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

FANNY KAPUSTA,
Petitioner,

v.

15IWCC0674

No. 03 WC 6815

LAWSON PRODUCTS,
Respondent.

DECISION ON PETITION UNDER §19(h)

This matter comes before the Commission on Petitioner's Petition under §19(h). A hearing was held on Petitioner's Petition on September 20, 2014 in Chicago before Commission White. Both parties were represented by counsel and a record was taken.

In the underlying cases, the Arbitrator issued a decision on June 17, 2005, in which he found Petitioner suffered a work-related accident on November 5, 2002 and awarded her 5&3/7 weeks temporary total disability benefits and 77.5 weeks of permanent partial disability benefits representing loss of 50% of the right foot. Respondent sought review of that decision and the Commission modified the Decision of the Arbitrator. The Commission reduced the average weekly wage from $755.22 to $746.00, based on a stipulation of the parties, reduced the benefit rates in accordance with the modified average weekly wage, increased temporary total disability benefits to 16 weeks, and specified the award of medical expenses. Petitioner filed her Petition for Review under §19(h) on September 28, 2009.

Findings of Fact and Conclusions of Law

1. Petitioner testified that on November 5, 2002 she tripped over an open file cabinet drawer; her right foot "did not come with" her. She received an award of 50% loss of the right foot. Since the award she was told the screws in her right foot are broken. That has caused her foot to become destabilized. It causes "chronic pain and terrible, terrible cramping" in her foot and lower calf. She wakes up screaming two or three times a week. She uses orthopedic shoes and walked in a CAM walker because Dr. Kudrna told her "it was ruining" her hip.

2. She had a §12 medical examination with Dr. Holmes on October 24, 2013 who told her "absolutely the only way to fix this was to do another surgery." He recommended removing the screws and fusing the foot and the ankle was also destabilized; "that was never repaired originally, so he needs to go in and repair that as well."

3. Petitioner also testified that originally, she was able to control her pain through Tylenol, massage therapy, and physical therapy, but now nothing helps "not Tylenol, not prescriptions." She was using a cane because of her foot. Her general practitioner, Dr. Muzammil, recommended she use it. She cannot walk as much as she used to. She is an artist and she can't attend festivals and art fares, or go to museums because there is too much walking. She informed the attendees of the hearing that it was going to rain later in the day and because of the pain she was "feeling today it is going to be a doozy."

4. Petitioner indicated she could not get the foot surgery because she already had "6, 7, 8, 9" hospitalizations for recurrent bowel obstructions, Crohn's flare up, a pilonidal cyst removal, and breast reduction. Initially, she could handle the condition, but currently she cannot. She hopes that the recommended fusion surgery could help her return to work, though she acknowledged other health issues. No other treatment had been recommended to her.

5. On cross examination, Petitioner testified she believed the recommended surgery was approved by insurance. She agreed that "the reason it has taken this long is because of these other issues." Chubb has approved medication for her foot condition.

6. On April 21. 2005, Petitioner returned to Dr. Kodros, who performed open reduction with internal fixation surgery on her foot two years earlier. He noted she continued to have some pain in the midfoot, mostly associated with weightbearing. She did pretty well in gym shoes but had difficulty finding dress shoes she could wear. Petitioner had been using a postop shoe which seemed to work, but she had "difficulty with it breaking down."

7. X-rays findings were consistent with posttraumatic arthritis. Dr. Kodros agreed to prescribe a hinged CAM boot for Petitioner to use as needed. They discussed that if her difficulty persisted, arthrodesis of the affected joints would be the only surgical option.

8. Petitioner continued to complain of foot pain to Dr. Kodros over the next four-year period. Dr. Kodros continued to treat her conservatively.

9. On November 6, 2008 Petitioner presented to Dr. Kudrna who noted Petitioner had a 6-year history of dealing with a Lisfranc nonunion and cuboid fracture. She was walking in a boot. She had really sharp hip pain that can radiate all the way into the back. Dr. Kudrna ordered a bone scan to evaluate inflammatory arthritis.

10. On December 4, 2008, Dr. Kudrna noted the bone scan taken November 22, 2008 showed "literally normal hips." He thought she had "pretty much referral of pain from her lumbar spine and from her ambulatory patterns here because of the Lisfranc issue."

11. On May 14, 2009, Petitioner returned to Dr. Kodros and reported chronic pain in various areas. He noted that the only thing that appeared to manage her activity-related symptoms was use of the CAM boot. X-rays still showed the hardware intact and the foot in proper alignment. He noted posttraumatic arthritis and possible metatarsalgia. However, "the relative severity and diverse nature of her pain and symptoms and limited response only to the use of a CAM walker, would seem to be not readily explainable by these entities alone."

12. At that time, Dr. Kodros was reluctant to recommend surgery due to the diffuse nature of Petitioner's symptoms because surgery may not provide her "overall therapeutic response even if successful and uncomplicated." He recommended continued conservative treatment and a new solid brace.

13. An MRI taken August 22, 2009 showed mild edema at the insertions of the gluteus medius and minimus tendons upon the right greater trochanter, mild edema of the greater trochanters bilaterally possible representing trochanteric bursitis, and mild diffuse bilateral atrophy of the gluteus maximus muscles.

14. On October 3, 2009, Petitioner returned to Dr. Kudrna regarding her right hip pain around the trochanter area into the right groin. Dr. Kudrna noted the MRI showed the hip was "clean save some tendinopathy." Dr. Kudrna indicated they could go ahead with an injection, but as she was "walking around with this poor situation with the foot" he thought she would "continue to irritate the abductors." Therefore, she was going to get a 2nd opinion regarding the foot.

15. Petitioner had a § 12 medical examination with Dr. Virkis on March 30, 2011 regarding her hip condition. In his report, Dr. Virkis noted Petitioners' date of initial injury was November 5, 2002 and she last worked in October of 2009. Her injury was a Lisfranc fracture and she was treated by Dr. Kodros. Over the last few years she experienced increasing hip, neck, and back pain. In particular her right hip began hurting two years previously. On average the hip pain was 7/10 and she had trouble sleeping and walking/standing. She had numerous neck, shoulder, and spine injections and that, as well as recurrent Crohn's disease, which was the reason she did not have treatment for her hip. She was planning on getting injections under the supervision of Dr. Kudrna in the near future.

16. Dr. Virkis noted that on examination, Petitioner showed tenderness to palpitation far in excess of what would be expected. She showed global weakness on the right, particularly in the abductors and quadriceps. There was also weakness in the dorsiflexors. Petitioner was "hyperreflexic bilaterally at the ankles and knees,

with bilateral clonus in the legs." The rest of the neurological exam was normal. An MRI taken August 22, 2009 showed mild edema at the insertions of the gluteus medius and tenderness compatible with insertional strains. A bone scan was essentially normal regarding the hip.

17. Dr. Virkis diagnosed irritable right hip from an unknown etiology. He noted that diagnosis was difficult because of symptom magnification. He did not feel her hip complaints were related to her accident of November 2002, or to overuse because of the need to wear a boot. He noted that Petitioner walked with a Trendelenburg gait on the left, placing greater weight on the left. He also did not believe her back complaints were related to her accident noting that she did not have treatment for that or her hip for several years after the accident. She was not at maximum medical improvement because she was due for injections. Thereafter, she should have strengthening physical therapy at which time she would be at maximum medical improvement. Petitioner subjectively reported that she cannot walk or sit for prolonged periods. However, because Petitioner's previous job was a desk job, she should not need any work restrictions.

18. Another MRI was taken on December 23, 2011 showed mild degenerative changes in the right hip with diffuse grade II/III chondral thinning posteriorly in the joint, suspected small CAM type deformity along the anterior femoral head neck junction, suggesting possible femoral ancetabular impingement, and degenerative changes in the labrum without discrete tear. An arthrogram provoked 5/10 pain response at its highest.

19. On February 24, 2012, Dr. Kudrna wrote an open letter indicating Petitioner had worn a CAM boot for 10 years for a condition unrelated to her hip. "Because of the boot, the pain in her hip has increased. This may have aggravated the painful right hip." He recommended consultation at the Mayo Clinic.

20. Dr. Holmes performed an examination of Petitioner pursuant to §12 of the Act on November 7, 2013 regarding her foot condition. He noted that Petitioner had open reduction and internal fixation of the 1st and 2nd TMT joints, uneventful postoperative recovery, and extensive physical therapy. She was returned to work on February 5, 2003 at maximum medical improvement, at which time it was noted that she may need a fusion in the future. On July 22, 2013, a fusion was recommended, apparently by Dr. Levi, even though no records of Dr. Levi are included in the transcript.

21. Dr. Holmes noted that Petitioner saw Dr. Kodros the previous summer who opined she did not need any additional treatment. She was taken out of her CAM walker about two years previously by her hip surgeon because it was thought that was causing problems with her hip. Currently, Petitioner reported a dull throbbing pain and swelling over the midfoot and dorsal aspects of the foot with some radiation into the ankle and great toe. The pain was worse with weightbearing. Petitioner left work in 2009 due to other health issues.

22. Dr. Holmes indicated that x-rays showed screwed fixation from 1st cuneiform to the 2nd metatarsal and from the 1st metatarsal to the 1st cuneiform and persistent patency at the joint between the 1st cuneiform to the 2nd metatarsal. The 2nd joint appeared to be properly fused, but the screw from the 1st metatarsal to the 1st cuneiform was broken. The x-rays also suggested a crack in the cuboid, representing an old injury. Dr. Holmes diagnosed posttraumatic arthritis.

23. Dr. Holmes opined that Petitioner's condition had not satisfactorily responded to conservative treatment. He provided a "qualified" agreement with the recommendation of Dr. Levi for a fusion, because Petitioner's co-morbidities may defeat a successful union. She would probably need a bone graft. He did not believe repair of the cuboid crack was necessary. Dr. Holmes opined the need for fusion was related to the 2002 injury.

Petitioner argues she proved that her condition has materially worsened requiring the fusion of her foot and she proved a current hip condition of ill being. She sites her testimony as well as the opinions of Dr. Holmes and Dr. Kudrna. In her brief, Petitioner does not seek prospective medical treatment or specify a recommended additional permanent partial disability award. In its brief, Respondent asserts that it has authorized the prospective surgery for "several years." That assertion appears to be corroborated by Petitioner's testimony that it had been authorized by insurance and Chubb, Respondent's workers' compensation insurance carrier, had authorized medication for her foot. In addition, her failure to refute Respondent's assertion is telling.

The Commission concludes that the award of additional permanent partial disability benefits is not appropriate here. First, Petitioner has not met her burden of proving she has a permanent hip condition of ill being that is associated with the initial foot injury. The most recent MRI suggests a CAM deformity, which is congenital in nature. In addition, Dr. Virkis is persuasive when he noted that by favoring her right foot condition, Petitioner's gait actually placed greater strain on her left hip rather than the right hip, militating against causation to an alleged condition of ill being of the right hip.

