STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nathan Daniels,
Petitioner,

vs. NO: 10WC 47066

14IWCC0071

Caterpillar, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employer-employee relationship, notice, prospective medical, 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 December 4, 2012, 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.

DATED: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANIELS, NATHAN
Employee/Petitioner

Case# **10WC047066**

CATERPILLAR INC
Employer/Respondent

14IWCC0071

On 12/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN. WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NATHAN DANIELS,

Case # **10** WC **47066**

141WCC0071

Employee/Petitioner
v.

CATERPILLAR INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **September 21, 2012**. 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. [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. [ ] What was the date of the accident?
E. [x] **Was timely notice of the accident given to Respondent?**
F. [x] **Is Petitioner's current condition of ill-being causally related to the injury?**
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] **Other 8(a) Prospective Medical**

FINDINGS

On **November 11, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, Petitioner earned $**0**; the average weekly wage was $**0.**

On the date of accident, Petitioner was **36** years of age, *single* with **3** children under 18.

Petitioner *has not* received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **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** .

ORDER

- Based on the above findings, no benefits are awarded.
- The respondent shall pay the petitioner the sum of $ **N/A**/week for a further period of **N/A** weeks, as provided in Section **N/A** of the Act, because the injuries sustained caused

N/A

- The respondent shall pay the petitioner compensation that has accrued from **N/A** through **N/A** , and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 of the Act.

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

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

S/ Malkus

Signature of Arbitrator

11-27-2012

Date

ICArbDec p. 2

DEC - 4 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Nathan Daniels, Petitioner, is 38 years old. He was hired by Caterpillar in September 2003 as a Lathe Operator, CNC Specialist. In October 2007, he moved to being a Metalworking Specialist in the Forge Department. In the Forge Department, Petitioner finished tractor links for D9, D10, and D11 models. He also finished D11 tarsands. There were four main jobs in the forge area. Petitioner said he would rotate between at least 3 of the 4 jobs on a weekly basis.

Petitioner explained the process of making tractor links in the forge area. He testified they would start with raw billets that sometimes had to be cut. The billets would be loaded into an automated heat inductor system and sometimes the billets at 2300 degrees would have to be picked up with large tongs to put back on the line. The billets then had to be sprayed so they did not stick together. This was done with a spray gun similar to what is used at a car wash. In the forge press area, Petitioner indicated he would have to use an air impact gun and wrench for tightening and adjusting the machinery and fork truck to accommodate the different sized billets. Petitioner would also use from time to time a 3-foot hammer to knock pieces of the machinery back into place. Petitioner testified this was the most difficult of the four jobs in the forge area.

Petitioner testified he would use an impact wrench to change dyes. This involved taking out/putting in 12 large bolts. This task was not done every shift. In the punch press part of the forge area, Petitioner used a large rod to move the billets along and flip every third billet to inspect it. This step also stamped a serial number in the link. If the number was wrong it would have to be grinded off and corrected.

On March 31, 2009, Petitioner reported to the Caterpillar medical office in his building and filled out a Caterpillar Employee Incident Report. Petitioner described the incident occurring on March 30, 2009 as "Swinging a long hammer at transfer fingers for adjustment on Line 2 main press noticed pain and popping noise in shoulder and hand on right side…." On line seven of the incident report, Petitioner described his injury or pain as "pain sharp in shoulder, tingle and numbness in right hand." (Resp. Ex. 1)

On the initial nursing assessment from March 31, 2009, the examining nurse listed Petitioner's right shoulder, right hand, right elbow and right arm as being effected by the incident. The "Narrative" section of the nursing report indicates, "Currently has dull ache when lifting arm, has pain pinch and pop in right shoulder, has pain in fingers and warm feeling going from palm to right elbow." (Resp. Ex. 1)

Petitioner first saw Dr. Kent Miller at the Caterpillar medical office on April 16, 2009. In the exam notes, Dr. Miller states Petitioner has right shoulder soreness for approximately 1 year from an insidious onset over time and the pain was mild before 3/30/09 event. Petitioner mentioned transient tingling/paresthesia in the last 3 fingers of the right hand occurring over the last 6 months and worsening over time with heat sensation eventually going to the elbow. In addition to his shoulder assessment, Dr. Miller wrote Petitioner had right lateral epicondylitis and right ulnar neuritis. (Resp. Ex. 1)

On 4/23/09, Petitioner saw Dr. Miller again. Dr. Miller wrote in the exam notes "Elbow better…" and "resolving right lateral epicondylitis and resolving right ulnar neuritis." On 5/4/09, after examining Petitioner Dr. Miller wrote "Right lateral epicondylar area still exhibits mild point tenderness over the epicondyle" and "Mild residual right lateral epicondylitis." On 5/13/09 and 5/27/09, Petitioner saw Dr. Miller but only Petitioner's right shoulder was discussed in the exam notes. On 7/2/09, after examining Petitioner, Dr. Miller wrote "Also reporting constant tingling and hair dryer sensation of variable intensity on ulnar forearm to elbow and last 3 digits of right hand." On 8/11/09, after examining Petitioner, Dr. Miller wrote "Paresthesia resolved but still has slight [decreased] sensation in ulnar distribution below elbow on right. Tinel [negative] at elbow

and wrist." This is the last exam Petitioner had with Dr. Miller where his right elbow and hand condition were mentioned. In his last visit with Dr. Miller on 9/28/09 only the shoulder was discussed. (Resp. Ex. 1)

According to the Caterpillar medical notes, work restrictions were placed on Petitioner from 3/31/09 through his shoulder surgery date of 8/26/09. (Resp. Ex. 1) Caterpillar was able to accommodate these restrictions. After his shoulder surgery on 8/26/09, Petitioner received TTD benefits. Petitioner's employment ended with Caterpillar on October 15, 2009, but Petitioner's TTD benefits for his shoulder condition continued through his release from treatment in December 2009.

On 7/21/09, Petitioner was seen for a consultation by Dr. Garst at the referral of Dr. Miller. On the "Shoulder History" form in addition to the information on Petitioner's shoulder, it is mentioned, "Patient has numbness and pain in his right palm and numbness in his lateral right hand as well." On 8/26/09, Dr. Garst performed surgery on Petitioner's right shoulder. On 9/8/09, Dr. Garst examined Petitioner for his shoulder condition but noted "He had full range of motion of his right elbow." On 10/13/09, Dr. Garst examined Petitioner for his shoulder condition. On 11/13/09, Dr. Garst examined Petitioner for his shoulder condition and noted "he is significantly improved." On 12/15/09, Dr. Garst examined Petitioner and released him back to regular duty for his shoulder as of 12/21/09 and stated "See him back as needed, but if there are any further problems or concerns, he will return." (Resp. Ex. 4)

After being released from Dr. Garst, Petitioner contacted Shannon Ahten, a workers' compensation adjuster for Caterpillar, regarding a settlement for his right shoulder condition. In January 2010, Petitioner contacted Shannon Ahten to accept a settlement offer for his right shoulder condition. On 2/17/10, Petitioner met with Shannon Ahten and Mark Peters, an attorney for Caterpillar to sign settlement contracts for his right shoulder condition. Then Petitioner, Shannon and Mark went before Arbitrator Mathis to have the contracts approved. (Resp. Ex. 6)

After his TTD benefits stopped on December 21, 2009, Petitioner received unemployment benefits from 1/9/10 to 7/31/10. On 6/21/10, Petitioner began to work at CNH, a farm equipment manufacturer, through STS Staffing, a temp agency. (Resp. Ex. 5) Petitioner's job at CNH was a mig welder and he performed his welding duties approximately 6 hours a day. Petitioner testified in August 2010 while working for CNH, his hand and elbow symptoms returned. Petitioner testified the hand and elbow numbness and pain that returned when he was working at CNH was at the same intensity it had been during his time at Caterpillar. Petitioner quit working for CNH on 10/3/10. (Resp. Ex. 5) Petitioner testified he had to quit working for CNH because his hand and arm numbness and pain was so bad he couldn't perform his job duties. Petitioner testified he began working for Midas as a mechanic in October 2010. His job duties involved changing tires, oil and sparkplugs. Petitioner used a half-inch air impact wrench to perform his work duties at Midas. Petitioner testified he stopped working for Midas on or about 12/20/10 because of his hand and elbow symptoms. It was at that time Petitioner decided to get a job with less hand intensive job duties.

In August 2010, Petitioner contacted Shannon Ahten to report his hand and elbow symptoms from the 3/30/09 incident had returned. After calling to report the symptoms, Petitioner received a letter from Shannon Ahten stating any further treatment was being denied. Shannon testified she denied Petitioner's request for treatment in August 2010 because Petitioner had closed out the 3/30/09 incident with the shoulder settlement in February 2010 and Petitioner had not worked for Caterpillar since 10/15/09. Shannon Ahten also testified she was not aware of Petitioner's ongoing right hand and elbow symptoms until Petitioner called her in August 2010 and she had received no treatment requests for the right elbow and hand condition from 3/30/09 through August 2010.

Petitioner testified after his symptoms returned while working for CNH and after Caterpillar denied further treatment, Petitioner sought the help of an attorney. Petitioner further testified he returned to see Dr. Garst on

11/8/10, because of the hand and arm symptoms that returned when he was working for CNH. On 11/8/10, after performing an examination, Dr. Garst diagnosed Petitioner with probable carpal tunnel syndrome and/or cubital tunnel syndrome in the right arm and recommended an EMG/NCV. On November 22, 2010, Dr. Garst called Petitioner to relay the results of the EMG/NCV. The test showed mild right carpal tunnel and cubital tunnel syndrome. Surgery and conservative care were discussed and Petitioner was to call Dr. Garst back to discuss further. (Resp. Ex. 4) At the time of trial, Petitioner had not yet undergone any treatment by Dr. Garst for his right hand and elbow condition.

Petitioner testified he had paresthesia, numbness, tingling, and pain in his elbow and hands every day from 3/30/09 through the day of trial. He testified sometimes the pain wakes him up at night. Petitioner testified he has known since 3/30/09, his ongoing right hand and elbow symptoms were related to his work at Caterpillar. Petitioner testified his shoulder condition from 3/30/09 was accepted and all necessary workers' compensation benefits were paid. Petitioner testified from 3/30/09 through his last day at Caterpillar on 10/15/09 no one denied treatment for his ongoing right hand and elbow condition.

Petitioner testified he did not request treatment from anyone for his ongoing right hand and elbow symptoms until he contacted Shannon Ahten in August 2010. Petitioner testified he did not mention his ongoing elbow and hand symptoms to Shannon Ahten until he contacted her in August 2010 while working for CNH. Petitioner admitted he had talked with Shannon on September 9, 2009 to discuss a settlement for a prior work comp claim on his forearm. He also admitted he talked with Shannon in December 2009, January 2010 and February 2010 for his shoulder settlement.

Petitioner testified he did not mention his ongoing right hand and elbow symptoms to Dr. Garst at any of the visits from July to December 2009 because he was only treating for his right shoulder not his hand and elbow. Petitioner testified he knew Dr. Garst treated elbow conditions because Dr. Garst had been his surgeon for his left-sided carpal and cubital tunnel releases in 2006. Petitioner testified after his left-sided carpal and cubital tunnel treatment in 2006, he immediately began treating with Dr. Garst for his left shoulder condition. Petitioner testified he did not mention his ongoing right elbow and hand symptoms to Dr. Garst until 11/8/10.

In his deposition, Dr. Garst testified Petitioner returned to see him on 11/8/10 with complaints of right hand pain and numbness and a history of "he has numbness and tingling in his right hand and it's been getting worse." (Pet. Ex. 1, Pg. 14) Dr. Garst was given a lengthy hypothetical by Petitioner's attorney and he opined, based on the hypothetical, Petitioner's condition on 11/8/10 was related to his work at Caterpillar. (Pet. Ex. 1, Pg. 23) Dr. Garst testified he had treated Petitioner regularly from 2005-2009 for other conditions and during those years there were no indications he had right carpal or cubital tunnel syndrome. (Pet. Ex. 1, Pg. 25.) Dr. Garst opined Petitioner's job duties as a mechanic were hand intensive and could have been contributive to Petitioner's right elbow and hand condition but Dr. Garst acknowledged Petitioner had only been doing this job for one month. Dr. Garst did author a letter to Petitioner's attorney dated March 15, 2011. In that letter Dr. Garst opined Petitioner's carpal and cubital tunnel syndrome could be related to welding duties at Caterpillar. (Resp. Ex. 4) Dr. Garst admitted in his deposition he gave this opinion on a false impression. (Pet. Ex. 1, Pg. 29)

On 2/8/2012, Petitioner saw Dr. Leon Benson for an examination pursuant to Section 12. Dr. Benson opined the symptoms Petitioner presented with at the exam were not related to his work at Caterpillar because so much time had passed between his work at Caterpillar and the onset of the current symptoms. (Resp. Ex. 2) In his deposition, Dr. Benson testified the Petitioner's symptoms were "reasonably mild so it would stand to reason they're relatively recent in forming." (Resp. Ex. 3, Pg. 14) Dr. Benson did testify Petitioner's job duties with Caterpillar could have aggravated his right elbow and arm condition, but if Petitioner had symptoms in 2009 it was a temporary aggravation. (Resp. Ex. 3, Pg. 22)

THE ARBITRATOR MAKES THE FOLLOWING FINDINGS WITH REGARD TO:

(C.) Did an accident occur that arose out of and in the course of Petitioner's employment with Caterpillar? and

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

Petitioner is alleging two dates of injury for his right hand and elbow condition. The first date of accident is 3/30/09 which corresponds with the Employee Incident Report filled out with Caterpillar medical on 3/31/09. Petitioner is trying to relate his current right arm and elbow condition back to the conditions reported on 3/30/09, but there is no credible evidence to support Petitioner's position. The second date of accident, 11/11/10 corresponds to the date of Petitioner's EMG/NCV with Dr. Russo. In this claim Petitioner is trying to allege the findings on the EMG and his current condition are related to his work at Caterpillar, but again, there is no credible evidence to support this.

With regard to the issue of accident, both doctors, Dr. Garst and Dr. Benson, opined that Petitioner's carpal tunnel and cubital tunnel could have arisen out of the job duties as described at Caterpillar before 3/30/09, but to the contrary, primarily all evidence presented at trial, even Petitioner's own testimony, dispute his current condition is causally related to the 3/30/09 incident or his work duties at Caterpillar. The Arbitrator finds the following facts most important in breaking the causal relationship between Petitioner's current condition and his work at Caterpillar:

1. Petitioner's right elbow and hand were examined by Dr. Miller and addressed in most of Dr. Miller's exam notes through 8/11/09 and no treatment was ever recommended by Dr. Miller for the right elbow and hand.

2. Dr. Miller's notes in August 2009, state Petitioner's paresthesia had resolved.

3. Petitioner did not mention ongoing elbow or hand complaints to anyone until August 2010 nor did he request any treatment for the condition until that same time.

4. Despite seeing him regularly from August to December 2009, Petitioner did not seek treatment from Dr. Garst for the right elbow and hand.

5. Petitioner let almost a year pass before he saw Dr. Garst again in November 2010.

6. Petitioner had regular direct contact with his work comp adjuster, Shannon Ahten, from September 2009 through February 2010 and didn't mention the ongoing symptoms or the need for treatment until August 2010.

7. Dr. Garst testified Petitioner had no signs of right carpal tunnel or cubital tunnel at least through December 2009.

8. Dr. Garst's causation opinion is based on inaccurate information. The hypothetical presented to him alleged Petitioner worked in a hand intensive job with Caterpillar from January 2009 through his last day of employment in October 2010, a span of 10 months. When in fact, from 3/31/09 to 8/25/09 Petitioner was working light duty with significant restrictions. After 8/25/09, Petitioner was off work for his shoulder surgery and never returned to work for Caterpillar. Also in the hypothetical, Dr.

Garst was asked to assume Petitioner was on unemployment through September 2010. This is not true. Petitioner began working as a welder in June 2010.

9. Petitioner had not performed his regular duty job with Caterpillar since 30/30/09. He began working at a hand intensive job in June 2010 and another hand intensive job October 2010. It wasn't until after performing work duties as a welder and a mechanic, he sought treatment with Dr. Garst for his right elbow and hand.

10. Dr. Garst opined both welding duties and mechanic duties could cause carpal tunnel and cubital tunnel syndrome.

11. Petitioner testified his right elbow and hand symptoms returned after he began working for CNH as a welder. Petitioner went on to testify the return of the symptoms caused Petitioner to call Shannon and request approval for treatment in August 2010, seek consultation with an attorney shortly thereafter and seek treatment with Dr. Garst in November 2010.

Petitioner's testimony about the continuation of his symptoms from 3/30/09 is not credible. He could have mentioned the ongoing symptoms on several occasions to Dr. Miller, Shannon Ahten or Dr. Garst, but he didn't. He could have requested treatment on several occasions from Dr. Miller, Shannon Ahten or Dr. Garst, but he didn't. Beyond Dr. Miller's August 2009 note, the only evidence of additional right hand and arm symptoms came after not performing his regular work duties at Caterpillar for 18 months and after working for two different employers. The fact Petitioner testified his symptoms returned after working at CNH in itself says he didn't have symptoms everyday since 3/30/09. With such a gap in time, no treatment, no mention of symptoms and alternate employment, there is nothing to support causal connection. Based on all evidence, the Arbitrator finds there is sufficient evidence of an accident occurring on 3/30/09, but not for the accident date of 11/11/10. The Arbitrator finds with regard to causation, Petitioner failed to prove his current right elbow and hand condition is causally related to the 3/30/09 incident or to his work duties at Caterpillar. Based on these findings, no other findings are necessary and all requested benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nathan Daniels,
Petitioner,
vs. NO: 11WC 17421

14IWCC0072

Caterpillar, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employer-employee relationship, notice, prospective medical, 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 December 4, 2012, 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.

DATED: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANIELS, NATHAN
Employee/Petitioner

Case# **11WC017421**

CATERPILLAR INC
Employer/Respondent

14IWCC0072

On 12/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NATHAN DANIELS, Case # **11** WC **17421**

Employee/Petitioner
v.

14IWCC0072

CATERPILLAR INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **September 21, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] **Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**
D. [ ] What was the date of the accident?
E. [x] **Was timely notice of the accident given to Respondent?**
F. [x] **Is Petitioner's current condition of ill-being causally related to the injury?**
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] **Other 8(a) Prospective Medical**

FINDINGS

On **March 30, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**45,315.40**; the average weekly wage was $**871.45.**

On the date of accident, Petitioner was **35** years of age, *married* with **3** children under 18.

Petitioner *has not* received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **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** .

ORDER

- Based on the above findings, no benefits are awarded.
- The respondent shall pay the petitioner the sum of $ **N/A**/week for a further period of **N/A** weeks, as provided in Section **N/A** of the Act, because the injuries sustained caused **N/A**
- The respondent shall pay the petitioner compensation that has accrued from **N/A** through **N/A** , and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 of the Act.

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

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

D. Mathis

Signature of Arbitrator

11-27-2012

Date

DEC - 4 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

This claim was consolidated with case 10 WC 47066 and all written findings by the Arbitrator are attached to that case number.

14IWCC0072

STATE OF ILLINOIS)
) SS.
COUNTY OF HENRY)

☒ 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

Marilyn Hancock,
Petitioner,

vs. NO: 10WC 25331

14IWCC0073

Illinois Department of Corrections - Dixon,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, 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 11, 2012, 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.

DATED: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANCOCK, MARILYN Case# **10WC025331**
Employee/Petitioner

IL DEPT OF CORRECTIONS-DIXON
Employer/Respondent

14IWCC0073

On 12/11/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

1097 SCHWEICKERT & GANASSIN
MARK M WILSON
2101 MARQUETTE RD
PERU, IL 61354

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0988 ASSISTANT ATTORNEY GENERAL
BRETT D KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 11 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF HENRY)

- [ ] 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

MARILYN HANCOCK,
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS-DIXON,
Employer/Respondent

Case # 10 WC 25331

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Kewanee**, on **11/14/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 **4/30/10**, 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 $**44,999.76**; the average weekly wage was $**865.38**.

On the date of accident, Petitioner was **50** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10, and she has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her left arm, elbow, and hand is causally related to any alleged injury on 4/30/10. The petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

12/4/12
Date

DEC 11 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old corrections officer, alleges she sustained an accidental injury to her left upper extremity due to repetitive trauma that arose out of and in the course of her employment, and manifested itself on 4/30/10. Petitioner had been employed by respondent for 30 years, and assigned to the Control Room in Housing Unit 27 for 2 years. Her shift was from 7 am to 3 pm. Petitioner is claiming that she sustained an accidental injury to her left upper extremity due to the repetitive way her left hand reached for the control panel buttons and chuck hole.

Respondent offered into evidence pictures of a control room that was similar to the control room where she worked on in Housing Unit 27 (RX7-9). Petitioner testified that she would sit in the same position as the officer in the photos. Petitioner testified that the chuck hole was beyond her reach if sitting in the chair. She stated that to reach it she would have to get up from her chair and lean forward. When she did this petitioner would push up off the desktop with the palm of her left hand and then extend with her right hand to the reach the chuck hole. When petitioner operated the control panel she would grab the edge of the desk with her left hand and scoot over to reach the control panel with her left hand. Petitioner testified that sometimes her chair had wheels and sometimes it did not. At times she sat in a plastic chair like the one shown in Respondent Exhibit 7. Petitioner stated that the floor tile in the Control Room was old, brittle and torn up, leaving the surface very rough. She also stated that there were some holes in the wood subsurface, and the wheels did not always turn.

Petitioner testified that she would go from the control panel to the chuck hole all day long. She stated that she was busy all day long except during early morning at about 8, during lockdown, and during breakfast and lunch. Petitioner testified that other than at these times she was continuously scooting her chair to reach the chuck hole and control panel. Petitioner would primarily use the front door and day room door buttons on the control panel. These buttons opened theses doors.

Petitioner used the front door and day room door buttons to open those doors to let the inmates move through the building for job assignments, go to the library or medical, in guard lines, gym lines and back and forth from meals. By pushing the button on the control panel the door would unlock. Petitioner testified that if there was a line of 40 inmates she might have to press the button 15 times because the inmates were not good about holding the door open for each other. Petitioner testified that she operated the control panel three out of the five days she worked a week. The other two days petitioner went to court with the inmates. When she went to court she carried a lot of bags filled with things such as lunches and extra shackles. She testified that the bag weighed 10-20 pounds. Even though she had another officer with her she would usually carry the bags and the

other officer would handle the inmates. She carried the bags anywhere from 100 feet to ½ of a block. She also opened doors.

Petitioner testified that she noticed problems with her left upper extremity in the spring of 2010. The pain in her left elbow started 5 months earlier. She stated that she noted numbness when she carried heavy items with her left hand. Petitioner gave a history of a right carpal tunnel release in 1992.

When petitioner first noticed her symptoms in her left upper extremity she called her primary care physician Dr. Inciong, who referred her to Dr. Shin and prescribed a Medrol dose pack. Petitioner presented to Dr. Shin on 4/30/10. She complained of left elbow pain and some popping sensations for the past 5-6 months. She stated that she had no known injury but did do a lot of reaching to the left over and over again at work. She stated that a prescription of Medrol dose pack gave her some relief. However, as soon as she finished it the pain returned in 2-3 days. She rated her pain from 4 to 10 on a scale of 10. She also stated that she had taken Naprosyn in the past with some relief. She described the pain as stabbing, dull and sharp in nature in her olecranon, over the olecranon bursa and over the distal end of the triceps. She also stated that sometimes it would radiate up her arm just along the most distal aspect of the triceps musculature. She stated it was fairly intermittent and was getting worse. She also reported numbness and tingling due to carpal tunnel on the left, and weakness in the left hand due to her carpal tunnel. She gave a history of smoking a pack of cigarettes a day for the past 30 years. She gave a history of numbness and tingling in both hands in the past, and a carpal tunnel release on the right in the past.

Following an examination and imaging, Dr. Shin assessed left elbow pain, left olecranon bursitis, left triceps tendonitis, and left carpal tunnel syndrome. Dr. Shin discussed her history of left carpal tunnel with petitioner. Petitioner stated that she did not undergo a left carpal tunnel release when she had the right done because she only had weakness, numbness and tingling, and not any pain. Dr. Shin recommended surgery because petitioner had bilateral thenar atrophy with the left side worse than the right. He recommended a left carpal tunnel release to prevent further thenar musculature loss. With respect to her left elbow he recommended Aleve and physical therapy to decrease the inflammation.

Petitioner gave notice to respondent on 5/5/10 when she reported an injury due to opening locks and the way she used her left hand to use the control panel. She alleged carpal tunnel syndrome of the left hand. Petitioner filled out an accident report that day and reported repetitive strain injury to her left hand while opening locks.

On 6/7/10 petitioner returned to Dr. Shin. He discussed the risks and benefits of the surgery with petitioner. Petitioner reported that her complaints were unchanged. Dr. Shin noted that her thenar atrophy on the left was the same as the right, maybe slightly worse. She had positive Tinel's sign and Durkan's test on the left. Dr. Shin assessed left carpal tunnel syndrome. Dr. Shin recommended an EMG of the left upper extremity, as it appeared to be a standard of care in this region and because her symptoms were milder on her left side than on her right side when she had surgery. Dr. Shin reviewed petitioner's job duties and anticipated that she would be off work 2-3 weeks after surgery, then return to light duty. Dr. Shin noted that her olecranon bursa and triceps region was improved. Petitioner also asked Dr. Shin to evaluate her bilateral knees which were painful and weak. Dr. Shin assessed bilateral knee pain, bilateral patellofemoral syndrome, bilateral knee degenerative joint disease, and left triceps tendonitis.

