeling and petitioner received texts on where and when to work. Petitioner confirmed his work hours were 8:00 a.m. to 5:30 p.m.

On cross-examination petitioner indicated occasionally he would wear clothing such as t-shirts with the name of the respondent, JJD New Construction & Remodeling. Petitioner admitted that he had his own work pouch with a hammer and small tools but the power equipment and larger work tools were provided by Mr. David Munoz Valente. Petitioner indicated he would go to Mr. Valente's house to pick up the power equipment. Petitioner confirmed that Mr. David Munoz Valente would pay him in check or cash. Petitioner understood that Mr. Valente could terminate him at any time. Petitioner indicated that he could not work any other jobs for other people and that he did not have his own business.

On cross-examination petitioner indicated he received one day of training. Petitioner indicated this his co-workers saw him fall on the date of accident. Petitioner confirmed that he did return to work in June of 2018 but working for a restaurant delivering food.

The Arbitrator inquired of petitioner whether he still has Mr. David Munoz Valente's telephone number. Petitioner confirmed he did and gave the number as 1-708-953-9864. Petitioner did not know Mr. Valente's home address but knew he had 3 children and drove a black Jeep-Cherokee.

The respondent, JJD New Construction & Remodeling on the date of the alleged accident of December 18, 2017 did not have workers' compensation insurance. (PX4).

MEMORANDUM OF DECISION OF THE ARBITRATOR

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (A) WHETHER THE RESPONDENT WAS OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKER'S COMPENSATION ACT THE ARBITRATOR CONCLUDES AS FOLLOWS:

Petitioner, via a Spanish interpreter, stated in order to perform his work as a demolitionist, carpentry and other remodeling work he used power tools such as a table saw, skill saw and grinder. Pursuant to 820 ILCS 305/3: "(t)he provisions of this Act hereinafter following shall apply automatically . . . to all employers and all their employees, engaged in any department of the following enterprises. . . namely: (15.) (a)ny business or enterprise in which electric, gasoline or other power-driven equipment is used in the operation thereof." Based upon the unrebutted testimony of the petitioner, the Arbitrator finds and concludes that the respondent automatically was subject to and under the Illinois Workers' Compensation Act.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (B.) WHETHER THERE EXISTED AN EMPLOYER-EMPLOYEE RELATIONSHIP BETWEEN THE RESPONDENT AND THE PETITIONER THE ARBITRATOR CONCLUDES AS FOLLOWS:

Petitioner stated that he saw an advertisement for the respondent's company on social media in June of 2016. Petitioner made an appointment with the owner, David Munoz Valente for an interview. Petitioner went to one of the respondent's job sites in Berwyn for the interview. Mr. Valente asked petitioner his work experience. Mr. Valente indicated to petitioner he would hire petitioner to do remodeling work and start petitioner at $15/hour. Petitioner understood he would work Monday through Saturday from 8:00 a.m. to 5:30 p.m. Petitioner received pay from Mr. Valente by check or cash with no tax or other deductions. Petitioner indicated he would deposit the checks or cash in his personal back. (PX5).

Mr. Valente would text/call the petitioner each morning to advise petitioner where he had to appear for work. Petitioner would wear a tool pouch and bring small items such as a hammer and drill but the majority of the tools were provided by Mr. Valente including power tools such as a table saw, skill saw and grinder. Petitioner worked with other employees of the respondent and he would text the owner when he arrived at the job site. Occasionally petitioner wore clothing such as t-shirts with the company logo but not all the time. Petitioner understood that Mr. Valente could terminate him at any time and Petitioner could not work any other jobs. Based upon the unrebutted testimony of the petitioner the Arbitrator finds and concludes that the respondent and petitioner had an employer-employee relationship as defined by the Illinois Workers' Compensation Act.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (C.) WHETHER AN ACCIDENT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT AND (D.) THE DATE OF ACCIDENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

On December 18, 2017, Mr. Valente instructed petitioner to go to 2636 North Nordica in Chicago to do demolition work. Petitioner understood that he was working for respondent on that date and arrived at approximately 8:00 a.m. Petitioner had to cut the roof as part of the remodeling project that day. At approximately 11:45 a.m. it was nearing lunchtime so the employees descended from the roof. The petitioner descended from the roof on a ladder. When petitioner stepped onto the ladder to climb down the ladder fell over causing the petitioner to fall from the second floor to the first floor. Petitioner indicated that his co-workers saw him fall.

Petitioner tried to get up but had too much difficulty. One of the co-workers contacted the owner and afterwards the co-worker took Petitioner to Stroger Cook County Hospital. In reviewing the medical records the Arbitrator notes that the initial hospital visit at Stroger Cook County Hospital occurred on December 18, 2017, the date of the accident. (PX1: 1). The

Arbitrator notes that the registered time of arrival indicated 13:38 p.m. [1:38 p.m.]; that the information presented indicated:

"Pt was on a ladder two stories up at work when he slipped on the ladder and fell forward onto the ground, falling on his LUE, LLE and left forehead."
(PX1: 41).

Considering the totality of the evidence, including the unrebutted testimony of petitioner and the medical evidence, the Arbitrator finds and concludes that the petitioner, Mr. Rosendo, incurred an accident arising out of and in the course of his employment when he fell from a ladder while descending the roof of the residence at which he was performing demolition work for his employer, JJD Construction & Remodeling, LLC.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (E.) NOTICE OF THE ACCIDENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner stated that a week after his accidental injury when Stroger Cook County Hospital discharged him, he spoke to the owner of JJD Construction & Remodeling, LLC's owner, Mr. David Munoz Valente, by telephone. Petitioner's unrebutted testimony indicated Mr. Valente called petitioner at which time Mr. Rosendo explained the accident to Mr. Valente. Mr. Valente offered to help petitioner but never did. The Arbitrator queried petitioner as to whether or not he had Mr. Valente's telephone number and petitioner provided his number as 1-708-953-9864. The Arbitrator finds and concludes that petitioner gave notice of the accidental injury when he reported the events to Mr. David Munoz Valente a week after its occurrence.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (F.) WHETHER OR NOT THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENTAL INJURY THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner, Mr. Rosendo, stated that prior to December 18, 2017, he suffered no accidents or injuries to his left hand, left leg, left arm or left wrist. Petitioner also noted that since that date

he has suffered no new accidents or injuries to his left hand, left leg, left arm or left wrist. Petitioner did indicate in November of 2018 he had a fall and injured his right hand.

The emergency physician at Stroger Cook County Hospital confirmed on the date of the accident there was no pertinent past medical history and petitioner's only precondition consisted of "prediabetes." (PX1: 46). After numerous radiographic imaging, the physicians at Stroger Cook County Hospital diagnosed petitioner as suffering from: "L distal radius fracture noted from the left forearm to the left wrist and L distal tibial fracture with distal fibular displacement." (PX1: 44-47).

Dr. Paul M. Lamberti noted that "(h)e is a construction worker who fell and sustained an injury to his left distal radius as well as a pilon. His date of injury was 12/18/2017. He underwent an open reduction and internal fixation on 12/19 of his ankle by Dr. Garapati. He is now here for his wrist. He has a fairly complicated intraarticular fracture, in which his lunate is swollen back into a defect and is rubbing on the entire portion of the radial cancellous bone. . . ." (PX1: 58). The Arbitrator notes that no other medical opinion on causality was submitted into evidence. Based upon the credible testimony of the petitioner the Arbitrator finds and concludes that the petitioner's current condition of ill-being, namely left distal radius fracture, left distal tibial fracture with distal fibular displacement and left closed pilon fracture are causally related to the petitioner's accident of December 18, 2017.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING G. (EARNINGS), H. (AGE), AND I. (MARITAL STATUS) THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner noted that he was paid $15/hour initially for respondent but raised to $17/hour and that petitioner worked six days per week from 8:00 a.m. to 5:30 p.m. Calculating petitioner's hours of 48 hours per week x $17/hour results in an average weekly wage of $816

per week. Petitioner also indicated his birth date of October 16, 1982 making him 35 years of age at the time of the injury. Petitioner also identified his marriage certificate and confirmed he was married at the time of his injury. (PX6). Petitioner also identified birth certificates of his four children dependent upon him at the time of his injury. (PX7). Based upon the unrebutted testimony of the Petitioner, the Arbitrator finds and concludes that the petitioner's average weekly wage was $816 per week; that he was 35 years of age, married with four dependents at the time of his injury.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J.) WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER WERE REASONABLE AND NECESSARY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The Arbitrator notes the IWBF did not object to the submission of the medical bills other than as to liability. The Arbitrator, having found that the petitioner was an employee of the respondent; that the petitioner suffered an accidental injury arising out of and in the course of his employment on December 18, 2017; and that petitioner's current condition of ill-being is causally related to that injury, the Arbitrator finds and concludes that the medical services provided to the petitioner were reasonable and necessary in an attempt to alleviate his condition of ill-being. Therefore, the Arbitrator orders respondents to pay petitioner those medical expenses submitted as PX3 subject to the Medical Fee Schedule.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K.) WHAT, IF ANY TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The petitioner was temporarily and totally disabled from December 19, 2017 through April 26, 2018, a period of 18 and 3/7th weeks. The Arbitrator bases this conclusion on the medical records that demonstrate the petitioner underwent the first of his three surgeries on December 19, 2017, (PX1: 243-244), and his treating physician did not release him to return to

any work until April 26, 2018. (PX1: 75). The Arbitrator found no other release to return to work until Dr. Lamberti noted on April 26, 2018 the petitioner "can go back to construction work but explained to the patient that he should start slow (sic) and progress slowly." (PX1: 75). Therefore, the Arbitrator finds and concludes that the petitioner is entitled to receive $544 per week for 18 and 3/7th weeks as provided in Section 8(b) of the Act as he was temporarily and totally disabled from December 19, 2017 through April 26, 2018.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L.) THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that 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 demolitionist at the time of the accident. The Arbitrator notes petitioner's current duties are similar but less demanding to what he did prior to his injury. Because of this difference, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 35 years old at the time of the accident. Because of this younger age, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the petitioner earns similar if not higher earnings. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes petitioner underwent four surgeries one involving external fixation and three involving internal fixation. Because of significant treatment and recovery, the Arbitrator therefore gives *greater* weight to this factor. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of left foot, 30% loss of use of the left leg, 35% loss of use of the left arm and 25% loss of use of the left hand pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC019534
Case Name	RAGLAND, BRANDON v. POWER MAINTENANCE CONSTRUCTORS
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0481
Number of Pages of Decision	13
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	James Clune

DATE FILED: 9/22/2021

/s/Maria Portela, 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

BRANDON RAGLAND,
Petitioner,

vs. NO: 16 WC 19534

POWER MAINTENANCE CONSTRUCTORS,
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, medical expenses, benefit rates, temporary total disability benefits and permanent partial disability benefits and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes a clarification as outlined below.

The Commission strikes Sections G, K and L of the Arbitrator's decisions as the findings regarding accident and causation render these sections moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2020 is hereby affirmed and adopted.

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

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

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

September 22, 2021

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

MEP/dmm
O: 081021
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAGLAND, BRANDON
Employee/Petitioner

Case# **16WC019534**
14WC005037

POWER MAINTENANCE CONSTRUCTORS
Employer/Respondent

On 9/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

1109 GAROFALO SCHREIBER STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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

Brandon Ragland
Employee/Petitioner

v.

Power Maintenance & Constructors
Employer/Respondent

Case # **16** WC **19534**

Consolidated cases: **14WC05037**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **7/30/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **3/7/2016**, 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 **$84,000.00**; the average weekly wage was **$1,615.38**.

On the date of accident, Petitioner was **41** years of age, *married* with **2** dependent children.

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

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

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

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

ORDER

The Arbitrator finds no causal relationship between the accident of March 7, 2016 and the petitioner's recurrent hernia, hernia treatment and lost time. Compensation is denied. See the attached findings of fact and conclusions of law.

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

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

Carl Lee
Signature of Arbitrator

9/12/20
Date

ICArbDec p. 2

SEP 15 2020

Brandon Ragland v Power Maintenance & Constructors, 16WC19534

Findings of Fact and Conclusions of Law

Findings of Fact:

On March 7, 2016 the petitioner was working as a boilermaker mechanic with a partner. The partners were welding roof tubes on a boiler. The tube was approximately ten feet long with a diameter of approximately 2.25 inches. The tube weighed approximately 40 – 50 pounds. The petitioner's partner moved the pipe and it started to drop. The petitioner caught the weight of the pipe and, as he stated, "felt the burn." The petitioner claimed to have looked and noted he "had a bulge." He then filled out an accident report. The petitioner later testified he did not have this bulge before this date; that he would have noticed something like that, being aware of the condition of his body.

The petitioner described that he looked at his "belly just to the side … to where I had a bulge protruding out of my stomach." He advised he felt a sudden burn and knew to look because "I've already had one hernia previously."

In fact, the petitioner had had two previous hernias that he did not link to his work. The second hernia was in July 2015 and actually consisted of three small hernias associated with prior multiple surgical incisions. The petitioner claimed he was aware of what it felt like because he had been through it. However, he did not testify that these were linked to his prior work duties. In fact he had no idea when he experienced the 2015 hernias. He had provided a history at that time to his doctor that they might have been present for five months.

Upon seeing his doctor in 2016 after the work incident he was advised by the doctor that he would not know what caused the hernia until he (the doctor) fixed the hernia. In the meantime the petitioner continued to work the job. He was not restricted in his work by his doctor. The petitioner was simply told to be careful. The job was five to six weeks. He finished the job, and was dispatched to another job. His doctor scheduled his hernia surgery for May 10, 2016. He continued to work until May 8, had his pre-op on May 9, and was off work for his hernia surgery thereafter until July.

The petitioner lost time from May 8, 2016 through July 6, 2016 (8 4/7 weeks). On July 7, 2016 the petitioner returned to full duty with no restrictions.

The petitioner testified he did not know if the hernia he experienced was new, or was a complication from his surgery eight months earlier. Nevertheless, the petitioner improved in that the evidence shows the surgery had gone well and the petitioner was recovered well. The treating surgeon, Dr. McGinty, kept the petitioner off work until July 6, 2016. He was then released to full duty, with no restrictions.

The petitioner claims he does not have the abdominal strength he had previously and this affects his ability to work. The evidence does not support this complaint. Rather, the treating records show that the petitioner has been released to return to work without restrictions to his normal work duties and has worked in that capacity for four years.

The petitioner described a prior surgery to remove his gall bladder as running from his sternum to below his umbilicus. At the same time the petitioner requested the surgeon for his gall bladder problem to also repair an umbilical hernia. Thereafter Dr. McGinty had to repair a ventral hernia on August 18, 2015 which was associated with the gall bladder surgery. The petitioner was released to return to work full duty on September 28, 2015.

The parties have identified average weekly wage as an issue in this case. The petitioner testified on direct examination he was earning $3,000.00 per week because he was working seven days per week. However, his true annual income ranged from $70,000.00 to $80,000.00 per year. Overtime for any job depends on the job. It is not necessarily consistent.

After the petitioner's release to return to work full duty on or about July 5, 2016 he has continued with his non-work recreational activities as well. These activities include hunting, tilling with a tractor, and riding all-terrain vehicles.

Dr. Franklin McGinty testified (PX6) regarding the petitioner's various surgeries and, in particular, his hernias before and after the surgeries. McGinty described three hernias identified by CT scan on August 12, 2015. (PX 6 at pgs. 18-19) The petitioner had given a history that the hernias were present since February 2015. (PX6, pg. 13 – 14). These were described as being in the periumbilical area. (PX6 at page 14) These hernias were most likely incision hernias in that they were within the previous incision area from the gall bladder surgery. It is likely there was a breakdown in the fascia of the muscle where the prior surgery was closed with sutures. (PX6, pg. 15) Such hernias are not necessarily related to work activities. (PX6, pg. 16)

Dr. McGinty performed the repair surgery on August 18, 2015. McGinty agreed following this surgery there could be a recurrent incision hernia. (PX6, pg. 20) The petitioner was given a full duty release as of September 28, 2015. (PX6, pg. 20)

Following the alleged work incident of March 7, 2016 Dr. McGinty performed surgery to repair the petitioner's recurrent hernia. He testified this was on May 4, 2016 [actually May 10, 2016]. This hernia "was in the same vicinity as the prior hernia repair." (PX6, pg. 22)

Dr. McGinty was made aware of the surgical complications the petitioner experienced on November 28, 2014 (PX6, p 24-25). Dr. McGinty could not state with reasonable certainty the surgeries in November 28, 2014 would make the petitioner more susceptible to future surgeries. (PX6, pg. 27)

Dr. Joyce (RX2) was questioned regarding the same issue. Joyce advised that about one third of hernias will recur at an incision line. (RX2, pp. 8, 14) The petitioner's November 2014 surgery involved a large incision. This was actually two incisions within a very short time of one another due to a compromise of the petitioner's aorta during the gall bladder surgery in 2014. (See PX6) This predisposed the petitioner to recurrent incision hernias later. In fact, this is what happened to the petitioner. (RX2, pp.13-15) In the petitioner's case it was more in the range of 50% that he would have a future incision hernia given the nature of the surgeries in 2014. (RX2, pg. 15) His additional risk factors for hernia recurrence were his smoking history and his physical size. (RX2, pp. 17-18)

Dr. Joyce referenced the reports of Dr. Jason Keune. (RX3, August 20, 2017 and September 15, 2017) Dr. Keune referenced medical literature and a study regarding the causes of hernias, concluding that the causes are just not understood. Keune went on to state while it is possible intense physical exertion can cause recurrence, it is impossible to state that it is the situation in this case. "It is common to have hernia recurrence in people who do not physically exert themselves."

On cross-examination Dr. Joyce was asked about the tube and weight the petitioner caught as being the cause of the recurrent hernia. Joyce responded that the petitioner was destined to have a recurrent hernia, but speaking against the tube incident as being the cause is that a recurrent hernia does not cause a burning sensation. It is more likely the petitioner had a muscle strain at the time and this was the burning sensation he felt. The recurrent hernia was associated with a defect in the fascia due to the prior surgeries. (RX2, pp.22 – 24)

Legal Standard:

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission* (1970) 47 Ill.2d 144, 265 N.E. 2d 129. A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission* (1977) 68 Ill.2d 236, 369 N.E.2d 853. Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id.

The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission* (4th Dist. 1989) 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794. A claimant has the burden of proving all the elements of the claim in order to establish a right to compensation. *Greater Peoria Mass Transit District v. Industrial Commission* (1980) 81 Ill.2d 38, 43; 39 Ill.Dec. 817; 405 N.E.2d 796. The burden of the claimant is to prove a compensable injury by a preponderance of credible evidence. *A.M.T.C. of Illinois, Inc. v. Industrial Commission* (1979) 77 Ill.2d. 482, 488; 34 Ill.Dec. 132; 397 N.E.2d 804.

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission* (1982) 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 . The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission* (1983) 98 Ill.2d 20, 455 N.E.2d 86. To argue to the contrary would require that an award be entered or affirmed whenever a claimant testifies to an injury no matter how much his testimony may be contradicted by the evidence, or how evident it may be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission* (1956) 8 Ill.2d 407, 134 N.E. 2d 307. It is not enough that the petitioner is working when an accidental injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission* (1969) 44 Ill.2d 207, 214, 254 N.E.2d 522; see also *Hansel & Gretel Day Care Center v Industrial Commission* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission* (1980) 83 Ill.2d 213, 414 N.E.2d 740. In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission* (1986) 141 Ill.App.3d 289, 490 N.E.2d 124. Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See Generally, *Gallentine v. Industrial Commission* (2nd Dist. 1990)147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880, see also *Seiber v Industrial Commission* (1980) 82 Ill.2d 87, 411 N.E.2d 249; *Caterpillar v Industrial Commission* (1978) 73 Ill.2d 311, 383 N.E.2d 220.

Expert opinions must be supported by facts and are only as valid as the facts underlying them. *Gross v Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission* (1980) 79

Ill.2d 249, 253, 403 N.E.2d 221, 223; *Hosteny v Workers' Compensation Commission* (2009) 397 Ill.App.3d 665, 674.

Conclusions of Law:

C.

Did the petitioner sustain an accident that arose out of and in the course of his employment by respondent?

On March 7, 2016 the petitioner was holding a tube or pipe weighing approximately 40 – 50 pounds when his partner moved the tube and it started to fall. The petitioner caught the pipe and felt a burn in his abdomen. This describes an accidental injury, likely a muscle strain, but not a hernia. (RX2, pp. 22-24)

F.

Was the petitioner's condition of ill-being causally related to the injury?

The petitioner did not sustain a recurrent hernia as a result of his work at Power Maintenance. The petitioner was predisposed to recurrent hernias.

Of the four hernia repairs about which this Arbitrator is aware, the petitioner has only claimed the instant hernia to be related to physical activity. In fact, Dr. Keune (RX3) noted the petitioner had sustained another recurrent hernia (number four, and about which Mr. Ragland did not inform this Commission during his testimony) in July 2017. Since the petitioner did not relate this to a work incident or extreme physical intensity, this is further evidence of the petitioner's tendency to have recurrent hernias due to the condition of the fascia in his abdomen and not because of his physical activity. Since he performs heavy work every workday it would seem he should have hernias every day, or at least frequently and be restricted from heavy work by his doctors. Based on the medical evidence, however, he is simply one of the people for whom recurrent hernias are common in that he has a 30% - 50% chance of future recurrence on his own and without the contribution of work activities.

The petitioner had had two previous hernias that he did not link to his work before the instant hernia that is the subject of this workers' compensation claim. The first hernia he had requested that his gall bladder surgeon repair during a scheduled gall bladder surgery in November 2014. The second hernia followed the unfortunate complications due to gall bladder surgery and was treated in July

2015. "It" was actually three small hernias associated with the prior multiple incisions that occurred during his gall bladder surgery and complications.

The petitioner claimed during direct examination he was aware of what it felt like to experience a traumatic hernia because he had been through it. However, medical evidence, including the testimony of Dr. McGinty (PX6, pp. 13-15), contradicts this testimony. The petitioner did not testify that these prior hernias were linked to his work duties or to physical exertion, nor did Dr. McGinty. In fact the petitioner had no idea when he experienced the 2015 hernias. He had provided a history at that time to his doctor that they might have been present for as many as five months.

The Arbitrator finds there is no causal relationship between the accident of March 7, 2016 and the petitioner's recurrent hernia.

Compensation in this case is denied. The remaining issues in this case are rendered moot by this decision.

G.
What were the petitioner's earnings?

The petitioner estimated he was averaging $3,000.00 per week. However, in latter testimony he advised he would generally earn between $70,000.00 and $80,000.00 per year. In 2014 he confirmed he earned $84,000.00.

However, because of the Arbitrator's ruling under Issue F above, this issue is moot.

K.
What temporary benefits are in dispute?

The petitioner lost time from May 8, 2016 through July 6, 2016 (8 4/7 weeks). On July 7, 2016 the petitioner returned to full duty with no restrictions.

However, because of the Arbitrator's ruling under Issue F above, this issue is moot.

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

Because of the Arbitrator's ruling under Issue F above, this issue is moot.

To determine the level of permanent partial disability the Commission is to base its determination on the following factors pursuant to Section 8.1b(b):

1. the reported level of impairment pursuant to subsection (a);
2. the occupation of the injured employee;
3. the age of the employee at the time of the injury;
4. the employee's future earning capacity;
5. evidence of disability corroborated by treating medical records.

1. The reported level of impairment is unknown because neither party submitted an impairment rating under the authority of Section 8.1b(a). The Arbitrator places no relevance or weight on this factor.
2. The occupation of the injured employee was and is that of boilermaker. This is a heavy-duty job. The employee continues to work in this position without medically imposed restrictions. He has been released to full duty on the number of occasions he has been seen by doctors after his convalescence from treatment. The Arbitrator finds this relevant as an indication of his physical ability to work at his normal, heavy labor job without a restriction and has done so for many years. The Arbitrator places great weight on this factor.
3. The petitioner was 41 years old at the time of the alleged accident in this case. This is not a significant factor because the medical and factual evidence has not shown that petitioner's age has played any role in his ability to work or in his recovery.
4. There is no evidence that the petitioner's future earning capacity has been affected or limited by his alleged condition of ill-being. There is no evidence of wage loss or wage differential or lost earning capacity as a result of the accident or the petitioner's alleged condition of ill-being. The Arbitrator considers this to be relevant and places some weight on this factor as eliminates a significant form of evidence of disability.
5. The treating medical records do not provide evidence of disability. To the contrary, the treating medical records reveal that the petitioner can and has returned to his normal work without restrictions. The Arbitrator finds this relevant and places great weight on this factor.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC032123
Case Name	SCOTT, DARLA v. STATE OF IL DEPT OF HUMAN SERVICES
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0482
Number of Pages of Decision	16
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Jim Vainikos
Respondent Attorney	Charlene Copeland

DATE FILED: 9/22/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0482

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

Darla Scott,

Petitioner,

vs. NO: 16 WC 032123

State of Ill. Dept. of Human Srvs.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical treatment, temporary total disability ("TTD"), and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects a scrivener's error in the Arbitrator's Decision on page 11, the second sentence of the third paragraph, should read as follows, "She further testified that she was under strict time constraints in using her break time because management had complained about her time usage."

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 11, 2020, denying compensation, is modified as stated herein, and otherwise affirmed and adopted.

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)*.

September 22, 2021

o: 8/24/21
TJT/ahs
51

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

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

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

21IWCC0482

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCOTT, DARLA
Employee/Petitioner

Case# **16WC032123**

STATE OF IL DEPT OF HUMAN SERVICES
Employer/Respondent

On 3/11/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAR 11 2020

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DARLA SCOTT
Employee/Petitioner

v.

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

Case # **16 WC 32123**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **December 4, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 4, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of her employment.

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

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

In the year preceding the injury, Petitioner earned $**47,627.84**; the average weekly wage was $**915.92**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent child.

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

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

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

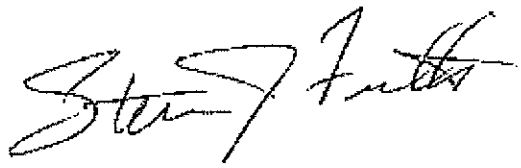
Respondent is entitled to a credit of $**0** under §8(j) of the Act.

ORDER

Petitioner failed to prove that she was injured in an accident that arose out of her employment by Respondent and that she failed to prove that her claimed condition of ill-being is causally related to the claimed work accident. Therefore, Petitioner's claim for benefits is denied.

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

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



Signature of Arbitrator

March 11, 2020
Date

ICArbDec p. 2

MAR 11 2020

DARLA SCOTT v. STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES
16 WC 32123

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

Petitioner Darla Scott has been employed as a Human Services Caseworker for Respondent Department of Human Services since September 2013. Her job duties include assessing various applicants to determine whether they are eligible to receive benefits under the Affordable Care Act. Her office was at 5050 North Broadway in Chicago. There were 4 different state departments housed in the building.

The State rented the building where Petitioner worked, which she described as old. The building as having 6 floors. Petitioner said that the building had heating problems as well as other maintenance issues and that the State decided to move its office to Homewood.

Petitioner testified that there were 2 banks of elevators: one in the back with 2 elevators and on in the front with 2 elevators. She testified that the elevators were often out of order. When elevators were of out of order she used a stairwell to navigate between floors.

During the office relocation process, Petitioner testified that she was a union steward who sat on the Geographical Impact Bargaining Unit. This unit was responsible for finding new locations for employees at the new offices in other state buildings. Petitioner was assigned to complete a roster of the employees in the building and finalize their new locations in other buildings. Employees' relocation requests were handled on a seniority basis. Petitioner testified she used her breaks and lunch time to walk around to all the employees to gather the information she needed to provide the union and management. Petitioner's 15-minute breaks were at 10:00 am and 2:00 pm,

and her 30-minute lunch break was at 12:00 pm. Breaks are paid by Respondent but not lunch.

Petitioner testified that everyone in the building would take breaks at the same time. That meant many people were circulating throughout the building at those specific times. Petitioner testified that she took the stairs between floors during her breaks because of the tremendous traffic of people moving around and the unreliable elevators. She testified that on the date of the accident, August 4, 2016, only half the elevators were working.

Petitioner testified that on August 4, 2016 the office was concluding the Impact Bargaining process, so her responsibility was to submit a roster to Labor Relations and to prepare a finalized roster for the employees. She said that because she was on union time so much, it became a problem for management. She testified that as a result she began utilizing her breaks and her lunches. She explained that she had 15-minute breaks so she had to utilize her break time to make sure she could go throughout the building.

Petitioner's office was on the third floor. She testified that on August 4, 2016, she planned to work her assigned relocation duties during her 10:00 break. She carried a clipboard with a spreadsheet of information identifying employees and their new locations. She also carried a tablet, notebook, union book, and extra paper. She walked downstairs to the second floor. She tried to hurry to contact as many employees as possible during the 15-minute break to obtain their preferences as to a new location. Petitioner testified she could speak to 10 employees during her break.

After speaking with other employees Petitioner noticed that she had only one minute left on her break. She then rushed to a stairwell to return to her office. On cross-examination she said that she did not want management to harass her because she had been e-mailed that she was using too much union time. That was why she used break time for Impact Bargaining activities. None of the e-mails was offered into evidence at trial. Petitioner added that she was paid by the State for this "union time."

Petitioner testified that when she began to ascend the stairwell, she was carrying a notebook, the clipboard with the roster, the tablet, and a union book. She was holding the materials in front of her chest with both hands. Petitioner testified that there was no handrail in the stairwell and that the lighting was dim. Petitioner stated that there were about 15 steps which were made of concrete. The stairs did not have any non-skid rubber strips to prevent slipping or falling.

Petitioner was wearing sandals when she tripped on the concrete steps when her right foot caught the edge of the step halfway up the staircase. She lost her balance but did not fall. She was able to catch herself with her hand. She managed to walk to her desk on the third floor but noticed that her right ankle and foot were swollen and painful, causing her to limp. Petitioner left her work for the rest of the day.

Petitioner testified that when she returned to work she notified her public assistance administrator, Kimberly Norton, and put in an Incident Report.

Petitioner began self-treatment of her right foot from August 4 to August 8, 2016. She applied ice and then heat. She took pain medication. She was unable to reduce the swelling and pain. She sought medical care August 8, 2016 at Edward Hospital emergency room. Petitioner's history was consistent: Petitioner rolled her right ankle while running up the steps at work. She was placed in a stirrup splint and given crutches. The initial assessment of her injury was sprained right ankle. Petitioner followed up with her care at Edward Medical Group on August 15, 2016. The examination revealed swelling over her right lateral malleolus.

Petitioner then consulted Dr. Bryan Lapinski at DuPage Medical Group August 25, 2016. Repeat X-rays revealed a small nondisplaced fracture of the right distal lateral malleolus. Dr. Lapinski placed Petitioner in a CAM boot. He prescribed physical therapy, Tylenol #3, and placed Petitioner on a restriction of weight bearing as tolerated. On September 19, 2016, Dr. Lapinski released Petitioner to return to work on light duty. Physical therapy began on October 15, 2016. On October 27, 2016, P.A. Jennifer Johnson released Petitioner from care at MMI, but Petitioner asked to complete the last few visits of physical therapy.

While Petitioner was off work from August 11 through September 19, 2016, she did not receive any benefits. Her group health insurance paid her medical bills.

Petitioner testified that she had not injured her right foot prior to this injury nor since the date of accident.

Petitioner testified that her right ankle is still painful when she walks. She cannot walk long distances without discomfort and does not use the treadmill to exercise, anymore. Her right ankle is still swollen, which requires her to wear wider shoes. The ankle is much stiffer thus causing her to alter her approach to walking up and down stairs. She now must take each step on the stairs one by one. Petitioner testified that her ankle is achy in cold, wet weather.

On cross-examination, Petitioner testified that breaks were paid time but not the lunch break. She also testified that she was not paid by the union when performing union business such as Impact Bargaining. She testified that the State pays for union business.

Respondent called Margaret Goodrich as a witness. She was the Local Office Administrator (LOA) since June 2015. Her responsibilities included overseeing the Medical Management Unit which consists of over 200 hundred staff. She is also responsible for the health and safety of the staff.

Ms. Goodrich described the building she worked out of on the date of Petitioner's claimed accident. She explained that there were 7 floors and that DHS was on the 2nd, 3rd and 4th floors. She described 3 sets of elevators and confirmed that while there were problems with the front elevator, none of them were out at the same time in the front and that staff could always use one of the other elevators.

Ms. Goodrich said she was familiar with Petitioner Darla Scott, who was one of the caseworkers responsible for processing Medicaid applications. Ms. Goodrich was asked what she does when she learns that an employee has sustained an injury on the premises. She said that because she is responsible for health and safety, she has to walk the building to learn where an accident occurred.

Ms. Goodrich first learned of Petitioner's accident 4 days later. Since Petitioner reported that she tripped up stairs, Ms. Goodrich walked through all 3 staircases, starting from the 4th floor down to the first, to see if there was any defect with the stairs or whether there was something that would cause Petitioner to trip but she did not find any defect.

Ms. Goodrich identified Respondent's Exhibit #1 as showing one of the stairwells on the east side of the building. She continued that she inspected the stairs and that there were no broken stairs, missing rails, or anything that would cause someone to trip. She noted that all 3 staircases look the same and have concrete stairs and all have railings. She added that she did not just check the stairs. She also inspected the platforms because she did not know if Petitioner tripped from the bottom, the middle, or the top. She also checked the weather reports to see if perhaps it had been raining but there was nothing about rain on that day.

Ms. Goodrich believed she took RX #1 a few weeks after Petitioner's accident. She testified that when she spoke with Petitioner about her accident Petitioner

identified the staircase in RX #1 as the one she tripped on.

Ms. Goodrich described the procedures in place when an office transfers to a different location. She explained that because it was a geographical move from the far North to far South, the agency knew that some of the staff would be affected. The union was responsible for talking to the staff to see whether they wanted to move to the new area, and she emphasized that it was a lengthy process.

Ms. Goodrich testified that Petitioner was one of the union stewards involved in the meetings regarding the move. She stated that it was not just a matter of asking the employee a question of whether they wanted to move or not. She explained that Petitioner would sit down and talk with each employee. Ms. Goodrich was asked whether the stewards such as Petitioner were ever advised that they needed to conduct their business during breaks. She answered, "Oh no. They couldn't just get up and just start doing union business. It has to be approved."

Ms. Goodrich denied that the union stewards were required to conduct Impact Bargaining activities only on their breaks. She further testified that no union steward had ever used their lunches or their breaks to conduct union business. "They have always did it on State time."

Ms. Goodrich further explained that the union stewards were not given time limits regarding the issue of the move:

> "Oh, no, there were no time limits. Ms. Scott and I – it was Terrence Roberts, Kendall Daniels, those were the key main steward that helped with the move. They were never told, 'I'm only going to give you 30 minutes. No, use your break.' Whatever it is they asked for, they always communicated with me and said, Ms. Goodrich, we need to meet with the staff because we have to get this list together because Labor was waiting for the list because Labor Relations was in communication with personnel because personnel had a list of staff that wanted to come to my office. So, they were trying to determine who they would swap with. So, no, the stewards never had a limited amount of time that they only can conduct business."

Ms. Goodrich identified Respondent's Exhibit #4, the department's monthly time sheets for August and September 2016. She explained what the various codes meant and the time sheet for August showed that Petitioner had requested 4 hours for union business on August 4, the date she reported.

Ms. Goodrich testified that Petitioner came to her office on August 9. She described Petitioner as having an air cast boot on her foot and she had crutches. She testified that Petitioner could barely get around. However, Ms. Goodrich saw Petitioner the next day at the Thompson Center when she was no longer walking with difficulty.

Ms. Goodrich identified Respondent's Exhibit #2, her August 11 e-mail to Denise Banks, the Workers' Compensation Coordinator, which she read into the record:

> "I wanted to share with you what I observed while at the Thompson Center yesterday. While at the Thompson Center at approximately 11 a.m., I observed Darla Scott walking as if she didn't have an ankle injury. She didn't notice that I saw her or was paying her any attention. After Ms. Scott sat down in a chair that was several rows from me, I spoke to her and said, "I noticed your ankle is better. You appear to be walking just fine today." Ms. Scott later replied by saying that she took a lot of Ibuprofen and it comes and goes. I found what I observed to be a mystery considering I had just saw Ms. Scott the day before in the office at 5050 N. Broadway come into my office with an air cast/splint on her leg and a crutch. She appeared to be having a difficult time walking and getting around. She came in late on Tuesday and also went home early complaining about her pain. What I saw is what some may call a miraculous recovery overnight. I later found it strange that when her name was called to follow the person who needed to see her she later begin to limp knowing I was sitting behind her."

Ms. Goodrich was questioned during cross-examination about whether a portion of the handrail was missing. She explained that there were no posts showing that there had ever been a railing because normally, if there is something broken, you would see where the holes were drilled. She was also asked whether she ever reported the accident to the landlord. She testified that she did notify CMS but that there was nothing to report in terms of anything out of the ordinary.

Ms. Goodrich was cross-examined about the lighting in the stairwell and whether the lights were working on the day Petitioner fell. She stated that if any lights had been out, she would have received an e-mail because her staff are "big complainers." She commented "that if a light was out, trust me, I would have known." She was asked if "that's a hundred percent guarantee?" to which Ms. Goodrich responded, "that's a hundred percent guarantee."

Respondent next called Kimberly Norton-Bolden. Ms. Norton-Bolden testified that she has been employed by the State for 20 years and that her current title was Assistant Local Office Administrator. She explained her job duties as overseeing the staff, delegating work and looking out for the health and safety of the staff. She would report to the LOA if she finds anything needing repair.

Ms. Norton-Bolden testified that she was familiar with Petitioner and saw her on a daily basis. She did become aware of Petitioner's fall when she was in a meeting a couple of days later and Petitioner came in wearing an air cast and boot and said that she had fallen.

Ms. Norton-Bolden then testified that she saw Petitioner was a couple of days later walking down the street going into the building. She identified Respondent's Exhibit #3, an e-mail dated August 15, 2016. She testified that it was an e-mail from her to Ms. Goodrich stating that on Friday, August 12 at 7:40 a.m., she observed Petitioner walking down the street wearing open-toed sandals and swinging an umbrella. She continued by describing Petitioner as walking with a normal gait without any noticeable pain or the assistance of crutches as she had done the day before. Ms. Norton-Bolden added that when someone asked Petitioner what happened to her crutch and why she did not have her foot bandaged, she began to limp and said she needed to put her bandage back on.

On cross-examination Ms. Norton-Bolden reiterated her observations stated in the e-mail. She confirmed her observations of Petitioner walking normally as stated in the e-mail.

Petitioner testified in rebuttal. She identified RX #1 as the staircase where she tripped. She confirmed that the handrails depicted in the photo were as they were on the day of her accident. Petitioner testified that the lighting in the stairwell was not as well-lit as in the photo. She said that the light fixture on the left side of the wall was not lit on the date of her accident.

Petitioner testified that she had no memory of having a conversation with Ms. Goodrich at the Thompson Center. Petitioner also corroborated the medical records wherein she was prescribed stirrups, splints, and crutches between August 8 and August 15, 2016. She had swelling in her right ankle and would remove the splint once in a while to give herself relief from the pain. The first time Petitioner was diagnosed with a fractured distal malleolus was on August 25th.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that she was injured in an accident that arose out of her employment by Respondent. The Arbitrator's finding is principally based on Petitioner's lack of credibility.

Petitioner testified that she was a union steward who sat on the Geographical Impact Bargaining Unit. This unit was responsible for finding new locations for employees at the new offices in other state buildings. Petitioner was assigned to complete
a roster of the employees in the building and finalize their new locations in other buildings. Employees' relocation requests were handled on a seniority basis. Petitioner testified she used her breaks and lunch time to walk around to all the employees to gather the information she needed to provide the union and management. This was also confirmed by Margaret Goodrich, the Local Office Administrator.

Petitioner further testified that in order for her to complete her survey for Geographic Impact she had to use her break time and lunch break to contact co-workers. She further testified that she was strict time restraints in using her break time because management had complained about her time usage.

Ms. Goodrich contradicted Petitioner's account of exclusive use of break time for Geographic Impact. Ms. Goodrich testified credibly that the time allotted for Petitioner's survey of her co-worker did not have specific time constraints. Ms. Goodrich explained that the process of seeking input from each employee was not something that could be accomplished quickly. Furthermore, she was adamant in her testimony that the State gives union stewards time to perform their duties and that no steward is required to conduct the impact bargaining process only on their breaks or lunch hour.

Petitioner testified to receiving "harassing" e-mails about the time she devoted to Geographic Impact but did not offer copies of the e-mails in evidence.

Petitioner testified that she tripped on a step in a stairwell as she was hurrying back to her desk at the end of her break. She chose to use the stairwell because it was the quickest route back to her desk. Petitioner testified that there was no handrail in that stairwell and that lighting was dim in the stairwell. Petitioner did not testify that dim lighting prevented her from seeing any of the steps in the stairwell. She did not testify that she tried to grab a handrail to prevent herself from tripping.

RX #1, the photo of the subject stairwell, which Petitioner authenticated and Ms. Goodrich, showed a well-lit area with a full handrail on one side and a partial handrail

on the other. RX #1 clearly repudiates Petitioner's testimony regarding an inferred defect in the stairs. There are no apparent defects in the treads or risers depicted in RX #1. A partial handrail is inconsequential inasmuch as Petitioner did not reach out to grab the supposed nonexistent handrail. Further, Ms. Goodrich testified credibly that the stairwell was well-lit when she inspected it after Petitioner's report of accident.

Ms. Goodrich also testified that she had observed Petitioner August 10, 2016 at the Thompson Center. At that time Ms. Goodrich observed Petitioner walking "as if she didn't have an ankle injury." Ms. Goodrich documented these observations in an e-mail to Denise Bank, Workers' Compensation Coordinator, on August 11, RX #2.

Petitioner's credibility was also assailed by the credible testimony of Ms. Norton-Bolden about her observations of Petitioner's inconsistent behavior in response to her claimed injury. Ms. Norton-Bolden observed Petitioner on August 12, 2016 walking with a normal gait and without apparent discomfort, unlike on the day before. Ms. Norton-Bolden then overheard someone ask Petitioner about her foot, whereupon Petitioner then began to limp and complain of pain. Ms. Norton-Bolden documented these observations in an e-mail to Ms. Goodrich on August 15, RX #3.

The evidence does not support Petitioner's claim that she was injured in an accident that arose out of her employment by Respondent. Petitioner failed to prove, by want of credibility, that she was injured by her encounter was a physical defect in her workplace.

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

It is not disputed that Petitioner was diagnosed and treated for a small nondisplaced fracture of the right distal lateral malleolus. As noted above, Petitioner's poor credibility did not support a finding of accident. Here, Petitioner's lack of credibility undermines her claim of causation. Margaret Goodrich and Kimberly Norton-Bolden testified credibly to observing post-accident behavior in Petitioner wholly inconsistent with Petitioner's claim of injury and ongoing pain and limitation.

Aside from this issue being mooted by finding Petitioner failed to prove accident, Petitioner's lack of credibility does not support a finding that her claimed accident was causally related to her claimed condition of ill-being.

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 evidence did show that Petitioner received reasonable and necessary medical to treat or relieve the effects of her small nondisplaced fracture of the right distal lateral malleolus. However, in light of Petitioner's failure to prove accident, this issue is moot.

K: What temporary benefits are in dispute? TTD

In light of Petitioner's failure to prove accident, this issue is moot.

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

In light of Petitioner's failure to prove accident, this issue is moot.

Steven J. Fruth, Arbitrator

March 11, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC034509
Case Name	KOOP, RICHARD J v. CITY OF ELGIN
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0483
Number of Pages of Decision	18
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Duda
Respondent Attorney	Fred Beer

DATE FILED: 9/22/2021

/s/ Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD J. KOOP,

Petitioner,

vs. NO: 11 WC 34509

CITY OF ELGIN,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Respondent's timely filed Petition for Review of the Decision of the Arbitrator. The issues on Review are whether Petitioner's firefighting activities were a causative factor in his development of coronary artery disease, entitlement to medical expenses, entitlement to temporary total disability benefits, entitlement to permanent partial disability benefits, and whether Petitioner is precluded from contesting the nature and extent of his permanent disability. Notice having been given to all parties, the Commission, 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 notes §19(e) obligates us to review all questions of law and fact that appear from the transcript; therefore, barring Respondent dismissing its Review, we have jurisdiction to consider Petitioner's argument as to the nature and extent of his permanent disability. We have done so here and find the award as written is appropriate and accurately reflects the evidence. This case was consolidated for hearing with case number 11 WC 34510.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 10, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,001.44 per week for a period of 4 weeks, representing April 8, 2011 through May 6, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $1,462.55 for medical expenses, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit of $104,554.94 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.94 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% 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.

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.

September 22, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 7/28/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOOP, RICHARD J
Employee/Petitioner

Case# **11WC034509**
11WC034510

CITY OF ELGIN
Employer/Respondent

On 9/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX
PALATINE, IL 60067

5541 FRED J BEER LAW OFFICES PC
2295 VALLEY CREEK DR
SUITE K
ELGIN, IL 60123

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard J. Koop
Employee/Petitioner

v.

City of Elgin
Employer/Respondent

Case # **11** WC **34509**

Consolidated cases: **11 WC 34510**

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 **May 8, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 21, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**78,112.32**; the average weekly wage was $**1,502.16**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**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 $**104,554.94** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $1,462.55, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $104,554.94 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,001.44/week for 4 weeks, commencing April 8, 2011 through May 6, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.94/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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 9, 2019
Date

ICArbDec p. 2

SEP 10 2019

Statement of Facts

This matter was tried in conjunction with consolidated case number 11 WC 34510 (DOA: April 11, 2011). A single transcript was prepared although the Arbitrator is entering separate decisions.

Petitioner Richard Koop testified that on January 21, 2011 he was employed by Respondent City of Elgin as a firefighter/EMT. He was hired in June 2002 as a firefighter/paramedic. He previously worked for Algonquin/Lake in the Hills Fire Protection District part-time from December 1998 until June 2002. He started as a firefighter and became a firefighter/EMT and firefighter/paramedic. His duties for both entities included fire suppression, responding to emergency, fire, EMS, auto accident calls.

He underwent a physical examination when he was hired by Respondent on April 22, 2002 (PX 4). He noted a family member had cancer. His musculoskeletal screening placed him in the Heavy to Very Heavy PDL. He noted he works out 6 days per week, doing cardio 3 days and weights 3 days. He was noted to have an elevated heart rate. It was strongly recommended he continue workouts. The 1.5 mile Run noted no risk factors including hypertension, diabetes, family history of heart disease, lack of exercise, high cholesterol, overweight, stress or smoker. Petitioner denied smoking now or in the past (PX 4). Petitioner testified that he did smoke ½ a pack to 1 pack per day from age 18 until he quit in 2002. He began occasional smoking at age 16. Pulmonary function notes mild obstructive lung disease. Petitioner passed his physical without limitations (PX 4). After he was hired, he underwent periodic partial physical exams with added blood work, blood pressure, and meeting with a doctor. He testified that over the years, the doctors told him he had heightened readings of cholesterol. He was not advised that he had hypertension.

Petitioner testified that in 2005, on a lengthy large fire scene, when it was very hot outside, he went to the hospital for shortness of breath. He underwent an echocardiogram. His doctor found that his potassium level was low. Petitioner has a stress test July 1, 2005 for a diagnosis of chest pain and palpitations which was read as normal (PX 5). Petitioner had a CT Healthy Heart Scan performed on March 12, 2008. It showed a coronary Artery Calcium Score of 36 in the LAD. This was noted to be a mild plaque burden. The hand-written notation advised to quit smoking, exercise and follow a low cholesterol, low fat diet (PX 6). Petitioner testified that he voluntarily underwent the CT heart scan at Sherman Hospital when the city offered a special lower price. Dr. McCarthy sent the heart scan report to Petitioner, but the Petitioner did not recall talking to him about the results. He was not referred to a cardiologist and he did not receive a prescription for medication.

Petitioner was initially assigned to Engine 1 for 2 years. Then he was assigned to Engine 6 for 8 ½ years, Engine 4 for 2 years and then to Quint 7. His assignments to Engine 4 and Quint 7 were after the 2011 incidents that are the subject of his pending cases. Engine 6 was located in the center of the city of Elgin and was one of the busiest engines that responds to more fires than any other engine. Engine 6 was also a basic life support engine ("BSL") that responded to medical emergencies until an ambulance arrived from another station. Engine 6 averaged 8 to 10 calls per 24 hours shift including EMS, rescue, and fire suppression in all kinds of weather.

The Respondent's alarm alerting system alerts the stations, radios on the engines, and the personal firefighter radios. In the stations, the pre-alert tone goes off, then the fire tones for the assigned station, and then the dispatcher describes the call and which engines are to respond. Petitioner worked 24 hour shifts for Respondent. He would eat, sleep, and, at times, would be awakened by the alarm alerting system.

Petitioner's job on Engine 6 was as a back-end firefighter that rode on the back step of the engine, would exit the engine rig with full personal protective equipment ("PPE) fire bunker or turnout gear, air pack, helmet, SCBS mask, fire jacket, fire pants, hood, gloves, radio, and flashlight, and remove the 200 foot water hose from the engine and stretch the hose to the structure on fire. In structure fires, he would encounter smoke and put on his mask, which would provide less than 30 minutes of air. He would change air bottles as necessary. After the fire attack and extinguishment, he would remove his mask while doing overhaul to check for any spot fires. While fighting fires, he was exposed to household items, insulation, drywall, dust, soot from the fire that was just put out, and asbestos in old buildings. Depending on the severity of the fire, the overhaul could take from 20 to 30 minutes or could take an hour or more. Prior to January 21, 2011, he had performed a fire overhaul lasting over an hour. He also performed multiple types of fire ventilation. Horizontal ventilation consisted of opening doors and windows for a fire on the first floor to help ventilate the smoke in coordination of the fire attack. He would also perform vertical ventilation where he would climb a ladder to the roof and make a hole in the roof. Depending on the weather conditions, he sometimes removed his mask while doing vertical ventilation if his mask fogged up.

When Petitioner was on Engine 6, he would respond to medical calls and administer medical care until the ambulance arrived. He would assist in carrying the patient to the ambulance. From 2002 to 2011, at least more than half of the calls were medical calls. He would also respond to emergencies involving auto accidents that may include car fires. For car fires, they would wear the same PPE gear and air mask if needed and would pull a hose to extinguish the fire if necessary. He would use a Halligan bar to pry open a door or hood or trunk or to break the windows. He typically would not breath in air from his mask and air tank during a car fire prior to 2011. It would take from 10 minutes to a half hour to extinguish a car fire, depending on the severity of the car fire. He would use the jaws of life to extricate a victim if necessary. Extrications are urgent and cause a high degree of adrenaline and elevated heart rate breathing and hyperawareness of the surroundings.

Petitioner testified that written reports were completed for every different type of call. A listing of fire incident reports disclosed multiple fire extinguishments including cooking fires, grass fires, residential fires, vehicular fires, rubbish fires, and commercial fires (PX 4, PX 20, PX 16-19). Petitioner testified that investigating is looking to see if there is a fire. It is in full turn-out gear, but there is no actual firefighting. Salvage is during actual fire suppression. It is trying to save property. Ventilating is getting the smoke and heated gasses out of the structure. Staging getting ready to engage in the firefighting but not actually doing firefighting. You are in your full protective PPE equipment ready to go but you are not involved in the actual fighting of the fire. Canceled in route would be going through the normal dispatching process and for some reason they are not needed and are called off. He testified that he responded to gas leaks and high levels of carbon monoxide. Before 2011, they used a monitor. The regular gear would not include the SCBA.

Petitioner testified that on January 21, 2011, his shift started at 7:00 am. At 7:30 AM, the regular alarm alerting system went off in the station telling Petitioner that there was a possible apartment fire. He responded on Engine 6. At the structure, there was not any smoke, but they went in to investigate with full PPE gear and air pack on his back, but no mask on. Petitioner was carrying a water extinguisher, ax, and Halligan bar which together weighed about 50 pounds. He proceeded up the outside rear stairwell to the third floor apartment. The outside temperature was below zero and bitterly cold. As he approached the apartment on the third floor, he felt much more winded than he normally would be in that situation. In the apartment, they found there was burnt food on a pan on the stove and that the food stopped burning. They ensured that the stove was turned off, searched the apartment, and opened some windows to clear the smoke haze. They then returned to Engine 6 and returned to the station. He still felt winded, which he thought may be due to breathing cold air.

At the station, Petitioner performed his regular house duties of general cleaning and maintenance of the station. He felt okay while performing his regular house duties. At around 10 AM, Petitioner was sitting at the kitchen table working on medical continuing education and started to have some chest pain that radiated down his left arm and into his jaw. He took a couple of aspirin. His engine driver, Steve Lundy, took his blood pressure. His crushing chest pain went up to 10/10 that brought him to his knees. Ambulance 4 took him to Sherman Hospital and provided him four chewable baby aspirin, three rounds of nitro, started an IV, put him on oxygen, and performed an EKG reading.

Petitioner testified that at the hospital emergency room, his chest pain went down from 10/10 to 2/10. When they moved him from the ambulance gurney to the hospital bed, his pain spiked up one more time to 8/10 which lasted for about two minutes. The hospital did more blood tests, a 12 lead, and chest x-ray. In the ER, his pain abated down to zero. He was not admitted into the hospital. The doctor told him he had an esophageal spasm. Petitioner told the doctor he did not have heartburn. The nurse gave him some acid reflux medicine and he was released back to his shift. He worked the rest of his 24 hour shift.

The ambulance report notes dispatch at 9:59 AM. The patient stated he was doing paperwork when he began to experience crushing chest pain (PX 5). The Sherman Hospital records note patient presents with chest pain radiating to the left side of the jaw, onset 1 hour ago, no prior episode. The history is that he developed chest pain shortly after eating breakfast this morning. He has no significant past medical history and no significant risk factors for coronary artery disease. EKG showed no evidence of ischemic abnormalities. The diagnosis was probable esophageal spasm/gastroesophageal reflex. Petitioner was reassured that his symptoms were not based on coronary artery disease. Petitioner was discharged to return to work without restrictions (PX 5).

From January 22, 2011 to April 3, 2011, Petitioner sought no medical treatment. He testified that he continued to have chest pain at work and at home. He researched his potential heart condition and self-medicated with acid reflux medicine and Tums. His chest pain was more frequent with exertion or exercising. He testified that he scheduled an appointment with Dr. McCarthy.

On April 6, 2011, Dr. Steven McCarthy examined Petitioner for complains of chest pain and discomfort for the last 3 months (PX 6). Dr. McCarthy noted the 2005 negative stress test and hyperlipidemia that started in 2009. Petitioner was not adhering to medication, diet, and exercise for his hyperlipidemia. Dr. McCarthy reviewed his recent lab studies going back to January of 2009 that showed he had some dyslipidemia and elevated triglyceride levels. His LDL levels were elevated. Dr. McCarthy recommended that he follow a low-cholesterol, low-fat diet, and increase physical activity. He diagnosed either GERD/esophageal spasms, but could not exclude underlying coronary artery disease. Dr. McCarthy ordered a Lexiscan Stress Myoview and prescribed omeprazole and ordered that he change his diet regarding the GERD (PX 6).

On April 8, 2011, Dr. Shiva Gupta conducted a nuclear stress test at Sherman Hospital (PX 5). Petitioner gave a history of chest pain on and off for 3 or 4 months. He was chest pain free. His chest pain was mainly exertional. His blood pressure was a little elevated at 159/103, but he was not in any acute distress (PX 5 Pages 75-76 of 207). His stress test was abnormal showing hypoperfusion in the anterior and septal areas with symptoms developing and post stress positive for myocardial ischemia (PX 6). Dr. Abnieska Silbert also examined Petitioner. Petitioner told Dr. Silbert he had chest pain. He used to smoke a pack of cigarettes for 15 years, but quit 8 years earlier. His family history was significant for coronary artery disease and high cholesterol. His blood pressure was 140/90. Petitioner was admitted to the CCU and monitored over the

weekend. He was scheduled for a cardiac catherization on Monday (PX 5, p 75-80 of 207). On April 11, 2011, Petitioner underwent a left heart catheterization and was found to have a proximal LAD left anterior descending artery (LAD) lesion at 99% occlusion. Dr. C. Dean Katsamakis performed an angioplasty and stenting (PX 5, p 83-86 of 207). On April 12, 2011, Dr. Gupta discharged Petitioner and advised him to follow up with Dr. McCarthy. He would need to continue medications for hypertension, hyperlipidemia, and coronary artery disease. Dr. Gupta advised him on a low-salt, low-cholesterol cardiac diet and regular exercise (PX 5, p 73-74 of 207).

Petitioner prepared an Employee's Injury/Illness reports on April 28, 2011. He described the January 21, 2011 episode beginning with the apartment fire (PX 2). He stated that after returning to the station, he did not feel well. At 9:45 AM he began to have chest pan radiating to his left arm and jaw (PX 2). He also prepared a report for April 11, 2011 (PX 3). He noted his first bout of chest pain was January 21, 2011 and that he continued to have varying degrees of chest pain on a daily basis. He detailed his visit to Dr. McCarthy, the stress test and his angiogram and stenting (PX 3). Petitioner filed a second claim alleging the date of accident is April 11, 2011, which claim is the subject of the consolidated case 11 WC 34510 decided in conjunction with this matter.

On May 2, 2011, Dr. Katsamakas conducted a follow up stress test of Petitioner which failed to show any evidence of ischemia. He was cleared to begin cardiac rehab (PX 8, PX 9). On May 5, 2011, Dr. Katsamakis noted Petitioner was doing well. He provided a family history of heart disease (grandfather), coronary artery disease (grandfather), hypertension (mother). He said he was a previous smoker. He quit smoking 8-9 years earlier. His total pack years was 1 PPD x 15 years. He exercised with cardio/weights 3 times a week. Dr. Katsamakis advised that since he was doing well, he should continue his present health management, and he could return to work light duty (PX 8, PX 9).

Petitioner testified that he returned to light duty on Monday, May 9, 2013 and returned to his full duty shift on May 24, 2011. He testified that his medical bills were paid by his group insurance. He paid $1,462.55 himself for deductibles and co-pays. Petitioner testified he used his sick time to cover the time, a Kelly day in there and a Kelly day trade to cover two other days. Sick time is a negotiated benefit. It accrues over time. You can turn it in at the end of your career. You receive money based on a formula. A Kelly day is an hour reduction to adjust annual salary and avoid the need for Respondent to pay overtime. Petitioner would receive the same paycheck each pay period. These days can be traded with other employees. That employee would work your shift and then you would work on his Kelly day. Petitioner testified he received a Kelly day on April 12, 2011. He swapped a Kelly day for April 24, 2011. Petitioner's Hours History was admitted as RX 9 showing seven 24 hour shifts of sick hours, one shift of Kelly days, and one shift of regular hours on April 24, 2011.

Petitioner followed up with Dr. Katsamakis who ordered another nuclear stress test. On October 5, 2011, Petitioner underwent an exercise test and another nuclear myocardial rest/stress SPECT exam test which demonstrated no abnormality (PX 10). On November 28, 2011, Dr. Katsamakis performed a repeat cardiac catheterization on Petitioner. He notes Petitioner has been complaining of intermittent chest discomfort primarily with exertion for the last 1 to 2 months. The test did not show any in-stent restenosis (PX 7, PX 15).

Petitioner testified that his medications included two blood thinners, Effient and aspirin, Crestor and Toprol. He has regular visits with Dr. Katsamakis. On June 23, 2014, Petitioner underwent an exercise stress test with SPECT imaging which showed: 1. Excellent exercise tolerance. 2. Negative stress EKG. 3. No clinical signs for coronary insufficiency present, the patent denied chest pain. 4. No arrhythmias were noted. The nuclear

rest and stress gated SPECT myocardial perfusion imaging showed: 1. The examination was normal showing no evidence of stress-induced ischemia. 2. Normal wall motion and contractility (PX 11).

On November 18, 2011, Dr. Kathleen Drinan conducted a medical record review at Respondent's request and prepared a report finding no causal connection (RX 3). On July 12, 2018, Dr. Barbara Cochran, M.D. completed an interview of Petitioner, reviewed medical records, and prepared a report regarding a causation analysis for his coronary artery disease at Petitioner's counsel's request (PX 13). Dr. Drinan authored a supplemental report in response to Dr. Cochran's opinions on October 6, 2018 (RX 5). Dr. Cochran authored a supplemental report on October 16, 2018 (PX 14). Dr. Drinan authored a further supplement on October 20, 2018 (RX 7).