Second, any additional permanent partial disability award for the foot condition would be premature. Because additional surgery has been approved but not yet performed, Petitioner is not at maximum medical improvement. She would be at maximum medical improvement only after she has the surgery and associated rehabilitation, at which time her current impairment could better be determined. In addition, even if some other of Petitioner's symptoms are somehow related to her foot condition, the permanency of those possible aggravations cannot be properly assessed until treatment for her foot condition is completed. Accordingly, at this time, Petitioner has not proven she is entitled to relief pursuant to §19(h) of the Act and the Commission does not grant her petition.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition for Relief Pursuant to §19(h) is not granted at this time and ultimate determination is deferred until Petitioner has completed medical treatment and she has achieved maximum medical improvement.

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

DATED: AUG 27 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-8/11/15
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Reyna Trujillo-Villalobos,

Petitioner,

vs. NO: 13 WC 40020

TM West Wholesale Baking Co.,

Respondent,

15IWCC0675

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, incurred medical,prospective medical, temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds that Petitioner proved that she had an accident on August 4, 2013 and that she is entitled to temporary total disability from August 24, 2013 through July 1, 2014. She is also entitled to the medical bills she incurred as well as prospective medical recommended by Dr. Martin Herman.

Petitioner credibly testified to her job duties as a donut maker. She testified that during the week she would lift dough weighing 20 to 25 pounds from the tubes and place them on the conveyer belts. This would take two to three hours and during that time, she would be lifting the dough repetitively. When the dough is finished in the one machine, she would spend the rest of

her time working on the second machine. This was her job all week except on Saturdays. (Transcript Pgs. 17-25)

On Saturdays from 2 a.m. through 7:30a.m. she would put chocolate on top of the donuts. She would fill the machine with chocolate. Once the machine dissolves the chocolate, she would take it out of the machine with 5-gallon buckets and bring them to another machine to put on the donuts. She testified that she has to carry more than 10 buckets, but is not quite sure. (Transcript Pgs. 26-29)

The Commission viewed the job analysis video put into evidence by the Respondent and found that Petitioner's description of her work was accurate with what was presented there. (Respondent Exhibit 4) The Petitioner performed these job duties for Respondent for almost 7 years. (Transcript Pgs. 14-16)

Petitioner began to develop left leg pain, which eventually spread to both her legs and lower back. An MRI performed on Petitioner by the Cook County Hospital on October 23, 2013 revealed an L4-L5 disc bulge and a superimposed large postocentral and left para central disc extrusion compressing the caudal nerve roots and severe stenosis. The MRI also indicated an L3-4 and L5-S1 degenerative disc disease. (Petitioner Exhibit 2, Respondent Exhibit 3)

Petitioner continued to work until August 23, 2013. August 4, 2013, she was seen at Cook County Hospital again and discussed with the doctors what exactly was causing her this pain. (Transcript Pgs. 31-33, 49) She informed Otilia Mora of her injury at work on August 19, 2013. She eventually had to stop working on August 23, 2013 because she could not stand up and had to have help getting dressed and putting on her shoes. (Transcript Pgs. 34-39)

Gladys Jaramillo testified that Petitioner's testimony was truthful in regard to what she did on the job. (Transcript Pgs. 60-63) Otilia Mora testified that the job video, Respondent Exhibit 4, was accurate in showing what the Petitioner does at work. However, the video did not show the Petitioner's job duties of putting chocolate on the donuts on Saturdays. (Transcript Pgs. 71-73)

The records of Cook County Hospital indicate that through December 6, 2013 Petitioner denied any recent trauma, which resulted in her leg and back pain. However, on December 5, 2013 she presented to the Illinois Orthopedic Network and gave a history of a work injury in August 2013. On March 25, 2014, she saw Dr. Erickson who found that she was injured performing her regular job duties. He felt at that time she needed a hemi-laminectomy. (Petitioner Exhibit 3)

Petitioner also saw Dr. Martin Herman at the Center of Brain and Spine Surgery. On June 26, 2014, he indicated that the Petitioner's low back pain and bilateral leg pain resulted from her lifting pans at work. He also recommended a lumbar laminectomy and discectomy at L4/5. (Petitioner Exhibit 5)

Respondent had Petitioner examined by a doctor of their choice on March 2, 2014. Based on his examination he felt that Petitioner had a herniated disc at L4/5 which was related to her

work and that she needed surgery. There were no Waddell findings at the time of his exam. Respondent provided Dr. Singh with questions pertaining to his first report. Although Dr. Singh indicates that Petitioner did not suffer a traumatic injury, he fails to comment in his second report as to whether Petitioner suffered repetitive trauma injuries. (Respondent Exhibit 1 and 2)

The Commission viewed Respondent Exhibit 4 and finds that the jobs performed in that video were repetitive. The Commission also finds the Petitioner credible in her description of the job she performed on Saturdays. These job duties were also repetitive.

An employee may be "accidently injured" under the Act as a result of the repetitive work he or she is required to perform. There need be no identifiable episode or collapse. As long as the Petitioner gives notice within 45 days from the date in which "both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person," Peoria County Belwood Nursing Home v. Industrial Comm'n 115 Ill. 2d 524 (1987) the Commission can find that the repetitive trauma was the cause of Petitioner's injury and proper notice was given. In this claim, the Petitioner credibly testified that the doctors at Cook County Hospital told her that her low back and leg problems were caused by her work activities and thus Petitioner gave proper notice to Otilia Mora on August 19, 2013. Therefore, the Commission finds that Petitioner proved she sustained accidental injuries on August 4, 2013 and that proper notice was given to Respondent.

As a result of the injuries sustained on August 4, 2013, Dr. Erickson, Dr. Herman, and Dr. Singh recommend that Petitioner have a lumbar laminectomy. The Commission orders that the Respondent pay for that treatment and follow up.

Petitioner is also entitled to temporary total disability from August 24, 2013 through July 1, 2014 or 44 3/7 weeks at a rate of $330.00, the statutory minimum with 4 dependents.

The Commission denies penalties and fees pursuant to §19(k), §19(l) and §16.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 44 3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,431.72 for medical expenses under §8(a) of the Act and pursuant to §8-2.

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

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

15IWCC0675

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 - 2015

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

HSF
O: 7/14/15
049

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

TRUJILLO-VILLALOBOS, REYNA
Employee/Petitioner

Case# **13WC040020**

TM WEST WHOLESALE BAKING CO
Employer/Respondent

15IWCC0675

On 7/29/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1072 EPSTEIN, JACK R LAW OFFICES
4346 W 26TH ST
SUITE 2000
CHICAGO, IL 60623

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

15IWCC0675

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)

Reyna Trujillo-Villalobos
Employee/Petitioner

v.

TM West Wholesale Baking Co.
Employer/Respondent

Case # **13** WC **40020**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joshua Luskin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 1, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 4, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**21,118.24**; the average weekly wage was $**406.12**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **4** dependent children.

Respondent ***is not liable for*** reasonable and necessary charges for all reasonable and necessary medical services.

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

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

ORDER

For reasons set forth in the attached decision, the petitioner failed to establish accidental injuries or a causal relationship to her employment; benefits under the Act are denied.

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

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

Signature of Arbitrator

29 July 2014
Date

ICArbDec19(b)

JUL 29 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REYNA TRUJILLO-VILLALOBOS, Petitioner,	)	15IWCC0675
vs.	)	No. 13 WC 40020
TM WEST WHOLESALE BAKING CO., Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act.

STATEMENT OF FACTS

The claimant, a Spanish-speaking woman, 40 years old on the date of hearing, worked at a baking company for approximately six to seven years. She testified she worked different shifts, ten days every two weeks on a rotating schedule, but had essentially the same job throughout that time. On weekdays she works on several machines and conveyors which take the dough, put it on a band and stretch it out over a conveyor to flatten the dough and make donuts. Saturdays she would work approximately half the shift on those machines and the other half on machines which frosted the donuts. A job video was introduced as RX4, and was acknowledged as accurate, but which did not include the frosting process. It demonstrated a worker taking dough from trays and putting it on a band, a process taking two to three hours per shift. After that assignment, she would be at a machine which stretched the dough over the conveyors and cut the dough into different shapes. The frosting process, which lasted about half the working day on Saturday, involved filling a five gallon bucket with melted chocolate and then emptying it into a machine which iced the doughnuts. The petitioner acknowledged that she could control the amount of icing put into the bucket to ensure she could lift it without discomfort. The claimant presently asserts low back injuries caused by repetitive trauma with an effective date of loss of August 4, 2013.

The medical records demonstrate that on October 10, 2010, the petitioner reported to Cook County Hospital ER complaining of severe low back pain radiating to the legs which had lasted for several days. Straightening of the spine was noted on x-rays. She denied any acute incident or trauma. She was prescribed medication and exercise and told to follow up with a personal physician. PX2. It is not clear if she did so. The petitioner did present at Cook County Hospital at one point in 2011, but that was for carpal tunnel syndrome (see PX2) and not related to the claim at bar.

On June 4, 2013, the petitioner presented to her primary care physician at Summit Medical Center. She reported headache and pain in her knee and feet over four days. She reported "lot of stress at home and work" but did not report any trauma. She was assessed with depression and anxiety as well as knee pain and given medication. PX1.

The petitioner testified that her symptoms increased and moved up into her low back and hip. She testified she went on vacation for a week in July 2013.

On July 25, 2013, she presented to the Cook County Hospital ER. She reported pain in her back and left leg over the course of approximately one month without any precipitating event or injury. X-rays were negative. She was assessed with muscle spasm and chronic sciatica and given medication. No reference to her work duties is present. See PX2 (pp29-32).

On August 4, 2013, the petitioner returned to Cook County Hospital. At this point she reported a three week history of low back pain radiating into the right leg. She was given medication and recommended to have an MRI scan. There are no references to her work activities, causation, or job restrictions at this time. PX2 (pp108-109).

On September 21, the petitioner presented at Cook County Hospital. She reported a three month history of pain radiating into both legs. She denied trauma or obvious neurological symptoms. No history of any work activity is present. She was recommended therapy and it was noted an MRI was pending. Work restrictions are not specifically delineated. PX2 (pp33-35).

On October 23, 2013, the petitioner underwent an MRI of the lumbar spine. It revealed multilevel disk degeneration with a disk herniation at L4-5 causing stenosis at that level. See PX2 (pp116-119).

On October 26, 2013, the petitioner presented at Cook County Hospital and discussed the results of the MRI. There is no history of workplace activities or causal connection. She was recommended ongoing therapy and a neurosurgical consultation. No work restrictions are listed. PX2 (pp110-112).

On December 5, 2013, the petitioner presented to Dr. Murtaza. She described an August 19, 2013 work accident. She stated her pain had begun in July and travelled up one leg into her back and now had pain in both legs. She stated she had seen another orthopedist (unnamed) who had recommended low back injections and/or surgery, as well as a foot specialist in September (unnamed) who had provided an injection which had helped. She reported her job activities included standing, walking, and extensive upper body activities. She was prescribed physical therapy and to be off work. PX3. The petitioner underwent substantial conservative care following that appointment. PX4.