On 6/24/10 petitioner underwent a left carpal tunnel release. Her postoperative diagnosis was left carpal tunnel syndrome. Petitioner followed up postoperatively with Dr. Shin. This treatment included physical therapy. On 6/30/10 petitioner reported decreased numbness in her thumb, index and middle finger. She stated that the little bit of elbow pain she had postoperatively was gone.

On 7/2/10 petitioner filed her Application for Adjustment of Claim. She alleged injuries to her left arm, elbow and hand while performing job duties. She alleged an accident date of 4/29/10. Petitioner amended this alleged date of accident to 4/30/10 at trial. Respondent had no objection.

On 7/16/10 petitioner reported to Dr. Shin steady but slow improvement. She also reported to Dr. Shin that she had new left elbow pain and a right wrist mass. She reported that she could use her hands more, but did not have full strength grip. She reported tenderness in the left elbow in the olecranon and the triceps area. She reported new pain over her lateral epicondyle. She stated that when she twists and picks up objects it hurts. She denied any numbness or tingling. She reported some radiation down the dorsal aspect of her forearm toward her wrist. Dr. Shin continued petitioner off for another week.

Petitioner was off work from 6/24/10 through 7/24/10. She returned to full duty work on 7/25/10. Petitioner testified that after returning to work she performed her full duty job until she retired in June of 2012. Petitioner testified that during this period she still had pain in her left hand and wrist or elbow when carrying anything heavy. She reported weakness in her left hand due a lot of muscle atrophy. She testified that she had a weak grip and her elbow bothers her once in a while when she lifts or turns it a certain way.

On 8/6/10 petitioner followed-up with Dr. Shin. Her carpal tunnel was doing quite well. Her triceps tendonitis was improved. Her medial epicondylitis and forearm strain symptoms were more severe. He

recommended that she continue her use of Aleve and therapy to help the thumb, forearm, and elbow. Dr. Shin noted that since some areas were feeling better and some worse, he just wanted to try to globally decrease the inflammation. Dr. Shin was of the opinion that petitioner's cubital tunnel syndrome was fairly mild. Dr. Shin recommended that petitioner try to keep her elbow straighter. On 9/6/10 petitioner reported that her triceps and medial epicondyle had improved back to normal, and her left cubital tunnel had improved slightly. Petitioner stated that she had returned to full duty three weeks prior and reported less problems than she expected. She reported some residual weakness in her left hand and grip. Dr. Shin continued petitioner in therapy and told her to keep her elbow straight. On 10/18/10 petitioner reported that the pain about her elbow was almost completely resolved. She stated that it was 90% better. She denied any deep radiation or pain, numbness or tingling into her hand. She stated that her left hand was still somewhat weak, but getting stronger. Dr. Shin assessed that her left carpal tunnel syndrome was doing well, her left triceps tendonitits was improved, her left medial epicondylitis was resolved, and her left cubital tunnel was resolved. Dr. Shin believed her strength would continue to improve in her left hand. Dr. Shin instructed her to continue with her home exercise program. Dr. Shin released petitioner from his care on an as needed basis.

On 8/5/11 Petitioner underwent an independent medical examination performed by Dr. Robert Eilers. Petitioner gave a history of developing numbness and tingling in the left upper extremity, as well as pain in the epicondylar area. She stated that she reported it on 4/29/10. She gave a history of working in the control room and transporting prisoners. She stated that she carries heavy bags of chains for handcuffs, leg irons and leg cuffs, as well as her weapon. She noted that while working in the control room she would sit at the counter and pass information under her window, and then open and close doors by pushing a button. She stated that these were beyond the normal arm's reach. She noted that she would have to scoot and reach continuously throughout the day. She stated that she would have to reach about 4 feet to reach the hole to pass things through and 4 feet to the control panel. She also stated that she was constantly twisting, turning and reaching in order to see the mirror and door behind her and to her side to carry out her job. She stated that she developed left hand numbness and tingling, as well as left elbow pain and stiffness. She stated that she could not straighten her left elbow, then took a leave and it helped somewhat. She stated that in January of 2010 she had to go qualify for firearms, and she could not use her right hand to cock the gun or pull the slide. Petitioner gave a history of her treatment with Dr. Shin.

Petitioner gave Dr. Eiler a work history of constantly reaching farther than the normal 24 inch reach that is usually accompanied in the front extremeties, such as a kitchen counter. Petitioner told Dr. Eiler she was reaching up to 4 feet, scooting a stool and reaching. Dr. Eiler was of the opinion that these actions caused

petitioner to hyperextend and reach out with the arm on a continuous basis, scooting chairs, grabbing at the counter in order to pull, and using her hand to pull along the desk and counter in order to reach out to turn on the switches to open and close the various panels. She stated that she did this repeatedly throughout an 8 hour day, outstretching her left arm. She also reported that she had to reach to pass folders and materials through the pass-through base of the window continuously, in addition to the looking over her shoulder to the window. With respect to the control panel she stated that she would have to reach over with her body and then push and lift her hand from those controls rather than having them within a close reach. Again she stated that she did this throughout the day, and this contributed to her condition. Dr. Eilers believed her setup was not ergonomically designed. He noted that with her constant reaching, she would lean on the elbow and reach forward, and this caused the olecranon bursitis that she had, and the constant reaching in order to reach the controls on the far side caused her triceps tendonitis. He noted that both these conditions improved in therapy.

Following an examination and record review Dr. Eilers' impression was left carpal tunnel secondary to repetitive work activities of reaching, pushing and using weapons, which was a recurring problem that she had had within her work setting; left triceps tendonitis, resolved; left medial epicondylitis which is resolving and showing minimal findings on examination; and resolving left cubital tunnel syndrome. Dr. Eilers opined that petitioner's findings were consistent with an overuse syndrome due to poor ergonomic design. He was of the opinion that it was relatively classic with her left upper extremity developing the carpal tunnel, the olecranon bursitis, as well as the median epicondylitis which she described due to having to reach up to 3-4 feet. He was of the opinion that petitioner was exceeding the normal reach zone of 2 feet by upwards of 2 feet to reach the control panel. Dr. Eilers believed petitioner did this anywhere from 40-100 times an hour in an 8 hour day. He believed this would be considered repetitive. He also believed that with scooting and reaching, generally one would have to lean on the elbow and reach out. Dr. Eiler also believed that her table heights were higher and almost to her chest level. He was of the opinion that this would be more aggravating because she would be reaching and extending and impacting the olecranon with these activities, as well as slightly supinating in order to try and reach the buttons at a distance, hyperextending and extending her wrist. Dr. Eilers was of the opinion that these types of patterns she described were consistent with poor ergonomic design, and have resulted in her epicondylitis, the olecranon bursitis, as well as the cubital tunnel syndrome. He was of the opinion that all these things are related to hyperextension, and her reaching and resting on the olecranon. He also believed her carpal tunnel was caused by these repetitive tasks, as well as those of lifting, carrying, and the hauling of chains and other devices.

Dr. Eilers opined that petitioner's work activities are the direct and proximate cause of her injuries that were diagnosed on 4/29/10. He further opined that the treatment for the olecranon bursitis, carpal tunnel and the epicondylitis is directly related to the injury she sustained. He recommended a more ergonomical work setting.

On 12/1/11 the evidence deposition of Dr. Eilers was taken on behalf of petitioner. Dr. Eilers believed that petitioner would push up onto her left elbow and the put her left palm on the table to scoot up, and then reach to the window with her right hand. He opined that she pressed the buttons with her left hand. Dr. Eilers noted that petitioner had left hand numbness, tingling and numbness for 30 years, but only worked for respondent for 19 years. He also testified that he did not know how much the duffle bag she carried to court weighed, how often or long she carried it, and which hand she carried it in. He also did not know what time frame she carried this bag to court. Dr. Eilers also testified that he did not know where the buttons she pushed were located in relation to where she worked, or how much pressure was needed to press the button. Dr. Eilers also believed petitioner had to reach four feet to reach the chuck hole over a very high table. Dr. Eiler testified that he did not see a written job description detailing the scope of petitioner's job activities. Dr. Eilers could not state with any certainty the frequency with which petitioner reached and/or pushed the buttons. He did not think it mattered. He believed it was the activity itself that caused the problem.

Petitioner testified that she had a history of left hand pain, numbness and tingling for over 30 years. Then she stated that her right hand problems started that far back and her left hand symptoms started more recently. She attributed her right carpal tunnel to the opening of locks at another prison. She stated that she had no pain in her left hand when she had her right carpal tunnel release done. She also stated that in the time period leading up to the alleged injury she had different duties and did not got to the towers.

On cross examination petitioner testified that while working she covered two meals per day for the inmates and got a 30 minute break for herself. Petitioner testified that the chuck hole is used for passage of inmate work cards or passes. Petitioner testified that she would buzz in using the control panel button 100-120 times a day. She also testified that she reached to the chuckhole 100 times a day. She testified that throughout the day she did not always sit to perform her job. She testified that if she performed her job standing she would have to reach forward to get to the chuck hole. Petitioner testified that if a large line of inmates was passing through the doors she did not use the chuck hole. That was used only for passes. Petitioner testified that she would buzz the inmates in for food lines, gym lines, yard lines and school lines. For each worker or person with a pass she would access the control panel twice.

Petitioner testified that each time she pushed the control panel button 100-120 times a day it only took a second. She also testified that it only took a few seconds each time she had to reach for the chuckhole 100 times

a day. She agreed that the total time she spent pushing the button on the control panel was 2 minutes a day, and reaching to the chuckhole was a total of 6 minutes a day. When petitioner carried the duffle bags it was to and from the courthouse one time each time she took a prisoner to court. Petitioner did this two times a week. She testified that she carried the bag with her left hand.

On redirect examination petitioner testified that it was the reaching for the chuckhole and pushing off the counter to reach the chuck hole that caused her problems. She testified that the act of pushing the button did not cause her problems, but rather grabbing the counter and scooting over to the control panel to push the button that caused her problems. Petitioner testified that she did not use her feet to move the chair over to the control panel because the floor tile was broken. Petitioner denied her symptoms in her left hand in 2004 were due to carpal tunnel. She testified that that she believed they were due to the ruptured disc in her neck at that time.

Curt Eubanks, Public Service Administrator and Unit Superintendent at Dixon, was called to testify on behalf of the respondent. Eubank was the Duty Administrator for the Dixon facility, and performed inspections tours of the institution. He had knowledge of the control room and the job duties. He also had general knowledge of the control room officer job from working occasionally as a control room operator from 1985-1989. He testified that he was familiar with Control Room 27. He agreed that the tile in that control room was worn like in the other control rooms.

Eubanks testified that a control room officer is responsible for the security of the housing unit through the control and movement of the inmates and surveillance of the inmates and staff. He stated that the control room officer is also responsible for logging unit activities and reporting incidents. Eubanks testified that the job is mostly performed while sitting. Eubanks testified that petitioner would leave the control room each morning to verify the inmate count in the housing unit. To do this, petitioner would leave the control room and physically walk the unit and verify the count of the inmates.

Eubanks agreed that when large blocks of inmates are in line movement there may be gaps and petitioner may be have to hit the control button multiple times to open the doors. He testified that the morning meal line contains about 100-125 inmates and 2 officers escort them. He also testified that the chuck hole is used for work passes, education passes, and medical, dental or psych passes. He stated that passes are used for individual movement. No passes were needed for group movement. Eubanks testified that during the day shift, which petitioner worked, she may be presented with up to 40-80 passes a day through the chuck hole. Eubanks testified that in addition to her work at the control panel petitioner was also required to take inventory of three sets of keys, radio and other special equipment and enter it on a shift report.

Petitioner testified that she has been a ½ pack a day smoker for twenty years.

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 INJURY?

Petitioner is alleging an accidental injury to her left arm, elbow and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

The arbitrator finds the credible medical evidence shows that petitioner was diagnosed with bilateral carpal tunnel syndrome in 2004 when she underwent her right carpal tunnel release. Although petitioner had complaints of tingling and numbness in her left hand at that time she did not have any pain. As such, petitioner did not undergo any surgery for the left hand in 2004.

It is unrebutted that petitioner has worked for respondent for 30 years, and has been assigned to the control room for the past two years. Respondent offered into evidence three pictures of another control room that petitioner testified was the same as the one in Housing Unit 27, where she worked. She also testified that she would sit in the same position as the female in the picture was sitting. The petitioner gave a history to Dr. Eilers that she would have to reach 4 feet to reach the chuck hole. Neither party offered into evidence the exact length of the table petitioner worked at. However, after viewing respondent's exhibit 9 the arbitrator finds that if petitioner was sitting where the officer in the picture is, like she stated, the distance she would need to reach to get to the chuck hole looks more like a distance of a two feet at most.

The petitioner testified that to reach the chuck hole she would place the palm of her left hand on the edge of the table and push up and then reach to the chuck hole with her right arm. Petitioner offered no testimony that she would put any weight on her elbow on the desk when she performed this movement. In fact, she stated all the weight was on her left palm when she pushed up off the table.

Petitioner testified to reach the control panel, which appears in respondent's exhibit to be no further than two feet from where the officer is positioned in the picture, she would grab the edge of the table with her left hand and scoot her chair over so that she could reach the control buttons with her left hand. Petitioner testified that her left elbow would be extended when she would reach to press the buttons on the control panel. The arbitrator finds that if this is the case the petitioner would most likely not scoot more than a foot or so from where the officer is seated in respondent's exhibit 9 to be able to reach the control panel with an extended left arm. If petitioner scooted over further than that there would be no need for her to have her arm fully extended to reach the buttons on the control panel.

Petitioner would only work in the control room 3 out of the 5 days she worked per week. At the beginning of her shift she would leave the control room to verify the count of inmates in the Housing Unit. This would take maybe 5 minutes. She testified that she worked in the control room from 7 am to 3 pm. Petitioner testified that she got a 30 minute lunch during that period. Eubanks also testified that in addition to her work at the control panel petitioner would also be required to take inventory of three sets of keys, radio and other special equipment and enter it on a shift report each shift.

Petitioner would press the buttons on the control panel to let inmates move through the building for job assignments, going to the library or medical, in guard lines, gym lines and to and from meals. Petitioner testified that it was not the act of the pushing the button on the control panel that caused her problems, but rather the act of grabbing the edge of the table to slide over to press the button. Petitioner testified that she may press the control panel button 100-120 times a day. However, she also testified that many of these button pushes were associated with lines of inmates moving through at one time. For example, she stated that if a line of 40 inmates were passing through a door she may have to hit the button on the control panel 15 different times. The arbitrator notes that even though petitioner may have to hit the button 15 times to get the line through the door, she would only have to shift over to the panel once to push the button 15 times to let the line go through. Based on this testimony, the arbitrator reasonably infers that even though petitioner may have to hit the control panel button 100-120 times per day, the actual number of times she would have to scoot herself over to the control panel using her left arm could be considerably less than the total number of buttons pushed given that there could be up to 15 button pushes associated with only one scooting with the left hand.

With respect to the chuck hole the petitioner testified that she had to press down with the palm of her left hand on the edge of the table to push up so that she would reach the chuck hole with her right hand to process the passes. Petitioner testified that she would have to get up on the palm of her left hand about 100 times a day

to reach the chuck hole. However, Eubanks testified that petitioner may be presented with only 40-80 passes a day through the chuck hole.

Petitioner testified that the total time per day she spent reaching to the chuck hole and reaching to the control panel was less than ten minutes during her entire shift.

Petitioner testified that the two days she is not in the control room she is transporting prisoners to court. She testified that she is usually responsible for carrying the duffle bag with lunches and extra shackles. She testified that the bag would weigh between 10-20 pounds and she would carry it in her left hand from the Housing Unit to the car, from the car to court, from court back to the car, and then back into the housing unit. The distance she would carry the bag would vary from 100 feet to ½ block when she was at court. The arbitrator finds the most petitioner would carry this bag is 6 times a day, two days a week, with most distances being very short.

Based on the above, as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10.

Petitioner provided a history to Dr. Shim of reaching to the left over and over again at work. The arbitrator finds this history inconsistent with the credible record. When petitioner had to reach to the chuck hole she pushed up on her left palm and in fact reached to the chuck hole with her right arm. And with respect to the control panel, petitioner testified that the reaching to push the button was not the problem. She stated that it was the grabbing of the table with her left hand to shift towards the control panel. Petitioner did this action far less than she did the pushing of the buttons on the control panel.

When petitioner presented to Dr. Eilers she reported that she had to scoot and reach continuously throughout the day. She also stated that she had to reach four feet to reach the chuck hole and another four feet to reach the control panel, and testified that she was constantly twisting, turning and reaching in order to see the mirror and door behind her and to her side. Dr. Eilers believed that petitioner would lean on her left elbow to reach the chuck hole. The arbitrator finds these activities are inconsistent with the testimony petitioner provided at trial and the credible evidence, including the respondent's exhibits 7-9. Additionally, in his deposition Dr. Eilers did not know the weight of the duffle bag petitioner carried, how long she carried it, or how much it weighed. He also did not know where the buttons petitioner pushed were in relation to where she worked. Dr. Eiler could also not state with any certainty the frequency with which petitioner reached and/or pushed button.

The arbitrator finds it discerning that Dr. Eilers did not feel that these things mattered as they relate to his opinions.

Based on the above, as well as the credible record, the arbitrator finds the opinions of Dr. Eilers and Dr. Shin were based on a job history that was not accurate with the actual duties petitioner performed. As such the arbitrator does not give much weight to the causal connection opinions of Dr. Shin and Dr. Eilers. The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her left arm, elbow, and hand is causally related to any alleged injury on 4/30/10.

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?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10, and she has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her left arm, elbow, and hand is causally related to any alleged injury on 4/30/10, the arbitrator finds these remaining issues moot.

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

Paul Smith,
Petitioner,

14IWCC0074

vs.

NO: 12WC 32900

State of Illinois - Southwestern Illinois Correctional Center,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, 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 14, 2013, 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.

DATED: FEB 0 3 2014

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

o012814
CJD/jrc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, PAUL
Employee/Petitioner

Case# **12WC032900**

ST OF IL/SOUTHWESTERN ILLINOIS CORRECTIONAL CENTER
Employer/Respondent

14IWCC0074

On 1/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0514 ASSISTANT ATTORNEY GENERAL
GLISSON, RICHARD C
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 14 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paul Smith
Employee/Petitioner

v.

State of Illinois / Southwestern Illinois Correctional Center
Employer/Respondent

Case # 12 WC 032900

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **November 9, 2012**. 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. [ ] 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 **7/25/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**45,816.00**; the average weekly wage was $**881.08**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **1** dependent child.

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

Respondent stipulated it will pay all appropriate charges for all reasonable and necessary medical services.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$649.00**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$528.65**/week for 24.3 weeks, because the injuries sustained caused the 15% loss of **Petitioner's left eye**, 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

Jan. 4, 2013
Date

JAN 14 2013

Findings of Fact

Petitioner is a Correctional Officer at Southwestern Illinois Correctional Center. As a part of his employment, Petitioner is a member of the TACT team. The TACT team is a Special Operations Response Team (SORT) that takes care of riots, hostages, staff assaults, major shakedowns, and searches of facilities. SORT is called in to handle violent situations within prisons throughout the State of Illinois. To be a part of this Special Operations Response Team, Petitioner is required to attend 40 hour certification training course in Springfield, Illinois.

Petitioner explained that part of his training includes getting sprayed in the face with a chemical agent known as pepper spray. The purpose of this portion of the training is to give the officer of an understanding of what it feels like to have a chemical agent deployed so that the officer does not panic and is able to fight through the sensation during a riot situation. Furthermore, the training assists the officers to have empathy so that the officer doesn't use this chemical agent on an inmate in an unjustified manner.

During the week of 7/25/12, Petitioner was in Springfield for TACT training. Petitioner described that he was to be sprayed with pepper spray and then go through an obstacle course. When an officer is sprayed with pepper spray, he is to cover one eye with his palm and then look at the instructor who that is going to spray him with the chemical agent. He is instructed to state his name, rank, and institution. After he does so, he is to close his eye and then be sprayed in the mucous membrane. As the officer opens his eye, the chemical agent is to run into the eye and you are to look at the instructor until you are told to run through the obstacle course. The first portion of the obstacle course requires throwing ten elbow strikes at an instructor holding a pad. The second portion of the obstacle course requires running to the next station in which the officer throws ten knee strikes to an instructor holding a pad. The third station requires the officer to throw ten punches, take an inmate down, and hand cuff the inmate. The officer is then to be taken to decontamination.

On 7/25/12, Petitioner testified that this procedure was not followed completely. As he stood in front of his instructor, he covered one eye, looked at him, began to state is name, rank, and institution, but before he could get any further than his name, he was sprayed directly into his left eye. Petitioner closed his eye, finished what he was supposed to say, opened his eyes and looked at the instructor and was sprayed again for the second time in his open eye. Petitioner testified that he was able to complete the obstacle course and his training in Springfield, however, with much difficulty.

Petitioner described that the second day, his left eye was very irritated and very red. It was sensitive to light and the vision on his left was "pretty much gone," meaning everything was blurry. He could not make out anything more than 5 feet away from his left eye. Petitioner testified that his right eye, while irritated initially, resolved with no problems. Petitioner's left eye became so sensitive to light that he had to wear sunglasses, not only inside the gymnasium in Springfield, but also in his house when he returned home. He folded a wash cloth over his eye and taped it underneath sunglasses so he could bear sitting on the couch and looking at the TV. He testified he experienced a migraine because of the filtering of the light into his eye. Petitioner decided that he needed medical treatment and obtained this as soon as he returned from training.

Medical records indicate that Petitioner saw Dr. Trent McDaniel on 7/27/12 at 4:30 p.m. Dr. McDaniel took a consistent history of injury and noted that Petitioner continued to suffer with redness, drainage, and photophobia in his left eye. Physical examination revealed that Mr. Smith had moderate diffuse conjunctivitis of the left eye. Fluorscein examination revealed two moderately sized corneal abrasions, one on the interior aspect and one on the inferior aspect of his left cornea. Assessment was corneal abrasion, secondary to pepper spray in his eyes two days ago. Dr. McDaniel contacted poison control and they recommended a referral to an eye doctor. Dr. McDaniel personally spoke with Dr. Johnson at Illinois Eye Surgeons in Breese, who agreed to see Mr. Smith right away. Petitioner was instructed to go straight to Dr. Johnson's office in Breese that evening for "further and immediate evaluation."

The record reflects that on the same date, Petitioner was seen by Illinois Eye Surgeons. The history was pepper spray in left eye with corneal abrasion. Dr. Johnson noted a positive examination for photophobia and pressure in Petitioner's eye. The records note "feels like someone is pushing on eye." Examination was positive for water, matted shut, yellow junk, and blurry vision. Petitioner's eye exam revealed 20/20 vision in the right eye and 20/40-2 in the left eye. Dr. Johnson's impression was injury from close range, pepper spray. Medication and follow up were recommended.

Petitioner testified as to his examination at Illinois Eye Surgeons. A paper stick was used to put different dyes in his eyes. He was able to see UV light that infiltrated the inside of his eye because of the hole pierced through his cornea. It was his understanding that the UV light should have only been on the outer portion of his eye. Petitioner understood his diagnosis that there was a chemical burning inside of his cornea and there had been a hole pierced into his cornea by the stream of pepper spray. Petitioner was referred to a retinal specialist the next day. He was given a contact lens bandage to place over his eye to keep air and everything out of it until he saw the specialist the following morning at the Maryville office. He followed up with the retinal specialist, who took the bandage lens out of his eye for his examination and put a fresh one on and had him leave it there until his healing had progressed. He was prescribed lubricating eye drops and steroid eye drops. Petitioner was required to use these eye drops 2-4 times a day. During his treatment, Petitioner testified that he remained sensitive to light, was not able to go outside without sunglasses, and was not able to step in any situation where the lights changed because his pupil wasn't able to dilate. He testified that his eye was irritated and burned quite a bit. Crushed pepper continued to ooze out of Petitioner's eye from where it was sprayed and his vision was interrupted.

Petitioner was last seen for treatment on August 27, 2012 at the Illinois Eye Surgeon facility. His vision remained 20/25 on the left and 20/20 on the right. The impression was of a corneal abrasion resolved, with normal pressure. (PX 4)

Petitioner testified that, prior to this incident, he had only ever had 20/20 vision in both of his eyes. He had never had any prior medical treatment to his eyes. Notably, the medical records reveal that as of his second examination, Petitioner's vision in his left eye had decreased to 20/50+, it reached 20/30+2, and eventually 20/25 as of his last visit. The vision in his right eye remained constant at 20/20. Petitioner testified that when he was hired with the Department of

Corrections, he underwent an eye exam where both eyes were a perfect 20/20. Respondent produced no evidence in reubittal.

Petitioner testified that since the incident, he has continued to work full duty and he was told at Illinois Eye Surgeons that his left eye was as good as it was going to get. Petitioner continues to use lubricating eye drops. Due to the chemical burn, his eye dries out very quickly and he has to use the drops so he doesn't feel like he has something in his eye when it gets dried out. With regard to his vision, Petitioner testified that it has "definitely deteriorated." Petitioner testified to difficulty looking over long distances or looking at anything small. He has to close his eye and just look with his right eye and this helps him to see more clearly. Petitioner testified that when he tries to read a book for an extended amount of time, he begins to get headaches, which has never happened before. In his spare time, Petitioner enjoys working on computers. It is now difficult for him to work on small parts, make repairs to mother boards, and plug wires because he gets headaches easily. When he's driving, it is difficult to make out signs that are further away because he is used to being able to see at those distances and he is not able to do that anymore. Petitioner testified that his vision is 20/25 in the left eye, with a borderline of 20/30.