Dr. Cochran testified by evidence deposition taken October 24, 2018 (PX 12). She testified that she is board certified in occupational and internal medicine. She is board eligible in occupational and environmental medicine. She has practiced in occupational medicine since 1990. She is not a cardiologist, but she has treated heart disease patients as an internal medicine doctor. Her current practice is devoted 20% to providing IME causation opinions for firefighters, 20% IME WC opinions regarding physical work injuries, and 60% Social Security Disability opinions. She interviewed, but did not examine the Petitioner. She took a prior medical history of his diagnoses and treatment, a social history of smoking and drinking, a family history, and an occupational history. She reviewed all of the treating medical records beginning with Sherman Hospital through follow up care provided by the cardiologists who have been treating the Petitioner since January 21, 2011(PX 12).

Dr. Cochran testified that she reviewed seven risk factors recognized for coronary artery disease. Petitioner was only 37 years old. He was not obese and was not sedentary, given his work outs several days per week. He did not have diabetes. She found that the family history of a grandparent with heart disease and his mother having high cholesterol does not include first degree relatives with heart disease and is not a risk factor. She noted that, while Petitioner had some high blood pressure readings prior to 2011, he was not diagnosed or treated for hypertension until after the January 2011 incident. She noted his smoking history, but given his quitting in 2002, nine years before the symptoms, she found this a negligible risk factor. She noted Petitioner did have high LDL. She did not find the 2008 CT scan results constituted a risk factor. Based on these findings, she opined that Petitioner did not have sufficient other risk factors to cause his coronary artery disease (PX 12).

Dr. Cochran opined that Petitioner's coronary artery disease was caused by the essential functions of a firefighter. She cited her review of the literature supporting that the strenuous activities of firefighting under emergency/alarm conditions requiring sudden, rapid and urgent response to emergencies created a mechanism of oxidative stress that caused inflammation in the arteries and the acceleration of the deposition of atherosclerotic plaque. She testified that this oxidative stress and coronary artery inflammation cause plaque in the arteries to develop and are more prevalent in firefighters as a result of the exposure to carbon monoxide and other toxins during fire suppression, the physical stress of wearing 100 pounds of equipment and physically fighting fires, and the psychological fight/flight stress when responding to fire alarms whether there is an actual fire or not. She cited articles on the cardiotoxicity of the substances found at fire scenes such as carbon monoxide, cyanides and particulate matter. She cited studies showing the risk of heart disease is much higher in firefighters during fire suppression. She opined that firefighting duties not only accelerate pre-existing condition; it is causative of the atherosclerosis. Her opinion is based upon the cumulative effect of his duties over his career as a firefighter. Even if Petitioner had multiple risk factors, his firefighting duties contributed to

his heart disease. She opined that the events on January 21, 2011 confirm that he was having a pre-coronary event. Those activities would contribute to atherosclerosis (PX 12).

Dr. Cochran testified that Petitioner did not suffer a heart attack on either incident date. She did not review any Elgin fire incident records and did not know how many fires Petitioner fought, what specific toxins he was exposed to, and how many times, if any, that he did not use his self-contained breathing apparatus while fighting fires, and how many times, if any, that he ran out of oxygen (PX 12).

Dr. Kathleen Drinan testified by evidence deposition taken December 14, 2018 (RX 8). She testified that she is a clinical cardiologist and Doctor of Osteopathic Medicine. She received a designation from the American College of Cardiology as a fellow. She is a fellow in the American College of Osteopathic Internists. She is board certified as a Registered Physician in Vascular Interpretation and Echocardiography. She is board certified by the American Osteopathic Board of Internal Medicine in Cardiovascular Disease, by the American Osteopathic Board of Internal Medicine and by the American Board of Clinical Lipid Pathology as a Clinical Lipid Specialist. She performs independent medical record review reports which compose less than 1% of her practice. She no longer performs cardiac catheterizations. None of her research involved occupational exposures to firefighters (RX 8).

Dr, Drinan testified she reviewed records and correspondence to complete her review in this matter. She did not interview or speak with Petitioner. She did not examine him. She opined that Petitioner's firefighting duties were not causative of his cardiac condition as diagnosed April 11, 2011. She testified that Petitioner had multiple risk factors. The condition of atherosclerosis had been identified in 2008 in the CT scan. Additionally, Petitioner had risk factors of a history of cigarette smoking, lipid abnormalities that were significant, elevated triglycerides and high blood pressure. She opined that Petitioner's heart condition was the natural progression of his underlying coronary artery disease and not caused directly by his firefighting activities (RX 8).

Dr. Drinan testified that she disagreed with Dr. Cochran's July 12, 2018 report. She agreed that there are seven classic risk factors, but disagreed that Petitioner's risk factors were minimal. She noted the lipid abnormality and the 2008 CT scan demonstrating atherosclerosis. She disagreed that Petitioner's smoking history would not contribute to his condition. She testified that there is an association of tobacco use and cigarette smoking increasing the risk for developing cardiovascular disease. She noted his family history was not a risk factor but was interesting. Dr. Drinan agreed that the literature found an increased incidence of coronary artery disease in firefighters for a multiplicity of reasons, but did not agree that there was a causal relationship to the development of CAD. Multiple risk factors including wearing heavy gear, stress, exposure to cardiotoxins and the stress of reacting to alarm bells could influence the development of an acute myocardial infarction, but do not cause the plaque to form without the lipid abnormality. She testified that Dr. Cochran's report did not change her opinions on causation (RX 8).

Dr. Drinan reviewed the studies cited by Dr. Cochran. She testified the studies discussed how firefighting activities could aggravate an underlying heart condition and cause a heart attack, not specifically whether firefighting activities could cause plaque to develop in the coronary arteries. The studies that discussed the development of plaque in the coronary arteries noted an increased incidence in firefighters. Dr. Drinan testified that they show an association but not evidence of causation. Other studies note that carbon monoxide exposure causes oxidative stress. She testified that the medical records contain no evidence of exposure to unsafe levels of carbon monoxide, or lactic acidosis of the muscle of the heart. It is speculative as to whether firefighter flight-or-flight response or high adrenaline levels can cause plaque to develop in a firefighter's

coronary arteries. Carrying 110 pounds of protective equipment and responding to firehouse alarm bells does not cause plaque to develop in the coronary arteries (RX 8).

Dr. Drinan testified that she disagreed with Dr. Cochran's description of Petitioner's smoking history. Based on Dr. McCarthy's statements that Petitioner was not adhering to medication, diet and exercise, she disagreed that Petitioner is physically active. Based on blood pressure readings from 2005 through 2011, she found Petitioner had undiagnosed hypertension. She disagreed that it takes 10 years to develop a plaque. The 2012 Hunter Study points out that duty related physiological stress influence risk factors and cause triggering of the sympathetic nervous system. In an individual having risk factors, the response to those stressors aggravates their risks and influences their risk for additional cardiovascular events. She testified that there was a study that suggests that inflammation may play a major role in atherosclerosis (RX 8).

Dr. Drinan reviewed the January 21, 2011 incident report. It could not allow Dr. Drinan to comment on whether the Petitioner's January 21, 2011 incident physical activities were the cause of his chest pain. She did not review any fire reports involving Petitioner. Petitioner still had a residual risk of chronic heart disease even after he stopped smoking. She disagrees that smoking cessation can reverse the risk level to that of a non-smoker. The more risk factors one has, the more likely to develop atherosclerosis. Atherosclerosis is multifactorial. The more risk factors, the more likely to develop the disease. Smoking is a risk factor.it is not a cause. Increased oxidative stress could increase a person's risk. High lipids are a risk factor, not causative. She testified that the articles reviewed show a higher risk of plaque deposition in firefighters than would be anticipated for persons of their age indicating a greater risk of plaque deposition. She agrees that the literature discloses that the incidence of coronary artery disease is greater among firefighters that the general population. She does not think that the association was causation. Dr. Drinan disputes that increased relative risk is evidence of causation (RX 8).

Petitioner continued to take aspirin as a blood thinner. He still sees Dr. Katsamakis. He notices that he has less endurance and stamina than I did before the stent and taking all the medications. He can't exercise or be physically active as long as he used to be able to. He bruises very easily and it's harder to control bleeding. He is concerned about hitting his head and causing a brain bleed. He had some sexual dysfunction after the stent and the medications. Due to the stent and the medications, his max heart rate is lower than it used to be, so he has to be careful when exercise or doing physical activity to monitor how he is feeling because he can very easily get to what his max heart rate is now.

Conclusions of Law

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

Petitioner is seeking compensation claiming that he suffered an occupational disease while employed by Respondent as a firefighter. He was diagnosed with coronary artery disease and atherosclerosis which necessitated the cardiac catheterization and stenting performed on April 11, 2011 to address the 99% blockage in the LAD. The claimant in an occupational disease case has the burden of proving that he suffers from an occupational disease and that a causal connection exists between the disease and has employment. *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467, 748 N.E.2d 339, 254 Ill. Dec. 893 (2001).

Section 1(d) of the Workers' Occupational Diseases Act ("OD Act"), states, in part:

"In this Act the term 'Occupational Disease' means a disease arising out of and in the course of the employment, or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence."

It is undisputed that Petitioner worked as a firefighter and became a firefighter/EMT and firefighter/paramedic for Respondent since 2002. His duties included fire suppression, responding to emergency calls, fire, EMS, auto accident calls. Petitioner's unrebutted testimony was that he was exposed to multiple risks on the various types of calls including the alarms, during fire suppression, accident extrication and emergency medical services, very strenuous activities. Petitioner testified that he performs this strenuous work while wearing heavy, insulated personal protective equipment ("PPE") in extremes of heat and cold. He testified he would remove his mask while doing overhaul to check for any spot fires. While fighting fires, he was exposed to household items, insulation, drywall, dust, soot from the fire that was just put out, and asbestos in old buildings. The articles testified to by both medical experts find that carbon monoxide is a common byproduct released by the combustion of contents in family residences. The Fire Suppression and Hazmat records produced by Respondent confirm that Petitioner was present at dozens of fires, and responded to numerous other calls. These occupational exposures constitute a risk peculiar to or increased by the employment and not common to the general public.

It is also undisputed that Petitioner had an episode of chest pain on January 21, 2011 shortly after the exertion of the call on that morning which led him to seek medical attention, resulted in finding of his coronary artery disease and performing of the cardiac catheterization and stenting performed on April 11, 2011 to address the 99% blockage in the LAD.

Petitioner initially raises the rebuttable presumption for firefighters to establish causal connection. The provisions of 820 ILCS 310/1(d) relating to a rebuttable presumption reads as follows:

"Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), emergency medical technician-intermediate (EMT-I), advanced emergency medical technician (A-EMT), or paramedic which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, EMT-I, A-EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission."

Petitioner has the necessary 5 years to qualify for the application of this presumption. The application of the statutory presumption has been addressed in *Johnston v. IL Workers' Comp. Com.*, 2017 IL App 160010WC, 80 N.E2d 573 (2d Dist. 2017) and *Simpson v. IL Workers' Comp. Com.,* 2017 IL App 160024WC, 79 N.E2d

643 (3d Dist. 2017). The Occupational Disease provision has been interpreted the same as the WC provision in *Ekkert v. Ill. Workers' Comp. Comm'n,* 2018 IL App (2d) 170447WC-U ; 2018 Ill. App. Unpub. LEXIS 2005 (2nd Dist, 2018). *Johnston* held that this presumption was a bursting-bubble presumption. *Johnston*, 2017 IL App (2d) 160010WC, ¶ 37. That is, the presumption places a burden on an employer to come forward with some evidence to negate it. Id. Once the employer does so, the presumption vanishes, and the trier of fact must then address the evidence as if the presumption never existed. Id. The ultimate burden of persuasion remains with the claimant. Id. ¶ 36 (quoting *Diederich,* 65 Ill. 2d at 100-01). Furthermore, this is not a "strong" presumption. It does not require a Respondent to come forward with some heightened quantum of evidence, such as clear and convincing. Id. Rather, it simply requires "the employer to offer some evidence sufficient to support a finding that something other than claimant's occupation as a firefighter caused his condition." (Emphasis in original.) It is not necessary for an employer to present evidence eliminating occupational exposure as a cause of a claimant's condition of ill being. Id. ¶ 51. It is sufficient to rebut the presumption if "the employer introduces some evidence of another potential cause of the claimant's condition." *Simpson*, 2017 IL App (3d) 160024WC, ¶ 46. Once rebutted, the Commission is free to resolve any factual dispute as it would in an ordinary workers' compensation case, without reference to the presumption. Id.

Respondent offered the testimony and reports of Dr. Drinan who opined that Petitioner's firefighter activities did not cause his cardiac atherosclerosis condition causing 99% blockage of his left anterior descending artery. His condition was the result of underlying cardiac risk factors, including past history of cigarette smoking, a history of hypertension, high cholesterol or significant lipid abnormalities, high/elevated triglycerides, being inactive and overweight, his March 12, 2008 heart scan showing calcium in his coronary artery, and his male sex. Based upon the standard as set in *Johnston* and *Simpson*, Respondent has presented sufficient evidence to fulfill its burden of production and rebut the presumption. Finding the presumption to be successfully rebutted, the Arbitrator must weigh the evidence to determine whether Petitioner has proven by a preponderance of the evidence that his coronary artery disease was causally related to his occupational exposures.

Petitioner offered the testimony of Dr. Cochran who opined that Petitioner's coronary artery disease was caused by the essential functions of a firefighter. She cited her review of the literature supporting that the strenuous activities of firefighting under emergency/alarm conditions requiring sudden, rapid and urgent response to emergencies created a mechanism of oxidative stress that caused inflammation in the arteries and the acceleration of the deposition of atherosclerotic plaque. She testified that this oxidative stress and coronary artery inflammation cause plaque in the arteries to develop and are more prevalent in firefighters as a result of the exposure to carbon monoxide and other toxins during fire suppression, the physical stress of wearing 100 pounds of FF equipment, and physically fighting fires, and the psychological fight/flight stress when responding to fire alarms.

Respondent presented the testimony of Dr. Drinan who opined that Petitioner's firefighter activities did not cause his cardiac atherosclerosis condition causing 99% blockage of his left anterior descending artery. His condition was the result of underlying cardiac risk factors, including past history of cigarette smoking, a history of hypertension, high cholesterol or significant lipid abnormalities, high/elevated triglycerides, being inactive and overweight, his March 12, 2008 heart scan showing calcium in his coronary artery, and his male sex.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill.

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

Having heard the testimony and reviewed the exhibits in this matter, the Arbitrator finds that the medical evidence supports Petitioner's claim that his occupational exposures contributed to his condition of ill-being. Dr, Cochran specifically opined that Petitioner's coronary artery disease was caused by the essential functions of a firefighter. While Dr. Drinan testified that she held an opposite conclusion, the underlying medical records and Dr. Drinan's own testimony are in conflict with her conclusion.

Petitioner's medical records and testimony dispute any claim that he was not active. He testified to his work outs. These are also included in the medical histories. Petitioner's height and weight dispute any claim of obesity. While Petitioner had some elevated blood pressure reading, he was not diagnosed with hypertension. Despite regular physical examinations, he was never placed on any medication or treatment regime for this condition. Petitioner was noted to have elevated cholesterol, but no medication was prescribed. The Arbitrator also notes that the 2008 CT scan only noted a mildly elevated risk factor from the calcium finding and no referral or treatment was initiated. The Arbitrator also notes that while Petitioner's smoking was acknowledged as a risk factor, although how significant is disputed, that he had stopped years before 2011. The Arbitrator finds notations in medical records advising patients on smoking cessation, diet and exercise are a norm regardless of medical findings. Post-surgical recommendations and medication for hypertension and hyperlipidemia are also standard protocols and do not imply prior disease.

The Arbitrator finds significant that Dr. Drinan acknowledged the findings of increased coronary artery disease among firefighters. She testified that the articles reviewed show a higher risk of plaque deposition in firefighters than would be anticipated for persons of their age indicating a greater risk of plaque deposition. She agrees that the literature discloses that the incidence of coronary artery disease is greater among firefighters that the general population. She agrees that the firefighting duties can stimulate the release of stress hormones and lease to oxidative stress. These are the elements identified by Dr. Cochran as a risk to develop coronary artery disease. Dr. Drinan admits that the more risk factors, the higher the likelihood of developing the disease. While she distinguishes in her testimony between an association and a cause, her testimony actually supports causation. She refers to smoking and the other risk factors as associations, just like firefighting, and then attributes Petitioner's condition to the other risk factors, while ignoring his employment. The Arbitrator finds this distinction unpersuasive. Dr. Cochran's opinions, the testimony of Dr. Drinan and the discussion of the medical studies and articles support that Petitioner's firefighting duties were at least a contributing factor in the development or progression of his coronary artery disease.

The Arbitrator finds that the appropriate date for the last exposure for the occupational disease was January 21, 2011, the date that Petitioner first suffered the symptoms and sought medical care for his chest pain. Petitioner's testimony and medical histories document that he continued to notice symptoms, but had no further acute episodes thereafter. It was the continued symptoms from his January 21, 2011 episode that resulted in his seeking further medical workup and ultimately the diagnosis and his surgery.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he was exposed to an Occupational Disease on January 21, 2011 resulting in coronary artery disease and a 99% blockage of the LAD.

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based upon the Arbitrator's findings with respect to Accident and Causal Connection, reasonable and necessary treatment for Petitioner's coronary artery condition would be causally connected. Dr. Drinan specifically opined that the treatment received was reasonable and necessary. PX 1 contains the bills for the treatment rendered as documented in the medical exhibits admitted. The exhibit documents the payments made by Respondent's group medical carrier Blue Cross/Blue Shield of $104,554.94 and by Petitioner for deductibles and co-pays totaling $1,462.55. There is also an outstanding balance noted on Dr. Burks statement dated May 1, 2011, but the Blue Cross/Blue Shield statement dated 2/7/2018 notes payment made on these charges.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services of $1,462.55, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $104,554.94 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. The undisputed testimony is that Petitioner was off work from April 8, 2011 through May 6, 2011.

Petitioner was paid sick time for 7 of the 9 shifts missed. He testified that this is a vested benefit per the union agreement. Respondent has made no claim for credit for these payments. Petitioner also testified that the additional two shifts were paid as Kelly days. These are a payroll device used by Respondent. No evidence was presented to dispute Petitioner's explanation of their use. The Arbitrator does not find that Respondent is entitled to credit for these payments which required Petitioner to work other days to repay the time.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled temporary compensation for a period of 4 weeks commencing April 8, 2011 through May 6, 2011.

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

Section 1(e) of the Workers' Occupational Diseases Act ("OD Act"), states:

"Disablement' means 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; and 'disability' means the state of being so incapacitated."

Petitioner's date of accident is before September 1, 2011 and therefore the provisions of Section 8.1b of the Act are not applicable to the assessment of partial permanent disability in this matter.

Petitioner was diagnosed with a proximal LAD left anterior descending artery (LAD) lesion at 99% occlusion. Dr. C. Dean Katsamakis performed an angioplasty and stenting. Following his procedure, Petitioner returned to light duty work within a month and was back to full duty firefighting shortly thereafter. On October 5, 2011, an exercise test and another nuclear myocardial rest/stress SPECT exam test demonstrated no abnormality. On November 28, 2011, a repeat cardiac catheterization did not show any in-stent restenosis. On June 23, 2014, an exercise stress test with SPECT imaging showed: 1. Excellent exercise tolerance. 2. Negative stress EKG. 3. No clinical signs for coronary insufficiency present, the patent denied chest pain. 4. No arrhythmias were noted. The nuclear rest and stress gated SPECT myocardial perfusion imaging showed: 1. The examination was normal showing no evidence of stress-induced ischemia. 2. Normal wall motion and contractility (PX 11).

Petitioner has continued with his full duty employment with Respondent. He admitted no further medical treatment since 2014. Petitioner continued to take aspirin as a blood thinner. He still sees Dr. Katsamakis. He notices that he has less endurance and stamina than I did before the stent and taking all the medications. He can't exercise or be physically active as long as he used to be able to. He bruises very easily and it's harder to control bleeding. He is concerned about hitting his head and causing a brain bleed. He had some sexual dysfunction after the stent and the medications. Due to the stent and the medications, his max heart rate is lower than it used to be, so he has to be careful when exercise or doing physical activity to monitor how he is feeling because he can very
easily get to what his max heart rate is now.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the injuries sustained as a result of the injury on January 21, 2011 caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC016193
Case Name	AGBEZOUHLON, KOAMI v. TYSON FOODS INC WORKERS' COMP
Consolidated Cases	No Consolidated Cases
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	21IWCC0484
Number of Pages of Decision	3
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Owolabi Alaba
Respondent Attorney	Matthew Rokusek

DATE FILED: 9/23/2021

/s/Stephen Mathis, Commissioner

Signature

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Koami Agbezouhlon,

Petitioner,

vs. No. 08 WC 16193

Tyson Foods, Inc.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the appellate court. On February 5, 2021, the appellate court filed a Rule 23 Order finding that Petitioner reached maximum medical improvement as of September 3, 2008, rather than June 19, 2008 found by the Commission. The appellate court ordered and directed the Commission to: (a) enter a finding that Petitioner reached maximum medical improvement as of September 3, 2008; (b) award Petitioner temporary total disability benefits from July 1, 2008, through September 3, 2008; (c) order Respondent to pay related medical bills incurred by Petitioner through September 3, 2008; and (d) remand the matter to the Arbitrator for further proceedings pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980). *Agbezouhlon v. Workers' Compensation Comm'n*, 2021 IL App (3d) 200161WC-U, ¶ 79. The Commission hereby complies with the Order of the appellate court.

The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to *Thomas*.

IT IS THEREFORE ORDERED BY THE COMMISSION that a finding is entered that Petitioner reached maximum medical improvement as of September 3, 2008.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $314.67 per week for a period of 9 2/7 weeks, from July 1, 2008, through September 3, 2008, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the related medical bills in evidence that Petitioner incurred through September 3, 2008, pursuant to §§8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. 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.

September 23, 2021

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

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d-08/25/2021
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/s/ *Deborah J. Baker*
Deborah J. Baker

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC000604
Case Name	BABUSKOW, PATRICK v. CITY OF CHICAGO, FLEET
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0485
Number of Pages of Decision	12
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Michael Rom
Respondent Attorney	Lucy Huang

DATE FILED: 9/23/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with 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

PATRICK BABUSKOW,

Petitioner,

vs. NO: 14 WC 604

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection and the nature and extent of Petitioner's permanent partial disability, including whether the injuries sustained resulted in his loss of trade, and being advised of the facts and law, modifies the Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner worked for Respondent as an electrician. On August 2, 2013, he was working in a bucket suspended in the air. As he was getting out of the bucket, he twisted his knee, felt pain in his knee, and the knee swelled. He reported the incident and continued working. Later that day, Respondent sent him to MercyWorks. An MRI was taken six weeks later which showed a 2/3 tear of the lateral meniscus with a predominant radial morphology. He was referred to an orthopedic surgeon. On April 22, 2014, Dr. Bach performed "arthroscopic medial plica and fat pad debridement (i.e. 2-compartment synovectomy)" for medial plica and fat pad syndrome.

On July 14, 2014, Dr. Bach noted that Petitioner struggled to regain motion and had more pain than normal after the arthroscopic soft-tissue debridement 12 weeks postop. He indicated Petitioner had burning sensation and discomfort with light-touch palpitation and was concerned that he had early stages of Complex Regional Pain Syndrome ("CRPS"). If he were determined to have CRPS, Dr. Bach recommended surgical intervention on scar tissue followed by aggressive physical therapy. In the interim, he administered a cortisone injection and stated that Petitioner remained unable to work. He ordered a repeat MRI that showed a small undersurface tear of the posterior horn of the lateral meniscus and mild chondromalacia with the lateral patellar facet and the trochlea. On October 14, 2014 Dr. Bach performed right-knee arthroscopic lysis of adhesions for thickened scar tissue anteromedially.

After the second surgery, Dr. Bach continued to treat Petitioner with injections, medications, and physical therapy. Petitioner eventually came under the care of Dr. Lubenow for CRPS. Petitioner had extensive treatment with Dr. Lubenow including physical therapy, epidural steroid injections, nerve block injections, long-term infusion of pain medication most notably Fentanyl, and even an experimental treatment for CRPS that was developed in Italy. There were also discussions about implanting a spinal cord stimulator to control Petitioner's pain level, but that procedure was never performed.

On February 22, 2016 an FCE was performed and determined to be valid. Petitioner was found to be able to function at the medium physical demand level, while his job required medium to heavy physical demand. While he appeared to be able to lift the required weight, he still had difficulty performing other necessary job tasks such as climbing ladders and prolonged standing. Work hardening was recommended. On May 8, 2016, Petitioner had the last work conditioning treatment after 32 visits and no missed appointments. He still complained of 6/10 pain and still could function at the medium physical demand level.

Petitioner testified that he returned to work in late May 2016, and was restricted to no work on uneven ground, no climbing ladders over six feet, and that he be allowed to wear shorts to reduce pain from the fabric touching his knee. He last saw Dr. Lubenow on December 19, 2019 and he has to return to him every three months. He prescribes Norco, but Petitioner asked for the smallest dosage (5 mg) so he could continue working. Currently, he took one tablet a day usually at lunchtime. Currently, he worked as an electrician repairing/replacing biometric employee swipe-in punch machines. He has been doing this job since his return to work in 2016. It's a full-time job.

Petitioner testified that currently, his knee was the same as it was prior to his first surgery. His range of motion was almost "nil." He could walk, but still had difficulty going down stairs. He had pain every day. Dr. Lubenow indicated that he was simply trying to isolate Petitioner's pain so that it does not spread throughout his body. Petitioner was worried about that possibility.

The Arbitrator found that Petitioner's stipulated accident caused his current conditions of ill-being of torn meniscus and CRPS. We agree with that determination and in any event, Respondent stipulated to causation after Petitioner's testimony. Therefore, that portion of the Corrected Decision of the Arbitrator is affirmed and adopted.

The Arbitrator awarded Petitioner 43 weeks of permanent partial disability benefits representing loss of the use of 20% of the right leg. In assessing Petitioner's partial permanent disability, the Arbitrator gave great weight to Petitioner's occupation of electrician. However, in doing so, he also noted that Respondent had accommodated his restrictions, and he was assigned to do electrician services that did not require the use of ladders, bending his right knee, or prolonged standing. The Arbitrator also gave significant weight to his age (45 at the time of the accident) and noted he would have to live with the condition for the rest of his life. He also gave significant weight to the fact that Petitioner was earning the same salary as he did prior to the injury. Finally, the Arbitrator noted that the medical records corroborated Petitioner's testimony about his ongoing complaints and impairments and supported his conclusion that a permanent partial disability award of 43 weeks representing loss of the use of 20% of the right leg was appropriate.

Petitioner argues the Arbitrator erred in awarding an award for partial loss of the use of his right leg. Petitioner argues that an award for loss of the person-as-a-whole is more appropriate because Petitioner sustained a loss of his normal occupation of electrician under §8(d)(2) of the Act. Petitioner testified that he could no longer work as he did previously as an electrician, and the record indicates that he had physical deficiencies that interfered with performing many activities associated with the profession of electrician. However, the record is clear that Petitioner actually worked as an electrician for Respondent from his return to work in May 2016 to the date of arbitration and that he was earning the same salary he would have earned had he not been injured. Therefore, the Commission concludes that an award based on loss of trade pursuant to §8(d)(2) is not appropriate in this claim.

While we find that an award based on Petitioner's loss of trade is not warranted here, we also find that the Arbitrator's permanency award is not adequate for the injuries Petitioner suffered. The Commission has no specific issue with the weight the Arbitrator gave to the statutory factors used to assess permanent partial disability. However, we interpret those statutory factors to support a larger permanency award. Petitioner developed CRPS post-surgery which Respondent's §12 medical examiner, the Arbitrator, and now the Commission have all determined were causally related to Petitioner's work-related accident. Petitioner has already had extensive treatment for that condition for over five years and testified he continues to see Dr. Lubenow every three months. As demonstrated by the records before us, CRPS is a persistent, painful, and debilitating condition that can continue indefinitely.

The Commission believes that Petitioner's development of CRPS should increase the statutory factor of evidence of disability corroborated by the medical record. In looking at the entire record before us, the Commission finds that an award of 96.75 weeks representing the

permanent loss of the use of 45% of the right leg is appropriate in this claim. The Commission modifies the Corrected Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator dated July 22, 2020 is modified as specified above and otherwise affirmed and adopted, which is attached hereto and made a part hereof.

IT IS FURTHER ORDERED BY THE COMMISISON that Respondent shall pay to University Pain Physicians the sum of $2,091.14 for medical expenses under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2 of the act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $721.66 per week for a period of 96.75 weeks because he sustained loss of the use of 45% of the right leg, as provided in §8(e) of the Act.

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

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

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.

September 23, 2021

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

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

DLS/dw
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/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0485

NOTICE OF ARBITRATOR DECISION

CORRECTED

BABUSKOW, PATRICK Case# **14WC000604**

Employee/Petitioner

CITY OF CHICAGO

Employer/Respondent

On 7/13/2020, 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 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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0010 CITY OF CHICAGO CORP COUNSEL
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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 - CORRECTED

Patrick Babuskow
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **604**

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

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**87,536.66**; the average weekly wage was $**1,683.40**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**122,172.55** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**122,172.55**.

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

ORDER

Per stipulation of the parties all TTD has been paid, with no overpayment or underpayment.

Respondent shall pay reasonable and necessary medical services directly to the medical provider, pursuant to the medical fee schedule, of $2,091.14 to University Pain Physician, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 43 weeks because he sustained a 20% loss of use of right leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

July 10, 2020
Date

JUL 13 2020

CORRECTED

FINDINGS OF FACT

At the time of the accident in this case, Petitioner, Patrick Babuskow ("Petitioner"), was a 45-year-old electrician for the Respondent, City of Chicago ("Respondent"). Petitioner was hired by the City of Chicago in 1993, and from that date until his accident on August 2, 2013, Petitioner worked on a bucket truck. (Transcript of Arbitration Proceedings ("Trans") at 10). Electricians who work on the bucket truck perform maintenance on all City lights that are elevated up to fifty-five feet in the air. (Id.). Petitioner was required to climb in and out of the bucket attached to a boom in order to perform electrical duties on these elevated lights. (Id. at 10-11). On August 2, 2013, Petitioner suffered an undisputed accident when he twisted his right knee while exiting the bucket. (Trans. at 12).

Petitioner was directed to Mercy Works for treatment and came under the care of Dr. Homer Diadula ("Dr. Diadula"). (Pet. Ex. 1). Dr. Diadula recommended an MRI which took place on September 13, 2013 and revealed a complex tear of the right lateral meniscus. (Pet. Exs. 1, 2). Based on the MRI results, Petitioner was referred to an orthopedic surgeon, Dr. Michael Maday ("Dr. Maday"), for further treatment. (Pet. Ex. 1). On October 9, 2013, Petitioner was treated by Dr. Maday and was advised that he required surgery to repair the torn lateral meniscus. (Pet. Ex. 3). Petitioner sought a second opinion from Dr. Bernard Bach ("Dr. Bach") from Midwest Orthopaedics at Rush on October 28, 2013. (Pet. Ex. 4). Dr. Bach conducted an examination and reviewed the MRI report and diagnosed Petitioner with right lateral meniscus tear. (Id.). Dr. Bach recommended a lateral knee arthroscopy and partial lateral meniscectomy. (Id.).

On December 2, 2013, Petitioner returned to Dr. Bach's office for a follow-up visit. (Id.). Petitioner continued to complain of occasional swelling with a clicking sensation and had difficulties squatting. (Id.). Petitioner also reported that he previously underwent a right knee open surgery when he was 13 years old. (Id.). Petitioner was diagnosed with right medial plica and fat pad syndrome and lateral meniscal horizontal tear. (Id.). Dr. Bach continued to recommend a right knee arthroscopic medial plica and fat pad debridement with partial lateral meniscectomy (Id.).

On April 22, 2014, Dr. Bach performed a right knee arthroscopic medial plica and fat pad debridement. (Id.). Following the initial surgical procedure, Petitioner continued to complain of pain, intermittent swelling, and stiffness of the right leg. (Id.; Trans. at 17). On June 9, 2014, Dr. Bach performed an epidural steroid injection on Petitioner's right knee due to the ongoing pain. (Id.).

On October 14, 2014, Dr. Bach performed a second surgery at RUSH Surgicenter consisting of arthroscopic lysis of adhesions in the right knee. (Pet. Ex. 4). Following the second surgery, Petitioner continued to have pain in the right knee as well as a burning sensation and pain to the touch. (Id.). On October 20, 2014, Petitioner was referred to Dr. Timothy Lubenow ("Dr. Lubenow"), a pain specialist, for further treatment (Id.; Trans. at 18). Five weeks after the second surgery, on November 17, 2014, Petitioner returned to Dr. Bach's office for a follow-up visit. Petitioner reported he was undergoing physical therapy; however, his knee pain had not improved. Dr. Bach recommended continuing with physical therapy (Pet Exs. 4, 6).

On November 20, 2014, Petitioner came under the care of Dr. Lubenow for pain management. (Trans. at 19). Dr. Lubenow performed multiple right lumbar sympathetic nerve blocks at L2 and L3. Dr. Lubenow diagnosed complex regional pain syndrome ("CRPS") in the

right lower extremity. (Pet. Ex. 7). In order to treat the CRPS, Petitioner was hospitalized from May 4, 2015 to May 8, 2015 for placement of an epidural catheter for short term infusion of pain medication. Petitioner indicated relief from the procedure, and as a result, a second procedure was performed inpatient from July 14, 2015 through July 18, 2015. (Id.). Both procedures involved catheters placed in the Petitioner's lumbar spine at L5-S1 and threaded to the right side of the L3 vertebral body. (Id.). The records from the July 14, 2015 hospitalization indicate that the May placement had a positive result concerning pain relief. (Id.). Petitioner testified that he desired the second epidural catheter infusion in order to exhaust all conservative measures before proceeding with a spinal cord stimulator. (Trans. at 28). Petitioner further testified that the second epidural catheter infusion also provided relief. (Id. at 21).

On May 28, 2015, at the request of the Respondent, Petitioner underwent an independent medical exam with Dr. Howard Konowitz ("Dr. Konowitz"). (Resp. Ex. 2). Dr. Konowitz opined that Petitioner suffered a right knee injury with postsurgical complex regional pain syndrome in the right lower extremity, and that the condition was related to the work injury. (Resp. Ex. 3). Dr. Konowitz recommended an ultrasound guided saphenous nerve block to the right knee. (Id.).

On December 7, 2015, Dr. Lubenow placed a tunneled lumbar epidural catheter in Petitioner's back at L5-S1, threaded to L3, for long term continuous infusion of clonidine, fentanyl and bupivacaine. (Pet. Ex. 7). Petitioner then underwent a six-week trial of the infusion at home. (Trans. at 22). The treatment provided enough pain relief that Petitioner was able to undergo multiple courses of physical therapy at ATI Physical Therapy. (Pet. Ex. 6). Petitioner advanced to work hardening and on May 9, 2016, underwent a functional capacity evaluation ("FCE") at ATI Physical Therapy. (Id.). The FCE was found to be valid and provided that Petitioner could return to work with restrictions of no use of a ladder over six feet and, no walking on uneven ground. (Id.). Petitioner retuned to work at a modified position which did not require him to work on the bucket truck. (Id.).

Petitioner continues to treat with Dr. Lubenow and is seen every three months. (Trans. at 26). Dr. Lubenow's last record, dated December 19, 2019, indicates that Petitioner was prescribed Norco 5mg once per day. (Pet. Ex. 7). The record indicates that Petitioner continues to have swelling, neuropathic pain, and the sensation of cold in the right knee. (Id.). Dr. Lubenow further noted allodynia in the right knee with limited flexion/extension on ROM testing. (Id.). Dr. Lubenow continued to impose restrictions of no unprotected ladders, no heights greater than six feet and that Petitioner be allowed to wear shorts due to his CRPS. (Id.). Petitioner testified that he usually takes the Norco at lunchtime in order to make it through the workday. (Trans. at 27-28)

At the time of the hearing, Petitioner testified he continues to experience pain and burning sensation with his right knee. (Trans at 32). Petitioner reported difficulties walking up and down the stairs or uneven ground and has reduced range of motion (Id.). Petitioner testified that he has continued to see Dr. Lubenow for follow-up visits every two to three months (Id. at 27).

CONCLUSIONS OF LAW

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

The Arbitrator repeats the findings set forth above as if fully set forth herein.

Petitioner alleges that there may remain an outstanding balance to University Pain Physicians in the amount of $2,091.11.[1] (Pet. Ex. 8). Respondent does not allege the charges from University Pain Physicians are for treatment or for charges which are not necessary or reasonable. Rather, Respondent argues that they may have paid the bills already, and if not, they should be directed to pay the bills. Respondent submitted into evidence a Payment Report documenting the payments made on this claim. (Resp. Ex. 1). This document demonstrates that numerous amounts were paid by Respondent but that there were dates of service which were not paid. (Id.).

The Arbitrator finds the treatment provided by Univeristy Pain Physicians to be reasonable and necessary for the care and treatment of Petitioner. As such and based upon the stipulation of the parties on the record (See Trans. at 4). Respondent shall pay any outstanding balances directly to University Pain Physicians pursuant to the fee schedule and Section 8(a) and 8.2 of the Act.

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

As detailed in the Findings of Fact *supra*, Petitioner sustained injuries to his right leg and has developed CRPS. As a result of this work-related injury Petitioner has permanent restrictions and has lost his ability to perform his normal job as an electrician and is prevented from performing tasks he previously performed for the Respondent. As Petitioner's accident occurred on August 2, 2013, §8.1(b) of the Act applies. 820 ILCS 305/8.1b(b) of the Act requires consideration of five factors in determining permanent partial disability:

1. The reported level of impairment pursuant to section (a);
2. The occupation of the injured employee;
3. The age of the employee at the time of the injury;
4. The employee's future earning capacity; and
5. Evidence of disability corroborated by the treating medical records.

The statute provides that no single factor shall be the sole determinate of disability. The statute requires a written order explaining the relevance and weight of any factors used in addition to the level of impairment as reported by the physician. (Id).

1. Reported level of impairment:

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits, the Arbitrator will assess Petitioner's permanent disability based upon the remaining enumerated factors. *See Corn Belt Energy Corp. v. Illinois Workers' Compensation* Commission, 2016 IL App. (3d) 150311WC.

2. Petitioner's occupation:

The record reveals that Petitioner was employed as an electrician. (Trans. at 9). Petitioner testified that he could not return to his normal position as an electrician as it would require the use of ladders, bending of his right leg, and standing on feet all day. (Trans. at 31). However, Petitioner

[1] Pertaining to listed balances on the following dates of treatment 5/24/18; 9/5/18; 12/12/18; 3/6/19; 6/12/19; 9/25/19; and 12/19/19.

is being accommodated by Respondent and by tasking him to provide electrician services to the city's biometric machines – a duty which does not require the use of ladders, bending of this right leg, or standing on his feet all day. (Trans. at 29). The Arbitrator gives this factor great weight.

3. Petitioner's age at the time of injury:

The Arbitrator notes that Petitioner was 45 years old at the time of his work accident with no prior history of symptoms, injury, or treatment to his right leg or back. Petitioner did not suffer from CRPS before the undisputed accident. Petitioner will have to live with the effects of his work accident for the rest of his life. As a result, the Arbitrator gives significant weight to this factor.

4. Petitioner's future earning capacity:

Petitioner has no loss of earnings. Nothing in the record, including his testimony, suggests that his future earning capacity has been affected by the injury sustained. (Pet. Ex. 6). Petitioner testified when he returned to work, he resumed earning the same wages as he had prior to the work incident (Trans. at 34). The Arbitrator places significant weight is placed on this factor.

5. Evidence of disability corroborated by the medical records:

The Arbitrator finds that Petitioner's disability has been corroborated by the treating medical records entered into evidence. Petitioner was diagnosed with and treated for a right medial plica and fat pad syndrome and lateral meniscal horizontal tear. The Petitioner now has permanent restrictions which prevent him from returning to his previous job repair streetlights, however Petitioner was able to return to work with the Respondent as an electrician earning the same pay under the restrictions.

Petitioner testified he continues to experience pain and burning sensation with his right knee. (Trans at 32). Petitioner reported difficulties walking up and down the stairs or uneven ground and has reduced range of motion (Id.). Petitioner testified that he has pain to touch on the right knee, as to often wears shorts, and takes prescription Norco a lunch time so as to get through the balance of his workday. (Trans. at 27-28). He also uses pants that zip off at the thigh when he needs to relieve the pain. (Id. at 18). All medical records submitted into evidence support Petitioner's credible testimony. The Petitioner's testimony, subjective complaints, objective findings and the opinions of the treating doctors and the independent medical examiner all support a permanent partial disability award of 20% loss of use of the right leg pursuant to Section 8(e) of the Act at a rate of $721.66 per week.

Signed: _____ July 10, 2020
SIGNATURE OF ARBITRATOR DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005404
Case Name	ARROYO, ANGELICA v. NESTLE USA, INC/ FERRARA CANDY
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0486
Number of Pages of Decision	23
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Randall Sladek
Respondent Attorney	Padraig McCoid, Lauren Zimmer

DATE FILED: 9/24/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angelica Arroyo,
Petitioner,

vs. No. 19 WC 005404

Nestle USA and Ferrara Candy,
Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of wage calculation, causal connection, medical expenses, prospective medical care, the duration of temporary disability, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

I. FINDINGS OF FACT

Petitioner, a 33-year-old production cleaner, was employed by Respondent Nestle to empty dust collection totes, change water buckets, wipe down machines, sweep, mop, and drive the scrubber on the production room floors. Petitioner was hired by Respondent Nestle 11 years prior to her accident and continued to perform the same tasks when Nestle was purchased by Respondent Ferrara on January 1, 2018.

On May 9, 2017, seven months prior to Ferrara's purchase of Nestle, Petitioner was pressing down the handle on the mop bucket to wring out the mop when she felt immediate pain in her right wrist. She reported her injury to her supervisor and was advised to report to Concentra for evaluation. On May 10, 2017, Dr. Weaver diagnosed Petitioner with tendinitis and

a ganglion cyst of her right wrist dorsum. He provided anti-inflammatories and a wrist brace and returned Petitioner to work full duty. She returned to the clinic later that month with ongoing complaints of numbness and pain from her hand to her elbow and burning pain to her shoulder and was sent for physical therapy and restricted to light duty.

Dr. Weaver referred Petitioner to Dr. Suchy, a Concentra orthopedist, in June 2017, but Dr. Suchy provided no additional treatment and found Petitioner capable of working full duty on June 27, 2017. Petitioner continued to work without restrictions or additional treatment until September 27, 2017, when she returned to Dr. Weaver with worsening symptoms. Dr. Weaver again referred her to Dr. Suchy, who aspirated the growing cyst, injected lidocaine, and suggested that excision of her ganglion cyst might be necessary if the injection was not successful in alleviating Petitioner's complaints. When Petitioner complained that the injection aggravated her right wrist complaints and she developed generalized bilateral wrist and neck complaints, Dr. Suchy referred her to Dr. Barakat, a Concentra hand specialist, and Dr. Murtaza, a Concentra spine specialist. Neither doctor provided a diagnosis that adequately explained her symptoms, and both Respondents obtained §12 opinions.

Dr. Tulipan examined Petitioner at Ferrara's request on January 7, 2019. He diagnosed her with right extensor tenosynovitis and a ganglion cyst and concluded that both conditions could have been causally related to her repetitive work activities. He found her other complaints unrelated and recommended conservative treatment for her right wrist.

Dr. Biafora examined Petitioner for Nestle on July 12, 2019. He agreed with Dr. Tulipan that Petitioner's ganglion cyst could have been related to her work activities and opined that excision surgery might be necessary.

Petitioner began treating with Dr. Fernandez on June 27, 2019. He recommended a right wrist arthroscopy for ganglion cyst excision and performed the excision on September 18, 2019. Dr. Fernandez noted a right wrist triangular fibrocartilage (TFC) tear and posterior interosseous nerve neuroma, which he also addressed during the surgery. Petitioner performed post-operative occupational therapy but continued to have generalized bilateral complaints.

Nestle obtained a second §12 exam by Dr. Biafora on February 6, 2020. Dr. Biafora did not believe Petitioner's current complaints were related to her work accident, found her at MMI, and returned her to work full duty.

Petitioner's complaints continued, and Dr. Fernandez ordered an updated EMG and MRI of the right wrist. He found evidence that the ganglion had recurred and there was a new TFC tear. The EMG revealed evidence of right cubital tunnel syndrome. Dr. Fernandez recommended repeat surgery to excise the ganglion and to repair the TFC tear. He also recommended a cubital tunnel release at the right elbow.

Dr. Biafora provided a supplemental report on August 24, 2020, after reviewing the updated test results and Dr. Fernandez's treatment recommendations. He opined that the recurrent ganglion was related to the May 9, 2017 work accident, but he found Petitioner's cubital tunnel syndrome unrelated as it only recently became symptomatic. Dr. Biafora agreed

that excision surgery and all of the treatment for Petitioner's right wrist thus far were reasonably required to cure or relieve Petitioner from the effects of her accidental injury.

The Arbitrator found that Petitioner had failed to prove that there was an employer/employee relationship between her and Respondent Ferrara Candy on the date of accident; Ferrara was therefore not liable under the Act. The Arbitrator found that Petitioner sustained injuries to her right wrist consisting of tendinitis and a dorsal ganglion cyst in a compensable work accident on May 9, 2017 while employed by Nestle. However, he found that Petitioner had failed to prove that any condition of ill-being she suffered after June 27, 2017 was causally connected to her work accident, so all medical and lost time benefits incurred after that date were denied, including prospective medical care. No penalties or fees were awarded. The Commission views the evidence differently and finds that Petitioner's current condition of ill-being, a right wrist ganglion cyst, is causally related to her May 9, 2017 work accident and awards benefits accordingly.

II. CONCLUSIONS OF LAW

A. Causal Connection

Petitioner bears the burden of proving by a preponderance of the evidence all the elements of her claim. *R&D Thiel v. Illinois Workers' Comp. Comm'n,* 398 Ill. App. 3d 858, 867 (2010). Among the elements that Petitioner must establish is that her condition of ill-being is causally connected to her employment. *Elgin Bd. of Educ. U-46 v. Illinois Workers' Comp. Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The work accident need not be the sole factor or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 205 (2003). If a claimant is in a certain condition before the accident, and that condition deteriorates after the accident, it is plainly inferable that the accident caused the deterioration. *Schroeder v. Illinois Workers' Comp. Comm'n,* 2017 IL App (4th) 160192WC, ¶25.

The Arbitrator found that Petitioner reached MMI with regard to her right wrist on June 27, 2017, when Dr. Suchy found she could return to work regular duty. He declined to find that Petitioner's ganglion cyst continued to require treatment, in part, due to Petitioner's varied complaints of pain and weakness in both hands, arms, and shoulders and in her neck and low back. The Commission agrees that the treating and examining doctors were unable to reach a diagnosis that would explain all of Petitioner's complaints. However, both treating physician, Dr. Fernandez, and Respondent Nestle's examining physician, Dr. Biafora, agreed that Petitioner's right wrist complaints at the time of arbitration were causally related to her work accident.

Notwithstanding, the Commission acknowledges the gap in treatment between Dr. Suchy's finding of MMI on June 27, 2017 and Petitioner's return to Concentra for worsening symptoms on September 27, 2018. The treatment gap does not, however, sever causal connection in this case. In so concluding, the Commission notes Petitioner's May 4, 2020 MRI documenting the recurrent cyst, Dr. Biafora's supplemental report of August 24, 2020 in which he concluded that the recurrent ganglion evidenced in Petitioner's MRI is causally related to her work accident, and Dr. Fernandez's opinion that the recurrent cyst is causally related.

Given the foregoing, the Commission concludes that Petitioner's current condition of ill-being with regard to her right wrist is causally related to her May 9, 2017 work accident.

B. Temporary Total Disability

The Arbitrator found that Petitioner had reached MMI by June 27, 2017, prior to the time her doctors restricted her work. Therefore, he awarded no TTD. Petitioner on review claims that Respondent Nestle had no defense to her claim for 5 and 4/7ths weeks of TTD from January 18, 2020 to February 26, 2020 (when Dr. Biafora found that she could return to work full duty) and an additional 7 and 4/7ths weeks for the period from August 24, 2020 through October 15, 2020 (when Dr. Biafora believed Petitioner should be restricted to 10 pounds lifting and Respondent failed to offer light duty). Because the Commission has concluded there is a causal connection between Petitioner's work accident and her recurrent ganglion cyst, it finds Respondent Nestle liable for a total of 13 and 1/7th weeks of TTD.

C. Medical Treatment Expenses

On review, Petitioner claims that Respondent Nestle is liable for $17,497.00, which is the amount of outstanding medical expenses billed by Dr. Fernandez, Petitioner's current treating physician at Midwest Orthopaedics. The Commission has determined, based upon Dr. Fernandez's and Dr. Biafora's opinions. that Petitioner's ganglion cyst is causally related to her work accident. In so concluding, the Commission relies on those same doctors' opinions that the treatment related to this cyst has been reasonable and necessary to cure the effects of her work accident on May 9, 2017. Pursuant to §8(a) and §8.2 of the Act, the Commission finds that Respondent Nestle is liable for the fee schedule amount for all treatment related to Petitioner's ganglion cyst prior to the time of hearing.

D. Prospective Medical Treatment

Dr. Fernandez has recommended that Petitioner undergo a second excision surgery of her recurrent ganglion cyst. Respondent Nestle's §12 examiner, Dr. Biafora, agreed with this treatment plan in his supplemental report. The Commission finds these doctors' opinions persuasive and orders Respondent Nestle to authorize and pay for the excision surgery recommended by Dr. Fernandez.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 16, 2020, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the outstanding Midwest Orthopaedics medical bill of $17,497.00 to Petitioner, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $576.27 per week for 13 and 1/7th weeks,

commencing on January 18, 2020 through February 26, 2020 and from August 24, 2020 through October 15, 2020, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall authorize and pay for the arthroscopic ganglion cyst excision surgery recommended by Dr. Fernandez, as provided in §8(a) and §8.2 of the Act.

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

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

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 removal of this cause to the Circuit Court by Respondent Nestle is hereby fixed at the sum of $23,340.00. 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.

September 24, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-9/16/21
068

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

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

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

21IWCC0486

ARROYO, ANGELICA
Employee/Petitioner

Case# **19WC005404**

NESTLE USA AND FERRARA CANDY
Employer/Respondent

On 12/16/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
PADRAIG McCOID
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
LAUREN ZIMMER
161 N CLARK ST SUITE 800
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)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Angelica Arroyo
Employee/Petitioner

v.

Nestle USA and Ferrara Candy
Employer/Respondent

Case # **19** WC **05404**

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 **October 15, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 9, 2017**, Respondent **Nestle USA** ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,536.03**; the average weekly wage was $**864.40**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **5** dependent children.

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

Respondent **Nestle USA** shall be given a credit of $**1,914.20** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**1,914.20**.

Respondent **Nestle USA** 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 ON MAY 9, 2017 THERE WAS AN EMPLOYEE/EMPLOYER RELATIONSHIP BETWEEN PETITIONER AND RESPONDENT FERRARA CANDY, PETITIONER'S CLAIM AGAINST THIS RESPONDENT FOR THE ACCIDENT ON MAY 9, 2017 IS DENIED.

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE HAS ANY CONDITION OF ILL-BEING AFTER JUNE 27, 2017 WHICH IS CAUSALLY CONNECTED TO THE ACCIDENT ON MAY 9, 2017, PETITIONER'S CLAIMS FOR MEDICAL, PROSPECTIVE MEDICAL AND TEMPORARY COMPENSATION AGAINST RESPONDENT NESTLE USA ARE DENIED.

PETITIONER'S CLAIM FOR PENALTIES AND ATTORNEY'S FEES IS DENIED,

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

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

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

Signature of Arbitrator

December 9, 2020
Date

ICArbDec19(b)

DEC 16 2020

Statement of Facts

The Arbitrator notes that Petitioner has filed a single application alleging entitlement to benefits against both Respondents Nestle USA and Ferrara Candy alleging a date of accident on May 9, 2017. Petitioner stated at the beginning of the hearing that she is alleging a repetitive trauma injury on that date.

Petitioner Angelica Arroyo testified that she was employed by Respondent Nestle in May 2017 as a production cleaner on the first shift. She had worked for Nestle since September 2006. She testified that she worked overtime and that the overtime was mandatory. She did the same thing every day. She would get to her workplace, take all the dust collector totes to even up. If they needed to get replaced, she would put an empty tote. After that, she would change water buckets for the operators and replace the water buckets on the machines. After her first break, she needed to wipe down, sweep, or mop. Before lunch, she would check the totes again. After lunch, she would run the scrubber for four hours, making sure the all the floors were scrubbed, and clean up dust. The scrubber worked like a car. It had four wheels and you drive it all over. You steer it with a steering wheel. It was hard. After that she would wash and rinse 20 plus mop buckets.

Petitioner testified that on May 9, 2017, she was rinsing the mop out. You must put it in the small basket in the bucket and forcibly pull down in order to get the mop very well dried. While doing that, she felt something like a crack, a pull in her right arm when she bent. She completed her task and at 2:00 she reported it to her supervisor. She told her that she was feeling pain and explained what happened. She was advised to seek medical treatment at Concentra. She went the next day.

Petitioner was seen at Concentra on May 10, 2017 (PX 5). She reported an injury on May 9, 2017 as a result of repetitive activity and pain developing in the right wrist over time from doing her regular work activities, getting worse over the past few weeks. She reported pain located in the right dorsal wrist. The pain radiates to the right hand, right forearm and right third finger. Associated symptoms include numbness in the hand and numbness and tingling to the right third finger. She denied any prior right wrist problems. Exam noted full range of motion with pain, normal strength, 4+ grip strength, negative Tinel's and Faber tests. Skin is normal at the injury site. X-rays of the wrist noted no acute findings. The assessment was right wrist tendinitis, cumulative trauma from repetitive motion, and a ganglion cyst of the dorsum of the right wrist. Petitioner was given Aleve and Tylenol and a glove and brace. She was allowed to continue regular work with supports (PX 5). Petitioner testified that no x-rays were taken of the right arm. The doctor did not examine her right arm.

Petitioner returned on May 19, 2017. Petitioner testified that her symptoms were worsening. She was having more numbness. Her whole arm would get numb. The Concentra records state the symptoms were unchanged. The pain is located in the right dorsal wrist. She reported sharp, constant pain of 8/10. The pain radiates to the right forearm and right shoulder. Associated symptoms include decreased range of motion, stiffness, swelling and tenderness, but no wrist bruising. Physical examination notes full range of motion in the elbow. The right forearm appears normal with tenderness. The right wrist notes the ganglion cyst with pain on range of motion and reduced flexion and extension. Petitioner was continued on medication and full duty work (PX 5). On May 26, 2017, Concentra notes that the symptoms are unchanged and at times the cyst is better. Petitioner was started on prednisone and physical therapy. Petitioner was returned to modified work with no lifting over 10 pounds, no vibratory tools, occasional grip/squeeze/pinch, and avoid forceful gripping (PX 5). On June 2, 2017, she was referred to orthopedic specialists (PX 5).

Petitioner saw Dr. Theodore Suchy on June 13, 2017 with a chief complaint of right wrist pain. The history was that her right wrist has been hurting for the last two months. She denied any specific injury, but stated she does a lot of repetitive work. Physical examination was limited to the right wrist. It documents a very small ganglion cyst over the dorsum of the wrist. There was slight synovitis. Tinel's and Finkelstein's, and carpal tunnel compression tests were negative, Range of motion was full in the fingers. Dr. Suchy's impression was tendonitis with asymptomatic ganglion. He continued physical therapy and returned Petitioner to regular duty with a wrist brace. He discussed a cortisone injection if symptoms worsened (PX 5). Petitioner participated in physical therapy. The notes record that the right shoulder is normal in appearance with no tenderness to palpation. Range of motion and strength are within normal limits. The right elbow is normal in appearance with no tenderness to palpation. Range of motion and strength are within normal limits. Petitioner reported improvement with pain. On June 27, 2017, Dr. Suchy notes Petitioner is doing much better. The ganglion is really not bothering her. She has some pain in the forearm. Dr. Suchy noted therapy appears helpful and released her from care to perform her regular work activities. He states she can wear the brace if she needs to (PX 5). Petitioner testified she did not mention her right elbow during the office visit. Petitioner testified that she returned to regular work.

Petitioner testified she sought no further treatment until September 27, 2018. In the interim, Respondent Ferrara entered into an agreement to purchase Respondent Nestle's confectionary business on January 16, 2018 (RFX 1). Respondent Ferrara was Petitioner's employer as of March 31, 2018 (RFX 1). Petitioner testified she did not go back to the doctor because she did not feel she was treated how she expected by a specialist. She testified she had the same symptoms on a daily basis. She finally went back to the doctor because she could not handle her symptoms anymore, so she had no choice. She testified that she has not sustained any work accidents since May 9, 2017.

Petitioner was seen by Dr. Weaver on September 27, 2018. She advised she was returning for a recheck of her injury. The Injury Date noted on the record is May 9, 2017. Petitioner reported symptoms are worsening and right wrist discomfort recurred and persisted. She reported pain located in the right dorsal wrist and pain radiating into the right hand and third finger and to the right arm at times to the right shoulder. Petitioner was referred back to Dr. Suchy (PX 5).

On October 2, 2018, Dr. Suchy performed an orthopedic evaluation in regard to a mass over the dorsum of the right wrist. Petitioner stated it has been going on for some time. Dr. Suchy notes he saw Petitioner for a traumatic dorsal ganglion a year ago. She never followed up, however, recently it has gotten worse, larger, and more painful. He notes a dorsal ganglion, moderate in size. He performed an aspiration and injected lidocaine. She was released to regular work and was to return in 3 to 4 weeks. Dr. Suchy stated that if this did not work, the next step would be surgical excision of the ganglion (PX 5). Petitioner returned to Dr. Suchy on October 23, 2018 with complaints in both the right and left wrist. Her right wrist pain does not appear to be specific, appears to be generalized pain throughout. His impression was generalized wrist pain, etiology unknown. He could not determine a diagnosis based upon his clinical findings and referred her to Dr. Barakat, a hand and upper extremity surgeon for a second opinion. Petitioner returned on November 14, 2018 with multiple complaints of bilateral wrist, hand and forearm pain. Dr. Suchy stated he cannot help her. He cannot determine a diagnosis (PX 5).

Petitioner saw Dr. Barakat on November 30, 2018. She reported fullness noted approximately a year and a half ago in the dorsal aspect of the right wrist. She returned to full duties. She stated that persistent symptoms and fullness at the right wrist early in October brought her back to Dr. Suchy, who injected her expected ganglion.

Since that time, she has started noticing worsening pain proximally and distally. Her pain description is somewhat all over including the dorsal DIP of the right middle finger, volar palm, ulnar hand, ulnar forearm, elbows. She started noticing left sided symptoms which are vague and nonspecific. She also noted some crepitus and cracking at the lower neck. Petitioner denied depression. Dr. Barakat notes Petitioner is somewhat confused with her description of her symptoms. He finds vague tenderness with normal sensation, range of motion and testing, His impression is diffuse non-specific symptoms bilaterally. He notes a ganglion which is not symptomatic and would not explain her symptoms. He recommended she see Dr. Murtaza for her neck and back. He continued a 5-pound restriction at work (PX 5).

Petitioner saw Dr. Murtaza on December 11, 2018 with complaints of right greater than left upper extremity and neck pain. She reported a work injury on May 9, 2017. She has been in the same job since she was 22. She stated she was pushing down on a bucket and felt a crack in her wrist. She was treated and sent back to work, but her symptoms never improved and only worsened over the following year. Since her injection, she has a cold-type sensation up to her shoulder and itchiness in the biceps and forearm. She complains of cervical spine pain and stiffness as well as different sensations into her arm. Past history notes anxiety and now increasing depression due to this work injury. Physical examination notes tenderness to palpation to the cervical paraspinal and trapezius musculature. There is weakness, right greater that left, in the upper extremities. Dr. Murtaza assessed right upper extremity neuropathic symptoms and mild left upper extremity symptoms as week as cervical spine pain. He recommended and EMG/NCV and cervical spine physical therapy (PX 5).