On January 9, 2014, the petitioner saw Dr. Murtaza again. At this time she reported severe low back and left leg pain following a work injury on August 28, 2013. He noted she was going to secure her MRI results and that she was seeing another

15IWCC0675

physician as well (unnamed). He recommended ongoing PT and medication and kept her off work at that time. PX3.

On February 6, 2014, Dr. Murtaza reviewed the MRI and opined there had been a work-related injury. He recommended a spine surgeon consultation. Dr. Murtaza renewed the spine surgeon referral on March 6, 2014. See PX3.

On March 25, 2014, the petitioner saw Dr. Erickson. She reported an initial injury in July 2013 transferring large amounts of dough in the bakery followed by a significant reinjury on August 19, 2013 doing the same activity. He reviewed the MRI and recommended hemilaminectomy at L4-5. PX3.

On March 27, 2014, the petitioner saw Dr. Singh at her employer's request pursuant to Section 12 of the Act. She provided a history through a translator. She reported working on a machine on August 19, 2013 and began feeling ankle pain, which then progressed to her back over the course of a month. Dr. Singh reviewed the MRI films as well as medical records beginning on October 29, 2013, but did not have access to the prior records. Notably, Dr. Singh was able to review at least one record from Dr. Ray, apparently at MacNeal Hospital, where the claimant had secured treatment; that record was not offered at trial. Based on the claimant's history he concluded there had been a work injury which was related to the disk herniation. He opined laminectomy and diskectomy at L4-5 was needed and she should be off work pending the surgery. RX1. At trial, the claimant disputed providing the history as delineated in Dr. Singh's report.

On April 10, 2014, Dr. Singh issued a supplemental report. He noted that the ankle pain reported by the claimant was not indicative of a herniated disk and that he had opined that the disk herniation was causally related based on her rendition of events. However, he noted, activities of daily living were also a plausible mechanism for the disk herniation, and the disk condition could have been degenerative in nature in the absence of any identifiable event. RX2.

On June 26, 2014, the petitioner saw Dr. Herman, a neurosurgeon. He noted an accident history that the petitioner was lifting pans in May or June 2013 and began having pain in the low back and legs, which worsened in July. Following review of the MRI and examination of the claimant, he recommended laminectomy and diskectomy at the L4-5 level. He prescribed her off work for two months at that time. PX5.

The petitioner testified that she told her supervisor, Otilia, that her back was hurting on or about August 19, 2013. The petitioner testified she was not sure if she told Otilia whether or not the petitioner believed her condition was or was not work-related. The petitioner expressed a desire to have the surgery.

The respondent called Ms. Gladys Jaramillo, their Quality Assurance Manager. Ms. Jaramillo is bilingual and spoke with the petitioner several times about her medical condition. The petitioner reported being in a lot of pain. Ms. Jaramillo inquired if the

15IWCC0675

condition was work related and the petitioner replied that she did not know. Ms. Jaramillo confirmed the work activities of the claimant as related in RX4.

The respondent also called Ms. Otilia Mora, the petitioner's direct supervisor, to testify. Ms. Mora confirmed the accuracy of the video job description and noted the chocolate pouring process is only two to three hours on Saturday. Ms. Mora testified that the petitioner would lift dough about one hour per shift. Ms. Mora testified the petitioner never reported an acute accident, and that when the petitioner did say that her back was hurting, the claimant said she did not know what happened. Ms. Mora testified that her own back had been hurt several years before, which was not work-related, and the claimant had asked for the name of Ms. Mora's private physician; the claimant never asked to see the company clinic.

The petitioner was recalled to the stand and admitted she never asked to see the company physician and did not recall if she specifically stated it was or was not work related. The petitioner testified that she had requested the name of Ms. Mora's private doctor, and Ms. Mora gave the claimant the name of a private chiropractor.

OPINION AND ORDER

Accident, Notice and Causal Relationship

As these issues are closely tied together in this matter, the Arbitrator will address them jointly. A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim. The claimant acknowledged during her testimony that no acute incident occurred and the claim is submitted under repetitive trauma theory with an effective date of loss of August 4, 2013. In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show that the claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987).

In this case, there is general agreement as to the medical diagnosis as well as the recommended course of care. However, the opinions relating her work to her medical condition do so based on a hypothetical occurrence which does not comport with the trial testimony. The petitioner testified that no specific incident occurred. She testified, and the job video demonstrates, that she lifts dough several times per hour for one to three hours per shift and that the machines do the work of kneading, stretching and cutting it. On Saturdays, she lifts buckets of icing which she controlled the weight of. No physician opined that either all or any of these activities caused her current low back condition.

15IWCC0675

The Arbitrator observes that no physician at the Summit Medical Center or Cook County Hospital offered a causation opinion or even mentioned any specific work duties.

The first reference to a work injury is the treatment of Dr. Murtaza. In his initial appointment, he does note the petitioner worked on a line making dough, and that she stood, walked and used her upper body. However, he does not describe how much she lifted or what percentage of the day she did so. More to the point, he stated she never had pain prior to the end of July, and that being only ankle pain, which is not consistent with the records of Summit Medical Center or Cook County Hospital. Lastly, he opines her work injury was August 19, 2013, which is apparently when she told him that her back pain began; this is again not consistent with her prior care. It also suggests he was informed of a specific injury; this is reinforced in his follow-up note of January 9, 2014, when he reported that she described a history of "severe low back and left lower extremity pain after a work injury on 08/28/2013." PX3.

Dr. Erickson's history describes two separate acute incidents, both transferring large sections of dough, one in July 2013 and one significant reinjury on August 19, 2013 causing "distinct pain into the left leg," neither of which is corroborated by either the contemporaneous medical records or the petitioner's trial testimony.

Dr. Herman, a credible and competent physician, was apparently provided a history of a specific accident occurrence of the claimant lifting heavy pans at work in May or June of 2013. This history is again not reflected in the medical records at the time and the claimant did not testify as to such an event.

Dr. Singh, the examining physician, noted that the claimant reported ankle pain while standing at a machine on August 19, 2013, which thereafter progressed into the back. Notably, the petitioner testified that she did not give him that history of accident. Assuming for the moment that she did not, his supplemental report does note that merely standing would not cause the disk herniation and normal activities of daily living could do so via a degenerative process.

The Arbitrator further notes that it appears the only physicians who were aware of the claimant's earlier complaints of low back pain with radicular symptoms were the ones at Cook County Hospital who did not opine as to causation.

The medical opinions regarding causal connection do not comport with the trial evidence. As those causal opinions have been based on an inaccurate description of the petitioner's employment activities and medical history, they lack persuasive power. They are legally 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 Commission*, 68 Ill.2d 24 (1977).

The Arbitrator does note that based on the asserted accident date of August 4, 2013, the claimant would have had to give notice on or before September 18, 2013. Ms. Mora did note that the claimant related some degree of information regarding a condition

15IWCC0675

of ill-being, though not one that was explicitly linked to work, by that time. While imperfect, the Arbitrator does believe this suffices to demonstrate adequate notice under Section 6 of the Act. However, this is moot for the above-stated conclusions as to accident and causal connection.

Medical Services (Past and Prospective)

The medical services provided to date and presently recommended were disputed based on accident and causal connection rather than their reasonableness and necessity. Given the above findings, these are denied.

Temporary Total Disability

The petitioner requested TTD from August 24, 2013, through July 1, 2014 (trial). Even had the claimant demonstrated accident and causation, restriction from employment is only supported by the submitted medical records following Dr. Murtaza's examination on December 5, 2013. Disability benefits from August 24 through December 4, 2013, would be denied based on a failure of proof. However, given the above findings as to accident and causal relationship, this issue is moot; TTD is denied.

Penalties and Fees

The Illinois Supreme Court has long recognized the imposition of penalties is a question to be considered in terms of reasonableness. *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 297 (1980); *Smith v. Industrial Commission*, 170 Ill.App.3d 626 (3rd Dist. 1988). The respondent correctly noted significant discrepancies in the history provided to various medical providers and submitted live testimony in contravention of the claimant's rendition of events. Penalties and fees would not be appropriate even assuming accident and causal connection had been demonstrated.

15IWCC0675

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos Deprow,
Petitioner,

vs.

No: 13 WC 26181
No. 13 WC 26149

U.S. Steel,
Respondent.

15IWCC0677

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b), having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability benefits and penalties and fees under Sections 19(k), 19(l) and 16 of the Act, and being advised of the facts and law, modifies the May 22, 2014 decision of Arbitrator Lee as stated below. The Commission otherwise affirms and adopts the Arbitrator's Decision, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 48 year old steel worker, sustained injuries to his right shoulder on July 26, 2013 at Respondent's steel mill in Granite City, Illinois. On that day, while the Petitioner was working with a large bearing block and holding chains attached to an overhead crane, the crane operator attempted to lift the bearing block. In the process, Petitioner's arms were violently jerked forward.

Thereafter, Petitioner began treating with orthopedic specialist Dr. Richard Lehman, who proposed right shoulder surgery. This surgery was performed about six months later. In the meantime, Dr. Lehman recommended restricted duty for Petitioner, which recommendation Respondent accommodated by having Petitioner do office work such as computer data entry, reviewing paperwork, and the like.

The shoulder surgery was performed on February 5, 2014. Dr. Lehman's post-operative diagnosis indicated that Petitioner had a torn rotator cuff accompanied by impingement syndrome, acromioclavicular arthritis, and breakdown of the glenohumeral joint. Thereafter, Petitioner was required to wear a sling around his arm for eight to twelve hours per day to immobilize the upper right extremity. Petitioner, who is right-hand dominant, had difficulty with tasks of daily living including brushing his teeth and bathing. His wife shaved him and drove him. At the time of trial, he was undergoing physical therapy twice per week as prescribed.

Petitioner was authorized off-work by Dr. Lehman after the surgery. On February 18, 2014, while still fully restricted from work, Petitioner was evaluated by Respondent's "in-house" physician, Dr. John Parker. Dr. Parker is employed by Respondent and is on staff at a medical clinic located adjacent to the mill. After examination, Dr. Parker concluded that Petitioner had a partial disability and released the claimant to "restricted duty of office work, no use of right arm." Respondent thereafter made an offer of such "one-armed work" to Petitioner. Petitioner's supervisor, Terry Patton, testified that the work would be tasks that Petitioner could do with just his left arm, and would be similar to the office work previously performed by Petitioner during the months prior to his surgery. However, Petitioner did not return to work, choosing to follow Dr. Lehman's orders to stay completely off-work. Respondent terminated temporary total disability payments on February 20, 2014.

At the time of the Section 19(b) hearing of March 25, 2014, Petitioner was still treating with Dr. Lehman. Petitioner testified that, as soon as Dr. Lehman released him back to work in any capacity with Respondent, he would comply with his physician's orders.