Petitioner also has difficulty shooting to qualify with different weapons annually with the Illinois Department of Corrections. Petitioner testified that this was the first year he was unable to qualify at the expert shooting level. His score dropped a total of 10 points. The two prior years of qualifying, he shot at the expert level. Additionally, he has had to change the way he shoots guns. Especially with rifles, where Petitioner is required to shoot to 150 yards, he can no longer get that far with both eyes open, so he has to close one eye to be able to see the target and shoot. Petitioner further testified that he loves to play billiards and longer shots are very difficult for him.

Conclusions of Law

With regard to whether Petitioner's current condition of ill-being is causally related to the injury (as it relates to nature and extent):

The Arbitrator finds that Petitioner's injury to his left eye is causally related to his work injury of 7/25/12. Both, Dr. McDaniel and Dr. Johnson at Illinois Eye Surgeons, related Petitioner's left eye condition to him being sprayed at a close range with pepper spray while in training for his employment. There is no other cause for the condition of his left eye in the record. Furthermore, Petitioner testified to perfect 20/20 vision prior to this incident and never having any other prior medical treatment with regard to either eye prior to this incident.

Respondent produced evidence in rebuttal, no witnesses to dispute Petitioner's testimony, and elected not to have Petitioner examined under Section 12 of the Act. As a result, based upon Petitioner's credible testimony, and the medical records of Dr. Trent McDaniel and Illinois Eye Surgeons, the Arbitrator finds that Petitioner's condition is causally related to his work injury of 7/25/12.

With regard to the reasonableness and necessity of Petitioner's medical services:

Petitioner's medical care and treatment was reasonable and necessary. He treated with his primary care physician who referred him to a specialist for approximately six weeks of care. Respondent stipulated it has or will pay the medical bills contained in Petitioner's group exhibit pursuant to Section 8.2, the medical fee schedule contained in the amendment to the Illinois Workers' Compensation Act. Respondent shall receive credit for any and all amounts previously paid. However, if Petitioner's group health carrier requests reimbursement, Respondent shall indemnify and hold Petitioner's harmless.

With regards to the nature and extent of the injury:

Pursuant to Section 8.1(b) of the Act, the following criteria must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after 9/1/11:

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

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

- (i) the reported level of impairment;
- (ii) the occupation of the injured employee;
- (iii) the age of the employee at the time of injury;
- (iv) the employee's future earning capacity; and
- (v) evidence of disability corroborated by medical records.

With regards to (i) of Section 8.1(b) of the Act:

Neither party submitted an AMA level of impairment in this matter. Consequently, the Arbitrator will consider the other four factors in rendering a decision with regard to permanent partial disability.

With regards to (ii) of Section 8.1(b) of the Act:

The Petitioner's occupation is Correctional Officer /TACT Team member whom the Arbitrator takes judicial notice of being heavy work and concludes that Petitioner's permanent partial disability will be larger than an individual who performs lighter work.

With regard to (iii) of Section 8.1(b) of the Act:

The age of Petitioner at the time of the injury was 30 years old. The Arbitrator considers Petitioner to be a younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual because he will have to live with his permanent partial disability longer.

With regard to (iv) of Section 8.1(b) of the Act:

At the present time, Petitioner's future earning capacity appears to be undiminished as a result of his injuries because he has been medically returned to his full time duties. However, upon his return to work, he has noted that his vision is worse and he is longer able to see long distances while driving and shooting, both of which are necessary for his job. The Arbitrator concludes that this may negatively affect Petitioner's future earning capacity.

With regard to (v) of Section 8.1(b) of the Act:

The Petitioner has demonstrated evidence of disability corroborated by his treating medical records. Petitioner's credibility testified that he currently experiences eye irritation, is required to use eye drops, experiences difficulty with vision loss, and experiences difficulty with tasks such as driving, reading, and shooting a gun. The medical records demonstrate that Petitioner has had reduced vision and continued symptoms up until the date of his last treatment.

The determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of all 5 factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, 820 ILCS 305/8.1b, the Petitioner has sustained accidental injuries that caused 15% loss of use of the left eye. The Arbitrator further finds that Respondent shall pay the Petitioner the sum of $528.65/week for a further period of 24.3 weeks, as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4
☐ 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

Terri Eggers,
Petitioner,

vs. NO: 12 WC 26650

Steak N' Shake,
Respondent.

14IWCC0075

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, medical expenses, prospective medical expenses, and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 April 15, 2013 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.

14IWCC0075

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,100.00. 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.

DATED: FEB 0 3 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-01/27/14
drd/wj
68

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

EGGERS, TERRI
Employee/Petitioner

Case# **12WC026650**

STEAK N' SHAKE
Employer/Respondent

14IWCC0075

On 4/15/2013, 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:

0717 MOOS SCHMITT & O BRIEN PC
HENRY A SCHMITT
331 FULTON ST SUITE 314
PEORIA, IL 61602

0358 QUINN JOHNSTON HENDERSON ETAL
JOHN F KAMIN
227 N E JEFFERSON ST
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TERRI EGGERS
Employee/Petitioner

v.

STEAK N' SHAKE
Employer/Respondent

Case # **12** WC **026650**

Consolidated cases: **N/A**

14IWCC0075

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **February 25, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [x] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **May 28, 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 $**5,077.04**; the average weekly wage was $**97.64**.

On the date of accident, Petitioner was **45** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of $**0** in TTD, $**0** in TPD, $**0** in maintenance, $**0** in non-occupational indemnity disability benefits, and $**0** in other benefits for which credit may be allowed under Section 8(j) of the Act.

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 $97.64/week for 39 1/7 weeks, commencing May 29, 2012 through February 25, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $10,157.00, as provided in Section 8(a) of the Act.

Petitioner's petition for penalties and attorney's fee is denied.

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

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

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

Nancy Lindsay
Signature of Arbitrator

4.10.13
Date

ICArbDec19(b)

APR 15 2013

Terri Eggers v. Steak N' Shake, 12 WC 026650 (19(b))

ADDENDUM TO
ILLINOIS WORKERS' COMPENSATION COMMISSION
Arbitration Decision

The issues in dispute are accident, notice, causal connection, medical, temporary total disability, and penalties and fees. Petitioner and Sherry Hall testified at arbitration.

The Arbitrator finds:

Petitioner was employed by Respondent in Mattoon, Illinois in May of 2012. Her primary job involved working the fountain which involved preparation of desserts, sundaes, and milk shakes – primarily milk shakes. Petitioner testified that for several years prior to May 24, 2012 Petitioner would use a spade, similar to a spatula, to scoop either ice cream or shake mix into containers used to prepare drinks at the fountain. Petitioner is right-handed.

Petitioner testified that about a week before May 28, 2012 they received a bulletin informing them not to use the spade/spatula anymore. Petitioner's manager, Jessica, took the spade away and instructed Petitioner to use a scoop that she would pull across the top of the containers of ice cream and mixtures. Petitioner testified that she worked a couple of days using the scoop and noticed "it" started getting really sore. Petitioner thought she had perhaps twisted her wrist. Petitioner denied having any problems with her right wrist before she started using the scoop.

Petitioner testified that on May 25, 2012 (a Friday) she was using the scoop all the time. Petitioner came in on Saturday but didn't make shakes. Petitioner testified that on Sunday her wrist was worse so she wrapped it. Petitioner then came in to work on Monday, May 28th, at 9:00 a.m. to tear down the fountain. Petitioner testified that she had her hand wrapped and when she saw Ben, one of the managers, she told him she thought she had irritated it scooping. Petitioner returned to using the spade. Jessica, another manager, came in at 11:00 and told Petitioner she couldn't use the spade and had to use the scoop or else leave. Petitioner testified that she left.

Petitioner's testimony regarding the foregoing was unrebutted.

The following day, May 29, 2012, Petitioner went to Sarah Bush Lincoln Health Center emergency room. According to the medical records, Petitioner complained of right forearm pain, noting that she worked for Respondent scooping ice cream. Petitioner explained that she had recently begun using a new scoop at work and since then had developed a grinding sensation when moving her right forearm. She reported improvement when she was off work and not scooping but when she resumed working, things got worse. Petitioner complained of pain but no numbness, tingling, redness, swelling or bruising. On physical exam, Petitioner had a positive Finkelstein's test and the doctor was able to palpate a grinding sensation in her forearm with

range of motion. Petitioner was also tender along the tendon. The doctor's impression was right forearm pain with probable tendinitis and he recommended rest at home and a thumb spica splint. An off work slip was provided. Additional conservative treatment measures were discussed. An x-ray was negative for evidence of fracture or bony lesions. (PX 4)

Petitioner testified that she has not worked for Respondent since May 28, 2012.

Petitioner testified that she also met with the general manager of her store, Sherry Hall, on the Monday she was to start her shift. She described to her that she was having forearm pain and testified that she told Sherry Hall she did not know what was wrong with her arm.

Petitioner presented to Dr. Sandercock, a board certified doctor of osteopathy, on May 31, 2012. At that time, Petitioner described right wrist and upper extremity pain, noting she was having trouble since she had switched ice cream scoops at work a week or so earlier. Petitioner described a "squeaking sensation in her arm" which Dr. Sandercock confirmed on examination. (PX 1) Dr. Sandercock diagnosed tendinitis in the right forearm and prescribed therapy and medication. He continued her off work for two weeks. At his deposition Dr. Sandercock explained that then tendons Petitioner had injured were the ones used to extend one's wrist and fingers. (PX 1)

Petitioner presented for an occupational therapy evaluation on June 6, 2012. Petitioner reported right wrist tightness, pain with range of motion, and decreased grip which she associated with scooping ice cream at work. Petitioner's attendance at physical therapy was described as inconsistent. At the June 28th visit she reported tripping over her cat and falling on her hand. (PX 4) At arbitration Petitioner was asked about the history provided at this visit. Petitioner denied giving the therapist that history as she didn't even have a cat at that time.

Petitioner remained under the care of Dr. Sandercock who treated Petitioner with medication, a corticosteroid injection, and suggested a trial of prednisone which Petitioner was unable to try due to its side effects. As of July 16, 2012 his diagnosis remained tendinitis albeit chronic. He ordered an MRI and continued to keep Petitioner off work. (PX 1)

Petitioner underwent an MRI of her right radius, ulna, and forearm on July 17, 2012 which was read as normal. (PX 1; PX 2)

An Addendum to the July 17th MRI report was issued on July 24, 2012 and discussed with Dr. Sandercock. In the Addendum it was noted that subtle, peritendinous edema at the intersection of the 1st and 2nd extensor tendons along the dorsal aspect of Petitioner's distal forearm was present. (PX 2)

Petitioner followed up with Dr. Sandercock on July 24, 2012. Her physical examination and diagnosis remained unchanged although Dr.Sandercock listed Petitioner's condition as that of right forearm intersection syndrome. Petitioner was still in therapy which he instructed her to continue going to. Otherwise, he told Petitioner she could return on an as-needed basis. (PX 1)

Petitioner returned to see Dr. Sandercock on August 9, 2012. Her complaints were unchanged and the doctor noted he wanted her to continue an aggressive occupational therapy program. Occupational Therapy was contacted by the doctor and it was reported that Petitioner had been inconsistent and noncompliant in her therapy program. Petitioner was advised of the importance of attending her therapy and given a prescription for meloxicam. Petitioner was to return in one month or as needed. Petitioner was given restrictions for work, a copy of which was mailed to Respondent. (PX 1)

Petitioner's attorney wrote Dr. Sandercock on September 25, 2012 requesting his opinion on causation between Petitioner's condition and her "work-related scooping of frozen shake base." (PX 1) In a letter to Petitioner's attorney dated October 8, 2012, Dr. Sandercock stated that it was his opinion that Petitioner's chronic tendinitis was caused by Petitioner's repetitive work-related scooping of frozen shake base. (PX 1; PX 3)

Petitioner next presented to Dr. Sandercock on October 9, 2012. Petitioner's symptoms had changed somewhat and she was now complaining of some numbness in her fingers. Petitioner was given a second injection. She questioned the possibility of carpal tunnel syndrome and, therefore, an EMG was ordered. (PX 1)

By letter dated October 19, 2012, Respondent's attorney forwarded information to Dr. Evan Crandall regarding an upcoming independent medical examination with Petitioner. Counsel wrote, "[Petitioner] was diagnosed with tendinits and intersection syndrome of her right forearm. We question whether or not this is related to the patient's work." (RX 1, dep. ex. 4)

The EMG was performed on October 25, 2012 and was normal. (PX 1)

Petitioner underwent an independent medical examination with Dr. Evan Crandall on October 24, 2012. Dr. Crandall issued a "24 Hour Quick Report" in which he indicated Petitioner needed a nerve conduction study and that he did not yet know if her condition was work-related and/or if she had reached maximum medical improvement. He did believe she could return to modified duty with no scooping using the right hand and no lifting over 15 lbs. (RX 1, dep. ex. 7) In his lengthier report of the same date, Dr. Crandall reviewed his physical examination noting a positive provocative test and positive arm raise test on physical examination. He found Petitioner's symptoms suggestive of, and consistent with, carpal tunnel syndrome and he agreed she needed a nerve conduction study. Once that was done, he would make further recommendations. In the interim, he recommended Petitioner refrain from scooping with her right hand. He did not believe that it was necessary to take her off work for five months. Based upon the medical records he reviewed, Dr. Crandall thought Petitioner's MRI was normal. He testified that if Petitioner did have carpal tunnel syndrome it would be work-related and that while she had minor medical risk factors for carpal tunnel syndrome (gender, menopause and smoking) these were not as important as the ice cream scooping. (RX 1, dep. ex. 2)

Dr. Crandall issued a supplemental report to Respondent's attorney on November 7, 2012[1]. In that report Dr. Crandall noted that the nerve conduction study was normal. He did not believe Petitioner had carpal tunnel syndrome but felt she should be treated conservatively with stretching exercises and anti-inflammatory medications as needed. He was also of the opinion Petitioner could return to work without any restrictions and that she had no objective evidence of any permanency. (RX 1, dep. ex. 3)

Petitioner returned to see Dr. Sandercock on November 26, 2012. Petitioner reported having seen Dr. Crandall and being advised by him that he felt she had a component of carpal tunnel syndrome even though the EMG did not correlate with that finding. Dr. Sandercock noted a positive Tinel's at the carpal tunnel and less tenderness at the intersection of the first and second compartments. Dr. Sandercock performed a carpal tunnel injection which he testified was done as a "partly diagnostic/partly therapeutic" measure. (PX 1) Dr. Sandercock testified that when he re-examined Petitioner six weeks later, she indicated some relief from the carpal tunnel injection. (PX 1)

By letter dated November 27, 2012, Respondent's attorney forwarded to Petitioner's attorney a copy of Dr. Crandall's initial and supplemental reports. Based upon Dr. Crandall's opinion that Petitioner could return to work without restrictions and the lack of any suggestion of permanent disability, Petitioner was asked to report to work. (PX 10)

Petitioner testified that after "we" got the November 27, 2012 report she called Sherry Hall about returning to work. Ms. Hall told her she would have to call her attorney. According to Petitioner, Ms. Hall later called her back and told her she could not come back to work with any restrictions – she had to be at one hundred percent and not need the brace. (See also PX 9, 12/11/12 correspondence) Petitioner did not return to work and she applied for unemployment which she has been receiving.

By letter dated November 30, 2012 Petitioner's attorney advised Respondent's attorney that Petitioner had contacted Ms. Hall and requested work but that, to date, Respondent had not offered her work. The letter also states that the opinions contained in the letters from Dr. Crandall appeared to be different from what Dr. Crandall told Petitioner at the time of the examination. (PX 9)

Petitioner testified that her right wrist still hurts and she has sharp pain in the front, back, and shooting up to her elbow. Petitioner testified that she performs her home exercises but they hurt. She also testified that she continues to wear her brace and does so all of the time except when showering or doing dishes. Petitioner sleeps with it on. Petitioner also testified that she tried scooping sherbet but it hurt really bad and almost had her in tears. Petitioner misses her work because she enjoyed it.

Petitioner was asked about any criminal background. Petitioner volunteered that prior to going to work for Respondent she had entered a plea in a forgery case stemming from a domestic

[1] The report is dated November 7, 2013

matter and a shared checking account. Petitioner received probation and ended up serving some prison time when she tested positive for drugs during her probation. Petitioner testified that Sherry Hall knew about Petitioner's past and there had never been any problems as a result of it. Petitioner testified she was grateful for the opportunity to work for Respondent.

Petitioner also testified that she was treated at Sara Bush Hospital on December 4, 2012 for an abcess on her right finger that is totally unrelated to this claim.

In follow-up with Dr. Sandercock on January 10, 2013 Petitioner reported some improvement with the carpal injection and she requested a second one; however, Dr. Sandercock felt it was too early for a re-injection and suggested waiting two weeks. Petitioner was diagnosed with carpal tunnel syndrome. (PX 1) As of January 29, 2013, Petitioner's complaints remained unchanged and she reported the injections provided only temporary relief. Petitioner had tried scooping some sherbet at home but was unsuccessful. Her right upper extremity was neurovascularly intact, her strength was 5/5, and Petitioner displayed good pronation and supination strength. He described the tenderness at the intersection of the first and second extensor compartments as "mild." Range of motion was excellent and a positive Tinel's was noted at the carpal tunnel. Dr. Sandercock expressed uncertainty as to how to proceed and why she was not improving. He suggested a second opinion. He injected her carpal tunnel. (PX 1)

Throughout the foregoing time period Dr. Sandercock continued to write work restrictions for Petitioner. As of January 29, 2013 Petitioner was to wear a brace on her right wrist and not lift, push, pull, or engage in high force gripping or grasping, or climbing or overhead work with her right hand. (PX 1)

Petitioner testified that she has provided Dr. Sandercock's work restrictions to Respondent who has advised her it cannot accommodate her restrictions.

Dr. Sandercock, a board certified doctor of osteopathy, was deposed on February 5, 2013. He testified consistent with his office notes and records. Additionally, he testified that he has continued to describe Petitioner's tendinits/intersection syndrome as chronic because it has lasted longer than he expected. While he has provided her with conservative treatment over time, Petitioner has felt she was getting worse. Dr. Sandercock explained that he ordered Mobic as an anti-inflammatory in light of the swelling shown on the MRI. Based upon Petitioner's reports, the Mobic helped reduce the inflammation but caused Petitioner to have an upset stomach. As of the date of his deposition, he felt Petitioner still needed work restrictions limiting the use of her right hand. She also needed to wear a brace. He was of the opinion that Petitioner's use of the new scoop caused or contributed to both conditions. Dr. Sandercock further testified that the fact Petitioner experienced some improvement in her wrist after the carpal tunnel injection supported a diagnosis of carpal tunnel syndrome.

Dr. Sandercock candidly testified that he has no idea why Petitioner's case has been so protracted. (P.X. 1, p. 26)

On cross-examination, Dr. Sandercock confirmed that the diagnostic and therapeutic injections initially given did not relieve any of the Petitioner's symptoms. He confirmed that his diagnosis of carpal tunnel was based upon the conclusions of Dr. Crandall, Respondent's examining physician. He noted that that was not something he initially felt she was suffering from but noted that the fact that Petitioner had some relief of symptoms from a carpal tunnel injection would support that diagnosis. He confirmed that the EMG/NCV study indicated Petitioner's nerves were working properly. (P.X. 1, p. 31)

Dr. Sandercock testified that he could not recall seeing any swelling and did not have any evidence of swelling recorded in his notes. He noted there is no evidence of swelling proximal to the wrist nor was there any evidence of a ganglion cyst or swelling over the dorsal extensor compartment. Dr. Sandercock also noted that the radiologist who originally read the MRI did not find any evidence of swelling and an addendum was prepared after Dr. Sandercock spoke to a second radiologist who authored an addendum. He further pointed out that extensor swelling isn't always seen with tendinits. (P.X. 1, p. 34)

Dr. Sandercock testified that occupational therapy was intended to assist Petitioner in developing the strength to be able to operate the ice cream scoop. He noted Petitioner had been inconsistent with therapy attendance which could prevent her from getting to a point where she could go back to work in an effective pain free manner. (P.X. 1, p. 36) He also noted Petitioner's strength has been normal throughout his treatment and confirmed that his work restrictions for the Petitioner at this point were limited to the fact that the Petitioner herself said she could not perform her work and he was relying upon her credibility in expressing pain complaints. (P.X. 1, pp. 37-38) Dr. Sandercock also confirmed that there was a disparity as Petitioner's physical exam findings have improved but her complaints have not. (P.X. 1, p. 39)

Dr. Crandall was deposed on January 22, 2013. (R.X. 1, p. 1) Dr. Crandall is board certified in plastic surgery and plastic surgery of the hand. Petitioner told Dr. Crandall that she was having right wrist and hand pain and had been having problems since May 24, 2012. He conducted an examination which showed negative ulnar Tinel's sign, a positive median Tinel's sign, a positive provocative test to the wrist, negative Phalen's test, positive arm raise, negative Finkelstein test. He noted no evidence of ganglions, triggering, or thenar muscle atrophy. He noted that the Petitioner's left upper extremity examination was normal. (R.X. 1, p. 9) He noted that on the objective testing, the only abnormal finding was that Petitioner had some decreased grip strength in the right hand compared to her left. When he saw her on that day, he suggested the Petitioner undergo a nerve conduction study, which Petitioner had scheduled the following day. He felt that Petitioner needed the study to determine if she had carpal tunnel syndrome and noted that that condition could not be diagnosed without such a study. (R.X. 1, pp. 10-11) He noted that she returned to her treating physician in Mattoon and had the EMG/NCV study the following day. He noted that that study was normal. In addition, he reviewed records including the MRI of the right wrist which was normal. Based upon his evaluation and the negative diagnostic test, he could not diagnose a particular condition of ill-being in the right upper extremity. (R.X. 1, p. 12) He acknowledged that Petitioner's job could cause carpal tunnel syndrome. (R.X.1, p. 12) He also felt Petitioner needed no work restrictions and had incurred no

evidence of any permanency. (R.X. 1, p. 13) Dr. Crandall recommended that Petitioner do stretching exercises and take anti-inflammatory medications as needed. However, Petitioner was not a surgical candidate and did not need to be off work. He confirmed that he did not find any evidence of forearm compartment syndrome or right forearm tendinitis. (R.X. 1, p. 13) He noted that if Petitioner was suffering from tendinitis in the first dorsal extensor compartment, she would have a positive Finkelstein test and swelling over the compartment, which Petitioner did not have. He noted that if Petitioner had second dorsal extensor compartment tendinitis, known as intersection syndrome, she would have had swelling just proximal to the wrist where the thumb extensor tendons cross over one another, which she did not have. He also noted that Petitioner had no evidence of ganglion, no point tenderness, and no swelling in her wrist or fingers and objectively there were no physical findings. (R.X. 1, p. 14) The Petitioner's report of some relief due to an injection in her carpal tunnel would not warrant surgery in the carpal tunnel as the nerve conduction study was normal. He noted that the latency reading of 2.7mm was a completely normal reading and this is not a case where Petitioner had borderline carpal tunnel. (R.X. 1, pp. 15-16) He further confirmed that he did not believe Petitioner was in need of work restrictions based upon his review of the records and diagnostic tests from May 2012 up until the time he had seen the patient. (R.X. 1, p. 16) On cross-examination, Dr. Crandall confirmed that the Petitioner attributed the onset of her symptoms to using a new ice cream scoop. He also noted that he performs several hundred IMEs a year and sees 1,000 new patients in a particular year. Almost all of his IMEs are for insurance companies. He noted that his initial intake from Petitioner indicated that she had worked at Respondent for four years and her last day of work was May 28, 2012. However, he would not characterize Petitioner's symptoms on May 24, 2012 as an injury. Dr. Crandall further confirmed that the Petitioner had symptoms consistent with carpal tunnel syndrome at his exam and agreed that she needed a nerve conduction study. (R.X. 1, p. 25) He also noted that at the time of his first exam he recommended Petitioner not scoop ice cream with the right hand pending completion of the nerve conduction study. He further noted his belief that if the Petitioner had scooped ice cream all day long with her right hand and if indeed she had carpal tunnel syndrome, it would be work related. Dr. Crandall did note that the Petitioner may benefit from an anti-inflammatory medication such as Celebrex. However, he disagreed with the diagnosis of chronic tendinitis as Petitioner had a normal MRI and no positive findings of tendinitis. (R.X. 1, pp. 30-31) Dr. Crandall confirmed that he had provided Petitioner a work restriction on the day of his visit because Petitioner had a nerve conduction study the next day. He confirmed he did not intend for it to be a permanent restriction and that when he saw the nerve conduction study was negative he opined that Petitioner could work without restrictions. (R.X. 1, p. 37) On re-direct, Dr. Crandall noted that his quick report, which had been identified as Exhibit 7 to his deposition, did contain a line indicating that it was "not yet determined" if Petitioner's condition was related to her work. He noted that any work restriction was pending completion of the nerve conduction study which he had offered to complete at his office, but she wanted to go back to her treating physician for same. He further noted that if the study performed at his office was identical to the one performed in Mattoon, he would not have given Petitioner a work restriction at that visit.