Petitioner began physical therapy on December 12, 2018. The EMG performed on January 10, 2019 was reported as normal. On January 17, 2019, Petitioner reported in physical therapy that she was not improving. On January 29, 2019, Dr. Murtaza confirmed the EMG was normal. He recommended a cervical MRI and, if it is normal, would suggest an IME for further recommendations (PX 5).

On January 7, 2019, Petitioner saw Dr. David Tulipan at Respondent Ferrara's request (PX 3). Petitioner provided a history of job duties that included working with a manual hand jack to lift pallets of product weighing between 600 and 700 pounds. She pushed 6-8 pallets throughout the day. She reported she was asymptomatic until May 9, 2017, when she was pushing down on the handle of a mop and felt a sudden "crack" in the back of her right wrist and developed dorsal wrist pain and swelling with some bruising. She noted the treatment for tendinitis and repetitive use and her return to work. She stated the mass in the right wrist grew and the hand pain increased radiating down to the dorsum of the middle finger. She stated that after her cortisone injection and return to work she has started to develop a multiplicity of other problems in her neck, shoulder girdle, and lower back with radiation into the shoulders and upper arms. Physical examination noted full range of motion in the cervical spine with subjective complaints. The remainder of the examination is unremarkable except for a small ganglion cyst and some evidence of mild extensor tenosynovitis. An X-ray of the right wrist that day showed no obvious arthritic changes, soft tissue calcification, or evidence of old trauma. Dr. Tulipan diagnosed right wrist dorsal ganglion cyst with mild extensor tenosynovitis (PX 3). He also diagnosed diffuse shoulder girdle, neck, and low back pain of unknown etiology. Dr. Tulipan opined the right extensor tenosynovitis could be related to the injury, and there was a small possibility the ganglion cyst was related. He found the other complaints of weakness in both extremities, pain radiating to the neck and shoulders, and pain in the lower back not related to the work accident on May 9, 2017. He recommended conservative treatment for extensor tenosynovitis and the ganglion cyst (PX 3).

Petitioner returned to Dr. Murtaza on February 12, 2019 with continued complaints in the cervical and lumbar spine. Based upon Dr. Tulipan's causation opinion, Dr. Murtaza stated he could no longer treat Petitioner and discharged her from his care (PX 5). Dr. Barakat provided a progress report on February 26, 2019. He noted she had an asymptomatic ganglion cyst and was not a surgical candidate. He notes she presented with diffuse symptoms, not localized. The EMG of the right upper extremity was negative. Her symptoms did not improve with therapy. Dr. Barakat opines that there is no treatment needed for the hand. She may need further workup for her neck (PX 5). Treatment was paid by Nestle (RFX1, RFX 4).

Petitioner underwent an MRI of the right wrist on June 5, 2019 at Midwest Orthopedics at Rush (PX 6). The impression was a bi-lobed dorsal ganglion cyst and non-specific degenerative signal along the ulnar side of the TFC with a small amount of fluid in the distal radial ulnar joint (PX 6). Petitioner saw Dr. Jon Fernandez on June 27, 2019. His note indicates she presents for reevaluation regarding her right wrist pain and numbness and tingling. He notes the MRI and the previous normal EMG. Petitioner gives a history of dorsal wrist pain for two years. His examination notes subjective complaints of paresthesia involving the ulnar digits but slightly median with two-point discrimination intact. He notes the mass. Range of motion is limited secondary to pain. Dr. Fernandez conclusion is right hand and arm pain with work activities 5/09/2017, atraumatic. He diagnosed a probable ganglion cyst and right-hand numbness and tingling, possible cervical origin versus early peripheral neuropathy. He recommended right wrist arthroscopy for ganglion cyst excision. He restricted Petitioner from regular work (PX 6). On July 1, 2019, Travelers, the carrier for Ferrara Candy authorized surgery (PX 6).

Petitioner was examined by Dr. Biafora on July 12, 2019 at the request of Respondent Nestle (PX4, RNX 3). Petitioner reported an injury to the right upper extremity in May 2017 while rinsing a mop bucket and reaching down with the right arm toward the floor to push squeezing the handle when she felt a crack in her right arm. She described her treatment and the surgical recommendation. She complained of pain in the right hand and wrist that radiates proximally. She has occasional numbness. She denied any left-hand symptoms. Dr. Biafora diagnosed a ganglion cyst. He had no explanation for Petitioner's diffuse right arm numbness. He stated that the mechanism of forcefully pushing down can cause an injury to the dorsal capsule and lead to a ganglion. He states that she has symptoms that are related to the ganglion and it would be reasonable to undergo the excision (PX4, RNX 3).

Dr. Fernandez took Petitioner off work as of September 17, 2019 and performed surgery on her right hand on September 18, 2019 consisting of arthroscopic debridement of the central TFC, open dorsal ganglion excision, excision of posterior interosseous neuroma, and burial of posterior interosseous neuroma into the interosseous muscle space. The postoperative diagnoses were right wrist triangular fibrocartilage tear, central; dorsal carpal ganglion cyst; and posterior interosseous nerve neuroma (PX 6).

Petitioner had an OT evaluation on September 30, 2019. Petitioner reported she had a repetitive use injury. She was feeling it already when finally, one day, she was washing her mop bucket when she felt like she was "on fire all the way to my neck." She stated she felt worse than before surgery. She had pain up her arm and across her neck, and down the other arm. She has burning and spasm into her neck with left hand use as well. She also noted she was depressed. She cannot do anything with her right arm including care for her 5 children. She reported she was working in sanitation, but after the injury changed to production. She reported her work duties included washing mop buckets, changing water in buckets with a high-powered industrial hose, cleaning equipment, running a scrubber for 4 hours, and changing totes. She has no guess how many pounds she lifts. She said that the hose was the hardest thing. The assessment notes that she has fear/apprehension

and guarding. She has a high nervous system reactivity. She has possible cervical involvement. She has significant psychosocial involvement. She has exhibits signs of central sensitization (PX 6).

On October 9, 2019, Dr. Fernandez noted subjective complaints of paresthesia into the entire right hand, he continued therapy and discussed either a diagnostic injection or an EMG if there were continued neurological complaints. On October 22, 2019, Petitioner reported that she was still having pain in her neck and right arm. She was also having issues on the left side as she had become "more left-handed." Dr. Fernandez recommended an evaluation for her cervical spine and right shoulder pain. He stated he had no good explanation for her symptoms. There is not much else he is going to be able to do for that. Petitioner remained on light duty restrictions. Petitioner continued occupational therapy. On October 28, 2019 she reported no improvement. The therapist notes she was on her phone using headphones for the entire session (PX 6). Petitioner continued therapy through December 11, 2019. Additional treatment was authorized and paid by Travelers on behalf of Ferrara (PX 6, PX 7, PX 12, RFX 3).

Petitioner testified that she was off work on FMLA for depression beginning in May 2019 through September 3, 2019. She had been on FMLA during the year before May 2017. She had received FMLA since 2008. Petitioner received TTD from Travelers from September 18, 2019 through November 14, 2019 totally $5,096.53 (RFX 2). In November 2019, Petitioner worked in a transitional duty program (PX 7) through around Christmas 2019 and was paid salary.

Dr. Biafora performed a second examination on February 6, 2020 and prepared a report dated February 26, 2020 (PX 11, RNX 3). Petitioner complained of pain over the dorsal hand to the dorsal aspect of the middle finger with pain radiating from the palmar aspect of the hand to the shoulder. She also complained of left thumb pain and palmar pain that radiated proximally to the arm towards her neck. Petitioner had bilateral right greater than left diffuse complaints radiated from her neck to her upper extremities. She alleged that this began when she was performing "light duty job" from November 14 through December 18, 2019. Dr. Biafora reviewed treating records of Dr. Fernandez through November 21, 2019 including the operative report, and therapy notes through December 11, 2019. Dr. Biafora opined that Petitioner did not have any right wrist findings to explain her upper extremity complaints. Provocative examination of the right wrist has not revealed any significant abnormalities. He opined that her current complaints were not related to her May 9, 2017 work accident. Her complaints suggested a possible cervical etiology but rendering an opinion on causation is beyond the scope of his practice. With respect to the right wrist injury from the May 9, 2017 work accident, Dr. Biafora opined that Petitioner was at MMI and could return to work without restrictions (PX 11, RN 3).

An EMG was performed on February 12, 2020. On February 18, 2020, Dr. Fernandez states the EMG demonstrates right cubital tunnel syndrome. On examination he notes a recurrent ganglion. He recommended surgery for to the right wrist ganglion excision and to the right elbow for an ulnar nerve transposition (PX 12). Petitioner underwent an updated MRI on May 4, 2020 which showed a recurrence of her dorsal carpal ganglion cyst and a new complex TFC tear (PX 12). On May 12, 2020, Petitioner reported to Dr. Fernandez that she has more pain to her wrist than before surgery. Dr. Fernandez reviewed the EMG and MRI studies and recommended a revision of the right dorsal wrist ganglion excision and an ulnar nerve in situ decompression at the elbow (PX 6). Petitioner testified that she wants to have the recommended surgeries and the referral to a doctor for her cervical spine.

Dr. Biafora prepared an addendum report on August 24, 2020 after reviewing Dr. Fernandez notes from February 18, 2020 and May 12, 2020 and the May 4 MRI of the right wrist (PX 11, RNX 3). Dr. Biafora stated

that Petitioner's recurrent dorsal wrist ganglion was related to her May 9, 2017 work accident based upon his earlier opinions that the forceful pushing down on the lever of a mop bucket reasonably can cause a dorsal wrist capsular injury leading to a ganglion. He notes that the ganglion is reasonably symptomatic as she weight-bears through the wrist. She did not exhibit physical examination findings consistent with cubital tunnel syndrome until her more recent evaluations so that condition was not related to her May 9, 2017 work accident. Dr Biafora opined that her cubital tunnel syndrome could not be attributed to her job duties because they did not require significant forced flexion through the elbows. Her left upper extremity complaints could not be explained by any compensatory activities as a result of her right upper extremity condition. Her treatment to date for her right wrist was related to the May 9, 2017 work accident based upon his prior analysis. Dr. Biafora felt a revision of the right dorsal wrist ganglion excision was reasonable. The recommendation for ulnar nerve in situ decompression at the elbow was not related to her work activities. Petitioner required work restrictions of avoiding forceful repetitive gripping and no pushing, pulling or lifting over 10 pounds (PX 11, RNX3).

Conclusions of Law

In support of the Arbitrator's decision with respect to (B) Employee/Employer Relationship, the Arbitrator finds as follows:

Petitioner has named both Nestle USA and Ferrara Candy as Respondents in this matter. As more fully addressed in the Arbitrator's finding with respect to Accident and Date of Accident below, the Arbitrator has found that Petitioner has proved an accident arising out of and in the course of her employment with a date of manifestation on May 9, 2017. The undisputed evidence is that on that date Petitioner was an employee of Nestle USA. The facility was transferred to Ferrara Candy in 2018.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that on May 9, 2017 she was an employee of Respondent Nestle USA. Based upon this finding, the Arbitrator will address the remaining issues solely as to Respondent Nestle USA, finding that Respondent Ferrara Candy did not have any employer/employee relationship with Petitioner on the only date of accident alleged herein.

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. 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. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). 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. An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006)*. An employee who alleges injury based on repetitive trauma must "show that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026, 106 Ill. Dec. 235 (1987); *Edward Hines*

Precision Components v. Industrial Comm'n, 356 Ill. App. 3d 186, 194, 825 N.E.2d 773, 292 Ill. Dec. 185 (2005).

Petitioner described her job duties as a cleaner for Respondent Nestle. She noted multiple activities requiring the repetitive use of her hands including mopping, sweeping, moving totes and cleaning mop buckets. Her medical histories provide similar details as to the activities required to perform her job. She testified that she noticed the symptoms in her right hand while performing these duties. This is also consistently noted in her medical records. The activities occurred during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties. These activities were a risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury.

The Arbitrator notes that Petitioner's initial medical histories describe repetitive activities and deny and specific injury. The medical records find she has a repetitive or cumulative trauma injury. Although she later describes a specific incident of pushing down on a mop bucket handle and feeling a crack, the arbitrator finds her statements as to the onset of her symptoms to her initial treating doctors in 2017 and to her therapist on September 30, 2019 more persuasive. Petitioner reported she had a repetitive use injury. She was feeling it already when finally, one day, she was washing her mop bucket when she felt like she was "on fire all the way to my neck." As more fully discussed in the Arbitrator's finding with respect to Casual Connection, the Arbitrator finds that Petitioner's statements concerning the onset, development, and extent of her subjective complaints unpersuasive and lacking credibility. However, the undisputed fact that she promptly reported symptoms in her right wrist and received treatment immediately following May 9, 2017, demonstrates the requisite nexus to the work activities described and found to constitute a repetitive trauma by the treaters at Concentra.

The standard for determining the manifestation date in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006); see also *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 612, 531 N.E.2d 174, 126 Ill. Dec. 41 (1988); *Three "D" Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 144 Ill. Dec. 794 (1989). The date on which the employee notices a repetitive trauma injury is not necessarily the manifestation date. *Oscar Mayer & Co.*, 176 Ill. App. 3d at 611; see also *Durand*, 224 Ill. 2d at 68. Instead, the date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date. *Oscar Mayer & Co.*, 176 Ill. App. 3d at 611; see also Durand, 224 Ill. 2d at 68-69. Courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand*, 224 Ill. 2d at 72. A formal diagnosis is not required. Id. However, because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. *Id.*; see also *Oscar Mayer & Co.*, 176 Ill. App. 3d at 610.

The unrebutted evidence is that Petitioner reported her symptoms in the right wrist to her supervisor and was sent to Concentra for treatment on May 9, 2017. On May 10, 2017, she began a course of treatment for her right wrist and provided a history of a repetitive trauma injury to her right hand from her job duties at Nestle and was diagnosed with right wrist tendinitis, cumulative trauma from repetitive motion, and a ganglion cyst of the dorsum of the right wrist, for which she received treatment. Based upon this evidence and Petitioner's allegations, May 9, 2017 is an appropriate date of manifestation.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent Nestle USA on May 9, 2017.

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

Petitioner's unrebutted testimony was that she reported the injury to her supervisor the same day as her injury. She testified that she was advised to seek medical attention and sent to Concentra, where she was seen the next day.

Based upon the record as a whole, the Arbitrator finds that Petitioner provided notice within the time limits specified in the Act to Respondent Nestle USA of her accident on May 9, 2017.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill. Dec. 83, 444 N.E.2d 122). In repetitive trauma cases, the claimant "generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Nunn v. Illinois Industrial Comm'n*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502, 109 Ill. Dec. 634 (1987); see also *Johnson v. Industrial Comm'n*, 89 Ill. 2d 438, 442-43, 433 N.E.2d 649, 60 Ill. Dec. 607 (1982) (reversing Commission's award of benefits where claimant failed to present any expert medical evidence supporting claim that her injuries were caused by repetitive work activities). Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, "expert testimony is necessary to show that claimant's work activities caused the condition complained of." *Nunn*, 157 Ill. App. 3d at 478; see also *Johnson*, 89 Ill. 2d at 442-43.

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

The medical evidence submitted in this matter includes multiple and varied opinions from the treating and examining physicians. In weighing the medical evidence, the Arbitrator must consider the information obtained by the physicians, and in particular the history and subjective presentation of the Petitioner. In doing so, the Arbitrator finds multiple inconsistencies in the Petitioner's presentation and contradictions to her testimony in the medical records which directly affect the weight of the medical opinions rendered.

Petitioner has presented various versions of the events of May 9, 2017. Her original medical histories deny any specific event and describe repetitive activities with symptoms developing over time. The records do not document the claimed pushing on the mop bucket handle until December 2018. Petitioner has stated in multiple histories that she had symptoms prior to this event as well as claiming she had no symptoms until this event. The pain intensity of the mop bucket event also has varied from increasing prior symptoms, to a "crack," to including pain in the entire arm. Her description of her symptoms on May 9, 2017 vary from having pain and swelling into her wrist, to telling Dr. Tulipan she had bruising (which is does not appear in the initial records, to reporting to her therapist that she felt like she was "on fire all the way to my neck."

Petitioner's symptoms as documented in the medical records have also evolved and are inconsistent with her current testimony that she had immediate symptoms in her entire right arm with numbness. Dr. Suchy's initial physical examination notes full range of motion in the elbow. Petitioner's treatment through her release in June 2017 focused entirely on her right wrist. Her complaints to Dr. Suchy were solely in the right wrist and hand. There were no x-rays or other diagnostics to the right arm. The only diagnosis was a dorsal ganglion cyst and tendinitis. Although there is a reference in the therapy records of pain radiating to the elbow and shoulder, Although there is a reference in the therapy records of pain radiating to the elbow and shoulder, physical therapy records state that the right shoulder is normal in appearance with no tenderness to palpation. Range of motion and strength are within normal limits. The right elbow is normal in appearance with no tenderness to palpation. Range of motion and strength are within normal limits. Petitioner's testimony that she had continuous symptoms since the accident are also contradicted by the medical records. On June 27, 2017, Dr. Suchy notes Petitioner is doing much better. The ganglion is really not bothering her. On October 2, 2018, Dr. Suchy notes he saw Petitioner for a traumatic dorsal ganglion a year ago. She never followed up, however, recently it has gotten worse, larger, and more painful.

The Arbitrator notes Petitioner's evolving symptoms and complaints. Beyond the original complaints in the right wrist, and allegations of radiation up the arm, Petitioner is raising complaints in the entire right upper extremity including the elbow and shoulder, her left upper extremity, her neck and back. As noted above, initial examinations of the right shoulder and elbow were normal. The 2019 EMG was normal. The Arbitrator also notes Petitioner's ongoing issues with depression and anxiety. Her therapy assessment notes that she has fear/apprehension and guarding. She has a high nervous system reactivity.

The Arbitrator also considers the fact Petitioner was released to full duty by Dr. Suchy in June 2017, returned to regular work and did not seek any further treatment until September 2018, over 15 months later. The Commission has considered such a gap in care in determining causal connection. See: *Richard Olcikas v. Dominick's Finer Foods, Inc.*, 2009 Ill. Wrk. Comp. LEXIS 1098 affirmed *Olcikas v. IWCC*, 2012 Ill. App. Unpub. LEXIS 26; 2011 IL App (1st) 103274WC-U; 2012 WL 6951575; *Jacob Haltom v. Center for Sleep Medicine*, 2013 Ill. Wrk. Comp. LEXIS 509; 13 IWCC 563, affirmed *Haltom v. IWCC*, 2015 IL App (1st) 133954WC-U; 2015 Ill. App. Unpub. LEXIS 1568; *Jose Ruben Meraz vs. Minute Men Staffing*, 2015 Ill. Wrk. Comp. LEXIS 30; 15 IWCC 30. The Arbitrator finds Petitioner's explanation that she sought no care because

she did not feel she was treated well not credible since she was not advancing any significant symptoms at the time of her discharge and she ultimately returned to the same facility for further treatment thereafter.

Given these inconsistencies and credibility issues in Petitioner's presentation, the Arbitrator finds the opinions of Dr. Suchy, Dr. Barakat and Dr. Murtaza most persuasive. On June 13, 2017, physical examination documents a very small ganglion cyst over the dorsum of the wrist. There was slight synovitis. Tinel's and Finkelstein's, and carpal tunnel compression tests were negative, Range of motion was full in the fingers. Dr. Suchy's impression was tendonitis with asymptomatic ganglion. He released Petitioner to return to full duty work, which she performed for over a year. When she returned in October 2018, Dr. Suchy notes the dorsal ganglion recently has gotten worse, larger, and more painful. He notes a dorsal ganglion, moderate in size. He performed an aspiration and injected lidocaine. On October 23, 2018, Dr. Suchy states her right wrist pain does not appear to be specific, appears to be generalized pain throughout. His impression was generalized wrist pain, etiology unknown. He could not determine a diagnosis based upon his clinical findings and referred her to Dr. Barakat. Dr. Barakat notes Petitioner is somewhat confused with her description of her symptoms. He finds vague tenderness with normal sensation, range of motion and testing, His impression is diffuse non-specific symptoms bilaterally. He notes a ganglion which is not symptomatic and would not explain her symptoms. He recommended she see Dr. Murtaza for her neck and back. Dr. Murtaza assessed right upper extremity neuropathic symptoms and mild left upper extremity symptoms as well as cervical spine pain. He recommended and EMG/NCV and cervical spine physical therapy. The EMG performed on January 10, 2019 was reported as normal. He provided no causation opinion.

Petitioner has now advanced additional and increasing complaints in the right wrist and hand as well as up the entire right arm including the elbow and shoulder. She is also advancing complaints in the left arm, neck and low back. Having reviewed the totality of the medical evidence and weighing the evidence in light of the lack of consistency in Petitioner's presentation, the Arbitrator finds that Petitioner has failed to prove that any of her current conditions of ill-being are causally related to the accident on May 9, 2017.

The Arbitrator notes that Dr. Fernandez has current diagnoses of recurrent dorsal ganglion cyst in the right wrist, right cubital tunnel syndrome in the elbow and has recommended evaluation of Petitioner's neck. His initial conclusion is right hand and arm pain with work activities 5/09/2017, atraumatic. He diagnosed a probable ganglion cyst and right-hand numbness and tingling, possible cervical origin versus early peripheral neuropathy. After the EMG, he noted cubital tunnel syndrome. He does not explain why this differed from the previous negative EMG. He does not address that gap in care nor that when he first saw Petitioner she had not been working for a month. His records do not include any detailed history of the Petitioner's work duties or the May 9, 2017 incident. He never advances any clear causation opinions.

With respect to Petitioner's complaints in the right elbow and shoulder, left hand and arm, neck and back, Dr. Tulipan found the complaints of weakness in both extremities, pain radiating to the neck and shoulders, and pain in the lower back not related to the work accident on May 9, 2017. On July 12, 2019, Dr. Biafora had no explanation for Petitioner's diffuse right arm numbness. On February 6, 2020, Dr. Biafora opined that Petitioner did not have any right wrist findings to explain her upper extremity complaints. Provocative examination of the right wrist has not revealed any significant abnormalities. He opined that her current complaints were not related to her May 9, 2017 work accident. Her complaints suggested a possible cervical etiology. On August 24, 2020, Dr. Biafora stated that Petitioner's did not exhibit physical examination findings consistent with cubital tunnel

syndrome until her more recent evaluations so that condition was not related to her May 9, 2017 work accident. Dr Biafora opined that her cubital tunnel syndrome could not be attributed to her job duties because they did not require significant forced flexion through the elbows. Her left upper extremity complaints could not be explained by any compensatory activities as a result of her right upper extremity condition. The recommendation for ulnar nerve in situ decompression at the elbow was not related to her work activities. The Arbitrator finds these opinions persuasive and supported by the treating records of Dr. Suchy, Dr. Barakat and Dr. Murtaza and the timeline of Petitioner's presentation. Petitioner's medical records do not document any significant complaints beyond her right wrist injury until November 2018. On November 30, 2018, she reported to Dr. Barakat that since Dr. Suchy injected her ganglion, she has started noticing worsening pain proximally and distally including the dorsal DIP of the right middle finger, volar palm, ulnar hand, ulnar forearm, elbows. She started noticing left sided symptoms which are vague and nonspecific. She also noted some crepitus and cracking at the lower neck. Petitioner told Dr. Murtaza on December 11, 2018 that since her injection, she has a cold-type sensation up to her shoulder and itchiness in the biceps and forearm. She complains of cervical spine pain and stiffness as well as different sensations into her arm.

The Arbitrator also finds that, while Petitioner's initial right wrist complaints were related to the May 9, 2017 accident, that the condition of ill-being after her discharge from Dr. Suchy in June 2017, as presented in the medical records beginning September 27, 2018, is no longer causally connected. Dr. Suchy initially treated the right wrist based upon cumulative trauma. Dr. Suchy's impression was tendonitis with asymptomatic ganglion. On June 27, 2017, Dr. Suchy notes Petitioner is doing much better. The ganglion is really not bothering her. Dr. Suchy released her from care to perform her regular work activities. Petitioner then went over a year without any medical treatment while working without restrictions.

When Petitioner did seek additional care, Petitioner stated the ganglion recently has gotten worse, larger, and more painful. On October 23, 2018, Dr. Suchy states her right wrist pain does not appear to be specific, appears to be generalized pain throughout. His impression was generalized wrist pain, etiology unknown. He could not determine a diagnosis based upon his clinical findings and referred her to Dr. Barakat. On November 14, 2018, Dr. Suchy stated he cannot help her. He cannot determine a diagnosis. On November 30, 2018, Dr. Barakat notes Petitioner is somewhat confused with her description of her symptoms. He notes a ganglion is not symptomatic and would not explain her symptoms.

Petitioner was evaluated by Dr. Tulipan and Dr. Biafora. The Arbitrator notes that the Petitioner presented the examiners with a history of a significant trauma while pushing on the handle of the mop bucket and continuous, ongoing and expanding symptoms thereafter. As noted above the Arbitrator finds this history inaccurate and the Petitioner's presentation lacking in credibility. Dr. Tulipan opined the right extensor tenosynovitis could be related to the injury, and there was a small possibility the ganglion cyst was related. Dr. Biafora stated that Petitioner's recurrent dorsal wrist ganglion was related to her May 9, 2017 work accident based upon his earlier opinions that the forceful pushing down on the lever of a mop bucket reasonably can cause a dorsal wrist capsular injury leading to a ganglion. Expert opinions must be supported by facts and are only as valid as the facts underlying them. Having found that these opinions are based on an inaccurate history, the Arbitrator finds the opinions of Dr. Barakat and Dr. Suchy that Petitioner's symptoms were unrelated to the ganglion persuasive. The Arbitrator notes that Dr. Fernandez surgery to remove the ganglion did not abate Petitioner's symptoms. In fact, since the surgery and without any work activities, the ganglion has again recurred.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as a result of the accident on May 9, 2017, Petitioner suffered a causally related injury only to the right wrist consisting of tendonitis with dorsal ganglion cyst. The Arbitrator finds this condition of ill-being causally related to the May 9, 2017 accident reached maximum medical improvement as of Petitioner's release from care on June 27, 2017. Any further subsequent condition of ill-being is not causally related to the accident on May 9, 2017.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Section 10 of the Act states that 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.

Overtime is excluded from the calculation of a claimant's average weekly wage unless the claimant is required to work overtime as a condition of her employment, or the overtime hours are part of the claimant's consistent weekly schedule. *Airborne Express, Inc. v. Illinois Workers' Compensation*, 372 Ill. App. 3d 549; 865 N.E. 2d 979; 2007 Ill. App. LEXIS 244; 310 Ill. Dec 259.

Petitioner testified that overtime working for Nestle was mandatory. Nestle offered Petitioner's wage records as RNX 2. The wage records include weeks wherein Petitioner worked greater that 40 hours and weeks she worked less that 20 hours. While she worked overtime in many weeks, the overtime was not regular and appears to have been for hours greater that a regular workday, greater that a regular work week and for working holidays or weekends. She received some overtime at 1.5x her regular pay and some at 2x her regular pay. Petitioner did not provide any explanation of why the overtime was mandatory such as disciplinary action for refusal. She did not explain how overtime was scheduled or who was required to work overtime. Given the Arbitrator's discussion of the inconsistencies in Petitioner's testimony related to her history and subjective complaints, and the fact that Petitioner was working as a cleaner rather than in production, the Arbitrator finds her conclusory statement that the overtime was mandatory unpersuasive. The Arbitrator therefore excludes her overtime hours from the calculation of her average weekly wage.

Petitioner testified that she missed some work for FMLA. The wage records reflect 4 weeks of no work and many partial weeks. No explanation was given for this. The Arbitrator finds it impractical to attempt to ascertain the weeks and parts thereof to calculate her average weekly wage. The Arbitrator finds that the most accurate method to determine the average weekly wage would be to use her hourly wage calculated on her regularly scheduled 40-hour workweek. Petitioner earned $21.43 per hour for 32 weeks and $21.97 per hour for 16 weeks. Using this calculation, Petitioner's average weekly wage would be $864.40 per week.

Based upon the record as a whole, the Arbitrator finds that Petitioner's average weekly wage on May 9. 2017 was $864.40 per week.

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based upon the Arbitrator's finding with respect to Causal Connection, only medical treatment related to the right hand and wrist through June 27, 2017 would be causally connected.

The medical exhibits and Nestle payment ledger submitted show that all Concentra bills have been paid. Petitioner has offered unpaid medical bills from Midwest Orthopedics at Rush for dates of service from June 5, 2019 through June 12, 2020. Based upon the Arbitrator's finding with respect to Causal Connection, these bills would not be for services causally related to the May 9, 2017 accident.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that Respondent Nestle USA is responsible for any unpaid medical bills as a result of the May 9, 2017 accident.

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

Petitioner is seeking prospective medical treatment as suggested by Dr. Fernandez consisting of a revision of the right dorsal wrist ganglion excision and an ulnar nerve in situ decompression at the elbow. He has also suggested a referral for a cervical spine evaluation. Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds any condition of ill-being in the Petitioner's neck or right elbow not causally related to the May 9, 2017 accident. The Arbitrator also finds any additional treatment recommended for the right wrist after June 27, 2017, including the recurrent ganglion not causally related.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that Respondent Nestle USA is responsible for any prospective medical care as a result of the May 9, 2017 accident.

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

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

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner reached maximum medical improvement for the causally related condition of ill-being in her right wrist on June 27, 2017. Petitioner was not disabled by her treating doctors at any time from May 9, 2017 through June 27, 2017 and did not allege any lost time during this period. Respondent Nestle paid stipulated temporary compensation of $1,914.20.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that Respondent Nestle USA is responsible for any temporary compensation as a result of the May 9, 2017 accident. Respondent Nestle is entitled to a credit of $1,914.20.

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

Based upon the Arbitrator's findings with respect to Accident and Employment, the Arbitrator has found that Respondent Ferrara Candy has no liability for the accident on May 9. 2017. Based upon the Arbitrator's findings with respect to Causal Connection, Medical, and Temporary Compensation, the Arbitrator has found that Respondent Nestle has paid all benefits due. Therefore, Petitioner's claim for penalties and attorney's fees is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC039240
Case Name	ROUSER, LAWONDA v. SPRINGFIELD SCHOOL
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0487
Number of Pages of Decision	10
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	John Langfelder

DATE FILED: 9/24/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0487

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawonda Rouser,

Petitioner,

vs. NO: 16 WC 039240

Springfield School Dist. 186,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Decision of the Arbitrator on the issues of medical expenses and prospective medical treatment.

As it pertains to temporary total disability ("TTD"), the Commission affirms the Arbitrator's Decision that Petitioner was temporarily totally disabled from September 21, 2017 through December 13, 2018, but corrects that this is a period of 64-1/7 weeks.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 15, 2019, is modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Petitioner's condition of ill-being regarding her right knee is causally related to the October 19, 2016, work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $253.00/week for 64-1/7 weeks, commencing September 21, 2017, through December 13, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a credit for all temporary total disability benefits previously paid to Petitioner.

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

IT IS FURTHER ORDERED that Respondent shall authorize and pay for prospective medical treatment as recommended by Dr. El Bitar, as provided under Section 8(a) and 8.2 of the Act.

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

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

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.

September 24, 2021

o: 9/7/21
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
NOTICE OF 19(b) ARBITRATOR DECISION

21IWCC0487

ROUSER, LAWONDA
Employee/Petitioner

Case# **16WC039240**

SPRINGFIELD SCHOOL DIST 186
Employer/Respondent

On 11/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICES OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

0265 HEYL ROYSTER VOELKER & ALLEN
JOHN LANGFELDER
PO BOX 9678
SPRINGFIELD, IL 62791

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LaWonda Rouser
Employee/Petitioner

v.

Springfield School Dist. 186
Employer/Respondent

Case # **16** WC **39240**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Urbana**, on **12/13/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/19/16**, 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 $**12,682.12**; the average weekly wage was $**253.00**.

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

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

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

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

ORDER

By stipulation of the parties Respondent shall pay any outstanding reasonable and necessary medical services, 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 authorize and pay for prospective medical care as recommended by Dr. El Bitar, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 63 1/7 weeks, commencing 9/21/17 through 12/13/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $Any for temporary total disability benefits that have been paid.

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

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

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

Michael K. Nowak, Arbitrator

11/13/18
Date

ICArbDec19(b)

FINDINGS OF FACT

Petitioner, was 41 years old at the time of injury and employed with the Springfield School District as a teacher's aide. Petitioner's duties included assisting the teacher with students. Her duties did include assisting children off the school bus. On October 19, 2016, the Petitioner testified she was assisting children from her classroom off the bus when she became aware of a student who would not leave the bus. While this student was not in Petitioner's class, she assisted the bus aid in getting the student off the bus because the student would not leave the bus without assistance. The Petitioner testified that the bus aid was not allowed to touch the student but the Petitioner was permitted to physically touch students. The Petitioner explained that usually the Vice Principal, Mr. Norman, assisted with students but he was unavailable at the moment.

The Petitioner testified she got onto the bus and was attempting to get the child out from under a seat but he was unwilling to leave the bus. The Petitioner testified she then picked up the child and proceeded to carry him off the bus. As she was carrying the child off the bus, Petitioner missed a step and landed on her right knee and twisted it when she came down. She noticed immediate pain in her knee and ankle. The Petitioner stated that as this was happening, Mr. Norman had approached the bus and witnessed the accident. Tena Nestler, a witness for the Respondent, also testified that the Petitioner reported this incident to her on the day of the accident.

The Petitioner testified she returned to work and did not seek medical care until after school that day because she knew it would leave the teacher, Tena Nestler, shorthanded. The Petitioner then took the next two days off because of the injury. The testimony concerning the two days off was confirmed by Respondent's own exhibits.

Petitioner then testified she did not formally report her injury until the following Monday. The Petitioner testified she reported her injury the following Monday due to the instruction from the Vice Principal, Mr. Norman. Petitioner did admit to having prior right knee problems, but that her pain due to this accident made them much worse. The Petitioner also testified that her right knee pain had improved prior to this accident and she had not treated for it since her release a year before the accident.

Respondent's witness, Tena Nestler, testified via deposition on November 27, 2018. Mrs. Nestler testified that the Petitioner worked in her classroom. Mrs. Nestler admitted that Petitioner did tell her on the day of injury that she had hurt herself in a manner consistent to what was testified on the date of trial. (RX- 3 pg. 11). However, Mrs. Nestler testified she did not notice any sign of injury on that day but admitted that the Petitioner did not want to get up and help the children as much that day. (RX-3 pg. 14) Mrs. Nestler then testified that Petitioner returned the following Monday and claimed that Petitioner's autistic son had re-injured Petitioner's knee over the weekend. (RX-3 pg. 14) Mrs. Nestler admitted that the Petitioner maintained her injury had occurred on October 19, 2016, not over the weekend. On cross examination, Mrs. Nestler also admitted that she had a contentious relationship with the Petitioner. (RX-3 pg. 19) This assertion was confirmed by the testimony of the Petitioner.

Petitioner testified she reported to St. John's hospital after work that day due to her right knee pain. A note from St. John's hospital noted that on October 19, 2016, Petitioner presented for an evaluation of the right

knee and ankle pain due to missing a step on a bus due to a fall that twisted her right lower extremity. Petitioner noted a large amount of pain in her right knee and ankle.

On October 25, 2016, the Petitioner reported for treatment at SIU. She was given light duty restrictions, pain medication and was told to return to work.

Petitioner returned on November 7, 2017, with continued pain in her right knee but that her right ankle pain had resolved. At this point a right MRI of the knee was ordered. The right knee exam suggested post traumatic patellar tendonitits.

On January 6, 2017, Petitioner saw Dr. El Bitar, an orthopedic surgeon, for her right knee pain for the first time. The Petitioner reported that her pain had continued for the past three months and she had attempted therapy and home exercises. Dr. El Bitar reviewed the X-rays taken the day of the accident and the MRI taken on December 22, 2016, which showed evidence of a tear in the posterior horn of the medial meniscus, mild joint effusion. The plan at that point was continue conservative treatment but that if pain persisted surgical intervention would be the next step.

The Petitioner returned on March 10, 2017, with the Petitioner noting some improvement with conservative treatment. However, the Petitioner was still struggling with pain in the right knee. At this point surgical intervention was suggested and agreed to by the Petitioner.

The Petitioner returned on August 4, 2017, the Petitioner still had pain complaints and while Petitioner was scheduled for surgery she had workers' compensation issues. Dr. El Bitar, again, recommended surgery.

The last recorded visit took place on September 1, 2017, the Petitioner again returned with reported knee pain. Petitioner was still using a brace on her right knee. Surgery was again suggested and the Petitioner was instructed to return as needed.

The Petitioner testified on the date of trial that she had attempted to return or have the surgery ran through her state aid insurance. The Petitioner testified the doctor's office would not accept her state insurance. The Petitioner testified she is still in pain in her right knee and would like to proceed to surgery. The Petitioner has not worked since her termination from the school district but did look for new employment within her last work restrictions. She even secured an interview with the bus company, first student, but was told that they could not hire her with her work restrictions.

Petitioner attended a section 12 exam on May 1, 2017, with Dr. John Krause. Dr. Krause recorded that Petitioner injured her right knee by twisting it when coming off a bus carrying a student. Dr. Krause documented he thought Petitioner had symptom magnification, right knee degenerative joint disease, and a questionable small tear of the posterior horn of the medical meniscus. Dr. Krause did not review the MRI films on that day. A second report was prepared on May 30, 2017. On this report Dr. Krause did review the MRI dated December 22, 2016. He agreed there as was a medial meniscus tear. But Dr. Krause opined that Petitioner only suffered a minor right knee sprain but did not suffer meniscal pathology on that day. He also agreed that as of the date of his exam Petitioner's exacerbation had resolved and that Petitioner did not need on-going treatment or restrictions.

On November 8th, 2017, Dr. El Bitar's testimony was taken in the form of a deposition. Dr. El Bitar testified he felt that Petitioner's complaints, physical exam, and diagnostics were consistent and did not note that Petitioner was magnifying her pain complaints. Dr. El Bitar testified that due to Petitioner's mechanical pain complaints in her right knee he felt that surgery was appropriate. (PX-4, pg. 20) Dr. El Bitar placed restrictions on Petitioner in September of 2017 and agreed they would still be in place until she has surgery or her pain subsided. (PX-4 pg. 22) Dr. El Bitar testified that twisting motion is the most aggressive type of an injury because it will rotate the meniscus and cause tears. (PX-4 pg. 22) Dr. El Bitar testified that twisting her knee in the manner described by Petitioner could have aggravated her underlying pathology or could have caused the meniscal tear he diagnosed. (PX-4 pg. 24).

CONCLUSIONS

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

The Arbitrator finds in favor of the Petitioner that her current condition and need for surgery is related to her accident on October 19, 2016.

To establish medical causal connection, the petitioner is not required to prove that the hazard to which he was exposed in the employment environment was the sole cause of the injury or even the principal cause. Rather a showing that the exposure at work was a "causative factor" in the resulting injury is sufficient. All Steel, Inc. v. Industrial Com'n, 221 Ill. App. 3d 501, 164 Ill. Dec. 32, 582 N.E.2d 240 (2d Dist. 1991).

While it is true that Petitioner suffered right knee pain before the accident, it is also true she was not treating for her right knee for months before the accident. Petitioner also testified, credibly, that while she did have some previous knee pain the accident made her knee much worse. The medical records entered into evidence all support this conclusion. It is noted by the Arbitrator that no prior physician offered surgery for Petitioner's right knee and it appears her condition had actually improved after the earlier treatment. Following this accident, Petitioner never had pain relief from her treatment.

The Respondent offered testimony from Tena Nestler, who testified that while Petitioner did report an injury to Mrs. Nestler she was not hurt until after her return the following Monday and that the Petitioner suffered a new injury due to her autistic son. The Arbitrator finds this testimony questionable for a few reasons. The first is the Petitioner actually sought treatment the day of the accident at the emergency room, and the pay roll records entered into evidence demonstrate that Petitioner had missed the two following days of work. The Petitioner testified that this was due to her right knee pain. These two facts support the testimony of the Petitioner who claimed her right knee was injured on October 19, 2016. The Arbitrator also notes that there was not any medical evidence submitted that a second injury was reported from the date of accident to the following Monday.

The Arbitrator found the testimony of Dr. El Bitar to be more persuasive than that of Dr. Kraus. Dr. El Bitar gave a more persuasive argument on why Petitioner was still having problems and determined so after have read the films of Petitioner's injuries. Dr. Krause determined that he thought Petitioner was malingering even without reviewing the films of Petitioner's right knee. The Arbitrator also found Dr. El Bitar's testimony regarding the twisting motion of a knee being an aggravating factor to Petitioner's injury to be persuasive. It

was noted that Petitioner reported the twisting motion to the emergency room, Mrs. Nestler, and in her accident report.

Under the Illinois Workers' Compensation act an injured employed only has to prove that the accident was a causative factor to their development of their injury. While Petitioner had suffered from right knee pain before this accident, the facts of the claim support that her right knee injury occurred on October 16, 2016. It was also noted that Dr. Kraus did not dispute any of the treatment through examination but only disputed the need for surgery for Petitioner. Therefore, the Arbitrator finds all treatment, to date, has been reasonable and necessary.

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

As documented earlier in the decision the Arbitrator finds the testimony of Dr. El Bitar to be more persuasive than the testimony of Dr. Krause. The MRI in this case did demonstrate a meniscal tear, and Petitioner's pain and symptoms continued for a very long period of time. The Arbitrator finds that the surgery Dr. El Bitar recommends is reasonable and necessary.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. El Bitar, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

The Respondent disputed both duration and liability in regards to the claimed TTD Dates. The Arbitrator awards the Petitioner TTD benefits from 9/21/2017 – 12/13/2018 of $253.00/week for 63 1/7 weeks. By the time of trial the Petitioner had not treated for an extended period of time this was due to her doctor's not wanting to see her until surgery, as confirmed by his testimony. Dr. El Bitar even confirmed that he considered Petitioner on her last restrictions until her surgery. It was also important to note that Petitioner did attempt to find work within her restrictions but it prevented her from securing new employment.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC035112
Case Name	MERRITT, STEPHEN v. ANTHONY DORMAN, INDV. AND/OR DBA JDR INSTALLATIONS INC
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0488
Number of Pages of Decision	16
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Kenneth Wolfe
Respondent Attorney	Will Dimas

DATE FILED: 9/24/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Merritt,

Petitioner,

vs. NO: 12 WC 35112

Anthony Dorman, individually & d/b/a
JDR Installations Inc., & IL State Treasurer, Ex-Officio
Custodian of the Injured Workers' Benefit Fund,

Respondent.

DECISION AND OPINION ON REVIEW

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

While affirming and adopting the Arbitration Decision, the Commission writes additionally on the issues of jurisdiction and employment relationship.

In the "Conclusions of Law" section of the decision, the Arbitrator found that "…the Arbitrator lacks jurisdiction to make the determination whether there was an employee and employer relationship." The Commission ultimately agrees that there was no jurisdiction and, consequently, finds the remaining issues are rendered moot.

Under the Illinois Workers' Compensation Act (Act), jurisdiction extends to "persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois." 820 ILCS 305/1(b)(2) (West 2011). A contract for hire arises where the last act necessary for its formation occurs. *Hunter Corp. v. Industrial Comm'n*, 268 Ill. App. 3d

1079, 1083 (1994).

Here, there is no credible evidence to support the proposition that the last act in the formation of the contract for hire in this case occurred in the State of Illinois. Contrary to Petitioner's assertions, the record fails to reveal any credible evidence of conditions precedent to the completion of a contract for hire occurring in Illinois that would be necessary to find proper jurisdiction in Illinois. The Commission is not persuaded by Petitioner's contentions that that he packed belongings sufficient for three months of work without having accepted a job offer from Mr. Dorman, or that Mr. Dorman, who had financial difficulty paying other employees, sent him a plane ticket for proposed work that Petitioner could have then rejected upon arriving in Illinois.

Accordingly, the Commission finds that Petitioner has failed to establish jurisdiction in Illinois, and strikes the subsequent findings in the Arbitration Decision relating to employee/employer relationship as moot. In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2019, is hereby affirmed and adopted as changed herein.

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). As there are no monies due and owing, there is no bond set by the Commission for the 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.

September 24, 2021

o: 9/16/21
BNF/wde
45

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

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MERRITT, STEPHEN Case# **12WC035112**

Employee/Petitioner

ANTHONY DORMAN IND & JDR INSTALLATIONS & IL STATE TREASURER EX OFFICIO CUSTODIAN OF IWBF

Employer/Respondent

On 10/28/2019, 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 1.60% 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:

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

0000 ANTHONY DORMAN INDV
AND JDR INSTALLATIONS
23 W WILLOW ST
LOMBARD, IL 60148

5604 ASSISTANT ATTORNEY GENERAL
DAVID CHRISTENSEN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Stephen Merritt
Employee/Petitioner
v.

Case # **12** WC **35112**

Anthony Dorman, ind. & JDR Installations & IL State Treasurer, Ex Officio Custodian of IWBF
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **Wheaton**, on **July 9, 2018 and August 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 12, 2011** Respondent ***was not*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment under Illinois Law.

Undetermined whether timely notice of this accident was given to Respondent.

Undetermined whether petitioner's current condition of ill-being is causally related to the accident.

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

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

Undetermined whether petitioner has received all reasonable and necessary medical services.

Respondent ***does not owe under Illinois law for*** all appropriate charges for all reasonable and necessary medical services.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

ORDER

Petitioner failed to prove petitioner and respondent were operating under and subject to the Illinois Workers' Compensation Act on December 12, 2011.

Therefore, petitioner's claim is hereby denied and case is dismissed.

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.

Christine MOny

Signature of Arbitrator

October 17, 2019

Date

ICArbDec p. 2

OCT 28 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Merritt	)	
	)	
Petitioner,	)	
vs.	)	**No. 12 WC 35112**
Anthony Dorman, Individually and	)	
d/b/a JDR Installations Inc. and	)	
Illinois State Treasurer,	)	
as Ex Officio Custodian of the Illinois	)	
Injured Workers' Benefit Fund,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on July 9, 2018 and August 29, 2018 in Wheaton, Illinois. Petitioner provided notice of the hearing date to Respondent, Anthony Dorman, who appeared and was present during the proceedings. As Respondent did not have workers' compensation insurance coverage, the Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund.

At issue in this hearing is as follows:

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 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 series 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 due petitioner?
L. What is the nature and extent of injury?

Other-Insurance Compliance and Liability of the Injured Workers' Benefit Fund

STATEMENT OF FACTS

Stephen Merritt, Petitioner, Testimony

Petitioner testified that he was born on September 21, 1969. On December 12, 2011, he was single and had no dependents.

In early December, 2011, petitioner met respondent, Anthony Dorman, through petitioner's sister, who was dating Dorman at the time. Petitioner's sister told petitioner that Dorman was looking for employees to start a job in Wisconsin to install restaurant equipment. Thereafter, Dorman, sent petitioner a plane ticket to fly up from Jacksonville Florida to Chicago. Petitioner and Dorman, along with petitioner's sister, Denise Stricklin, met at the airport in Chicago on December 11, 2011. They went to a restaurant for breakfast.

At breakfast, Dorman and petitioner discussed the job. Dorman advised petitioner would be paid $20 an hour for a forty-hour week. Taxes were to be withheld from petitioner's paycheck. Alex Henderson, respondent's foreman, was also present at the restaurant when the job was discussed. Dorman explained he was on another job in Ohio and he would meet Henderson and petitioner in Wisconsin to help unload equipment.

Petitioner and Henderson loaded up respondent's work van and drove to Eau Clair Wisconsin; arriving late on the evening of December 11, 2011 at the Days Inn. They stayed overnight at the Days Inn; arriving at the job site the next morning at 6:00 a.m. Six hours into the job, petitioner had an accident.

Petitioner testified he and Henderson were loading the equipment on pallets into the new structure. The equipment was on a rickety pallet with just a few band straps on it. Petitioner was at the back end of the pallet. As they were pushing the equipment uphill, the straps busted and the restaurant equipment on the pallet knocked petitioner over; pinning him to the ground. The equipment was a steam hood that was eight-foot-tall by twelve-foot-long and made of stainless steel.

Petitioner's right shoulder, right ribs and left knee came in contact with the steam hood, knocking off his hard hat and pinning him to the concrete floor. Four other construction workers on the jobsite picked up the hood to allow petitioner to extricate himself from underneath the hood. Henderson drove petitioner to Sacred Heart Urgent Care in Eau Clair. Henderson completed the paperwork while petitioner received treatment. Petitioner was admitted to the hospital until December 14, 2017.

Petitioner was in a lot of pain in his left leg, fractured ribs and split in the back of his scalp where it had hit the concrete floor. He was put in intensive care. He was discharged with a recommendation for physical therapy and placed on light duty. He went to his mother in Virginia Beach to convalesce over Christmastime. He was transferred via wheelchair to the flight line from Eau Claire Wisconsin to Chicago and then on to Virginia Beach where he was transferred to his mother's vehicle. He ambulated with a walker. He started physical therapy in Virginia Beach on December 23, 2011.

On December 27, 2011, he went to Sentara Princess Anne Hospital emergency room in Virginia Beach as his leg was swollen and he had a hematoma on the knee. He continued physical therapy until February 20, 2012. At the conclusion of the physical therapy he moved from a walker to a cane. Prior to concluding physical therapy, petitioner was seen on January 9, 2012, by Dr. Campbell at the Virginia Institute. Dr. Campbell recommended petitioner continue physical therapy and wean off pain medication. Dr. Campbell kept petitioner on sedentary work only. After concluding physical therapy, petitioner did not obtain any further medical treatment as he was accumulating medical bills and did not have money to pay for the bills.

Petitioner discussed payment of medical bills with Dorman in March, after returning to Florida. Dorman advised petitioner he was waiting for checks to clear in order to pay the bills. The bills, identified as Petitioner's Exhibit 8, remain unpaid.

At the request of petitioner's attorney, petitioner was examined by Dr. Steven Lancaster, of Jacksonville Orthopedic Institute, on September 29, 2016.

Petitioner returned to work at his own pressure cleaning company, called Thermo Wash, the week after July 4, 2012; specifically July 8, 2012. He was not capable of doing all of his jobs. He is not able to climb ladders; his knee gives out periodically causing him to fall. This has had an impact on his income. He is not able to do shopping plazas or restaurants. He had no income from the date of accident until he returned to working for himself on July 8, 2012. He was not paid for the six hours he worked on December 12, 2011.

He continues to have constant pain in his left leg. He had no problems with his ribs. His shoulder acts up once in a while when he lifts on the right side. He can't play softball for his church softball league. He denied prior problems with his left leg or right shoulder. He denied any new injuries to his left leg or right shoulder.

Petitioner learned the name of Dorman's company while in the hospital and the forms he signed had the company name on them.

On cross-examination by the State, petitioner confirmed the plane ticket was sent to him with Dorman's name on it as the purchaser. Petitioner spoke with Dorman via telephone the week before petitioner flew to Chicago. Petitioner had first spoke to his sister advising of the job and then spoke with Dorman. Petitioner confirmed he had the job with Dorman before he flew out to Chicago, or he would not have flown out to Chicago. Petitioner confirmed the meeting at the restaurant on December 11, 2011 lasted a few hours.

Petitioner confirmed only he and Henderson were on the jobsite for respondent. He denied knowing Baring Industries or Kraemer Brothers. However, he thought Kraemer Brothers were the general contractors on the job at the college; which is where the accident occurred. Petitioner understood the job would last for three months. He did not know until he arrived in Chicago that he would immediately be leaving for Wisconsin. He confirmed he knew the work he would be performing would be in Wisconsin before he arrived in Chicago.

He confirmed he had training in exhaust hood cleaning in September, 2011 at his own expense. He left Thermo Wash to do this job for respondent as it was slow during the winter months. Petitioner confirmed he filed a workers' compensation claim in Wisconsin, but it was told he had no claim in Wisconsin as respondent was established in Illinois.

Petitioner denied previously seeing Petitioner's Exhibit 12. He did not know Ron Heatley or Joe Rolebache.

Anthony Dorman Testimony

Anthony Dorman allowed the State to cross examine him rather than testifying on his own. Dorman incorporated JDR. Dorman identified Respondent's Exhibit 1 as the document that showed he incorporated JDR on June 13, 2009 and was dissolved on November 11, 2011. It was a union shop. JDR was in the business of kitchen installation that was done in prisons, casinos, schools and colleges. Dorman was an officer and his wife until she passed away in June, 2011. He previously had as many as 20 men on a job; but usually it was only three or four.

Dorman was on vacation with his son in Florida in August or September, 2011, when he met petitioner's sister; they had dinner. He denied offering petitioner a job as petitioner was not a union member,

Dorman was not sure where petitioner lived in Florida. He remembers he went to petitioner's house after dark in March or April, 2012.

Dorman confirmed JDR had a contract through Baring Industry out of Fort Lauderdale, Florida. Baring Industry sold the equipment to the school and then contracted with JDR to install the equipment. Dorman thought Kraemer Brothers might be the general contractor on the job. Dorman understood the school hired Baring Industries.

Dorman could not confirm or deny that he spoke with petitioner in 2011. He insisted he would not have hired him as he was non-union. He thought he believed he sent his "go to" guy, Ron Heatley, along with Alex Henderson, who was an apprentice at that time, to Wisconsin.

Dorman confirmed TCJ Mechanic hooked up the equipment once it was put in place by respondent. JDR was paid by Baring Industries.

Dorman agreed he signed the document identified in Petitioner's Exhibit 12, indicating he had workers' compensation insurance as he was under the impression he had it. He thought it was through Travelers Insurance. He believed he had workers' compensation insurance in Ohio and in Illinois. He was not sure about coverage in Wisconsin. However, he stated that if he had not supplied the proper documentation (including proof of insurance) then Baring would not have sent him the [purchase order].

Dorman denied he purchased a ticket for petitioner to fly to Chicago. He denied meeting with petitioner in Chicago on the morning before he left to go to Wisconsin.

On cross-examination Dorman thought he had workers' compensation insurance as Baring Industries would not have issued a purchase order without the correct paperwork. He had worked with Baring before and had no problems.

Dorman testified that he closed up shop in 2012 and filed for bankruptcy.

Dorman agreed he had a romantic relationship with petitioner's sister; she had been his child's baby-sitter. Dorman met petitioner when he was in Florida sometime during the summer of 2011 when he was on vacation.

The relationship between Dorman and Stricklin ended in the summer of 2012 when Dorman put her on a bus back to Florida.

Dorman assumed Ron Heatley was the one who called and advised of petitioner's accident in Eau Claire. He denied asking who go hurt. He just said to call 911.

Dorman denied any other one of his employees were hurt on the job.

Dorman had no answer why petitioner was at respondent's job site in Wisconsin when he got hurt.

Alex Henderson Testimony

Henderson identified Respondent Employer's Exhibit 1 as his time sheets for respondent.

Anthony Dorman Testimony

Dorman testified on August 29, 2018 and denied Petitioner's Exhibit 12 were legitimate. Dorman denied knowing employees listed on Petitioner's Exhibit 12.

On cross-examination, Dorman testified there would be no reason Baring Industries would have respondent's time sheets (PX.12); as the time sheets would only be submitted to the union.

Dorman confirmed Henderson filed a grievance with the union against respondent due to unpaid wages. Dorman agreed he approached Henderson in the parking garage thoroughfare to ask Henderson what was owed.

Dorman identified Respondent Employer's Exhibit 2 as respondent's timesheets. Dorman indicated that none of the writing on Respondent Employer's Exhibit 2 was his; it would have been Henderson's handwriting.

Lolita Parham Testimony

Lolita Parham was called by the State as a witness. She is an investigator for the Illinois Worker's Compensation Commission in insurance compliance. Parham identified IWBF Exhibit 7 as a report from the Secretary of State showing Kraemer Brothers LLC. was incorporated on August 19, 1997 and remained incorporated as of 2018. She confirmed Kraemer was authorized to do business in Illinois and were located in Plain, Wisconsin.

Parham identified IWBF Exhibit 6 as verification from the Wisconsin Compensation Rating Bureau that Kramer had a valid workers' compensation policy with Traveler's Insurance that covers Wisconsin, as well as Illinois, from January 1, 2011 to January 1, 2012.

Alex Henderson Testimony

Henderson was called as a rebuttal witness by petitioner. Henderson testified he was employed by respondent for three years, from 2008 to 2011, as a working foreman. Respondent was in the business of commercial kitchen installations.

Henderson met petitioner at a restaurant the day before they left [for Wisconsin]. The meeting resulted from Henderson advising Dorman that he needed help on the job. At the meeting with petitioner was Dorman, and petitioner's sister, Denise Stricklin. Henderson was aware that Dorman and Stricklin were dating. After the meeting Henderson and petitioner drove to Wisconsin, only stopping at Cabela's, to purchase a winter jacket and pants for petitioner as petitioner was wearing shorts and flip flops at the time of the restaurant meeting. They arrived in Eau Claire at 9 p.m. on the evening of December 11, 2011.

On December 12, 2011, Henderson and petitioner went to the job site. On that day, there were no other employees of respondent on the job site. Prior to that day, Ron Heatley had worked on the job with Henderson. Heatley was not on the job that day as Henderson had asked Dorman to replace Heatley. Henderson testified he did not like Heatley, as Heatley was not a good worker.

On December 12, 2011, Henderson and petitioner were unloading a truck and one of the exhaust hoods broke loose and landed on petitioner. The hood, made of stainless steel, was approximately 12 to 15 feet by four feet high; it was estimated to weigh 800 pounds. Henderson and three other workers lifted the hood off petitioner. Henderson drove petitioner to the hospital. He filled out the paperwork and called Dorman to report the accident. Henderson believed Dorman was upset and angry about the accident.

Henderson finished working that week. He submitted the time sheets to Dorman for the work he performed and was not paid. When Henderson asked Dorman for assistance after petitioner was injured, he was advised by Dorman to obtain local guys in Wisconsin through Craigslist. Henderson worked for respondent another couple of weeks after petitioner's accident. He left as he was owed about eight weeks of pay. This was the basis for his union grievance he filed. Henderson also confirmed Dorman did not always hire union workers. According to Henderson, Heatley went to Ohio to help Dorman. Henderson obtained two employees off Craigslist and gave their names to Dorman. Henderson stated he paid the two employees himself and never received reimbursement from Dorman, which was also part of the union grievance filed against respondent.

Henderson testified he drove the petitioner back to Illinois after he was discharged from the hospital.

Sacred Heart Hospital Records (PX.1; PX.2; PX.3)

The records reflect petitioner was admitted to the hospital through the emergency on December 12, 2011 and discharged on December 15, 2011. History was consistent with the accident described by petitioner in his testimony. His injuries included crushing injury of the left leg with possible partial quadriceps rupture and traumatic right rib injuries, including the 7th and 8th rib fractures with pulmonary contusion. It was recommended he undergo physical therapy in Virginia; two to three times a week for three to four weeks. It was thought he could do light duty for six weeks at which time he would be able to return to full-duty work.

On the admission sheet, the location of accident list JDR in Lombard, Illinois as the location of accident; and the insurance is listed as WC for JDR.

Sentara Princess Anne Hospital Records (PX.4 & PX.11)

Petitioner went to the emergency room on December 27, 2011 due to swelling in the left leg. DVT was ruled out.

Virginia Institute for Sports Medicine Records (PX.5)

Petitioner was seen by Dr. R. Campbell on January 9, 2012 for anterior pain, stiffness, anterior swelling and numbness of the left leg. He reported physical therapy was helping. Dr. Campbell recommended weaning off pain medication and continued physical therapy.

Petitioner could perform sedentary work, or working with a cane.

InMotion Physical Therapy Records (PX.6)

Petitioner attended physical therapy December 23, 2011 until discharge on February 20, 2011.