The Arbitrator found that Petitioner proved entitlement to temporary total disability payments from February 21, 2014 to March 25, 2014. The Commission agrees that the weight of the evidence supports the finding that Petitioner's total incapacity was ongoing at the time of trial, and thus affirms the award of temporary total disability payments as to this period. However, the Arbitrator also awarded "continuing temporary compensation benefits from March 26, 2014 until the Petitioner is allowed to return to light duty by orders of his treating physician." This award is inappropriate. An award of potentially disputed future temporary total disability benefits is appropriately the subject of a future Section 19(b) hearing. Accordingly, the Commission vacates this award of "continuing" benefits.

As to penalties and fees, the Commission notes that the imposition of such is determined on the basis of reasonableness. *See* Avon Products, Inc. v. Industrial Commission, 82 Ill.2d 297 (1980); Smith v. Industrial Commission, 170 Ill.App.3d 626 (3rd Dist. 1988). In the Avon case, the Court looked to Larson on Workmen's Compensation for guidance, noting that penalties for delayed payment are not intended to inhibit contests of liability or appeals by employers who honestly believe an employee is not entitled to compensation. 3 A. Larson, Workmen's Compensation §83.40 (1980). In addition, when the employer acts in reliance upon responsible medical opinion, or where there are conflicting medical opinions, penalties are not ordinarily imposed. 3 A. Larson, Workmen's Compensation §83.40, at 15 - 636 (1980).

In the case at hand, Respondent relied on Dr. Parker's opinion that Petitioner was capable of returning to work using just his left arm, and Respondent made such work immediately available. There was no testimony that Petitioner was incapable of making use of his left arm after surgery, and Respondent had accommodated him with similar work for months before his surgery. That the offer of "one-armed work" was made just two weeks after the surgery might evince an undue eagerness on the part of Respondent to get its employee back to work. However, all things considered, Respondent's conduct was not so unreasonable as to warrant penalties and fees. The Commission therefore vacates the Arbitrator's award of penalties and fees.

Lastly, as to Petitioner's claim of repetitive injury to his elbows that was alleged to have occurred on July 9, 2013, the Commission notes that Petitioner provided no testimony about any elbow injury during the hearing nor did he make any mention of such in any post-hearing brief. The medical

15IWCC0677

records submitted in evidence make sporadic reference to Petitioner's complaints of elbow pain, but largely focus on his right shoulder injury. Given the near-total silence on the part of Petitioner regarding the alleged elbow injury, the Commission finds no compensability as to any such injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the May 22, 2014 Decision of the Arbitrator, is hereby modified as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $734.13/week, commencing February 5, 2014 through March 25, 2014, a period of 7 weeks, that being the period of temporary total incapacity from work under Section 8(b) of the Act. Respondent shall receive credit for $2,253.30 in TTD benefits heretofore paid, as reflected by the stipulations of the parties.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of "continuing temporary compensation benefits" is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of penalties and fees under Sections 19(k), 19(l) and 16 of the Act are vacated.

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 injuries.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

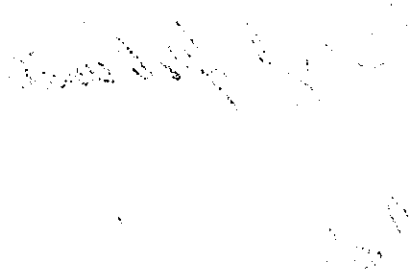
DATED: SEP 1 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/04/15
jdl/ac
68



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

DEPROW, CARLOS
Employee/Petitioner

Case# **13WC026181**

13WC026149

U S STEEL
Employer/Respondent

15IWCC0677

On 5/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2412 BEATTY & MOTIL
RONALD S MOTIL
PO BOX 730
GLEN CARBON, IL 62034

0299 KEEFE & DePAULI PC
JAMES M KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CARLOS DEPROW
Employee/Petitioner

v.

U.S. STEEL
Employer/Respondent

15IWCC0677

Case # 13 WC 26181

Consolidated cases: 13 WC 26149

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **3/25/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0677

FINDINGS

On the date of accident, **7/26/13 and 7/9/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**57,262.40**; the average weekly wage was $**1,101.20**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**2,253.30** for TTD, $**5,875.81** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,129.11**.

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

ORDER

Petitioner did prove entitlement to TTD benefits since February 21, 2014. Additionally, the claims for penalties and attorney's fees are allowed. See attached Conclusions.

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.

Ernest Lee
Signature of Arbitrator

5/19/14
Date

ICArbDec19(b)

MAY 22 2014

15IWCC0677

Case No. 13-WC-26181
Consolidated cases: 13-WC-26149

PETITIONER'S PROPOSED FINDINGS OF FACT AND PROPOSED 19B DECISION OF ARBITRATOR

The Arbitrator finds the following facts:

The Petitioner sustained accidental injuries to both elbows and his right shoulder on July 26, 2013. At the time of his injury, the Petitioner was employed as a steelworker by the Respondent since 1990 at the steel-making factory in Granite City, Illinois.

With regard to the accident of July 26, 2013, while working with a large bearing block and holding chains from an overhead crane, the crane operator tried to lift the bearing block and the chains violently jerked both of Petitioner's arms forward. Thereafter, as a result of the accident, the Petitioner began treatment with Dr. Richard Lehman, an orthopedic specialist in St. Louis, Missouri. After attempting a conservative course of physical therapy, Dr. Richard Lehman ultimately recommended surgical repair of the Petitioner's right shoulder and surgery was therefore performed on February 5, 2014 at the Webster Surgery Center in Webster Groves, Missouri.

Dr. Lehman's Operative Report, dated February 5, 2014, noted the post-operative diagnosis of a right torn rotator cuff; impingement syndrome; acromioclavicular arthritis; breakdown glenohumeral joint; and the performance of an acromioplasty. The specific procedures performed in the Operative Report reveal that Dr. Lehman performed a right shoulder arthroscopy; rotator cuff repair; acromioplasty; acromioclavicular joint debridement; extensive debridement of the distal clavicle; decompression of the subacromial space; extensive debridement of scar tissue; debridement of scar tissue anteriorly and posteriorly; anterior capsular release; inferior capsular release; release of additional scar tissue; and debridement of the subacromial space. Dr. Lehman also noted that due to the complexity of the procedure, it was necessary to perform surgery with the help of a certified assistant in order to help provide exposure, positioning, and suture management during the key steps of the shoulder reconstruction. Dr. Lehman noted that the procedure could not have been possible without the help of an assistant. (Petitioner's Exhibit 1).

On February 18, 2014, Dr. Lehman's office provided a direct off-work slip do Debbie Kilfoyle, the insurance representative for the Respondent, U.S. Steel. As of March 20, 2014, Dr. Lehman again provided a direct off-work slip to Ms. Kilfoyle advising that the Petitioner was to remain completely off work and that Dr. Lehman was recommending an outpatient strengthening program for the Petitioner while he was off work. (Petitioner's Exhibit 2).

As revealed by the medical records of Dr. Lehman, the treating orthopedic surgeon, the Petitioner has been ordered to stay off of work following the extensive surgery on February 5, 2014 up to the present time. On March 20, 2014, Dr. Lehman once again provided the Respondent's representatives with an off-work slip and was accompanied by an additional medical report explaining that while the Petitioner was off work, he should be provided with further treatment in the form of an outpatient strengthening program in order to "try and bump up his mechanics and improve his strength". Dr. Lehman also noted that the Petitioner was "still having some issues with his elbows, but asked him to isolate and rehab his shoulder initially and then could talk about his elbows at a later date". (Petitioner's Exhibit 2). Clearly, as a board certified orthopedic specialist, Dr. Lehman has a very credible reason to order the Petitioner to stay off work from the Respondent's steel mill while still obtaining treatment.

The Respondent in this matter has chosen to terminate temporary total disability benefits for the Petitioner on the basis of an opinion of one of its employees, Dr. John Parker. The Petitioner testified that Dr. Parker is on the staff of the Respondent's Veeder Health Clinic adjacent to the steel mill and only spent approximately five (5) minutes speaking with the Petitioner on February 20, 2014. The Petitioner testified that Dr. Parker did not order any diagnostic testing and the Petitioner did not see the Respondent's doctor reviewing any X-rays or other medical studies before recommending that the Petitioner return to work. Dr. Parker is not an orthopedic surgeon, does not perform shoulder surgery or perform other treatment for the Petitioner, and merely reviewed the Petitioner's injury on behalf of the Respondent and then ordered the Petitioner to return to work in the factory setting. Therefore, Dr. Parker's opinion is not credible as compared with the treating orthopedic surgeon. As a result, the Petitioner's temporary compensation benefits should not have been terminated, especially in light of Dr. Lehman's recommendation of further treatment while the Petitioner was ordered to remain off work.

The Petitioner testified at the hearing on March 25, 2014 that he continues to wear an arm sling on his right arm, as prescribed by Dr. Lehman, approximately eight to twelve (8-12) hours per day. Since the Petitioner is right hand dominant, the injury to his right shoulder causes him difficulty while showering, using the bathroom, and brushing his teeth. His wife must shave him and she primarily drives him when he has to use the family vehicle. The Petitioner testified that he still has an aching pain in the right shoulder and while at home, rests in a recliner. Further the Petitioner testified that he still receives physical therapy twice per week and has not been released to regular work or light duty by Dr. Lehman. The Petitioner testified that when Dr. Lehman would release him to light duty, he will comply with those orders of his treating physician.

Based upon the foregoing, the Arbitrator finds that the Petitioner is entitled to temporary compensation benefits from February 21, 2014 to March 25, 2014 and is Ordered to pay the Petitioner temporary compensation benefits from March 26, 2014 to the present or until the Petitioner's treating physician releases him to light duty which the Respondent can accommodate.

With regard to the Petitioner's Petitioner for Fees and Penalties pursuant to Sections 16, 19(k), and 19(l) of the Workers' Compensation Act, a review of this matter reveals that the Respondent, through its legal counsel, sent three separate letters to Petitioner's attorney on December 27, 2013, January 23, 2014, and February 17, 2014 advising that as soon as the treating surgeon, Dr. Lehman, would release the Petitioner to light duty, that light duty work would become available. (Arb. Exhibit #4). The Petitioner's testimony did verify the Petitioner's position that whenever Dr. Lehman would release the Petitioner to light duty, he would comply with that release and return to work. Dr. Lehman has not released the Petitioner to return to light duty or any type of work for that Respondent. He continues to order the Petitioner completely off work. However, despite the Respondent's previous willingness to agree with Dr. Lehman's recommendations as stated in said letters, the Respondent, as of February 24, 2014, by letter of Respondent's counsel, abruptly changed course, chose to ignore the opinions of Dr. Lehman, and terminated Petitioner's temporary compensation benefits.

Respondent lacked sufficient reason and evidence to support its cessation of temporary total disability benefits and, as a result, the cessation of benefits was not in good faith. The termination of TTD benefits, while Petitioner remains off work by orders of his treating physician, has caused hardship to the Petitioner and is a vexatious and unreasonable delay in the payment of said benefits.