Petitioner testified that PX 12 accurately reflected her weeks and days worked and gross earnings. The hand-written noted contained on it are those of her attorney. As of May 28, 2012,

Petitioner's hourly rate was $8.65. Petitioner did not receive tips because she worked in the back. Petitioner also testified that she missed more than five calendar days in the year before May 28, 2012 partly because of health problems and partly because she has a disabled son. Petitioner testified that Respondent worked with her on her schedule.

Sherry Hall testified on behalf of Respondent. Ms. Hall was the general manager of the restaurant where Petitioner worked. Petitioner and Ms. Hall are friends. Ms. Hall testified that Petitioner typically worked two to three days per week and from eleven to three or eleven to four. Petitioner frequently missed a lot of work and would ask not to be scheduled on occasion as she had a lot of things going on and had been very sick at one point in time. All in all, Ms. Hall believed Petitioner probably worked 12 to 15 hours per week. She worked with Petitioner as best she could to accommodate her schedule.

Ms. Hall testified that the Petitioner had come to her in late May 2012 complaining of pain in her hand and wrist. Ms. Hall testified that Petitioner stopped working on May 28, 2012. Ms. Hall further testified that in July of 2012 she received paperwork on Petitioner's workers' compensation claim and that between May of July of 2012 she and Petitioner had conversations from time to time. Ms. Hall stated that within the week following Petitioner's cessation of work they spoke. According to Ms. Hall, Petitioner didn't know what was going on with her arm and whether it was work-related or not. She mentioned some popping in her wrist and Ms. Hall agreed that she had some.

Ms. Hall further testified that she had nothing before October 8, 2012 telling her it was work-related issue.

On cross-examination Ms. Hall acknowledged that both Ben and Jennifer were managers. She also testified that once Petitioner is fully released and "corporate" allows it, Petitioner can return to work if she can work the hours given to her.

On re-direct examination Ms. Hall identified the First Report of Injury (RX 3) which she completed on July 27, 2012. Ms. Hall testified that she put down that Petitioner was uncertain if her condition was work-related. Ms. Hall completed this Form after she had received the Application for Adjustment of Claim from Petitioner's counsel in July 2012. She testified that she had called in the claim to the insurance company upon receipt of the application. Up to that point, it was not clear that Petitioner was claiming she had a work-related condition. Ms. Hall also testified that she had no medical documentation indicating that Petitioner's condition was related to work at the time and was not aware of any such documentation until Dr. Sandercock's letter of October 8, 2012. Ms. Hall also testified that Respondent does accommodate light duty restrictions for employees who are off work due to an accidental work-related injury. However, in this instance Petitioner was not offered light duty because her claim was not accepted.

<u>The Arbitrator concludes</u>:

1. Petitioner's testimony was credible.

2. Petitioner sustained an accident on May 28, 2012 that arose out of and in the course of her employment with Respondent. Petitioner credibly testified that her repetitive trauma claim was based upon switching to a new ice cream scoop. She started using the scoop at the direction of her employer on May 24, 2012. She had only used it for one or two days before reporting her difficulties on May 28, 2012. Petitioner's testimony was corroborated by the histories found in the records of the treating physicians.

3. Petitioner provided timely notice of her accident to Respondent. Petitioner's testimony regarding her conversations with Ben and Jessica, her supervisors, was unrebutted. Additionally, the Arbitrator notes that, while it is not a part of the record, Respondent acknowledged in its proposed decision that notice, albeit perhaps defective, was provided. No prejudice from any defective notice has been shown.

4. Petitioner's condition of ill-being in her right upper extremity, namely tendinits and intersection syndrome, is causally connected to her accident of May 28, 2012. This is based upon a chain of events and the opinions of Dr. Sandercock. The Arbitrator notes that Respondent's examining physician, Dr. Crandall, never rendered an opinion on the question of whether or not Petitioner's tendinits/intersection syndrome was work-related. Furthermore, Dr. Crandall only examined Petitioner the one time and her examination findings at that time (in particular the negative findings of tendinitis) could be attributable to the injection Dr. Sandercock had given her just a few weeks before and which Petitioner subsequently reported had a positive effect. While Dr. Crandall testified the MRI of Petitioner's forearm was normal it is not clear if he had the benefit of the Addendum report which showed swelling consistent with intersection syndrome/tendinitis and Dr. Crandall testified swelling is indicative of tendinitis. Furthermore, Dr. Crandall seemed more focused on the presence or absence of carpal tunnel syndrome than the state and prognosis of Petitioner's tendinitis. The Arbitrator is not concluding that Petitioner has right carpal tunnel syndrome; however, whatever carpal-tunnel like symptoms Petitioner experienced in the fall of 2012 are causally related to her work accident. They were also transient in nature as Petitioner responded to an injection and has no objective evidence of same at this time.

5. Regarding earnings, Petitioner testified that she worked part-time and often had to modify her work schedule to care for a disabled child. Sherry Hall confirmed this. Petitioner's wage records show that Petitioner worked part-time between 2.47 hours and 27.08 hours a week during the 52-week period preceding the injury, earning $8.65 per hour at the time of the occurrence. The Arbitrator adopts Respondent's wage statement and finds that Petitioner had an average weekly wage of $97.64.

6. Medical Bills. The itemization of Petitioner's medical treatment bills totals $10,157.00. (PX11) Petitioner identified that list of bills as being for her treatment of her right wrist injuries. Dr. Sandercock identified the bills as being related to his care of Petitioner for her right wrist injury and said that they "could be" related to the repetitive trauma injury alleged. He stated that Petitioner's treatment thus far was "reasonable and necessary to treat her for her right wrist tendinitis and carpal tunnel." (PX1, p.28)

   The Arbitrator finds that Petitioner's itemized treatment bills in the amount of $10,157.00 were for reasonable and necessary treatment of Petitioner's right wrist injury.

7. Temporary Total Disability Benefits. Petitioner testified that she has continued to treat with Dr. Sandercock for her right wrist pain since May 31, 2012. She has not had any intervening injuries or trauma and continues to have right wrist pain with gripping or grasping with her right hand. She has tried to scoop sherbet, but has experienced pain. Petitioner testified that Respondent has never offered her work with her restrictions.

   Dr. Sandercock testified that he has never released Petitioner to return to her regular work. He has not declared that Petitioner is at maximum medical improvement. His continuing restrictions as of January 29, 2013 include the following: "lifting, pushing, pulling restricted to 0 pounds; no high force gripping or grasping; must wear brace on right wrist." (PX 1, deposition Ex. #2)

   Dr. Sandercock admitted that his current work restrictions for Petitioner were based "principally on her credibility" and complaints. On re-direct, Dr. Sandercock testified that while Petitioner's chronic tendinitis has been particularly stubborn, her complaints have been consistent and he has "continued to treat her and give her the injections and the treatment . . . and the restrictions" based on his "feeling that she is credible." (Pet. Ex. 1, pp. 38-39)

   While the Arbitrator shares Dr. Sandercock's concern as to why Petitioner is not getting better when she has been off work for so long and is troubled by Petitioner's lack of full attendance and effort with aggressive occupational therapy, Respondent did not have Petitioner go back and see Dr. Crandall again or, alternatively, set up a second opinion as requested by Dr. Sandercock. While Petitioner appears at or very near maximum medical improvement, Petitioner is entitled to receive temporary total disability benefits from the Respondent in the amount of $97.64 per week for 39 1/7 weeks, being the period from May 29, 2012 through February 25, 2013.

8. Regarding penalties and attorney's fees, the facts are in dispute on all issues and Respondent's failure and refusal to pay TTD and medical was not unreasonable. Petitioner's Petition for Penalties and Attorney's Fees is denied.

.....

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sylvia Travis,
Petitioner,

vs. NO: 08 WC 45487

Gateway Center,
Respondent.

14IWCC0076

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, the nature and extent of Petitioner's 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 May 1, 2013 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 $30,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 0 3 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-01/28/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

TRAVIS, SYLVIA
Employee/Petitioner

Case# **08WC045487**

GATEWAY CENTER
Employer/Respondent

14IWCC0076

On 5/1/2013, 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:

0095 CALVO & MATEYKA
ROBERT W BUTLER
1517 E 20TH ST PO BOX 1384
GRANITE CITY, IL 62040

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Sylvia Travis
Employee/Petitioner

v.

Gateway Center
Employer/Respondent

Case # **08** WC **45487**

Consolidated cases: __

14IWCC0076

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 **Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **11/30/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/10/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,493.48**; the average weekly wage was **$509.49**.

On the date of accident, Petitioner was **44** 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 **$38,211.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$38,211.46**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $339.66/week for 112 3/7 weeks, commencing 10/1/08 through 10/27/10, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $38,211.46 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $335.00, subject to the Fee Schedule, as provided in Sections 8(a) and 8.1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $305.69/week for 97.925 weeks, because the injuries sustained caused the 15% loss of each arm, and 10% loss of each hand as provided in Section 8(e) of the Act. Respondent is entitled to a credit of 7.5% loss of the left arm from a prior claim, thereby reducing Petitioner's award on the left arm to 7.5% loss of use.

Respondent shall pay the Petitioner compensation that has accrued from **10/28/10** through **11/30/12**, 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

4/24/13
Date

MAY - 1 2013

Findings of Fact

Petitioner was employed by Respondent as a Housekeeping Supervisor beginning in early 2005. Her primary responsibility was to clean and to prepare and monitor the facilities for conventions and meetings. Her duties included vacuuming, sweeping, mopping, dusting, wiping, washing windows, emptying trash, scrubbing floors and tables, cleaning restrooms and any other activity need to keep the facilities presentable. As part of her duties she would monitor events by maintaining restrooms and trash removal. During events she would generally clean other parts of the facility and just check in from time to time. She was typically the only one working but the Respondent had several part time employees who helped with large events. While she had some supervisory duties, this was a very small percentage of her work.

Petitioner noticed that she was really tired one day while washing windows. She told one of the coordinators that her hand had swollen up severely. She also had tingling and things falling out of hands. Her hand also hurt and began to wake her up at night. Petitioner testified that these conditions came on while she spent two days buffing the floor in August 2008. Her right hand was really bad. Petitioner testified that the several days prior to August 10, 2008, she had been working buffing a large hall stripping and waxing the floors. She stated that she used a large industrial buffer and that the performance of that job increased her symptoms to where she went to see her doctor.

She first saw Dr. Dorothy Loderstedt on August 13, 2008. Dr. Loderstedt noted pain and numbness in the right upper extremity and hand, and ordered a right hand EMG/NCV performed August 25, 2008. The findings were consistent with mild right carpal tunnel syndrome. She treated Petitioner with anti-inflammatory medication and a right wrist split. On August 29, 2008 she referred Petitioner to see an orthopedic surgeon. In a note on December 9, 2008, Dr. Loderstedt opined that the history of heavy lifting, pushing & pulling at work were the causes of her carpal tunnel syndrome. She released Petitioner to light duty.

Petitioner attempted to return to work but was notified by the employer that it was not able to accommodate light duty. She began being paid TTD benefits October 1, 2008.

On December, 30, 2008, Dr. Khash Dehghan examined the Petitioner. He noted numbness and tingling in her upper extremity digits right worse than left. On exam, he found positive phalens and median compression test bilaterally and positive right sided tinels. He ordered a splint for the left wrist and surgery for the right wrist. He noted that if the splint did not help the left wrist that surgery would ultimately be necessary. He performed right carpal tunnel release surgery on March 9, 2009. On March 18, 2009, Dr. Dehghan noted Petitioner's complaints of numbness in her fingers improved but she complained that the left sided carpal tunnel was more noticeable. Dr. Dehghan ordered a left EMG study. On March 25, 2009 she reported continued numbness in her small and little fingers on the right side, and also numbness in the same fingers on the left side. Tinels over both cubital tunnels were positive. Splints were ordered for both elbows.

The left EMG conducted April 30, 2009 was positive for ulnar neuropathy but negative for carpal tunnel.

Petitioner returned to Dr. Dehghan on May 5, 2009. He opines on that date that "Ms. Travis's job was again reviewed with her. . . . She was advised that in my opinion, her job at Gateway Convention Center had contributed to and aggravated her bilateral carpal and cubital tunnel syndromes."

Dr. Dehghan performed a left carpal tunnel and left cubital tunnel release on August 3, 2009. She reported resolution of her left finger numbness and tingling on her August 11, 2009 visit. He ordered physical therapy on her hands and continued to keep her off of work.

On September 9, 2009, Dr. Dehghan noted continued numbness and tingling in her right small and ring fingers. He recommended surgery for the right carpal tunnel syndrome. Dr. Dehghan moved so the surgery was ultimately performed by Dr. Michael Beatty on December 8, 2009. Dr. Beatty and Dehghan were in the same office. He performed a release of right ulnar nerve. He continued her off work status.

On January 7, 2010, Dr. Beatty reported that Petitioner was "doing well regarding surgery, but her arms continue to bother her." She complained of numbness and tingling returning to her left elbow forearm area. Dr. Beatty ordered repeat EMGs which show left ulnar neuropathy. He recommended repeat elbow surgery.

Respondent sent Petitioner to Dr. Harvey Mirly for an IME on April 2, 2010. Dr. Mirly opined that "[w]ith regard to her current condition being causally related, she does report, and the job descriptions do support, vigorous use of the hands in her activities. She reports a lot of use of buffers, cleaning windows with an overhead pole, a lot of wiping, and I believe those are the types of activities that may contribute to the development of nerve compression injuries. . . ." Dr. Mirly notes that the testing performed on the Petititioner supported the diagnosis of right carpal tunnel and cubital tunnel syndrome, but do not support a similar diagnosis of carpal tunnel on the left side.

She returned to Dr. Beatty who surgically released the ulnar nerve in her left elbow on June 22, 2010. He released her to light duty beginning August 9, 2010. At 10 weeks postoperatively, she had complaints of discomfort in her shoulder region. Dr. Beatty referred her to Dr. Yadava who ordered some therapeutic exercises. She was released to full duty on November 10, 2010. Dr. Beatty released her from his care on November 17, 2010.

On August 18, 2011, Dr. Timothy Bradley performed a medical records review on behalf of the Respondent. He opined that based upon this review, Petitioner's carpal tunnel and cubital tunnel conditions were not related to her work activities. He cites National Institute for Occupational Safety and Health as his basis that said work did not cause her carpal tunnel syndrome. With regards to cubital tunnel he states that "there is no association known for occupational exposure". After this report was prepared, Respondent then scheduled Petitioner to see Dr. Bradley for an IME. Dr. Bradley after examining Petitioner reiterated his prior opinions regarding causation.

Petitioner attempted to return to her employment with Respondent upon her release from the doctor. She testified that she was not allowed to come back to work on a full time basis.

Dr. Beatty opined that the job duties performed by Petitioner caused or aggravated the conditions of bilateral carpal tunnel and cubital tunnel surgery. He further opined that the job activities and aggravation caused or necessitated the need for the carpal tunnel and cubital tunnel surgeries. Dr. Beatty last examined the Petitioner on March 6, 2012. She was working at this time as a home health nurse which she reported was much less physically demanding. She still described decreased sensation distribution of the medial antebrachial cutanious nerve on the left. She testified that now she gets occasional cramping in the left elbow region. She feels she has substantial loss of strength and estimates she can lift about 30 pounds when prior to the injury she occasionally moved much more with both arms. Her elbow is numb to the touch. Her hands fatigue quickly and her left elbow gets a sharp shooting pain occasionally. As a hobby she occasionally will make flower

arrangements. She reports that she has lost some sensation in her fingers and has a more difficult time gluing beads and other small items on her arrangements.

Respondent has paid all the medical bills with the exception of $335.00 to Dr. Beatty for his last follow up visit. Respondent has also paid all the temporary disability benefits from October 1, 2008 through October 27, 2010.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner sustained her burden of proof regarding the issue of accident. She credibly testified that she began noticing problems with her hands and arms while performing her duties on or around August 10, 2008, most notably after operating a floor buffing machine for 2 days. Her description of her job duties was credible and clearly depicted constant use of both hands and arms, which although may have been varied throughout the day, , ultimately lead to her complaints of her hands swelling, tingling, and losing sensation and grip strength after buffing floors for 2 days, 8 hours per day.

2. Petitioner's condition of ill-being is causally connected to her employment activities. The Arbitrator finds persuasive the opinions of Petitioner's treating physicians on this issue. Even Respondent's IME, Dr. Mirly provides support on the issue of causation favorable to the Petitioner. The opinions of Petitioner's various treating physicians and Respondent's IME, Dr. Mirly, outweigh those opinions of Respondent's second IME, Dr. Bradley, whose opinions on the issue of causation are clearly to the contrary.

3. Based on the findings above, Petitioner is entitled to TTD from October 1, 2008 through October 27, 2010. Respondent shall receive a credit for any TTD it has paid thus far toward the period in question.

4. Respondent shall pay any reasonable, related and necessary medical expenses incurred, subject to the fee schedule and in accordance with Sections 8(a) and 8.1 of the Act. This would include the outstanding medical expense from Dr. Beatty for $335.0.00

5. As a result of her injuries, Petitioner has sustained a 10% loss of use of each hand; 15% loss of use of her right arm; and 15% loss of use of her left arm – less a credit of 7.5% to the left arm from Petitioner's prior claim under case #99 WC 39563 – thereby reducing Petitioner's award for her left arm to 7.5% loss of use of the left arm.

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

Maria Diaz,
Petitioner,

vs. No: 09 WC 05887

14IWCC0077

Prairie Packaging,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice and medical expenses, and being advised of the facts and law, clarifies 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).

After considering the entire record, the Commission clarifies the award of medical expenses and affirms and adopts the remainder of the Decision of the Arbitrator.

The Arbitrator ordered the following:
"Respondent is to pay to Petitioner reasonable and necessary medical expenses incurred pursuant to Sections 8 and 8.2 of the Act."

At hearing, Petitioner submitted unpaid medical bills which she claimed as reasonable and related to the accident as Petitioner's Exhibits 5 through 7. Respondent disputed liability for these bills and admitted it did not pay any amount through its group medical plan for which credit may be allowed under §8(j) of the Act. (AX1).

The Arbitrator neglected to quantify the reasonable and necessary medical expenses awarded in her order. The Commission clarifies the Arbitrator's order to specify all medical bills contained in Petitioner's Exhibits 5 through 7 are awarded. The Commission orders Respondent pay to Petitioner related, reasonable and necessary medical expenses contained in Petitioner's Exhibits 5 through 7 pursuant to Section 8(a) and 8.2 of the Act.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the March 20, 2013 Decision of the Arbitrator is hereby clarified and otherwise affirmed or adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay to Petitioner reasonable and necessary medical expenses contained in Petitioner's Exhibits 5 through 7 pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is to authorize and pay for the prospective medical treatment as prescribed by Petitioner's treating physicians, Dr. Nassos and Dr. Morganstern, including the pre and post operative attendant care pursuant to Sections 8(a) and 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.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. 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.

DATED: FEB 03 2014

drd/adc
o-11/5/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

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

DIAZ, MARIA
Employee/Petitioner

Case# **09WC005887**

PRAIRIE PACKAGING
Employer/Respondent

14IWCC0077

On 3/20/2013, 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:

2208 CAPRON & AVGERINOS PC
MICHAEL ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Maria Diaz
Employee/Petitioner

v.

Prairie Packaging
Employer/Respondent

Case # 09 WC 05887

Consolidated cases: _____

14IWCC0077

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 **Chicago**, on **February 6, 2013**. 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. [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. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

14IWCC0077

FINDINGS

On the date of accident, **6/26/08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**14,710.28**; the average weekly wage was $**282.89**.

On the date of accident, Petitioner was **52** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**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 $**0** under Section 8(j) of the Act.

ORDER

- The Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of the injury pursuant to Sections 8 and 8.2 of the Act.
- Respondent is to authorize and pay for the prospective medical treatment as prescribed by Petitioner's treating physicians including the pre and post operative attendant care pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Carolyn Doherty
Signature of Arbitrator

3/20/13
Date

ICArbDec19(b)

MAR 20 2013

FINDINGS OF FACT

Petitioner, a 52 year old factory worker, testified that she worked on Respondent's assembly line wrapping cups coming off a conveyor belt, packing boxes with cups and lifting the boxes onto a pallet. Petitioner began working for Respondent in May 2006. Petitioner testified that she works a 12 hour shift from 7 am to 7 pm, 5 days per week. Petitioner was allowed 2 15 minute breaks and one half hour lunch break. The boxes filled with cups weigh from 20 to 50 pounds and on average there were 20 boxes on a pallet. Petitioner testified that she filled about 6 pallets per shift. As a packer, Petitioner rotated duties. She testified that part of the day she packed and part of the day she inspected but that lifting was always involved in all of the assigned job duties.

Prior to June 2008, the records from Clearing Clinic indicate that Petitioner was at the clinic on 3/19/08 for a physical examination. The records contain a "Pre-placement exam" report dated 3/19/08 indicating that Petitioner passed her exam and could return to work after having "surgery" at some point earlier in January 2008. The surgery was not work related and did not result from an injury according to the medical records. Petitioner's family doctor, Dr. Cardenas, also released Petitioner to work full duty at that time in March 2008. PX 1. Petitioner was diagnosed as a diabetic in 2000 and takes medication for diabetes and blood pressure.

A record from Dr. Cardenas dated 6/5/08, indicates that he had seen Petitioner and issued a "rtw" under a "Dx Neuropathy" as of 6/11/08. Thereafter, Petitioner returned to MacNeal Occupational Health Services at Respondent's request for a physical examination on 6/9/08 and noted that she had been off for "left hand numbness" and that her last day worked was 5/27/08. PX 1. The Physical Examination form dated 6/9/08 indicates a normal exam of Petitioner's shoulders, elbows, wrists, hands and fingers.

At trial, Petitioner testified that she noticed pain in her left arm beginning 8 weeks before she reported the pain to Respondent on June 26 2008. Petitioner testified that on June 26, 2008, she notified her supervisor "Jason" of her pain and was sent to Clearing Clinic with Respondent's approval. Petitioner testified that she did not report the problems with her arm when she first noticed the problems 8 weeks earlier despite her thought that the pain was related to her job duties.

The Authorization for Treatment form from MacNeal dated 6/26/08 indicates that Petitioner was to be rendered "treatment for on-the-job injury to her "L-hand/neck." A handwritten notation also notes that "Prairie wants doctor to fully evaluate her to see if this is work related." The treatment was authorized by Jason Clayton at Respondent. On the occupational information form Petitioner indicated "my job consist of lifting heavy boxes and I hurt my left wrist it feels numb and pain goes to my neck." The date of injury is listed as 5/1/08. In the treatment notes of Dr. Orig Petitioner complained that "my job consist on lifting heavy boxes and I hurt my left wrist, feels numb and pain goes up to my neck." Under history of present illness it is noted, "this is the initial visit for Maria Diaz, a 52 year old female, whose primary complaint is pain located in the neck to left fingers. She considers it to be severe. It has been about 8 weeks since the

onset of pain. She has noticed that it s made worse by pt unsure. It is improved with pt unsure. Her pain level is 10/10." After examination and cervical x-rays the initial diagnosis was neck strain and it was noted that "the cause of this problem is probably related to work activities." PX 1. Petitioner's left shoulder lifting was limited to 5 pounds or less and no above shoulder level work was to be performed. PX 1.

The diagnosis of left shoulder strain was continued at the next visit on 7/2/08. Petitioner continued under work restrictions and her pain medication was continued. PT was recommended. As of 7/15/08, a cervical MRI was ordered to rule out disc herniation. Petitioner began physical therapy under a continued diagnosis of neck strain. She reported on the PT patient questionnaire that the injury occurred while "lifting 20 -40 lb boxes – put on a skid." PX 1. The cervical MRI of 7/25/08 showed no disc herniation but mild spondylosis of the cervical spine and small disc osteophytes at multiple levels. As of 7/30/08, Petitioner continued with PT and noted an improving pain level. Petitioner was prescribed one more week of PT and was to return to regular duty as of the next visit. Petitioner was in fact discharged from care on 8/8/08 and was returned to work regular duty.

On 10/17/08, Petitioner had and EMG of her left arm ordered by her family physician, Dr. Cardenas. PX 2. The EMG indicated left carpal tunnel syndrome. Petitioner continued to treat thereafter with Dr. Cardenas who noted positive Phalen and Tinel's signs on the left hand. Petitioner was released to restricted duty in November 2008 by Dr. Cardenas. Petitioner also underwent an injection to her wrist. PX 2.

On 3/2/09, Petitioner began treating with Dr. Nassos at Diversy Medical Center who diagnosed left carpal tunnel related to her work activity. He placed Petitioner on restricted work duty and eventually ordered left carpal tunnel release surgery due to the failure of conservative care. On 4/27/09, Dr. Nassos noted that Petitioner needed the surgery and that without it he would recommend an FCE with permanent restrictions. Petitioner testified that she was afraid to have the surgery at that time but eventually agreed to the surgery in June 2009. Petitioner thereafter was seen by Dr. Morgenstern at Diversy in April 2010. He also recommended surgery to her left hand. She treated with him through September 2010 at which time he advised Petitioner that she would have pain and permanent restrictions until she underwent the carpal tunnel surgery. PX 2. Dr. Morgenstern also noted that Petitioner's left carpal tunnel was the "direct result of the patient's work-related activities that initially developed approximately March 2008." PX 2. In his report dated July 9, 2012, he opined that Petitioner's activities "involved repetitive motion and repetitive motion is known to be a cause of carpal tunnel syndrome and aggravation of carpal tunnel syndrome." PX 4. Petitioner requests the surgery at trial.