Medical Bills (PX.8)

The following medical bills are claimed by petitioner:

$414.00 Chippewa Valley Orthopaedics (12/12/2011-12/13/2011)
$902.00 Eau Claire Medical Clinic
$189.00 Emergency Physicians of Tidewater (12/27/2011)
$130.00 Grace Home Respiratory, Inc. [walker] (12/15/2011)
$700.00 Infinity Healthcare (12/12/2011)
$6,195.16 Physical Therapy [Infinity Healthcare] (23/23/2011 to 01/20/2012)
$2,295.35 Medical X-ray Consultations, Ltd. (12/12/2011-12/13/2011)
$206.00 Patient First (12/27/2011)
$74.00 Sentra Medical Group (12/27/2011)
$1,695.00 Sentra Health Care (12/27/2011)
$20,688.10 Sacred Heart Hospital (12/12/2011-12/15/2011)
$272.00 Virginia Institute for Sports Medicine (01/09/2012)
$1,645.00 Princess Anne Hospital/Sentra Princess Ann (12/27/2011-12/29/2011)

Certified Letters to Anthony Dorman (PX.9)

The letters sent to Anthony Dorman confirms dates of hearing on May 31, 2019 and July 9, 2018.

NCCI Certification (PX.10)

The affidavit of Roguens Loriston with NCCI confirmed there was no workers' compensation policy for Anthony and Denise Dorman, individually and or D/B/A JDR Installations, Inc. in effect on December 12, 2011.

University of Wisconsin at Eau Claire Job Documents (PX.12)

Invoices and payments to and from Baring Industries and JDR, as well as waiver and release of lien between Kraemer and JDR. In addition, the records include the JDR timesheets for Ron Heatley, Alex Henderson and Joe Rolebache for December, 2011.

Illinois Secretary of State Corporation Report (IWBF Ex. 1)

The Secretary of State report indicates JDR Installations, Inc. was incorporated on June 13, 2009 and involuntarily dissolved on November 11, 2011.

Florida Profit Corporation for Thermo Wash, Inc. (IWBF Ex. 2 & IWBF Ex. 3)

The Florida Profit Corporation shows Thermo Wash incorporation was filed on March 13, 2001 and dissolution occurred on October 4, 2002.

Ohio Bureau of Workers' Compensation Invoice (IWBF Ex. 4)

The invoices show payments by Anthony Dorman/JDR of $1,990.00 in August, 2011.

Travelers Insurance Notice of Premium Audit (IWBF Ex. 5)

The audit for the coverage period from 09/19/2010-09/19/2011 showed payment was due in the amount of $104.00.

Wisconsin Compensation Rating Bureau Report (IWBF Ex. 6)

The documents confirm Kraemer Brothers, LLC of Plain, Wisconsin, was insured for workers' compensation with Travelers for the entire year of 2011. An endorsement included coverage for Illinois.

Illinois Secretary of State Corporation Report (IWBF Ex. 7)

The Secretary of State report shows Kraemer Brothers, LLC. were authorized to do business in Illinois as of August 19, 1997 and continuing.

JDR Timesheets for Alex Henderson (Respondent/Employer Ex. 1 & Ex.2)

These are time sheets for Alex Henderson

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law:

The Arbitrator questioned the credibility of the petitioner, Anthony Dorman and Alex Henderson due to their inconsistency, contradictory and incredulous testimony. Petitioner claimed he packed for three months and flew up from Florida to Chicago without first determining the amount he was going to be paid. Dorman flat out denied petitioner worked for him despite the evidence supporting

the fact petitioner was mysteriously on Dorman's jobsite in Eau Claire Wisconsin when he was injured on December 12, 2011. Henderson claimed he paid two employees himself, that he hired off Craigslist as instructed by Dorman, and never received reimbursement. Henderson also claimed he drove the petitioner back to Illinois the day after the accident, even though petitioner remained in the hospital in Wisconsin until December 15, 2011 and he turned in timesheets showing he worked that day.

A. In support of the Arbitrator's decision with regard to whether Petitioner and Respondent were operating under and subject to the Illinois Workers Compensation or Occupational Diseases Act, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that on December 12, 2011, Respondent-Employer JDR was not operating under and subject to the Illinois Workers' Compensation Act. Pursuant to the Act, Illinois may acquire jurisdiction over a claim (1) if the contract for hire was made in Illinois, (2) if the accident occurred in Illinois, or (3) if the claimant's employment was principally located in Illinois. 820 ILCS 305/1(b)(2). Petitioner does not claim that the accident occurred in Illinois or that the employment was principally located in Illinois. The only remaining basis would be if the contract for hire was made in Illinois.

Courts have held that the location in which a contract is made is where the last act necessary for the formation of the contract occurred. See *Cowger v. Indus. Comm'n*, 313 Ill. App. 3d 364, 370, 728 N.E.2d 789, 793 (2000). In *Cowger*, the employment agreement had three conditions precedent to employment. After having completed the other conditions the claimant travelled to Indiana to take a drug test. Therefore, the Court held that the last act necessary occurred in Indiana. *Cowger v. Indus. Comm'n*, 313 Ill. App. 3d 364, 370–71, 728 N.E.2d 789, 794 (2000).

In *Chambers v. Indus. Comm'n of Illinois*, 139 Ill. App. 3d 550, 487 N.E.2d 1142 (1st Dist. 1985), a nurse who was contacted in Indiana and flown to Chicago to complete insurance and tax withholding paperwork and to undergo two weeks of training was found to have been hired in Indiana not Chicago. The Court relied on the evidence including "that the petitioner arrived at the Chicago office dressed in a new nurse's uniform and apparently ready for work or training..." *Chambers v. Indus. Comm'n of Illinois,* at 553.

In this matter, there were no remaining conditions precedent to employment. The testimony was clear that Petitioner left Florida ready for work. Petitioner had discussed the work with his sister and Dorman. He knew he would be working in Wisconsin. He had packed for 3 months.

He arrived the day before work began. Petitioner was ready to work when he left Florida. Further, Petitioner testified that he would not have flown to Chicago if he did not already have the job. Petitioner's later testimony that he did not have the job until pay was discussed is not credible. The Arbitrator does not believe that Petitioner discussed the job in multiple phone calls, arranged travel, discussed the type of work, the time frame and the location of the job, had trained in the same type of work the same month he met Dorman, and was flown to Chicago by Dorman, but did not discuss pay prior to leaving Florida. It seems much more probable that Petitioner knew he had the job and had been hired prior to leaving Florida. Petitioner had lived and worked in Florida for 25 years, was in Chicago for only a couple of hours and was packed to live in Wisconsin for three months.

The Arbitrator finds the only credible explanation is that Petitioner accepted the job in Florida and was flown to Chicago to meet Henderson to be transported to Wisconsin.

Based upon the above, the Arbitrator finds that Respondent-Employer was not operating under and subject to the Illinois Workers' Compensation Act at the time of the alleged injury.

B. In support of the Arbitrator's decision as to whether there is a relationship one of employee and employer, the Arbitrator makes the following conclusions of law:

As petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to make the determination whether there was an employee and employer relationship.

C. In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator makes the following conclusions of law:

Petitioner proved he was injured in an accident on December 12, 2011 in Eau Claire, Wisconsin, However, as petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to make the determination that petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent.

D. In support of the Arbitrator's decision as to the date of accident, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner presented sufficient, credible evidence that an accident occurred on December 12, 2011 in Eau Claire, Wisconsin.

E. In support of the Arbitrator's decision with regard to whether Petitioner gave the Respondent notice of the accident within the time limits stated in the Act, the Arbitrator makes the following conclusions of law:

As petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to make this determination.

F. In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner was injured in an accident that occurred on December 12, 2011 in Eau Claire Wisconsin. However, as petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to make a determination as to whether petitioner's condition of ill-being is causally related to the claimed injury.

G. In support of the Arbitrator's decision with regard to what the Petitioner's earnings were in the year preceding the Accident and what the Petitioner's average weekly wage was calculated pursuant to Section 10 of the Act, the Arbitrator makes the following conclusions of law:

As petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to make a determination as to his average weekly wage.

H. In support of the Arbitrator's decision with regard to what the Petitioner's age, the Arbitrator makes the following conclusions of law:

Petitioner testified, and the medical records confirm, his date of birth is September 21, 1969. The Arbitrator, therefore, finds petitioner was 42 years of age at the time of the accident.

I. In support of the Arbitrator's decision with regard to Petitioner's marital status at the time of injury, the Arbitrator finds the following conclusions of law:

Petitioner testified he was single with no dependents at the time of his accident. Therefore, the Arbitrator finds petitioner's marital status was single; and that petitioner had no dependents at the time of the accident.

J. In support of the Arbitrator findings as to whether the medical services that were provide to Petitioner reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary, the Arbitrator makes the following:

Although petitioner submitted evidence that he incurred $35,140.61 in medical expenses to treat his injuries he sustained in an accident on December 12, 2011 in Eau Claire, Wisconsin, as petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to award medical bills pursuant to the act.

K. With respect to the Arbitrator's decision with regard to temporary total and temporary partial disability, the Arbitrator makes the following conclusions of law:

According the medical records, specifically the records from Sacred Heart Hospital, petitioner should have been able to work light duty for six weeks and then able to return to full-duty work. However, as petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator lacks jurisdiction to award temporary disability pursuant to the Act.

L. In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

The medical evidence supports a finding that petitioner suffered a crushing injury to his left leg and two rib fractures. However, as petitioner and respondent were not operating under and subject to the Illinois Workers' compensation Act, the Arbitrator lacks jurisdiction to award permanent partial disability pursuant to the Act.

O. In support of the Arbitrator's decision with regard to the question of insurance compliance and automatic coverage, the Arbitrator makes the following conclusions of law:

As petitioner and respondent were not operating under and subject to the Illinois Workers' Compensation Act, the question of insurance compliance and automatic coverage is moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC002942
Case Name	WINFREY, ELIZABETH v. PORTILLO RESTAURANT GOURP ETAL
Consolidated Cases	16WC025921, 17WC010057, 15WC002943
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0489
Number of Pages of Decision	16
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Christopher Williams
Respondent Attorney	Daniel Swanson

DATE FILED: 9/24/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth K. Winfrey,

Petitioner,

vs. NO: 15 WC 2942

Portillo Restaurant Group; Portillo's Hot Dogs,

Respondent.

DECISION AND OPINION ON REVIEW

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

The decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on review, the Commission reverses the Arbitrator's denial of accident and writes additionally to address the accident analysis.

The "arising out of" component required to establish a compensable accident is primarily concerned with causal connection and is satisfied when a claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d. 193, 203. However, while it is recognized that Arbitrator's ruling pre-dates relevant case law, the Commission must evaluate this case in light of a recent decision.

In *McAllister*, the Illinois Supreme Court reversed the Commission's determination that the claimant, a restaurant employee whose knee "popped" after kneeling to look for carrots at work, failed to show that his injury arose out of his employment. *McAllister v. Illinois Workers'*

Compensation Comm'n, 2020 IL 124828, ¶ 2. Our supreme court found that the claimant's knee injury "arose out of" an employment-related risk because the evidence established that at the time of the occurrence his injury was caused by one of the risks distinctly associated with his employment as a sous-chef. *Id*. ¶ 47. The court also observed that "that an employee who sustains an injury while rendering reasonably needed assistance to a coworker in furtherance of the employer's business is considered to have suffered an injury arising out of and in the course of employment when the act performed is within the reasonable contemplation of what the employee may do in the service of the employer." *Id*. ¶ 48; see also *id*. ¶ 52.

The *McAllister* court further held that *Caterpillar Tractor v. Industrial Comm'n*, 129 Ill. 2d 52 (1989), prescribes the proper test for analyzing whether an injury "arises out of" a claimant's employment when the claimant is injured performing job duties involving common bodily movements or routine "everyday activities." *Id*. ¶ 60. The court overruled *Adcock v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130884WC and its progeny "to the extent that they find that injuries attributable to common bodily movements or routine everyday activities, such as bending, twisting, reaching, or standing up from a kneeling position, are not compensable unless a claimant can prove that he or she was exposed to a risk of injury from these common bodily movements or routine everyday activities to a greater extent than the general public." *McAllister*, 2020 IL 124828, ¶ 64. That is, "[o]nce 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." *Id*.

Accordingly, a risk is distinctly associated with an employee's employment if, 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. *Id*. ¶ 46 (citing *Caterpillar Tractor*, 129 Ill. 2d at 58).

Here, Petitioner testified that on December 15, 2014 she was reaching overhead with her left hand to put up a soup label and her left shoulder pinched after which she felt another pinch in her left shoulder while performing work duties as a cashier, including taking orders, and reaching to hand customers change and pulling her arm back to her side. These acts are clearly "within the reasonable contemplation of what the employee may do in the service of the employer." See *McAllister*, 2020 IL 124828, ¶ 48. Thus, the Commission finds that Petitioner sustained an accident while performing an act Respondent might reasonably expect her to perform to fulfill her job duties.

Accordingly, the Commission reverses the Arbitrator's denial of accident under the analysis set forth in the *McAllister* decision, and finds accident by a preponderance of evidence in this case. In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has proven an accident in this claim by a preponderance of evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's rulings on all remaining issues in the Decision filed October 28, 2019 are affirmed and adopted.

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

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

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). As there are no monies due and owing, there is no bond set by the Commission for the 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.

September 24, 2021

o: 9/16/21
BNF/wde
45

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

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0489

WINFREY, ELIZABETH
Employee/Petitioner

Case# **15WC002942**

15WC002943
16WC025921
17WC010057

PORTILLO'S
Employer/Respondent

On 10/28/2019, 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 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIEDERMANN LAW GROUP
CHRIS WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

2097 KRAKER FANNING & OLSEN
DANIEL SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elizabeth Winfrey
Employee/Petitioner

v.

Portillo's
Employer/Respondent

Case # **15** WC **2942**

Consolidated cases: **15 WC 2943; 16 WC 25921; 17 WC 10057**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **July 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 15, 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 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 $**10,650.94**; the average weekly wage was $**322.76**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0.00** 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 AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON DECEMBER 15, 2014 AND FURTHER FAILED TO PROVE THAT ANY CONDITION OF ILL-BEING IN HER LEFT SHOULDER WAS CAUSALLY CONNECTED TO HER EMPLOYMENT WITH RESPONDENT, THE 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

October 22, 2019
Date

OCT 28 2019

ICArbDec p. 2

Statement of Facts

This matter was heard in conjunction with consolidated matters 15 WC 2943 (DOA: 1/4/2015), 16 WC 25921 (DOA: 6/22/2016), and 17 WC 10057 (DOA: 3/7/2017). Respondent was represented by Daniel Swanson of Kraker, Fanning & Olsen with respect to 15 WC 2942, 15 WC 2943 and 16 WC 25921 (R1X). Respondent was represented by Stuart Pellish of Holecek & Associates with respect to 17 WC 10057 (R2X). A single transcript was prepared. The Arbitrator has issued separate decisions for each of the consolidated matters.

Petitioner has a history of a motor vehicle accident on March 25, 2013. She was treated by Dr. Salehi for cervical and lumbar spine injuries (R2X 8). She saw Dr. Salehi on May 22, 2013 with radiating complaints primarily into the right arm and leg. She noted a prior lumbar herniated disc in 2002 with a flare up in 2008. Petitioner was diagnosed with cervical spondylosis and a herniated disc and lumbar spondylosis. On June 20, 2013, she reported increased pain with cervical injections and pain down her left arm with numbness. Petitioner underwent a C5-6 discectomy and disc arthropathy on June 27, 2013. On July 10, 2013, Petitioner reported resolution of her right arm pain, but continued pain that radiates to the left shoulder. Petitioner was kept off work through October 1, 2013. On January 9, 2014, Petitioner reported no complaints in her neck but continued low back pain due to the L4-5 level. Petitioner would be a surgical candidate if she would lose weight (R2X 8).

Petitioner Elizabeth Winfrey testified that she was employed by Respondent Portillo's on December 15, 2014. Her job was front cash. Her duties were to take customer orders, receive money and give change, stock, sweep, mop, and put up soup labels. The soup label was a sign identifying the soups were available that day that goes on hooks. It is not heavy. She testified that on December 15, 2014, she was reaching overhead with her left hand to put up the soup label and her left shoulder pinched. She was standing on a 3 step ladder. She continued to work that day. 15 to 20 minutes later, she was running the cash register. She was handing a customer his change with her left hand and felt a pinch in the left shoulder. She testified she reported this to her manager Derrek the same day. Petitioner testified the changer for coins was not working. She did not report this to anyone.

Derrek Waxton testified that he worked for Respondent for 11 years and his present job title is manager. On December 15, 2014, he was working as a manager in Batavia. He is familiar with Petitioner in this case, Mr. Waxton testified that he could not recall having a direct conversation with Petitioner on December 15, 2014 about an injury she sustained at work. Mr. Waxton testified that there is a procedure if an employee reported an accident. The accident would be documented on an accident form. He would fill it out and fax it to the corporate office. He would write out the specifics of the accident including date, time and mechanism of injury in his handwriting. The process is followed 90% to 95% of the time. Mr. Waxton testified that he is familiar with the cash registers. In the normal operation of the cash registers, the coins come down the chute to the customer. He was not aware of any mechanical breakdown with the cash register at Respondent's location in Batavia on December 15, 2014; the cash register that Petitioner was working on.

Petitioner initially testified that on January 4, 2015, she was again standing on the ladder, putting up the soup label and felt her left shoulder crack like a piece of chalk. She then stated that she was working the cash register and her shoulder was hurting really bad. She was writing down orders, and taking money back and forth. Petitioner testified the changer for coins was not working. She did not report this to anyone. [This is the subject of consolidated case 15 WC 2943 decided in conjunction with this matter.] She testified she reported this to her manager Peter. She continued working for a short time.

Peter Castillo testified that he is employed by Respondent and has been employed for 16 years. On December 15, 2014 and on January 4, 2015, he was the manager at the Batavia restaurant. He testified that he does not recall having a direct conversation with the Petitioner on January 4, 2015, when she claimed to have reported an injury to him at work. Respondent has a procedure if a worker reported a work accident. He would fill out a report of accident relating the details of what happened that day and then he faxes it to the main office. He testified that when he talked to Petitioner on January 12, 2015 and prepared the handwritten report, she did not mention, and he did not have a conversation with her about an incident occurring on January 4, 2015. Mr. Castillo testified he does not recall a change return mechanism being broken in the cash register on January 4, 2015. Petitioner did not tell him about a cash register malfunction when he spoke to her and prepared the accident report on January 12, 2015 for the December 15, 2014 incident. He testified that he is familiar with the cash registers at Respondent. Change comes down the chute to Petitioner and the front cashier employees merely hand dollar bills back to the customers. He testified that change mechanism malfunction in the cash register is not a frequent occurrence. He testified that he does not recall any cash register malfunction on December 15, 2014.

Mr. Castillo identified R1X 4, which is an Illinois Form 45, Employer's First Report of Injury, with his name listed at the bottom of the report. The report of the accident, which he hand-wrote on January 12, 2015, was typed out by the corporate office. R1X 4, dated January 12, 2015, reflects an accident date of December 15, 2014. Petitioner reported the injury on January 12, 2015. The Form 45 states she was injured handing a customer her change (R1X 4). Petitioner gave a recorded statement on January 13, 2015. She stated she did not remember the date of the accident, but they put down December 15 because it was around her birthday. She stated she was injured handing dollar bills back to the customer. The change comes out of a machine. She told the adjuster that she puts up the signs for the soup and they slam a door into her every day. She does not know if that happened. She stated she hurt herself again on January 4, 2015 giving change to a customer. She started hurting when she pulled her arm back (R1X 2). The Application for Adjustment of Claim signed by Petitioner on January 16, 2015 states the accident occurred doing cashier work involving stretching, bending and extending her arm and shoulder (R1X 5).

Petitioner first sought treatment from her primary care doctor at Fox Valley Medical Associates on January 5, 2015 (PX 1). Petitioner reported that she felt a pull in her left shoulder while working the cash drawer. Yesterday it happened again. She stated since the first time, the symptoms have been severe. Examination noted Petitioner is 67 inches tall and weighs 270 pounds. The diagnosis was left shoulder joint pain. An MRI was ordered for possible rotator cuff tear v. brachial nerve injury v. neck related. He noted that he would then await Dr. Bathina recommendations (PX 1, p 13-14). The January 9, 2019 MRI report noted moderate arthrosis of the AC joint, no joint effusion, a degenerative intrasubstance tear of subscapularis, tendinosis of the supraspinatus and infraspinatus, a possible interior labral tear, and a small area of strain to the deltoid (PX 1, p 31-32).

Petitioner was seen by Dr. Ramesh Bathina on January 30, 2015 for left cervical medial branch blocks at C4-C7. Pain is noted in the left axilla, left interscapular area and to some extend in left side of neck. Second area of pain is in the left shoulder. Dr. Bathina notes the history of the 2013 MVA with cervical injections and a C5-7 fusion. He notes the neck pain is unrelated to the workplace injury and pre-existing to the workplace injury. Petitioner received the injection and a prescription for Norco. She received additional blocks on February 17, 2015 (PX 1, p 15-18).

Petitioner was seen by Dr. Tu at G&T Orthopedics on January 19, 2015 (PX 2). She reported a left shoulder injury of January 4, 2015 while working at a cash register handing out change. She noted her 2013 motor vehicle accident, but stated her symptoms had improved. Dr. Tu reviewed her MRI and found no evidence of a full thickness rotator cuff tear, but a possible SLAP tear. His impression was a left shoulder strain and proximal bicipital tendinitis. Dr. Tu ordered physical therapy and restricted her work activity (PX 2 p. 8).

Petitioner began therapy at Premier Therapy on January 23, 2015 (PX 3). She identified the mechanism of her injury as handing a person change at the cash register. She had therapy though February 25, 2015 and was discharged for poor attendance on April 17, 2015 (PX 3, p 1-3). On March 2, 2015, Petitioner returned to Dr. Tu. He noted she did not complete her therapy. His examination noted full range of motion with negative impingement testing, negative Hawkins, O'Brien and Speed tests. Strength was 5/5. There was no tenderness and normal sensation. He diagnosed a resolved left shoulder strain and returned her to work full duty (PX 2, p 7).

She returned to Dr. Tu on April 16, 2015 complaining of radiating neck pain. He noted a history of cervical spine issues treated by Dr. Salehi. His examination of her left shoulder was completely negative. He diagnosed a possible cervical radiculopathy. He stated that her current symptoms are not from her shoulder and referred her to Dr. Salehi for a neck evaluation (PX 2, p 6).

Petitioner visited Dr. Salehi on April 30, 2015 describing injuring her left shoulder in December and again in January (R2X 8). She stated that she tried returning to work in February, but her pain worsened and also began radiating into the neck. Dr. Salehi ordered flexion/extension x-rays and a cervical MRI to determine if her symptoms are cervical or left shoulder related. On May 7, 2015, he opined that her current symptoms were not related to her cervical spine and referred her back to Dr. Tu. Dr. Salehi prescribed Norco on May 12, 2015 (R2X 8). She returned to Dr. Tu on May 7, 2015. Her physical examination remained completely negative. Dr. Tu diagnosed shoulder pain of unknown origin. He performed a diagnostic lidocaine injection. He stated Petitioner could continue working full duty (PX 2, p 5).

Petitioner sought treatment from Dr. Fink at Goldcoast Orthopedics beginning May 13, 2015 (PX 4). Dr. Fink noted injury dates of December 15, 2014 and January 14, 2015 to her left shoulder. Dr. Fink's May 17, 2015 record states that Petitioner is a cashier and pulled her shoulder while reaching on December 15, 2014. She states she is taking Norco. She reports a history of surgery to her neck. Dr. Fink's examination notes limited range of motion in the shoulder, positive tenderness, positive impingement signs. He notes the MRI shows a partial tear. He diagnosed clinical impingement syndrome. Petitioner reported the injection did not help. Dr. Fink recommended surgery and took Petitioner off work (PX 4, p 99-100). Petitioner underwent surgery on May 28, 2015 consisting of arthroscopy and open repair of left rotator cuff with Neer acromioplasty. The post-operative diagnosis was a partial tear of rotator cuff greater than 50%, impingement syndrome and obesity (PX 4, p 95-96). Petitioner saw Dr. Fink for postoperative care (PX 4). She had physical therapy with Premier Therapy beginning June 29, 2015 through August 31, 2015 (PX 3).

Petitioner was seen at Presence Mercy Medical Center on November 23, 2015 (PX 5). She gave a history of a fall on ice yesterday. Her chief complaint was left shoulder pain as well as head, cervical, low back and left arm pain. X-rays of the head, cervical spine, left shoulder, left arm and left shoulder were normal. Lumbar spine x-rays noted changes at L4-5 and L5-S1 (PX 5, p 8-59).

Petitioner was returned to work without restrictions by Dr. Fink on December 14, 2015 (PX 4, p 82). Petitioner testified that she returned to work for Respondent in a full duty capacity.

Petitioner saw Dr. Fink on June 1, 2016 (PX 4, p 93). His handwritten note indicates she is status post rotator cuff on 5/28/15. This is due to a repetitive use W/C case (PX 4, p 78). Cervical spine x-rays noted no loosening of the plate or screws in the cervical fusion. She had full range of motion in her left shoulder and was complaining of neck pain (PX 4, p 93). Dr. Fink assessed radiculopathy. He noted her pain is from the neck not the shoulder. He advised Petitioner to follow up with Dr. Salehi who had performed neck surgery in 2013 (PX4 p. 93). She was given work restrictions of no lifting over 20 pounds (PX 4, p 77).

Petitioner testified that she continued working through June 22, 2016. On that date, she was standing on a ladder putting up the soup label. As she was reaching overhead, she felt like a piece of chalk cracked in her left shoulder. This incident is the subject of the consolidated case 16 WC 25921. Petitioner also testified that she is not sure of the exact date. Petitioner's Employee Statement prepared July 14, 2016 lists the date as simply June 2016 (R1X 7). The Form 45, by Joe Biasco, lists the date of accident as June 1, 2016 (R1X 6). Petitioner recalled giving a recorded statement to Claire Usher, a Zurich claims adjuster, on July 20, 2016 (R1X 3). Petitioner stated in her recorded statement that she did not know when the injury occurred in June 2016. She was not sure of the exact date. She reported in the statement that the ladder would on occasion be struck by coworkers coming through a door, but did not state that this occurred at the time of the accident. She stated she told Joe what happened that day, but she did not fill out the reports until July (R1X 3).

Petitioner was seen at Goldcoast Orthopedics on June 29, 2016. The handwriting of the note is Dr. Massarella (PX 4). The History Sheet dated June 29, 2016 lists the accident date as "the end of June." The description is "on a ladder reaching overhead and felt my left shoulder crack like a piece of chalk. A CT arthrogram of the left shoulder was ordered (PX 4, p 73-75). The typed office note for this visit is signed by Dr. Fink and includes no history of accident. The handwritten note included some of his handwriting adding an accident history (PX 4, p 75, R1X 8).

The July 1, 2016 CT scan ordered by Dr. Massarella revealed a full-thickness tear of the rotator cuff (PX 4, p 71). Dr. Fink took Petitioner off of work on July 18, 2016 (PX 4, p 70). His note states that she reinjured her left shoulder when reaching overhead and that paperwork was filled out on July 14, 2016. The CT scan found a re-tear of the rotator cuff. X-rays show the previous anchors in place. Repeat surgery was scheduled (PX 4, p 67). Dr. Fink prepared a narrative note on August 19, 2016. He notes the history of injury and opines that this is a new injury. He diagnosed a re-tear of the left rotator cuff tear and recommended surgery to repair the new tear (PX 4, p 62).

Dr. Fink performed an open rotator cuff repair on September 8, 2016. The operative report notes that the previous repaired area of the rotator cuff was intact. There was a new tear. His postoperative diagnosis was traumatic re-tear of the left rotator cuff (PX 4, p 60-61). Petitioner was kept off work until October 5, 2016 when she was released to work with restrictions (PX 4, p 56). Petitioner testified she returned to work for Respondent and for Circle K. She followed up through January 2, 2017 where it was noted that her shoulder was doing well (PX 4, p 53). Dr. Fink ordered an MRI of Petitioner's cervical spine which revealed post fusion changes, but was otherwise unremarkable (PX 4, p 51). On February 1, 2017, Petitioner was returned to work with no overhead work with her left shoulder (PX 4, p 50).

Petitioner reported that she suffered a new injury to her right leg and back on March 7, 2017 and began an additional course of treatment for these body parts. This accident is addressed in the consolidated claim 17 WC 10057 decided in conjunction with these matters. Petitioner testified she was given additional restrictions for this injury.

On April 5, 2017, Dr. Fink noted Petitioner has full range of motion in the shoulder. She reported occasional pain and electric shock like feeling. Dr. Fink discharged her from care and released her to return to regular duty work (PX 4, p 36-37).

Dr. Fink testified by evidence deposition taken June 27, 2018 (PX 9). Dr. Fink testified to his initial treatment of Petitioner beginning May 13, 2015. Dr. Fink testified that he did not review any medical records prior to seeing Petitioner for the first time. He recorded a history of reaching and pulled her shoulder on December 15, 2014. He opined that the injury in combination with her developmental acromion caused her condition. The space is more narrowed and caused rubbing. He testified to his surgery and postoperative treatment. He noted a release to return to full duty on December 14, 2015. He testified that Petitioner cancelled the appointment scheduled for September 15, 2015. He last saw her on August 17, 2015 and had her off work. He provided the full duty release after Petitioner requested it by telephone. He testified she might have been able to work in September, but he did not see her at that time. On January 27, 2016, he discharged her to be seen as needed (PX 9).

Dr. Fink testified that when he saw Petitioner on June 1, 2016, her complaints were related solely to her neck and not her shoulder. There was no symptomology with her shoulder on that date. She had good range of motion. He testified that she saw him again on June 29, 2016 where she reported an accident the previous week where she was on a ladder reaching and her left shoulder cracked like a piece of chalk breaking in her. He performed surgery on September 8, 2016 and confirmed that Petitioner had a traumatic re-tear of her rotator cuff. He testified that reaching overhead can cause stress on the rotator cuff. He testified that people feel something tear in their shoulder with a rotator cuff tear, however, they usually do not refer to it as chalk breaking. He testified that Petitioner was now at MMI for her left shoulder (PX 9).

Dr. Guido Marra testified by evidence deposition taken July 27, 2018 (R1X 1). Dr. Marra testified that he is board certified in orthopedic surgery. Dr. Marra performed an Independent Medical Examination on January 4, 2016. Petitioner related a history of performing overhead work on December 15, 2014, when she felt pain. Then 15 or 20 minutes later, while handing a customer change at the counter and pulling back, she felt a pop in her left shoulder. She underwent a rotator cuff repair on May 28, 2015. Dr. Marra opined that handing back change is not going to be sufficient to cause aggravation to the point where you need surgery any more than life would be. If Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear. Dr. Marra opined that Petitioner reached maximum medical improvement and did not require any restrictions. He noted that Petitioner had already returned to work by the time of his examination on January 4, 2016. The treatment performed at the time was reasonable, but not related to the claimed injury of December 15, 2014, as the mechanism of injury of giving change and reaching forward would be insufficient to cause a rotator cuff tear requiring surgery (R1X 1).

Dr. Marra testified that on April 26, 2018, he prepared an Addendum report after Petitioner alleged that she reinjured her shoulder in June 2016, while reaching overhead to put a soup label on a hook. Dr. Marra testified that he reviewed the July 15, 2016 Form 45, First Report of Injury, reflecting an accident date of June 1, 2016. (R1X 6). He did not know who prepared this document. Dr. Marra also testified that he reviewed the treatment

records of Goldcoast Orthopedics and the handwritten medical note dated June 29, 2016. Dr. Marra assumed the incident of putting the soup labels up overhead occurred on June 1, 2016. Dr. Marra testified that Dr. Fink's medical note from June 1, 2016 did not reflect the history of any mechanism of shoulder injury but contained Petitioner's complaints of neck pain. Dr. Marra testified that, initially, he believed Petitioner was putting up a box of soup ladles on a shelf on June 1, 2016, when she felt pain in her left shoulder. Dr. Marra clarified that if she was putting up a one or two ounce soup label, as opposed to multiple ladles in a box, weighing 5-10 pounds overhead on a shelf, that would be insufficient force to support a causal connection between the mechanism of injury and a rotator cuff tear.

Dr. Marra opined that the mechanism of reaching overhead to put a label that weighs a few ounces is insufficient to cause a re-tear of the left rotator cuff. The amount of force that is placed upon a tendon or rotator cuff depends on the weight that is applied to the arm, the position of the hand in space, the further the arm is away from the body and the further the arm is overhead. It takes more than ounces to tear your rotator cuff. Otherwise everybody would be incapacitated. Dr. Marra testified that the need for surgery was not related to the June 2016 injury, when she strained her shoulder putting soup labels away. Dr. Marra testified that Petitioner reached the point of maximum medical improvement for her left shoulder condition of ill-being and could return to work without restrictions as of April 26, 2018.

Petitioner testified that she returned to work for Respondent for a few months after her back surgery but could not handle it and was taken off work by Dr. Fink for her back complaints. She has attempted to work at Circle K and Thornton's but had severe back pain. She has not worked since. She testified she cannot lift her left arm as far as she used to. She gets pain down her arm and a tingling in her fingers. She is left handed. She cannot write for long periods and her handwriting is sloppy.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury 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. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). 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. 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.

Petitioner testified that on December 15, 2014, she was reaching overhead with her left hand to put up the soup label and her left shoulder pinched. 15 to 20 minutes later, she was handing a customer his change with her left hand and felt a pinch in the left shoulder. She testified she reported this to her manager Derrick the same day. 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). The Arbitrator finds the Petitioner's testimony not credible in that it is contradicted by virtually all of the testimony and evidence submitted.

Derrek Waxton testified that he could not recall having a direct conversation with Ms. Winfrey on December 15, 2014 about an injury she sustained at work. Mr. Waxton testified that there is a procedure if an employee reported an accident. The accident would be documented on an accident form. Mr. Waxton testified that he was not aware of any mechanical breakdown with the cash register that Petitioner was working on. The Arbitrator notes that she sought no medical treatment for almost 3 weeks thereafter. At Fox Valley Medical Associates on January 5, 2015, Petitioner reported that she felt a pull in her left shoulder while working the cash drawer. Peter Castillo testified that when he talked to Petitioner on January 12, 2015 and prepared the handwritten report, she did not tell him about a cash register malfunction when he spoke to her and prepared the accident report on January 12, 2015 for the December 15, 2014 incident. He testified that he does not recall any cash register malfunction on December 15, 2014. The Form 45 states she was injured handing a customer her change. In a recorded statement on January 13, 2015, Petitioner stated she did not remember the date of the accident, but they put down December 15 because it was around her birthday. She stated she was injured handing dollar bills back to the customer. The Application for Adjustment of Claim signed by Petitioner on January 16, 2015 states the accident occurred doing cashier work involving stretching, bending and extending her arm and shoulder. Given the contradiction of Petitioner's testimony as to the mechanism or injury, the date on which it may have occurred and the delay in seeking medical attention or in reporting the incident, the Arbitrator finds that Petitioner failed to establish that any accident occurred.

Further, assuming she noticed pain while providing change to a customer, although the simple act of handing bills to the customer would be in the course of Petitioner's employment, to arise out of the employment requires a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. As discussed more fully below with respect to Causal Connection, Dr. Marra stated that this is an activity of ordinary life and Petitioner's condition was not caused by this activity performed during her employment. Dr. Fink's causation opinions are not credible.

Based upon the record as a whole, the Arbitrator finds that Petitioner 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 December 15, 2014.

In support of the Arbitrator's decision with respect to (F) Causal Connection, 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)*. Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

Petitioner offered the opinions of Dr. Fink that the injury in combination with her developmental acromion caused her condition. Respondent offered the opinions of Dr. Marra that handing back change is not going to

be sufficient to cause aggravation to the point where you need surgery any more than life would be. If Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear. The mechanism of injury of giving change and reaching forward would be insufficient to cause a rotator cuff tear requiring surgery.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the evidence, including the deposition testimony of Dr. Fink and Dr. Marra, the Arbitrator finds the opinions of Dr. Marra more persuasive and finds Dr. Fink's testimony lacks credibility. The Arbitrator notes Dr. Marra's credentials including board certification and a specialty in upper extremity cases. Dr. Fink completely relied on Petitioner's reported history which was both inaccurate and incomplete. Dr. Fink did not review any medical records of Petitioner's prior treatment. He was unaware of Dr. Tu's records which include an initial diagnosis of a resolved strain and return to full duty on March 2, 2015. Petitioner's return in April 2015 resulted in his opinion that the Petitioner's complaints were not related to the shoulder but rather the pre-existing cervical spine condition. Dr. Fink was unaware of the significant recent treatment of her cervical spine including prior pain complaints across the left shoulder and injections occurring in January and February 2015. He had not reviewed Dr. Tu's May 7, 2015 diagnosis of shoulder pain of unknown origin or the significance of Petitioner's response to the diagnostic lidocaine injection provided on that date. The Arbitrator also notes that on May 7, 2015 Dr. Tu's physical examination remained completely negative, and Dr. Tu stated Petitioner could continue working full duty. Yet a week later, Dr. Fink found limited range of motion in the shoulder, positive tenderness, positive impingement signs and took Petitioner off work. The Arbitrator also notes Dr. Fink's unconvincing explanation of the mechanism of the injury of rubbing across the acromion. Dr. Marra testified that the Type 2 acromion is not unusual. Dr. Marra testified credibly and persuasively that if Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence, that any condition of ill-being in the left shoulder is causally connected to her employment with Respondent on or about December 15, 2014.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical, Temporary Compensation and Nature & Extent are moot.

Petitioner's claim for compensation is hereby denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC002943
Case Name	WINFREY, ELIZABETH v. PORTILLO RESTAURANT GROUP ETAL
Consolidated Cases	15WC002942 16WC025921 17WC010057
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0490
Number of Pages of Decision	11
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Christopher Williams
Respondent Attorney	Daniel Swanson

DATE FILED: 9/24/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth K. Winfrey,

Petitioner,

vs. NO: 15 WC 2943

Portillo Restaurant Group; Portillo's Hot Dogs,

Respondent.

DECISION AND OPINION ON REVIEW

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

The decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on review, the Commission reverses the Arbitrator's denial of accident and writes additionally to address the accident analysis.

The "arising out of" component required to establish a compensable accident is primarily concerned with causal connection and is satisfied when a claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d. 193, 203. However, while it is recognized that Arbitrator's ruling pre-dates relevant case law, the Commission must evaluate this case in light of a recent decision.

In *McAllister*, the Illinois Supreme Court reversed the Commission's determination that the claimant, a restaurant employee whose knee "popped" after kneeling to look for carrots at work, failed to show that his injury arose out of his employment. *McAllister v. Illinois Workers'*

Compensation Comm'n, 2020 IL 124828, ¶ 2. Our supreme court found that the claimant's knee injury "arose out of" an employment-related risk because the evidence established that at the time of the occurrence his injury was caused by one of the risks distinctly associated with his employment as a sous-chef. *Id*. ¶ 47. The court also observed that "that an employee who sustains an injury while rendering reasonably needed assistance to a coworker in furtherance of the employer's business is considered to have suffered an injury arising out of and in the course of employment when the act performed is within the reasonable contemplation of what the employee may do in the service of the employer." *Id*. ¶ 48; see also *id*. ¶ 52.

The *McAllister* court further held that *Caterpillar Tractor v. Industrial Comm'n*, 129 Ill. 2d 52 (1989), prescribes the proper test for analyzing whether an injury "arises out of" a claimant's employment when the claimant is injured performing job duties involving common bodily movements or routine "everyday activities." *Id*. ¶ 60. The court overruled *Adcock v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130884WC and its progeny "to the extent that they find that injuries attributable to common bodily movements or routine everyday activities, such as bending, twisting, reaching, or standing up from a kneeling position, are not compensable unless a claimant can prove that he or she was exposed to a risk of injury from these common bodily movements or routine everyday activities to a greater extent than the general public." *McAllister*, 2020 IL 124828, ¶ 64. That is, "[o]nce 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." *Id*.

Accordingly, a risk is distinctly associated with an employee's employment if, 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. *Id*. ¶ 46 (citing *Caterpillar Tractor*, 129 Ill. 2d at 58).

Here, Petitioner testified that on January 4, 2015 she was "at the cash register and [her] shoulder and [her] left arm was hurting really, really bad and the pain was very uncontrollable." She explained the activities that she was engaged in at the time: "writing the customer's orders down on the bag, and [she] was taking the customer's order and taking money back and forth." These acts are clearly "within the reasonable contemplation of what the employee may do in the service of the employer." See *McAllister*, 2020 IL 124828, ¶ 48. Thus, the Commission finds that Petitioner sustained an accident while performing an act Respondent might reasonably expect her to perform to fulfill her job duties.

Accordingly, the Commission reverses the Arbitrator's denial of accident under the analysis set forth in the *McAllister* decision, and finds accident by a preponderance of evidence in this case. In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has proven an accident in this claim by a preponderance of evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's rulings on all remaining issues in the Decision filed October 28, 2019 are affirmed and adopted.

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

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

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). As there are no monies due and owing, there is no bond set by the Commission for the 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.

September 24, 2021

o: 9/16/21
BNF/wde
45

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

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

/s/*Marc Parker*
Marc Parker

21IWCC0490

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINFREY, ELIZABETH
Employee/Petitioner

Case# **15WC002943**

15WC002942
16WC025921
17WC010057

PORTILLO'S
Employer/Respondent

On 10/28/2019, 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 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIEDERMANN LAW GROUP
CHRIS WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

2097 KRAKER FANNING & OLSEN
DAN IEL SWANSON
300 A RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elizabeth Winfrey
Employee/Petitioner

v.

Portillo's
Employer/Respondent

Case # **15** WC **2943**

Consolidated cases: **15 WC 2942**
16 WC 25921; 17 WC 10057

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **July 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 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.

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

In the year preceding the injury, Petitioner earned $**10,650.94**; the average weekly wage was $**322.76**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0.00** 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 AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON JANUARY 4, 2015 AND FURTHER FAILED TO PROVE THAT ANY CONDITION OF ILL-BEING IN HER LEFT SHOULDER WAS CAUSALLY CONNECTED TO HER EMPLOYMENT WITH RESPONDENT, THE 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

October 22, 2019
Date

OCT 28 2019

Statement of Facts

This matter was heard in conjunction with consolidated matters 15 WC 2942 (DOA: 12/15/2014), 16 WC 25921 (DOA: 6/22/2016), and 17 WC 10057 (DOA: 3/7/2017). Respondent was represented by Daniel Swanson of Kraker, Fanning & Olsen with respect to 15 WC 2942, 15 WC 2943 and 16 WC 25921. Respondent was represented by Stuart Pellish of Holecek & Associates with respect to 17 WC 10057. A single transcript was prepared. The Arbitrator has issued separate decisions for each of the consolidated matters.

The Arbitrator incorporated by reference the Statement of Facts detailed in the consolidated decision in Case 15 WC 2942 as the Statement of Facts herein.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury 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. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). 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. 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.

Petitioner testified that on December 15, 2014, she was reaching overhead with her left hand to put up the soup label and her left shoulder pinched. 15 to 20 minutes later, she was handing a customer his change with her left hand and felt a pinch in the left shoulder. On January 4, 2015, she was working the cash register and her shoulder was hurting really bad. She was writing down orders, and taking money back and forth. 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). The Arbitrator finds the Petitioner's testimony not credible in that it is contradicted by other testimony and testimony and evidence submitted.

Mr. Waxton testified that there is a procedure if an employee reported an accident. He testified that he does not recall having a direct conversation with the Petitioner on January 4, 2015, when she claimed to have reported an injury to him at work. Respondent has a procedure if a worker reported a work accident. He would fill out a report of accident relating the details of what happened that day and then he faxes it to the main office. He testified that when he talked to Petitioner on January 12, 2015 and prepared the handwritten report, she did not mention, and he did not have a conversation with her about an incident occurring on January 4, 2015. Mr. Castillo testified he does not recall a change return mechanism being broken in the cash register on January 4,

2015. Petitioner did not tell him about a cash register malfunction when he spoke to her and prepared the accident report on January 12, 2015. Peter Castillo testified that when he talked to Petitioner on January 12, 2015 and prepared the handwritten report, she did not tell him about a cash register malfunction when he spoke to her and prepared the accident report on January 12, 2015 for the December 15, 2014 incident. The Form 45 states she was injured handing a customer her change. In a recorded statement on January 13, 2015, Petitioner stated she did not remember the date of the initial accident, but they put down December 15 because it was around her birthday. She stated she hurt herself again on January 4, 2015 giving change to a customer. Given these contradiction of Petitioner's testimony as to the mechanism or injury, her testimony that it was still hurting from the onset of symptoms in December 2014 and her history at Fox Valley Medical Associates on January 5, 2015 that since the first time, the symptoms have been severe, the Arbitrator does not find that there was any employment activity on January 4, 2015 which would be considered a new accident.

Further, assuming she noticed pain while providing change to a customer, although the simple act of handing bills to the customer would be in the course of Petitioner's employment, to arise out of the employment requires a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Cases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones. That is, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been. *Nanette Schroeder v. The Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC (4th Dist., 2017). As discussed more fully below with respect to Causal Connection, Dr. Marra stated that this is an activity of ordinary life and Petitioner's condition was not caused by this activity of her employment. Dr. Fink's causation opinions are not credible.

Based upon the record as a whole, the Arbitrator finds that Petitioner 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 January 4, 2015.

In support of the Arbitrator's decision with respect to (F) Causal Connection, 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)*. Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

Petitioner offered the opinions of Dr. Fink that the injury in combination with her developmental acromion caused her condition. Respondent offered the opinions of Dr. Marra that handing back change is not going to be sufficient to cause aggravation to the point where you need surgery any more than life would be. If Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear. The mechanism of injury of giving change and reaching forward would be insufficient to cause a rotator cuff tear requiring surgery.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the evidence, including the deposition testimony of Dr. Fink and Dr. Marra, the Arbitrator finds the opinions of Dr. Marra more persuasive and finds Dr. Fink's testimony lacks credibility. The Arbitrator notes Dr. Marra's credentials including board certification and a specialty in upper extremity cases. Dr. Fink completely relied on Petitioner's reported history which was both inaccurate and incomplete. Dr. Fink did not review any medical records of Petitioner's prior treatment. He was unaware of Dr. Tu's records which include an initial diagnosis of a resolved strain and return to full duty on March 2, 2015. Petitioner's return in April 2015 resulted in his opinion that the Petitioner's complaints were not related to the shoulder but rather the pre-existing cervical spine condition. Dr. Fink was unaware of the significant recent treatment of her cervical spine including prior pain complaints across the left shoulder and injections occurring in January and February 2015. He had not reviewed Dr. Tu's May 7, 2015 diagnosis of shoulder pain of unknown origin or the significance of Petitioner's response to the diagnostic lidocaine injection provided on that date. The Arbitrator also notes that on May 7, 2015 Dr. Tu's physical examination remained completely negative, and Dr. Tu stated Petitioner could continue working full duty. Yet a week later, Dr. Fink found limited range of motion in the shoulder, positive tenderness, positive impingement signs and took Petitioner off work. The Arbitrator also notes Dr. Fink's unconvincing explanation of the mechanism of the injury of rubbing across the acromion. In fact, Dr. Fink never provides a specific opinion of causation for the alleged January 4, 2015 reinjury. Dr. Marra testified that the Type 2 acromion is not unusual. Dr. Marra testified credibly and persuasively that if Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence, that any condition of ill-being in the left shoulder is causally connected to her employment with Respondent on or about January 4, 2015.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical, Temporary Compensation and Nature & Extent are moot.

Petitioner's claim for compensation is hereby denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC025921
Case Name	WINFREY, ELIZABETH v. PORTILLOS
Consolidated Cases	15WC002942 15WC002943 17WC010057
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0491
Number of Pages of Decision	13
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Christopher Williams
Respondent Attorney	Daniel Swanson

DATE FILED: 9/24/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth Winfrey,

Petitioner,

vs. NO: 16 WC 25921

Portillos,

Respondent.

DECISION AND OPINION ON REVIEW

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

The decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on review, the Commission writes additionally to address the accident analysis.

The "arising out of" component required to establish a compensable accident is primarily concerned with causal connection and is satisfied when a claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d. 193, 203. However, while it is recognized that Arbitrator's ruling pre-dates relevant case law, the Commission must evaluate this case in light of a recent decision.

In *McAllister*, the Illinois Supreme Court reversed the Commission's determination that the claimant, a restaurant employee whose knee "popped" after kneeling to look for carrots at work, failed to show that his injury arose out of his employment. *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 124828, ¶ 2. Our supreme court found that the claimant's knee

injury "arose out of" an employment-related risk because the evidence established that at the time of the occurrence his injury was caused by one of the risks distinctly associated with his employment as a sous-chef. *Id*. ¶ 47. The court also observed that "that an employee who sustains an injury while rendering reasonably needed assistance to a coworker in furtherance of the employer's business is considered to have suffered an injury arising out of and in the course of employment when the act performed is within the reasonable contemplation of what the employee may do in the service of the employer." *Id*. ¶ 48; see also *id*. ¶ 52.

The *McAllister* court further held that *Caterpillar Tractor v. Industrial Comm'n*, 129 Ill. 2d 52 (1989), prescribes the proper test for analyzing whether an injury "arises out of" a claimant's employment when the claimant is injured performing job duties involving common bodily movements or routine "everyday activities." *Id*. ¶ 60. The court overruled *Adcock v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130884WC and its progeny "to the extent that they find that injuries attributable to common bodily movements or routine everyday activities, such as bending, twisting, reaching, or standing up from a kneeling position, are not compensable unless a claimant can prove that he or she was exposed to a risk of injury from these common bodily movements or routine everyday activities to a greater extent than the general public." *McAllister*, 2020 IL 124828, ¶ 64. That is, "[o]nce 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." *Id*.

Accordingly, a risk is distinctly associated with an employee's employment if, 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. *Id*. ¶ 46 (citing *Caterpillar Tractor*, 129 Ill. 2d at 58).

Here, Petitioner alleged a work accident occurring on June 22, 2016. She explained that she was "standing on the ladder and putting up the soup label. And as [she] was reaching overhead, [she] felt her shoulder like -- it felt like a piece of chalk had cracked." This act is "within the reasonable contemplation of what the employee may do in the service of the employer." See *McAllister*, 2020 IL 124828, ¶ 48.

However, as noted by the Arbitrator the totality of evidence undermines Petitioner's allegation that this alleged accident occurred as claimed. The record contains varying reports of dates of injury spanning over a six-week period. Accordingly, the Commission finds that Petitioner has failed to establish that she sustained an accident traceable to a specific date in this claim. See *International Harvester Co. v. Industrial Comm'n*, 56 Ill.2d 84, 89 (1973).

With the above clarifications, the Commission affirms the Arbitrator's denial of accident. In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2019 is hereby affirmed and adopted, but changed with respect to the accident analysis.

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

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

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). As there are no monies due and owing, there is no bond set by the Commission for the 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.

September 24, 2021

o: 9/16/21
BNF/wde
45

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

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

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINFREY, ELIZABETH
Employee/Petitioner

Case# **16WC025921**

15WC002942
15WC002943
17WC010057

PORTILLOS
Employer/Respondent

On 10/28/2019, 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 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMAN LAW GROUP
CHRIS WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

2097 KRAKER FANNING & OLSEN
DANIEL SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elizabeth Winfrey
Employee/Petitioner

v.

Portillo's
Employer/Respondent

Case # **16** WC **25921**

Consolidated cases: **15 WC 2942**
15 WC 2943; 17 WC 10057

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **July 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, Petitioner ***did 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 $**22,256.00**; the average weekly wage was $**428.00**.

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*** 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 AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON JUNE 22, 2016 AND FURTHER FAILED TO PROVE THAT ANY CONDITION OF ILL-BEING IN HER LEFT SHOULDER WAS CAUSALLY CONNECTED TO HER EMPLOYMENT WITH RESPONDENT, THE 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

October 22, 2019
Date

OCT 28 2019

ICArbDec p. 2

Statement of Facts

This matter was heard in conjunction with consolidated matters 15 WC 2942 (DOA: 12/15/2014), 15 WC 2943 (DOA: 1/4/2015), and 17 WC 10057 (DOA: 3/7/2017). Respondent was represented by Daniel Swanson of Kraker, Fanning & Olsen with respect to 15 WC 2942, 15 WC 2943 and 16 WC 25921. Respondent was represented by Stuart Pellish of Holecek & Associates with respect to 17 WC 10057. A single transcript was prepared. The Arbitrator has issued separate decisions for each of the consolidated matters.

Petitioner has alleged two prior injuries to her left shoulder on December 15, 2014 and January 4, 2015. These disputed claims are the subject of consolidated cases 15 WC 2942 and 15 WC 2943 decided in conjunction with this matter. As more fully discussed in the statement of facts in 15 WC 2942, Petitioner sought treatment with Fox Valley Medical Associates, Dr. Tu and Dr. Fink. She underwent surgery on May 28, 2015 consisting of arthroscopy and open repair of left rotator cuff with Neer acromioplasty. The post-operative diagnosis was a partial tear of rotator cuff greater than 50% and impingement syndrome. Petitioner was returned to work without restrictions by Dr. Fink on December 14, 2015 (PX 4, p 82). Petitioner testified that she returned to work for Respondent in a full duty capacity. As more fully described in the statement of facts in 15 WC 2942, Petitioner also had significant non-occupational medical care resulting from prior work injuries, motor vehicle accidents and falls.

Petitioner saw Dr. Fink on June 1, 2016 (PX 4, p 93). His handwritten note indicates she is status post rotator cuff on 5/28/15. This is due to a repetitive use W/C case (PX 4, p 78). Cervical spine x-rays noted no loosening of the plate or screws in the cervical fusion. She had full range of motion in her left shoulder and was complaining of neck pain (PX4 p. 93). Dr. Fink assessed radiculopathy. He noted her pain is from the neck not the shoulder. He advised Petitioner to follow up with Dr. Salehi who had performed neck surgery in 2013 (PX4 p. 93). She was given work restrictions of no lifting over 20 pounds (PX 4, p 77).

Petitioner testified that she continued working through June 22, 2016. On that date, she was standing on a ladder putting up the soup label. As she was reaching overhead, she felt like a piece of chalk cracked in her left shoulder. Petitioner also testified that she is not sure of the exact date. Petitioner's Employee Statement prepared July 14, 2016 lists the date as simply June 2016 (R1X 7). The Form 45, prepared by Joe Biasco, lists the date of accident as June 1, 2016 (R1X 6). Petitioner recalled giving a recorded statement to Claire Usher, a Zurich claims adjuster, on July 20, 2016 (R1X 3). Petitioner stated in her recorded statement that she did not know when the injury occurred in June of 2016. She was not sure of the exact date. She believed it was the early part of June. She reported in the statement that the ladder would on occasion be struck by coworkers coming through a door, but did not state that this occurred at the time of the accident. She stated she told Joe what happened that day, but she did not fill out the reports until July (R1X 3).

Petitioner was seen at Goldcoast Orthopedics on June 29, 2016. The handwriting of the note is Dr. Massarella (PX 4). The History Sheet dated June 29, 2016 lists the accident date as "the end of June." The description is "on a ladder reaching overhead and felt my left shoulder crack like a piece of chalk. A CT arthrogram of the left shoulder was ordered (PX 4, p 73-75). The typed office note for this visit is signed by Dr. Fink and includes no history of accident. The handwritten note included some of his handwriting adding an accident history (PX 4, p 75, R1X 8).

The July 1, 2016 CT scan ordered by Dr. Massarella revealed a full-thickness tear of the rotator cuff (PX 4, p 71). Dr. Fink took Petitioner off of work on July 18, 2016 (PX 4, p 70). His note states that she reinjured her left

shoulder when reaching overhead and that paperwork was filled out on July 14, 2016. The CT scan found a re-tear of the rotator cuff. X-rays show the previous anchors in place. Repeat surgery was scheduled (PX 4, p 67). Dr. Fink prepared a narrative note on August 19, 2016. He notes the history of injury and opines that this is a new injury. He diagnosed a re-tear of the left rotator cuff tear and recommended surgery to repair the new tear (PX 4, p 62).

Dr. Fink performed an open rotator cuff repair on September 8, 2016. The operative report notes that the previous repaired area of the rotator cuff was intact. There was a new tear. His postoperative diagnosis was traumatic re-tear of the left rotator cuff (PX 4, p 60-61). Petitioner was kept off work until October 5, 2016 when she was released to work with restrictions (PX 4, p 56). Petitioner testified she returned to work for Respondent and for Circle K. She followed up through January 2, 2017 where it was noted that her shoulder was doing well (PX 4, p 53). Dr. Fink ordered an MRI of Petitioner's cervical spine which revealed post fusion changes, but was otherwise unremarkable (PX 4, p 51). On February 1, 2017, Petitioner was returned to work with no overhead work with her left shoulder (PX 4, p 50).

Petitioner reported that she suffered a new injury to her right leg and back on March 7, 2017 and began an additional course of treatment for these body parts. This accident is addressed in the decision in the consolidated claim 17 WC 10057 decided in conjunction with these matters. Petitioner testified she was given additional restrictions for this injury.

On April 5, 2017, Dr. Fink noted Petitioner has full range of motion in the shoulder. She reported occasional pain and electric shock like feeling. Dr. Fink discharged her from care and released her to return to regular duty work (PX 4, p 36-37).

Dr. Fink testified by evidence deposition taken June 27, 2018 (PX 9). Dr. Fink testified to his initial treatment of Petitioner beginning May 13, 2015. Dr. Fink testified that he did not review any medical records prior to seeing Petitioner for the first time. He recorded a history of reaching and pulled her shoulder on December 15, 2014. He opined that the injury in combination with her developmental acromion caused her condition. The space is more narrowed and caused rubbing. He testified to his surgery and postoperative treatment. He noted a release to return to full duty on December 14, 2015. He testified that Petitioner cancelled the appointment scheduled for September 15, 2015. He last saw her on August 17, 2015 and had her off work. He provided the full duty release after Petitioner requested it by telephone. He testified she might have been able to work in September, but he did not see her at that time. On January 27, 2016, he discharged her to be seen as needed (PX 9).

Dr. Fink testified that when he saw Petitioner on June 1, 2016, her complaints were related solely to her neck and not her shoulder. There was no symptomology with her shoulder on that date. She had good range of motion. He testified that she saw him again on June 29, 2016 where she reported an accident the previous week where she was on a ladder reaching and her left shoulder cracked like a piece of chalk breaking in her. He performed surgery on September 8, 2016 and confirmed that Petitioner had a traumatic re-tear of her rotator cuff. He testified that reaching overhead can cause stress on the rotator cuff. He testified that people feel something tear in their shoulder with a rotator cuff tear, however, they usually do not refer to it as chalk breaking. He testified that Petitioner was now at MMI for her left shoulder (PX 9).

Dr. Guido Marra testified by evidence deposition taken July 27, 2018 (R1X 1). Dr. Marra testified that he is board certified in orthopedic surgery. Dr. Marra performed an Independent Medical Examination on January 4,

2016. Petitioner related a history of performing overhead work on December 15, 2014, when she felt pain. Then 15 or 20 minutes later, while handing a customer change at the counter and pulling back, she felt a pop in her left shoulder. She underwent a rotator cuff repair on May 28, 2015. Dr. Marra opined that handing back change is not going to be sufficient to cause aggravation to the point where you need surgery any more than life would be. If Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear. Dr. Marra opined that Petitioner reached maximum medical improvement and did not require any restrictions. He noted that Petitioner had already returned to work by the time of his examination on January 4, 2016. The treatment performed at the time was reasonable, but not related to the claimed injury of December 15, 2014, as the mechanism of injury of giving change and reaching forward would be insufficient to cause a rotator cuff tear requiring surgery (R1X 1).

Dr. Marra testified that on April 26, 2018, he prepared an Addendum report after Petitioner alleged that she reinjured her shoulder in June 2016, while reaching overhead to put a soup label on a hook. Dr. Marra testified that he reviewed the July 15, 2016 Form 45, First Report of Injury, reflecting an accident date of June 1, 2016. (R1X 6). He did not know who prepared this document. Dr. Marra also testified that he reviewed the treatment records of Gold Coast Orthopedics and the handwritten medical note dated June 29, 2016. Dr. Marra assumed the incident of putting the soup labels up overhead occurred on June 1, 2016. Dr. Marra testified that Dr. Fink's medical note from June 1, 2016 did not reflect the history of any mechanism of shoulder injury but contained Petitioner's complaints of neck pain. Dr. Marra testified that, initially, he believed Petitioner was putting up a box of soup ladles on a shelf on June 1, 2016, when she felt pain in her left shoulder. Dr. Marra clarified that if she was putting up a one or two ounce soup label, as opposed to multiple ladles in a box, weighing 5-10 pounds overhead on a shelf, that would be insufficient force to support a causal connection between the mechanism of injury and a rotator cuff tear.