In assessing Section 19(k) penalties in the amount of $2,383.55, the Arbitrator has considered the amount of compensation payable at the time of the Award in the amount of $4,767.10. This represents 50% of the temporary total disability benefits due through April 6, 2014. In addition, Section 19(l) penalties are awarded in the amount of $1,350.00, representing 44 days of delay in payment of compensation following the

Respondent's cessation of TTD benefits. Section 16 attorney's fees are also awarded to the Petitioner in the amount of $715.06.

CONCLUSIONS:

1. The Arbitrator finds the Petitioner is entitled to temporary compensation benefits from February 21, 2014 to March 25, 2014 and is also ordered to pay continuing temporary compensation benefits from March 26, 2014 until the Petitioner is allowed to return to light duty by orders of his treating physician, Dr. Richard Lehman.

2. The Arbitrator finds that the Petitioner is entitled to the amount of $2,383.55, representing Section 19(k) penalties.

3. The Arbitrator finds that the Petitioner is entitled to receive payment of $1,350.00, representing Section 19(l) penalties.

4. The Arbitrator finds that the Petitioner is entitled to receive the amount of $715.06, representing Section 16 attorney's fees.

5. For the foregoing reasons, Petitioner's claim for benefits is allowed.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Starcevic,

Petitioner,

vs. NO: 11 WC 16404

Illinois Dept. of Natural Resources,

15IWCC0676

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical, wages, temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator and remands this matter back to an Arbitrator in Chicago for a reopening of proofs and a rehearing.

The Arbitrator denied the Respondent a continuance to obtain the records of Dr. Christopher McIntire in Hammond, Indiana. The Petitioner denied that he had ever seen him for prior back problems but later admitted on cross-examination that he had seen the Doctor "one time years ago." (Transcript Pgs. 40-41) Respondent Exhibit 7, St. Margaret Medical Center Records, mention Dr. McIntire as a family doctor with the last visit made to him in May of 2010, less than a year before the date of loss. The Commission finds that this is not "one time years ago." Respondent advised the Arbitrator that Dr. McIntyre name was recently discovered and they requested a continuance to obtain the doctor's out of state records. The Arbitrator denied Respondent's request and ordered that proofs will be closed on that date. The Arbitrator's denial of a continuance to the Respondent to obtain what could be crucial evidence was improper.

The Respondent also requested a continuance on the date of trial when Respondent discovered that Petitioner was making a claim for a higher average weekly wage. This was Respondent's first knowledge of a claim for a higher weekly wage, even though Petitioner

15IWCC0676

accepted the temporary total disability based on Respondent's calculation of the average weekly wage. The Arbitrator should have granted the Respondent a short continuance so that they could obtain the payroll records of Petitioner.

Petitioner received $89,656.22 in temporary total disability payments as of May 1, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the findings of the Arbitrator are reversed and this matter is remanded back to an Arbitrator in Chicago to reopen proofs and a rehearing of this claim.

DATED: SEP 1 - 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 7/15/15
049

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

STARCEVIC, GARY
Employee/Petitioner

Case# **11WC016404**

ILLINOIS DEPARTMENT OF NATURAL RESOURCES
Employer/Respondent

15IWCC0676

On 7/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

5165 ASSISTANT ATTORNEY GENERAL
JEANNIE D SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

JUL 10 2014

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0676

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION
19(b)

Gary Starcevic
Employee/Petitioner

v.

Illinois Department of Natural Resources
Employer/Respondent

Case # **11** WC **16404**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **May 1, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 10, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,164.16**; the average weekly wage was $**1,080.08**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**89,656.22** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**89,656.22**.

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

ORDER

Respondent shall be given a credit of $**89,656.22** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**89,656.22**.

Respondent shall pay Petitioner temporary total disability benefits of $720.05/week for 158.86 weeks, commencing April 16, 2011 through May 1, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $5,869.00, as provided in Sections 8(a) and 8.2 of the Act directly to the office of Petitioner's attorneys.

Respondent shall approve and pay for future medical treatment recommended by Dr. Levin, including repeat diagnostic tests of the lumbar spine and a L4 laminectomy and fusion at L4-5.

Respondent shall pay to Petitioner penalties of $**0**, as provided in Section 16 of the Act; $**0**, as provided in Section 19(k) of the Act; and $**0**, as provided in Section 19(l) of the Act.

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

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

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

Signature of Arbitrator

7/10/14
Date

ICArbDec19(b)

JUL 10 2014

BEFORE THE WORKERS' COMPENSATION COMMISSION

Gary Starcevik,	)	
	)	
Petitioner,	)	
	)	
v.	)	**No. 11 WC 16404**
	)	
Illinois Dept. of Natural Resources, State of Illinois	)	**15IWCC0676**
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

On January 10, 2011, Petitioner was employed as a site technician, maintenance worker with the Illinois Department of Natural Resources. Petitioner had been employed by Respondent on that date for the last 22 years.

As a maintenance worker, the Petitioner's duties included emptying bags from 55 gallon metal garbage cans, cutting down trees, plowing snow, shoveling snow, cleaning, painting, trimming bushes, cutting grass, and weed whipping. The Petitioner uses tools to perform these tasks, including shovels, snow blowers, and occasionally heavier equipment like jackhammers. In the course of his duties, the Petitioner described lifting objects weighing anywhere from 20 to 75 pounds. The Petitioner testified that he was responsible for emptying 150 garbage cans per day, with garbage bags weighing from 20 to 40 pounds. Petitioner testified that his work also involved repetitive bending and twisting to perform most of his duties.

On January 10, 2011, the Petitioner was standing in the bed of a pickup truck tossing garbage bags into a dumpster. As he was throwing a 40 to 50 pound bag into the dumpster, he experienced "excruciating" pain in his lower back. Petitioner testified that the pain radiated from his lower back into his waist and groin area.

On January 11, 2011, the Petitioner reported the accident to his supervisor and asked for permission to do as little as possible for a couple of days. Petitioner testified that he had excruciating pain in his lower back with pain radiating upwards on both sides of his spine.

On January 15, 2011, St. Margaret Mercy Hospital emergency room records noted Petitioner's complaint of pain in his left groin that began 5 days earlier. (Px 4, Rx 7). Petitioner was diagnosed with a left groin (inguinal) strain, prescribed Vicodin, ordered off work for three days, and instructed to follow up with his primary care physician (Id). The ER records do not reflect any complaint of

lower back pain. At trial, the Petitioner testified that he did report pain in his lower back, radiating into his groin while at the ER.

On January 17, 2011, Dr. Thomas Kampner at Franciscan Hammond Clinic Specialty Center noted Petitioner's complaints of lumbar pain radiating into the left flank and groin that began while unloading a truck the week prior. Dr. Kampner diagnosed a lumbar strain, ordered Petitioner off-work until a "Recheck" with Dr. Richard Rodarte in 2 days. (PX 6, RX 9).

On January 17, 2011, the Petitioner filled out an accident report at the request of his supervisor. The Petitioner reported that he "felt a pulling sensation in groin and lower left side of back" while throwing garbage bags off a truck on January 10, 2011". (PX 9, RX 1).

On January 19, 2011, Dr. Rodarte at Hammond Clinic noted the Petitioner's history of "heavy lifting three days ago. Now with left groin area pain radiating posterior." The doctor recommended physical therapy Petitioner three times a week for 2 weeks and placed the Petitioner on light duty restrictions. (PX 6, RX 9). The Petitioner testified that after receiving these restrictions he spoke with his boss, but was not offered any light duty work by the Respondent.

From February 1, 2011 through February 14, 2011, the Petitioner underwent physical therapy at Hammond Clinic Specialty Center. (PX 6, RX 9).

On February 16, 2011, Dr. Rodarte noted that the Petitioner had continued back pain and had experienced very limited progress during therapy. Dr. Rodarte order Petitioner to hold off on further physical therapy, placed him on off-work status and referred Petitioner to a spine specialist. (PX 6, RX 9).

On February 25, 2011, Dr. Tyndall at Orthopaedic Specialists of Northwest Indiana examined the Petitioner. Dr. Tyndall noted in the history that Petitioner's accident occurred while twisting and pulling a 40 pound garbage bag on January 10, 2011. Dr. Tyndall noted that Petitioner "denied any leg or buttock pain but states that he has a band-like back pain at the lumbosacral junction that radiates up into his upper lumbar spine." The doctor diagnosed the Petitioner with acute post traumatic low back pain and L4-5 spondylolisthesis with neurogenic low back pain. Dr. Tyndall noted that Petitioner had pre-existing lumbar osteoarthritis which was exacerbated by his recent injury. The doctor noted that Petitioner likely had slight listhesis at L4-L5 which worsened when Petitioner twisted his back. Dr. Tyndall recommended a MRI of the lumbar spine and possible injections. (PX 5, RX 11).

On March 9, 2011, the Petitioner's lumbar MRI revealed degenerative changes throughout the lumbar spine, including L4-5 spondylolisthesis with stenosis. (PX 5, RX 11).

On March 9, 2011. Dr. Tyndall reviewed the MRI results and diagnosed Petitioner with L4-L5 stenosis and acute low back pain. He recommended resuming physical therapy and prescribed Vicodin and Mobic. The doctor ordered Petitioner to remain off work until he is re-evaluated. (PX 5, RX 11).

On April 27, 2011, Dr. Tyndall noted that injections had been approved for the Petitioner's lumbar spine, due to continued pain after therapy. Petitioner wanted another opinion prior to

undergoing injections. Dr. Tyndall noted that another opinion would be reasonable and referred the Petitioner to Dr. Marc Levin. (PX 5, RX 11).

On May 19, 2011, Dr. Levin at Community Spine and Neurosurgery Institute noted the Petitioner's continued lower back pain. After examining the Petitioner, Dr. Levin's impression was that Petitioner had degenerative disc disease and mild spondylolisthesis that was not caused by the injury, but "certainly the symptoms started in that the condition was aggravated by the injury." and recommended a series of lumbar injections. (PX 3, RX 12).

On October 6, 2011, Dr. McClenic administered bilateral L4-L5 and L5-Si facet joint injections to Petitioner.

In November of 2011, the Petitioner underwent a series of three epidural steroid injections and one facet injection in the lumbar spine. (PX 3, RX 12).

Between December of 2011 and January 19, 2012, Dr. McClenic administered a series of bilateral transforaminal epidural steroid injections at L3-L4 to Petitioner.

On February 2, 2012, Dr. McClenic noted that Petitioner's low back pain had not resolved with medications, physical therapy or steroid injections. The doctor referred Petitioner back to Dr. Levin for possible surgical intervention.

On March 8, 2012, the Petitioner followed up with Dr. Levin. At that time, Dr. Levin informed the Petitioner that there was no further conservative treatment that would benefit him. Dr. Levin recommended a new set of x-rays and an MRI to determine if surgery was appropriate. (PX 3, RX 12).

On April 4 and April 6, 2012, a lumbar MRI and x-rays were taken of Petitioner.

On April 23, 2012, Dr. Levin reviewed the above mentioned tests and recommended that the Petitioner undergo a L4-L5, L5-S1 laminotomy, foraminotomy, and a L4-5 interspinous fusion. Dr. Levin kept the Petitioner off work. (PX 3, RX 12).