Petitioner testified that she was laid off from Respondent in 2010 for productivity problems. At the time she was laid off, Petitioner was under permanent restrictions from Dr. Morgenstern of carrying, pushing and pulling no greater than 20 pounds with the left upper extremity and no repetitive motion to the left wrist and hand until the patient receives surgical intervention. PX 2. These restrictions are in place until the surgery is approved. PX 2, PX 4. Since that time she has by employed through temporary agencies. Petitioner testified that the work she performs today is different from her job with Respondent as she does not have to lift at work. Furthermore, she

changes job duties and locations. Petitioner works a few days per week and all jobs involve assembly work.

Her last left hand treatment was in 2010 with Dr. Morgenstern. Since last seeing Dr. Morgenstern she notices pain in her hand when lifting and testified that the pain increases with lifting or activity. Petitioner testified that if she does not use the left wrist she does not have pain. Finally, she testified that her pain is the same now as it was in 2008, 2009 and 2010.

Respondent submitted the reports of Section 12 examining physician, Dr. Vender. RX 1. In his report dated 2/1/10, Dr. Vender diagnosed Petitioner with bilateral carpal tunnel worse on the left after performing repeat electrodiagnostic studies. Based on Petitioner's complaints and on the objective and diagnostic findings, Dr. Vender agreed that surgery on the left was indicated. Petitioner testified that she has no symptoms on the right side and is not looking for right sided treatment. Dr. Vender asked for a video of Petitioner's job duties to determine if her duties involved forceful and exertional activities on a regular and consistent basis so as to causally relate her condition and her job duties. In his second report dated March 10, 2010, Dr. Vender noted that he reviewed a written job analysis and a video of the job duties at issue. Petitioner agreed the video depicted her job duties but noted that her lifting duties were not depicted. Dr. Vender determined that no forceful activities were demonstrated and that her job activities did not contribute to her carpal tunnel. RX 1.

CONCLUSIONS OF LAW

The foregoing findings of fact are incorporated into the following conclusions of law.

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of accident? Was timely notice of the accident given to Respondent? Is Petitioner's current condition of ill-being causally related to the injury?

Based on a review of Petitioner's medical records, the first mention of left hand complaints is in early June 2008. A record from Dr. Cardenas dated 6/5/08, indicates that he had seen Petitioner and issued a "rtw" under a "Dx Neuropathy" as of 6/11/08. Thereafter, Petitioner returned to MacNeal Occupational Health Services at Respondent's request for a physical examination on 6/9/08 and noted that she had been off for "left hand numbness" and that her last day worked was 5/27/08. PX 1. The Physical Examination form dated 6/9/08 indicates a normal exam of Petitioner's shoulders, elbows, wrists, hands and fingers.

At trial, Petitioner credibly testified that she noticed pain in her left arm beginning 8 weeks before she reported the pain to Respondent on June 26 2008. Petitioner testified that on June 26, 2008, she notified her supervisor "Jason" of her pain and was sent to Clearing Clinic with Respondent's approval. Petitioner testified that she did not report the problems with her arm when she first noticed the problems 8 weeks earlier despite her thought that the pain was related to her job duties. The records from June 26, 2008 and subsequent thereto as summarized above all reflect Petitioner's left hand and arm complaints and the relation of those complaints to Petitioner's job duties. The Authorization for Treatment form from MacNeal dated 6/26/08

indicates that Petitioner was to be rendered "treatment for on-the-job injury to her "L-hand/neck." A handwritten notation also notes that "Prairie wants doctor to fully evaluate her to see if this is work related." The subsequent records are replete with job histories and work duty descriptions connecting Petitioner's complaints to her work for Respondent and specifically to her lifting of boxes.

The Arbitrator is mindful that Petitioner noticed the symptoms as early as May 1, 2008 and that the condition was not "reported" until June 26, 2008. However, Respondent was aware Petitioner was off work in May and early June 2008 for "left hand numbness" based on the return to work exam records from MacNeal at PX 1. Accordingly, the Arbitrator finds that Petitioner sustained repetitive trauma type injuries to her left hand which reasonably manifested on June 26, 2008, the first date she sought medical care for the condition with Respondent's knowledge that Petitioner attributed the condition to her work duties. Respondent requested that a full exam be given on that date to determine "if this was work related." PX 1. The Arbitrator finds that Respondent received timely and proper notice of the injury and of its relation to Petitioner's job activities.

Petitioner underwent conservative care for her left hand complaints while continuing to work light duty for Respondent. While working light duty, Petitioner wore a splint. Petitioner was given a diagnosis of left carpal tunnel as of October 2008 and then a surgical diagnosis in April 2009 after further diagnostic testing confirmed left carpal tunnel and conservative measures failed. The Arbitrator assigns greater weight to the opinion of Petitioner's treating physicians than to the opinion of Dr. Vender. Drs. Nassos and Morgenstern opined that Petitioner's condition was caused by the cumulative and repetitive nature of Petitioner's job duties for Respondent. Again, all of Petitioner's treating records buttress these opinions.

Based on the above and on the record in its entirety, the Arbitrator finds Petitioner sustained repetitive trauma to her left hand manifesting on June 26, 2008, that Respondent received proper and timely notice and that Petitioner's current condition of ill-being is causally related to her job for Respondent.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? K. Is Petitioner entitled to any prospective medical care?

Based on the findings of accident and causal connection, the Arbitrator further finds that Respondent is to authorize and pay for the prospective medical treatment prescribed by Drs. Nassos and Morgenstern to treat Petitioner's left hand carpal tunnel pursuant to Section 8(a) of the Act. The order of prospective treatment includes the prescribed surgery and the pre and post surgical attendant care.

Further, based on the findings of accident and causal connection, Respondent is to pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her condition pursuant to Sections 8 and 8.2 of the Act.

STATE OF ILLINOIS)
)
SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Peppers,
Petitioner,

vs. NO: 08 WC 01934

14IWCC0078

Rockford School District #205,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review of the December 12, 2012 Arbitration Decision in case number 08 WC 1934 was filed by attorney Francis M. Brady of Brady, Connolly & Masuda, P.C. on or about January 10, 2013. The Petition for Review requested the Commission to review the Arbitration Decision and consider the issues of jurisdiction, medical expenses and whether the Arbitrator could order the Respondent in claim 08 WC 1934 to be reimbursed by the Respondent in case 96 WC 65881 for medical bills paid. The Decision of the Arbitrator is attached hereto and made a part hereof.

A consolidated hearing was held before Arbitrator Holland on November 14, 2012 for claims 96 WC 65881 and 08 WC 1934. Petitioner's claim 96 WC 65881 named Respondent Rockford Board of Education #205, represented by attorney Francis M. Brady of Brady, Connolly & Masuda, PC., and Petitioner's claim 08 WC 1934 named Respondent Rockford School District #205, represented by attorney Patrick Morris of Wiedner & McAuliffe, Ltd.

Arbitrator Holland issued separate decisions for claim 96 WC 65881 and claim 08 WC 1934 on December 12, 2012. In his Decision on claim 08 WC 1934, the Arbitrator found that Petitioner did sustain a injury on October 19, 2007 arising out of and in the course of her employment, but that her present condition of ill-being was not causally related to the injury sustained on that date. The Arbitrator found the October 19, 2007 work injury was a temporary aggravation of a pre-existing condition. He further found that only three medical bills in evidence were reasonable, necessary and related to the October 19, 2007 work injury, namely a

November 13, 2007 office visit with Dr. MacKenzie, a December 3, 2007 epidural steroid injection and flouroguide and a December 11, 2007 office visit with Dr. MacKenzie. The Arbitrator ordered Respondent to pay the sum of $1614.00 for the above mentioned necessary medical services as provided in Section 8(a) of the Act. The Arbitrator made further findings regarding claim 96 WC 65881 and ordered Respondent in claim 08 WC 1934 to reimburse Respondent in claim 96 WC 65881 for benefits provided to Petitioner.

The Commission has issued a separate Decision and Opinion on Review in response to a timely Petition for Review of the December 12, 2012 Arbitration Decision in claim 96 WC 65881. However, the Commission notes that an Arbitration Decision was entered in case 96 WC 65881 on June 9, 2003. The Arbitration Decision was not appealed and it became the final decision of the Commission on or about July 9, 2003. As such, Arbitrator Holland lacked jurisdiction to hear any subsequent evidence or make any subsequent findings regarding claim 96 WC 65881. The Commission, in separate Decision and Opinion on Review, has vacated Arbitrator Holland's December 12, 2012 Arbitration Decision in claim 96 WC 65881. As such, any findings the Arbitrator made regarding claim 96 WC in the December 12, 2012 Decision for claim 08 WC 1934 are void.

With regard to the current Petition for Review in claim 08 WC 1934 filed by attorney Francis M. Brady of Brady, Connolly & Masuda, P.C., the Commission makes the following findings:

Mr. Brady represented Respondent Rockford Board of Education #205 for claim 96 WC 65881. The only named Respondent in claim 08 WC 1934 is Rockford School District #205 and that party is represented by attorney Patrick Morris of Wiedner & McAuliffe, Ltd. The Commission notes that while the employer of Petitioner is in essence the same in both claims, the Respondents, insurers and counsel in claims 96 WC 65881 and 08 WC 1934 are different. The only Petition for Review in claim 08 WC 1934 was filed by Mr. Brady on or about January 10, 2013. Both Petitioner and Respondent in claim 08 WC 1934 have argued in their Statement of Exceptions that the December 12, 2012 Arbitration Decision should be affirmed and adopted by the Commission. The Commission finds that no party to the proceeding in claim 08 WC 1934 filed a timely Petition for Review of the December 12, 2012 Arbitration Decision. Therefore, the Commission lacks jurisdiction to issue a Decision and Opinion on Review.

The Commission notes that the Arbitrator made findings in his Decision for claim 08 WC 1934 regarding claim 96 WC 65881. As noted above, the December 12, 2012 Decision in claim 96 WC 65881 has been vacated by the Commission in a separate decision. Further, the Commission notes that it has jurisdiction to order only a named Respondent to pay benefits as provided for under the Act to a named Petitioner in the case before it. A Petitioner files his Application for Adjustment of Claim stating an injury was sustained on a specific date that arose out of and in the course of employment with a named Respondent in order to establish his rights under the provisions of the Act to recover compensation directly from the named party and, for attainment of that end, it is immaterial who is ultimately chargeable with payment of compensation for his injuries. (*See* QBE Insurance v. IWCC, 2013 Ill. App. (5th) 120336WC).

For the foregoing reasons, the Commission lacks jurisdiction to issue a Decision and Opinion on Review of the December 12, 2012 Arbitration Decision without a party to the proceeding bringing a timely Petition for Review. The Commission dismisses the Petition for Review filed January 10, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petition for Review filed January 10, 2013 is hereby dismissed. The Commission lacks jurisdiction to issue a Decision and Opinion on Review of the December 12, 2012 Arbitration Decision. All other issues moot.

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.

DATED: FEB 0 3 2014

drd/adc
o-11/05/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEPPERS, LISA
Employee/Petitioner

Case# **08WC001934**

ROCKFORD BOARD OF EDUCATION DISTRICT NO. 205
Employer/Respondent

14IWCC0078

On 12/12/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

2489 BLACK, JIM LAW OFFICE
BRAD A REYNOLDS
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

1120 BRADY CONNOLLY & MASUDA PC
FRANCIS M BRADY
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)
COUNTY OF **Winnebago**)

- [ ] 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

Lisa Peppers

Case # **08** WC **01934**

Employee/Petitioner

v.

Rockford

Rockford Board of Education District No. 205
Employer/Respondent

14IWCC0078

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas J. Holland**, arbitrator of the Commission, in the city of **Rockford**, on **November 14, 2012**. 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 the 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 the petitioner's employment by the respondent?

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

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

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

G. [ ] What were the petitioner's earnings?

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

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

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

K. [ ] What amount of compensation is due for temporary total disability?

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

M. [ ] Should penalties or fees be imposed upon the respondent?

N. [ ] Is the respondent due any credit?

O. [ ] Other _____

FINDINGS

- On **October 19, 2007**, the respondent ***was*** operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship ***did*** exist between the petitioner and respondent.
- On this date, the petitioner ***did*** sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident ***was*** given to the respondent.
- In the year preceding the injury, the petitioner earned $ **17,160**; the average weekly wage was $ **330.00**.
- At the time of injury, the petitioner was **48** years of age, ***married*** with **0** children under 18.
- Necessary medical services ***have not*** been provided by the respondent.
- To date, $ **1,565.80** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **N/A**/week for _____ weeks, from _ through _____, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the further sum of $ **1614.00** for necessary medical services, as provided in Section 8(a) of the Act. (see decision for findings on medical)
- The respondent shall pay $ **0** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0** in attorneys' fees, as provided in Section 16 of the Act.

_____

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

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

Douglas F Holland
Signature of arbitrator

12-10-11
Date

DEC 12 2012

IN AND BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

Lisa Peppers, Employee/Petitioner,	)	Case No. 08 WC 01934
v.	)	
Rockford Board of Education; District No. 205, Employer/Respondent.	)	14IWCC0078

DISPUTED ISSUES

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

The Arbitrator takes judicial notice of Petitioner's Exhibit 7, as well as First Respondent's Exhibit 1 which are the Illinois Industrial Commission Arbitration Decision regarding the nature and extent of injury, concerning Case No. 96 WC 65881 involving Petitioner, Lisa Peppers and Respondent, Rockford Board of Education; District No. 205. In a prior written Decision of the undersigned, the Petitioner was found to have sustained injury to her low back as the result of a work injury on September 19, 1996, while restraining a student in the course of her employment as a para-professional for the Respondent. See PX 7. It was noted in the Decision of the Arbitrator that Petitioner's then medical records offered into trial on the date of the hearing, May 14, 2003, demonstrated that the Petitioner had disc pathology in her low back and that surgical treatment of her complaints had been recommended by Dr. Fanscali. See PX 7. At the time of the initial Arbitration, the Arbitrator found that although surgery had been recommended, the Petitioner had not submitted to surgery but testified that is an option for her in the future. The Arbitrator awarded permanent partial disability (PPD) against the Respondent, in the amount of 15% permanent loss of use of the body as a whole, pursuant to Section 8(d)(2) of the Act. See PX 7.

The Petitioner continued to work for the Respondent after the parties' hearing on May 14, 2003 as a paraprofessional. At the time of the hearing, the Petitioner testified that she would experience periodic flare-ups of her low back pain since the injury and that she no longer lifts or moves heavy objects either at work or at home. The Petitioner continued working for the Respondent, following the hearing, and continued to experience periodic flare-ups, as demonstrated by her treatment records. The Petitioner testified in situations of flare-up that she would take medications and would schedule an appointment to get a spinal block. According to the Petitioner, her symptoms would generally improve until she experienced another flare-up.

Medical records demonstrate that the Petitioner was referred by her primary care physician, Dr. Kinigakis, for consultation with Dr. Sean McKenzie at ROA on account of

low back pain and pain radiating down her bilateral legs and feet. Right toe cramping was also reported. The initial consult with Dr. McKenzie was done on May 10, 2006. See PX 1. Petitioner received a lumbar epidural steroid injection by Dr. McKenzie on May 16, 2006. She was then seen in follow-up on July 21, 2006 with ongoing right-sided low back pain with a reported increase down the right leg with burning. Dr. McKenzie ordered an updated lumbar MRI. See PX 1. After review of the lumbar MRI, physical therapy was ordered. LESI and L5-S1 nerve block were then performed by Dr. McKenzie on August 28, 2006. By November 5, 2006, Ms. Peppers was reporting improvement in her symptoms, but still complaining of right calf pain. PX 1. There is no other medical treatment rendered for her low back symptoms in 2006.

Nearly a year later on July 9, 2007, the Petitioner saw her Rheumatologist, Dr. Danstill, for a non work-related condition, Crohn's disease. In the July 9, 2007 appointment with Dr. Danstill, he noted low back pain with radiculopathy and indicated she was to see Dr. McKenzie for consideration of LESI. PX 1. On July 13, 2007, the Petitioner was seen by Dr. McKenzie with bilateral calf burning from the knees to her foot, along with pain radiating to her bilateral thighs. See PX 1. The radiating pain was worse on the left than the right and her large toe was numb. See PX 1. Dr. McKenzie prescribed gabapentin and also prescribed an updated lumbar MRI. See PX 1. When seen again on August 1, 2007, there was no change in her symptoms. The diagnosis was lumbar radiculopathy. The plan was to perform LESI. See PX 1. On August 9, 2007, a lumbar epidural steroid injection was performed, which reportedly improved her symptoms by 10%, when she was re-examined on August 15, 2007. On September 12, 2007, a repeat LESI along with L5-S1 selective nerve block, were performed by Dr. McKenzie. See PX 1. On September 19, 2007, the Petitioner reported most of her low back pain was gone although she reported some residual pain in her right leg. The diagnosis remained lumbar radiculopathy. The plan was to reinject the Petitioner on an as-needed basis. PX 1.

Petitioner testified that she was working at the Maria Montessori for the Respondent as a paraprofessional when she sustained a new injury on October 19, 2007. The Petitioner testified she was setting up lunch tables, along with the students, in the lunch room. Petitioner explained several of the tables were broken and that she had to put weight on the tables to bring them down. Petitioner testified that as she placed weight on the table, that the table broke and she fell to the ground with the table, landing on her buttocks. The Petitioner testified that immediately after the incident, the 'fire' down her leg came back and that it was constant. The Petitioner testified that one time prior to October 19, 2007, she recalled a constant burning 'fire' down her leg.

According to medical records reviewed, Ms. Peppers was first seen by Dr. McKenzie on November 13, 2007. See PX 1. Dr. McKenzie noted a history that the Petitioner had reinjured her back when lifting a table on October 19, 2007, and that she felt shooting pain in her low back which radiated down her bilateral legs since the episode. See PX 1. At her first visit following the October 19, 2007 incident, Dr. McKenzie prescribed Lyrica and performed a repeat LESI. See PX 1. On December 3, 2007, the Petitioner was seen again by Dr. McKenzie, who performed a repeat LESI and selective nerve block at L5-S1. On December 11, 2007, the Petitioner was reporting that she felt better. The

diagnosis of lumbar radiculopathy remained the same. The plan was to continue her on Lyrica, and she was to return as needed. PX 1.

Subsequently, Respondent #1 and Respondent #2 could not come to an agreement, as to who was responsible for additional medical treatment. Petitioner was not then seen due to delay in authorization of medical treatment, until she was seen by Dr. Stephen Heim on May 2, 2008. When seen on May 2, 2008, the Petitioner gave a history of back pain in her lower extremities and she reported that in the intervening three (3) plus years since last seeing Dr. Heim, her symptoms had slowly intensified. It was primarily her lower extremity symptoms that troubled her to the greatest degree. See PX 3. The Petitioner did not report the October 19, 2007 specific injury to Dr. Heim when seen on May 2, 2008. See PX 3; Deposition Transcript pages 19-20. Dr. Heim obtained x-rays and compared them to x-rays that he had obtained of the Petitioner in January of 2005. After performing physical exam and considering the x-ray results, Dr. Heim's diagnosis was progressive Grade II L5-S1 Spondylolytic Spondylolisthesis with right greater than left L5 radiculopathy. See PX 3; Deposition Transcript page 21. Dr. Heim recommended an updated lumbar MRI as well as lumbar discogram, which were performed on August 18, 2008. The lumbar discogram was performed only at L3-4 and L4-5. These levels were tested because they needed to rule out these levels as being symptomatic. Dr. Heim testified that he already knew L5-S1 was a problem. See PX 3; Deposition Transcript pages 22-23. Based on discogram results, Dr. Heim recommended and subsequently performed a one (1) level lumbar fusion with instrumentation at L5-S1 on October 23, 2008 at Central DuPage Hospital. See PX 3; Deposition Transcript pages 22-23. Shortly after surgery, the Petitioner developed a high fever of 104 degrees and she developed a pulmonary embolism and pneumonia in her right lung. Dr. Heim testified those were complications of the lumbar surgery which he performed on October 23, 2008. See PX 3; Deposition Transcript pages 25-26. After completing doctor ordered rehabilitation, the petitioner was release to full-duty work by Dr. Heim on January 15, 2009. See PX 6.

Petitioner testified at the time of the hearing that the surgery performed by Dr. Heim resolved her 'fire' down her legs. The Petitioner testified she had an excellent outcome from lumbar surgery. The Petitioner testified that she has not seen Dr. Heim since 2008 when she was released. Petitioner did testify to some limitation regarding range of motion regarding her lumbar spine and noting some symptoms, especially in cold weather.

The Arbitrator finds that the Petitioner sustained her burden of proving an accident occurred that arose out of and in the course of her employment by the Respondent on October 19, 2007. Petitioner testified she was setting up lunch tables, along with students, when she sustained injury to her low back on October 19, 2007. Certainly, Petitioner was performing acts assigned to her within her job duties at the time of the incident.

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

Petitioner testified she reported the 10-19-07 injury to Sara Jones with Respondent in a timely fashion. No evidence was offered to the contrary.

F. Is the Petitioner's present condition of ill-being causally related to the October 19, 2007 injury?

Respondent #1 and Respondent #2 disagree as to which of Petitioner's work injuries was the cause of her low back L5-S1 instrumented fusion, performed by Dr. Heim on October 23, 2008. On the one hand, Respondent #1 argues that the October 19, 2007 injury was a permanent aggravation of a pre-existing condition and a contributing factor to the need for Petitioner's low back surgery, thus relieving them of further responsibility for Petitioner's low back condition. On the other hand, Respondent #2 argues that the October 19, 2007 injury was merely a temporary aggravation of a pre-existing condition, which does not relieve Respondent #1 of their obligation to pay for causally related medical treatment, necessitated by Petitioner's original September 19, 1996 work injury.

The Arbitrator has carefully considered the testimony of the Petitioner and her treating medical records, along with the expert opinions of Dr. Heim and Dr. Singh. For the reasons listed below, the Arbitrator finds Petitioner failed to sustain her burden of proving that her present condition of ill-being is causally related to the October 19, 2007 injury. Instead, the Arbitrator find the Petitioner's present condition of ill-being is causally related to Case No. 96 WC 65881.

Several reasons support the Arbitrator's finding that there is a causal relationship between Petitioner's low back treatment with Dr. Heim from May 2, 2008 through January 15, 2009, and the Case No. 96 WC 65881 injury. First and foremost, the Arbitrator notes that at the time of the original hearing between the parties; it was contemplated by the Petitioner's surgeon that she required low back surgery. Medical records confirm that the low back surgery contemplated at the time of the parties original hearing in 2003 was a lumbar fusion. Dr. Heim performed the same surgery contemplated by the Petitioner's treating physician in 2003, on October 23, 2008.

Second, Petitioner's treating medical records from ROA demonstrate significant and ongoing low back pain with radiculopathy and bilateral leg pain throughout the middle of 2006, as well as 2007. The Petitioner was seen as recently by Dr. McKenzie, as September 19, 2007, regarding her low back pain (exactly one month prior to the episode with the lunch table in October). On September 12, 2007, Dr. McKenzie performed an LESI and L5-S1 selective nerve block for the diagnosis of lumbar radiculopathy.

Third, the Arbitrator considers the opinion of Dr. Stephen Heim, who is the treating physician, and adopts it as credible and persuasive. Dr. Heim significantly did not record a history of the table incident from the Petitioner when he saw her on May 2, 2008. On the issue of causation, Dr. Heim testified that it was his opinion to a reasonable degree of medical certainty, that Ms. Peppers's symptoms and subsequent care were related to the injury of September 19, 1996, and not the injury of October 19, 2007. See PX 3; Deposition Transcript pages 26-27. When specifically asked by Respondent #1's counsel whether the October 19, 2007 incident was the explanation for the worsening in her condition between the dates Dr. Heim saw the Petitioner in 2005 and 2008, Dr. Heim acknowledged that it was possible, though he testified her plain x-ray progression and the

progression seen on the MRI of January 7, 2008 is much more consistent with the gradual progressive process than an acute one. See PX 3; Deposition Transcript pages 40-41. All this is to say that while Dr. Heim acknowledged the Petitioner's symptoms had worsened between May of 2008 and January of 2005 when he had last seen her, it was Dr. Heim's position that the worsening of her symptoms was best explained by a gradual degenerative process associated with the original injury, rather than an acute process caused by the October 19, 2007 work injury.

Forth, Respondent #1 arranged an IME exam with Dr. Kern Singh. See PX 4-5. In his original IME report, dated August 28, 2008, Dr. Singh diagnosed isthmic spondylolisthesis at L5-S1. See PX 5. Regarding causality and apportionment, Dr. Singh (who was retained by Respondent #1), testified he believed the patient sustained an aggravation of her pre-existing degenerative condition in September of 1996. He concurred with Dr. Heim's assessment and believed the patient would benefit from a posterior laminectomy with instrumented fusion at L5-S1. See PX 5. It should be noted that subsequent to his initial report, Dr. Singh did write a subsequent report where he opined that the October 19, 2007 injury was an aggravation of the pre-existing low back condition, caused by the original work accident. Thereafter, Dr. Singh wrote a third opinion finding the surgery Dr. Heim performed in October of 2008, was not related to either the September 19, 1996 work injury, nor the October 19, 2007 work injury, in contradiction to two (2) prior written reports he had authored for Respondent #1. Law of the case principles bind the Arbitrator to his prior ruling. Dr. Singh's suggestion that surgery done by Dr. Heim at L5-S1 regarding the Petitioner was not related to either work injury is incompatible with law of the case principles and is rejected by the Arbitrator.