Dr. Marra opined that the mechanism of reaching overhead to put a label that weighs a few ounces is insufficient to cause a re-tear of the left rotator cuff. The amount of force that is placed upon a tendon or rotator cuff depends on the weight that is applied to the arm, the position of the hand in space, the further the arm is away from the body and the further the arm is overhead. It takes more than ounces to tear your rotator cuff. Otherwise everybody would be incapacitated. Dr. Marra testified that the need for surgery was not related to the June 2016 injury, when she strained her shoulder putting soup labels away. Dr. Marra testified that Petitioner reached the point of maximum medical improvement for her left shoulder condition of ill-being and could return to work without restrictions as of April 26, 2018.

Petitioner testified that she returned to work for Respondent for a few months after her back surgery but could not handle it and was taken off work by Dr. Fink for her back complaints. She has attempted to work at Circle K and Thornton's but had severe back pain. She has not worked since. She testified she cannot lift her left arm as far as she used to. She gets pain down her arm and a tingling in her fingers. She is left handed. She cannot write for long periods and her handwriting is sloppy.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury 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. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). 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. 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.

Petitioner testified that on June 22, 2016, she was standing on a ladder putting up the soup label. As she was reaching overhead, she felt like a piece of chalk cracked in her left shoulder. 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). The Arbitrator finds the Petitioner's testimony not credible in that it is contradicted by the preponderance of evidence submitted including her own testimony.

The reported date of injury claimed by Petitioner is inconsistent. Petitioner made no report of any accident until July 14, 2016. She was seen at Goldcoast Orthopedics on June 1, 2016 with significant complaints but was advised that they were caused by her non-occupational cervical spine conditions. The handwritten history appears to indicate she is status post rotator cuff on 5/28/15. This is due to a repetitive use W/C case. The handwritten notes of Dr. Massarella from June 29, 2016 do not contain a history of accident. This was added by Dr. Fink. Dr. Fink's typed note dated June 29, 2016 does not contain an accident history. He testified that these are typed later and that it does not appear that he actually saw Petitioner on June 29. The July 18, 2016 note confirms that the accident was not reported until July 14, 2016. The First Report of Injury, prepared by Joe Biasco on July 15, 2016, lists the accident date as June 1, 2016. In the recorded statement taken on July 20, 2016, Petitioner stated "I can't give you a specific date. I don't know the date. Like I can tell you like June 7 or anything like that. I believe it was June, the beginning." Petitioner admitted at trial that she has no idea on which date the alleged incident occurred. Given Petitioner's dramatic description of the event, the Arbitrator finds her failure to promptly report this incident, her continued working, and failure to seek prompt medical attention not credible.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence, that any condition of ill-being in the left shoulder is causally connected to her employment with Respondent on or about June 22, 2016.

In support of the Arbitrator's decision with respect to (F) Causal Connection, 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)*. Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

Petitioner offered the opinions of Dr. Fink that the injury in combination with her developmental acromion caused her condition. Respondent offered the opinions of Dr. Marra that if Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear. The mechanism of injury of lifting a few ounces overhead would be insufficient to cause a rotator cuff tear requiring surgery.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the evidence, including the deposition testimony of Dr. Fink and Dr. Marra, the Arbitrator finds the opinions of Dr. Marra more persuasive and finds Dr. Fink's testimony lacks credibility. The Arbitrator notes Dr. Marra's credentials including board certification and a specialty in upper extremity cases. Dr. Fink completely relied on Petitioner's reported history which was both inaccurate and incomplete. Dr. Fink did not review any medical records of Petitioner's prior treatment. As discussed more fully in the Decision in 15 WC 2942, the Arbitrator notes inconsistencies between Dr. Tu's May 7, 2015 negative physical examination and Dr. Fink's findings of limited range of motion in the shoulder, positive tenderness, positive impingement signs a week later. The Arbitrator also notes Dr. Fink's unconvincing explanation of the mechanism of the injury of rubbing across the acromion. The Arbitrator also finds Dr. Fink's testimony concerning his recordkeeping questionable and easily error prone or revision. The notations as to the onset of shoulder symptoms in June are inconsistent and contradictory. Dr. Marra testified that the Type 2 acromion is not unusual. Dr. Marra testified credibly and persuasively that if Petitioner was not lifting significant weight in an overhead fashion, it does not cause any significant strain on the rotator cuff to cause a tear.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence, that any condition of ill-being in the left shoulder is causally connected to her employment with Respondent on or about June 22, 2016.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical, Temporary Compensation and Nature & Extent are moot. Petitioner's claim for compensation is hereby denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC010057
Case Name	WINFREY, ELIZABETH v. PORTILLO'S
Consolidated Cases	15WC002942 15WC002943 16WC025921
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0492
Number of Pages of Decision	15
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Christopher Williams
Respondent Attorney	Stuart Pellish

DATE FILED: 9/24/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth Winfrey,

Petitioner,

vs. NO: 17 WC 10057

Portillos,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2019 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. 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.

September 24, 2021

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

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BNF/ma
045

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

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0492

WINFREY, ELIZABETH
Employee/Petitioner

Case# **17WC010057**

15WC002942
15WC002943
16WC025921

PORTILLO'S
Employer/Respondent

On 10/28/2019, 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 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP
CHRIS WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

0532 HOLECEK & ASSOCIATES
STUAT PELLISH
PO BOX 64093
ST PAUL, MN 53164

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elizabeth Winfrey
Employee/Petitioner

v.

Portillo's
Employer/Respondent

Case # **17** WC **10057**

Consolidated cases: **15 WC 2942**
15 WC 2943; 16 WC 25921

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **July 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**22,256.00**; the average weekly wage was $**428.00**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $256.80/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claim for medical benefits and temporary compensation 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

October 22, 2019
Date

OCT 28 2019

Statement of Facts

This matter was heard in conjunction with consolidated matters 15 WC 2942 (DOA: 12/15/2014), 15 WC 2943 (DOA: 1/4/2015), and 16 WC 25921 (DOA: 6/22/2016). Respondent was represented by Daniel Swanson of Kraker, Fanning & Olsen with respect to 15 WC 2942, 15 WC 2943 and 16 WC 25921. Respondent was represented by Stuart Pellish of Holecek & Associates with respect to 17 WC 10057. A single transcript was prepared. The Arbitrator has issued separate decisions for each of the consolidated matters.

Petitioner testified she hurt her back in La Crosse, Wisconsin in 2001. She had testing including an MRI. She had another accident to her back in 2008. She treated with Dr. McGivney. Petitioner was treated for her lumbar spine in 2010. A March 30, 2010 lumbar x-ray showed disc degeneration at L4-5 (R2X 3). Petitioner treated at Rush Copley Orthopaedics (R2X 7). She underwent an MRI of the lumbar spine on April 28, 2010 that revealed mild degenerative disk changes at L3-L4 and L4-L5 with a circumferential annular disc bulge at L3-L4 and annular bulging at L4-L5. Dr. McGivney noted her degenerative changes were pre-existing but exacerbated by her fall. He recommended pain management. He placed her on a 15 pound restriction with no repetitive bending, stooping, twisting or jerking. He limited her to standing or sitting for two hours at a time. On September 20, 2010, Dr. McGivney noted that injections and therapy had not helped. He made her restrictions permanent. Petitioner was discharged from care by Dr. McGivney on November 17, 2010 with work restrictions of no lifting over 15 pounds, no standing more than two hours, and no sitting more than two hours at a time in an eight-hour period for back pain and worsening leg pain. He referred her back to Dr. Bradshaw for a possible repeat MRI and referral to physical medicine and rehab to try and manage her back pain (R2X 7).

Petitioner has a history of a motor vehicle accident on March 25, 2013. She was treated by Dr. Salehi for cervical and lumbar spine injuries (R2X 8). She saw Dr. Salehi on May 22, 2013 with radiating complaints primarily into the right arm and leg. Her pain diagram included pain in the low back and down the entire right leg. She noted a prior lumbar herniated disc in 2002 with a flare up in 2008. Petitioner was diagnosed with cervical spondylosis and a herniated disc and lumbar spondylosis. On June 20, 2013, she reported increased pain with cervical injections and pain down her left arm with numbness. Petitioner underwent a C5-6 discectomy and disc arthropathy on June 27, 2013. On July 10, 2013, Petitioner reported resolution of her right arm pain, but continued pain that radiates to the left shoulder. Petitioner was kept off work through October 1, 2013. The Premier physical therapy notes dated July 15, 2013 report low back pain of 4/10 and right leg symptoms 3-4 times per week including pain to the knee and below the knee numbness to the toes (R2X 8). On January 9, 2014, Petitioner reported no complaints in her neck but continued low back pain due to the L4-5 level. Petitioner would be a surgical candidate if she would lose weight. Dr. Salehi referred her to Dr. Hussain for pain management and attempts at weight loss to perform a lumbar fusion (R2X 8).

Petitioner testified to two alleged injuries to her left shoulder occurring December 15, 2014 and January 4, 2015 which are the subject of consolidated cases 15 WC 2942 and 15 WC 2043. As more fully discussed in the decisions in those matters, she testified to the accident mechanism and her treatment for these injuries including surgery by Dr. Fink on May 28, 2015 consisting of an arthroscopy and open repair of left rotator cuff with Neer acromioplasty. Petitioner was returned to work without restrictions by Dr. Fink on December 14, 2015. In conjunction with the work up for her shoulder, she was seen by Dr. Salehi on April 30, 2015 to differentiate her symptoms between her prior surgical fusion and her left shoulder. Petitioner gave a history that her back pain had resolved over time (R2X 8).

Petitioner was seen at Presence Mercy Medical Center on November 23, 2015 (PX 5). She gave a history of a fall on ice yesterday. Her chief complaint was left shoulder pain as well as head, cervical, low back and left arm pain. X-rays of the head, cervical spine, left shoulder, left arm and left shoulder were normal. Lumbar spine x-rays noted changes at L4-5 and L5-S1 (PX 5, p 8-59).

Petitioner testified to a third injury to her left shoulder on June 22, 2016 which is the subject of consolidated case 16 WC 25921 and is more fully discussed in the decision on that matter. She testified to the mechanism of injury and her treatment including an open rotator cuff repair on September 8, 2016. Petitioner was returned to work with no overhead work with her left shoulder.

Petitioner testified that on March 7, 2017, she was working at Respondent and her concurrent employer Circle K. She testified that she was walking through the salad bowl, the area where salads are prepared, on her way to get a drink. She had already clocked in for her shift. A co-worker, Adon, shoved a second co-worker, Ursula. Petitioner testified Ursula fell into her, causing her knee to snap and her back to pinch. The weight of her body fell on Petitioner. She grabbed the counter to keep from falling. She did not fall. She testified another co-worker, Lupe, grabbed her so she would not fall. She continued working after the incident. She testified her back became too painful. She was unable to complete her work shift.

Elza Cardosa testified that on the date of the incident, she was working in salad preparation. Petitioner was working in the front of the store. Petitioner was walking through the salad preparation area. Ms. Cardosa testified Adon did not push her. He did not fall into her. She testified she was not engaged in horseplay. She testified that she turned around and while doing this, she hit Petitioner with her shoulder. Ms. Cardosa testified she did not fall into Petitioner. She could not recall Petitioner making any sounds of pain. She observed Petitioner putting one hand onto the salad counter. She testified that Petitioner walked back to where she came from. There was no indication of her being in pain. She did not see the Petitioner get a glass of water.

Petitioner first treated at the emergency department at Mercy Hospital on March 8, 2017, complaining of low back pain and right knee pain with tingling to her right thigh following a co-worker bumping her at work yesterday (PX 5, p 74). She gave a history of herniated discs in her back and right sided sciatica. She denied numbness, tingling or weakness (PX 5, p 86). Petitioner had a positive right straight leg raising test. She was noted to have chronic back pain with sciatica. She was given a Medrol Dosepak and referred to her primary care physician, Dr. Bradshaw (R2X 5)

Petitioner presented to Dr. Fink on March 20, 2017 with an accident history of walking through the salad bowl to get a drink when she was caught in the line of horseplay when another employee fell into her (PX 4, p 49). Dr. Fink's notes indicate prior injuries of 2001 and 2008 (PX 4, p 45). Dr. Fink took her off of work and ordered an MRI (PX4 p. 44). He indicated that this was the first time she was treating with him for her back and that during all of the shoulder treatments through 2015-2016, she had never complained of any back pain (PX 4, p 42). The MRI on March 27, 2019 noted a broad-based disk herniation at the L4-L5 level and an annular disk bulge at L3-L4 (PX 4, p 43). Petitioner was seen at the emergency department at Mercy Hospital on March 29, 2017 complaining of increased back pain (PX 5, p 118). She returned to Dr. Fink on April 5, 2017 complaining of increased numbness and pain in her low back extending down her legs. He noted the MRI showed bulging discs at L3-4 and L4-5. Her 5/09/13 MRI also showed bulging discs at L3-4 and L4-5. He ordered a discogram (PX 4, p 35).

Petitioner underwent a discogram on May 11, 2017 with Dr. Fink that was positive for concordant pain at L3-L4 and L4-L5 (PX 4, p 31-32). On July 6, 2017, Petitioner underwent a lumbar discectomy at L3-L4 and L4-L5, neuroforaminectomy at L3-L4 and L4-L5, and radiofrequency annuloplasty at L3-L4 and L4-L5 (PX 4, p 20-22).

On July 10, 2017, Petitioner returned to Mercy Hospital's emergency department. She reported she was recently in a car accident which caused back (PX 5, p 159). Dr. Fink kept Petitioner off work. On October 18, 2017, he released her to full duty as of November 8, 2017 when she was returned to full duty (PX 4, p 16). On November 20, 2017, he restricted her to 10 pound lifting and five hours per day, four days per week, working only for Respondent and not her second job (PX 4, p 15). She was taken off work on December 18, 2017 (PX 4, p 14). On January 15, 2018, Dr. Fink discharged Petitioner to a home exercise program. His examination noted some pain while she was working and in cold weather. No pain at home. His objective finding was negative straight leg raising (R2X 11). He opined that she is permanently disabled from doing her job because she is unable to stand for a long period of time (PX 4, p 12).

Petitioner returned on July 18, 2018 and received a return to work full duty (PX 4, p 11). Dr. Fink then noted on August 1, 2018 that she can only do a sit down job and cannot walk or stand for periods of time (PX 4, p 10). He noted that these were permanent restrictions (PX 4 p. 10).

Dr. Fink testified by evidence deposition taken June 27, 2018 (PX 9). He testified to the history provided to him by Petitioner on March 20, 2017 and complaints in the right knee and back. He testified to his physical examination findings of right paraspinal muscle tenderness, right positive straight leg raising, decreased sensation on the right L3, L4 and L5 dermatomes. He noted the MRI and discogram findings. He testified to his July 6, 2017 two level discectomy. He testified to his January 15, 2018 note stating Petitioner could not do her job because she could not stand for long periods. He opined that the Petitioner's back condition was caused by the accident. He stated that she never complained of low back pain during his treatment of her shoulders. He did not have any data that she had any other trauma to her low back. He testified she had some developmental things in her back, but she was not symptomatic until the injury. He testified Petitioner will need medication in the future (PX 9).

Dr. Fink testified that the Petitioner told him she needs to stand to do her job as a cashier. He does not know how long. She told him she has difficulty standing. Dr. Fink testified that she can do a sitting job. She can work 5 hours per day, 4 days per week. She can lift 20 pounds. He testified a functional capacity evaluation could determine her work capacity. The mechanism was a force and twisting. The more force the more it could lead to an aggravation. He had no data on her prior back treatment. He was unaware of prior lumbar MRIs. He then testified to her history of injuries in 2001 and 2008. He testified that he did not know of the 2013 treatment or the 2013 MRI. He opined that a prior herniated disc was aggravated by the injury.

At Respondent's request, Petitioner was examined by Dr. Jerry Bauer on October 8, 2018. Dr. Bauer testified by deposition taken February 11, 2019 (R2X 1). Dr. Bauer testified he performed a physical examination of Petitioner. He reviewed various medical records, including treating records prior to March 7, 2017. Petitioner gave a history of the 2001 back injury with a herniated disc. She had a 2008 injury working at Jewel developing low back pain shooting down her right leg. She had an MRI finding a herniated disc. She had the car accident in 2013 with a cervical fusion. She prepared a pain diagram consistent with radicular pain in the right side. Physical examination noted no limp. She had limited extension and tenderness to palpation She had good strength. Reflexes were symmetrical. Sensation was intact. Straight leg raising was negative but resulted in pain in the hip area (R2X 1).

Dr. Bauer opined Petitioner had an underlying degenerative condition in her spine, with severe degenerative disc disease at L4-L5. She had a history of herniated disc. Petitioner's weight would accelerate the progression of the condition. Dr. Bauer compared the 2013 MRI and the 2015 x-rays with the 2017 MRI. He noted the findings were similar. There was no change between the 2013 and 2017 MRIs. He testified that degenerative osteophytes and stenosis, not the herniated disc were causing her symptoms. The necessity for surgery was not caused in whole or in part by the March 7, 2017 accident. He further opined the March 7, 2017 accident did not cause or aggravate Petitioner's condition. He opined the surgery performed was not necessitated by the March 7, 2017 accident. Dr. Bauer opined Petitioner was capable of returning to her prior employment positions. He testified the neurological examination was unremarkable. Petitioner had subjective complaints. She could work as a cashier. She has no objective evidence to need work restrictions. He opined that Petitioner is at maximum medical improvement (R2X1).

Petitioner testified that she returned to work for Respondent with sitting/standing restrictions, but that she only lasted a few months. She testified that her body could no longer handle the work and that Dr. Fink modified her restrictions to no work permanently. She last saw Dr. Fink in 2018. Petitioner testified that she has attempted to find other work. She first attempted to work again at Circle K in September 2018. She made it three days, but could no longer handle the pain after that. Circle K was a standing job. Petitioner testified that she also tried to work at Thornton's Gas in June 2019. She made it five days at Thornton's, but stopped due to her back pain. She did not ask Thornton's to honor her restrictions. She attempted to work at these jobs because of financial reasons. She testified that she has applied for around five or six other jobs in addition to these two, but has not received job offers. She applied to Walgreens, Speedway Gas, White Castle, and Dollar General. Petitioner testified she has pain in her low back when standing or walking.

Petitioner testified she was approved for Social Security Income in November 2018. As part of the determination process for eligibility, she was examined by two doctors. Respondent's counsel wrote on February 20, 2019 and March 4, 2019 to Petitioner's counsel asking for a Release to be signed by Ms. Winfrey which was needed to obtain these records from the Social Security Administration (R2X 5, R2X 6). The release was not signed by Petitioner and was not presented to Respondent's counsel.

Petitioner was shown photographs depicting her carrying a basket of laundry from her car (R2X 9). She acknowledged the person depicted was her. She was not using a cane while carrying the basket of laundry. Surveillance video of Ms. Winfrey was admitted into evidence as R2X 10. Petitioner is seen walking and driving. She carries large baskets of laundry and later placed them into her car. She is seen bending at the waist. Petitioner testified the baskets were not heavy.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury 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. *International Harvester Co. v. Industrial Comm'n.*, 56 Ill. 2d 84, 89 (Ill. 1973). 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. 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.

Petitioner testified that on March 7, 2017, she was walking through the area where salads are prepared, when a co-worker engaged in horseplay shoved a second co-worker who fell into her, causing her knee to snap and her back to pinch. Elza Cardosa testified that as Petitioner was walking through the salad preparation area, she turned around and hit Petitioner with her shoulder. Ms. Cardosa testified Adon did not push her. He did not fall into her. She testified she was not engaged in horseplay. She testified that she did not fall into Petitioner. She could not recall Petitioner making any sounds of pain. She observed Petitioner putting one hand onto the salad counter. She testified that Petitioner walked back to where she came from. There was no indication of her being in pain.

The Arbitrator heard the testimony in this matter as well as the consolidated cases and has reviewed the evidence submitted. The Arbitrator notes Petitioner's inconsistent testimony with respect to the mechanism of accident in both this case and the consolidated shoulder cases. Petitioner consistently attributes the lack of reporting to multiple different supervisors. Petitioner also consistently misrepresents her physical condition from the prior injuries and her non-occupational falls, misrepresenting the treatment, diagnoses and seriousness of the conditions. Based upon the totality of the evidence, the Arbitrator finds Petitioner not credible as to the exact description of the March 7, 2017 contact. The Arbitrator finds that based upon the testimony of Ms. Cardosa, that there was an incident but the description of the incident by Ms. Cardosa more persuasive. Her description is consistent with the initial triage history at Presence Mercy Medical Center that a co-worker bumped her yesterday.

This incident as described by Ms. Cardosa would still be during Petitioner's employment and at a place where the claimant may reasonably perform employment duties, and while a claimant engages in some incidental employment duties and originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury..

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on March 7, 2017.

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

Petitioner testified that she gave notice to Roxie, a crew chief and Phil, a manager. Ms. Cardosa testified that Adon, the other employee present at the time of the contact was also a crew chief. Petitioner sought medical care are Presence Mercy Medical Center on March 8, 2017. She saw Dr. Fink who took her off work on March 20, 2017. Based upon the unrebutted testimony, the Arbitrator finds that Respondent had notice of the injury within the time limit stated in the Act.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct. 3d Dist. 2014) If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Nunn v. Industrial Comm'n, 157 Ill. App. 3d 470, 476, 510 N.E.2d 502, 505, 109 Ill. Dec. 634 (1987)*. Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, "expert testimony is necessary to show that claimant's work activities caused the condition complained of." *Nunn*, 157 Ill. App. 3d at 478; see also *Johnson*, 89 Ill. 2d at 442-43. "Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions."

Petitioner presented the opinions of Dr. Fink that the Petitioner's back condition was caused by the accident. He opined that a prior herniated disc was aggravated by the injury. Respondent presented the opinions of Dr. Bauer that Petitioner had an underlying degenerative condition in her spine, with severe degenerative disc disease at L4-L5 and a history of herniated disc. Dr. Bauer found no change between the 2013 MRI and the 2015 x-rays and the 2017 MRI. The degenerative osteophytes and stenosis, not the herniated disc, were causing her symptoms. He opined the March 7, 2017 accident did not cause or aggravate Petitioner's condition. He opined the surgery performed was not necessitated by the March 7, 2017 accident.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the evidence, including the deposition testimony of Dr. Fink and Dr. Bauer, the Arbitrator finds the opinions of Dr. Bauer more persuasive and finds Dr. Fink's testimony lacks

credibility. The Arbitrator notes that Dr. Fink did not review any medical records of Petitioner's prior treatment. He was not aware of the prior MRI studies. He completely relied on Petitioner's reported history which was both inaccurate and incomplete. He was unaware of the low back surgical recommendation in 2013, the 2015 injury and treatment and the extent of the prior injuries in 2001 and 2008. He was unaware of the prior permanent restrictions. He also relied on Petitioner's explanation of the accident, which the Arbitrator found exaggerated and not credible. The Arbitrator also notes Dr. Fink's evasive, combative and defensive behavior on cross examination. In contrast, Dr. Bauer based his opinions on complete, accurate information and a logical analysis, and presented his opinions in a professional and unbiased manner.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that she suffered a strain to her lower back and an exacerbation of her degenerative lumbar condition on March 7, 2017. The Petitioner's causally connected condition of ill-being reached maximum medical improvement and returned to her pre-existing condition as of March 20, 2017. Petitioner failed to prove by a preponderance of the evidence that any condition of ill-being thereafter in the low back and right leg as diagnosed and treated by Dr. Fink was causally connected to the accidental injury sustained on March 7, 2017,

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based upon the Arbitrator's finding with respect to Causal Connection, the only treatment causally connected to the accident would be the Presence Mercy Medical Center care on March 8, 2017. Petitioner offered no unpaid medical bill for this care. All bills admitted for treatment of the low back were for further treatment thereafter under the supervision of Dr. Fink and would not be causally related.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that Respondent is responsible for any medical care for the accidental injury sustained on March 7, 2017.

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

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

Petitioner is seeking temporary compensation from March 20, 2017, the date Petitioner was taken off work by Dr. Fink, through July 10, 2019, being the date of hearing in this matter. Based upon the Arbitrator's finding with respect to Causal Connection, including the Arbitrator's finding that Dr. Bauer's opinions are persuasive

and Dr. Fink's opinions are not credible, the Arbitrator finds any lost time after March 20, 2017 was not causally related to the accident on March 7, 2017.

The Arbitrator also notes Dr. Bauer's persuasive opinion that Petitioner could work her regular job duties as a cashier. The Arbitrator finds Dr. Fink's opinions as to Petitioner's work capacity lack credibility. The Arbitrator notes that his off work records and restrictions change from visit to visit from full duty to permanently disabled without any objective basis. His opinion seems to be offered at the whim of Petitioner's subjective complaints and reported abilities rather than any medical basis whatsoever. The Arbitrator notes his testimony on cross examination contradicting his own records and his combative refusal to provide any medical support for his opinions.

The Arbitrator also notes Dr. Bauer's persuasive opinion that Petitioner was at maximum medical improvement. The Arbitrator finds that Dr. Fink concedes as much by his statement that her condition is permanent and his discharging her from care. Having reached maximum medical improvement, Petitioner would no longer be entitled to temporary total disability thereafter. The Arbitrator finds that Petitioner would not be eligible for maintenance benefits either.

By its plain terms, Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *W.B. Olson, Inc.*, 2012 IL App (1st) 113129WC at ¶ 39; see also *Nascote Industries v. Industrial Comm'n.*, 353 Ill. App. 3d 1067 at 1075. Thus, if the claimant is not engaging in some type of "rehabilitation" (whether it be physical rehabilitation, formal job training, or a self-directed job search), the employer's obligation to provide maintenance is not triggered. Petitioner's two aborted attempts to return to work at Circle K and Thornton's and the five or six other efforts over a period of at least two years would not be considered a sufficient self-directed job search to entitle her to maintenance benefits.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she is entitled to any temporary total compensation or maintenance benefits.

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

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter. Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator is considering only that component of Petitioner's condition of ill-being that is found to be causally related to the accident on March 7, 2017, being a strain to her lower back and an exacerbation of her degenerative lumbar condition which reached maximum medical improvement and returned to her pre-existing condition as of March 20, 2017.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator 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 cashier at the time of the accident and that, based upon the persuasive opinion of Dr. Bauer, she is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner did not return to Respondent and has not worked since the accident other than two brief attempts. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. This would make her an older worker. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that although Petitioner has not returned to work, Dr. Bauer's persuasive opinion was that she could do her regular work as a cashier. As more fully discussed in the Arbitrator's finding with respect to Temporary Compensation, the Arbitrator does not find Dr. Fink's restrictions credible or persuasive. Because of this, 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 that the records of Dr. Fink lack credibility. The Arbitrator does note that on January 15, 2018, his examination noted some pain while she was working and in cold weather. No pain at home. His objective finding was negative straight leg raising. Dr. Bauer's physical examination noted no limp. She had limited extension and tenderness to palpation She had good strength. Reflexes were symmetrical. Sensation was intact. Straight leg raising was negative but resulted in pain in the hip area. The Arbitrator also considers Petitioner's presentation in the surveillance video. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC026236
Case Name	GREER, MARK v. CHESTER MENTAL HEALTH CENTER
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0493
Number of Pages of Decision	14
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Jason Coffey
Respondent Attorney	Aaron Wright

DATE FILED: 9/24/2021

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Greer,

Petitioner,

vs. NO. 19WC 26236

State of Illinois Chester Mental Health Center,

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 prospective medical care, causal connection and 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 November 24, 2020 is hereby affirmed and adopted.

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

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

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

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

September 24, 2021

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

SJM/sj
o-08/25/2021
44

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0493
NOTICE OF 19(b) ARBITRATOR DECISION

GREER, MARK Case# **19WC026236**
Employee/Petitioner

ST OF IL/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

On 11/24/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERKHOVER COFFEY ET AL
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0558 ASSISTANT ATTORNEY GENERAL
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
SPRINGFIELD, IL 62794

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

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

NOV 24 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mark Greer
Employee/Petitioner

v.

State of Illinois/Chester Mental Health Center
Employer/Respondent

Case # **19** WC **26236**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 22, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 26, 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 $**58,033.42**; the average weekly wage was $**1,116.03**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**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 for medical bills paid pursuant to the group health insurance plan under Section 8(j) of the Act.

ORDER

Based upon the findings as to causal connection, the Arbitrator finds Petitioner is entitled to prospective medical care since he has not reached maximum medical improvement. Respondent shall authorize and pay for the treatment recommended by Dr. Matthew Gornet, including, but not limited to, a disc replacement at C3-4, fusion at L5-S1, and disc replacements at L3-4 and L4-5.

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

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

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

Signature of Arbitrator

11/17/20
Date

ICArbDec19(b)

NOV 24 2020

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARK GREER, Employee/Petitioner, v. STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER, Employer/Respondent.	)	Case No. 19-WC-26236

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on September 22, 2020, pursuant to Section 19(b) of the Act. The issues in dispute are causal connection and prospective medical treatment. All other issues have been stipulated.

TESTIMONY

Petitioner is 56 years old and has worked as a Security Therapy Aide at Chester Mental Health Center since April 2007. His job duties include supervising mental health recipients and ensuring the safety of patients and co-workers in the facility. Petitioner testified his job is dangerous as he restrains combative mentally insane patients on a daily basis. Petitioner testified that on 7/26/19 he was monitoring patients in the dining room when a patient began fighting with staff. The patient got out of his seat and punched Petitioner in the forehead. Petitioner grabbed the patient's arms in an effort to subdue him and they both fell to the floor with the patient landing on top of him. Petitioner fell directly on his back. Petitioner testified he was not eating at the time of the altercation as the employees do not eat at the facility.

Petitioner reported the incident immediately and completed an Employer's First Report of Injury noting mild concussion, muscle strain lower back, right knee abrasion, and neck soreness. The incident was witnessed by co-workers named Luckan Cleveland and Erin Stauffer, who completed witness reports.

Petitioner was taken to the emergency department at Chester Memorial Hospital on the date of injury. He followed up with his primary care physician who ordered an MRI and physical therapy which Petitioner underwent. Petitioner was referred to Dr. Matthew Gornet who recommended further MRI testing and injections. Petitioner underwent injection therapy that did

not permanently alleviate his neck and back pain. Dr. Gornet is recommending surgery and Petitioner desires to undergo same.

Petitioner testified he has no medical history of lumbar spine surgery or major injury to his low back preceding 7/26/19. However, Petitioner testified he underwent a cervical spine surgery in 2013 but did not have any stretches of lost time from work since being released in 2013. Petitioner testified he has worked full duty from 2013 through the date of his accident. Petitioner admitted he has seen a chiropractor on various occasions prior to 7/26/19 for minor adjustments. Petitioner testified he saw the chiropractor four times in 2019 prior to his work injury, including on 7/24/19. The chiropractor never took Petitioner off work. Petitioner was also taking narcotic pain medication prior to seeing Dr. Gornet. Dr. Gornet recommended he cease taking narcotics and Petitioner has complied with that request.

On cross-examination, Petitioner testified he began receiving chiropractic care with Dr. James Wittenauer in 2015. Petitioner admitted to providing a pain score of 9 in his left upper back on 5/6/15 but that his pain resolved in a couple of days and described it as muscle tightness. Petitioner testified he received chiropractic care in 2018 after he fell in the mud. He rated his low back pain 6 out of 10, mid-back pain 5 out of 10, and tension headaches and cervical pain 3 out of 10. Petitioner was involved in a motor vehicle accident on 3/20/19 where he totaled his truck and he returned to Dr. Wittenauer complaining of stiffness and soreness. Petitioner presented to Dr. Wittenauer on 6/20/19 complaining of neck pain for one month or longer. He informed Dr. Wittenauer an MRI was performed that showed degenerative changes at levels C4-5, C6-7. Petitioner stated physical therapy was recommended but he wanted to attempt chiropractic treatment first.

Petitioner underwent an MRI in April 2019 but did not have an independent recollection of the test. He testified he saw Dr. Wittenauer on 7/24/19, two days prior to his work accident, complaining of pain and charley horses in his low back and rated his low back pain 5 out of 10. He also reported neck pain and tension headaches at 8 out of 10, and mid-back pain 5 out of 10. He told Dr. Wittenauer his symptoms were aggravated by driving, sitting, standing, and sleeping for prolonged periods.

Petitioner testified that nobody told him he had a disc herniation at C3-4 prior to his accident on 7/26/19. He testified he had another MRI after his work accident that revealed a disc herniation at C3-4.

MEDICAL HISTORY

Petitioner completed an Illinois Form 45 on 7/26/19 that indicates Petitioner injured multiple body parts, including mild concussion, muscle strain lower back, right knee, and neck soreness. Petitioner's supervisor also completed a Supervisor's Report of Injury detailing Petitioner reported lower back and neck injuries. Petitioner's co-worker, Lucken Cleveland, completed an incident report stating Petitioner had red marks and a bruise above his right eye and pain in his neck. Another co-worker, Erin Stauffer, completed an incident report noting Petitioner had a red mark and bruising to his forehead and neck.

Petitioner was taken to the emergency department at Chester Memorial Hospital following the accident. Petitioner reported being struck in the right side of his face above his eye and fell backwards to the ground. Petitioner complained of pain in his back and head with an abrasion to his right knee. Petitioner underwent a CT scan of the head and lumbar x-rays. He was diagnosed with an acute lumbosacral myofascial strain and contusion to the forehead.

Petitioner was referred to Dr. Matthew Gornet on 9/30/19. Dr. Gornet took a consistent history of accident. Petitioner reported he grabbed the patient's arm to keep from being punched again and they twisted and fell striking a chair and subsequently fell to the ground. Petitioner admitted a history of neck and back pain, chiropractic treatment, and a cervical spine surgery prior to 7/26/19. Dr. Gornet performed a physical examination and reviewed x-rays and lumbar MRI films from 8/15/19. Dr. Gornet felt Petitioner's mechanism of injury could easily have aggravated a pre-existing condition or caused an injury. Dr. Gornet felt Petitioner was suffering from disc injuries at L3-4 and L4-5, and potentially L5-S1. Dr. Gornet also felt there was an injury at C3-4 and recommended a cervical MRI.

In October 2019, Petitioner underwent injections levels L3-4 and L5-S1. He followed up with Dr. Gornet on 12/15/19 and reported minimal relief from the injections. Dr. Gornet read the cervical MRI to reveal a large herniation at C3-4 above the level of Petitioner's previous fusion at C4-C7. Dr. Gornet recommended a cervical disc replacement at C3-4.

On 4/1/20, Petitioner was examined by Dr. Michael Chabot pursuant to Section 12 of the Act. Dr. Chabot is a board-certified orthopedic surgeon. At the time of the examination Petitioner complained of severe, sharp, aching, burning, electric shocking-type pain involving the low back. Dr. Chabot reviewed a lumbar MRI dated 8/15/19 interpreted by Dr. Ruyle as revealing disc dessication at L1-2 and L3-4, disc herniations at L3-4, L4-5, L5-S1 with spondylothesis at L5-S1, and left-sided pars defect and facet arthropathy. Dr. Chabot noted evidence of disc dessication at all levels with disc space narrowing at L4-5 by 50% and L3-4 by 40%, and disc dessication with Grade 1 spondylolisthesis at L5-S1. Dr. Chabot noted a central slightly to the left extruded disc herniation at L3-4 with mild facet arthropathy. At L5-S1, he noted an obvious left-sided pars defect and most likely the presence of a right-sided pars defect obscured partially because of facet arthropathy. Dr. Chabot did not appreciate evidence of a focal disc herniation. He noted a high intensity zone to the right at L5-S1. Dr. Chabot noted Petitioner was treating with Dr. Gornet who recommended a disc replacement at C3-4 and a fusion at L5-S1, with disc replacements at L3-4 and L4-5.

Dr. Chabot noted Petitioner's history of facial/cranial contusion/blow, history of neck and back strains, history of chronic neck and back pain predating the injury of 7/26/19. He stated Petitioner's level of subjective complaints and lack of objective physical findings strongly suggest symptom embellishment/magnification. He noted the medical records failed to document that Petitioner acutely complained of neck pain following his injury and that the mechanism of injury would suggest he sustained a strain or contusion injury to the C-spine as a result of the blow to his face/head. He noted advanced degeneration at C3-4 above Petitioner's prior fusion. He opined there was no way to determine if this chronically elevated degenerated level is responsible for his ongoing complaints as suggested by Dr. Gornet. The changes at this level are chronic and that any surgical intervention at this time would be to address the chronic changes at

C3-4 above his prior fusion from C4-C7 and not his work injury. Dr. Chabot further opined that the changes at L5-S1 are chronic and degenerative. The pars defects and spondylothesis and disc degeneration pre-existed his injury. Dr. Chabot opined that the disc degeneration and disc bulging/protrusions at L3-4 and L4-5 most likely represent chronic degenerative changes unrelated to the injury of 7/26/19.

Dr. Matthew Gornet testified via evidence deposition on June 2, 2020. Dr. Gornet is a board-certified orthopedic surgeon who specializes in spine surgeries. Dr. Gornet testified consistently with his medical records. He testified Petitioner suffered a disc injury in his lumbar spine and cervical spine due to the 7/26/19 work injury. Dr. Gornet recommends a single level disc replacement at C3-4, fusion at L5-S1, and disc replacements at L3-4 and L4-5.

Dr. Gornet opined Petitioner has a solid fusion and was doing reasonably well and able to work. An altercation such as the one Petitioner was involved in on 7/26/19 could easily cause an injury. Dr. Gornet testified the injury occurred at C3-4 as the previous fusion is solid which creates a stress riser or lever arm which blew out the disc during the altercation. The objective MRI films are extremely compelling and show an obvious disc herniation that is consistent with Petitioner's subjective complaints. Dr. Gornet identified the C3-4 level on the MRI film that shows significant intrusion upon Petitioner's spinal canal.

Dr. Gornet opined Petitioner has pre-existing disc degeneration at multiple levels, including isthmic spondylolisthesis. He opined the altercation of 7/26/19 injured the degenerative discs which is objectively seen on diagnostics. Dr. Gornet noted a herniation at L3-4 and tears of the discs at L4-5 and L5-S1. Dr. Gornet testified Petitioner could have aggravated some of the degeneration at L5-S1 causing that level to become symptomatic.

Dr. Gornet witnessed no evidence of symptom magnification by Petitioner and noted he ceased taking narcotic pain medication for his neck and back as recommended. Dr. Gornet opined if it were not for the altercation on 7/26/19 Petitioner would not likely require further treatment. Dr. Gornet believed Petitioner's current condition and need for cervical and lumbar surgery was causally connected to his work injury. Dr. Gornet testified he was aware Petitioner had medical treatment on his neck and back prior to his work injury and could not recall if he had seen any prior MRI films or chiropractic notes regarding Petitioner prior to 7/26/19.

Dr. Chabot testified via evidence deposition on 9/11/20. Dr. Chabot is a board-certified orthopedic surgeon fellowship trained in spine surgery. Dr. Chabot testified he took a history from Petitioner that he was eating dinner at a mental health facility in Chester on 7/26/19 when a patient hit him across the face causing him to fall backwards landing on the ground. Dr. Chabot reviewed medical records and performed a physical examination. Dr. Chabot reviewed the lumbar MRI performed on 8/15/19 and diagnosed Petitioner with a lumbar strain as related to the 7/26/19 accident. Dr. Chabot opined that the changes on the MRI were chronic and long-standing. Dr. Chabot felt surgery was unnecessary and Petitioner could return to work full duty. Dr. Chabot also diagnosed Petitioner with a neck strain.

On cross-examination, Dr. Chabot agreed he relies on the history of injury to be accurate in providing his opiniones. Dr. Chabot testified Petitioner did not have any signs of radicular

pain, but admitted he complained of electric-shock type pain into the low back and pain radiating into the bilateral arms and elbows. Dr. Chabot agreed that persistent headaches could be a symptom of a neck injury.

Medical records of Dr. James Wittenauer, D.C. were admitted into evidence. The records date back to 5/6/15 which Dr. Wittenaur recorded as Petitioner's initial office visit. Petitioner reported his symptoms were aggravated when he does nothing in particular because it is always there. On 7/7/16, Petitioner reported to Dr. Wittenauer he had a new problem located in his mid-back, low back, right sacroiliac articulation, and neck. Petitioner reported lifting a chair three weeks ago when he felt pain in his mid-back that gradually radiating to his lower and upper back.

On 9/29/17, Petitioner reported to Dr. Wittenauer he had been hurting, sore, and uncomfortable all week. On 10/16/17, Petitioner reported to be quite a bit better and then it all came back. Dr. Wittenauer noted Petitioner's symptoms continue to be aggravated when he drives, sits, sleeps, walks, and is at work. Petitioner reported that his problems are still relieved when he takes prescription medications, rests, and stretches. The office note dated 11/22/17 indicates Petitioner was slightly worse and he reported the same activities still aggravate his condition. On 1/15/18, Petitioner reported he was doing better until he fell on ice. On 1/19/18, Petitioner stated he lifted a patient today and felt like he pulled his back again. On 1/30/18, Petitioner reported his upper back was getting better, but his low back is the worst. He stated he saw his primary care doctor who prescribed him muscle relaxers. On 3/13/18, Petitioner reported he was doing good until he slipped in the mud yesterday causing him to fall and jar his low back. On 3/19/18, Petitioner reported he lifted a 40-pound bag of dog food with his left arm and pulled his shoulder and back out again.

On 7/11/18, Petitioner reported he lifted something yesterday and he was hurting worse and could not go to work today. On 8/10/18, Petitioner reported he had been painting and he had pain between his shoulder blades. On 8/16/18, Petitioner reported he was not sleeping well due to stress from a divorce and his body hurt all over. On 9/23/18, Petitioner reported he has been looking up more and his upper back, left shoulder blade, and neck has been hurting pretty bad the last few days. He stated he has some tingling in his left shoulder. On 11/30/18, Petitioner reported hurting the last two weeks from falling out of his bathtub and landing on his back. On 3/20/19, Petitioner reported he totaled his truck last week in a car accident and the airbags went off. He has been stiff and sore all week and he has not been working. On 6/20/18, Petitioner reported to Dr. Wittenauer he had been hurting the last month or longer in his neck and an MRI was performed that showed degeneration above his fusion. Petitioner returned to Dr. Wittenauer on 7/24/19, two days before the work incident, stating he was hurting more in his lower back and having a lot of charley horses there. On a pain scale of 0-10, Petitioner reported his neck and back pain and tension headaches were an 8, and his mid-back was a 5.

CONCLUSIONS OF LAW

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

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Comp. Comm'n*, 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 NE.2d 665, 672 (Ill. 2003). 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. *Id.*

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 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 parties stipulated Petitioner suffered a work injury on July 26, 2019 when he was punched in the face and fell to the ground on his back. Petitioner underwent a C4-C7 cervical fusion in 2013 and has worked full duty for Respondent in the same position since reaching MMI. No evidence was introduced showing Petitioner returned to his prior surgeon with complaints. Despite significant chiropractic treatment prior to his accident, Petitioner was able to work full duty in a physically demanding and dangerous job until 7/26/19. The Arbitrator finds Petitioner's testimony to be credible.

The chiropractic care Petitioner received since 2015 was sporadic and never resulted in Petitioner missing extended periods of work. Petitioner sought chiropractic care seven times in the twelve-month period prior to his accident on 7/26/19. He reported specific incidents of painting, stress, looking up for extended periods, a car accident, and falling out of the bathtub. These activities caused pain in his upper, mid, and lower back, with some tingling and pain in his left shoulder. On 6/20/19, Petitioner reported to Dr. Wittenauer he had been hurting the last month or longer in his neck and an MRI was performed in April 2019 that showed degeneration above his fusion. On 7/24/19, Petitioner reported he was hurting more in his lower back and having a lot of charley horses in that area. On a pain scale of 0-10, Petitioner reported his neck and back pain and tension headaches were an 8, and his mid-back was a 5.

Petitioner had no upper extremity neurological symptoms when he was examined by Dr. Wittenauer on 6/20/19. At that visit, he reported the cervical MRI revealed degenerative changes and there was no evidence in the record the MRI suggesting any disc herniations. Petitioner testified he was never told he had a cervical disc herniation prior to his accident. Following the

work injury, MRI films demonstrate a large cervical herniation at C3-4, as well as herniations and tearing at L3-4, L4-5, and L5-S1. Furthermore, the evidence presented does not show the Petitioner's injuries were the result of a normal degenerative process of the preexisting condition. Petitioner worked full duty throughout his chiropractic treatment and was taken off work after his 7/26/19 accident.

The Arbitrator finds the opinions of Dr. Matthew Gornet more persuasive than those of Dr. Michael Chabot. Dr. Gornet testified Petitioner had a solid fusion at C4-C7 and was doing reasonably well and able to work until his altercation on 7/26/19. Dr. Gornet opined that the altercation Petitioner was involved in of being punched in the head and falling flat on his back on the ground could easily cause spinal injuries. Dr. Gornet testified the injury occurred at C3-4 as the previous fusion is solid which creates a stress riser or lever arm which blew out the disc during the altercation. The objective films show a disc herniation that is consistent with Petitioner's subjective complaints. Dr. Gornet identified the C3-4 level on the MRI film that shows significant intrusion upon Petitioner's spinal canal. Dr. Gornet opined if it were not for the altercation on 7/26/19 Petitioner would not likely require further treatment. Dr. Gornet believed Petitioner's current condition and need for cervical and lumbar surgery was causally connected to his work injury.

Dr. Chabot admitted he never reviewed any cervical MRI films or reports that predated Petitioner's accident. Dr. Chabot's Section 12 report does not list the April 2019 cervical MRI as a record he reviewed. Dr. Chabot testified Petitioner did not have any signs of radicular pain, but admitted he complained of an electric-shock type pain into the low back and pain radiating into the bilateral arms and elbows. Dr. Chabot agreed that persistent headaches could be a symptom of a neck injury. Dr. Chabot's diagnosis of cervical and lumbar strains following Petitioner's accident is unsupported by the evidence.

Based on the credible testimony of Petitioner and the medical evidence, the Arbitrator finds Petitioner has met his burden of proof that his current condition of ill-being is causally related to the injury.

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).

Based upon the above findings as to causal connection, the Arbitrator finds that Petitioner is entitled to prospective medical care since he has not reached maximum medical improvement. Respondent shall authorize and pay for the treatment recommended by Dr. Matthew Gornet, including, but not limited to, a disc replacement at C3-4, fusion at L5-S1, and disc replacements at L3-4 and L4-5.

Arbitrator Linda J. Cantrell

11/17/20
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC023156
Case Name	ELLIS, KELLIE v. MENARD C.C.
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0494
Number of Pages of Decision	17
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Kenton Owens

DATE FILED: 9/24/2021

/s/Stephen Mathis, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kellie Ellis

Petitioner,

vs. NO. 17WC 23156

State of Illinois Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issues of accident, benefit rates, wage calculations, medical expenses, causal connection, prospective medical care, notice, 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 28, 2021 is hereby affirmed and adopted.

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

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

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

September 24, 2021

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

SJM/sj
o-8/25/2021
44

/s/*Deborah Simpson*
Deborah Simpson

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0494

ELLIS, KELLIE
Employee/Petitioner

Case# **17WC023156**

ST OF IL/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 1/28/2021, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JAN 28 2021

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

Kellie Ellis
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # **17** WC **23156**

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 **Herrin**, 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. ☒ 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 16, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**76,753.31**; the average weekly wage was $**1,476.03**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay the reasonable and necessary medical services directly to the medical providers, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 1, 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 and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall pay Petitioner the sum of $**775.18**/week for a further period of **59.025** weeks, as provided in Sections **8(e)9 and 8(e)11** of the Act, because the injuries sustained caused **12.5% loss to Petitioner's right hand (at 205 week hand value) and 20% loss to Petitioner's right foot**.

Respondent shall pay Petitioner compensation that has accrued from **12/5/2019** through **11/12/20** on Petitioner's right foot injury and **9/15/20** through **11/12/20** on Petitioner's right hand injury, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

1/19/21
Date

JAN 28 2021

STATE OF ILLINOIS)
) **SS**
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KELLIE ELLIS,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-23156
	)	
STATE OF ILLINOIS/	)	
MENARD CORRECTIONAL CENTER,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Herrin on November 12, 2020. The issues in dispute are accident, notice, and causal connection as to Petitioner's right wrist, and medical bills and the nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner was 51 years old, married, with two dependent children at the time of the accident. Petitioner was employed at Respondent's Menard Correctional Facility as a Correctional Lieutenant. She had worked at that facility for over twenty-five years and as a correctional lieutenant for four years before retiring on 12/1/18. Petitioner testified that on June 16, 2017 she was escorting a line of inmates back to their cell house when a fight broke out. The inmates began to punch and grab ahold of her and other officers. While attempting to apprehend one of the inmates he stomped on her right foot. Petitioner then attempted to restrain and handcuff an inmate on the ground when her right hand became caught in the handcuffs. Petitioner testified that during the altercation she thinks she threw a punch with her right hand.

Following the incident Petitioner noticed her right hand was swollen and sought treatment with the health care unit at the facility. She was examined and ordered to go to the hospital. Prior to going to the hospital, Petitioner reported the incident to Major Bradley and had her employer fill out an employee's notice of injury form on her behalf as she could not write with her injured, dominant hand. Upon arrival to the hospital, Petitioner noticed pain and throbbing in her right foot and ankle in addition to pain in her right hand and wrist. Petitioner filled out an incident report when she returned to work on 6/21/17.

Petitioner underwent x-rays and followed up with Dr. Nathan Mall on 8/22/17. She underwent physical therapy for her hand and foot injuries that helped a little. She underwent an

MRI on her hand and foot and was referred to Dr. Hagan to evaluate her foot injury. Dr. Hagan administered a diagnostic injection in her ankle/foot and ultimately performed surgery on 8/27/19. Petitioner testified that prior to surgery she had burning and tingling in her toes, instability with gait, and a popping sensation. Petitioner testified that surgery improved the numbness and tingling in her toes, but her foot/ankle is still unstable and her foot rolls and pops sometimes when she walks. She still has shooting pain in her foot/ankle. She is not able to run very well and cannot stand on her foot longer than 45 minutes at a time. She still experiences numbness and tingling in her big and second toes. Petitioner takes 800 mg of Ibuprofen per day that helps her symptoms a little.

Petitioner testified that following the accident she had numbness and tingling in her right hand, pain from her elbow to her hand, loss of grip strength, and cramping in her forearm and hand. Dr. Mall ordered a nerve conduction study. She later sought treatment with Dr. Steven Young because Respondent denied her treatment and Dr. Young was in her health insurance network. She was examined by Dr. Young on 4/30/20 who ordered another nerve conduction study and diagnosed right carpal tunnel syndrome. Petitioner testified she had not been diagnosed with carpal tunnel syndrome prior to her accident on 6/16/17. Dr. Young's records state Petitioner's left hand symptoms were worse. Petitioner testified she told Dr. Young she had pain in both of her hands but described the right hand pain and cramping was worse and kept her up a night. She provided a history of accident to her right hand to Dr. Young. Dr. Young's records also state Petitioner is a cigarette smoker. Petitioner testified she does not smoke cigarettes and may have smoked a cigarette socially in college over thirty years ago.

Petitioner testified she had aches and pains in her hands and feet prior to the accident as they work on concrete floors and turn keys all day. She testified that the achiness she experienced prior to her accident would resolve over night before her shift the next day. She testified that her symptoms following the accident were totally different than before in that the pain, numbness, and tingling in her right hand was constant and interrupted her sleep and did not resolve overnight.

Petitioner underwent right hand surgery by Dr. Young that relieved the numbness and tingling in her thumb and index finger. The cramping in her forearm has improved tremendously and she can almost touch her thumb and fingers together again and her grip strength is improving. Petitioner testified she has some difficulty opening jars but her hands no longer fall asleep. Petitioner testified she can do most activities involving her right wrist and foot but cannot perform them for long periods of time and she takes more breaks and rest more than she did before the accident. Petitioner testified that while she has completed treatment with Dr. Hagan for her foot, she still participates in water aerobics to alleviate her right foot symptoms.

MEDICAL HISTORY

Petitioner reported to Chester Memorial Hospital where the history of injury was taken. Petitioner reported her right foot was weak and throbbing with pain. She was examined and noted to have right hand, right wrist, and right foot pain. X-rays taken of Petitioner's right wrist and foot and were negative. She was discharged with a prescription for Tramadol and instructed to follow up with her primary care physician. Petitioner was taken off work until 6/21/17.

Petitioner was evaluated by board-certified orthopedic surgeon Dr. Nathan Mall on 8/22/17. He took a consistent history of Petitioner's accident, noting she was involved in an inmate altercation on 6/16/17 where she sustained injuries defending herself and physically restraining combative inmates. Petitioner presented with pain and burning on the top of her right foot instability in the foot and ankle region. Petitioner also complained of right hand pain and soreness with some catching of her fingers. Examination revealed pain over the second, third, and fourth metatarsals of her right foot with some subjective numbness. Dr. Mall noted swelling of her right foot and pain to palpation over the ATFL and calcaneofibular ligaments of the right ankle. X-rays of the hand, wrist, and foot appeared normal. Dr. Mall recommended an MRI of Petitioner's right foot. With respect to the right hand, Dr. Mall noted they would keep an eye on the triggering and recommended an anti-inflammatory medication. He recommended physical therapy for both her ankle and hand.

On 9/6/17, Petitioner underwent an MRI of her right foot and the radiologist noted mild nonspecific soft tissue swelling over the dorsum of the foot, mild degenerative changes, tarsometatarsal articulation in the third and fourth digits, and first metatarsophalangeal joint degenerative change. Petitioner returned to Dr. Mall later that day and noted she continued to have pain to palpation over the peroneal tendons, forefoot, and ankle ligaments laterally. Dr. Mall reviewed the MRI and noted it did not demonstrate evidence of fracture of the fourth or fifth metatarsal. Dr. Mall recommended physical therapy for range of motion, stretching, and strengthening of her right foot and to follow up in four to five weeks and released her to work full duty.

On 10/18/17, Petitioner returned to Dr. Mall at which time it was noted she continued to have right wrist pain with gripping and grasping activities as well as some triggering in her long and ring fingers on the right hand. Dr. Mall noted the pain had been present since the accident but was improving with anti-inflammatories. He noted her right foot was improving with physical therapy, but she had numbness and tingling in the top of her foot and symptoms that travelled from the lateral aspect of the foot down into the top of the foot. Examination of her right hand and wrist showed palpable triggering of the ring finger more than the long finger, pain to palpation over the A1 pulley in both digits, and pain to palpation over the scapholunate joint in the right wrist as well as over the triangular fibrocartilage complex (TFCC). Dr. Mall assessed a possible right wrist scapholunate injury and TFCC injury with palpable triggering of the ring and long fingers as well as possible right ankle peroneal nerve entrapment. Dr. Mall recommended Petitioner see Dr. Robert Hagan for the right foot to evaluate for nerve entrapment and an MRI arthrogram of her right wrist. He noted if Petitioner's wrist failed to improve, a cortisone injection would be the next step.

Petitioner underwent the MRI arthrogram of her right wrist on 10/26/17 that revealed proximal surface TFCC linear abnormal signal that could indicate a proximal surface tear. A volar ganglion cyst near the radial metaphyseal and styloid levels as well as a small interosseous cyst with internal contrast within the distal radial metaphysis were also noted. Dr. Mall noted Petitioner continued to have pain to palpation over the TFCC, the ring and long fingers, the A1 pulleys, and pain over the scapholunate and radioscaphoid joint. Dr. Mall noted continued pain along the peroneal tendon as well as lateral ankle ligaments and peroneal nerve distribution.

Upon reviewing the MRI, Dr. Mall noted fraying of the TFCC but no distinct tearing. He diagnosed Petitioner with right wrist pain and possible right ankle peroneal nerve entrapment. Dr. Mall again referred Petitioner to Dr. Hagan for further treatment of her right foot and continued physical therapy for her right wrist.

Petitioner returned to Dr. Mall approximately six weeks later at which time he noted her current symptoms included right wrist numbness and tingling, sometimes at work but mostly at night, and continued right foot pain. Examination showed a mildly positive flexion compression test and Tinel's of the right wrist. He noted this was not present on the left side. Dr. Mall diagnosed Petitioner with right peroneal nerve irritation of the ankle and possible right carpal tunnel syndrome. Dr. Mall recommended an EMG/nerve conduction study of the right wrist and evaluation of the right ankle with Dr. Hagan.

Petitioner underwent an EMG/nerve conduction study on 5/10/18 with Dr. Daniel Phillips. Dr. Phillips noted Petitioner was having throbbing aching pain, intermittent global numbness, and weakness in her right upper extremity. Her right extremity symptoms were to a greater degree than her left upper extremity symptoms. Upon exam, positive Tinel and Phalen signs at the carpal tunnels were noted, which were stronger on the right. The study showed the median sensory latencies across the carpal tunnels were significantly prolonged and worse on the right. Dr. Phillips concluded there were significant chronic bilateral sensorimotor median neuropathies across the carpal tunnels.

On 5/10/18, Dr. Mall noted continued numbness and tingling in her right hand with some symptoms in her left, however, her right hand was substantially worse. Examination showed a positive flexion compression test of the bilateral wrists, a positive Tinel's test on the right, and a mildly positive Tinel's test on the left. Dr. Mall noted the EMG/nerve conduction studies demonstrated carpal tunnel syndrome of the right and left upper extremities. He assessed her with bilateral carpal tunnel syndrome, and recommended Petitioner undergo a right carpal tunnel release.

Petitioner was evaluated by Dr. Anthony Sudekum on 8/30/18 pursuant to Section 12 of the Act. Dr. Sudekum took a history of Petitioner's injuries noting the 6/16/17 accident and her prior medical records. He noted after the incident, Petitioner immediately noticed swelling in her right hand and wrist and pain in her dorsal right hand, wrist, and into her lateral elbow, which was throbbing and tingling. Dr. Sudekum stated since the accident, she had continued constant numbness in her right index finger and thumb, with occasional numbness of her right ring finger and small fingers. Petitioner admitted she had some tingling and numbness in her left hand, but it was much milder than her right hand symptoms. Dr. Sudekum noted she had completed physical therapy without relief. Petitioner denied having any current pain in her hand or wrist, but had a tight feeling and stiffness in her right hand. Dr. Sudekum noted Petitioner had constant numbness/tingling in her right index finger and thumb with occasional numbness and tingling in her right ring and small fingers. He noted her right hand symptoms woke her up at night. She reported milder symptoms in her left hand. Her symptoms were worse at night and also when driving, writing for a significant amount of time, typing, or turning keys at work. Examination showed positive Tinel's tests bilaterally at the wrists: however, Tinel's was equivocal on the right and negative on the left. He also noted positive Tinel's test at the left elbow, and positive

Phalen's bilaterally at the elbows. Pain was noted in the right dorsal wrist and distal forearm with resisted wrist flexion, but not the left. Dr. Sudekum stated he did not believe the work-related accident caused or aggravated Petitioner's right carpal tunnel syndrome. He noted Petitioner could undergo continued conservative treatment for her right carpal tunnel syndrome, but if her symptoms failed to resolve, a right open carpal tunnel release should be considered.

On 10/15/18, Petitioner was evaluated by Dr. Robert Hagan for her right foot condition. Dr. Hagan noted Petitioner presented with chronic right foot and ankle pain following a work-related injury in June 2017. She complained of burning and pain in the anterior lateral portion of the ankle and radiating on to the top of the foot. Her current pain was a 5 out of 10, with it being a 7 out of 10 on average. He noted the pain only decreased to 4 out of 10 with rest and increased to 8 out of 10 with activity. The pain awakened her two to three times a night. He noted she had been referred to him for an evaluation of a peripheral nerve-injury. Examination of the right ankle revealed some chronic swelling due to BMI and size and a guarded range of motion due to her pain. She was tender over the sinus tarsi and anterior lateral ankle. A moderate decrease in light touch perception was noted within the deep dermatome and the superficial peroneal nerve distal to the lateral leg entrapment was mildly tender.