In June of and July of 2012, the Petitioner underwent heart treatment, including the placement of two stents. Due to this heart treatment, the Petitioner has also been placed on Plavix.

In July of 2012, Dr. Levin noted that Petitioner had not yet made a decision regarding the back surgery.

Dr. Levin has noted that surgery would not be performed while the Petitioner is on Plavix.

At the time of trial, the Petitioner continued taking the Plavix, as prescribed by his heart physician.

Petitioner testified that he was to follow up with his heart physician in the near future and it would be determined at that point whether the medication needed to be continued.

On August 28, 2012, the Petitioner underwent a Section 12 examination performed by Dr. Babak Lami at the request of the Respondent. (RX 5). Dr. Lami diagnosed Petitioner with degenerative disc disease at L3-L4, L4-L5, and L5-S1 with a grade I degenerative spondylolisthesis at L4-L5. *Id.* Dr. Lami opined that Petitioner sustained a back sprain as a result of the January 10, 2011 work accident. *Id.* Dr. Lami noted that Petitioner's MRI findings are all degenerative in nature and were not caused by the work accident. The doctor's exam of Petitioner did not reveal symptoms related to spinal stenosis or radiculopathy. *Id.* Dr. Lami opined that Petitioner was not a good surgical candidate due to his ongoing cardiac issues. According to Dr. Lami, Petitioner was at MMI at the time of the IME and could return to work full duty. *Id.* Dr. Lami did not recommend any further treatment, other than a home exercise program. However, Dr. Lami concluded, "I would recommend return to work with no lifting more than twenty pounds on a routine basis and occasionally lifting up to thirty pounds and no repetitive twisting and bending. If needed, one may consider a functional capacity evaluation (FCE)." (RX 5).

At trial, the Petitioner testified that he was not offered any light duty work by the respondent after Dr. Lami's examination.

From September of 2012 through the date of trial, Dr. Levin has continued recommending surgery for the Petitioner and has continued keeping the Petitioner on an off-work status. (PX 3, RX 12).

On January 29, 2014, Dr. Levin drafted a narrative report, detailing the history of the Petitioner's medical treatment and his opinions regarding the Petitioner's condition. Dr. Levin also continues prescribing Hydrocodone, which the Petitioner takes daily for pain relief. Dr. Levin diagnosed the Petitioner with pre-existing spondylosis, spondylolisthesis, and disc space degeneration at L4-5, L5-S1 which was asymptomatic prior to his injury and was made symptomatic by the injury. Dr. Levin further opined that all treatment to that date had been reasonable and necessary. (PX 1).

At trial, the Petitioner testified that in the years prior to his January 10, 2011 accident he had received some treatment for his lumbar spine. The Petitioner specifically testified to an accident that he sustained in October of 2009. At that time, the Petitioner fell backward and landed on a lawnmower. The Petitioner was seen at St. Margaret Mercy and was diagnosed with a back contusion. The records from Dr. Margaret Mercy reflect that the Petitioner was seen in October and November of 2009 and underwent a short course of physical therapy. Petitioner was released with a diagnosis of a resolved contusion. (RX 7).

From November of 2009 through January 10, 2011 the Petitioner testified that he had sought no further treatment for his lumbar spine. During that period of time, the Petitioner worked in a full duty capacity and had no restrictions from his lumbar spine. The Petitioner testified that he did not sustain any new accidents to his lumbar spine since January 10, 2011.

At trial, the Petitioner testified to the current condition of his lumbar spine. He explained that, prior to January 10, 2011, he had never experienced a pain like he now experiences. The Petitioner maintained he is in pain twenty-four hours a day. If he stands for more than eight or

nine minutes, his lumbar spine tightens and becomes very painful. He is only able to walk about one block before having to sit down to rest. The muscles in the Petitioner's lumbar spine become "rock solid" and the pain is "unbearable." The Petitioner stated that he has not had a single day without back pain since January 10, 2011.

Dr. Marc Levin testified by deposition on March 24, 2014. Dr. Levin is a board certified neurosurgeon who has been practicing neurosurgery for 37 years. (PX 7 @ 4-5). Dr. Levin first began treating the Petitioner on May 19, 2011. (PX 7 @ 9). Dr. Levin testified that the Petitioner had participated in physical therapy which was not helpful. The doctor then sent the Petitioner for a series of epidural injections meant to reduce the inflammation in the lumbar area, around the disc spaces and the nerves but the injections did not provide long term relief. (PX 7 @ 11-12).

When asked what caused that inflammation, Dr. Levin answered, "Well, the aggravation of all that area from the injury that he sustained" on January 10, 2011. (PX 7 @ 11).

In April of 2012, due to continued back pain despite physical therapy and injections, Dr. Levin began discussing possible surgical intervention with the Petitioner. (PX 7 @ 13).

In June and July of 2012, the Petitioner continued to follow up with Dr. Levin. However, the Petitioner had also come under the care of a heart doctor, where he had stents implanted and was placed on Plavix, which put a hold on any back surgery. (PX 7 @ 13-14).

As of January 29, 2013, Dr. Levin diagnosed the Petitioner with lumbar degenerative disc disease, spondylolisthesis and lumbar stenosis. Dr. Levin explained that those changes were not acute changes, but the Petitioner was not having any symptoms from them prior to his January 2011 injury and the accident caused his condition to become symptomatic with pain in the lower back and into the leg. (PX 7 @ 15-16).

Dr. Levin further testified that all treatment he had reviewed and administered for the Petitioner had been reasonable and necessary. (PX 7 @ 16).

Dr. Levin continued to recommend future lumbar treatment, including a L4 laminectomy and a L4-5 fusion. (PX 7 @ 17). The Petitioner continued to follow up with Dr. Levin through the date of the deposition and none of Dr. Levin's opinions had changes regarding treatment. (PX 7 @ 18). Dr. Levin explained that the purpose of the proposed surgery is to relieve the Petitioner's pain by removing bone and tissue to take pressure off the nerves, while also stabilizing the slippage from spondylolisthesis through the L4-5 fusion. (PX 7 @ 18-19).

Dr. Levin further opined that the need for the proposed surgery is causally related to the Petitioner's January 10, 2011 work accident. (PX 7 @ 19). Dr. Levin continued to keep the Petitioner off work, recommending at the most no lifting over 15 pounds repetitively, no repetitive bending, no squatting, and no climbing. (PX 7 @ 20).

On cross-examination, Dr. Levin testified that he had not reviewed any records from before the Petitioner's January 10, 2011 work accident. (PX 7 @ 20-21). Dr. Levin's understanding of the accident was gained from the Petitioner's statements to him, as well as the histories in the records of Dr. Tyndall and St. Margaret Mercy Medical Center. (PX 7 @ 21).

Dr. Levin also explained that Dr. Rodarte's records, which indicated that the Petitioner had lumbar pain radiating into the left groin, were indicative of radicular symptoms. (PX 7 @ 23). The first report of pain radiating beyond the groin and down the leg was in April of 2012. (PX 7 @ 24-25).

Dr. Levin testified that the typical symptoms of L4-5 spondylolisthesis are mostly back pain. Sometimes individuals can have radicular pain. The inability to stand for long period of time or walk for long distances, which the Petitioner had, were also symptoms of lumbar stenosis. (PX 7 @ 25-26).

In addition, Dr. Levin testified that most people with degenerative conditions like the Petitioner's live their lives without any symptoms at all. However, the Petitioner here "had this aggravating event that occurred and made this condition symptomatic." (PX 7 @ 28).

On re-direct examination, Dr. Levin explained that only pre-accident records indicating that the Petitioner had back pain from 2009 through his date of accident could change his opinion. He further testified that the 2009 incident sounded like the Petitioner only had some isolated incidence of muscle strain. (PX 7 @ 32).

Prior to any surgery, Dr. Levin would want updated lumbar studies. (PX 7 @ 33).

Dr. Babak Lami testified by deposition that he is a board certified orthopedic spinal surgeon. (RX 6 @ 5-6). Dr. Lami examined the Petitioner on August 28, 2012. (RX 6 @ 9). Dr. Lami reviewed some medical records and took a history of accident from the Petitioner. (RX 6 @ 12).

Dr. Lami performed a physical examination of the Petitioner, focusing on the spine. (RX 6 @ 15-16). The Petitioner had painful motion in the lumbar spine and walked with a slight limp, which was attributed to a knee injury. (RX 6 @ 16-17). There were no radicular symptoms in the Petitioner's presentation, nor did Dr. Lami find any neurological deficits. (RX 6 @ 17).

Dr. Lami found that the Petitioner had mainly axial low back pain with degenerative changes at multiple levels of the spine, including grade I spondylolisthesis at L4-5. (RX 6 @ 18).

Dr. Lami felt that there were no acute findings on the Petitioner's MRI and the condition of his spine was degenerative in nature. (RX 6 @ 19). Dr. Lami felt that given the mechanism of injury and objective findings, the Petitioner's injury should have resolved by the time of his examination. (RX 6 @ 20). Dr. Lami felt that the Petitioner was at maximum medical improvement and was not a candidate for surgery. (RX 6 @ 21).

Dr. Lami further felt that the Petitioner could work at full duty, noting that he worked at full duty with the degenerative changes before the accident. However, Dr. Lami testified that if one were to rely upon the Petitioner's subjective complaints of symptoms, then he would recommend a restriction of no lifting more than 20 pounds and occasional lifting up to 30 pounds without repetitive bending or twisting. (RX 6 @ 23). However, he felt that those restrictions would be due to the degenerative process and not to the Petitioner's accident. (RX 6 @ 24).

Dr. Lami did note that the Petitioner was seen for an x-ray of the lower back in 2009 and was treated on November 16, 2009 for a lower back contusion that had resolved. (RX 6 @ 27).

Dr. Lami further testified that it was possible for the mechanism of injury described by Mr. Starcevic to aggravate the degenerative condition of his spine and noted in his Section 12 report that the Petitioner possibly aggravated his degenerative back. (RX 6 @ 29-30).

Dr. Lami opined that the Petitioner's current complaints of pain were caused only by his degenerative back condition. (RX 6 @ 39).

Dr. Lami made testified that the lack of notation of back complaints at the ER on January 15, 2011 was in part the basis for his belief that the Petitioner's back pain was not related to his January 10, 2011 accident. (RX 6 @ 40-42).

The Petitioner testified that his set work schedule for the respondent was 5 days per week, 7 ½ hours per day at $29.38 per hour, during the period leading up to his work accident. The Petitioner did work occasional overtime, which was given by his supervisor on a voluntary basis.

CONCLUSIONS OF LAW

(F) Causal Connection

After reviewing all evidence and testimony in this matter, the Arbitrator hereby finds that the Petitioner's current condition of ill-being is causally related to his January 10, 2011 work accident.