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

The Arbitrator finds that Petitioner's October 19, 2007 work injury was merely a temporary aggravation of a pre-existing condition. The Arbitrator specifically finds that only three (3) medical visits with ROA are causally related to the October 19, 2007 work injury, as listed below:

- November 13, 2007 office visit to Dr.MacKenzie-$149.00
- December 3, 2007 epidural steroid injection $801.00, and flouroguide for $569.00
- December 11, 2007 office visit to Dr. MacKenzie-$95.00

The Arbitrator finds Respondent #2 is responsible for these three medical bills which Respondent #1 has already paid. Respondent #2 is ordered to reimburse Respondent #1 for only those 3 dates of service at ROA identified above. All other medical bills, which are causally related to Case No. 96 WC 65881, are the responsibility of Respondent #1. The Arbitrator has issued a separate decision concerning Case No. 96 WC 65881, identifying those medical bills for which Respondent #1 is responsible for paying, which remain unpaid at this time. The Arbitrator's decision in Case No. 96 WC 65881 also directs Respondent #1 to reimburse Respondent #2 for all other medical expenses, which

were paid by Respondent #2, that the Arbitrator finds are not causally related to the October 19, 2007 work injury.

STATE OF ILLINOIS)
)
SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Peppers,
Petitioner,

vs. NO: 96 WC 65881

14IWCC0079

Rockford Board of Education #205,
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 jurisdiction, accident, medical expenses and whether the Arbitrator improperly directed reimbursement, and being advised of the facts and law, vacates the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

Petitioner filed an Application for Adjustment of Claim on or about December 17, 1996, alleging injury to her back, body as a whole and both legs in the scope and course of her employment for Respondent, Rockford Board of Education #205 on or about September 19, 1996. The claim was assigned case number 96 WC 065881. A final hearing was bifurcated and heard on May 14, 2003 and May 16, 2003 before Arbitrator Douglas Holland.

Arbitrator Holland issued a decision on June 9, 2003. The Arbitrator found Petitioner did sustain accidental injuries that arose out of and in the course of her employment and ordered Respondent to pay Petitioner $114.70/week for a period of 75 weeks as provided in Section 8(d)2 of the Act, because the injuries she sustained caused a 15% loss of use of Petitioner's body as a whole. The June 9, 2003 Arbitration Decision was not appealed and became the final decision of the Commission on or about July 9, 2003.

Despite the fact that a final decision had been entered in this case in 2003, Arbitrator Holland reheard case 96 WC 65881 on November 14, 2012 in consolidation with a pending claim, 08 WC 1934, Petitioner had set for hearing before the Commission. Arbitrator Holland then issued an Arbitration Decision in case 96 WC 065881 on December 12, 2012, awarding Petitioner additional medical benefits under Section 8(a) of the Act.

The Commission finds that Arbitrator Holland lacked jurisdiction to hear any evidence or make any findings in claim 96 WC 65881 after the Arbitration Decision in the case became the final decision of the Commission in July 2003. The Commission notes that no party to the proceeding has filed a Petition for Review under Section 8(a) of the Act to petition the Commission to review the case.

For the forgoing reasons, the Commission vacates the Arbitrator's December 12, 2012 decision in case 96 WC 065881. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2012 is hereby vacated for lack of jurisdiction.

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.

DATED: FEB 03 2014

drd/adc
o-11/05/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEPPERS, LISA
Employee/Petitioner

Case# **96WC065881**

ROCKFORD BOARD OF EDUCATION DISTRICT NO. 205
Employer/Respondent

14IWCC0079

On 12/12/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

2489 BLACK, JIM LAW OFFICE
BRAD A REYNOLDS
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0560 WIEDNER & MCAULIFFE LTD
PATRICK J MORRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)
COUNTY OF **Winnebago**)

- [ ] 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

Lisa Peppers Case # **96** WC **65881**

Employee/Petitioner

v. **Rockford**

Rockford Board of Education District No. 205
Employer/Respondent

14IWCC0079

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas J. Holland**, arbitrator of the Commission, in the city of **Rockford**, on **November 14, 2012**. 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 the 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 the petitioner's employment by the respondent?

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

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

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

G. [ ] What were the petitioner's earnings?

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

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

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

K. [ ] What amount of compensation is due for temporary total disability?

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

M. [ ] Should penalties or fees be imposed upon the respondent?

N. [ ] Is the respondent due any credit?

O. [ ] Other _____

FINDINGS

- On **September 19, 1996**, the respondent _____ *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- In the year preceding the injury, the petitioner earned $ **7,646.80**; the average weekly wage was $ **191.47**.
- At the time of injury, the petitioner was **37** years of age, *married* with **3** children under 18.
- Necessary medical services *have not* been provided by the respondent.
- To date, $ **0** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **N/A**/week for _____ weeks, from _ through _____, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $ _____/week for a further period of _____ weeks, as provided in Section _____ of the Act, because the injuries sustained caused _____.
- The respondent shall pay the petitioner compensation that has accrued from _____ through _____, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **189,477.22** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0** in attorneys' fees, as provided in Section 16 of the Act.

_____

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

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

Douglas F. Holland
Signature of arbitrator

12-10-12
Date

DEC 12 2012

IN AND BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

Lisa Peppers, Employee/Petitioner,	)	Case No. 96 WC 65881
v.	)	
Rockford Board of Education; District No. 205, Employer/Respondent.	)	14IWCC0079

DISPUTED ISSUES

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

The Arbitrator takes judicial notice of Petitioner's Exhibit 7, as well as First Respondent's Exhibit 1 which is the Illinois Industrial Commission Arbitration Decision regarding the nature and extent of injury, concerning Case No.: 96 WC 65881 involving Petitioner, Lisa Peppers and Respondent, Rockford Board of Education; District No. 205. In a prior written Decision of the undersigned, the Petitioner was found to have sustained injury to her low back as the result of a work injury on September 19, 1996, while restraining a student in the course of her employment as a para-professional for the Respondent. See PX 7. It was noted in the Decision of the Arbitrator that Petitioner's then medical records offered into trial on the date of the hearing, May 14, 2003, demonstrated that the Petitioner has disc pathology in her low back and that surgical treatment of her complaints had been recommended by Dr. Fanscali. See PX 7. At the time of the initial Arbitration, the Arbitrator found that although surgery had been recommended, the Petitioner had not submitted to surgery but testified that is an option for her in the future. The Arbitrator awarded permanent partial disability (PPD) against the Respondent, in the amount of 15% permanent loss of use of the body as a whole, pursuant to Section 8(d)(2) of the Act.

The Petitioner continued to work for the Respondent after the parties hearing on May 14, 2003 as a paraprofessional. At the time of the hearing, the Petitioner testified that she would experience periodic flare-ups of her low back pain since the injury and that she no longer lifts or moves heavy objects either at work or at home. The Petitioner continued working for the Respondent, following the hearing, and continued to experience periodic flare-ups, as demonstrated by her treatment records. The Petitioner testified in situations of flare-up that she would take medications and would schedule an appointment to get a spinal block. According to the Petitioner, her symptoms would generally improve until she experienced another flare-up.

Medical records demonstrate that the Petitioner was referred by her primary care physician, Dr. Kinigakis, for consultation with Dr. Sean McKenzie at ROA on account of low back pain and pain radiating down her bilateral legs and feet. Right toe cramping was

also reported. The initial consult with Dr. McKenzie was done on May 10, 2006. See PX 1. Petitioner received a lumbar epidural steroid injection by Dr. McKenzie on May 16, 2006. She was then seen in follow-up on July 21, 2006 with ongoing right-sided low back pain with a reported increase down the right leg with burning. Dr. McKenzie ordered an updated lumbar MRI. See PX 1. After review of the lumbar MRI, physical therapy was ordered. LESI and L5-S1 nerve block were then performed by Dr. McKenzie on August 28, 2006. By November 5, 2006, Ms. Peppers was reporting improvement in her symptoms, but still complaining of right calf pain. There is no other medical treatment rendered for her low back symptoms in 2006. PX 1.

Nearly a year later on July 9, 2007, the Petitioner saw her Rheumatologist, Dr. Danstill, for a non work-related condition, Crohn's disease. In the July 9, 2007 appointment with Dr. Danstill, he noted low back pain with radiculopathy and indicated she was to see Dr. McKenzie for consideration of LESI. On July 13, 2007, the Petitioner was seen by Dr. McKenzie with bilateral calf burning from the knees to her foot, along with pain radiating to her bilateral thighs. See PX 1. The radiating pain was worse on the left than the right and her large toe was numb. See PX 1. Dr. McKenzie prescribed gabapentin and also prescribed an updated lumbar MRI. See PX 1. When seen again on August 1, 2007, there was no change in her symptoms. The diagnosis was lumbar radiculopathy. The plan was to perform LESI. See PX 1. On August 9, 2007, a lumbar epidural steroid injection was performed, which reportedly improved her symptoms by 10%, when she was re-examined on August 15, 2007. On September 12, 2007, a repeat LESI along with L5-S1 selective nerve block, were performed by Dr. McKenzie. See PX 1. On September 19, 2007, the Petitioner reported most of her low back pain was gone although she reported some residual pain in her right leg. The diagnosis remained lumbar radiculopathy. The plan was to reinject the Petitioner on an as-needed basis. PX 1.

Petitioner testified that she was working at the Maria Montessori for the Respondent as a paraprofessional when she sustained a new injury on October 19, 2007. The Petitioner testified she was setting up lunch tables, along with the students, in the lunch room. Petitioner explained several of the tables were broken and that she had to put weight on the tables to bring them down. Petitioner testified that as she placed weight on the table, that the table broke and she fell to the ground with the table, landing on her buttocks. The Petitioner testified that immediately after the incident, the 'fire' down her leg came back and that it was constant. The Petitioner testified that one time prior to October 19, 2007, she recalled a constant burning 'fire' down her leg.

According to medical records reviewed, Ms. Peppers was first seen by Dr. McKenzie on November 13, 2007. See PX 1. Dr. McKenzie noted a history that the Petitioner had reinjured her back when lifting a table on October 19, 2007, and that she felt shooting pain in her low back which radiated down her bilateral legs since the episode. See PX 1. At her first visit following the October 19, 2007 incident, Dr. McKenzie prescribed Lyrica and performed a repeat LESI. See PX 1. On December 3, 2007, the Petitioner was seen again by Dr. McKenzie, who performed a repeat LESI and selective nerve block at L5-S1. On December 11, 2007, the Petitioner was reporting that she felt better. The

diagnosis of lumbar radiculopathy remained the same. The plan was to continue her on Lyrica, and she was to return as needed. PX 1.

Subsequently, Respondent #1 and Respondent #2 could not come to an agreement, as to who was responsible for additional medical treatment. Petitioner was not then seen due to delay in authorization of medical treatment, until she was seen by Dr. Stephen Heim on May 2, 2008. When seen on May 2, 2008, the Petitioner gave a history of back pain in her lower extremities and she reported that in the intervening three (3) plus years since last seeing Dr. Heim, her symptoms had slowly intensified. It was primarily her lower extremity symptoms that troubled her to the greatest degree. See PX 3. The Petitioner did not report the October 19, 2007 specific injury to Dr. Heim when seen on May 2, 2008. See PX 3; Deposition Transcript pages 19-20. Dr. Heim obtained x-rays and compared them to x-rays that he had obtained of the Petitioner in January of 2005. After performing physical exam and considering the x-ray results, Dr. Heim's diagnosis was progressive Grade II L5-S1 Spondylolytic Spondylolisthesis with right greater than left L5 radiculopathy. See PX 3; Deposition Transcript page 21. Dr. Heim recommended an updated lumbar MRI as well as lumbar discogram, which were performed on August 18, 2008. The lumbar discogram was performed only at L3-4 and L4-5. These levels were tested because they needed to rule out these levels as being symptomatic. Dr. Heim testified that he already knew L5-S1 was a problem. See PX 3; Deposition Transcript pages 22-23. Based on discogram results, Dr. Heim recommended and subsequently performed one (1) level lumbar fusion with instrumentation at L5-S1 on October 23, 2008 at Central DuPage Hospital. See PX 3; Deposition Transcript pages 22-23. Shortly after surgery, the Petitioner developed a high fever of 104 degrees and she developed a pulmonary embolism and pneumonia in her right lung. Dr. Heim testified those were complications of the lumbar surgery which he performed on October 23, 2008. See PX 3; Deposition Transcript pages 25-26. After completing doctor ordered rehabilitation, the petitioner was release to full-duty work by Dr. Heim on January 15, 2009. See PX 6.

Petitioner testified at the time of the hearing that the surgery performed by Dr. Heim resolved her 'fire' down her legs. The Petitioner testified she had an excellent outcome from lumbar surgery. The Petitioner testified that she has not seen Dr. Heim since 2008 when she was released. Petitioner did testify to some limitation regarding range of motion regarding her lumbar spine and noting some symptoms, especially in cold weather.

Respondent #1 disputes their obligation to pay medical bills associated with the Petitioner's lumbar surgery and any medical treatment after October 19, 2007, on the grounds that the October 19, 2007 was an intervening accident, relieving Respondent #1 of their obligation to be responsible for Petitioner's medical needs as the result of Case No. 96 WC 65881. Respondent #2 argues that the October 19, 2007 incident was merely a temporary aggravation of a pre-existing condition, which did not resolve Respondent #1 of their obligation to pay for Petitioner's work-related future medical expenses, regarding her low back including the surgery done by Dr. Heim in October of 2008.

It is for the Arbitrator to determine whether the October 19, 2007 work injury described by the Petitioner involving the lunch table, relieves or absolves Respondent #1 from any obligation regarding Petitioner's future medical benefits after October 19, 2007.

After review of the testimony of the Petitioner, and in consideration of treating medical records, along with the opinions of Dr. Heim and Dr. Singh, the Arbitrator finds that Respondent #1 was responsible for the Petitioner's lumbar surgery performed by Dr. Heim on October 23, 2008 at Central DuPage Hospital. Specifically, the Arbitrator finds that the October 19, 2007 incident involving the lunch table was merely a temporary aggravation of a pre-existing condition. The Arbitrator finds that the Petitioner achieved MMI for the October 19, 2007 injury on December 11, 2007. The Arbitrator specifically finds that treatment dates November 13, 2007, December 3, 2007, and December 11, 2007, are causally related to the October 19, 2007 injury, and that Respondent #2 is responsible for payment of those medical bills only. All subsequent treatment is causally related to the September 19, 1996 work injury, including the lumbar surgery performed by Dr. Heim.

Several reasons support the Arbitrator's finding that there is a causal relationship between Petitioner's low back treatment with Dr. Heim from May 2, 2008 through January 15, 2009, and the Case No.: 96 WC 65881 injury. First and foremost, the Arbitrator notes that at the time of the original hearing between the parties; it was contemplated by the Petitioner's surgeon that she required low back surgery. Medical records confirm that the low back surgery contemplated at the time of the parties original hearing in 2003 was a lumbar fusion. Dr. Heim performed the same surgery contemplated by the Petitioner's treating physician in 2003, on October 23, 2008.

Second, Petitioner's treating medical records from ROA demonstrate significant and ongoing low back pain with radiculopathy and bilateral leg pain throughout the middle of 2006, as well as 2007. The Petitioner was seen as recently by Dr. McKenzie, as September 19, 2007, regarding her low back pain (exactly one month prior to the episode with the lunch table in October). On September 12, 2007, Dr. McKenzie performed an LESI and L5-S1 selective nerve block for the diagnosis of lumbar radiculopathy.

Third, the Arbitrator considers the opinion of Dr. Stephen Heim, who is the treating physician, and adopts it as credible and persuasive. Dr. Heim significantly did not record a history of the desk incident from the Petitioner when he saw her on May 2, 2008. On the issue of causation, Dr. Heim testified that it was his opinion to a reasonable degree of medical certainty, that Ms. Peppers's symptoms and subsequent care were related to the injury of September 19, 1996, and not the injury of October 19, 2007. See PX 3; Deposition Transcript pages 26-27. When specifically asked by Respondent #1's counsel whether the October 19, 2007 incident was the explanation for the worsening in her condition between the dates Dr. Heim saw the Petitioner in 2005 and 2008, Dr. Heim acknowledged that it was possible, though he testified her plain x-ray progression and the progression seen on the MRI of January 7, 2008 is much more consistent with the gradual progressive process than an acute one. See PX 3; Deposition Transcript pages 40-41. All this is to say that while Dr. Heim acknowledged the Petitioner's symptoms had worsened

between May of 2008 and January of 2005 when he had last seen her, it was Dr. Heim's position that the worsening of her symptoms was best explained by a gradual degenerative process associated with the original injury, rather than an acute process caused by the October 19, 2007 work injury.

Fourth, Respondent #1 arranged an IME exam with Dr. Kern Singh. See PX 4-5. In his original IME report, dated August 28, 2008, Dr. Singh diagnosed isthmic spondylolisthesis at L5-S1. See PX 5. Regarding causality and apportionment, Dr. Singh (who was retained by Respondent #1), testified he believed the patient sustained an aggravation of her pre-existing degenerative condition in September of 1996. He concurred with Dr. Heim's assessment and believed the patient would benefit from a posterior laminectomy with instrumented fusion at L5-S1. See PX 5. It should be noted that subsequent to his initial report, Dr. Singh did write a subsequent report where he opined that the October 19, 2007 injury was an aggravation of the pre-existing low back condition, caused by the original work accident. Thereafter, Dr. Singh wrote a third opinion finding the surgery Dr. Heim performed in October of 2008, was not related to either the September 19, 1996 work injury, nor the October 19, 2007 work injury, in contradiction to two (2) prior written reports he had authored for Respondent #1. Law of the case principles bind the Arbitrator to his prior ruling. Dr. Singh's suggestion that surgery done by Dr. Heim at L5-S1 regarding the Petitioner was not related to either work injury is incompatible with law of the case principles and is rejected by the Arbitrator.

In summary, the Arbitrator finds that the October 19, 2007 work injury does not relieve Respondent #1 of their obligation to pay work-related future medical treatment, concerning the Petitioner. The Arbitrator specifically find that all medical treatment after the parties' initial hearing on May 14, 2003 and prior to October 19, 2007 is causally related to Case No.: 96 WC 65881, and Respondent #1 is responsible for this treatment. The Arbitrator further finds Respondent #1 is not responsible for medical treatment rendered at ROA to the Petitioner concerning the October 19, 2007 work injury, but limits that treatment to the following visits: November 13, 2007, December 3, 2007, and December 11, 2007. The Arbitrator thereafter finds that Respondent #1 is responsible for the Petitioner's remaining medical treatment concerning her low back and including low back surgery done by Dr. Heim, as well as post-surgery complication which resulted in the Petitioner's hospitalization for a pulmonary embolism at OSF St. Anthony.

Respondent #2 offered Rx 1, which is a compilation of all medical bills and TTD that Respondent #2 paid with regards to the Petitioner after the October 19, 2007 work injury. The Arbitrator now orders Respondent #1 to reimburse Respondent #2 for all medical bills contained in Respondent #2's Exhibit 1, in the amount of **$181,846.47**. Respondent #1 is not required to reimburse Respondent #2 for TTD benefits paid by Respondent #2 to Petitioner following her low back surgery with Dr. Heim.

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

The Arbitrator finds all medical services provided to the Petitioner were reasonable and necessary and causally related to her September 19, 1996 work injury, with the exception of the three (3) visits at ROA in November 2007 and December of 2007. Respondent #1 is ordered to pay Respondent #2 for all medical bills paid by Respondent #2, regarding the Petitioner, as demonstrated by Respondent #2's Exhibit 1 in the total amount of $181,846.47. Respondent #1 is further ordered to pay the unpaid medical bills, as listed below:

Medical Provider	Date of Service	Total Outstanding Balance
1. Central DuPage Hospital	8/18/2008	$7,630.75

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Stanley,
Petitioner,

vs.

Wal-Mart,
Respondent.

14IWCC0080

NO: 12 WC 4762

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 15, 2013 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.

DATED: FEB 0 3 2014
KWL/vf
O-1/28/14
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

141WCC0080

STANLEY, ANTHONY
Employee/Petitioner

Case# **12WC004762**

WAL-MART
Employer/Respondent

On 7/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTUR BLVD
SPRINGFIELD, IL 62704

0560 WIEDNER & MCAULIFFE LTD
MATTHEW ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0080

Anthony Stanley
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # 12 WC 04762

Consolidated cases: NA

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield/Urbana**, on **April 15, 2013 and May 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/21/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $ **27,360.71**; the average weekly wage was $ **547.21**.

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

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

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

Respondent shall be given a credit of $ **0.00** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **5,918.13** in other benefits for which credit may be allowed pursuant to Section 8(j) of the Act.

Respondent is entitled to a credit for any medical bills it has paid through a group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

- Petitioner failed to provide notice as required under Section 6(c) of the Act.
- Petitioner failed to prove he sustained an accident on September 21, 2011 that arose out of and in the course of his employment with Respondent.
- Petitioner failed to prove causal connection.
- Petitioner's claim for compensation is denied.

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

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

Nancy Lindsay
Signature of Arbitrator

7-10-13
Date

JUL 15 2013

This case originally went to arbitration on April 15, 2013; however, proofs were not closed until May 17, 2013. The disputed issues are: accident; notice; causal connection; temporary total disability; medical expenses; and the nature and extent of Petitioner's injury. Witnesses testifying at arbitration included Petitioner; Rod Wooldridge; Derrick Thaxton; Melody Sharp; Phillip Crawford; and Dwayne Maglone.

The Arbitrator finds:

According to the Decatur Memorial Hospital records (PX 1) Petitioner went to the emergency room on January 19, 2011 regarding a right wrist sprain/strain. The triage note states that Petitioner noted the onset of right hand and wrist pain after working/lifting pallets for Respondent. Petitioner denied any known injury but remarked he had performed the same job for 11 years. Additional history regarding Petitioner's activities at the time of the onset was noted. On physical examination Petitioner denied any pain to his proximal forearm, elbow, upper arm or shoulder. X-rays of Petitioner's right hand were taken. Petitioner was given a thumb spica wrist brace to wear at work, along with medication, and told to report to DMH Corporate Health the next day. (PX 1)

On January 20, 2011 Petitioner completed an Associate Statement regarding an injury occurring on January 17, 2011. Petitioner was lifting pallets but unsure how the injury occurred. Petitioner reported it on January 20, 2011 to "Drew." (RX 8) Melody Sharp completed the Employer's First Report of Injury on that date. (RX 8 – 0003). According to Respondent's records, Petitioner received treatment at DMH Corporate Health and was given temporary work restrictions which Respondent was able to accommodate. (RX 8 – 0004 to 0006)

According to Respondent's "Call In Sheets" Petitioner was absent from work on August 26, 2011 due to illness/injury. (PX 9) Petitioner was late for work on August 28, 2011 due to illness/injury. (PX 9)

According to Dr. Jones' records Petitioner called the doctor's office on August 30, 2011, requesting an appointment for left shoulder pain. (RX 10 – 0008; PX 3) Petitioner reported that his symptoms began three days earlier and were not work-related. (RX 10 – 0008) Petitioner provided his group medical insurance information at that time. (RX 10 – 0008) An appointment was scheduled for September 15, 2011; however, Petitioner did not show up for that appointment or call to cancel. (RX 10 – 008 through 0013)

Petitioner called in absent on September 21, 2011 due to illness/injury. (PX 9, p. 4)

Petitioner presented at the emergency room at Decatur Memorial Hospital on September 22, 2011. (PX 1 pg. 18 PX 3, pp. 7-12) The triage note indicates Petitioner reported intermittent pain over the preceding two days. Petitioner stated he could move his arm without difficulty but experienced intermittent pain and noted that certain movements exacerbated the pain. The mechanism of injury was reportedly unknown. (PX 1 p. 18) Petitioner denied any trauma and only mentioned that he did a lot of overhead lifting at work. Petitioner noticed pain with

abduction/flexion of his left shoulder. (PX 1 pp. 14-21) Emergency room documentation also notes Petitioner stated the shoulder pain had been present on an intermittent basis for four days. On physical examination Petitioner was tender to palpation of the glenohumeral joint and had positive pain with resisted abduction/flexion of his left shoulder. Petitioner was diagnosed with a muscle strain and was released to return to work with restrictions. He was also given medication and a sling and told not to use his left arm for ten days at which point he could return to full duty work without any restriction if he felt well. (PX 1, p. 16)

On/about September 30, 2011 Petitioner applied for an FLMA leave of absence effective September 21, 2011 through October 1, 2011 due to Petitioner's left shoulder. The emergency room physician completed the healthcare provider statement. (RX 1)

On October 4, 2011 (a Tuesday), Petitioner again called Dr. Jones' office requesting an appointment. (RX 10 – 0020, PX 3, p. 13) Dr. Jones' records indicate that Petitioner was experiencing left shoulder pain and had been to DMH ER "last Wednesday," and the date of onset of symptoms was "last Wednesday." In the space where one would indicate whether the injury was work-related, the following was marked out – "Yes, WalMart." In its place was written, "No." (PX 3, p. 13; RX 10 - 0020) Petitioner was to call back with workers' compensation information. Petitioner did call back on October 6, 2011 and advised "will not be work comp." (PX 3, p. 13; RX 10- 0020)

Petitioner next sought treatment from Dr. Duncan, his primary care physician, on October 11, 2011. (PX 2 p. 1) Prior to that date, Petitioner had not seen Dr. Duncan since 2007. (PX 2 p. 4) Petitioner explained he had left shoulder pain, had been in the ER and had been told he had tendinitis. He denied any trauma but reported performing lots of overhead activities, including stocking shelves. Petitioner was instructed about shoulder exercises and the use of Aleve for pain.