Dr. Hagan performed a diagnostic injection of the peroneal nerve above the level of the ankle. Before the injection, she had abnormal gait, pain at rest and standing, and was unable to simulate stair steps or walking. Petitioner's symptoms improved following the injection. Dr. Hagan diagnosed right anterior lateral ankle pain with sinus tarsi pain. He noted Petitioner responded well to the diagnostic injection of the deep peroneal nerve to simulate anterior lateral denervation. Dr. Hagan recommended ankle denervation surgery.

Dr. Sudekum testified by way of evidence deposition. He testified consistently with the conclusions stated in his report. He noted Petitioner's history and Dr. Mall's diagnosis of right peroneal nerve irritation of the ankle and bilateral carpal tunnel syndrome. Dr. Sudekum testified he examined Petitioner and reviewed the diagnostic studies and diagnosed Petitioner with right carpal tunnel syndrome and right thumb basilar joint arthritis. Dr. Sudekum acknowledged that carpal tunnel syndrome can be caused by trauma, such as a significant acute injury, a bad fracture, or compartment syndrome. He also acknowledged that pain and symptoms begin immediately for acute carpal tunnel injuries and admitted that Petitioner reported tenderness of her right wrist and dorsal hand at the hospital immediately following the work accident. He also noted that Petitioner continued to experience right hand pain when she saw Dr. Mall at her first visit in August 2017. However, Dr. Sudekum opined Petitioner's right carpal tunnel syndrome was not related to the June 2017 work accident.

Dr. Sudekum testified he had performed about 251 Independent Medical Evaluations for the State of Illinois. He also testified he had made $1,904,000.00 over the past eight and a half years performing records reviews, exams, surgical procedures, testing, and providing testimony for the State of Illinois. Dr. Sudekum was paid over $6,000 for his evaluation and record review of Petitioner and $2,000 for his deposition. Dr. Sudekum admitted he did not have any records predating the 6/16/17 accident that indicated Petitioner had any problems with her right upper extremity, no indication from Petitioner's oral history or any doctor's history that indicated Petitioner had any right upper extremity symptoms prior to the accident, and no evidence

Petitioner had ever received any kind of test or MRI of her right upper extremity prior to the accident. Dr. Sudekum did not examine Petitioner's foot and had no opinions concerning her right foot and ankle injury. Dr. Sudekum noted there was no evidence in any of the medical records that suggested Petitioner was exaggerating her symptoms. He stated that if conservative treatment failed Petitioner, he would recommend surgery, specifically a right open carpal tunnel release.

Dr. Nathan Mall testified by way of evidence deposition. He is board-certified in orthopedic surgery, seeing approximately 150 patients per week and performing 10 to 15 surgeries per week. He testified he completes one to two independent medical evaluations per week which are requested by defense attorneys or employers 90% of the time. Dr. Mall noted carpal tunnel syndrome is something he regularly treats in his practice. He stated that he evaluated Petitioner following a work accident involving an inmate altercation on June 16, 2017, during which she was defending herself and physically restraining inmates, causing pain and burning on the top of her foot as well as right hand pain with catching in her fingers. He believed the greater problem initially was her foot, but recommended she monitor her hands and take anti-inflammatories to manage her symptoms. Dr. Mall did not examine her for carpal tunnel syndrome initially, as he was focused primarily with her foot and ankle condition. Examination of her foot revealed pain over the metatarsal and pain over her ankle ligaments. He recommended an MRI of her foot and to continue using anti-inflammatories for her right hand to reduce the swelling.

Dr. Mall testified the MRI of Petitioner's foot showed no evidence of a fracture but showed some soft tissue swelling over the dorsum. Dr. Mall testified that on 10/18/17 Petitioner was continuing to have right wrist pain with gripping and grasping activities. She continued to have some locking of her long and ring fingers, but had been in slightly less pain since starting on the anti-inflammatories. He noted the foot was stronger but still had some numbness and tingling. He recommended an MRI of her wrist to further evaluate her symptoms and referred her to Dr. Hagan, a peripheral nerve specialist, for her foot.

Upon receiving the results of Petitioner's right wrist MRI, he observed fraying of her TFCC and recommended therapy. Petitioner returned on 12/12/17 with complaints of numbness and tingling in her hands, right greater than left, at nighttime and while at work. Dr. Mall examined Petitioner for carpal tunnel syndrome in the right hand that revealed a positive flexion-compression and Tinel's test of the right wrist, neither of which were positive in the left wrist. He stated that Petitioner reported early on that she had locking in her fingers, which were a symptom associated with carpal tunnel syndrome. Dr. Mall recommended an EMG/nerve conduction study which confirmed his diagnosis. He stated that her symptoms were still primarily in her right wrist. Dr. Mall recommended a right carpal tunnel release, as her right wrist was much more symptomatic than her left.

Dr. Mall testified that Petitioner had risk factors for carpal tunnel syndrome, but she started to have symptoms and inflammation only after the 6/16/17 accident which would have led to nerve compression issues. Dr. Mall testified that the inflammation from the injury either caused or contributed to her right carpal tunnel syndrome. He testified it was significant that her symptoms were mainly on the right side as that was the wrist she injured during the work

altercation. Dr. Mall stated that if Petitioner's carpal tunnel symptoms did not resolve she would benefit from surgery. He testified that he did not detect any mild right thumb basal or joint arthritis on her x-rays or during his clinical evaluation, but it can be one of many factors for carpal tunnel syndrome, as can inflammation and injury. Dr. Mall testified it was his opinion the inflammation and injury from the work accident is what caused her carpal tunnel symptoms. In responding to Dr. Sudekum's claim that her condition would have progressed the same regardless of the incident, Dr. Mall testified that would be speculation. He testified Petitioner is essentially asymptomatic on the left side which demonstrates the right side is in fact different than the left. Dr. Mall testified Dr. Phillips' report showed the latency was longer on the right side, showing her right wrist carpal tunnel was worse than the left. He testified Petitioner tried conservative treatment in the form of anti-inflammatories and physical therapy, but remained symptomatic.

Petitioner followed up with Dr. Mall on 4/9/19 for wrist pain. She was last seen by him on 5/10/18 where she was diagnosed with bilateral carpal tunnel syndrome with the right wrist symptomatic. He noted she was now beginning to experience left-sided symptoms but the right side was worsening. Examination showed positive flexion compression and Tinel's tests of both wrists. He recommended proceeding with a right wrist carpal tunnel release.

On 8/5/19, Petitioner returned to Dr. Hagan for a re-evaluation of her right foot. He noted that after the injection Petitioner still had the same pain in the right anterior lateral ankle with some heel and lateral calcaneal discomfort. Examination revealed exquisite focal tenderness over the anterior lateral ankle and sinus tarsi region. He noted decreased light touch within the DPN dermatome between her first and second toe as well. Dr. Hagan's continued to recommend surgery.

On 8/27/19, Dr. Hagan performed a resection and burial of the deep peroneal nerve at the level of the mid-distal leg. On 9/16/19, Dr. Hagan noted Petitioner was doing well and her pre-operative symptoms had resolved including the pain on the lateral side of her right foot. He noted improving sensation in her fourth and fifth digits and that her swelling was minimal. He recommended she continue to wear a compression sock and take NSAIDS/Tylenol. Petitioner could return to work with restrictions of seated work with intermittent standing only. Petitioner returned to Dr. Hagan on 10/17/19 and reported most of her pre-operative symptoms were gone. She had some pain where the ankle meets the top of the foot but she was well healed. Dr. Hagan recommended she continue to wear compression socks, take Tylenol for discomfort, and released her to work full duty. She returned to Dr. Hagan for a final time on 12/5/19 and some occasional sharp pains were reported when putting her full weight on the ankle, but overall was doing very well. Dr. Hagan released Petitioner was at maximum medical improvement.

On 4/30/20, Petitioner presented to Dr. Steven Young at the Orthopaedic Institute of Southern Illinois for evaluation of her carpal tunnel syndrome. Dr. Young noted her main complaint was bilateral hand numbness, tingling, weakness, and cramping. He noted the onset of pain occurred after a physical altercation with several inmates at work. He noted she had a nerve conduction study completed in 2018, but her symptoms progressed, particularly on the left. Physical examination showed positive Tinel's at the bilateral ulnar nerves, positive median nerve compression tests bilaterally, and positive Tinel's bilaterally. Dr. Young assessed bilateral carpal

tunnel syndrome and bilateral cubital tunnel syndrome. He recommended completing a new nerve conduction study.

The nerve conduction study was completed on 5/15/20 that revealed moderately severe bilateral carpal tunnel syndrome. Dr. Young performed a right carpal tunnel release on 8/4/20. On 8/18/20, Dr. Young noted Petitioner was still having some numbness and tingling to her thumb and index finger, but overall was doing well and her cramping was gone. Dr. Young kept Petitioner on a five-pound lifting restriction. Petitioner returned on 9/15/20 and reported no pain and very little numbness or tingling, which was improving each day. Dr. Young released her at that time.

CONCLUSIONS OF LAW

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

Petitioner testified without rebuttal that she suffered an accidental injury to both her right hand/wrist and her right foot on June 16, 2017, when an inmate fight broke out and Petitioner had her right foot stomped on and her right hand caught in an inmate's handcuffs while trying to subdue him. The incident as she described in her testimony is consistent with all accounts throughout her medical records, accident reports, and Respondent's Section 12 examination. Petitioner testified that she reported the accident to Major Bradley immediately following the incident. She also had a TRISTAR Workers' Compensation Employee's Notice of Injury form filled out on the day of the accident. The Supervisor's Report of Accident was completed on June 21, 2017 when she returned to work. The Arbitrator finds Petitioner's testimony to be credible in light of the medical records submitted into evidence, which all support the accidental injury on June 16, 2017.

Respondent disputes accident and notice with respect to Petitioner's right wrist but stipulated Petitioner sustained an accident and provided proper notice with respect to the right foot. The record is clear that Petitioner sustained accidental injuries to her right hand and right foot on 6/16/17. Petitioner reported the injuries to her wrist and foot in a timely matter, and even indicated that a representative of Respondent had to complete the accident report for her because she could not write with her injured hand. No alternative history or contrary evidence was presented to suggest Petitioner suffered an injury to her right wrist in any other manner or at any other time than as she described to her medical providers and at trial. Petitioner sought immediate medical treatment for her wrist following the accident at both the health care unit on site and later at the hospital at the direction of her employer.

Petitioner testified she notified Major Bradley of the accident before reporting to the emergency room. Major Bradley was not called by Respondent as a witness to rebut Petitioner's testimony regarding notice.

Based upon the foregoing, the Arbitrator finds Petitioner met 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 16, 2017, and that timely notice of the accident was given to the employer.

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

The parties stipulated that Petitioner sustained a compensable injury on June 16, 2017 with respect to her right foot. Respondent disputes that Petitioner's right wrist condition is causally related.

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). 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 workers' compensation claimant's injury. *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011). The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003). [Emphasis added]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000).

Petitioner testified credibly and without rebuttal that prior to June 16, 2017 she was working full duty and did not have any right hand or wrist pain. Since the work-related accident, Petitioner required work restrictions and treatment for her right wrist including medication, physical therapy, injections, and surgery.

The Arbitrator finds Petitioner's testimony to be credible in light of the medical records submitted into evidence, which support the accidental injury on 6/16/17 as a cause of Petitioner's current condition of ill-being. There is no history in the record that evidences any pre-existing right hand or wrist problems. The history of Petitioner's mechanism of injury and her onset of complaints are consistent throughout the medical records, depositions of both Dr. Sudekum and Dr. Mall, and supportive of Petitioner's testimony. There was no evidence presented at the hearing or in any of the depositions that suggest Petitioner had any complaints or problems in her right wrist prior to June 16, 2017.

The Arbitrator relies on the credible opinions of Dr. Mall in finding a causal connection between Petitioner's right hand and wrist conditions and the work accident. The Arbitrator finds the opinions of Dr. Mall to be persuasive given the physical examination findings, objective findings on Petitioner's diagnostic and electrodiagnostic studies, the consistent history in Petitioner's medical records, Petitioner's lack of any significant pre-existing symptoms or treatment to her right hand and wrist prior to June 16, 2017, and her persistent complaints of pain and catching in her right wrist, hand, and fingers since the accident.

The Arbitrator is not persuaded by Dr. Sudekum's opinion that Petitioner's right hand and wrist complaints are not related to the 6/16/17 work accident. Her symptoms were explained by Dr. Mall who testified that she had pain and inflammation in her right wrist since the accident, which can often cause nerve compression issues such as carpal tunnel syndrome. Dr. Sudekum's opinion is further unpersuasive as he testified that carpal tunnel syndrome can in fact be caused by a significant acute injury, such as the one Petitioner sustained on 6/16/17. Dr. Sudekum acknowledged there was no indication from Petitioner's oral history or any doctor's documented history that indicated Petitioner had any right upper extremity symptoms prior to the accident. Dr. Sudekum claims Petitioner could not have developed carpal tunnel syndrome by the acute event because she did not have immediate pain and symptoms, yet he admitted she did immediately report tenderness of her right wrist and dorsal hand at the hospital following the incident and additionally complained of right hand complaints to Dr. Mall at her first visit in August 2017.

Based on the foregoing, the Arbitrator finds that Petitioner met her burden of proof that her current condition of ill-being in her right wrist/hand is causally connected to the injury that occurred on 6/16/17.

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

Upon establishing causal connection and the reasonableness and 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 (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 (2001).

Given the above findings as to accident, notice, and causal connection, the Arbitrator finds that the medical treatment rendered to Petitioner has been reasonable and necessary in the quest to cure Petitioner of the effects of her work-related injuries. In addition to Dr. Mall's testimony establishing the reasonableness of Petitioner's care and treatment, the Arbitrator notes that Petitioner testified to significant improvement following surgery, although she continues to have some symptoms despite same. Dr. Sudekum further testified that if Petitioner failed conservative treatment he would recommend a right open carpal tunnel release. Respondent does not dispute that Petitioner's right foot injury was causally connected to the injury that occurred on 6/16/17.

The Arbitrator finds that Petitioner is entitled to medical expenses related to her right wrist/hand and right foot. Respondent shall pay reasonable and necessary medical services directly to the medical providers, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 1, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

(i) Level of Impairment: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) Occupation: Petitioner retired from her job as a Correctional Lieutenant at Menard Correctional Center on December 1, 2018. Therefore, the Arbitrator places no weight on this factor.

(iii) Age: Petitioner was 51 years old at the time of her injury. Although Petitioner is retired, she must live with her disability for an extended number of years. The Arbitrator places some weight on this factor.

(iv) Earning Capacity: Petitioner retirement from employment with Respondent on 12/1/18. The Arbitrator gives no weight to this factor.

(v) Disability: Petitioner sustained a traumatic onset of carpal tunnel syndrome that required surgical intervention at the ulnar and median nerve, as well as right anterior lateral ankle pain with sinus tarsi pain that required surgical intervention at the deep peroneal nerve of the right foot. Petitioner testified she continues to have cramping in her arms and trouble gripping. She testified she cannot perform activities longer than 45 minutes and she takes more breaks and rests more than she did before the accident.

Based upon the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in 12.5% loss of the right hand pursuant to Section 8(e)9 and 20% loss of the right foot pursuant to Section 8(e)11 of the Act.

Arbitrator Linda J. Cantrell

1/19/21
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC029706
Case Name	LOPEZ, VANESSA v. STATE OF IL DEPT OF HUMAN SVCS
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0495
Number of Pages of Decision	15
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Richard Victor
Respondent Attorney	Dan Kallio

DATE FILED: 9/24/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vanessa Lopez,
Petitioner,

vs. NO: 16 WC 29706

State of Illinois Dept. of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2020, is hereby affirmed and adopted.

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

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

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.

September 24, 2021

o9/15/21
DLS/rm
046

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0495
NOTICE OF ARBITRATOR DECISION

LOPEZ, VANESSA
Employee/Petitioner

Case# **16WC029706**

ST OF IL DEPT OF HUMAN SERVICES
Employer/Respondent

On 7/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

6368 ASSISTANT ATTORNEY GENERAL
NDUBUISI VINCENT OBAH
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CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
801 S 7TH ST
SPRINGFIELD, IL 62794

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

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

JUL 27 2020

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Vanessa Lopez
Employee/Petitioner

v.

State of Illinois-Dept. of Human Services
Employer/Respondent

Case # **16** WC **29706**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **January 14, 2020 and June 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. ☒ 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 16, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$43,420.00**; the average weekly wage was **$835.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** 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 AND IN THE COURSE OF HER EMPLOYMENT AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL-BEING WAS CAUSALLY CONNECTED TO HER EMPLOYMENT, THE 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

July 23, 2020
Date

JUL 27 2020

Statement of Facts

Petitioner Vanessa Lopez testified that she was employed by Respondent State of Illinois, Department of Human Services for 20 years. She was a Human Services Case Manager. In early 2014 she was promoted to Local Office Administrator. She was promoted by Bob Holas, the Regional Director of Region II. She testified she received a phone call from him. She interviewed and was told she had the job. Mr. Holas did not tell her about her job duties. He did not tell her anything else about the job. He said Gayle Stricklin, the local office administrator with Will County would train her. Petitioner was to work in Kane County.

Petitioner testified she started in early 2014. They serviced walk-up applicants seeking Medicaid, food stamps, and other assistance, checking status of their benefits, making changes, or having questions. She performed her duties through June 2014. She received orders from Gayle Stricklin, who came 1 to 2 times per week to tell her what to do. She would assess the level of wait time, number of applications. She told Petitioner the lobby waiting time was too long; that she needed to reach the average number of food stamp applications. Petitioner testified she did not have the personnel needed. She testified Gayle Stricklin did not provide instruction how to do the job. She just gave orders and set deadlines. She testified she was not trained and felt harassed when that did not happen. Her schedule was from 8:30 AM to 5:00 PM, but she would work 7:00 AM to 7:00 PM, and still could not complete the tasks. Bob Holas retired in February 2014 and Gayle Stricklin became Regional Director. She would get upset with Petitioner. Petitioner testified that she felt harassed and pressured by the expectations. Petitioner would get emails about the lobby being too slow, why she was not moving more people, and why she was not at her desk. Petitioner testified she began having symptoms of panic and anxiety. She would cry at her desk. She felt diminished and trapped.

Petitioner testified she had anxiety and depression before when her husband died, like for a normal person feeling a loss. She had been dealing with psychological issues over the course of her life. But after her promotion, it became worse, constant day to day. She testified she notified Gayle Stricklin on June 16, 2014. They were in the office. Petitioner testified she told Ms. Stricklin about the job and what it was doing to her. Ms Stricklin was not doing what was agreed. She told her she was not training her. The office was not functioning, and she was creating more complications. She could not implement other ideas and would be reprimanded if she did not do what she was told. She felt she was being treated unfairly. She was exhausted and depressed. She could not work because of the demands. Petitioner testified she had a panic attack on her last day of work. She testified Ms. Stricklin told her things will go back to what it was before. Petitioner told her she could not handle it and cried. She could not take it anymore.

Gayle Stricklin testified that she was employed by the State of Illinois for 37 years. She was a Local Office Administrator from 1996 to 2014. She was in Lake County from 1996 to 1999 and in Will County from 1999 to 2014. The job of a Local Office Administrator was to oversee the operations of the office to assure that customer questions were addressed, benefits were provided timely and procedures were followed. In that capacity, she did not train other Local Office Administrators. She became a Regional Administrator in March 2014. She oversaw 12 offices including DuPage and Kane County. Robert Holas was the prior Regional Administrator. He promoted Petitioner to Local Office Administrator in Kane County in March 2013. Ms. Stricklin was not part of that conversation. She had no information about that conversation. She was not advised to train Petitioner. At the time of Petitioner's promotion, Ms. Stricklin was Petitioner's equal. As Regional Administrator, she would provide guidance to new Local Office Administrators. She would visit the local offices 1 to 2 times per month depending on what was going on. She testified she did not visit Petitioner 1 to 2 times per week.

Ms. Stricklin testified she communicated with the Local Office Administrators mostly be email. These would be mostly group emails. These could address the number of people waiting in the lobby. That was to insure they were on top of it, not as criticism of Petitioner or reflection on job performance. She would not have occasion to call Petitioner. She does not recall how often she would have done so. She does not recall any specific conversations with Petitioner. The amount of guidance to local offices would depend on the skill of the administrator. She testified that there were hiring freezes and that the staffing of 40-45 employees in Kane County was below full staffing, as were all offices. The understaffing was not significant. The job duties could be handled by the staff.

Ms. Stricklin testified that discipline would start with a discussion and work improvement plan. Then there could be counseling, oral reprimand, written reprimand, suspension and termination, which would require approval by labor relations and administration. She testified that she likely gave Petitioner instructions and time deadlines for assignments and told her what should be done, just like she did to all. She never disciplined Petitioner. She never told her she could lose her job. Local Office Administrators were not fired for missing deadlines. There would be no discipline for that. Extensions would be given. Petitioner never told her that she could not get her work done. Petitioner was not required to take work home or work extra hours. Overtime would be paid with prior approval.

Ms. Stricklin testified that Petitioner never told her she was suffering psychological issues. She does not recall any conversation with Petitioner behind closed doors. She does not recall ever seeing Petitioner crying. Petitioner did not tell her she was being treated unfairly. Petitioner did not tell her she was having panic attacks, anxiety, or depression. Ms. Stricklin was not aware Petitioner felt harassed or unappreciated. Ms. Stricklin testified she was not aware Petitioner had anxiety, depression, or panic attacks until she was contacted to testify in this matter.

Petitioner testified she saw her family doctor, Dr. Mercado. Petitioner was seen on July 14, 2014 for panic attacks (PX 1). She reported her symptoms had been controlled with Wellbutrin for 2 months, but the last few weeks, symptoms are back. Dr. Mercado noted a history of cluster headaches, with relapse of symptoms last weekend with left side of face diaphoresis, sweating, and sharp pain. He diagnosed anxiety, increased her dosage of Wellbutrin and took Petitioner off work for a week. He also noted knee pain and a rash of uncertain etiology (PX 1).

Petitioner testified that the medication worked somewhat. She missed sporadic time from work in 2014 and 2015. She was doing the same job with the same symptoms. On March 10, 2015, Petitioner saw Dr. Mercado for a URI. She noted her anxiety has been under control, but the Wellbutrin affects her focus/concentration (PX 1). On June 4, 2015, Petitioner advised she had stopped Wellbutrin due to being unable to concentrate. She was having a flair up of anxiety and unable to work. Dr. Mercado altered her medication and took her off work to June 15, 2015 (PX 1). On September 26, 2015, Petitioner was seen for abdominal pain and care for her mood disorder with anxiety and panic attacks. She reported it was mostly under control but occasionally requires use of Benzodiazepine and that she is unable to work due to sedative effect. Catherine Gianan APN authored a note on October 3, 2015 stating Petitioner suffered from PTSD. She opined that the Petitioner's mental condition is a direct result of work-related issues (PX 2). On January 18, 2016, Petitioner requested FMLA paperwork for a lump on her abdomen. A CT scan was ordered (PX 1).

Petitioner testified she was still doing the same job with the same symptoms. She stopped working March 1, 2016. She felt she could not work. She had a panic attack and was crying. She testified Dr. Mercado took her off work. Petitioner was seen on April 4, 2016 with complaints of bilateral shoulder pain aggravated with range of motion (PX 1). Dr. Mercado recommended a home exercise program. He notes she needs a GI workup for constipation. He also noted difficulty controlling anxiety. Petitioner reported sedation and only takes it at night. He recommended a medication change with off work for 48 hours. On April 22, 2016, Petitioner reported sudden onset of anxiety and nervousness and feeling shortness of breath and palpitations, with no known triggers. Dr. Mercado diagnosed anxiety. He noted uncontrolled mood disorder and advised evaluation by Psychiatry (PX 1).

Petitioner began treatment at Institute for Personal Development on April 26, 2016 (PX 2). She gave a history that she started to struggle with anxiety and depression 3 years ago. She has worked for the Department of Human Services for over 20 years and 3 years ago got a promotion. She was promised training but never transitioned well, did not get any support or training. She felt she was just thrown under the bus. She was pressured by her supervisor, felt harassed. She stated she was advised by people around her and her PCP to quit her job. She reported anxiety and daily panic attacks and depression. She stated she avoids calls from the office, occasionally has flashbacks of past events related to work. She was diagnosed with panic attacks, major depressive disorder and generalized anxiety disorder. She was provided medications and started individual psychotherapy. The Psychosocial History notes her boyfriend and two daughters live with her. It notes harassed and assaulted by co-worker (PX 2). Petitioner was seen through June 7, 2016 (PX 2). She testified the treatment did not help.

Petitioner underwent Vitamin B12 injections for anemia (PX 1). She suffered an episode of syncope and was admitted to Provena Mercy Medical Center emergency department (PX 4b). Petitioner saw Dr. Mercado on June 23, 2016 asking to be referred to a different provider (PX 1). Petitioner was seen by Dr. Hangora at Hinsdale Psychiatry on June 28, 2016 (PX 3). Petitioner reported working in a toxic environment for the past 2 years. She has been mistreated/bullied at work and was recently physically pushed by one of her colleagues, which has been a traumatic experience for her. Due to the stressful environment at work she has developed symptoms of depression/anxiety/PTSD over the last 2 years. She took a leave from work on 4/27/16. Dr. Hangora assessed PTSD and depressive disorder (PX 3).

Petitioner was seen at the Behavior Health Services at Provena Mercy Medical Center from July 12, 2016 through August 12, 2016 (PX 4b). On July 20, 2016, Dr. Gallagher notes Petitioner is most interested in her diagnosis and resultant disability. She indicated she is not able to return to work and is hoping to obtain disability which is job related. His assessment is that Petitioner presents with evidence of anxiety and depression of mild to moderate degree, complicated by maladaptive and self-defeating attitudes and patterns of behavior. She is passively resistive to consideration of alternatives and options available to her, and she is focused almost exclusively on ways to obtain disability and have it determined to be job related (PX 4b). On July 21, 2016, Dr. Gallagher reviewed secondary gain with Petitioner, which he notes was poorly understood. On July 27, 2016, Dr. Gallagher notes Petitioner discussing her other health concerns. She continues to focus on disability and insists she is not able to return to work now or maybe never. On August 9, 2016, Dr. Gallagher notes Petitioner is preoccupied with issues of disability and obtaining disability status. She is reminded she has no clear symptoms of PTSD and to prove PTSD as a result of the job environment is difficult (PX 4b).

Dr. Mercado notes a left shoulder injury from falling down the stairs on July 7, 2016 and a rash on September 2, 2016 (PX 1). Petitioner had additional therapy at Institute for Personal Development from July 23, 2016 through September 13, 2016. Leslie Noa Mora authored a letter to Petitioner's attorney on September 23, 2016 stating Petitioner's diagnosis was major depressive disorder and panic disorder. Her symptoms began 3 years ago due to work related stressors (PX 2). Petitioner saw Dr. Mercado on December 2, 2016 for an incisional hernia. She was cleared for her 2/23/17 hernia surgery by Dr. Mercado on February 17, 2017 (PX 1).

Petitioner returned to Presence Mercy Medical Center on May 17, 2017 for assessment and readmission to the IOP program. She reported that over the last few weeks, she has been having daily panic attacks that are increasing in frequency and intensity and increased depression. She reported she is on disability and was recently approved for SSDI. She stated that her symptoms of PTSD began after being promoted and are primarily work related. Dr. Okon notes Petitioner is limping because she is bow legged and it hurts (PX 4b). On June 16, 2017, Petitioner reported "losing it" at Wal-Mart when she was disrespected by the management. Petitioner also reported being upset by a finding there was a patient she knew in the program. She continued in the program through her discharge on June 27, 2017 (PX 4b).

Petitioner returned to the Institute for Personal Development from July 18, 2017 through January 23, 2018. The records note that recent events have triggered past trauma experiences (PX 2). On August 22, 2017, she reported she has not attempted to drive due to accident from black outs. On September 5, 2017, she reported a major panic attacks after she received the call that her brother passed away (PX 2). On September 27, 2017, she reported that recent events, her niece just had a stillbirth, brought back painful memories of her own miscarriage. She reported the trauma she suffered from work including being forced to attend a meeting which she anticipated to be heated and stressful. She was 5 months pregnant and pleaded to her supervisor to let her out but was told she had to attend. After the meeting, she started bleeding and lost her baby. She was asked to work the next day and fell into depression. Five years ago, she never applied for promotion but got the position of Public Administrator. She recalled crying while the office celebrated for her. She decided to ask for a demotion and be a case worker. She passed her certification, went to the interview and got accepted only to be revoked by her supervisor who blocked the transfer. While a Public Administrator, her supervisor transferred her to another office, giving her a job out of her job description counting cables. Then she was forced to fire an elderly employee, who needed a job and insurance for her cancer treatment. She reported for 3 months she had nightmares, seeing the face of that employee in her dreams. The same year she suffered sexual harassment form a male employee. She stated she filed a report and he was found guilty. The next day, he showed up in her office ad her supervisor told her to grow up and stop whining. Then an anonymous employee accused her of fraud, which was found to be false (PX 2). Petitioner was diagnoses with panic disorder, PTSD, major depressive disorder and generalized anxiety disorder. She was placed on valium and Gabapentin and scheduled for therapy (PX 2).

On October 31, 2017, Petitioner met with Joy Miller LCPC. She reported hating her brothers, noting her older brother raped her. She stated her husband died 12 years ago and older daughter was not kind to him for which she cannot forgive her. She holds grudges and doesn't forgive people if they hurt her. She reported that she was traumatized at work by her boss who made a pass at her at a company party. The boss got mad and made her life her job hell. She stated there were numerous instances of abuse at work. Petitioner was to continue psychotherapy (PX 2). On November 14, 2017, Petitioner reported stress due to the status of her work comp case. On December 19, 2017, she reported work-related issues with HR are ongoing. On January 23, 2018, she noted ongoing stress about her medical insurance (PX 2).

Petitioner saw Dr. Charles Hillenbrand on April 8, 2018 on referral from Catherine Gianan APN for consultation and treatment (PX 5). Dr. Hillenbrand detailed multiple physical issues including orthopedic, pain management, grand obesity, anemia, insomnia and a recent hernia surgery. He noted psychological issues of PTSD from the death of her husband from cardiac issues including family conflicts. She reported a sexual assault by a male supervisor, a sexual assault by a female supervisor during a party, including description of her work issues involving her demotion, firing an elderly employee to which she attributes her miscarriage. She also noted her niece's miscarriage. Dr. Hillenbrand also identified panic attacks, dysthymia, anxiety disorder, and being a target of perceived adverse discrimination or persecution due to her Puerto Rican descent and prior obesity. Dr. Hillenbrand's assessment included generalized anxiety disorder with childhood onset which may be related to the deformity of her left leg, childhood onset PTSD, demoralization, depressive disorder due to a medical condition. He also noted restless leg syndrome, chronic pain syndrome, morbid obesity, anemia, GERD, and abdominal hernia. He also noted that she is a victim of prejudicial treatment based on her nationality and obesity (PX 5).

Petitioner testified that since she started this job in 2014, the only intervening traumatic event was the death of her brother. She testified she still has the same symptoms since she got the promotion in 2014. She testified she went through so much at that office, that she does not want to go out. She questions her capacities. She suffers panic attacks. She is depressed.

Dr. Hillenbrand transcribed his handwritten office notes (PX 6). He noted that she was indisposed in late April and missed work from 4/08 to 4/28. She was referred to a cardiologist and orthopedist in June 2018 and was given a cane. Petitioner discussed with Dr. Hillenbrand concerns about attending the Respondent's examination. After seeing Dr. Hartman, she told Dr. Hillenbrand about unusual circumstances during the examination including instructions by Dr. Hartman to "close her eyes," asking her daughter to answer for her, and telling her that her answers don't matter because he had already decided what he was going to do. On October 6, 2018, Dr. Hillenbrand discussed Dr. Hartman's examination with Petitioner's daughter (PX 6).

Petitioner saw Dr. Elliot Harman for an examination at Respondent's request on August 1, 2018 (RX 1). Dr. Hartman reviewed Petitioner's medical records, conducted an interview of Petitioner, and administered multiple psychological tests to evaluate Petitioner's mental condition. He noted Petitioner was scattered and it was difficult to determine time sequences and event development. He also noted unusual responses to certain questions. Dr. Hartman noted that Petitioner's test results showed evidence of symptom magnification, and purposeful malingering. He noted her results were below the level of brain damaged individuals and were below the expected results of random answers suggesting a deliberate attempt to answer incorrectly. He opined that Petitioner did not meet the required criteria for a diagnosis of PTSD. Her work situation would not qualify as sufficiently severe or extreme. He stated concern over the drugs Petitioner was taking and noted the possibility of an underlying neurological condition such as dementia. He opined that there is no valid relationship between her symptom portrayal and her work conditions (RX 1).

On October 7, 2018, Dr. Hillenbrand prepared a letter concerning the conduct of Dr. Hartman's examination. He notes that Petitioner was told to stop her medications before attending the examination and was then told to take her anxiety medication during the testing which slowed her cognitive ability. She was then harassed for being slow. He noted Dr. Hartman had no supervision during the tests. He noted one test was in Spanish. He reported Dr. Hartman did not provide instructions and the pages turned faster than she could read them. He also repeated that Dr. Hartman told her to close her eyes and asked her daughter to answer for her. He concludes that Dr. Hartman trusts his tests more that his clinical acumen. He states the testing described by

Petitioner was not "standard." He states the entire testing procedure was biased and the results have no scientific validity and should be discarded (PX 6).

Dr. Hillenbrand prepared a report to Petitioner's counsel on November 2, 2018. He stated Petitioner suffered PTSD earlier in life and also has had PTSD consequences of the events that occurred at work including the sexual assault by a coworker and a sexual assault by a supervisor (PX 6). On August 20, 2019, Dr. Hillenbrand received an email from Ms. Gianan with a file attached listing work incidents including the sexual harassment by the male and female supervisors, and subsequently being given unnecessary workloads and being required to attend stressful meeting, the unwanted promotion and the supervisor blocking of her request for a demotion and assignment to meaningless work, being forced to fire an elderly employee and many other instances of bullying and threats (PX 6).

On May 24, 2019, Dr. Hartman testified by evidence deposition (RX 2). He is a Board-Certified forensic neuropsychologist. Dr. Hartman opined that Petitioner's mental condition deteriorated on its own, and a work-related injury/illness did not cause it (RX 2). Her mental deterioration was organic and not caused by her work duties. Dr. Hartman testified that when Petitioner was asked general questions regarding drug use, she became upset. Dr. Hartman stated that Petitioner became anxious during questioning and repeatedly said, "I am not a drug user." Petitioner was "scattered" during his interview with her. Dr. Hartman testified that Petitioner's performance on the psychological tests he administered was not realistic for anyone who was not admitted to a nursing home. Dr. Hartman opined that Petitioner did not have Post Traumatic Stress Disorder because Petitioner did not have any severe, life-threatening event that is required for that diagnoses. From a clinical standpoint, Petitioner's work did not worsen her psychiatric or psychological condition (RX 2).

Dr. Hartman testified he did not harass Petitioner during the testing. He noted that she was taking an extreme amount of time on questions that should be answered within seconds and he did tell her to go from question to question, but he did not tell her just "hurry up." He did not tell her to just close her eyes. He did not suggest her daughter answer for her. He testified Petitioner asked her daughter to leave the room because the baby was being too noisy. He did not reach conclusions about the exam until after he reviewed the test results (RX 2).

Dr. Hartman testified that if Petitioner has a deteriorating mental condition, it could make doing the same job duties progressively harder and she could feel that the work was getting harder rather that her ability to do it was deteriorating. He would not be surprised if Petitioner had a distorted view of how things went for her or the overall structure of the evaluation. If you have a paranoid way of viewing things, casual remarks or innocuous statements can be viewed as personal or hostile (RX 2).

On November 14, 2019, Dr, Hillenbrand issued a letter with revisions to his note of April 8, 2018 incorporation a listing of work stresses provided by Petitioner. They include the male supervisor sexual harassment that happened years ago and the sexual advance by the female supervisor during the agency summit. Petitioner then stated that she believed that the situations thereafter were to ensure that no allegations against the female supervisor were made. She lists over a dozen events including her job status, lack of training, being forced to perform certain duties and monitoring and procedures. She also notes an incident of workplace violence when a supervisor yelled and pushed his chair backward into the wall (PX 6).

Dr. Hillenbrand testified by evidence deposition taken November 15, 2019 (PX 7). He is board certified psychiatrist. He testified to her childhood physical disabilities resulting in anxiety and PTSD. He testified that she told him about work experiences. They included unwanted attention from a man at work after her husband

died. She was given work duties she was unsuited for. She felt she was not adequately trained for one particular job. He did not testify that these events actually occurred, but Petitioner believed what she was describing was real. He testified that Petitioner had a history of PTSD and these events were superimposed on that history. She was predisposed to further PTSD events. He testified she felt harassed based on her physical shape, being short and overweight. She felt there was bias against her being from Puerto Rico. He noted her issues with iron malabsorption from her gastric bypass surgery, sleep disorder, and restless leg syndrome. He diagnosed generalized anxiety disorder, sleep difficulties and depression secondary to other factors. He prescribed clonazepam. Petitioner had counseling with Ms. Gianan (PX 7).

Dr. Hillenbrand testified to Petitioner's perceptions of her evaluation with Dr. Hartman. She immediately was elated, feeling she had done well. She was very upset when she received the results. He detailed his remarks in his letter. Dr. Hillenbrand opined that the condition for which he treated Petitioner was an aggravation of her preexisting psychological condition. It was worsened by her perception of events that transpired at work. He opined that Petitioner was not capable of gainful work. He testified that Petitioner was initially enthusiastic to return to work but has gotten worse and is now terrified of return to work. This is related to her perception of events at work. He suspects she will never return to work (PX 7).

Dr. Hillenbrand testified that a person with preexisting PTSD would be highly sensitive to things that would not bother a person without PTSD. She is more sensitive to perceived rejection. She would perceive things such as gossip were about her even if it did not exist. He testified the list of work items listed in his November 14th letter were from an email he received from Petitioner. He did not interview any coworkers about these claims. Dr. Hillenbrand testified to his report detailing his concerns about Dr. Hartman's evaluation. He spoke with Petitioner's daughter to verify what Petitioner told him about Dr. Hartman's conduct. He did not speak with Dr. Hartman. He found many aspects of his report difficult to believe (PX 7).

Conclusions of Law

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

Petitioner is seeking compensation as a result of her mental disability which she claims is a result of the multiple incidents at work as detailed in the medical records and her testimony. While Petitioner's testimony and the medical records include reference to certain incidents characterized as sexual assaults, there is no date or time reference on these incidents and Petitioner's symptoms and treatment, as well as the focus of her testimony and the Application in this matter are on the work environment including her claims of being untrained, overworked, harassed, devalued and unappreciated following her promotion. It is this work issue that she initially discusses with her treaters and upon which she focuses her claim. This non-traumatic stressor would be considered under the mental-mental theory of psychological claims. The Commission has been extraordinarily cautious in awarding benefits under the Illinois Workers' Compensation Act in the case of a "mental-mental" injury without any physical incident or injury. A claimant can only establish a right to benefits for a mental-mental injury under the Act Where the psychological injury was caused by a "sudden severe emotional shock traceable to a definite time, place and cause which caused psychological injury or harm . . . though no physical trauma or injury was sustained." *Pathfinder v Industrial Comm.*, 62 Ill.2d 556, 563 (1976). Subsequent decisions have been equally diligent in narrowly defining when an employee might recover benefits for a mental-mental injury. In order to prevail on a mental-mental claim, the claimant must present

objective evidence supporting inferences of psychological injury, causation, and disability. *Board of Education of the City of Chicago v. Industrial Comm'n,* 83 Ill. 2d 475, 487-88, 416 N.E.2d 237, 48 Ill. Dec. 206 (1981).

Psychological injuries are compensable when the injuries are related to and caused by a physical trauma or injury ("physical-mental") or when the injuries are caused by sudden severe emotional shock traceable to a definite time and place and cause even though no physical trauma or injury was sustained ("mental-mental"). City *of Springfield v. Industrial Comm'n*, 291 Ill. App. 3d 734, 738, 685 N.E.2d 12, 14, 226 Ill. Dec. 198 (4th Dist. 1997). Recovery for non-traumatically induced mental disease is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of the mental disorder. *Runion v. Industrial Comm'n*, 245 Ill. App. 3d 470, 473, 615 N.E.2d 8,10,185 Ill. Dec. 713 (5th Dist. 1993). Consequently, claims for mental disabilities resulting from arguments with co-workers and/or supervisors have been denied (see *City of Springfield v. Industrial Comm'n*, 214 Ill. App. 3d 301, 573 N.E.2d 836, 158 Ill. Dec. 23 (4th Dist. 1991); *General Motors Parts Division v. Industrial Comm'n*, 168 Ill. App. 3d 678, 522 N.E.2d 1260, 119 Ill. Dec. 401 (1st Dist. 1988)), as have been claims following disciplinary actions taken by employers (see *Esco Corp. v. Industrial Comm'n*, 169 Ill. App. 3d 376, 523 N.E.2d 589, 119 Ill. Dec. 833 (4th Dist. 1988)). Mental disability claims of schoolteachers who feared for their safety as well as teachers who actually were assaulted by students have also been denied. See *Board of Education v. Industrial Comm'n*, 182 Ill. App. 3d 983, 538 N.E.2d 830, 131 Ill. Dec. 455 (1st Dist. 1989); *Chicago Board of Education v. Industrial Comm'n*, 169 Ill. App. 3d 459, 523 N.E.2d 912, 120 Ill. Dec. 1 (1st Dist. 1988). In each instance, the court held that mental disorders such as anxiety, emotional stress or depression which develop over time in the normal course of the employment relationship do not constitute compensable injuries. In each instance the claimant was exposed to nothing more than the usual employment tensions. Based upon this standard, Petitioner has failed to establish a compensable work-related claim.

The Arbitrator heard the testimony and observed the witnesses in this matter. The Petitioner's testimony was unfocused and rambling. This is consistent with Dr. Hartman's assessment that she was "scattered." The timeline in her testimony was confused and contradicted by both Ms. Stricklin and her medical records. She argues that the promotion, which she testified she did not want, was in 2014. But Ms. Stricklin credibly testified it occurred in 2013, before she became the Regional Administrator. This is supported by Petitioner who agrees she was promoted by Mr. Holas. Petitioner's focus in her testimony and the progression of her condition is the unwanted promotion and her perceived lack of adequate training thereafter. Her medical records expand the number of work-related and non-work-related events as her treatment progresses from these initial complaints of unfair treatment and lack of training following her promotion. Her testimony also includes multiple work-related specific events including reassignments, pressure and criticism, but Dr. Hillenbrand also notes childhood abuse, feelings of discrimination for being from Puerto Rico, and being of short stature. Reviewing the totality of the evidence, the Arbitrator does not find any credible evidence of a sudden severe emotional shock traceable to a definite time and place, or a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience from an objective standpoint.

Petitioner's description of her "abuse" lacks credibility and is not persuasive from an objective basis due to her preexisting PTSD, as described by her own treating physicians. On July 20, 2016, Dr. Gallagher notes Petitioner is most interested in her diagnosis and resultant disability. She indicated she is not able to return to work and is hoping to obtain disability which is job related. This is in sharp contrast to Dr. Hillenbrand's statement that she was initially enthusiastic to return to work. Dr. Gallagher's assessment is that Petitioner presents with evidence of anxiety and depression of mild to moderate degree, complicated by maladaptive and self-defeating attitudes and patterns of behavior. She is passively resistive to consideration of alternatives and options available to her, and she is focused almost exclusively on ways to obtain disability and have it determined to be job related. On July 21, 2016, Dr. Gallagher reviewed secondary gain with Petitioner, which he notes was poorly understood. On July 27, 2016, Dr. Gallagher notes Petitioner continues to focus on

disability and insists she is not able to return to work now or maybe never. On August 9, 2016, Dr. Gallagher notes Petitioner is preoccupied with issues of disability and obtaining disability status. She is reminded she has no clear symptoms of PTSD and to prove PTSD as a result of the job environment is difficult. Dr. Hartman's assessment agrees with this.

Dr. Hillenbrand testified to Petitioner's childhood physical disabilities resulting in anxiety and PTSD. He testified that she told him about work experiences including unwanted attention from a man at work after her husband died, being given work duties she was unsuited for, and feeling she was not adequately trained for one particular job. He did not testify that these events actually occurred, but Petitioner believed what she was describing was real. Dr. Hillenbrand testified that a person with preexisting PTSD would be highly sensitive to things that would not bother a person without PTSD. She is more sensitive to perceived rejection. She would perceive things such as gossip were about her even if it did not exist. Dr. Hartman, in contradicting Petitioner's version of her experience during his evaluation, testified he would not be surprised if Petitioner had a distorted view of how things went for her or the overall structure of the evaluation. If you have a paranoid way of viewing things, casual remarks or innocuous statements can be viewed as personal or hostile. Dr. Hartman's testimony is more credible that Petitioner's. His statements about her approach to the tests is consistent with Dr. Hillenbrand's discussion of Petitioner trying to do well rather than simply respond to the questions. Her inability to complete the tests Dr. Hartman described as simple would be relevant to her admitted inability to do her work in a timely fashion. The Arbitrator also finds Ms. Stricklin's testimony more credible that Petitioner as to the work environment. Thus, Petitioner's subjective perception of the events would not constitute objective evidence. Nothing beyond Petitioner's testimony was offered to support the claim.

Even accepting that Petitioner was correct that she was poorly trained, understaffed, and placed under pressure to perform in those conditions, the events still fail to rise to the level required for compensability. These conditions have been held to be the day-to-day emotional strain and tension which all employees must experience. Claims for mental disabilities resulting from arguments with co-workers or supervisors have been denied. *City of Springfield v Industrial Comm.*, 214 Ill. App. 3d 301 (4th Dist. 1991). Claims were unsuccessful if based on a fear for the workers' safety. *Board of Education v Industrial Comm.*, 182 Ill. App. 3d 983 (1st Dist. 1998). Claims have failed where based on disciplinary action taken by the employer. *Esco Corp. v Industrial Comm.*, 169 Ill.App.3d 376, 523 N.E.2d 589 (4th Dist. 1988). In *Smith v. Ludeman Mental Health Center,* 04 WC 59682, 2010 Ill. Wrk. Comp. Lexus 732 (July 14, 2010), the Commission affirmed the decision of the Arbitrator finding no accident where the Petitioner claimed she had anxiety and was stresses out due to her workload duties alleging physical symptoms as a result. In that case the Commission noted, "As for the Petitioner's "mental-mental" case, the Commission has been extraordinarily cautious in awarding benefits under the Illinois Workers' Compensation Act in the case of a "mental-mental" injury without any physical incident or injury." In most instances where the trauma related to anxiety connected to the normal employment duties and relationships, benefits have been denied no matter how stressful the particular circumstances may have been.

The Arbitrator also finds that, based upon the lack of credible testimony of a sufficiently traumatic event, that Petitioner's condition is not causally connected to her employment with Respondent.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment, and further failed to prove by a preponderance of the evidence that any condition of ill-being was causally connected to her employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary Compensation, and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the issues of Notice, Medical, Temporary Compensation, and Nature & Extent are moot. Petitioner's claim for compensation is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC016404
Case Name	STARCEVIC, GARY v. ILLINOIS DEPARTMENT OF NATURAL
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0496
Number of Pages of Decision	16
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Tyler Berberich
Respondent Attorney	Joseph Blewitt

DATE FILED: 9/24/2021

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Starcevic,

Petitioner,

vs. NO: 11 WC 016404

Illinois Department of Natural Resources,

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 maintenance period awarded 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 18, 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.

September 24, 2021

/s/ *Maria E. Portela*

o092121
MEP/ypv
049

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

21IWCC0496

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STARCEVIC, GARY
Employee/Petitioner

Case# **11WC016404**

ILLINOIS DEPARTMENT OF NATURAL RESOURCES
Employer/Respondent

On 11/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

6143 ASSISTANT ATTORNEY GENERAL
KRISTIN LEASIA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

NOV 18 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gary Starcevic,
Employee/Petitioner

v.

Illinois Department of Natural Resources,
Employer/Respondent

Case # **11** WC **16404**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **October 1, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 10, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,101.76**; the average weekly wage was $**1,078.88**.

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

Respondent shall be given a credit of $**151,773.78** for TTD, $**0** for TPD, $**28,847.40** for maintenance, and $**0** for other benefits, for a total credit of $**180,621.18**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $719.25/week for 332-5/7 weeks, commencing April 16, 2011 through August 30, 2017, as provided in Section 8(b) of the Act. Respondent shall receive credit for all amounts paid.

Respondent shall pay Petitioner maintenance benefits of $719.25/week for 95 weeks, commencing August 31, 2017 through June 26, 2019, as provided in Section 8(a) of the Act. Respondent shall receive credit for all amounts paid.

Respondent shall pay Petitioner permanent and total disability benefits of $719.25/week for life, commencing June 27, 2019, as provided in Section 8(f) of the Act.

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

Respondent shall pay reasonable and necessary medical and vocational services of $1,936.25, as provided in Section 8(a) and 8.2 of the Act.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

November 18, 2019
Date

NOV 18 2019

MEMORANDUM OF DECISION OF ARBITRATOR
STATEMENT OF FACTS

Arbitration History

On May 1, 2014, this matter was heard by Arbitrator Jessica Hegarty pursuant to a 19(b) Petition filed by Petitioner. Following that hearing, Arbitrator Hegarty filed a decision with the Workers' Compensation Commission ("the Commission") on July 10, 2014. Arbitrator Hegarty found that the current condition of Petitioner's lower back was causally related to his January 10, 2011 work accident and ordered Respondent to pay temporary total disability benefits ("TTD") from January 10, 2011 through May 1, 2014, pay medical bills related to the treatment of Petitioner's lower back injury and approve and pay for surgery that had been recommended by Petitioner's treating physician, Dr. Marc Levin. (PX 2).

Respondent filed for review of Arbitrator Hegarty's decision. On September 1, 2015, the Commission reversed the Decision of Arbitrator Hegarty and remanded the case back to an arbitrator in Chicago to reopen proofs and rehear the claim. The Commission found that Arbitrator Hegarty had erred in not allowing Respondent a continuance to receive pre-accident medical records that they had subpoenaed and to get wage records for Petitioner. (PX 2).

On June 15, 2016, this claim was brought to Arbitration again on another 19(b) Petition before Arbitrator Deborah Simpson. On August 30, 2016, Arbitrator Simpson filed a decision with the Commission. Arbitrator Simpson found that Petitioner's condition of ill-being, which included a L4 disc herniation, permanent aggravation of degenerative disc disease, spondylolisthesis and stenosis in his lumbar spine, was causally related to his January 10, 2011 work accident. Therefore, Arbitrator Simpson ordered Respondent to pay TTD in the amount of $719.25 per week for 269.71 weeks, commencing April 16, 2011 through June 15, 2016. It was further ordered that Respondent was to pay outstanding medical related to the treatment of Petitioner's lumbar spine and to "approve and pay for future medical treatment recommended by Dr. Levin, including a L4 laminectomy and fusion at L4-5 and requisite x-rays, MRI's or other necessary diagnostic testing." (PX 2). Respondent did not file for review of Arbitrator Simpson's decision.

As of the June 15, 2016 hearing, Petitioner's treating physician, Dr. Levin, had diagnosed Petitioner with an L4 disc herniation, permanent aggravation of degenerative disc disease, spondylolisthesis and stenosis in his

lumbar spine and had recommended that he undergo surgical repair. While awaiting surgery, Petitioner was following up with Dr. Levin every 3 months to renew his medications. (PX 2).

Medical

The records reflect that after the June 15, 2016 hearing, Petitioner continued to follow up with Dr. Levin every 3 months as ordered. On each occasion, Dr. Levin would renew his Norco prescription for pain management. Petitioner was also kept off work by Dr. Levin during this time. (PX 3).

On December 19, 2016, Dr. Levin noted Petitioner continued to have back pain with radiation into the left leg from his previously diagnosed L4 disc herniation. Dr. Levin recommended Petitioner undergo an updated MRI, as it has been a long time since his last radiological examinations. (PX 3).

Petitioner did undergo the recommended MRI, which was reviewed by Dr. Levin on March 21, 2017. Dr. Levin's MRI interpretation was as follows, "marked degenerative disk disease at L3, L4, and L5. The L4 disk herniation is now desiccated. He does have a small disk herniation at L5-S1." Dr. Levin discussed with the Petitioner that if surgery did move forward, it would have to include a three-level fusion from L3-S1, rather than the single level surgery previously recommended. Dr. Levin asked Petitioner to follow up in 3 months and specifically opined that "he cannot return to the work that he used to do." (PX 3).

On August 30, 2017, Dr. Levin drafted a narrative report concerning his opinion of Petitioner's condition. Dr. Levin diagnosed Petitioner with "chronic low back and bilateral leg pain. Initial L4 disc herniation which has become desiccated, and degenerative disc disease at L3, L4 and L5 which was pre-existing but markedly aggravated by the injury." Dr. Levin opined these conditions were causally related to Petitioner's January 10, 2011 work accident. Regarding the previously proposed surgery, Dr. Levin stated that although he had initially recommended an instrumented fusion, he could not fully recommend that treatment any longer due to the time that had passed since his injury. Dr. Levin did not feel that Petitioner would receive maximum benefit from that procedure. If Petitioner chose not to undergo that surgery, Dr. Levin opined Petitioner had reached MMI and needed permanent restrictions including "no repetitive bending and no lifting over 20 pounds. No prolonged sitting or standing. He would need to change positions every so often." Dr. Levin also recommended the continued use of Hydrocodone for pain. (PX 5).

On March 20, 2018 and March 29, 2018, Petitioner was seen at Innovative Express Care by Dr. John Zautcke. After examination and taking of Petitioner's medical history, Petitioner was certified as having a condition (spinal cord disease) that is recognized by the state as qualifying for medical marijuana use. (PX 4).

The records reflect Petitioner continued to follow up with Dr. Levin every 3 months with ongoing lower back pain. On June 30, 2018, Dr. Levin noted Petitioner continued to have lower back pain and had a known lumbar disc herniation from his work-related injury. At that time, Petitioner had started smoking medical marijuana to reduce the amount of Hydrocodone he needed. Over the course of the next few visits with Dr. Levin, Petitioner's Hydrocodone prescription was lowered, although it was still being prescribed as of the date of Arbitration. (PX 3).

Most recently, Petitioner was seen by Dr. Levin for his 3-month visit on September 26, 2019. Dr. Levin noted Petitioner continued to have lower back pain, radiculopathy and some neck pain. Dr. Levin renewed Petitioner's Norco prescription and again recommended a follow up appointment in 3 months. (PX 3).

Respondent has offered no medical evidence or opinions to dispute the causation opinions, treatment recommendations, or permanent restrictions Dr. Levin imposed on Petitioner.

At Arbitration, Petitioner testified concerning the current condition of his lumbar spine. Petitioner testified his lower back condition is still getting worse over time. Petitioner sits in a recliner for most of the day, sitting on top of one pillow with another behind his back. He does not sit straight up in his chair or the muscles in his back will become "rock solid" and painful. Bending, stooping, standing, or walking for long periods also cause pain in his lower back.

Vocational Rehabilitation

The records detail and Petitioner credibly testified regarding his previous work history and skills. Petitioner has a ninth-grade education and did not complete his GED. Petitioner testified he does not have any computer skills. He does have a computer at home, but as of the date of arbitration, he had not opened his computer in approximately a year and a half. He described himself as being "like a 6 year old" on the computer. Petitioner further explained that his work history included working as a security guard from 1984 to 1987, then working

for Respondent in various maintenance positions from 1987 through his injury in January of 2011. Petitioner's testimony is fully supported by the reports of Independent Rehabilitation Services ("Independent Rehab"). (PX 6 – 11).

After being given permanent restrictions by Dr. Levin, Petitioner testified he looked for work by speaking with his connections throughout his community. As the head of a youth baseball league, Petitioner testified he knew many people throughout his community and he spoke with many of them about the possibility of having work within his permanent restrictions. Petitioner spoke with family, friends, and anyone else he could reach out to about whether they had any jobs available or possible job leads. Despite his efforts, Petitioner did not receive any interviews and was not offered any jobs.

Petitioner began formal vocational rehabilitation on January 18, 2018 when he first met with Kathy Mueller of Independent Rehab. (PX 6).

While the initial vocational rehabilitation plan from Independent Rehab involved Petitioner creating an updated resume, improving his key boarding skills and applying for jobs, the online job search function was taken over by Mr. Patsavas, who applied for jobs on Petitioner's behalf. Both the vocational reports and Petitioner's testimony indicate this was due to Petitioner's lack of computer skills. Despite this direct assistance from Mr. Patsavas in completing job applications, Petitioner received no interviews or job offers throughout the time he worked with Independent Rehab.

Due to the lack of success with vocational rehabilitation, Mr. Patsavas performed a labor marker survey to further target possible job opportunities for the Petitioner. However, after a thorough examination of job openings in Petitioner's geographic area from June 1, 2019 through June 26, 2019, Mr. Patsavas concluded, "It is this consultant's professional opinion as a Certified Rehabilitation Consultant and with a reasonable degree of Vocational Certainty and with over 33 years in the field, that based on the Labor Market Research completed, a Viable and Stable Labor Market does not exist for Mr. Starcevic. This opinion is based on all of the barriers that have been documented above as well as the fact that Mr. Starcevic has not been employed for over 8 ½ years, he has not had any formal education for the past 50 years above the ninth grade level, and his overall lack of transferrable skills which have been documented in this report." (PX 12). As of the date of Arbitration, Petitioner testified that he is still unemployed.

CONCLUSIONS OF LAW

I. On the issue of unpaid medical bills and vocational services charges, the Arbitrator hereby finds and concludes:

Petitioner has proven by a preponderance of the credible evidence entitlement to payment of disputed medical and vocational charges in the amounts of $1,586.25 for vocational rehabilitation services and reimbursement to Petitioner of $350.00 for medical expenses paid by Petitioner pursuant to Section 8(a) of the Act and 8.2 of the Act.

It is the undisputed opinion of Petitioner's treating physician, Dr. Levin, that the current conditions of Petitioner's lumbar spine, including chronic low back and bilateral leg pain, initial L4 disc herniation which has become desiccated, and degenerative disc disease at L3, L4 and L5 are causally related to his January 10, 2011 work accident. (PX 3).

Respondent has offered no medical opinions or evidence to dispute the treatment recommendations made by any of Petitioner's treating physicians. The Arbitrator further notes Respondent has not offered any argument to dispute these claimed charges, even though this was a disputed issue at trial.

Therefore, the arbitrator hereby finds all treatment related to Petitioner's lumbar spine, as detailed in Petitioner's Exhibit 3 and 4 has been reasonable, necessary and causally related to Petitioner's January 10, 2011 work accident.

Further, there is no dispute Petitioner's permanent physical restrictions prevented him from returning to his previous line of employment and entitle him to vocational rehabilitation pursuant to Section 8(a) of the Act. It appears that all but one bill from Independent Rehab Services was paid by Respondent and the Arbitrator finds that there is no basis to dispute the remaining bill from that vocational rehabilitation provider. The single charge from Independent Rehab appears to be for the labor market survey performed in June of 2019. A labor market survey is a common piece of vocational rehabilitation services and is certainly covered by Section 8(a) as an expense incidental to the vocational retraining of Petitioner.

Based upon the above findings, the Arbitrator hereby orders Respondent to pay $1,586.25 in for vocational rehabilitation services and reimburse Petitioner $350.00 for medical expenses paid by Petitioner pursuant to Section 8(a) of the Act.

II. On the issues of TTD and maintenance benefits, the arbitrator hereby finds and concludes:

Petitioner has proven by a preponderance of the credible evidence entitlement to payment of disputed TTD and maintenance benefits, totaling $719.25 per week for 95 weeks, commencing August 31, 2017 through June 26, 2019.