It is undisputed that the Petitioner sustained an accident while working for the respondent on January 10, 2011. On that date, the Petitioner was bending, lifting and twisting repeatedly to throw garbage bags from the bed of a pickup truck into a dumpster. While lifting and twisting to throw a 40 pound bag, the Petitioner testified that he felt immediate pain in his lower back on the left side and into his left groin.

After beginning his treatment with St. Margaret Mercy emergency room, Dr. Rodarte at Hammond Clinic, the Petitioner was referred to a back specialist, Dr. Tyndall. On February 25, 2011, the Petitioner was examined by Dr. Tyndall at Orthopaedic Specialists of Northwest Indiana. Dr. Tyndall diagnosed acute post traumatic low back pain and L4-5 spondylolisthesis with neurogenic low back pain. Dr. Tyndall concluded "It is likely he had preexisting lumbar osteoarthritis which was exacerbated by this recent injury. It is also likely that he had slight listhesis at L4-L5 which worsened when he twisted his back." (PX 5, RX 11).

The Petitioner was later referred by Dr. Tyndall to Dr. Marc Levin, who has been the Petitioner's treating physician since May of 2011. Dr. Levin diagnosed the Petitioner with lumbar degenerative disc disease, spondylolisthesis and lumbar stenosis. Dr. Levin explained in his deposition testimony that the accident caused the Petitioner's condition to become symptomatic with pain in the lower back and into the leg. (PX 7 @ 15-16). Dr. Levin further explained that most people with degenerative conditions like the Petitioner's live their lives

without any symptoms at all. However, the Petitioner here "had this aggravating event that occurred and made this condition symptomatic." (PX 7 @ 28).

The Respondent relies upon the opinion of Dr. Lami to dispute causation. However, Dr. Lami himself has testified that the Petitioner could have sustained at least an aggravation of the preexisting condition in his lumbar spine during his January 10, 2011 accident. (RX 6 @ 33-34). Dr. Lami provides no reasonable explanation in his deposition testimony as to why the Petitioner's symptoms have continued through the date of trial or when his symptoms would have stopped being from the aggravation and started, seamlessly, to be caused by his degenerative condition alone. Dr. Lami concluded that if the Petitioner's explanation of his symptoms were accepted he would place him on restrictions of no lifting more than 20 pounds and occasional lifting up to 30 pounds without repetitive bending or twisting. (RX 6 @ 23).

After hearing the testimony in this case, the Arbitrator finds that the Petitioner's testimony regarding his accident, symptoms, and continued disability through the date of trial to be honest and credible. Therefore, Dr. Lami's lack of explanation of how and when the Petitioner's lumbar symptoms stopped emanating from an aggravation and began being caused by something else leaves serious doubt as to his credibility in this Petitioner's case.

Furthermore, Dr. Lami has based a portion of his opinions on the lack of lumbar pain noted in the records of St. Margaret Mercy from January 15, 2011. However, from a review of the records and the credible testimony of the Petitioner, it is clear that the Petitioner did in fact began experiencing lumbar pain immediately after his January 10, 2011 work accident, which has continued through the date of trial. The records of Dr. Kampner at Hammond Clinic on January 17, 2011, two days after the treatment at St. Margaret Mercy, detail the Petitioner's January 10, 2011 work accident and the lumbar pain since that time. (PX 6, RX 6). In addition, Dr. Rodarte's first treatment note on January 19, 2011, details the Petitioner's sudden onset of lower back pain (PX 6, RX 6), Dr. Tyndall records the Petitioner's January 10, 2011 lower back accident in his first treatment note of February 25, 2011 (PX 5, RX 11), and Dr. Levin records the Petitioner's work accident and continued lower back pain. (PX 3, RX 12). The Petitioner also reported a lower back injury when he filled out the official accident report on January 17, 2011, at the request of his supervisor. (PX 9, RX 1). All records in this case, other than the single ER note from St. Margaret Mercy, indicate that the Petitioner did in fact injure his lower back on January 10, 2011.

The opinions of Dr. Levin and Dr. Tyndall that the Petitioner sustained an aggravation of the pre-existing degenerative condition of his lumbar spine are supported by the records and are more persuasive than the opinion of Dr. Lami. Dr. Levin has treated the Petitioner from March 8, 2012 and has had the opportunity to review all of the Petitioner's treatment records from other providers, in addition to regular examinations of the Petitioner's condition. Dr. Levin has opined that the Petitioner's lumbar condition was aggravated by the January 10, 2011 work accident, necessitating the course of treatment since that time.

G. Average Weekly Wage

At trial, the Petitioner testified that his set work schedule for the respondent was 5 days per week, 7 ½ hours per day at $29.38 per hour, during the period leading up to his work accident.

The Petitioner did work occasional overtime, which was given by his supervisor on a voluntary basis. According to this testimony, the Petitioner would earn $1,101.75 per week in straight time pay. The Petitioner's voluntary overtime would not be included in the average weekly wage. The respondent offered no testimony to dispute the Petitioner's description of his work hours and pay rate.

A review of Petitioner's Exhibit 12 shows that the Petitioner was paid $2,141.00 every two weeks in January and February of 2010 and $2,198.50 every two weeks in October of 2010. The Petitioner's average weekly wage during those pay periods was $1,080.08. (PX 12).

In addition, the respondent submitted benefit payment logs indicating that while the Petitioner was receiving TTD, he was paid anywhere from $1,361.03 to $1,519.21 per week, most commonly being paid $1,424.23. These payments would equate to an average weekly wage that is similar to the average weekly wage calculated from the available check stubs. (RX 4).

The Arbitrator notes that the pay stubs submitted by the Petitioner equates to an average weekly wage which is closely related to the wage used by the respondent to pay the Petitioner's TTD benefits and finds that this evidence is the strongest available evidence regarding the Petitioner's average weekly wage for the year prior to his accident. Therefore, the Arbitrator hereby finds that the Petitioner's average weekly wage was $1,080.08 per week.

J. Medical Bills

As detailed above, the Arbitrator has found that the current condition of the Petitioner's lumbar spine is causally related to his January 10, 2011 work accident. Based upon the opinion of Dr. Levin that all treatment received by the Petitioner to date has been reasonable and necessary (PX 7 @ 16), the Arbitrator further finds that the treatment the Petitioner has receive to his lumbar spine has been reasonable and necessary. The respondent in this case has offered no evidence or testimony to dispute the reasonableness or necessity of the treatment received to date by the Petitioner.

Therefore, the Arbitrator orders respondent to pay unpaid medical bills related to the treatment of the Petitioner's lumbar spine, as contained in Petitioner's Exhibit 8. Respondent shall therefore pay $5,689.00 in unpaid medical bills directly to the office of Petitioner's attorneys.

K. Prospective Medical Care

To treat the Petitioner's symptomatic condition, Dr. Levin has recommended L4 laminectomy and L4-5 fusion surgery. The Petitioner has continued to follow up with Dr. Levin through the date of trial and Dr. Levin has testified that he continues to recommend that surgical procedure. PX 7 @ 18-20).

As detailed in the sections and findings above, the Petitioner did sustain a work related accident on January 10, 2011, the current condition of ill-being in his lumbar spine is causally related to that accident, and the opinions of Dr. Levin regarding the Petitioner's condition are more persuasive than those of Dr. Lami.

Based upon the above findings, the Arbitrator hereby orders respondent to approve and pay for the lumbar spine treatment recommended by Dr. Levin, including the diagnostic films and L4 laminectomy and L4-5 fusion.

L. TTD

At trial, the Petitioner testified that after his accident he was paid full-time hourly pay, using vacation and sick days, through April 15, 2011. The Petitioner began receiving TTD payments from the respondent on April 16, 2011.

As of the date of trial, the Petitioner is being kept completely off work by Dr. Levin. (PX 3). As detailed in the sections above, the Arbitrator has found the opinion of Dr. Levin more persuasive than that of Dr. Lami in this matter. For those same reasons, the Arbitrator also finds the opinions Dr. Levin regarding the Petitioner's work capacity to be more persuasive than the opinion of Dr. Lami. Dr. Levin, as the Petitioner's treating physician, is in the best place in this matter to recommend necessary treatment and restrictions for the Petitioner.

The records reflect that the Petitioner has been kept off work or has been on restrictions due to his work injury from January 16, 2011 through May 1, 2014. (PX 3, 4, 5, 6). There is no evidence that the respondent has ever offered any light duty work to the Petitioner during the period which the Petitioner was cleared to work light duty.

Therefore, the Arbitrator orders respondent to pay Petitioner temporary total disability benefits of $720.05/week for 158.86 weeks, commencing April 16, 2011 through May 1, 2014, as provided in Section 8(b) of the Act.

M. Penalties and Fees

Although the Arbitrator has found the opinion of Dr. Levin more persuasive than that of Dr. Lami, the respondent's reliance on the opinion of Dr. Lami in this specific case was not so unreasonable as to constitute a ground of penalties and attorneys fees. Therefore no such penalties or fees are awarded.

N. Credit

A review of the benefit payment logs submitted by the respondent reveals that the respondent paid $89,656.22 in TTD benefits. Therefore, the Arbitrator finds that the respondent is due credit of $89,656.22 for payments of TTD made to Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brad Prunkard,
Petitioner,

vs.

No: 12 WC 42797
No. 12 WC 42798

Vermillion Ass'n of Special Education,
Respondent.

15IWCC0678

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b), having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, temporary total disability, and penalties and fees, and being advised of the facts and law, reverses the Arbitrator's Decision in Case No. 042798, reduces the Arbitrator's award of penalties and fees and otherwise affirms and adopts the November 5, 2014 Section 19(b) Decision of Arbitrator William Gallagher in Case No. 12 WC 042797, both of which Decisions are attached hereto and made a part hereof. The Commission further remands Case No. 042797 to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 54 year old maintenance custodian, alleged two separate injuries to the same body part, his lumbar spine. In Case No. 12 WC 042797, he alleged a repetitive trauma injury to his "whole body" from doing labor and construction work, culminating on October 11, 2012. In Case No. 12 WC 042798, Petitioner alleged an acute injury to his "whole body" when he bent over to pick up lumber on November 30, 2012. These cases were consolidated and tried before Arbitrator Gallagher in Urbana on September 24, 2014. Arbitrator Gallagher found that Petitioner suffered two compensable work injuries and awarded him reasonable and necessary medical expenses, excluding those expenses related to Petitioner's treatment at L1-2 for his degenerative condition, temporary total disability for 95 weeks, and penalties and fees totaling $30,914.97. The Arbitrator denied Petitioner's request for prospective medical treatment, finding him at maximum medical improvement and in need of no further treatment.

Respondent appealed, arguing primarily that Petitioner's lower back condition was congenital and degenerative and that he aggravated his condition performing woodworking at home. Respondent further urged that the award of penalties and fees was unreasonable. Petitioner's treating physician conceded that Petitioner's spinal stenosis at L1-2 was not work-related, but causally connected Petitioner's need for two lumbar surgeries at L4-5 to his work activities. Petitioner suffered from pre-existing degenerative disc disease, which was likely exacerbated by his weight and smoking, but his employment required heavy lifting, turning and twisting, all of which added to the strain on his lumbar spine.