A clinical information form was updated by Dr. Jones' clinical assistant on October 11, 2011, indicating that Petitioner did not sustain an injury. (RX 10 – 0032 through 0034; PX 3, pp. 25 - 27) No history of a work injury was recorded. (RX 10 – 0032 through 0034)

Dr. Jones first saw Petitioner on October 13, 2011, at which time Petitioner reported left shoulder pain for the past three weeks. (RX 10 – 0028; PX 3) No history of a work-related injury or description of Petitioner's job duties was documented on that visit. Petitioner did report pain which would awaken him if he rolled over onto his left side. (RX 10 – 0028 through 0030). On physical examination, Dr. Jones found weakness of Petitioner's supraspinatus with pain, weakness of external rotation without pain, and the presence of atrophy of the supraspinatus. Dr. Jones ordered an MRI of Petitioner's left shoulder (PX 3, pp. 22-23) In the interim, Dr. Jones diagnosed Petitioner with left shoulder pain. Petitioner indicated he did not need a note for work. The doctor's note indicates Petitioner's work status was full duty. (RX 10 – 0029; PX 3, p. 23)

An MRI of Petitioner's left shoulder was obtained on October 18, 2011, which suggested a full-thickness tear of the rotator cuff without retraction. (PX 1 pg. 24) Petitioner returned to Dr. Jones on October 27, 2011, with no change in his symptoms. (RX 10 – 0040) Following a review of the MRI, Dr. Jones recommended surgery. (RX 10 – 0040).

Petitioner returned on October 27, 2011, to discuss the results of the MRI (PX 3, p. 33-34). Dr. Jones diagnosed left rotator cuff sprain and strain and discussed with Petitioner the need for surgery noting Petitioner would call when ready to schedule surgery (PX 3, pp. 33-34)

The records of Dr. Jones reflect that Petitioner called on November 8, 2011, requesting surgery be scheduled after Thanksgiving and the date of November 28, 2011, was agreed upon. (PX 3, p. 31)

Dr. Jones admitted Petitioner to Decatur Memorial Hospital on November 28, 2011. (PX 1 pp. 31, 35) No mention of a work-related injury was documented in the history and physical. (RX 10 – 0047) Dr. Jones performed a debridement arthroscopy with arthroscopic subacromial decompression, and debridement of a partial thickness rotator cuff tear. (PX 1 p. 35) He discharged Petitioner with a post-operative diagnosis of left partial thickness rotator cuff tear with impingement. (PX 1 pg. 35; RX 10 – 0043)

Respondent faxed Dr. Jones' office a Certification of Health Care Provider for Associate's Serious Health Condition (FMLA) form on November 29, 2011 (PX 3, pp. 48-50).

Petitioner returned to Dr. Jones post-operatively on December 6, 2011. (RX 10 – 0059) Dr. Jones completed the leave of absence paperwork indicating Petitioner was unable to work and faxed it back to Respondent. (RX 10 – 0059; see also PX 3 and RX 2) Petitioner was wearing a sling and taking 4 pain pills a day (PX 3, p. 52-53). Dr. Jones prescribed different medication, physical therapy for Petitioner, and kept Petitioner off work (PX 3, pp. 51 - 53).

Petitioner's therapy was conducted at Decatur Memorial Hospital. (PX 1 pp. 41-62, PX 3, p. 53) Although Petitioner was given a Patient History form on December 15, 2011, which asked "When & how did the problem start?" Petitioner did not complete the form. (PX 1 p. 41) Petitioner was wearing a sling and taking 4 pain pills a day (PX 3, p. 52-53). The initial therapy evaluation reported Petitioner was seen on December 15, 2011, and noted Petitioner's subjective comments were "hands went numb after work – in September, worked up to surgery – stocks shelves at [Respondent], surgery November 28, 2011, and wearing sling and immobilizer." It was also noted that Petitioner had 'problems with his right shoulder [illegible] this past summer." (PX 1, p. 44)

On January 6, 2012, the Hartford contacted Dr. Jones' office requesting an attending physician statement of functionality in support of Petitioner's claim for short-term disability benefits. A decision on Petitioner's income replacement was pending until that information was received. (RX 10 – 0062; PX 3, p. 55) Dr. Jones completed and signed the form, checking "no" when asked "[i]s this condition due to illness or an injury that is work-related," and indicating that his condition was the result of "sickness" rather than injury or pregnancy. The completed form further noted Petitioner was unable to lift/carry above his shoulder, reach at waist/desk level with his left arm, or reach below waist/desk level with his left arm. (RX 10 – 0063).

Petitioner returned to Dr. Jones on January 17, 2012. Petitioner reported his shoulder was doing pretty good. (PX 3, pp. 62-63) Dr. Jones recommended Petitioner stop using the sling but continue physical therapy. Although Petitioner wanted to return to full duty Dr. Jones kept him

on light duty and Petitioner was given a work slip stating no use of the left arm. (PX 3, pp. 61, 62-63)

Petitioner signed his Application for Adjustment of Claim on February 3, 2012, alleging a left arm injury due to stocking shelves and unloading trucks. The alleged date of accident was September 18, 2011. (AX 2)

On February 7, 2012 Respondent's Personnel Manager, Melody Sharp, faxed several pages to "Eric" at CMI. The cover sheet states, "Eric – we have no claim on this – How do you want me to proceed? He had a claim 1-17-11 for his wrist." (RX 3 - 0002) Attached to the cover sheet is a 2/3/12 letter from Petitioner's attorney's office enclosing a copy of the Application for Adjustment of Claim which had been filed on Petitioner's behalf. (RX 3 – 0003) A copy of the Application was attached. (RX 3 – 0004 to 0006)

By February 16, 2012, Petitioner was ready for therapy to be over. He felt he had made huge improvements and was discharged. (PX 1, pp. 70-71)

On February 21, 2012 Ms. Sharp faxed a copy of the Initial Notice of Case Filing to Eric at CMI. Ms Sharp wrote, "Eric I received this today in the mail. It's from the associate I asked you about a week or 2 ago. We have no file on him that he ever reported this." (RX 4)

An Associate's Statement was completed February 23, 2012. Petitioner claimed he injured his left shoulder on September 18 or 19 at 6:45 a.m. lifting some cans and his "hands went numb, start early that night." Petitioner claimed a left shoulder injury. There were no witnesses and Petitioner acknowledged he did not report it. (RX 5)

Petitioner returned to Dr. Jones' office on February 28, 2012, with continued discomfort and reporting he was taking 2 pain pills per day. Petitioner also had "brown spots" on his shoulder (PX 3, pp. 73-74). On physical examination, Dr. Jones found slight discomfort with forward elevation and a well healed incision (PX 3, p. 73). Petitioner had completed his physical therapy. Dr. Jones refilled medications for Petitioner and again released Petitioner to light duty work with no overhead and no lifting more than 5 pounds (PX 3, pp. 74-75).

The records of Dr. Jones reported Petitioner was seen again on April 10, 2012, with left shoulder pain anteriorly (which Petitioner rated at 7/10 at worst) left shoulder pain with movement, and pain when lifting his arm (PX 3, pp. 95, 97-99). It was noted by Dr. Jones this was a disputed workers' compensation issue. Petitioner was again given medications and work restrictions of 15 pounds lifting, waist level work only, and limited overhead work (PX 3, p. 97, 95). The records of Dr. Jones reveal that Petitioner was last seen on May 17, 2012, at which time Petitioner was doing good but had some soreness in upper arm (PX 3, p. 105). On physical examination, Dr. Jones found full motion and he released Petitioner to return to regular work and return to his office as needed (PX 3, pp. 104-106, 104; RX 10).

On April 30, 2012 Petitioner signed his Application for Adjustment of Claim in 12 WC 04762, a claim involving an alleged right hand injury due to stocking shelves. Petitioner alleged an accident date of January 19, 2011. (RX 7)

In correspondence dated September 11, 2012, Respondent advised Petitioner's attorney that it was disputing notice for this claim. (RX 14) Specifically, Respondent's attorney asked "[w]ould you please identify to whom and when your client allegedly provided oral notice of this injury?" (RX 14 – 0002) Petitioner's attorney replied on September 17, 2012, that "Mr. Stanley has informed me that he initially reported the work accident to Phil . . . on or about September 18, 2011, and before he went to the emergency room at Decatur Memorial Hospital on September 22, 2011." (RX 15 – 0002)

The deposition of Dr. Tyler Jones was taken on March 13, 2013. (PX 4) Dr. Jones is a board certified orthopedic surgeon licensed in the State of Illinois. He has been practicing in the Decatur area for approximately ten years. His practice is focused on shoulders, knees, hips, and fractures (primarily hands and elbows).

Dr. Jones testified that he initially saw Petitioner on October 13, 2011. Prior to that visit, Petitioner had contacted Dr. Jones' office on August 30, 2011 and spoke to someone in the front office who answers the phone. On the form generated after that conversation it indicates Petitioner had an onset of complaints three days earlier but it was not work-related. There was also mention of Blue Cross Blue Shield. An appointment was scheduled for September 15, 2011, but Petitioner failed to appear for it.

Dr. Jones further testified that Petitioner again contacted his office on October 4, 2011, regarding some problems with left shoulder pain. Petitioner indicated he had been to the emergency room the previous Wednesday and the "date of injury/onset of symptoms" date was listed as "last Wednesday." The form further indicates that Petitioner called back on October 6, 2011 and indicated the visit would not be "work comp" and, therefore, a reference to the visit being work-related was marked out and the word "No" written in. According to Dr. Jones, the note taker was Lisa Barber, his nurse.

Dr. Jones also testified that Petitioner referred himself to the doctor. On his October 13, 2011, questionnaire/history form Petitioner reported he was experiencing left shoulder pain due to movement and lifting. Petitioner also provided information as to his occupation as a grocery stocker on the third page of the history form.

At the time of their initial visit on October 13, 2011 Dr. Jones also had the ER records from Petitioner's earlier September 22, 2011 visit. Dr. Jones could not recall how he received those records or whether he actually reviewed them. At most, he felt it was a possibility. When he actually saw Petitioner, Petitioner's chief complaint was a three week history of left shoulder pain. Petitioner reported he was right hand dominant and denied any history of trauma. Petitioner explained to the doctor that his left shoulder had begun hurting approximately three weeks earlier especially with "above head movement." Petitioner had received no treatment and noted the pain would wake him up if he rolled over onto his left side.

Dr. Jones testified that he examined Petitioner's left shoulder noting full motion but some weakness and discomfort through his rotator cuff, especially in the area of the supraspinatus, the muscle that raises one's arm. Dr. Jones further noted some atrophy in Petitioner's supraspinatus which suggested Petitioner had not been using the muscle for a longer period of time (beyond

that of three weeks). The atrophy would have taken some time to occur but it would not be acute in nature. Dr. Jones explained, however, that people can have non-painful rotator cuff tears and not seek treatment. Petitioner also had a positive impingement sign which is frequently seen when the rotator cuff is irritated. X-rays of Petitioner's shoulder revealed AC joint arthritis, a common finding associated with aging and consistent with Petitioner's age of 51. Petitioner glenohumeral joint, the main shoulder joint, looked good. In light of Petitioner's physical examination findings, Dr. Jones ordered the MRI which revealed a full thickness rotator cuff tear. Dr. Jones also explained that the MRI indicated the tendon had not retracted (or shrunk) and retraction is frequently seen when a rotator cuff tear has been present for awhile. However, he could not state the age of Petitioner's tear. The MRI did not show any fat having infiltrated into Petitioner's left shoulder so he did not believe Petitioner's tear was a "real chronic" one. No dye was inserted into Petitioner's shoulder at the time of the MRI and, therefore, one could not determine the extent of the tear. However, according to the operative report, Petitioner's tear was only partial and not full thickness. Dr. Jones could not explain why the MRI showed pathology in the infraspinatus muscle as opposed to the supraspinatus. According to Dr. Jones, "MRIs aren't foolproof." (PX 4, p. 19)

Dr. Jones further testified that Petitioner was treated conservatively at first but was not given any work restrictions. Petitioner then telephoned him that he would like to schedule surgery sometime after Thanksgiving. Surgery was performed on November 28, 2011. During surgery Dr. Jones found a partial thickness rotator cuff tear and some spurring on the undersurface of the AC joint. Petitioner's tendon was debrided so that the spurs were removed and flattened down thereby allowing the rotator cuff to have more room. The tear was in the supraspinatus. Petitioner was unable to work using his left arm for six weeks thereafter to allow for standard therapy and recovery.

Post-operatively Dr. Jones monitored Petitioner's condition noting Petitioner's progression with pain, motion, and physical therapy. As of February 22, 2012 Petitioner had met all of his therapy goals and was being discharged from the formal program to his home exercise program. As of February 28, 2012 Petitioner was reporting slight discomfort with forward elevation of his arm to which the doctor explained that full recovery could take up to a year. Petitioner was allowed to continue with a pain pill but it was reduced in strength. Work restrictions of no overhead activity and a 5 pound weight limitation were given. Dr. Jones also recalled Petitioner mentioning some brown spots on his shoulder but he really could not remember what they were all about. He thought he probably recommended a visit to his dermatologist.

Dr. Jones followed up with Petitioner on April 10, 2012. Petitioner described his shoulder pain as located anteriorly and rated a 7/10 at its worst. Petitioner reported pain with movement but that he was performing his home exercise program and taking Naprosyn rather than narcotic medicine for any pain. Petitioner also reported he was unable to work as a stocker for Respondent due to arm discomfort. They also discussed Petitioner's lack of formal physical therapy after February of 2012 because of Petitioner's disputed work comp issue. Petitioner was given Tramadol and a Medrol dose pack and Dr. Jones reiterated the need for compliance with the shoulder exercise program on a daily basis. Petitioner's work restrictions included 15 lb. waist level work and limited overhead activity. Dr. Jones recalled nothing more about the disputed work comp issue.

Dr. Jones testified that Petitioner returned to see him on May 17, 2012, at which time Petitioner described his shoulder as doing "good" with some soreness but he was only taking one Tramadol every four hours (Tramadol being a mild pain pill). Petitioner was performing his home exercises and had full motion on exam. Petitioner was released from care and told to call if he had any problems.

Dr. Jones described Petitioner's diagnosis as rotator cuff tear with impingement syndrome. During the deposition he was shown a written job description for a stocker's position as well as the records of the emergency room visit at Decatur Memorial Hospital noting information concerning the mechanism of injury to which Petitioner replied that he did a lot of overhead activity stocking shelves at work and recalled no trauma. (PX 4, p. 30) Dr. Jones was given a hypothetical question regarding the work duties Petitioner has performed as a stocker for Respondent since 1999 (unloading trucks that come in in the evening, taking the pallets of merchandise to the floor with a pallet jack, and unloading the merchandise on approximately 12 pallets every night and placing the merchandise on various shelves of the store of which, at least two of the shelves are at shoulder level if not above and where most of Respondent's Great Value brand merchandise is located on those top shelves and he may also have to rotate older stock off the shelf and replace it with newer stock so that the older stock is in the front – an activity done several hundred times an evening – and with weights ranging from a pound to up to 10 to 15 lbs), and a history of Petitioner having performed those duties as a stocker in August of 2011 when he noticed left shoulder pain, called the doctor's office, did not state that his injury was a work comp injury and an appointment was scheduled for September 15, 2011 which Petitioner failed to appear for and that Petitioner continued to work thereafter and on September 19, 2011 Petitioner was performing his stocker duties when he again noticed left arm/shoulder pain and mentioned it to several co-workers but continued to work and notice symptoms eventually going to the emergency room on September 22, 2011 and then calling Dr. Jones' office on October 4, 2011, seeing Dr. Duncan on October 11, 2011 and then presenting for care with Dr. Jones as understood by the doctor. With the foregoing in mind and assuming the foregoing as true, Dr. Jones opined the work duties were a contributing factor to Petitioner's shoulder pain. While he could not say whether the work duties caused the rotator cuff tear he could say the work duties were an aggravation of the rotator cuff tear. Dr. Jones explained that overhead activities would not cause pathology in everyone and other activities could contribute to an underlying rotator cuff. (PX 4, pp. 31-34) Based solely on what Petitioner reported to him, this was not a work injury but Dr. Jones did not know what occurred with Petitioner initially reporting it was a work injury at the time of the second intake form in his office, and then changing his mind (PX 4, pp. 53-54) Dr. Jones also opined the complaints of a rotator cuff tear as found on the MRI and during surgery, could be aggravated by any overhead activity including reaching up to get a cup of coffee, changing a light bulb, adjusting a mirror of the car, and putting on clothes, but not with everyday waist level activities (PX 4, pp. 54-55)

Dr. Jones opined Petitioner is on the smaller height size for a male and he knows what a stocker has to do to put merchandise on the shelves but does not necessarily know the amount of merchandise stocked, having been in Wal-Mart and other stores. However, he did not know how much of Petitioner's work duties required overhead work but also noted that pulling a pallet does not require overhead work (PX 4, p. 55 - 59) Dr. Jones opined that work duties at shoulder level

would aggravate Petitioner's condition and activities above shoulder level would significantly aggravate Petitioner's condition (PX 4, p. 58) Dr. Jones explained overhead activities are known to cause pathology within the shoulder that could include an impingement syndrome and a rotator cuff tear (PX 4, pp. 34-35) Dr. Jones did not have any records or information there were other activities Petitioner performed overhead other than work duties (PX 4, pp. 35-37) Dr. Jones explained that initially they didn't know this was a work injury or being filed under work comp. "So there are questions that we might have asked back then knowing that this was a work injury that we did not at that point." We didn't inquire into recreation and home. (PX 4, p. 35) Dr. Jones opined the treatment he rendered Petitioner was necessary, reasonable, and medically appropriate based on his expertise in orthopedics (PX 4, p. 37)

On cross-examination Dr. Jones testified that he obtained a history of injury from Petitioner when he first examined him; however, Petitioner did not report a work-related injury. (PX 4 p. 39) Petitioner also did not report that he was seeking treatment for a workers' compensation claim. (PX 4 p. 40) Dr. Jones testified that Petitioner never reported a work-related injury to him. (PX 4 pp. 41, 61)

Dr. Jones admitted completing the attending physician statement of functionality on January 6, 2012, and stating the injury was not work-related. (PX 4 p. 44) Throughout the entire treatment, "we treated him as not a work-related injury." (PX 4 p. 52) If the claim was reported as a work-related injury, he would have submitted the bills to the workers' compensation carrier not Petitioner's group medical insurance. (PX 4 p. 40)

According to Dr. Jones, Petitioner had spurring on his x-rays that was unrelated to his alleged injury, which could cause the rotator cuff tear. (PX 4 p. 46) These spurs were the result of arthritis, which caused his shoulder impingement. (PX 4 pp. 59-60)

Dr. Jones testified he saw Petitioner for the last time on May 17, 2012. (PX 4 p. 50) At that time, Petitioner had full motion in his shoulder. (PX 4 p. 50) He did not document any loss of strength, and confirmed that he would have documented any loss of strength in his record. (PX 4 pp. 50-51) He advised Petitioner to call his office if he had any further complaints, and confirmed that Petitioner had not done so as of the date of his deposition. (PX 4 p. 51)

At arbitration Petitioner testified that he has been employed by Respondent as a stocker for 13 years. Petitioner testified he works the overnight/third shift (10:00 p.m. – 7:00 a.m.) and his job duties include pulling pallets (weighing 300 – 400 lbs) off the trucks with a pallet jack, delivering them to the proper area in the store to be shelved, and stocking merchandise on the shelves. According to Petitioner there are typically six shelves per isle, and the top shelf is about 5'9" high, approximately one inch higher than Petitioner. He testified that he would stock the shelves overhead approximately two times per shift, and that 600 of the 1200 items he would stock would go on the top two shelves. He explained that he mostly stocked Great Value brand products, which were mostly on the top two shelves. Petitioner used both hands and arm to lift and place the merchandise on the shelves.

Petitioner denied having any left arm or shoulder complaints, injuries, or treatment before August of 2011. Petitioner testified that he first noted "a little" pain in his shoulder in August of

2011 while stocking cans of Great Value beans. Petitioner called Dr. Jones' office to schedule an evaluation. Petitioner testified he could not recall if he was asked if his injury was work-related when he called. Although an appointment was scheduled for September 15, 2011, he testified that he cancelled his appointment because his mother was ill. On cross-examination Petitioner testified he told Dr. Jones' office that his shoulder was work-related.

Petitioner testified that he reported his injury to Phil Crawford at 1:30 in the morning on September 18, 2011. He identified Mr. Crawford as Respondent's representative at trial. Petitioner testified that he told Mr. Crawford he did not think he was going to "make it" because his shoulder was really hurting to which Mr. Crawford told him there was nothing wrong with him and he should continue working. Petitioner testified that he said nothing further to Mr. Crawford regarding his shoulder. On cross-examination Petitioner agreed that he never told Mr. Crawford that he had a work-related shoulder injury. Rather, he told Mr. Crawford that his shoulder hurt.

Petitioner testified that he continued working and his shoulder continued to hurt. Petitioner called in on September 21, 2011 and reported he would not be working. Petitioner testified he then sought treatment at Decatur Memorial Hospital on September 22, 2011. After being released from the hospital, Petitioner testified he went to Respondent's personnel office and reported his injury to "Diane," who Petitioner believed was an assistant to Melody. Petitioner testified Diane asked if he was taking ten days off and he replied in the affirmative. On cross-examination Petitioner admitted he did not tell the emergency room physician he had a work-related injury.

Petitioner testified that Melody told him he would need to get paperwork from the doctor allowing him to return to work after his ten days were up. According to Petitioner Melody gave him a form to have completed by the doctor and Petitioner had the emergency room doctor fill it out. Petitioner testified he returned the completed form to Melody and then he reported to work. Petitioner was not wearing a sling when he returned to work and had no restrictions. Petitioner clocked in and went to the break room like he normally did. In the break room were the night managers, "Rod" and "Brian" and other stockers, including Dwayne Maglone. Rod asked Petitioner if it was workman's comp and explained that Petitioner should clock in if it was and go home if it wasn't. Petitioner returned to work and noticed his shoulder would hurt while working.

Petitioner testified that in early October of 2011 he returned to see Dr. Jones. When calling the office he told them he was a stocker. Petitioner thought he called the doctor's office to tell them his shoulder was workers' comp. Petitioner testified he also thought he called Melody and asked her if his shoulder was workers' comp and she said no. Petitioner testified his conversation with Melody occurred before he called Dr. Jones' office the second time and told the office who to bill (ie., that his visit would not be work-related). On cross-examination Petitioner testified that when he first saw Dr. Jones he not only told him he was a stocker for Respondent but that his shoulder was due to a work-related injury.

Petitioner next sought treatment from Dr. Duncan because he needed an annual check-up. Petitioner testified that he told the doctor about his left shoulder and what he was doing when he

noticed the complaints. On cross-examination Petitioner acknowledged that he did not report a work-related injury to Dr. Duncan at that time. He saw Dr. Duncan because he needed a primary care physician.

Petitioner testified that he requested paperwork from Ms. Sharp.

Petitioner further testified that he provided paperwork to Rod Woolridge in early October 11, 2011 and that Mr. Woolridge asked him whether his condition was "workers' compensation."

Petitioner further testified that he called the store and spoke to Ms. Sharp in October of 2011, and asked her whether his condition was work-related and that she said no.

Petitioner testified that he told Dr. Jones that he was a stocker and explained his job duties as a stocker when they initially met with one another. He also testified that he told Dr. Jones that his injury was work-related during his initial office visit. When asked if Dr. Jones was lying during his testimony, Petitioner was somewhat evasive but responded, "I couldn't say that about him like that."

Petitioner also testified that in February of 2012, he was contacted by Melody Sharp and asked to come in to fill out paperwork and to undergo a drug screen. He met with Derek Thaxton, an assistant manager, and Melody at that time. Petitioner identified the associate statement identified as Respondent's Exhibit 5 and explained that Mr. Thaxton filled it out after asking him questions. Petitioner then signed the form without reading it first. Mr Thaxton explained that if an associate asked for help completing the statement, he would read the question and record their response. He confirmed that he asked Petitioner "when did you report your injury," and that his response was "didn't." This is consistent with the associate statement signed by Petitioner. (RX. 5) After completing the form, he gave it back to Petitioner, who reviewed the form and signed it. Mr. Thaxton then signed the form in acknowledgement.

The next day, the store completed the Employer's First Report of Injury for this claim. (RX 6 – 0002)

Petitioner received a full duty release from Dr. Jones on May 17, 2012. He returned to his regular job duties following that date, and has not sought additional medical treatment since that date. Petitioner testified he has not returned to Dr. Jones because he had been busy and his mother died.

Petitioner testified that he still has a little soreness in his left shoulder. Petitioner denied any difficulty with his left shoulder when pulling pallets. Petitioner uses a heating pad daily and takes three to six Advil every four or six hours (Petitioner initially testified to six hours but on cross-examination said it was every four hours). Petitioner continues to work as a stocker for Respondent.

Petitioner testified he was "a little tired" as he worked the third shift the day before his arbitration hearing and then drove from Decatur to Springfield after getting off work at seven o'clock in the morning.

Dwayne Maglone testified on Petitioner's behalf. Mr. Maglone has been employed by Respondent for approximately 13 years, initially in the maintenance department for approximately 6 months, and then as a stocker on the third shift, and had been a supervisor for Respondent his first 3 years of employment. Mr. Maglone works with Petitioner on the third shift, but they work independently of one another in the aisles of the store, with Mr. Maglone working on displays. Mr. Maglone regularly works in the grocery department and is familiar with the Great Value products (Respondent's product brand) and stated the Great Value products are typically stocked next to the name brand version of the product, such that canned foods are stocked next to the Great Value canned foods on the shelves. In the juice aisle, all the Great Value brands are kept in the same area in that aisle.