Since June 15, 2016, the previous date of arbitration, the records reflect that Petitioner was kept completely off work by Dr. Levin through August 30, 2017 when Dr. Levin opined that Petitioner would be at MMI without surgery and assigned permanent physical restrictions. (PX 3, PX 5). Given that there is no dispute as to the causal relationship between Petitioner's lower back condition and his January 10, 2011 accident and that the restrictions placed by Dr. Levin are due to that condition, the Arbitrator finds and concludes Petitioner was temporarily and totally disabled from April 16, 2011 (the beginning date of TTD benefits awarded by Arbitrator Simpson) through August 30, 2017. Therefore, Respondent is ordered to pay TTD benefits of $719.25 per week for 332-5/7 weeks, commencing April 16, 2011 through August 30, 2017, as provided in Section 8(b) of the Act.

After being assigned permanent restrictions by Dr. Levin, Petitioner testified he looked for work by speaking with his connections throughout the community. As the head of a youth baseball league, Petitioner testified he knew many people throughout his community and he spoke with many of them about the possibility of having work within his permanent restrictions.

Petitioner began formal vocational rehabilitation on January 18, 2018 when he first met with Kathy Mueller of Independent Rehabilitation Services ("Independent Rehab"). (PX 6). The reports from Independent Rehab show Petitioner met with Ms. Mueller or David Patsavas numerous times from January 2018 through January 2019. During that time, Mr. Patsavas applied to jobs on Petitioner's behalf due to Petitioner's lack of computer skills and education. Petitioner testified that he did not receive any calls for interviews or job offers during that period. (PX 7 – 11).

As detailed previously, due to the lack of success with vocational rehabilitation, Mr. Patsavas performed a labor marker survey to target possible job opportunities for the Petitioner. However, after thorough examination of job openings in Petitioner's geographic area from June 1, 2019 through June 26, 2019, Mr. Patsavas concluded, "It is this consultant's professional opinion as a Certified Rehabilitation Consultant and with a reasonable degree of Vocational Certainty and with over 33 years in the field, that based on the Labor Market Research completed, a Viable and Stable Labor Market does not exist for Mr. Starcevic. This opinion is based on all of the barriers that have been documented above as well as the fact that Mr. Starcevic has not been employed for over 8 ½ years, he has not had any formal education for the past 50 years above the ninth-grade level, and his overall lack of transferrable skills which have been documented in this report." (PX 12).

The Arbitrator has heard Petitioner's testimony regarding his education, work history, and his efforts in working with Independent Rehab as well as looking for work on his own through his community connections and finds Petitioner's testimony credible in each of these regards.

Respondent has offered no evidence or testimony to dispute the diligence of Petitioner's job search efforts or the opinions of Ms. Mueller or Mr. Patsavas concerning Petitioner's course of vocational rehabilitation or Petitioner's employability.

A petitioner is due maintenance benefits when their medical condition has stabilized, but they are still engaged in a vocational rehabilitation program. *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill.2d 107, 561 N.E.2d 623, 149 Ill.Dec. 253 (1990); *Connell v. Industrial Commission*, 170 Ill.App.3d 49, 523 N.E.2d 1265, 120 Ill.Dec. 354 (1st Dist. 1988).

Based upon all evidence and testimony in this case, the Arbitrator hereby finds that Petitioner was engaged in a bona fide program of vocational rehabilitation from August 31, 2017 through June 26, 2019.

Therefore, it is ordered that Respondent shall pay Petitioner maintenance benefits of $719.25 per week for 95 weeks, commencing August 31, 2017 through June 26, 2019, as provided in Section 8(a) of the Act.

III. On the issue of the nature and extent of Petitioner's disability, the Arbitrator hereby finds and concludes:

Petitioner has proven by a preponderance of the credible evidence that he is permanently and totally disabled pursuant to Section 8(f) of the Act effective June 27, 2019.

Petitioner in this case is claiming that he is permanently and totally disabled pursuant to Section 8(f) of the Act, and nature and extent was at issue at trial. However, the Arbitrator notes Respondent agreed that Petitioner is permanently and totally disabled in its post-trial submission to the Arbitrator.

A claimant can satisfy his burden of proving he is not capable of obtaining gainful employment by showing either of the following: 1) that work was not available, in other words a diligent but unsuccessful attempt to find work; **or** 2) that based upon his age, experience, training, and education, he is unable to perform any but the most unproductive tasks for which no stable labor market exists. *Alano v. Industrial Commission*, 282 Ill.App.3d 531, 534-5 (Ind. Comm. Div. 1996).

The burden is on the employee to initially prove that his condition is such that he is unable to perform any services for which there is a reasonably stable market. The burden then shifts to the employer to show that some kind of suitable work is regularly and continuously available. *Sterling Steel Casting Co. v. Industrial Commission*, 74 Ill.2d 273, 384 N.E.2d 1326, 1329, 24 Ill.Dec. 168 (1979).

Petitioner in this case has proven that he is not capable of obtaining gainful employment through the unrebutted opinion of his vocational counselor, David Patsavas.

In his June 27, 2019 report, Mr. Patsavas opined that due to the barriers detailed in that report, which included but were not limited to Petitioner's age, his lack of computer skills, lack of transferrable skills within his restrictions from previous employment, and lack of education, that a stable labor market does not exist for the Petitioner. (PX 12).

Mr. Patsavas' opinion is fully supported by Petitioner's unsuccessful job search efforts and the unsuccessful effort of Mr. Patsavas in applying for jobs on the Petitioner's behalf.

Based upon all the testimony and evidence in the record, Petitioner has clearly satisfied his burden of proving that his condition is such that he is unable to perform any services for which there is a reasonably stable labor market. Respondent has failed to show that some kind of suitable work is regularly and continuously available. The vocational opinion of Mr. Patsavas stands alone in this case, as Respondent has offered no evidence or testimony to dispute, let alone rebut, this opinion.

Based upon the unrebutted opinion of Mr. Patsavas and a review of the record, the Arbitrator finds Petitioner is permanently and totally disabled, pursuant to Section 8(f) of the Act, as of June 27, 2019.

Therefore, Respondent shall pay Petitioner permanent and total disability benefits of $719.25 per week for life, commencing June 27, 2019. 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.

Robert M. Harris

Robert M. Harris, Arbitrator

Date: November 18, 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC007632
Case Name	TATE, KATHLEEN v. DEPT OF CHILDREN & FAMILY SERVICES
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b REMANDED ARBITRATION
Decision Type	Commission Decision
Commission Decision Number	21IWCC0497
Number of Pages of Decision	18
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Danielle Curtiss

DATE FILED: 9/27/2021

/s/Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHLEEN TATE,

Petitioner,

vs. NO: 13 WC 7632

STATE OF ILLINOIS,
DEPARTMENT OF CHILDREN
& FAMILY SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability (TTD), prospective medical treatment, and penalties, and being advised of the facts and law, affirms and adopts, but clarifies and corrects the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission writes to correct the scrivener's error contained within the findings section of the Decision of the Arbitrator. The Arbitrator noted that the Petitioner "did not" sustain an accident that arose out of and in the course of her employment. However, under the conclusions of law section, the Arbitrator noted that the Petitioner was "hit in the head by a ceiling tile…" and that it was "accepted as true that a ceiling tile hit her in the head…." The Arbitrator then stated that the Petitioner sustained "cervical, lumbar, thoracic strains, and contusions as a result of the work accident" and placed Petitioner at maximum medical improvement on May 27, 2014.

Furthermore, the Respondent stipulated that Petitioner sustained an accident arising out of and in the course of her employment. Therefore, the Commission clarifies the findings section to indicate that Petitioner "did" sustain an accident that arouse of and in the course of her employment.

The Commission also corrects the clerical error contained within the order section of the Decision of the Arbitrator. The Arbitrator correctly awarded TTD benefits from February 14, 2013 through May 27, 2014. The duration of the disability, however, is incorrectly listed as 70 and 6/7 weeks instead of 66 and 6/7 weeks. Therefore, the Commission corrects the clerical error contained within the order section to reflect that Petitioner is entitled to TTD benefits for 66 and 6/7 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 2020 is hereby affirmed and adopted but clarified and corrected as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Pursuant to §19(f)(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.

September 27, 2021

Christopher A. Harris
Christopher A. Harris

CAH/tdm
O: 9/16/21
052

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0497
NOTICE OF ARBITRATOR DECISION

TATE, KATHLEEN Case# **13WC007632**
Employee/Petitioner

DEPT OF CHILDREN & FAMILY SERVICES
Employer/Respondent

On 12/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
801 S 7TH ST
SPRINGFIELD, IL 62794

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305 / 14

DEC 2 - 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

21IWCC0497

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

Kathleen Tate
Employee/Petitioner

v.

Department of Children and Family Services
Employer/Respondent

Case #**13** WC **7632**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Charles Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **August 17, 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. [ ] 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 care

FINDINGS

On the date of accident, **February 13, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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 $***90,395.96***; the average weekly wage was $***1,738.38.***

On the date of accident, Petitioner was ***50*** years of age, ***single*** with ***no*** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**79,472.85** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**79,472.85**

ORDER

- The Respondents shall pay Petitioner temporary total disability benefits of **$1,158.92**/week, for **70 and 6/7** weeks, commencing **2/14/13 through 5/27/14,** pursuant to §8(a) of the Act.
- Respondent-Employer is due a credit in the amount of **$49,140.28** under section 8(j) of the act.
- No prospective medical is ordered. Further treatment is not warranted.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

December 1, 2020
Date

DEC 2 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kathleen Tate	)	
	)	
Employee/Petitioner	)	
v.	)	
	)	Case No. 13 WC 7632
State of Illinois, Department of Children and Family Services	)	
	)	**Chicago, IL**
	)	
Employer/Respondent	)	

FINDINGS OF FACT

Petitioner pursued this action under the Workers' Compensation Act and sought relief from the Respondent-Employer Illinois Department of Children and Family Services (hereinafter "DCFS"). On August 17, 2020, the parties appeared at a hearing before Arbitrator Charles Watts. Patrick Shifley of Dworkin and Maciariello appeared on behalf of Petitioner. Assistant Attorney General Danielle Curtiss of the Illinois Attorney General's Office appeared on behalf of Respondent. At hearing, Petitioner's Exhibits 1-11 and Respondent's Exhibits 1, 3, 4, and 5 were admitted into evidence. The issues at hearing were causation, unpaid medical, outstanding temporary total disability benefits, and prospective medical care. After hearing the proofs and reviewing the evidence presented, the Arbitrator makes the following findings on the disputed issues.

Testimony

Petitioner has been employed at DCFS since 1993. (T 8). In 2013, Petitioner's held the role of Supervisor, where she was responsible for supervising seven employees. *Id.* Petitioner also made decisions on the lives of children and families. (T 9). As part of the job, Petitioner carried case files, attended court hearings, added paper to the copy machine as needed and completed time sheets. *Id.*

On February 13, 2013, Petitioner was returning from lunch when she walked into the door of her office. (T 10). Petitioner opened the door, then attempted to shut it, and it would not shut all the way. *Id.* She pushed the door closed, and heard a hollow sound, which she described as unusual. *Id.* The door became ajar slightly, and Petitioner pushed the door shut a second time. *Id.* At this point, something hit Petitioner on the head. *Id.* Petitioner noted that she felt unsafe, and then something hit her in the back of the right leg. *Id.* Petitioner had to balance herself on her left leg to keep from falling. *Id.* Petitioner discovered after the accident that a piece of the drop ceiling had fallen on her. (T 15). Petitioner described the height of the ceiling to be twice her height. *Id.*

Petitioner pushed the button to get onto the elevator, but it was not working. (T 9-10). Petitioner testified that she crawled up the steps and saw her supervisor at the top of the steps. (T 11). Petitioner reached her office, and felt dazed, like her brain was expanding. *Id.* Petitioner attempted to complete an "unusual incident report" but was unable to finish because she was unable to type. *Id.* Petitioner was then taken to the St. Bernard Hospital emergency room. (PX 1)

Following the accident, Petitioner experienced cervical pain, headaches, eye pain, and back pain (T 22-23). Petitioner had issues with her balance, and experienced memory loss. (T 23). Petitioner treated with Dr. Kern Singh, then at the VA hospital. (T 27). Petitioner did not undergo the surgery recommended by Dr. Singh, because DCFS would not authorize it. (T 28).

Petitioner testified on direct examination that she stopped driving after she nearly caused a head-on collision with a school bus. (T 21). After that incident, Petitioner gave away her car, and family members drove her to doctor appointments. *Id.*

Petitioner denied having returned to work since her accident, and is a current Social Security recipient. (T 32)

Petitioner opened a retail clothing store named "Ghorgus 1" in 2017. (T 51). She was the owner, and she and friends and family worked there. (T 52). Petitioner, along with family and friends, set up the store for business. *Id.* Petitioner handled inventory, set up a budget, and ran the store, with the help of friends. (T 54).

At some point in 2019, Petitioner began driving again, and worked for Postmates. (T 32, T 37). Postmates in an app-based food delivery company. (T 46-27). Petitioner worked for Postmates for approximately six months. In this role, Petitioner was required to use her smartphone to receive the food orders, which she would then pick up and deliver to customers. (T 46). Petitioner said she had a friend help her complete this job, but it helped with her memory to work at Postmates. (T 47). Petitioner drove around Chicago delivering food. *Id.* She made an average of 20 deliveries per week (T 49). She made approximately $2.00 per delivery. (T 50). Petitioner never informed Postmates of any work restrictions. (T 49). She stopped working there when the pain became too great on her tailbone. (T 32).

Petitioner testified on direct examination that she never experienced back or neck pain, 24-hour headaches, or neurological issues prior to the alleged accident. (T 31). Petitioner has not returned to work for DCFS. (T 32). She receives income from Social Security. *Id.*

Petitioner testified that the income received from her retail operation did not cause an offset from her Social Security. (T 59-60)

Petitioner testified that she still experiences back pain, short-term memory loss, and cervical pain. (T 29). The back pain is located in Petitioner's mid and lower back, which radiates down towards her buttock area. (T 30). Petitioner testified that she lives in a two-story house with her niece. (T 35). Petitioner does laundry, climbs stairs, dresses herself, and drives herself to doctor appointments. (T 34-35). She is not able to complete these tasks without some degree of difficulty. (T 64). She holds a valid driver's license. (T 32).

Summary of Petitioner's Medical Treatment

Petitioner sought treatment on February 13, 2013 at St. Bernard emergency room. (PX 1). Petitioner reported that dry wall fell on her head, and was experiencing neck, back, head, and ear pain. *Id.* She was diagnosed with a mild head trauma. *Id.* There was no cut, abrasion, or swelling noted. *Id.* Her neck was normal. *Id.* She was discharged alert and oriented times three with a steady gait. *Id.* She denied loss of consciousness. *Id.*

Petitioner was seen by Dr. Valek at Mt. Greenwood Family Medicine on February 15, 2013. (PX 7) The note indicates that Petitioner showed a picture of the ceiling tile that fell on her head to Dr. Valek but could not give Dr. Valek an approximate weight of the tile. (PX 7) Petitioner's complaints were pain in her head, neck, shoulders, right hip, and abdomen. (PX 7)

Petitioner next sought treatment on February 17, 2013 at Little Company of Mary emergency room. (PX 2). She reported that dry wall fell on her while at work. *Id.* Petitioner complained of nausea and dizziness. *Id.* She underwent a CT of the cervical spine which revealed cervical spondylosis. *Id.* Petitioner was diagnosed with a concussion, acute cervical and lumbar strain, and chronic cervical degenerative joint and disc disease. *Id.*

On February 22, 2013, Petitioner received care from Little Company of Mary, and complained of headache, sensitivity to loud noises, dizziness with sudden bending or turning. (Px 2). Past history was noted and included muscle spasms, blood transfusion, fibroid removals in 1998 and 2009, a total abdominal hysterectomy in 2010 and a cyst on her left ovary was removed in 2010. (PX 7)

Petitioner saw Dr. Foreman at Chicago Pain and Orthopedic on March 18, 2013. (PX 4). Petitioner complained of persistent headaches, and neck pain, and low and mid back pain. *Id.* Upper extremity radicular symptoms still present. *Id.*

On March 20, 2013, Petitioner underwent an imaging study from Preferred Open MRI. (T 18, PX 3) The findings were spondylosis at C5-6 and C6-7 with bilateral posterior osteophyte complexes causing moderate bilateral foraminal narrowing, as well as mild spinal stenosis at L4/5, foraminal stenosis at L4/5, and left neural foraminal stenosis at L5/S1. (PX 3)

On March 23, 2013 the Petitioner was seen Consultants in Neurology on the Referral of Dr. Michael Foreman at Associated Medical Centers of Illinois. The impression given was that she was status post head injury. (PX 8)

Petitioner underwent eight chiropractic treatments with Ashley Daliege, DO between February 26, 2013 through March 13, 2013. (RX 5). She underwent 20 sessions between March 31, 2013 and May 10, 2013. (RX 5).

On April 18, 2013 the Petitioner was seen at Chicago Pain and Orthopedic Institute by the referral of Dr. Foreman. (PX 4) She gave a history consistent with her testimony. She reported pain across the low back, neck pain, and neurological symptoms. Cervical epidural

injection was recommended, and she was referred for physical therapy by Dr. Foreman, and was continued off work. (PX 4)

The Petitioner was also seen at Associated Medical Centers of Illinois (AMCI) for physical therapy. From April 18, 2013 through May 13, 2013. (PX 6)

On May 22, 2013 the Petitioner was seen again at Chicago Pain and Orthopedic. She continued to complain of neck pain and lower back pain, and she was continued off work. (PX 4)

On June 28, 2013 the Petitioner was seen again at Chicago Pain and Orthopedic. She continued to complain of neck pain and lower back pain, and she was continued off work. (PX 4)

On July 2, 2013 the Petitioner was seen again at Chicago Pain and Orthopedic. She was treated with a cervical interlaminar epidural injection. (PX 4)

On July 26, 2013, the Petitioner was seen again at Chicago Pain and Orthopedic. She reported moderate improvement subsequent to her injection, but continued to experience cervical pain, as well as ongoing lumbar spine pain. She was continued off work. (PX 4)

Petitioner underwent an MRI of the lumbar spine on August 9, 2013 which revealed: mild degenerative changes; mild spinal stenosis at L4-L5; Lateral recess and neural foraminal stenosis at L4-L5; and borderline left neural foraminal stenosis at L5/S1. (PX 2)

On September 10, 2013, the Petitioner was seen again at Chicago Pain and Orthopedic. She underwent a cervical interlaminar epidural injection. (PX 4)

On September 27, 2013, the Petitioner was seen again at Chicago Pain and Orthopedic. She only reported mild improvement after the second injection and continued to experience lumbar spine pain and radicular pain along the L4-L5 dermatome. (PX 4)

On October 8, 2013, the Petitioner was seen again at Chicago Pain and Orthopedic. She underwent a cervical interlaminar epidural injection. She continued to complain of cervical and low back radiating pain. She was to consult further with a neurosurgeon and an FCE was considered to measure her work capacity. (PX 4)

On October 15, 2013, she underwent a bilateral L4-L5 transforaminal epidural steroid injection and selective nerve root block. (PX 2) Petitioner followed up with Dr. Vargas on November 1, 2013, and no change after the epidural steroid injections was noted. *Id.* Dr. Vargas recommended a consultation with a neurosurgeon. *Id.*

On December 2, 2013 the Petitioner was seen again at AMCI by Dr. Michael Foreman. She reported ongoing cervical and lumbar spine pain. She was recommended a spine surgeon evaluation and discharged to the care of a spine specialist. (PX 6)

On December 12, 2013, Petitioner underwent a lumbar discography at L2-L3, L3-L4, L4-L5, and L5-S1 levels with Dr. Vargas. (PX 2) He noted concordant discogenic pain at L4-L5.

Id. Petitioner underwent another lumbar CT which revealed a 3-4 MM broad based posterior disc herniation indenting the thecal sac without significant spinal stenosis at L4-L5. *Id.* A mild bilateral neuroforaminal narrowing was noted. *Id.* Significant facet arthrosis at this level was also noted. *Id.* At the L5-S1 level, There was a 3-4 posterior disc herniation which appeared central and indents the thecal sac without significant spinal stenosis nor significant neuroforaminal narrowing. *Id.*

On January 3, 2014, Dr. Vargas proceeded with an uneventful provocative functional lumbar discogram at L2-L3, L3-L4, L4-L5 levels. *Id.* The study revealed discogenic pain concordinant intraoperatively with ongoing pain at L4-L5. Level, with controls at L3-L3, L3-L4, and L5-S1 levels. *Id.* Dr. Vargas opined that that the symptoms for which Petitioner was being seen were directly related to the injury. *Id.* A lumbar spine fusion was recommended. *Id.*

Petitioner saw Dr. Kern Singh on February 19, 2014 at Midwest Orthopedic at Rush. (PX 8). Petitioner reported pain to her neck, low back, and upper extremity. *Id.* A neurological examination revealed no findings. *Id.* She was diagnosed with cervical and lumbar muscular strain. *Id.* Work conditioning was recommended. *Id.*

Petitioner underwent eight sessions of work conditioning at Associated Medical Centers of Illinois between March 6, 2014 and April 3, 2014. (PX 6). She was discharged on April 3, 2014, with a note that her goals had not been achieved. Petitioner reported pain at 8.5/10 in her neck and low back, and loss of range of motion. *Id.* The physical therapist noted that Petitioner did not feel ready to go back to work. *Id.* Petitioner reported short-term memory loss, and that processing during daily activities was diminished, and she was more sensitive to noises and lights. *Id.* She reported having intermittent dizziness that almost makes her black out. *Id.* She stated that she did not feel mentally or physically able to return to work. Petitioner reported that her job was very stressful and her headaches, memory loss, and issues with processing will prevent her from doing her job. *Id.* She was able to walk for 15 minutes on the treadmill but experiences pain the entire time. *Id.*

On March 14, 2014, Petitioner followed up with Dr. Singh. (PX 8). Petitioner reported that her symptoms had increased, her neck pain, in particular. *Id.* Petitioner was diagnosed with soft tissue strain to neck and lower back, and degenerative disc disease at L4-L5, and L5-S1. *Id.* Recommended MRI of cervical spine. *Id.*

Petitioner underwent a cervical spine MRI on April 21, 2014 which revealed loss of disc height and intensity at C5-C6, and C6-C7, resulting in bilateral neuroformainal narrowing. (PX 8). A cervical spine X-ray revealed loss of disc height and disc space collapsed at C5-C6 and C6-7. *Id.* Petitioner was diagnosed with degenerative disc disease at C5-C6, and C6-C7. *Id.* Petitioner followed up with Dr. Singh on May 5, 2014., who recommended a cervical fusion at C5-C6, and C6-C7. *Id.*

Petitioner next treated at Jesse Brown Veterans Affairs Medical Center ("VA") for tension headaches. (PX 9). Petitioner followed up with Dr. Singh. (PX 8). Dr. Singh opined that Petitioner sustained an aggravation of underlying degenerative condition, and axial mechanism from the ceiling landing on her head would be a plausible mechanism of injury. *Id.* He continued

to recommend a cervical fusion. *Id.* Dr. Singh was deposed on January 29, 2015, at which time he stated there is no way to determine when the degenerative changes began. (PX 10).

On March 4, 2015 the Petitioner was seen at Little Company of Mary for lower right side pain radiating down her right leg, as well as headache which had been ongoing since a head injury in 2013. She was diagnosed with clinical depression due to chronic pain and headache. (PX 7)

Petitioner followed up at the Jesse Brown VA Medical Center on April 23, 2015, with complaints of tension headaches. She was diagnosed with a refractory migraine, chronic post traumatic stress disorder, and depressive disorder. (PX 9).

On June 3, 2016 the Petitioner was seen for an FCE at the VA with complaints of low back pain and neck pain, as well as a history of post-concussion syndrome from work injury. At that time she reported neck pain of 5 – 7 out of 10, and back pain of 4-7 out of 10. The test considered the requirements of a light physical duty position as a social worker and found her unable to meet the standing and walking requirements, as well as noting impaired right sided tactile feeling requirements. She was found to be capable of sedentary work, but not light duty work. (Px 9)

On September 22, 2017, Petitioner underwent a left spine MRI at the VA Medical Center, which revealed mild multilevel degenerative arthritis in the lumbar spine. *Id.*

The next treatment record submitted is dated over two years' later, on December 3, 2019. *Id.* On this date, Petitioner underwent an EMG at the VA Medical Center. *Id.* The EMG revealed the following: (1) Normal nerve conduction study of the right lower extremity; (2) No electrodiagnostic evidence of mono or polyneuropathy in the right lower extremity; (3) Lumbosacral radiculopathy cannot be excluded as patient declined needle EMG. *Id.* Petitioner was diagnosed with stable right sided traumatic brain injury, chronic low back pain, discogenic degenerative disc disease, depression, and post traumatic stress disorder. *Id.*

On December 18, 2019, Petitioner underwent trigger point injections at the VA. *Id.* On January 15, 2020, she followed up, complaining of constant low back pain. *Id.* Petitioner reported that she has difficulty walking, sitting, and driving for long periods of time. *Id.* Petitioner followed up on February 7, 2020 at the VA, complaining of low back pain. *Id.* Petitioner reported that the pain is aggravated by sitting on her right side, and worse with forward bending. *Id.* She had poor memory and was very forgetful. *Id.* Petitioner reported that she drives and lives alone. *Id.* The last VA record is dated April 24, 2020. *Id.* On this date, Petitioner called the VA to follow up with a complaint of hyperpigmentation of her right hand, which occurred after using old gloves. *Id.*

Petitioner denies having had any intervening events or accidents which altered her medical condition since the workplace accident of 2013. (T 32)

Petitioner testified that she is currently capable of doing laundry, using stairs, dressing herself and driving a car. (T 36) She lives in a single family residence with her niece. (T 36) She

testified that these activities took longer than before her accident, due to inability to lift heavier loads, to frequently go up and down stairs, or to keep track of recipes, purchase amounts, or other mental activities. (T 65)

Testimony of Dr. Kern Singh

The Parties took the evidence deposition of Dr. Singh on January 29, 2015. (PX 11) Dr. Singh testified as a practicing orthopedic neurosurgical spine surgeon at Rush University where he was the associate professor in the Department of Orthopedic Surgery at Rush University Medical Center. (PX 11 p 5) Dr. Singh testified that 5%-10% of his practice was medical legal consultation, which was then broken down 70% respondent hired and 30% petitioner hired §12 exams. (PX 11 p 5)

Dr. Singh testified that he treated the Petitioner beginning on February 19, 2014 when she provided him with a history of being hit with a part of the ceiling in the entry-way at her work. (PX 11 p 7) She reported a history of radiating neck pain, radiating low back pain, and a medical treatment history of physical therapy and epidural spine injections. (PX 11 p 7) Petitioner denied a relevant medical history of any prior treatment. (PX 11 p 8) Dr. Singh did not review any medical records from Petitioner's prior treating physician Dr. Vargas and so the entire history of Petitioner's medical course was from Petitioner herself. (PX 11 p 22)

Dr. Singh testified that he had recommended the Petitioner undergo a fusion surgery at C5-6 and C6-7 beginning April 28, 2014. (PX 11 p 15) Dr. Singh testified that the need for the surgery was indicated by radicular pain distributed along the C6 and C7 dermatomes along with muscle weakness, as well as by the findings of foraminal narrowing apparent on the MRI. (PX 11 p 16)

Dr. Singh believed that the Petitioner's mechanism of injury, downward pressure due to an object striking her from above, was correlated with the C6 and C7 radiculopathy. (PX 11 p 17) Dr. Singh testified that the Petitioner had suffered from pre-existing disc degeneration which was asymptomatic prior to the date of injury and which was aggravated by her injury. (PX 11 p 18-20)

Dr. Singh testified that he disagreed with the recommendation of lumbar surgery by Dr. Vargas because Petitioner was not a good candidate because he could not localize Petitioner's pathology in her lower back to a particular dermatomal distribution in her legs. (PX 11 p 23-24)

Section 12 Examination with Dr. Kornblatt

On May 27, 2014, Petitioner underwent an Independent Medical Examination ("IME") with Dr. Kornblatt. (RX 5). Petitioner was diagnosed with cervical, thoracic, and lumbar myofascial pain with a diagnosis of two-level cervical degenerative disc disease and one-level lumbar degenerative disc disease with axial cervical thoracic, and lumbar pain. *Id.* Dr. Kornblatt noted that Petitioner did not present with any cervical radiculopathy or myelopathy, thoracic myelopathy, or lumbar radiculopathy. *Id.*

Dr. Korblatt opined that Petitioner's current condition was unrelated to the work accident, as the work accident did not cause cervical degenerative disc disease, or lumbar degenerative disc disease, which were pre-existing conditions. *Id.* Those conditions were not caused, aggravated or accelerated, by the work accident. *Id.* Dr. Kornblatt further noted that the work accident resulted in a self-limiting cervical, thoracic, and lumbar strains and contusions, which should have reached maximum medical improvement ("MMI") by 12-16 weeks post injury. *Id.* Dr. Kornblatt found that Petitioner reached MMI regarding the work related accident, and that Petitioner presented without any objective medical basis on which to base ongoing activity and or/work restrictions. *Id.* Petitioner was authorized to work within a medium demand level. *Id.* Dr. Kornblatt determined that restrictions of medium physical demand level are appropriate and are unrelated to the work injury. *Id.*

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Board of Trustees v. Industrial Commission, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980).

The Arbitrator notes that it is well established that a Petitioner carries the burden of proving her case by a preponderance of the evidence. "Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Parro v. Industrial Commission*, 630 N.E.2d 860 (1st Dist. 1993); *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried her burden is her credibility. See, *Parro*, supra. Credibility is the quality of a witness, which renders her evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony.

The Commission is not required to find for a claimant merely because there is some testimony which, if it stood alone and undisputed, might warrant such a finding. *Burgess v. Industrial Commission*, 523 N.E.2d 1029 (1st Dist. 1988). The mere existence of testimony does not require its acceptance, *U.S. Steel Corporation v. Industrial Commission*, 8 Ill. 2d 407 (1956), and the Commission is not required to accept unrebutted testimony. *Sorenson v. Industrial Commission*, 281 Ill.App.3d 373, 384 (1996). Where the sole support for an award rests on the claimant's own testimony, and claimant's actual behavior and conduct is inconsistent with that testimony, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972). Moreover, the Commission does not

To determine whether a claimant has met his requisite burden of proof by a "preponderance of credible evidence," it is necessary for the Commission to look for consistency and corroboration between a witness' testimony, conduct, and other documentary evidence to determine the truth of the matter. Where that other evidence tends to impeach or undermine a claimant's testimony, there may be sufficient cause to find that a claimant has failed to meet his requisite burden.

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was not credible. First, exaggeration is simply another form of lying. The records are replete with instances of complaints of 8 or 9 out of 10 pain. The starting point of this case is important – Petitioner was hit in the head by a ceiling tile of undetermined weight. Without more description, the Arbitrator finds it likely that this ceiling tile, which fell from the ceiling of a government building, to be relatively light and unlikely to be able to cause such an extraordinary number of ailments that are supposed to have persisted for more than seven years. At trial, Petitioner's body language was entirely exaggerated as if she was acting. Multiple bouts of crying made her less believable because it seemed staged. Petitioner's pace of speech and manner of answering questions was indicative of someone searching for an answer meant to elicit sympathy rather than simple and quick answers to clear questions. This matters because it offers a way to interpret Petitioner's many interactions with medical professionals. In their histories, her pain complaints are exaggerated and always concern multiple body parts. Pain complaints are diffuse, covering many parts of her body. While it is accepted as true that a ceiling tile hit her in the head, Petitioner is also a middle-aged woman who has had fibroids

removed and a hysterectomy. She had degenerative disk disease that the Arbitrator finds had to believe was entirely asymptomatic prior to the accident in this case and then became debilitating. There is also recurrent reference to mental conditions such as depression and cognitive disability.

In short, Petitioner's lack of credibility is enough of a reason to find for Respondent in this case, however, to be thorough and certain, the issue of causation is now analyzed.

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder* v. Ill. *Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

Petitioner's testimony, in addition to Dr. Kornblatt's IME dated May 27, 2014, makes it more probable than not that Petitioner's current condition of ill-being is not causally related to the work accident. Petitioner testified that she has not returned to DCFS since the date of accident in 2013. However, during this time off, she held two separate jobs that seem to be of equivalent demand as the job she had at DCFS. First, Petitioner owned and operated a retail clothing store in 2017. (T 51). She set up the store for business, worked with a budget, and ran the store. (T 54). Petitioner testified that the store was not successful, so it eventually closed.

Petitioner also worked for Postmates for six months. In this role, Petitioner used her smartphone to receive the food orders, which she would then pick up and deliver to customers. (T 46). Petitioner said she had a friend help her complete this job, but it helped with her memory to work at Postmates. (T 47). Petitioner drove around Chicago delivering food. *Id.* (T 50). She stopped working there when the pain became too great on her tailbone. (T 32). Petitioner never informed Postmates of any work restrictions. (T 49). This is important because Petitioner offers an FCE done at the VA as evidence that she can only perform sedentary work. A close read of that FCE report reveals that it was a very close call on the difference between light duty – what a DCFS social worker is – and sedentary work. The Arbitrator finds the two jobs post DCFS to be more persuasive evidence of capability than the FCE.

Petitioner submitted a narrative from Dr. Kern Singh from August 2014. (PX 10). Dr. Singh opined that Petitioner sustained an aggravation of underlying degenerative condition, and

axial mechanism from the ceiling tile landing on her head would be a plausible mechanism of injury. *Id.* There was no mention of the weight of the tile nor was any proof offered that the tile that fell on Petitioner's head any different from the sort of drop-ceiling tiles found in government buildings all over the world. Dr. Singh continued to recommend a cervical fusion. *Id.* He testified at the deposition that there is no way to determine when the degenerative changes began. (PX 10).

Despite Dr. Singh's recommendations to remain off work, Petitioner did not, in fact, remain off work. Instead, she held two separate jobs. Either Petitioner was actually capable of returning to work at DCFS, and just failed to do so, or she was working outside of her restrictions, thus potentially worsening her condition. Based on her actions, Petitioner is not credible, and was capable of returning to work with DCFS and just failed to do so.

The Arbitrator notes, importantly, that it is also plausible that a standard ceiling tile falling on Petitioner's head is not the cause of her largely subjective symptomatology in her cervical spine let alone her lumbar spine, leg, head, etc., or depression, post-traumatic stress, cognitive, and balance issues.

Narrative opinions were submitted by both the Petitioner and the Respondent. (RX 5; PX 10). The Arbitrator finds Dr. Kornblatt's IME credible. The Arbitrator finds that Petitioner sustained cervical, lumbar, thoracic strains, and contusions as a result of the work accident. (RX 5). The evidence reflects that Petitioner still suffers from cervical degenerative disc disease and lumbar degenerative disc disease, despite three epidural steroid injections, eight work conditioning sessions, and numerous chiropractic visits. (PX 8). Rather, the accident was a temporary aggravation of the pre-existing condition, which would have resolved itself within 16 weeks of the accident. (RX 5). He found that Petitioner was capable of returning to work light duty. *Id.*

As such, the Arbitrator finds that Petitioner was at MMI on May 27, 2014, and her current condition is not causally related to the work accident. No further medical care after May 27, 2014 is the responsibility of Respondent.

J. Were the medical services provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

As detailed above in Section F, this Arbitrator finds that Petitioner's ongoing complaints are not causally related to the February 13, 2013 accident. Petitioner was at MMI on May 27, 2014. No further medical treatment is therefore warranted.

The Arbitrator finds that the Petitioner has established a preponderance of the credible evidence that the medical bills up to May 27, 2014 are reasonable, necessary and causally related to the accident, and that the Respondent shall pay for those medical expenses under Section 8(a) of the Act and pursuant to the Illinois Fee Schedule.

The Arbitrator finds that Petitioner has not established that medical bills after the date of May 27, 2014are reasonable, necessary, and causally related to the accident.

K. Is Petitioner entitled to temporary total disability?

Petitioner alleges that she is entitled to temporary total disability ("TTD") from February 13, 2013 through the date of hearing of August 17, 2020. (Arb 1). Petitioner was paid TTD from March 1, 2013 through July 9, 2014. (RX 3). As indicated above, the Arbitrator found that Petitioner was at MMI on May 27, 2014. Dr. Kornblatt's IME opined that Petitioner was capable of returning to a medium-duty job. (RX 5). As Petitioner holds a light-duty job with DCFS, Petitioner was capable of returning to work effective May 27, 2014. Therefore, this Arbitrator finds that Petitioner is entitled to TTD from February 14, 2013 through May 26, 2014. Further, the Arbitrator grants Respondent a credit for all TTD paid, including from March 1, 2013 through July 9, 2014.

L. Is Petitioner entitled to prospective medical care?

As detailed above in Section F, this Arbitrator finds that Petitioner's ongoing complaints are not causally related to the February 13, 2013 accident. Petitioner was at MMI on May 27, 2014. Prospective medical care is not warranted.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC026865
Case Name	CAMPBELL,JAMES v. ADM
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0498
Number of Pages of Decision	13
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	Jessica Bell

DATE FILED: 9/27/2021

/s/ Barbara Flores, Commissioner

Signature

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☒ Modify (down)	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Campbell,

Petitioner,

vs. NO: 19 WC 26865

ADM,

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 causal connection, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327 (1980).

The Arbitrator's decision delineates the facts of the case in detail. As relevant to the issues on review, the Commission modifies the decision and writes additionally to address causal connection, temporary total disability, medical expenses, and prospective medical treatment.

A. Causal Connection

The Arbitrator found causal connection to Petitioner's current lumbar condition of ill-being. In so doing, the Arbitrator found Petitioner to be credible, and also found the testimony of treating surgeon, Dr. Rahman, to be more persuasive than that of Dr. Zelby. The Arbitrator noted that the majority of Petitioner's testimony was corroborated by Respondent's witness, Mr. Howard, who was Petitioner's supervisor. The Arbitrator noted concern regarding the lack of

consistent back complaints throughout Petitioner's treatment, but relied on the January 22, 2019 medical record, which stated that although Petitioner's back was doing better, he had not done much to test it out, so he was unsure if he could do his full job. The Arbitrator found that this matched Petitioner's testimony that his back pain was manageable until he returned to full duty. The Arbitrator further noted that Dr. Rahman causally connected Petitioner's need for surgery to the January 17, 2019 accident. Accordingly, the Arbitrator found causal connection to Petitioner's current low back condition. Upon close review of the record as a whole, the Commission modifies the Arbitrator's causal connection ruling.

While Respondent's witness, Mr. Howard, corroborated the mechanism of Petitioner's January 17, 2019 injury, he did not corroborate Petitioner's testimony regarding his subsequent ongoing back condition. Petitioner testified that he did not treat for his back from February through July of 2019 because he was taking muscle relaxers and was only performing restricted job duties that did not inconvenience his back. The medical records reveal that Petitioner was immediately returned to full duty after the accident and not placed off work for any back complaints until August 14, 2019. A February 12, 2019 record indicates Petitioner was still working full duty, and did not have any back complaints at that time. An April 5, 2019 record reveals that Petitioner was also still performing duties such as throwing hoses, which contradicts his testimony that he was only performing restricted work, or duties at that time that did not inconvenience his back. The Commission does not find this evidence to support Petitioner's testimony.

Even considering Petitioner's right knee injury treatment and limitations, the evidence establishes that Petitioner worked full duty after the accident for nearly six weeks until February 26, 2019 and he again worked full duty from July 8, 2019 through August 14, 2019 with no need for medical treatment or recommended surgical intervention to address his low back. Petitioner was still performing duties requiring bending, kneeling, crawling and maneuvering a power-washer. Instead, the record suggests that Petitioner's decrease in, or lack of, complaints was due to improvement in his lumbar condition that had reached maximum medical improvement. Petitioner's testimony that his back pain was manageable until returning to full duty is inconsistent with the evidence.

Moreover, the evidence as a whole does not support Dr. Rahman's conclusion that Petitioner's back condition was remained causally related to the accident. An August 1, 2019 St. Mary's emergency room record suggests that an intervening accident occurred, breaking the chain of causation between the January 17, 2019 accident and Petitioner's current back condition and need for surgery. This is supported by medical records and the deposition testimony of Petitioner's own treating physician, Dr. Rahman.

The record reveals two incidents affecting Petitioner's lumbar spine while employed by Respondent. The first was the accident occurring on January 17, 2019, wherein Petitioner was diagnosed with pelvic and low back contusions with no tenderness, was prescribed Tylenol/Ibuprofen, and subsequently had back complaints until January 25, 2019. He sought no further medical care thereafter, even while working full duty. The second, and intervening, event[1] occurred on August 1, 2019, wherein Petitioner suffered sharp lumbar pain with

[1] No application for adjustment of claim was filed as a result of this incident at work.

tenderness. Diagnostic tests revealed bilateral pars fractures with grade 1 spondylolisthesis at L5-S1 and moderate bilateral neuroforaminal stenosis at L5-S1 secondary to a disc bulge. This occurrence led to new ordered back treatment including therapy and neurosurgery, neither of which had been recommended as a result of the January 17, 2019 accident at work and which now prevented Petitioner from working full duty.

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury. *Vogel v. Industrial Comm'n*, 354 Ill. App. 3d 780, 786 (2005). The determinant issue is whether the injury of January 17, 2019 played a "causative role" in the Petitioner's current condition. See *Teska v. Industrial Comm'n*, 266 Ill. App. 3d 740, 742 (1994). The Commission concludes that it did not and finds that the intervening event on August 1, 2019 severs causal connection between Petitioner's current low back condition of ill-being and the January 17, 2019 accident at work.

The August 1, 2019 incident caused a permanent change in Petitioner's condition of ill-being. The record reflects that Petitioner observed a noticeable increase in pain compared to his post-January 17, 2019 condition, which extended beyond left lumbar pain to bilateral lumbar pain. Also subsequent to August 1, 2019, Petitioner was referred for physical therapy and neurosurgery, neither of which were necessary nor prevented Petitioner from working full duty after the January 17, 2019 accident at work.

Moreover, while Dr. Rahman found causal connection to the January 17, 2019 accident, he admitted that his causal connection opinion would change if he learned that Petitioner's back pain subsided five days after the accident and did not become problematic again until he began treating with Dr. Rahman. Since medical records reveal Petitioner had no back complaints after January 25, 2019 until the August 1, 2019 incident, and Dr. Rahman did not have the benefit of reviewing all of Petitioner's medical records, the Commission is not persuaded by Dr. Rahman's causation opinion, which would change per his testimony.

Based on the totality of evidence, the Commission finds although Petitioner suffered a compensable accident on January 17, 2019, the intervening event on August 1, 2019 permanently worsened and changed the nature of his lumbar condition leading to a surgical recommendation thereby breaking the chain of causation. Thus, the Commission modifies the Arbitrator's causal connection ruling, finding that Petitioner's accident-related lumbar condition resolved by January 25, 2019, and that his current condition of ill-being is not causally connected to the January 17, 2019 accident.

B. Medical Expenses

Having modified causal connection, the Commission also modifies the award for medical expenses accordingly. The Commission awards medical expenses for all back-related treatment from January 17, 2019 through January 25, 2019.

C. Prospective Medical Care

In accordance with the modification of causal connection, the Commission also vacates the Arbitrator's award for prospective surgery recommended by Dr. Rahman, as Respondent's liability for Petitioner's January 17, 2019 accident terminated on January 25, 2019, before any surgical intervention was contemplated.

D. Temporary Total Disability

Also, in accordance with the modification of causal connection the Commission vacates the Arbitrator's award of temporary total disability benefits, as no related temporary disability benefits accrued between the date of accident and January 25, 2019.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's current condition of ill-being is not causally related to the accident in question, and that causal connection to Petitioner's work-related lumbar condition terminated as of January 25, 2019.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses related to his lumbar condition through January 25, 2019, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER FOUND BY THE COMMISSION that Respondent is not liable for the prospective surgery recommended by Dr. Rahman.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner is not entitled to any temporary total disability benefits in relation to his work-related lumbar injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 30, 2021 is hereby affirmed as modified herein.

The bond requirement in Section 19(f)(2) of the Act is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). As there are no monies due and owing, there is no bond set by the Commission for the 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.

September 27, 2021

o: 9/16/21
BNF/wde
45

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Christopher A. Harris*
Christopher A. Harris

/s/*Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC026865
Case Name	CAMPBELL,JAMES v. ADM
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Edward Lee, Arbitrator

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	Jessica Bell

DATE FILED:4/30/2021

INTEREST RATE FOR THE THE WEEK OF APRIL 27,2021
0.03%

/s/ Edward Lee, Arbitrator
Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Campbell
Employee/Petitioner

v.

ADM
Employer/Respondent

Case # **19 WC 026865**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **March 15, 2021** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **January 17, 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.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

Petitioner has not received all reasonable and necessary medical services.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the proposed surgical procedure by Dr. Rahman.

The respondent shall pay Petitioner 79.57 weeks of TTD at the rate of $455.93 subject to the credit of payments already made, and those of their short term, long term disability programs.

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.

Edward Lee
Signature of Arbitrator

Findings of Fact

James Campbell, Petitioner, is a 49 year old who worked at the wash bay with ADM, Respondent, in 2019 and worked with Respondent since December of 2018. (Trans. Pg. 7-8, 9) The Petitioner testified that his job required him to clean out semi tank size tanks that had been filled with oil and chocolate. (Trans. pg. 8)

The Petitioner testified that on January 17, 2019, he was going down into a tank to check if it was clean. He used a towel to not leave footprints. As he was getting onto the ladder to get out of the tank, the ladder swung in and he fell backwards landing on his back and injuring his leg and back. (Trans. pg. 10-12) He felt a little pain and Kevin, his supervisor, was present at the accident. (Trans. pg. 12) (Respondent did not dispute accident)

The January 17, 2019, occupational visit at HSHS Occupational Health documented a January 17, 2019, accident that had the Petitioner falling off a ladder and falling into a tank, approximately 3-4 feet. The Petitioner reported pain in his lower leg and left lower back pain. The diagnosis at that time was of a sprain of unspecified collateral ligament of the right knee, and contusion of the lower back. The Petitioner was given a regular duty release at that time. (PX-1)

A follow-up exam occurred on January 22, 2019. The Petitioner reported right knee stiffness but improvement and improvement to his back but Petitioner was not sure if he could do his full job. Petitioner was ordered to have an x-ray on his knee and perform regular duty work. (PX-1)

On January 25, 2019, the Petitioner reported his knee was still feeling better but it would become sore at 2-3 hours of work. No other complaints reported at that time. Under the chief compliant section of the report low back pain was still listed.

On February 12, 2019, the Petitioner reported he was doing his regular job and working through the pain. The MRI results were reviewed at that time with a noted Grade 1 partial tear of the medial collateral ligaments. Small joint effusion. Mild partial thickness tear of the tibial insertion of the ACL. A referral order was then made to Dr. Sams for February 26, 2019. (PX-1)

On February 26, 2019, the Petitioner saw Dr. Sams for an evaluation of right knee pain. The Petitioner denied prior knee complaints and described his pain as starting from his fall at work. Dr. Sams opined that Petitioner's right knee injury was consistent with a medial meniscus tear. Two weeks of physical therapy were recommended and restrictions of avoiding ladders. If no progress was made, then Dr. Sams would consider a knee arthroscopy with partial meniscectomy. (PX-2)

On April 5, 2019, the Petitioner reported he was working with restrictions but continued to have complaints of sharp stabbing pain in the medial aspect of his knee. It was causing difficulty at work and he was unable to work out as well. Dr. Sams recommended surgery at that time and recorded that Petitioner's injury exacerbated his knee. (PX-2)

On May 1, 2019, the Petitioner underwent a right knee arthroscopy w/ partial medial meniscectomy. (PX-2)

On May 17, 2019, the Petitioner returned for a post-operative visit with some improvement noted. Petitioner was then released to light duty office work at that time. (PX-2)

A follow up exam took place July 2, 2019, the Petitioner reported that he was doing very well with no pain reported. He was released to return on an as needed basis with no restrictions as of July 8, 2019. (PX-2)

On August 1, 2019, the Petitioner reported to St. Mary's Emergency room with lower back pain, while trying to bend and connect machinery at work. Petitioner reported stabbing pain in his back at ADM. X-rays were taken that found grade 1 anterolisthesis at L5 on S1. (PX-4)

On August 16, 2019, the Petitioner reported to PA Phillippe Shills that he had injured his back on August 1. He was there for a referral for neurosurgery. He was given light duty restrictions on August 14 - August 21, 2019 with a return to work on August 22nd.

The Petitioner returned to Dr. Sam's on August 30, 2019, with right knee pain. The Petitioner described pain in his knee for the past 3-4 weeks, especially with squatting. He was prescribed anti-inflammatory and again released with no restrictions placed. (PX-3)

That same day, August 30, 2019, Petitioner reported to Dr. Atluri, a primary care physician, with reported back pain and right knee pain. The Petitioner described the January accident and that he was having a hard time performing his job. He set up an appointment with a neurosurgeon the following week. He was given light duty restrictions of no repetitive lifting, bending, crawling, and no steps. (PX-3)

On September 3, 2019, the Petitioner saw Dr. Mohammed Rahman, a neurosurgeon, it was recorded the Petitioner was there for low back pain and that his pain started after a work injury. The x-rays reviewed showed a L5 pars fracture with spondylolisthesis at L5-S1. Dr. Rahman recommend obtaining a CT scan of the lumbar spine and an MRI of the Lumbar Spine. (PX-5)

The Petitioner returned on October 8, 2019, upon reviewing the lumbar CT and MRI, Dr. Rahman recommended a L5-S1 Decompressive Lumbar Laminectormy with transforminal Lumbar Interbody Fusion. (PX-5)

The Petitioner testified that he has been off work and on disability since October of 2019 to the date of the trial. (Trans. pg. 28)

Dr. Rahman was deposed on February 13th, 2020. During the deposition, he reviewed the two dates of treatment and the diagnostic studies he ordered. Dr. Rahman identified what he opined was a chronic L5 pars fracture. (PX-6 pg. 7) Dr. Rahman noted that this fracture was identified in a 2016 CT taken before the accident in question. The reason the CT was taken in 2016 was not due to back pain but due to Petitioner's stomach issues. (PX-6 pg. 8) Dr. Rahman was given a lengthy hypothetical that dictated Petitioner injuring his back in January of 2019 when he fell off a ladder. Petitioner's pain persisted throughout but only grew worse when he returned to work full duty after his knee surgery and was released from care. Based upon the hypothetical facts, the Doctor opined that the Petitioner's January injury was an exacerbating and aggravating factor to his condition resulting in a need for surgery. (PX-6 pg. 11-14)

A records review by a Dr. Zelby was performed on August 8th, 2020. The medical history was reviewed. Based upon Petitioner's chronic findings on his diagnostic studies, it was Dr. Zelby's opinion that Petitioner's condition was chronic in nature. Petitioner did not consistently complain of his back issues and the August manifestation was simply a manifestation of Petitioner's chronic and degenerative back condition, not related to the January accident date. Dr. Zelby did agree that surgical intervention could be appropriate in this claim but not related to the work injury described.

In addressing why Petitioner did not continue to treat for his low back pain, Petitioner testified that the medication he was on for his knee helped his back pain, and that he was on light duty for most of the time in question. Petitioner testified that it was not until he was returned to work full duty that his pain increased and he sought further medical care.

A Kevin Howard, the third shift supervisor and supervisor to Petitioner, testified on behalf of the Respondent. (Trans. pg. 41-42) Mr. Howard testified that he did recall Petitioner having knee complaints while working but did not recall any time that Petitioner complained about his back, or any difficulty performing tasks due to his back. (Trans. pg. 44-45) Mr. Howard did confirm that Petitioner had an incident at work in August of 2019, he also confirmed Petitioner's description of his light duty assignment.

Conclusions of Law

In regard to disputed issues (F), (J) and (K), the Arbitrator makes the following conclusions of law:

The Arbitrator finds the testimony of Petitioner and Dr. Rahman to be more persuasive than thatof Dr. Zelby. Petitioner was found to be a credible witness. Almost all of his testimony concerning his job duties, light duty assignment, incidents were corroborated by Respondent's witness. The fact that Petitioner did not have consistent complaints of back pain throughout his treatment was concerning to the Arbitrator but the last note by occupational care documenting that Petitioner's back was doing better but he had not worked on it so he was unsure, matched Petitioner's testimony that his back pain was manageable until he returned to full duty work. A timeline that was confirmed by Respondent's witness.

Dr. Rahman agreed that Petitioner's condition was degenerative in nature but confirmed the timeline and nature of Petitioner's complaints but still linked the aggravation to Petitioner's January of 2019 injury. The fact that both physicians do agree that surgical intervention is necessary is persuasive to the Arbitrator.

Therefore, the Arbitrator finds in favor of the Petitioner in regard to causation, medical treatment, and prospective medical treatment.

In regard to disputed issues (L) the Arbitrator makes the following conclusions of law:

The Petitioner has been off work since October 15, 2019 until March 15, 2021. He was also off work from May 1, 2019 - June 9, 2019 for a total of 79.57 weeks. The respondent shall pay Petitioner 79.57 weeks of TTD at the rate of $455.93 subject to the credit of payments already made, and those of their short term, long term disability programs.

Edward Lee
Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC027913
Case Name	OLVERA, ROSARIO v. FEDERAL SIGNAL
Consolidated Cases	18WC004086
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0499
Number of Pages of Decision	13
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Mark Vizza

DATE FILED: 9/27/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosario Olvera,

Petitioner,

vs. NO: 17 WC 27913

Federal Signal,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, temporary disability, permanent disability, fees and penalties, and being advised of the facts and law, changes 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 met her burden of proving a compensable accident and causation to a current condition of ill-being of her left knee. The Arbitrator awarded Petitioner 8&4/7 weeks of temporary total disability benefits, $43,680.93 in medical expenses, 32.25 weeks of permanent partial disability benefits representing loss of the use of 15% of the left knee, and imposed penalties of $2,455.94 under §19(k), $10,000.00 under §19(l), and fees of $2,491.19 under §16. The Commission affirms and adopts the findings of the Arbitrator as well as her award in its entirety.

However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because this matter was not adjudicated under §19(b) and because the Decision of the Commission disposes of the instant claim in its entirety, the matter will not be remanded for determination of any additional benefits. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator and otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 26, 2021, is hereby affirmed and adopted with the changes noted above.

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.

There is no bond for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 27, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson

o9/15/21
DLS/rm
046

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0499
NOTICE OF ARBITRATOR DECISION

OLVERA, ROSARIO
Employee/Petitioner

Case# **17WC027913**
18WC004086

FEDERAL SIGNAL
Employer/Respondent

On 1/26/2021, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA
MARK F VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rosaria Olvera
Employee/Petitioner

v.

Federal Signal
Employer/Respondent

Case # **17** WC **27913**

Consolidated cases: **18 WC 4086**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **New Lenox**, on **9-10-2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Burden of proof under 19(l)**

FINDINGS

On the date of accident, **6/29/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**44,698.16**; the average weekly wage was $**859.58**.

On the date of accident, Petitioner was **61** 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 $1,859.59. for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $1,859.59..

ORDER

See consolidated case 18 WC 4086.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Jason C. Hyatt

Signature of Arbitrator

1-19-2021

Date

ICArbDec19(b)

JAN 26 2021

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSARIO OLVERA,
Petitioner,

v.

No.: 17 WC 27913 (*consolidated with*)
18 WC 4086

FEDERAL SIGNAL,
Respondent.

ADDENDUM TO THE DECISION OF THE ARBITRATOR

The Petitioner, Rosario Olvera, filed an application for adjustment of claim under the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2006) (Arb. 1).

17 WC 27913 and 18 WC 4086 have been consolidated.

This matter proceeded to hearing on September 10, 2020 in New Lenox, Illinois. (Id.) The following issues are in dispute:

- Accident
- Causal connection
- Unpaid medical bills
- TTD
- Penalties/fee's under sections 19(k), 19(l) and 16 of the Act (Id.).

Petitioner was employed by Respondent on the alleged accident date, June 29, 2017 (Id.) Petitioner testified that her job duties included lifting and stacking computer motherboards, moving heavy carts, and some type of seated work.

Prior to the incident at issue, Petitioner underwent left knee surgery in April 2016. An injection was administered to Petitioner's left knee approximately one week before the alleged accident. Petitioner testified that following her April 2016 surgery she returned to work for Respondent and was working full duty with no restrictions on June 29, 2017.

Regarding her alleged accident, Petitioner testified that on June 29, 2017 she was pulling and turning a heavy cart when she felt a sudden, sharp left knee pain. She notified Respondent of the incident a few days later, after which, Respondent sent her for medical treatment.
The medical records state that on July 5, 2017 Petitioner presented to Laura Healy, FNP at WorkForce Health in Monee, IL with a history of "pulling a very heavy cart" when she felt a "pull' in her left knee resulting in medial left knee pain that had not improved over the July 4th weekend (PX 1).

Petitioner reported a prior left knee arthroscopy in April of 2016 (Id.). On exam, Nurse Healy noted mild swelling over the medial aspect of Petitioner's knee and pain with palpation. Nurse Healy diagnosed a left knee sprain, applied a hinged knee brace and instituted seated work restrictions. A prescription for Naproxen was issued "per company protocol" (Id.)

On July 11, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee burning and swelling. An MRI without contrast was ordered (Id.)

On July 21, 2017 MRI of Petitioner's left knee noted the following:

1. Small knee joint effusion;

2. Fairly advanced degenerative disease of the medial meniscus, a tear in the anterior horn of the medial meniscus and extrusion of the body the meniscus into the medial joint recess;

3. Moderate degenerative changes in the patellofemoral joint;

4. Mild linear scarring along the posterior margin of Hoffa's fat pad secondary to previous arthroscopic surgery;

5. A tear in the anterior horn of the medial meniscus and advanced degenerative disease of the medial tibiofemoral compartment (Id.)

On July 25, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee pain accompanied by a pulling sensation. Nurse Healy recommended continued use of the knee brace and work restrictions through August 3, 2017 (Id.)

Nurse Healy obtained Petitioner's medical records concerning her left knee from Oak Orthopedics. A left knee MRI from September 14, 2015 indicated the following:

1. A complex tear of the anterior horn, complex tear of the medial meniscus and moderate thinning of the articular cartilage of the medial femorotibial compartment;

2. A medial collateral ligament sprain and lateral subluxation of the patella with mild thinning of the articular cartilage at the patellofemoral compartment.

On August 3, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee pain, swelling, numbness with weightbearing, and a burning sensation when walking. (Id.). On exam, Nurse Healy noted "the left knee appears more swollen than previously, over the medial aspect". Antalgic gait and pain with palpation were also noted on exam. Nurse Healy diagnosed a left knee strain, DJD of the left knee, and a medial meniscus tear. Petitioner signed a release related to her April 2016 arthroscopic surgery. Work restrictions were continued (Id.).

On August 8, 2017 Petitioner was released from care by Nurse Healy. No exam notes are contained in this record. Pursuant to her review the September 2015 MRI, the April 2016 surgical report, and the MRI from July 21, 2017, Nurse Healy noted the following:

> *After review of MRI and arthroscopic documentation, no new meniscal tear is present in Left knee. Will therefore discharge Rosario with advice to follow up with orthopedic doctor that she has seen in the past.*

Petitioner's work restrictions were continued pending that examination. Nurse Healy noted she "advised Rosario that her employer may elect not to continue restricted duty as she has been discharged" from our care (Id.)

Petitioner testified, and the exhibits corroborate, that up to this point in her treatment, she had only treated with Nurse Healy and had not been examined by any medical doctor (Id.)

The Petitioner introduced, and the Arbitrator takes judicial notice of, the Illinois Department of Professional Regulation Report indicating Laura Healy was licensed as an Advanced Practice Registered Nurse during 2017 (Px 9)

On August 23, 2017 Petitioner presented to orthopedic surgeon Dr. David Mehl at Specialty Physicians of Illinois. Dr. Mehl noted that Petitioner had a received a Synvisc injection in June 2017 and that one week later, she was injured at work on June 28, 2017 when she was pulling a cart and twisted her left knee (Px 2).

Dr. Mehl reviewed the July 21, 2017 MRI, noting a new medial meniscus tear and moderate degenerative disease (Id.). Regarding her prior surgery in April 2016, Dr. Mehl noted he performed a partial medial meniscectomy with resection of Petitioner's meniscus tear. According to Dr. Mehl, no remaining tear was present in Petitioner's left meniscus as evidenced by post-surgical imaging:

> *I have pictures showing the meniscectomy with complete resection of the tear.*
> *Work Comp is claiming that this was a preexisting problem, which is absolutely not the case and not true."*

Dr. Mehl noted that worker's comp "is claiming that this was a preexisting problem. Which is absolutely not the case and not true" (Id.).

On exam, Dr. Mehl noted severe tenderness over the medial joint line, positive McMurray's, limited range of motion and moderate crepitus. The doctor diagnosed a "[w]ork-related new left knee medial meniscus tear and moderate pre-existing left knee degenerative joint disease". He opined that Petitioner's work related injury necessitated a repeat left knee arthroscopy with partial medial meniscectomy and chondroplasty (Id.) Seated work restrictions with no twisting/turning were instituted (Id.).
On August 24, 2017 Jeannine Marciniak, Senior Claims Examiner at Respondent's carrier issued a letter to Petitioner denying liability for her accident claim. Ms. Marciniak relied upon the discharge

report in which Nurse Healy opined that "no new meniscus tear" was present in Petitioner's left knee (Id.).

On October 25, 2017 Dr. Mehl noted his request for surgery had been denied by Respondent's carrier and again opined that Petitioner's current condition was related to her work injury:

> *We submitted a claim through workman's comp due to an MRI demonstrating a medial meniscus tear and moderate DJD; however, that was denied with a designation of pre-existing condition. This claim by workman's comp is not the case because we performed a L knee arthroscopy on her on April 2016… and a medial meniscectomy and have pictures demonstrating the removal of the previous tear. There in fact is proof that this injury at work must have been the inciting event that caused a re-tear of the medial meniscus.*

Petitioner's seated work restrictions were continued (Id.)

On December 20, 2017 Dr. Mehl again noted the Petitioner was in need of surgery and that such would proceed under her personal insurance as her workers compensation had been denied. Petitioner's sedentary work restrictions were noted (Id.)

On December 29, 2017 the Petitioner underwent a repeat left knee arthroscopy, diffuse chondroplasty and partial medial meniscectomy, performed by Dr. Mehl at Franciscan Health Chicago Heights. The post-operative diagnosis noted a work related new medial meniscus tear (Px 5).

On January 3, 2018 Petitioner followed up with Dr. Mehl who issued off work restrictions for an additional 3 weeks (Px 2).

On February 21, 2018 Dr. Mehl released Petitioner to seated work beginning February 26, 2018 (Px 2)

Physical therapy records indicate that on March 19, 2018, after completing 24 sessions for her left knee, Petitioner's complaints included intermittent pain with ambulation and stair climbing along with decreased left quad strength and stability. The therapist noted that Petitioner met 3/4 of her short term and 1/3 of her long term goals (Px 4)

On March 21, 2018 a Synvisc injection was administered to Petitioner's left knee. Dr. Mehl advised Petitioner to follow up for another injection in 6 months. He again opined the injury and need for treatment were work related. Petitioner was released to full duty work. (Px 2)

Petitioner testified she hastened her return to work in advance of medical recommendations due to financial considerations. This is corroborated by Dr. Mehl's December 20, 2017 note in which he placed her off work through March 5, 2018, but the Petitioner returned to light duty work on February 26, 2018. (Px 2)

The parties stipulated the Petitioner had received $1,859.59 in short term disability (STD) benefits at the rate of $371.91 per week, significantly lower than the stipulated TTD benefit rate of $573.05.

Petitioner testified the difference between her earnings and her STD benefit caused economic hardship.

On June 18, 2020 (almost three years following her alleged work accident) the Petitioner was examined by Dr. James Leonard, an orthopedic surgeon at Midwest Orthopaedic Consultants, pursuant to Respondent's Section 12 request (Rx 1).

Regarding permanency, Petitioner testified she has pain and weakness in her left knee. She further testified that she cannot walk, sit or stand for long periods of time. She continues to wear a knee brace every day.

Petitioner testified she retired in January 2019, in part, due to concerns for her safety as she no longer felt her knee was safe to work on.

CONCLUSIONS OF LAW

See consolidated case 18 WC 4086.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC004086
Case Name	OLVERA, ROSARIO v. FEDERAL SIGNAL
Consolidated Cases	17WC027913
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0500
Number of Pages of Decision	17
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Mark Vizza

DATE FILED: 9/27/2021

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosario Olvera,

Petitioner,

vs. NO: 18 WC 4086

Federal Signal,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, temporary disability, permanent disability, fees and penalties, and being advised of the facts and law, changes 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 met her burden of proving a compensable accident and causation to a current condition of ill-being of her left knee. The Arbitrator awarded Petitioner 8&4/7 weeks of temporary total disability benefits, $43,680.93 in medical expenses, 32.25 weeks of permanent partial disability benefits representing loss of the use of 15% of the left knee, and imposed penalties of $2,455.94 under §19(k), $10,000.00 under §19(l), and fees of $2,491.19 under §16. The Commission affirms and adopts the findings of the Arbitrator as well as her award in its entirety.

However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because this matter was not adjudicated under §19(b) and because the Decision of the Commission disposes of the instant claim in its entirety, the matter will not be remanded for determination of any additional benefits. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator and otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 26, 2021, is hereby affirmed and adopted with the changes noted above.

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.

There is no bond for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

September 27, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson

o9/15/21
DLS/rm
046

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0500

OLVERA, ROSARIA
Employee/Petitioner

Case# **18WC004086**
17WC027913

FEDERAL SIGNAL
Employer/Respondent

On 1/26/2021, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN & MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA
MARK F VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **Will**)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rosaria Olvera
Employee/Petitioner

v.

Federal Signal
Employer/Respondent

Case # **18** WC **4086**

Consolidated cases: **17 WC 27913**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **New Lenox**, on **9-10-2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Burden of proof under 19(l)**

FINDINGS

On the date of accident, **6/29/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**44,698.16**; the average weekly wage was $**859.58**.

On the date of accident, Petitioner was **61** 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 $1,859.59. for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $1,859.59..

ORDER

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $515.75/week for 32.25 weeks, due to the injuries sustained which caused a 15% loss of the left leg, as provided in Section 8(e) of the Act (See attached Addendum for analysis).

TTD

Respondent is liable for TTD from December 29, 2017 through February 26, 2018 which equals 8 and 4/7 weeks of TTD at a rate of $573.06 for a total of $4,911.07, subject to Respondent's credit for $1,859.59 for STD benefits paid under 8(j). 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.

MEDICAL

Respondent shall pay reasonable and necessary medical services of $43,680.93, as provided in Section 8(a) of the Act.

Penalties

Respondent shall pay to Petitioner penalties of $2,491.19, as provided in §16 of the Act; $2,455.94, as provided in § 19(k) of the Act; and $10,000.00, as provided in § 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.

Jason C. Myatt

Signature of Arbitrator

1-19-2021
Date

ICArbDec19(b)

JAN 26 2021

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSARIO OLVERA,
Petitioner,

v.

No.: 18 WC 40861 (*consolidated with*)
17 WC 27913

FEDERAL SIGNAL,
Respondent.

ADDENDUM TO THE DECISION OF THE ARBITRATOR

The Petitioner, Rosario Olvera, filed an application for adjustment of claim under the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2006) (Arb. 1).

17 WC 27913 and 18 WC 4086 have been consolidated.

This matter proceeded to hearing on September 10, 2020 in New Lenox, Illinois. (Id.) The following issues are in dispute:

- Accident
- Causal connection
- Unpaid medical bills
- TTD
- Penalties/fee's under sections 19(k), 19(l) and 16 of the Act (Id.).

Petitioner was employed by Respondent on the alleged accident date, June 29, 2017 (Id.) Petitioner testified that her job duties included lifting and stacking computer motherboards, moving heavy carts, and some type of seated work.

Prior to the incident at issue, Petitioner underwent left knee surgery in April 2016. An injection was administered to Petitioner's left knee approximately one week before the alleged accident. Petitioner testified that following her April 2016 surgery she returned to work for Respondent and was working full duty with no restrictions on June 29, 2017.

Regarding her alleged accident, Petitioner testified that on June 29, 2017 she was pulling and turning a heavy cart when she felt a sudden, sharp left knee pain. She notified Respondent of the incident a few days later, after which, Respondent sent her for medical treatment.
The medical records state that on July 5, 2017 Petitioner presented to Laura Healy, FNP at WorkForce Health in Monee, IL with a history of "pulling a very heavy cart" when she felt a "pull' in her left

knee resulting in medial left knee pain that had not improved over the July 4th weekend (PX 1). Petitioner reported a prior left knee arthroscopy in April of 2016 (Id.). On exam, Nurse Healy noted mild swelling over the medial aspect of Petitioner's knee and pain with palpation. Nurse Healy diagnosed a left knee sprain, applied a hinged knee brace and instituted seated work restrictions. A prescription for Naproxen was issued "per company protocol" (Id.)

On July 11, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee burning and swelling. An MRI without contrast was ordered (Id.)

On July 21, 2017 MRI of Petitioner's left knee noted the following:

1. Small knee joint effusion;

2. Fairly advanced degenerative disease of the medial meniscus, a tear in the anterior horn of the medial meniscus and extrusion of the body the meniscus into the medial joint recess;

3. Moderate degenerative changes in the patellofemoral joint;

4. Mild linear scarring along the posterior margin of Hoffa's fat pad secondary to previous arthroscopic surgery;

5. A tear in the anterior horn of the medial meniscus and advanced degenerative disease of the medial tibiofemoral compartment (Id.)

On July 25, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee pain accompanied by a pulling sensation. Nurse Healy recommended continued use of the knee brace and work restrictions through August 3, 2017 (Id.)

Nurse Healy obtained Petitioner's medical records concerning her left knee from Oak Orthopedics. A left knee MRI from September 14, 2015 indicated the following:

1. A complex tear of the anterior horn, complex tear of the medial meniscus and moderate thinning of the articular cartilage of the medial femorotibial compartment;

2. A medial collateral ligament sprain and lateral subluxation of the patella with mild thinning of the articular cartilage at the patellofemoral compartment.

On August 3, 2017 Nurse Healy noted Petitioner's complaints of persistent left knee pain, swelling, numbness with weightbearing, and a burning sensation when walking. (Id.). On exam, Nurse Healy noted "the left knee appears more swollen than previously, over the medial aspect". Antalgic gait and pain with palpation were also noted on exam. Nurse Healy diagnosed a left knee strain, DJD of the left knee, and a medial meniscus tear. Petitioner signed a release related to her April 2016 arthroscopic surgery. Work restrictions were continued (Id.).

On August 8, 2017 Petitioner was released from care by Nurse Healy. No exam notes are contained in this record. Pursuant to her review the September 2015 MRI, the April 2016 surgical report, and the MRI from July 21, 2017, Nurse Healy noted the following:

> *After review of MRI and arthroscopic documentation, no new meniscal tear is present in Left knee. Will therefore discharge Rosario with advice to follow up with orthopedic doctor that she has seen in the past.*

Petitioner's work restrictions were continued pending that examination. Nurse Healy noted she "advised Rosario that her employer may elect not to continue restricted duty as she has been discharged" from our care (Id.)

Petitioner testified, and the exhibits corroborate, that up to this point in her treatment, she had only treated with Nurse Healy and had not been examined by any medical doctor (Id.)

The Petitioner introduced, and the Arbitrator takes judicial notice of, the Illinois Department of Professional Regulation Report indicating Laura Healy was licensed as an Advanced Practice Registered Nurse during 2017 (Px 9)

On August 23, 2017 Petitioner presented to orthopedic surgeon Dr. David Mehl at Specialty Physicians of Illinois. Dr. Mehl noted that Petitioner had a received a Synvisc injection in June 2017 and that one week later, she was injured at work on June 28, 2017 when she was pulling a cart and twisted her left knee (Px 2).

Dr. Mehl reviewed the July 21, 2017 MRI, noting a new medial meniscus tear and moderate degenerative disease (Id.). Regarding her prior surgery in April 2016, Dr. Mehl noted he performed a partial medial meniscectomy with resection of Petitioner's meniscus tear. According to Dr. Mehl, no remaining tear was present in Petitioner's left meniscus as evidenced by post-surgical imaging:

> *I have pictures showing the meniscectomy with complete resection of the tear.*
> *Work Comp is claiming that this was a preexisting problem, which is absolutely not the case and not true."*

Dr. Mehl noted that worker's comp "is claiming that this was a preexisting problem. Which is absolutely not the case and not true" (Id.).

On exam, Dr. Mehl noted severe tenderness over the medial joint line, positive McMurray's, limited range of motion and moderate crepitus. The doctor diagnosed a "[w]ork-related new left knee medial meniscus tear and moderate pre-existing left knee degenerative joint disease". He opined that Petitioner's work related injury necessitated a repeat left knee arthroscopy with partial medial meniscectomy and chondroplasty (Id.) Seated work restrictions with no twisting/turning were instituted (Id.).
On August 24, 2017 Jeannine Marciniak, Senior Claims Examiner at Respondent's carrier issued a letter to Petitioner denying liability for her accident claim. Ms. Marciniak relied upon the discharge

report in which Nurse Healy opined that "no new meniscus tear" was present in Petitioner's left knee (Id.).

On October 25, 2017 Dr. Mehl noted his request for surgery had been denied by Respondent's carrier and again opined that Petitioner's current condition was related to her work injury:

> *We submitted a claim through workman's comp due to an MRI demonstrating a medial meniscus tear and moderate DJD; however, that was denied with a designation of pre-existing condition. This claim by workman's comp is not the case because we performed a L knee arthroscopy on her on April 2016… and a medial meniscectomy and have pictures demonstrating the removal of the previous tear. There in fact is proof that this injury at work must have been the inciting event that caused a re-tear of the medial meniscus.*

Petitioner's seated work restrictions were continued (Id.)

On December 20, 2017 Dr. Mehl again noted the Petitioner was in need of surgery and that such would proceed under her personal insurance as her workers compensation had been denied. Petitioner's sedentary work restrictions were noted (Id.)

On December 29, 2017 the Petitioner underwent a repeat left knee arthroscopy, diffuse chondroplasty and partial medial meniscectomy, performed by Dr. Mehl at Franciscan Health Chicago Heights. The post-operative diagnosis noted a work related new medial meniscus tear (Px 5).

On January 3, 2018 Petitioner followed up with Dr. Mehl who issued off work restrictions for an additional 3 weeks (Px 2).

On February 21, 2018 Dr. Mehl released Petitioner to seated work beginning February 26, 2018 (Px 2)

Physical therapy records indicate that on March 19, 2018, after completing 24 sessions for her left knee, Petitioner's complaints included intermittent pain with ambulation and stair climbing along with decreased left quad strength and stability. The therapist noted that Petitioner met 3/4 of her short term and 1/3 of her long term goals (Px 4)

On March 21, 2018 a Synvisc injection was administered to Petitioner's left knee. Dr. Mehl advised Petitioner to follow up for another injection in 6 months. He again opined the injury and need for treatment were work related. Petitioner was released to full duty work. (Px 2)

Petitioner testified she hastened her return to work in advance of medical recommendations due to financial considerations. This is corroborated by Dr. Mehl's December 20, 2017 note in which he placed her off work through March 5, 2018, but the Petitioner returned to light duty work on February 26, 2018. (Px 2)

The parties stipulated the Petitioner had received $1,859.59 in short term disability (STD) benefits at the rate of $371.91 per week, significantly lower than the stipulated TTD benefit rate of $573.05.

Petitioner testified the difference between her earnings and her STD benefit caused economic hardship.

On June 18, 2020 (almost three years following her alleged work accident) the Petitioner was examined by Dr. James Leonard, an orthopedic surgeon at Midwest Orthopaedic Consultants, pursuant to Respondent's Section 12 request (Rx 1).

Regarding permanency, Petitioner testified she has pain and weakness in her left knee. She further testified that she cannot walk, sit or stand for long periods of time. She continues to wear a knee brace every day.

Petitioner testified she retired in January 2019, in part, due to concerns for her safety as she no longer felt her knee was safe to work on.

CONCLUSIONS OF LAW

Credibility of Petitioner

The Arbitrator observed Petitioner's affect and presentation and found her to be a credible witness who presented as sincere, open, and honest. She withstood rigorous cross-examination by Respondent's attorney. The medical evidence in the record evidence documents a history of consistent reporting regarding Petitioner's accident, symptoms, and prior left knee treatment. The Arbitrator found no evidence of malingering or symptom magnification. Accordingly, Petitioner's testimony is deemed credible and afforded a great deal of weight by the Arbitrator

ACCIDENT

Petitioner's credible, unrebutted testimony established that she sustained a work related accident and injury on June 29, 2017. On that date, Petitioner was pulling and turning a heavy cart when she felt sharp pain in the medial aspect of her left knee. This history of accident and mechanism of injury are consistently documented in the medical evidence contained in the record.

Based on a preponderance of the credible evidence contained in the record the Arbitrator finds that Petitioner has sustained her burden with respect to this issue.

CAUSAL CONNECTION

The Arbitrator finds the evidence contained in the record, including the Petitioner's credible testimony, the supporting medical records, and the opinions of Dr. Mehl, supports a finding that the meniscus tear in Petitioner's left knee identified by Dr. Mehl was causally related Petitioner's June 2017 work related accident.
Regarding her pre-existing left knee condition, Petitioner underwent left knee surgery in April of 2016 and was released to full duty work for Respondent on July 11, 2016. Petitioner continued

working her full duty job for nearly one year before the work accident at issue. Petitioner's job required her to lift and stack computer motherboards and push/pull heavy carts of equipment. Although an injection was administered to Petitioner's left knee one week before this work accident there is no evidence that a second arthroscopic procedure was indicated between the time that Petitioner returned to full duty work (following her first surgery) and the accident at issue.

The evidence supports a finding that Petitioner's knee deteriorated *after* this accident, resulting in her inability to perform her pre-accident job duties. Petitioner was restricted to sedentary work duties by Respondent's occupational provider days after this accident. (Px 1).

The Arbitrator places significant weight on and adopts the opinions of Petitioner's treating surgeon, Dr. Mehl, whose conclusions are supported by objective medical testing and his personal observations of the Petitioner's condition over the course of several years.

Regarding the condition of Petitioner's pre-work accident left knee, Dr. Mehl noted that following the partial medial meniscectomy he performed on Petitioner in April of 2016 no remaining tear was present. Pursuant to his review of the post-work accident left knee MRI (performed less than 3 weeks after the accident at issue), Dr. Mehl noted a new medial meniscus tear and moderate degenerative disease in Petitioner's left knee(Id.). Dr. Mehl opined that Petitioner's work related accident was causally connected to her condition which necessitated a repeat left knee arthroscopy and partial medial meniscectomy and chondroplasty (Id.)

The Arbitrator finds the opinions of Respondent's IME less credible as he did not provide a sufficient foundation to establish the reliability of his opinion. Many facts upon which Dr. Leonard based his opinion are either irrelevant or contradicted by the record. Dr. Leonard did not address, much less refute Dr. Mehl's opinion and Dr. Leonard failed to address the fact that Petitioner was working full duty before the accident yet was restricted to sedentary work duties after. Further, Dr. Leonard did not review critical medical evidence including the surgical images that document the condition of Petitioner's first knee surgery in April 2016 and Dr. Mehl's surgical report from the December 29, 2017 documenting the repeat left knee arthroscopy, diffuse chondroplasty and partial medial meniscectomy (Rx 1).

After careful consideration, the Arbitrator finds Petitioner has sustained her burden regarding this issue.

MEDICAL BILLS

The Arbitrator finds the Petitioner has proven by a preponderance of the credible evidence that the medical services provided through March 21, 2018 were reasonable and necessary. The Arbitrator relies upon the treating medical records contained in the record and the opinions of Dr. Mehl.

The Respondent is liable for the following unpaid bills:

Specialty Physicians of Illinois	$3,284.00

Vertical Plus MRI	$1,632.00
Monee WorkForce Health	$629.00
Franciscan Alliance Surgery	$19,136.93
Franciscan Alliance Physical Therapy	$13,896.00
NorthStar Anesthesia	$5,103.00

TTD

The Petitioner has proven by a preponderance of the credible evidence that she was temporarily totally disabled from December 29, 2017 through February 26, 2018 which equals 8 and 4/7 weeks of TTD.

The parties stipulated to a credit for STD benefits paid under 8(j) in the amount of $1859.59.

NATURE AND EXTENT OF THE INJURY

Because Petitioner's accident occurred after September 1, 2011, the Commission must base its decision on the five factors of Section 8.1(b) of the Act for guidance in determining nature and extent. The five factors are: (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.

Subsection (i) of §8.1(b) is not relevant as no AMA rating was provided by either party.

Subsection (ii) of §8.1(b), the occupation of the injured employee, is given moderate weight. Although Petitioner returned to her prior position for Respondent, she elected to retire approximately one year after her surgery because she felt unsafe performing her job duties due to the condition of her left knee.

Subsection (iii) of §8.1(b), the age of the injured employee, is given moderate weight. The Petitioner was 61 years old at the time of this accident. More likely than not, Petitioner will continue to experience pain and limitations related to her left knee for the remainder of her life.

Subsection (iv) of §8.1(b), the employee's future earning capacity, is given no weight as no evidence was introduced by either party regarding this issue.

Subsection (v) of §8.1(b), the evidence of disability corroborated by the medical records, is given significant weight. Petitioner testified she has pain and weakness in her left knee and cannot walk, sit, or stand for long periods of time and has to time wear a knee brace every day. The Arbitrator finds Petitioner's testimony regarding permanency is corroborated by the medical records which reflect a diagnosis of a meniscus tear injury requiring a repeat arthroscopic left knee partial medial meniscectomy. The therapy records indicate that on March 19, 2018, after completing 24 physical therapy sessions, Petitioner's complaints included intermittent pain with ambulation and stair

climbing along with decreased left quad strength and stability. The therapist noted that Petitioner met 3/4 of her short term and 1/3 of her long term goals

Regarding Petitioner's prior left knee surgery, there is no evidence of a credit on that limb, nor claim that it was a work place related accident.

Pursuant to the above analysis the Arbitrator awards the Petitioner 15% of the left leg.

PENALTIES AND FEES

The Arbitrator finds the Petitioner is entitled to penalties pursuant to Sections 19(l) and 19(k) and attorney's fees under Section 16 of the Act. The Respondent produced no witnesses or correspondence regarding their denial of benefits at time of trial.

Petitioner's June 29, 2017 work related accident and subsequent injuries were well documented. She treated with Respondent's occupational health care provider from July 5, 2017 until her discharge on August 8, 2017. Between the accident date and her discharge from care by Nurse Healy, Petitioner was not seen, nor was her case evaluated, by a medical doctor.

The treating records of Dr. Mehl contain several written requests for authorization of the proposed surgery. Dr. Mehl's first request for authorization occurred on August 23, 2017. Dr. Mehl reviewed the July 21, 2017 MRI, noting a new medial meniscus tear and moderate degenerative disease (Px 2). Dr. Mehl indicated that following the partial medial meniscectomy he performed in April 2016 surgery no remaining tear was present in Petitioner's left knee as evidenced by radiological images:

Respondent's denial of Petitioner's claim was written by Respondent's carrier on August 24, 2017 (Px 8).). The correspondence quotes the determination of Laura Healy, FNP of Monee WorkForce Health as the justification for denial. (Id.).

On October 25, and December 20, 2017 Dr. Mehl noted that his requests for surgery had been denied by Respondents carrier.

The Arbitrator finds Respondent's reliance on the opinion of a family nurse practitioner to contradict the opinion of a treating orthopedic surgeon to have been unreasonable.

Further, the Respondent waited 34 months after the accident to obtain a Section 12 examination (more than 2 years after the Petitioner reached MMI). Pursuant to his June 2020 IME, Dr. Leonard found a work related aggravation of the Petitioner's existing condition. He further opined Petitioner could have benefitted from a cortisone injection, a medial unloader brace, or physical therapy due to her injuries. (Rx 1) Had Respondent availed themselves of their Section 12 rights in July or August of 2017, Petitioner would likely have undergone the non-surgical recommendations per Dr. Leonard's June of 2020 report.

The Arbitrator notes that *had* she found Dr. Leonard's conclusions more credible that Dr. Mehl's, she would nonetheless award penalties as Dr. Leonard found that additional conservative care would have been reasonable and related. It is *possible* that Petitioner's claim could have resolved by following Dr. Leonard's recommendations care, including the injections, bracing, and therapy retrospectively suggested by Dr. Leonard. That this option was not explored is the result of Respondent's neglect.

The Arbitrator finds that Respondent has failed to provide any meaningful evidence to deny the treatment recommended by Dr. Mehl (or the treatments eventually approved by their IME Dr. Leonard). The Respondent's failure to approve requested care during the period of August 2017 through December 2017 is therefore unreasonable and deserving of penalty.

Regarding the claim for payments of TTD benefits after the Petitioner's surgery, the Arbitrator finds that the Respondent behaved in a vexatious manner. The Respondent made its denial of TTD at that time without medical basis, as the Section 12 examination was more than 24 months after her return to work. Per prior Commission decisions (as in *Emily Thomas v. Pace* No. 14 W.C. 3543, No. 16 I.W.C.C. 0172) the Respondent has an obligation to seek out a timely Section 12 examination and to provide benefits in the advance of such exam.

The Arbitrator finds it appropriate to award the Petitioner the full amount of penalties available. While Respondent now relies on the opinion of Dr. Leonard to deny TTD, it had no such justification at that time. The credit of $371.91 per week for 5 weeks did not adequately replace Petitioner's TTD at $573.05 owed for 8 4/7 weeks, and the Petitioner's unrebutted testimony regarding economic hardship and an early return to work stand unrebutted.

The Petitioner was owed temporary total disability benefits from December 29, 2017 through February 26, 2018, a period of 8 and 4/7 weeks which remain unpaid at the rate of $573.05 for a total of $4,911.88. Pursuant to Section 19(k), Respondent shall pay to Petitioner penalties of 50% of $4,911.88, or $2,455.94.

Respondent shall further pay Petitioner penalties under Section 19(l) which equal $30 per day for each day benefits were withheld. As the Respondent continued to deny payment of pre-surgical medical bills which were reasonable per Dr. Leonard's Section 12 report, the Arbitrator awards penalties from 8/23/17 through 9/10/20 (date of trial), a period of 1114 days, for a maximum statutory benefit of $10,000.

Finally, Respondent shall pay additional attorney's fees to Petitioner's attorney in the amount of $2,491.19 (that being 20% of the $2,455.94 and $10,000 awarded above pursuant to Section 16).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC010957
Case Name	TAYLOR, NANCY A v. CITY OF CHICAGO
Consolidated Cases	No Consolidated Cases
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0501
Number of Pages of Decision	24
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Patrick Nicholson
Respondent Attorney	Matthew Locke

DATE FILED: 9/30/2021

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NANCY TAYLOR,

Petitioner,

vs. NO: 14WC 10957

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care,temporary total disability, penalties pursuant to Sections 19(k), 19(l), and attorneys' fees pursuant to Section 16, and being advised of the facts and law, corrects 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. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission hereby corrects the Decision of the Arbitrator to award maintenance benefits commencing October 25, 2018 through November 19, 2019.

The Commission, after reviewing the issue of penalties pursuant to Section 19(l) and 19(k), and attorneys' fees under Section 16 of the Act views the evidence differently. Petitioner sustained serious injuries in a work-related accident on March 7, 2014. She was employed by Respondent as a tree trimmer when a large, heavy tree trunk fell on her causing a comminuted,

displaced pelvic fracture, spinal injuries, and injury to her right knee and right shoulder. Her pelvic fracture was unstable and required surgical reduction which was performed by Dr. Chandler. Petitioner underwent multiple surgeries and her rehabilitation was complicated by the combination of upper and lower extremity injuries, and pelvic and spinal instability. She was treated by a team of physicians that included specialists in orthopedics, physical medicine, and pain management.

Petitioner was confined to a wheelchair for a period and then progressed to a walker and finally relied upon a cane when ambulating outside her home. She underwent extensive physical therapy to treat severe back pain and regain as much function as possible. In 2016 she underwent a spinal fusion and a spinal cord stimulator was installed in November 2016 for intractable back pain.

On April 25, 2017 Dr. Chandler, Petitioner's treating orthopedic surgeon placed permanent restrictions that included a 10 lb. lifting limitation, no overhead lifting, limited standing and walking, no stairs or climbing, and no use of heavy equipment. Petitioner underwent a Section 12 evaluation by Dr. Candido at the request of Respondent on September 26, 2017. Dr. Candido opined that she was able to return to light duty work with a 25 lb. lifting restriction and limitations on walking and no overhead lifting.

Petitioner underwent a Functional Capacity Evaluation on April 11, 2018 which was suspended due to concerns about exertional blood pressure elevation. A second FCE was performed on April 26, 2018 following medical clearance, which the evaluator determined to be not valid and not representative of Petitioner's functional performance.

Respondent terminated Petitioner's temporary total disability benefits on May 12, 2018 without explanation. Petitioner filed a Petition seeking penalties and fees. Respondent did not file a response to the Petition. On June 12, 2018 Dr. Chandler commented on the invalid FCE in his clinical note attributing the "submaximal performance" to a misinterpretation of Petitioner's baseline threshold of pain by the evaluator. TTD benefits were not restored until August 12, 2018.

Respondent City of Chicago sent a letter dated August 2, 2018 stating that the suspension of TTD benefits was the result of an IME by Respondent's retained Section 12 examiner Dr. Candido. In a report dated July 14, 2014 Dr. Candido gave Petitioner a full duty work release and declared her to be at MMI without having reevaluated her since September 2017.

Respondent fails to explain how the termination of TTD benefits on May 12, 2018 could possibly have been based upon an opinion from Dr. Candido that was not received until July 14, 2018.The Commission finds that these benefits were terminated without the benefit of any medical opinion.

The Commission finds Dr. Candido's credentials to be relevant in evaluating the validity and persuasiveness of his opinions. Dr. Candido is board certified in anesthesiology and maintains a pain management practice. He is not trained in orthopedics or rehabilitation medicine. His qualifications to opine on Petitioner's functional ability to return to full duty work as a tree trimmer given the severity of her injuries are not persuasive. It is difficult to comprehend the logic employed by Respondent in relying upon a Section 12 expert whose expertise is in pain management to evaluate the care and treatment rendered Petitioner and assess her functional abilities.

The Commission finds that Respondent's conduct in withholding temporary total disability benefits for the period of May 12, 2018 through August 2, 2018 was objectively unreasonable and represents the vexatious conduct Sections 19(k) and 19(l) of the Act were intended to address. The Commission finds that TTD benefits were reinstituted by the efforts of Petitioner's attorney in filing a Petition for Penalties and Fees. For the foregoing reasons the Commission awards penalties in the amount of $2,209.37 pursuant to Section 19(k) of the Act, penalties pursuant to Section 19(l) in the amount of $5,523.42, and attorneys' fees pursuant to Section 16 in the amount of $2,209.37.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $920.57 per week commencing May 12, 2018 through August 7,2018, for a period of 241 5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses, adjusted pursuant to the medical fee schedule of $22,430.00 to Dr. Angelopoulos, $3,378.25 and $724.00 to South Chicago Orthopedics, $801.45 to ATI, $2,442.20 to Dr. Troy, $5,666.78 to Prescription Partners, and $1,020.00 to Premier Healthcare Services pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner maintenance benefits of $920.57 per week for a period of 55 6/7 weeks commencing October 25, 2018 through November 19, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment recommended by Dr. Steven Chandler, Dr. Richard Troy, Dr. George Angelopoulos, and any necessary follow up care.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $258,773.37 for temporary total disability benefits, maintenance benefits, and the permanent partial disability advance that has been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties pursuant to Section 19(k) of the Act in the sum of $2,209.37, penalties pursuant to Section 19(l) of the Act in the sum of $5,523.42, and attorneys' fees pursuant to Section 16 of the Act in the sum of $2,209.37.

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 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.

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.

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 the Circuit Court.

September 30, 2021

o- 08/18/21
SM/msb
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

21IWCC0501

TAYLOR, NANCY A
Employee/Petitioner

Case# **14WC010957**

CITY OF CHICAGO
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:

0147 CULLEN HASKINS NICHOLSON ET AL
PATRICK B NICHOLSON
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0010 CITY OF CHICAGO CORP COUNSEL
MATTHEW LOCKE
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STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nancy A. Taylor
Employee/Petitioner

Case # 14 WC 010957
Consolidated Cases: None

v.

City of Chicago
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Illinois Workers' Compensation Commission, in the city of **Chicago**, on **November 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. ☐ 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, **3/7/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$71,804.79**; the average weekly wage was **$1,380.86.00**.

On the date of accident, Petitioner was **51** 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 **$204,275.12** for TTD, **$0** for TPD, **$50,889.95** for maintenance, and **$3,608.30** for PPD advance, for a total credit of **$258,773.37**.

Respondent is entitled to a credit of **$0** under §8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $920.57/week for **241 &5/7** weeks, **commencing March 8, 2014 through October 24, 2018**.

Respondent shall pay Petitioner maintenance benefits of $920.57/week for **55 & 6/7** weeks, **commencing March 7, 2014 through November 19, 2019** as provided in §8(a) of the Act.

Respondent shall be given a credit of $258,773.37 for temporary total disability benefits, maintenance benefits, and the permanent partial disability advance that has been paid.

Respondent shall pay reasonable and necessary medical services, adjusted pursuant to the medical fee schedule, of $22,430.00 to Dr. Angelopoulos, $3,378.25 and $724.00 to South Chicago Orthopedics, $801.45 to ATI, $2,442.20 to Dr. Troy, $5,666.78 to Prescription Partners, and $1,020.00 to Premier Healthcare Services.

Respondent shall further authorize and pay for prospective medical treatment recommended by Dr. Steven Chandler, Dr. Richard Troy, Dr. George Angelopoulos, and any necessary follow up care.

Respondent shall pay Petitioner penalties of $10,000.00, as provided in §19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

April 8, 2020
Date

APR 14 2020

Nancy Taylor v. City of Chicago
14 WC 10957

INTRODUCTION

This matter proceeded to hearing on November 19, 2019 before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is the Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to the Petitioner reasonable and necessary? Has the Respondent paid all appropriate charges for all reasonable and necessary medical services? Is the Petitioner entitled to any prospective medical care?; ***L:*** What temporary total disability benefits are in dispute? TTD; and ***M:*** Should penalties be imposed upon Respondent?

FINDINGS OF FACT

Petitioner Nancy Taylor was employed by Respondent City of Chicago Bureau of Forestry as a tree trimmer. Petitioner's essential duties, as set forth in the job description from Respondent (PX #16) included climbing trees, being lifted in a mechanical device to remove tree limbs with power saws or pruners, cut tree trucks on the ground with power saws, loading tree trunks onto trucks, paring trees and using various equipment for planting, transplanting and pruning trees. The logs weigh from 50-75 pounds. Petitioner worked for Respondent about 10 years.

Petitioner testified that on March 7, 2014, a tree trunk approximately 18 inches in diameter and 7 feet long fell on her, after she had fallen to the ground. She had been cutting the tree when she stopped to help a colleague. When she returned to cutting the tree, she heard a crackling sound, which she knew to mean something was going to happen with the tree. Petitioner then threw her chainsaw away and fell to the ground. The tree trunk came down on her between her knees and chest. She testified that her whole body was numb.

Petitioner was transported by ambulance to Advocate Trinity Hospital with complaints of back pain, hip pain, and right thigh pain (PX #2). A CT confirmed a comminuted fracture of the left ilium at the sacroiliac joint with mild separation of fracture fragments, fractures of the bilateral superior and inferior pubic rami. The right superior pubic ramus fracture is comminuted with small displacement. CT of the lumbar spine demonstrated no fracture or spondylolisthesis but a small disc herniation or bulge at L4-5 contributed to mild central canal stenosis. CT of the cervical spine demonstrated asymmetric left-sided facet arthrosis at C2-3 and moderate disc space narrowing and

degenerative changes at C5-6. There were also disc osteophyte complexes at C4-5 and C5-6, contributing to central spinal canal stenosis. Petitioner was then transferred to Advocate Christ Hospital.

Petitioner was admitted to Advocate Christ Hospital and remained an inpatient until March 15, 2014. On March 11, 2014, Petitioner underwent an open reduction internal fixation of her pelvis for pelvic ring fractures with bilateral superior and inferior pubic rami fractures and left iliac c-wing fracture with a disruption of the left sacroiliac joint by Dr. Steven Chandler, D.O. (PX #3).

Petitioner was then transferred to Manor Care for rehabilitative care. She used a wheelchair and walker until on April 10, 2014. While in Manor Care, Dr. Durudogan Petitioner's complaints of pain and problems to her right shoulder. An MRI of the right shoulder was ordered by Dr. Chandler, which showed a moderately sized full thickness anterior supraspinatus insertional tear with prominent tendinosis in the remainder of the supraspinatus and infraspinatus and peritoneal tightness with no significant muscle atrophy (PX #4 & PX #5).

When Petitioner was discharged to home, she received home occupational and physical therapy, as well as nursing visits (PX #5). Dr. Chandler prescribed a course of physical therapy which began at Athletico on May 20, 2014. Dr. Chandler noted that Petitioner needed to be full weight bearing before he could perform right shoulder surgery. Petitioner was initially discharged from Athletico on August 4, 2014 with limited stair negotiation, right shoulder causing severe night pain, difficulty brushing hair, fastening bra, and reaching. Petitioner's primary complaint of severe low back pain was noted (PX #13).

On August 5, 2014, Dr. Chandler performed a right shoulder arthroscopy for repair of the full thickness rotator cuff tear and impingement syndrome along with degenerative labral tear and hypertrophic bursa/bursitis repair. Petitioner was prescribed a sling and cane as well as additional physical therapy. Petitioner returned to Athletico on August 22, 2014 with difficulty ambulating, severe low back and hip pain, and difficulty sleeping.

Petitioner underwent a series of epidural steroid injections at L5-S1 by Dr. Jido August 29 and September 24, 2014. Dr. Chandler prescribed a lumbar MRI which on October 21, 2014 demonstrated post-surgical changes at L5-S1. Dr. Chandler prescribed additional physical therapy and home exercise program as well as Norco. Petitioner continued her physical therapy at Athletico.

Because of continuing low back complaints Dr. Chandler then referred the Petitioner to an orthopedic spine specialist, Dr. Richard Troy. On December 9, 2014, Dr. Troy noted constant low back pain across the left and right side as well as the left gluteal region and the posterior aspect of the left leg. Dr. Troy administered and SI joint injection. He recommended a CT scan of the pelvis, continued physical therapy, Norco and Lyrica (PX #11).

Petitioner also continued treating with Dr. Chandler, who on January 5, 2015 noted right thigh pain and that Petitioner had a large hematoma. He indicated that there was a strong possibility that she has a quadriceps muscle tear, so he ordered an MRI and a CT myelogram in addition to Norco.

The January 12, 2015 MRI of the right femur revealed a probable partial thickness sartorius tendon tear along the superficial fascia of the anteromedial aspect of the mid-thigh. Petitioner continued in her therapy at Athletico.

On February 21, 2015 Dr. Troy administered a left SI joint injection.

On March 9, 2015, Dr. Troy noted minimal relief from the SI joint injection and recommended a repeat injection as well as Norco and Tramadol. On March 20, 2015, Dr. Chandler noted that if the second SI joint injection did not provide relief, a SI joint fusion would be the next step. He prescribed continued physical therapy due to weakness and renewed the Norco prescription. Petitioner continued in her therapy at Athletico.

Dr. Chandler "wrote a "To Whom It May Concern" letter March 20, 2015, stating his treatment of Petitioner for pelvic fracture, lateral compression type II bilateral and superior and inferior pubic rami fractures, and left SI joint disruption. He also noted petitioner's complete tear right rotator cuff tendon, strain of right thigh with Sartorius muscle grade 2 partial tear, bicipital tendonitis-right, herniated disc (L4-5) central, lumbar canal stenosis, and posttraumatic arthritis left SI joint.

On April 1, 2015 Dr. Troy administered a left SI joint cortisone injection.

On May 6, 2015, Dr. Troy removed the cannulated screw going across the sacroiliac joint and associated washer. He also gave a left sacroiliac injection. Dr. Chandler noted his agreement with the removal of the screw, as well as a fusion in his office notes of May 1 and July 1, 2015.

On August 13, 2015, the Petitioner was discharged for her shoulder and back from Athletico, having attended 159 sessions.

On August 16, 2015, Dr. Troy performed a left SI joint fusion with instrumentation.

On October 21, 2015, Dr. Chandler noted that Petitioner's shoulder range of motion had improved, but with weakness, particularly overhead. He indicated that Petitioner could perform no overhead work over 10 pounds with no lifting, pushing, pulling or carrying over 25 pounds. He prescribed additional physical therapy.

Petitioner returned to Athletico on November 11, 2015. Dr. Chandler prescribed a knee brace as well as additional therapy and home exercise program. Petitioner continued treating at Athletico. On January 13, 2016, Dr. Chandler noted back pain into the right leg. He read the MRI to show a partial tear to the sartorius muscle of the right leg and prescribed continued physical therapy. A CT scan on February 18, 2016 of the pelvis demonstrated extensive pelvis reconstruction surgery and SI fusion.

On April 11, 2016, Athletico noted that Petitioner attended 71 visits, and could a two-hand lift to the shoulder with 11 pounds and a one hand lift to the shoulder and eye levels with only 5 pounds.

Petitioner received a Toradol injection by Dr. Chandler on April 13, 2016. Due to the restrictions on the Petitioner's back, physical therapy was limited on what could be done with the shoulder.

Dr. Troy administered bilateral facet joint injections at L4-5 and L5-S1 on April 27, 2016

Petitioner saw Dr. Angelopoulos on June 8, 2016 for pain management on the referral of Dr. Troy. Dr. Angelopoulos recommended a spinal cord stimulator, Fentanyl, and Norco and that he assume Petitioner's care for pain management (PX #9).

Petitioner underwent an MRI on her right knee which demonstrated a right medial meniscus tear. Dr. Chandler recommended arthroscopic surgery.

On October 12, 2016, Petitioner was evaluated by Dr. Peter Loss Brown who gave psychological clearance for a spinal cord stimulator. He noted the onset of some depressive symptoms about 5 years before but that the symptoms had been well managed (PX #9).

After reviewing the psychological evaluation, Dr. Angelopoulos proceeded with the placement of Infineon leads in the hope of capturing the entire painful area with a spinal cord stimulator trial. On December 1, 2016, Dr. Angelopoulos noted that the Petitioner had good relief in her back and legs and scheduled a permanent placement. Petitioner reported 50-60 % pain relief.

On February 23, 2017 when Dr. Troy performed a T8 laminectomy, spinal cord decompression at T8-9 level, spinal cord stimulator placement overlying the T6 and T7 posterior aspect of the spinal canal (PX #11).

Petitioner was reevaluated by Dr. Chandler on March 16, 2017, with 8/10 pain. Petitioner was taking Cyclobenzaprine and Hydrocodone and using a cane. Due to the recent procedures to her back and pain in the right knee, she had been unable to do physical therapy. Her knee was giving out. Dr. Chandler gave Petitioner a cortisone injection to the right knee.

On April 12, 2017, Dr. Chandler performed a right knee arthroscopy with a partial medial meniscectomy and limited debridement and sub-chondroplasty of the medial tibial plateau (PX #5). He ordered post-operative physical therapy.

Petitioner returned to Athletico on April 18, 2017. Low back pain, radiculopathy, and decreased knee range of motion and strength were all noted. On April 25, 2017, Dr. Chandler stated Petitioner's permanent restrictions were limited standing and walking, right upper extremity limited, no overhead, no lifting more than 10 pounds, other restrictions per the spine surgeon, limited distance walking, no stairs, no climbing, no pushing, no pulling, and no use of heavy equipment (PX #8).

Dr. Troy administered a left SI injection May 23, 2017.

On May 24, 2017, Athletico noted that Petitioner had improved knee strength and mobility, but remains with significant functional limitations and pain free stair climbing. It was noted that Petitioner was limited in completion of functional activities due to the severity of chronic low back pain.

At the last session of physical therapy on April 18, 2017 at Athletico, the physical therapist noted that Petitioner was "very motivated." At her time of discharge from that session of physical therapy Petitioner had attended 40 appointments.

Dr. Chandler wrote a "To Whom It May Concern" note April 25, 2017 setting forth petitioner's permanent restrictions: limited standing and walking, right upper extremity limited, no overhead, no lifting › 10 lbs., other restrictions per spine surgeon, limited distance walking, no stairs, no climbing, no push, no pulling, and no use of heavy equipment (PX #8).

Petitioner completed her treatment with Athletico on September 18, 2017. At that time, it was noted that no further improvement and tolerance for functional activities would occur, due to the severity of chronic low back pain. It was recommended that further medical intervention and pain management be suggested due to the chronic low back pain. Petitioner was discharged as no further functional improvement would be indicated. Petitioner's pain was noted to be 5/10.

The Petitioner was examined pursuant to §12 of the Act at the request of Respondent by anesthesiologist Dr. Kenneth Candido on September 26, 2017 (RX #2). Dr. Candido had reviewed Petitioner's medical records. He noted that his exam was consistent with limited lumbar flexion and limited lumbar extension. Those range of motion maneuvers were limited by stiffness and by pain. Dr. Candido noted that subjectively, Petitioner rated her pain at 5/10 in the low back at rest and up to 8/10 with activity.

Dr. Candido related Petitioner's injuries to the reported injury of March 7, 2014. He diagnosed low back pain, lumbar spondylosis, status post pelvic fracture, status post pelvic surgery, status post SI joint fusion, status post spinal cord stimulator placement, and status post total knee arthroplasty. Dr. Candido further opined that Petitioner was at MMI and could return to Light Duty type work with no carrying or lifting more than 25 pounds, no ambulating more than 30 minutes without 10 minutes of rest, and no overhead activity, pending a functional capacity evaluation. He noted her overall prognosis for a full recovery was good, with the only limitations being some moderate restrictions in her lumbar range of motion. Dr. Candido noted that while Petitioner is neurologically and orthopedically intact, she is deconditioned. He recommended increasing her activity level with home exercise, rather than with a formal prescription for physical therapy. Finally, Dr. Candido specifically opined that Petitioner, based on the MRI of her lumbar spine, did not require spinal injections or additional medical care and treatment.

On November 3, 2017, Petitioner underwent a lumbar CT that showed mild lower lumbar degenerative disc disease and moderate facet joint osteoarthritis at most

pronounced L4-5 level without significant central spinal canal stenosis or neuroforaminal stenosis.

On November 25, 2017, Dr. Chandler reiterated his permanent restrictions.

On November 28, 2017, Dr. Troy referred the Petitioner back to Dr. Angelopoulos to evaluate for facet injections. Dr. Troy also recommended an LSO back brace, with injections at L4-5 and L5-S1.

On March 8, 2018, Dr. Angelopoulos indicated that he had reviewed the Dr. Candido report which recommended light duty. He recommended a diagnostic medial branch block to determine what components of her persistent mechanical low back pain are secondary to the facet joints which Dr. Troy also recommended.

On April 11, 2018, the Petitioner underwent a functional capacity evaluation at Athletico. The examination had to be stopped due to concerns with the Petitioner's high blood pressure.

Petitioner underwent a second FCE with Athletico on April 26, 2018 with a different examiner. The examiner opined that the Petitioner had an "inconsistent performance/unacceptable effort." The examiner noted that the Petitioner's job description is that of a HEAVY physical demand level. The examiner noted that Petitioner demonstrated the physical capabilities of tolerance to function at the LIGHT physical demand level delineated by a two-hand 12 inch to waist lift of 20 pounds.

Respondent suspended temporary total disability benefits without explanation on May 12, 2018.

On May 17, 2018, Dr. Troy noted that Petitioner had failed surgical intervention, had only moderate to mild relief with the spinal cord stimulator, and may need a pain pump. Petitioner continued treating with both Dr. Troy and Dr. Angelopoulos with pain medications of Meloxicam, Norco, and Tramadol.

On June 12, 2018, Dr. Troy reiterated his restrictions. He opined that the submaximal performance on the FCE may have been underlying misinterpretation of Petitioner's underlying base line threshold of pain. Dr. Troy reiterated the restrictions of a 10-pound lifting restriction, limited bending, standing, walking, no kneeling, squatting, overheard work with occasional twisting.

In an addendum July 14, 2018, Dr. Candido, after reviewing the FCE and other of Petitioner's medical records, opined that Petitioner's substandard effort undermined the utility of the examination and reiterated his opinion that Petitioner showed a complete absence of any sensory or motor defects in the bilateral upper or lower extremities. In consideration with Petitioner's intact strength and motor function, Dr. Candido, opined Petitioner was at MMI and that she could return to full duty without any restrictions.

On July 24, 2018, Dr. Angelopoulos was cutting down on the Norco and starting extended release of Tramadol. He noted that Petitioner's work status was unchanged and consistent with the form filled out by Dr. Troy on June 12, 2018. He again recommended an LSO back brace.

Petitioner underwent another FCE at ATI August 8, 2018, which was determined to be valid. The examiner concluded that Petitioner's capabilities fell below the level stated by the job description provided by the employer. Petitioner demonstrated capabilities at a LIGHT to MEDIUM demand level. It was noted that Petitioner reported lumbar pain, right knee pain, and right shoulder pain during the desk to chair, chair to floor, above shoulder, stairs, carry, kneel/crawl, prolonged sitting and during prolonged standing.

On October 9, 2018, Dr. Candido wrote another addendum relative to Petitioner's work restrictions. He agreed that Petitioner was capable of working light-medium work duty in accordance with the valid FCE completed on August 8, 2018. He agreed with the majority of the findings but disagreed with the apparent restriction of work of 7 hours per day. When specifically asked to review the job description, Dr. Candido opined the Petitioner falls below the requirements of her regular job duties which were in the medium-heavy category.

The Petitioner's temporary total disability benefits were reinstated on October 25, 2018. She then began vocational rehabilitation with Vocamotive and had an initial interview on November 14, 2018 (PX #21).

On January 25, 2019, Dr. Troy ordered another lumbar CT scan. He noted that the Petitioner was in vocational rehabilitation and driving one hour back and forth. He also noted that secondary to the drive, Petitioner had increasing low back discomfort for acute exacerbation. He again recommended an LSO back brace.

Petitioner returned to Dr. Chandler on March 5, 2019 with complaints of patella femoral pain with pain going up and down stairs, kneeling and squatting. Driving an hour to vocational rehabilitation aggravated her symptoms. Dr. Chandler injected her right

knee, reiterated her light duty restrictions, and recommended additional physical therapy for the right shoulder.

The March 7, 2019 the lumbar CT scan revealed multilevel degenerative changes, severe degenerative facet changes at L4-5 and hardware in the left SI region (PX #11).

Dr. Troy on March 29, 2019, noted 7/10 low back pain and occasional pain into the left thigh of 7/10. He again recommended bilateral L4-5 facet injections and an LSO brace. He recommended that Petitioner continue to see Dr. Angelopoulos for follow up regarding the facet injections.

On April 17, 2019, the Petitioner was involved in a motor vehicle accident. She was seen at Morris Hospital where she was examined. She was given Norco and an injection. There was no other treatment relative to the motor vehicle accident (PX #23).

On April 16, 2019, the Petitioner returned to Dr. Angelopoulos. He again prescribed the LSO brace and continued with the current medications of Norco, Meloxicam and Tramadol.

On July 30, 2019, the Petitioner was contacted by the Respondent regarding potential reasonable accommodations for employment with the Respondent (PX #20). As of the date of arbitration, Petitioner's restrictions were not accommodated by the Respondent.

On July 16, 2019, Dr. Troy again recommended facet injections and possible medial branch blocks. On July 25, 2019, Dr. Angelopoulos again recommended an LSO back brace and medial branch blocks which would be diagnostic in scope in order to determine what role the lumbar facet joints are playing the persistent low back pain. This was be a prelude to possible radiofrequency ablation of the lumbar medial branch nerves.

On July 30, 2019, Petitioner received bilateral lumbar facet injections and diagnostic medial branch blocks by Dr. Angelopoulos. Some improvement was noted.

On October 27, 2019, Dr. Angelopoulos performed a right radiofrequency ablation of the lumbar medial branch nerves in order to provide Petitioner with more permanent relief from her facet joint pain. A left medial branch radiofrequency ablation was performed on September 11, 2019.

As of the date of arbitration, the Petitioner had ongoing treatment with both Dr. Troy and Dr. Angelopoulos. Petitioner is continuing in her participation in vocational rehabilitation with Vocamotive. She had computer training and was performing a job search, which as of the date of arbitration was unsuccessful.

On cross-examination, Petitioner testified about the limitations noted in the August 2018 FCE, that she was capable of doing those activities on an occasional basis. Petitioner acknowledged the discrepancy between her FCE performance and her testimony, but stated that it was because at the FCE she put in her maximum effort.

CONCLUSIONS OF LAW

F: Is Petitioner's current condition of ill-being causally related to the accident?

This issue was not genuinely disputed. The evidence clearly demonstrated that on March 7, 2014 petitioner was severely injured when a tree trunk fell on her, fracturing her pelvis and pubic bones. Petitioner also sustained injuries to her right shoulder and right knee. All of these injuries required extensive medical care, including surgery. Petitioner testified credibly to ongoing limitations in complaints.

Accordingly, the Arbitrator finds that Petitioner proved that her current conditions of ill-being are causally related to her workplace injury on March 7, 2014.

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?

Petitioner sustained objectively significant injuries which required extensive medical care including surgeries, physical therapy, and pain management. There is no dispute that the medical services provided to petitioner were reasonable and necessary up to the §12 IME by Dr. Candido on July 14, 2017. Respondent disputes payment of Petitioner's medical treatment after the July 14, 2017 IME based on Dr. Candido's opinion that Petitioner was at MMI.

Dr. Candido is a board-certified anesthesiologist who respondent retained to examine a patient with orthopedic injuries to her pelvis, pubic bones, right shoulder, and right knee, Dr. Candido evaluated Petitioner then current condition and whether further medical care was necessary.

Dr. Candido summarized his diagnoses as including low back pain, lumbar spondylosis, status post pelvic fracture, status post pelvic surgery, status post SI joint fusion, status post spinal cord stimulator placement, and status post total knee arthroplasty, all of which are orthopedic and not within the realm of Dr. Candido's expertise in anesthesiology. Based on his examination and review of Petitioner's records, including the April 26, 2018 FCE which noted inconsistent performance and unacceptable effort, Dr. Candido concluded that Petitioner was at MMI.

The Arbitrator finds the opinions of Dr. Candido unpersuasive and unreliable. First, the Arbitrator notes that Dr. Candido is an anesthesiologist, not an orthopedic surgeon. Dr. Candido's opinions are in conflict Petitioner's treating board-certified orthopedic surgeons. That alone, given Petitioner's considerable orthopedic issues, undermines the reliability and persuasiveness of Dr. Candido's opinions. The Arbitrator also finds that Dr. Candido misplaced his later reliance on the April 2018 FCE. Dr. Troy aptly noted on June 12, 2018 that the FCE examiner most likely misinterpreted Petitioner's effort because of her limitations due to pain.

In summary review of Petitioner's medical history Dr. Candido noted that Petitioner had had a total knee arthroplasty, when in fact Petitioner had an arthroscopic meniscectomy and chondroplasty. Further, in his summary Dr. Candido overlooked the T8 laminectomy attendant with the spinal cord stimulator insertion. These oversights indicate a lack of a thoroughness necessary for a reliable and persuasive opinion.

It does not take a trained healthcare professional to appreciate that Petitioner sustained painful, disabling, and limiting injuries which included a fractured pelvis that required open reduction with internal fixation, removal of pelvic fixation hardware, right rotator cuff arthroscopy, SI joint fusion, spinal cord stimulator, numerous rounds of pain intervention procedures such as facet and medial branch block injections, as well as multiple rounds of physical therapy. It does not take a trained healthcare professional to appreciate that a constellation of these maladies may cause pain and discomfort which may inhibit function sufficient to invalidate an FCE. Dr. Candido 's reliance on the April 26, 2018 FCE was wholly unsupported by the scope of Petitioner's injuries, necessary medical care, and common sense.

Accordingly, the Arbitrator rejects Dr. Candido's opinion that Petitioner was at MMI on July 14, 2017 as being unsupported by the evidence. Therefore, the Arbitrator awards all medical charges and fees incurred by Petitioner after June 14, 2017, finding that the medical care relating to those charges and fees was reasonable and necessary, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Although not affecting the above reasoning and findings, the Arbitrator notes that assuming that Dr. Candido is correct about MMI, medical expenses to help alleviate pain from a condition causally related to the complaints employee occurred after she has reached MMI are compensable. *Elmhurst Memorial Hospital v. Industrial Commission*, 323 Ill.App.3rd 758 (2001).

K: Is Petitioner entitled to any prospective medical care?

The Arbitrator previously found the causal relationship between the accident of March 7, 2014 and Petitioner's current conditions of ill-being. The Arbitrator previously found that the medical services provided to the Petitioner as of the date of arbitration were reasonable and necessary and awarded the billing to Petitioner as noted above.

Based on the foregoing, the Arbitrator finds that Petitioner proved that the recommended pain management and LSO brace as recommended by both Dr. Troy and Dr. Angelopoulos are reasonably necessary to cure to relieve Petitioner's current condition of ill-being and in particular her severe chronic ongoing pain. The Arbitrator further finds that Petitioner proved that the physical therapy recommended by Dr. Chandler is reasonably necessary to cure or relieve Petitioner's condition of ill-being.

Therefore, Respondent is hereby ordered to authorize and pay for the procedures and treatment recommended by Dr. Angelopoulos, Dr. Troy and Dr. Chandler as well as any related medical care.

L: What temporary total disability benefits are in dispute? TTD

Petitioner received temporary total disability benefits up to May 12, 2018, benefits were suspended without explanation at that time. However, prior to May 12, 2018 Petitioner's treating physicians had placed work restrictions which prevented her from returning to her regular job as a tree trimmer. Respondent reinstated benefits October 25, 2018 as maintenance, which was undisputed (ArbX #1).

Petitioner's benefits were terminated based on the opinions of Respondent's retained §12 examining physician, Dr. Candido, that petitioner was at MMI and capable of returning to full duty work. The Arbitrator previously found Dr. Candido's opinions to be unreliable and unpersuasive. Therefore, the Arbitrator finds the restrictions placed by Petitioner's treating physicians to be reliable and reasonable.

Inasmuch as Respondent was unable to accommodate Petitioner's work restrictions, Petitioner is entitled to temporary total disability benefits commencing March 8, 2014 through October 24, 2018, 241 & 5/7 weeks, with credit due to Respondent

for benefits it paid. There was evidence of Petitioner's participation in vocational rehabilitation through Vocamotive, but without stating the start date.

Accordingly, the Arbitrator awards the disputed temporary total disability benefits to Petitioner for the time period from May 12, 2018 through October 24, 2018.

M: Should penalties or fees be imposed upon Respondent?

As noted above, Respondent terminated temporary total disability benefits unilaterally and without explanation as of May 12, 2018. Respondent apparently relied on the opinions of its retained §12 examining physician, Dr. Candido. As also noted above, the arbitrator did not find Dr. Candido's opinions reliable more persuasive. Despite the lack of reliability and persuasive nature of Dr. Candido's opinions it was neither reasonable nor vexatious for respondent to rely on those opinions.

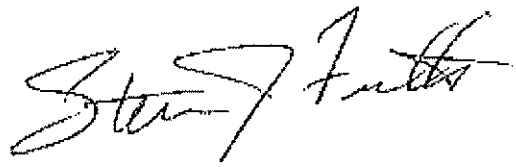
Therefore, the Arbitrator finds that Petitioner failed to prove that she is entitled to penalties pursuant to §19(k) of the Act.

However, Respondent's termination of total temporary disability benefits without explanation or reason stated in writing within 14 days, in violation of provisions of §19(l) of the Act. The number of days that payments temporary total disability benefits were not paid, from May 12, 2018 through November 19, 2019, totals 557 days.

On August 2, 2018, Respondent issued a letter indicating that benefits had been suspended as of May 11, 2018. The reason given was a "full duty release per July 14, 2018 independent medical exam addendum." This does not abate the requirements of 14 days in which to explain termination of benefits.

Therefore, the Arbitrator awards the maximum §19(l) penalty of $10,000.00 since the number of days at $30.00 a day exceeds $10,000.00.

Given the Arbitrator's finding that Respondent's reliance on the opinions of Dr. Candido was neither frivolous nor vexatious, the Arbitrator declines to award §16 attorneys' fees as a further penalty.



Steven J. Fruth, Arbitrator

April 8, 2020
Date