Mr. Maglone testified that a meeting is held every evening when the overnight stockers report to work about 10:00 p.m. to inform them regarding work expectations and aisle assignements. Mr. Maglone identified Rod as a manager for the third shift and the person conducting the break room meeting for the stockers before Petitioner was off work for his surgery. Mr. Maglone could not identify the exact date the meeting with Rod occurred but he thought it was months before Petitioner's surgery. During that meeting, Rod asked Petitioner if his injury was work-related and Petitioner responded in the affirmative.

Phillip Crawford testified on behalf of Respondent. Mr. Crawford is employed by Respondent as a shift manager or co-manager and knows Petitioner as one of the overnight stockers. Mr. Crawford is familiar with Respondent's policy for reporting work-related injuries and stated the policy in September of 2011 to be if the employee had an injury, the employee is supposed to immediately report it to their immediate supervisor, an assistant manager of the store, then the immediate supervisor reports it on an incident report and if it is an accident where the employee needs medical care, then an accident report is completed by the associate and someone in management. Mr. Crawford stated if an employee were to report they hurt their shoulder and needed medical treatment, an accident report or an associate's statement would be completed, and not an incident report. Mr. Crawford indicated this policy is followed 100% of the time. Mr. Crawford identified the associate's statement as the accident report. Mr. Crawford acknowledged if the employee does not immediately report the accident, the employee has 45 days to report it, but was not certain what happens with Respondent's policy.

Mr. Crawford heard Petitioner testify that Petitioner reported his left shoulder injury to him on September 18, 2011. Mr. Crawford denied he had any conversation with Petitioner with regard to a work injury on September 18, 2011, because Mr. Crawford was working days at that time. Mr. Crawford indicated his hours of employment for days were 7:00 a.m. to 8:00 p.m., and he would not have reported to work earlier than 7:00 a.m. on September 18, 2011, and not at 1:30 a.m. Mr. Crawford went to days in April of 2011 and worked days until September of 2012, when he went to the overnight shift. Mr. Crawford indicated an overnight shift manager may be called in if another overnight shift manager did not report, but that had never happened, and he had never covered for another co-manager who was on vacation. Mr. Crawford could not really recall when he first learned of Petitioner's alleged work injury to the left shoulder but

thought it was when Respondent's attorney contacted him. Mr. Crawford denied Petitioner ever told him he had pain in his shoulder.

Mr. Crawford identified Rod Woolridge as a co-manager, and acknowledged Mr. Woolridge held that position in September of 2011. Mr. Crawford identified the store manager as the top management person, the co-manager or shift manager as the second management person, and then the assistant manager. Mr. Crawford thought Brian Pendergrass was the assistant manager for the overnight stockers in September of 2011 and that Mr. Pendergrass and Terry were assistant managers for the overnight stockers in January of 2011. Mr. Crawford identified Drew Hiteman as a co-manager. Mr. Crawford was not aware of any manager or supervisor in the personnel office by the name of Diane in September of 2011 to the present. Mr. Crawford was not aware of any employee by the name of Diane that worked for Respondent, but acknowledged other employees go into the personnel office to use the terminals for computer based learning.

Melody Sharp testified on behalf of Respondent. Ms Sharp presently works at Sam's Club and has been employed by Respondent for 21 years. Ms. Sharp knows Petitioner as Ms. Sharp worked at the same store as Petitioner from September of 1991 until July of 2012, and worked the hours of 8:00 a.m. to 4:30 p.m., Monday through Friday. Ms. Sharp had Saturdays and Sundays off and also took off days for personal reasons on occasion. Ms. Sharp did not review her schedule to see if she had taken off any time during the period of August of 2011 through May 2012.

Ms. Sharp was formerly the personnel manager for Respondent and her duties included hiring employees, handling insurance for employees, FMLA, safety and accidents and proceedings with Respondent's insurance company, and dealing with employees alleging work-related injuries. Ms. Sharp stated Respondent's policy for reporting a work-related injury to be even if the employee feels he or she does not need medical treatment at the time, anything needs to be documented and there are both accident reports and incident reports (the latter of which is used when the employee feels he or she does not need medical attention). Ms. Sharp indicated all employees are trained in this policy on day one and there is a workmen's compensation poster in the hallway outside the break room. Ms. Sharp also testified that if an employee came to her reporting a work-related injury she would document such in the employee's file and the employee would also complete the paperwork. Ms. Sharp further stated if an employee telephoned her and reported a work-related injury, she would document that and advise the employee to immediately come in and complete the paperwork. Ms. Sharp says that she does this 100% of the time. Ms. Sharp indicated that besides the associate's statement for a work injury, there is information inputted into the computer to Respondent's insurance carrier, CMI, such as shown in Respondent's Exhibit 8. Ms. Sharp stated she had not seen RX 8 but the report had her name on it. RX 8 contained information concerning Petitioner's work injury of January 2011. Ms. Sharp explained she inputs information into the computer 100% of the time contemporaneous with the completion of an accident report. Ms. Sharp stated the employee's supervisor does not fill out any separate report from the associate's statement.

Ms. Sharp was aware Petitioner reported some work-related injuries while working for Respondent, including an injury to his right hand on January 19, 2011 and an injury to his left

shoulder on September 21, 2011. Ms. Sharp believed she assisted Petitioner in the documentation concerning his leave of absence for the work accident of January 19, 2011. Ms. Sharp learned of Petitioner's accident of September 21, 2011, when she received paperwork from Petitioner's attorney as shown in Respondent's Exhibit 3 on or about February 7, 2012. After receiving this paperwork from Petitioner's attorney, Ms. Sharp made copies of the paperwork and faxed the paperwork to the adjuster at Respondent's insurance carrier and thought she also mailed the original paperwork to them. Ms. Sharp also pulled Petitioner's medical file to make certain she had not previously missed anything but did not find any incident or accident reports or any records suggesting Petitioner had reported a work-related injury. Ms. Sharp initially indicated if she had an accident report she would have sent the adjuster a fax saying there was no claim on this but if there was a claim, she would fax the claim number to the adjuster so he would know which one it was. When Ms. Sharp faxed the documents to the adjuster on February 7, 2012, there was no claim number entered in Respondent's system. Ms. Sharp also subsequently received a claim form from the Commission as shown in Respondent's Exhibit 4. After receiving the form from the Commission, Ms. Sharp again looked at her file to see if there was any claim for the left shoulder injury and did not find one. Ms. Sharp then sent the adjuster a copy of the form from the Commission as shown in Respondent's Exhibit 4. The adjuster did not instruct Ms. Sharp to open a claim at that time.

Ms. Sharp identified Respondent's Exhibit 5 as an associate's statement that is completed when an employee seeks medical attention, and noted RX 5 was completed on February 23, 2012 after Ms. Sharp had received the documents from Petitioner's attorney and the form from the Commission. Ms. Sharp indicated that another Employer's First Report of Injury was generated but she did not personally complete that form as it was prepared by Jason Farmer, the store manager.

Ms. Sharp did not think she spoke with Petitioner in October of 2011 about his alleged shoulder injury. Had she spoken with Petitioner in October of 2011, Ms. Sharp would have informed Petitioner he had 24 hours to fill out the paperwork. Ms. Sharp, as personnel manager, it is not her position to say whether an injury is work-related or not and acknowledged she does not have any medical and legal training and has not been trained in what is or is not an accident under the Illinois Workers' Compensation Act. Ms. Sharp denied she ever told Petitioner his injury was not work-related.

According to Ms. Sharp, Petitioner did complete FMLA paperwork for his shoulder injury and that paperwork provides an opportunity to indicate whether the condition is work-related. Ms. Sharp explained if an employee chooses to complete the FMLA paperwork and the employee has the time allowed, the employee's job is protected up to 12 weeks initially. Ms. Sharp stated Petitioner completed the FMLA paperwork and removed himself from the schedule. Ms. Sharp was not aware of any restrictions Petitioner had for his left shoulder the end of September of 2011 through the early part of October 2011, as she typically looks at the dates the employee is going to be gone from work, and did not remember seeing the reference in Respondent's Exhibit 1 Petitioner had a sling for his left upper extremity with no use of the left upper extremity for 10 days. Ms. Sharp did not know whose handwriting was on Respondent's Exhibit 1, but stated it was not her handwriting.

Ms. Sharp explained the FMLA forms have a question as to whether the requested medical leave is for pregnancy, workers' compensation, disability, or one's own serious health condition and Petitioner did not indicate on the FMLA form why Petitioner was on medical leave. Ms. Sharp indicated when she receives an FMLA form that does not have markings on it in appropriate areas she provides it to the store manager who decides to approve it or indicate if more information is needed. Ms. Sharp explained if an employee had checked under the family care leave section the option of parent that would be sufficient for completing the reason for leave request and the marking of a sub-box is sufficient but the employee would be questioned further if they thought it was not complete enough. Ms. Sharp did not recall Petitioner was questioned further about the FMLA form he submitted. Ms. Sharp identified the signature on page 3 of the form to be that of Drew Hiteman, a co-manager for the third shift.

Ms. Sharp testified that she has never had an assistant when she was in the personnel office but there had been two training coordinators in the personnel office who were not members of management but their names were not Diane or Wendy, but Lisa and Theresa. Ms. Sharp was not aware of any employee by the name of Diane but knows a co-manager by the name of Rod. Ms. Sharp noted all employees can go into the personnel office and complete training on the computers in the office.

Ms. Sharp further testified that any completed accident reports would have been in the Petitioner's file and Ms. Sharp did not find any. Ms. Sharp goes to the employee file whenever she is asked a question about or by an employee to make certain she is accurate in her responses. Ms. Sharp said Petitioner's file did not have a statement from his supervisor with respect to the accident Petitioner sustained in January of 2011. Ms. Sharp also testified that if Petitioner called her to inquire if there was a report of injury for September of 2011 in his file, Ms. Sharp would go to the file and look in it; however, Ms. Sharp did not remember receiving a call from Petitioner of that nature and she would have made a record of such a call and put that in Petitioner's file.

Derrick Thaxton testified on behalf of Respondent. Mr. Thaxton is employed by Respondent and has been at the store where Petitioner works for 11 years as an assistant manager and presently works the third shift, or the hours of 8:00 p.m. until 8:00 a.m. Mr. Thaxton held the position of nighttime assistant manager in September of 2011 and February of 2012. Mr. Thaxton became aware of Petitioner's alleged left shoulder injury when Petitioner came in and told Mr. Thaxton he needed to fill out some papers. Mr. Thaxton noted Respondent's policy for reporting accidents is for the employee to report it to the supervisor immediately but the employee can report it later that day. Mr. Thaxton noted when an employee reports an accident to him which does not require emergency medical assistance, he goes to the personnel office and obtains a file to complete or have the employee complete it, and he does this 100% of the time.

Mr. Thaxton stated that on February 23, 2012, he had just returned from vacation and was told to go to the personnel office because Petitioner was there, but did not know what time this occurred only that he was working days which are the hours of 8:00 a.m. until 8:00 p.m. Mr. Thaxton thought Rod or Jason had told him there was an associate in the personnel office that needed to speak with a member of management and he did not even know who the associate was until he went to the personnel office.

Mr. Thaxton stated Petitioner told him he needed to fill out a report for his shoulder and Mr. Thaxton asked Petitioner if he had talked with anyone yet, and Petitioner responded no, so Mr. Thaxton went and got a manila file folder that had blank associate statements in it, and gave Petitioner the statement and Petitioner chose to have Mr. Thaxton complete the statement which was RX 5. Mr. Thaxton explained that an incident report, an accident report, and an associate's statement are all the same thing, and said all of these forms are in one packet. Mr. Thaxton assumed Petitioner was hurt when Petitioner said it was an incident and knew he had the right form as Petitioner answered the questions. Mr. Thaxton explained that an incident report is used when something happened but it is fixed with a band-aid and an accident report is used when it is something more than a band-aid. Mr. Thaxton identified RX 5 as the form he completed for the Petitioner on February 23, 2012. He was unaware that Petitioner was not working at the time he met the Petitioner in the personnel office.

After Petitioner chose to have Mr. Thaxton complete the statement, Mr. Thaxton said he began on line 1 asking Petitioner each question and wrote down Petitioner's responses including spelling Petitioner's name, date of birth, height and weight, and the date and time of injury, which Petitioner indicated was September 18 or 19, 2011, at 6:45 a.m. Question 4 on the statement asked Petitioner if he had reported his injury and Petitioner's response was he did not. After completing the statement, Mr. Thaxton gave Petitioner the statement to read and asked Petitioner if there were any changes to the statement. Mr. Thaxton said Petitioner reviewed the statement after it was completed and then signed it, but did not know how long Petitioner to look over the statement as Mr. Thaxton got a Kleenex and came back to the table after 2-3 minutes Mr. Thaxton then signed the statement as a witness.

Mr. Thaxton said Petitioner would not have reported to him on February 23, 2012, as he was working days but an employee can speak to any member of management regardless. Mr. Thaxton did not recall Petitioner's responses to the questions without looking at the statement.

Mr. Thaxton testified that he did not question Petitioner about the answer to when was Petitioner injured in which Petitioner indicated it was early that night, around 6:45 a.m., and his hands going numb. Mr. Thaxton did not put "hands" in the section about what part of the body was injured to be consistent with what had been conveyed to him in paragraph 3. Mr. Thaxton did not specifically ask Petitioner if he had told anyone about the injury besides filling out the associate's statement. In responding to question 4, Mr. Thaxton wrote it was not reported immediately because it was thought to just be numb and indicated that was something Petitioner told Mr. Thaxton. Mr. Thaxton initially left blank the question whether Petitioner had any complaints but then wrote "still hurting."

Mr. Thaxton testified he could not remember if the statement had a section indicating whether the statement was completed by a party other than the injured associate, but then looked at the statement and saw a provision to that effect. Mr. Thaxton stated there had never been a personnel manager or training coordinator by the name of "Diane" during his employment at the store and he did not think there was any employee, department manager, assistant manager, co-manager, or store manager by that name. Mr. Thaxton did not review Petitioner's personnel file on February 23, 2012.

At this point in the arbitration proceedings, the case was bifurcated to allow for the testimony of Rod Woolridge. Mr. Woolridge is employed by Respondent and has been at the store where Petitioner works for 14 years. He has held the position of shift manager over the entire store for the last 7 years. Mr. Woolridge presently works days but worked the third shift in 2011, or the hours of 7:00 p.m. until 8:00 a.m. Mr. Woolridge knew Petitioner was an overnight stocker and, as such, normally stocked merchandise in the grocery aisles. Mr. Woolridge acknowledged there is a meeting every evening in the break room to address the duties of the employees for the evening, and the shift manager conducts the meeting.

Mr. Woolridge recalled a period of time in the fall of 2011 when Petitioner was not working as an overnight stocker and then returned to work as such. Mr. Woolridge thought Petitioner was absent during that time because Petitioner had lost a family member. Mr. Wooldridge was unaware Petitioner missed work during that time because of his left shoulder. Mr. Woolridge acknowledged Dwayne Maglone was an overnight stocker in the fall of 2011. Mr. Woolridge could not remember a meeting with the overnight stockers in the fall of 2011 when he asked Petitioner whether he had been off work for a work-related injury.

Mr. Woolridge explained Respondent's policy for reporting work accidents. According to Mr. Wooldridge if an employee reports an injury, the manager stops what he is doing, completes the paperwork, and gets the accident entered into the system. Mr. Woolridge indicated he does this 100% of the time. Mr. Woolridge knows Petitioner and was not aware Petitioner alleged a shoulder injury on September 18, 2011, and did not recall Petitioner reported the injury to him or about October 4, 2011. Mr. Woolridge stated if Petitioner had told him he had a work-related injury, he would have stopped what he was doing and retrieved the paperwork to fill out and entered it in the system. He also acknowledged he would have initially asked Petitioner if he had completed the appropriate paperwork. Mr. Woolridge never completed an accident report for Petitioner's injury on October 4, 2011.

Petitioner had several prior claims before the Illinois Workers' Compensation Commission which were resolved prior to this hearing. (RX 9) This includes a claim against Respondent for a January 19, 2011, injury to his right hand. (RX 7 – 0002)

The written job description for stocker describes the essential functions of the position to be maintaining merchandise presentation by stocking and rotating merchandise, removing damaged or out-of-date goods, setting up, cleaning, and organizing product displays, signing and pricing merchandise appropriately, securing fragile and high-shrink merchandise, and receiving and stocking merchandise throughout the facility The written job description further notes the physical activities required of a stocker require reaching overhead and below the knees, including bending, twisting, pulling, and stooping, and moving, lifting, carrying, and placing merchandise and supplies weighing less than or equal to 50 pounds without assistance. (PX 5)

Regarding the issues of Accident (A); Causal Connection (F); and Notice (E) the Arbitrator concludes:

Based on the evidence and testimony presented Petitioner failed to prove he sustained an accident on September 21, 2011, failed to prove that he gave timely notice of an accident; and failed to prove that his left shoulder condition of ill-being was causally connected to his employment with Respondent. This is based upon the credible testimony of Respondent's witnesses and the lack of corroboration in the medical records to support Petitioner's testimony. Petitioner's testimony was not credible as it was contrary to and inconsistent with the medical records and testimony of other witnesses.

As Petitioner had two prior claims before the Commission, and his January 19, 2011 injury occurred while in Respondent's employment approximately eight months prior to the current injury, the Arbitrator finds that Petitioner was familiar with Respondent's reporting requirements and knew how to report a work accident/injury.

The Arbitrator views the medical records in consideration of the long-standing legal principle, as expressed by the Supreme Court in Shell Oil v. Industrial Comm'n, that contemporaneous medical records are more reliable than later testimony because "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." 2 Ill.2d 590, 602 (1954). Petitioner admitted that he did not report a work injury during his initial evaluations at Decatur Memorial Hospital and with Dr. Duncan, which is supported by the records from both facilities. While Petitioner testified he reported his injury to Dr. Jones', his testimony was rebutted both by Dr. Jones' medical records and Dr. Jones himself.

While Petitioner claims an accident date of September 21, 2011, the significance of that date is unclear. Petitioner did not even work that day, having called in absent. While he testified that he called in because his shoulder hurt, nothing about that day (or Petitioner's testimony) explains how/why a repetitive trauma shoulder condition would have manifested itself that day. Petitioner denied any left shoulder problems before August of 2011. He then testified that he began to notice "a little" pain in his left shoulder while working during August. However, when he begins to treat for his shoulder problem, he gives various onset dates – August 27, 2011 and September 20, 2011 (see the ER record of September 22, 2011). He also described the pain as intermittent. While some of the records make reference to Petitioner's overhead lifting at work, the Arbitrator finds the references lacking in further details to allow her to conclude or infer that Petitioner was associating the onset of his symptoms with that activity. The Arbitrator also notes that Petitioner failed to provide any details to the physical therapist concerning when and how his shoulder problem began and Dr. Jones testified Petitioner never spoke of a work accident or injury.

Further, causation was not addressed in any of the medical records. Dr. Jones' completed a physician statement for the Hartford indicating the claim was not work-related. While he admitted in his deposition that Petitioner's symptoms could have been aggravated by the alleged activity, he also stated that any overhead activity would have aggravated the Petitioner's complaints. The only opinion supporting causation was based on a three and half page hypothetical and job descriptions solely provided by Petitioner's attorney and those facts were

not established at trial. Petitioner provided no testimony regarding anything occurring on September 19, 2011. Dr. Jones was clear that Petitioner did not report his job duties to him during his treatment and that he did not have a clear understanding of how often Petitioner would stock merchandise overhead. Finally, Dr. Jones testified "If you go purely by my medical record and my discussions with the patient it was not a work injury." (PX 4, p. 53) Dr. Jones could not testify as to how much of Petitioner's job duties require overhead work or how much of his job duties required overhead lifting. (PX 4 p. 56) He acknowledged job duties below shoulder level would not aggravate Petitioner's condition. (PX 4 p. 57)

Taken as a whole, such evidence is insufficient to prove a causal link between the Petitioner's employment and his claimed injuries, as the right to recover benefits cannot rest upon speculation or conjecture. County of Cook v. Industrial Comm'n, 68 Ill.2d 24 (1997) Additionally, the assumed facts presented to Dr. Jones during his deposition were, in fact, not true and accurate. Therefore, Dr. Jones' opinion is not persuasive. No other doctor provided an opinion on causal connection.

The Illinois Supreme Court has held that Section 6(c) of the Workers' Compensation Act prohibits any claims under the Act unless the employee gives notice of his injury within 45 days of the accident. Lambert v. Industrial Comm'n., 79 Ill. 2d 243, 247 (1980). The giving of notice to the employer within 45 days of the accident pursuant to section 6(c) of the Workers' Compensation Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. Ristow v. Industrial Comm'n, 39 Ill. 2d 410, 413 (1968). Mere knowledge that the Petitioner was having problems with her finger is not sufficient to establish proper notice for a workers' compensation claim. In White v. Industrial Comm'n, 374 Ill.App.3d 907 (2007), although the employer knew the Petitioner was injured before the date in question, the record did not show the appraisal of "industrial injuries." The Appellate Court held that the purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. White, 374 Ill. App. 3d at 911.

Petitioner failed to give timely notice of his alleged accident to Respondent. In support of her decision, the Arbitrator notes: (1) Petitioner was familiar with Respondent's polices for reporting a work-related injury; (2) there is no contemporaneous documentation of a work-related injury in the medical records or Respondent's files; and (3) Respondent's witnesses directly rebutted Petitioner's allegation.

While Petitioner did miss some time from work in August and September of 2011 which were logged in as "illnesses/injuries," the call-in sheets do not establish notice as required under the Act. At a minimum, they do not state whether the absence is due to illness or injury nor do they provide sufficient details from which Respondent would have known a work accident (specific or repetitive) was being reported.

Petitioner is not new to workers' compensation claims, and is familiar with Respondent's policy for reporting work injuries, based on the fact that he had a prior work injury approximately eight months before this accident and promptly reported same. Furthermore, after Petitioner reported his prior accident to Respondent, the accident was documented in Respondent's files (RX 8). No such documentation exists for Petitioner's instant claim. There

was no accident report until February 23, 2012, after Respondent received Petitioner's Application for Adjustment of Claim (RX 5). Thereafter the associate statement was completed. Respondent then completed the First Report of Injury on February 24, 2011 (RX 6), which is consistent with Respondent's practices for Petitioner's prior injury.

None of the medical records presented suggest that Petitioner's injury was caused by his job duties. Petitioner himself testified that he did not report a work-related injury to Decatur Memorial Hospital or Dr. Duncan. The physical therapy records do not document a work accident. Although Petitioner claims that he told Dr. Jones his claim was work-related, that testimony was not supported in the medical records (PX 2, RX 10) and was directly rebutted by Dr. Jones' testimony. (PX 4 pg. 40) That Petitioner would report a work accident but not mention it in the medical records is contrary to both common sense and Petitioner's prior familiarity with workers' compensation procedure (ie., his conduct in January of 2011).

While investigating the claim, Respondent specifically asked Petitioner to identify to whom he reported his accident. (RX 14) Petitioner only identified "Phil" (Mr. Crawford) who, at arbitration, credibly rebutted Petitioner's testimony. Even if one assumes Petitioner spoke with Mr. Crawford as he claims, Petitioner admitted that he did not tell him about a work accident involving his shoulder. At most, he simply reported his shoulder hurt. That is not enough information to establish notice of a work accident had been given. All four of Respondent's witnesses denied any knowledge of Petitioner's alleged work injury prior to the receipt of Petitioner's Application for Adjustment of Claim.

Although Mr. Maglone testified for Petitioner, his testimony is not persuasive. Petitioner specifically chose to call Mr. Maglone rather than Mr. Woolridge, even though Mr. Maglone is not a supervisor and his knowledge of an alleged accident would not be sufficient to establish that Respondent had notice of an alleged work injury. Mr. Maglone could not recall when the alleged conversation between the Petitioner and Mr. Woolridge took place or any other detail from that conversation. Further, his testimony was directly rebutted by Mr. Woolridge.

Petitioner also testified that he spoke with "Diane" in Respondent's personnel office. He did not know her last name and "believed" she was an assistant to Melody Sharp. Melody Sharp credibly rebutted this testimony. The Arbitrator also finds that Petitioner did not give adequate or sufficient notice of a work-related accident to Melody Sharp in September or October of 2011 when they were communicating with one another regarding leave of absence paperwork.

The Arbitrator notes that prior to arbitration Petitioner never indicated he gave notice to anyone other than Mr. Crawford. While there may be no requirement that a claimant identify everyone to whom he gave notice prior to arbitration practicality suggests one would, especially if it would aid in the determination of the compensability of a claim and avoid litigation. The Arbitrator also finds quite significant the events of February of 2012 as documented by Respondent's records, including the faxes between Ms. Sharp and CMI and Petitioner's Associate's Statement dated February 23, 2012 in which he denied having ever reported an accident.

The Arbitrator finds that Respondent first learned of Petitioner's alleged injury upon receipt of the Application for Adjustment of Claim, which was, at least, 136 days[1] after the alleged injury. Accordingly, Petitioner's claim is denied for failure to provide proper notice under the Act.

In light of the foregoing, all other issues are moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

[1] (9/22/11 – 2/3/12 (date Petitioner signed Application))