The Commission agrees with the Arbitrator that Petitioner's repetitive work activities were causally related to his need for his first lumbar surgery and that the failure of the first surgery to relieve Petitioner's complaints required a second revision surgery. The Commission, however, further finds that Petitioner failed to prove that he suffered a second separate and distinct acute work accident. The Commission finds the alleged second accident constituted a symptomatic flare-up of Petitioner's repetitive stress injury, without further trauma or damage. Therefore, the Commission reverses the Arbitrator's Decision in Case No. 12 WC 042798 and affirms the Decision in Case No. 12 WC 042797 with the modification described below.

The Commission finds the Arbitrator's award of penalties and fees excessive. Arbitrator Gallagher awarded Petitioner penalties and fees against Respondent for its failure to follow through on its pledge to bring Petitioner's temporary total disability payments up to date and continue paying until he reached maximum medical improvement. Respondent's pledge to pay followed a pre-trial conference between the parties held before Arbitrator McCarthy on June 19, 2013. On August 1, 2013, Petitioner's counsel wrote to Respondent's attorney in reference to the June pre-trial, Respondent's pledge to pay Petitioner temporary total disability, and Respondent's failure to make the promised payments. Respondent finally made payments of $8,310.75 on December 11 and $32,310.75 on December 26, 2013 and commenced regular weekly payments of $739.83 on December 27, 2013. On February 27, 2014, Respondent terminated the weekly payments based upon its §12 examiner's report.

Arbitrator Gallagher assessed penalties on the entire amount pledged and not paid by Respondent until December 2013, or a total of $40,621.50. Specifically, he assessed §19(k) penalties of $20,482.48, §19(l) penalties of $5,280.00 and §16 attorneys' fees of $5,152.49. Respondent argued on appeal that this amount was excessive. The Commission agrees with the Arbitrator that Respondent's behavior in failing to pay the pledged past due temporary total disability within a reasonable amount of time was egregious. However, the Commission reduces the amount of penalties and fees to a total of $11,662.78. The Commission bases its assessment of penalties and fees upon $8,877.96, representing the 12 weeks of back temporary total disability Respondent pledged, then failed, to pay within a reasonable amount of time following the pre-trial hearing referenced above. The Commission's calculations follow:

§19(k) penalties	$4,438.98
§19(l) penalties	5,280.00
§16 fees	1,943.80
Total penalties and fees	$11,662.78

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the November 5, 2014 Decision of the Arbitrator in Case No. 12 WC 042798 is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that the November 5, 2014 Decision of the Arbitrator in Case No. 12 WC 042797 is modified with regard to the amount of penalties and fees awarded, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $739.83 per week for a period of 95 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to Petitioner's lumbar spine injury, as contained in Petitioner's Exhibits 3, 4, 5, and 6, excluding those charges incurred for treatment pertaining to the surgery at L1-2, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $6,884.32 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for prospective medical as provided in Sections 8(a) and 8.2 of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties of $4,438.98, as provided in §19(k) of the Act, and $5,280.00, as provided in §19(l) of the Act. Respondent is further ordered to pay to Petitioner attorneys' fees of $1,943.80, as provided in §16 of the Act.

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

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

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 notice of intent to file for review in the Circuit Court has expired without the filing of such notice of intent, or after the time of completion of any judicial proceedings, if such a notice has been filed.

15IWCC0678

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

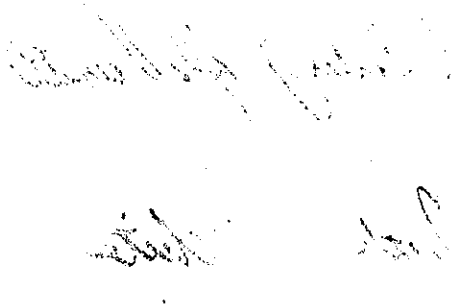
DATED: SEP 1 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/04/15
jdl/dak
68



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

PRUNKARD, BRAD
Employee/Petitioner

Case# **12WC042797**
12WC042798

VERMILION ASSOCIATION OF SPECIAL EDUCATION
Employer/Respondent

15IWCC0678

On 11/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO & LICHTENBERGER
TODD D LICHTENBERGER ESQ
510 N VERMILION ST
DANVILLE, IL 61832

2904 HENNESSY & ROACH PC
PAUL N BERNARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brad Prunkard
Employee/Petitioner

15IWCC0678

v.

Vermillion Association of Special Education
Employer/Respondent

Case # 12 WC 42797

Consolidated cases: 12 WC 42798

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on September 24, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident (manifestation), October 11, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $38,411.74; the average weekly wage was $1,109.74.

On the date of accident, Petitioner was 54 years of age, married with 1 dependent child(ren).

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

Respondent shall be given a credit of $48,485.32 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $48,485.32.

Respondent is entitled to a credit of $6,884.32 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibits 3, 4, 5 and 6 excluding those charges incurred for treatment pertaining to the surgery at L1-L2, as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit of $6,884.32 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner's petition for prospective medical is denied.

Respondent shall pay Petitioner temporary total disability benefits of $739.83 per week for 95 weeks, commencing October 23, 2012, through November 16, 2012, and December 3, 2012, through September 2, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner penalties of $5,152.49, as provided in Section 16 of Act; $20,482.48, as provided in Section 19(k) of the Act; and $5,280.00, as provided in Section 19(l) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 3, 2014
Date

NOV 5 - 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent. In 12 WC 42797, the Application alleged that Petitioner sustained a repetitive trauma injury to the "Whole Body" from doing "labor/construction." The Application alleged a date of accident (manifestation) of October 11, 2012 (Arbitrator's Exhibit 2). In 12 WC 42798, the Application alleged that on November 30, 2012, Petitioner was bending over to pick up lumber and sustained an injury to the "Whole Body." (Arbitrator's Exhibit 3). Prior to being tried, these two cases were consolidated.

These cases were tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Petitioner's counsel also filed a petition for Section 19(k) and Section 19(l) penalties as well as Section 16 attorneys' fees. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner worked for Respondent as a maintenance custodian. Petitioner testified that his job involved a significant amount of heavy construction including lifting walls and other things he was building. On October 11, 2012, Petitioner stated that he experienced low back pain and "catches" in his back that he attributed to the work he was doing.

Prior to the manifestation date, Petitioner sought medical treatment from Dr. Gary Page, a chiropractor, on October 3, 2012. At that time, Petitioner complained of neck and low back pain. Petitioner stated that the neck pain had been present since February 27, 2012, and he attributed it to the activities of daily living. In regard to the low back pain, Petitioner stated that he began to experience it on October 1, 2012, at his place of employment. Dr. Page diagnosed Petitioner with a lumbosacral sprain/strain (Petitioner's Exhibit 1).

Petitioner continued to work and was again seen by Dr. Page on October 12, 2012. Dr. Page's record of that date again noted that Petitioner's low back pain began on October 1, 2012, and was caused by Petitioner's work activities (Petitioner's Exhibit 1).

Petitioner subsequently sought medical treatment at Carle Spine Institute on October 16, 2012, when he was seen by Dr. Zeeshan Ahmad. At that time, Petitioner complained of right buttock pain going down the leg which he had been experiencing for three to four months. Petitioner stated that virtually anything exacerbated the pain especially prolonged standing. Dr. Ahmad authorized Petitioner to return to work with a 20 pound lifting restriction and that Petitioner be allowed to sit every two hours. He ordered an MRI scan (Petitioner's Exhibit 2).

An MRI scan of the lumbar spine was performed on October 23, 2012, which revealed multilevel degenerative disc disease and a severe spinal stenosis at L1-L2. Dr. Ahmad saw Petitioner on October 25, 2012, and reviewed the MRI scan. He opined that Petitioner's complaints of sciatic pain were more consistent with a disc herniation at L4-L5 on the right side. He recommended Petitioner have an epidural steroid injection and continued Petitioner's work restrictions (Petitioner's Exhibit 2).

On October 31, 2012, Dr. Ahmad gave Petitioner an epidural steroid injection at L4-L5. On November 16, 2012, a physician with Carle (whose signature illegible) authorized Petitioner to return to work but with lifting restrictions and Petitioner being permitted to sit every 30 minutes if needed (Petitioner's Exhibit 2).

Petitioner testified that he returned to work for Respondent and, on November 30, 2012, he was in the process of building wall with two by fours. He bent over to pick up the framework of a wall and experienced excruciating pain in his low back.

Petitioner was subsequently seen by Dr. Ahmad on December 3, 2012, who referred him to Dr. James Harms, an orthopedic surgeon, who evaluated Petitioner that same day. Dr. Harms also reviewed the MRI and opined that it revealed severe narrowing of the spinal canal at L1-L2 and almost as severe narrowing at L4-L5 but with a herniated disc. Dr. Harms authorized Petitioner to be completely off work and recommended surgery (Petitioner's Exhibit 2).

Dr. Harms performed surgery on December 7, 2012, and the procedure consisted of a laminotomy at L1-L2 bilaterally and a laminotomy at L4-L5 bilaterally. After the surgery, Petitioner received physical therapy and, on February 27, 2013, Dr. Harms released Petitioner to return to work with restrictions of no lifting, pushing or pulling anything in excess of 25 pounds (Petitioner's Exhibit 2).

When seen at physical therapy on March 5, 2013, Petitioner reported that he had no back pain but that it had ached for 24 hours after his last session. The Carle records indicated that on March 12, 2013, Petitioner called and advised that he woke up Monday morning with a sharp pain in his back and that he had been doing some woodworking that weekend (Petitioner's Exhibit 2).

At trial, Petitioner testified that he has a small workshop at his house where he does some woodworking. However, Petitioner stated that he builds small wooden objects such as birdhouses and towel racks and that the heaviest thing he might build would be no more than three to four pounds.

Petitioner continued to receive physical therapy. When Petitioner was seen by Dr. Harms on April 24, 2013, Petitioner advised that he had a flare-up of his back pain because of repetitive lifting he was required to do at physical therapy (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Michael Kornblatt, an orthopedic surgeon, on April 29, 2013. In connection with his examination of Petitioner, Dr. Kornblatt reviewed medical records provided to him by Respondent. In his report dated May 2, 2013, Dr. Kornblatt opined that the herniated disc at L4-L5 was caused by Petitioner's work activities but that the spinal stenosis at L1-L2 was not related to Petitioner's work activities. He further opined that the accident of November 30, 2012, was an aggravation of Petitioner's pre-existing condition at L4-L5 and that the surgery of December 7, 2012, at L4-L5 was appropriate. He further opined that Petitioner could work with restrictions of lifting occasionally up to 30 pounds and frequently up to 15 pounds (Respondent's Exhibit 2; Deposition Exhibit 2).

Petitioner continued to receive physical therapy and, on May 15, 2013, a second MRI scan of the lumbar spine was performed. This scan revealed a recurrent right paracentral extrusion versus free disc fragment at L4-L5. Dr. Harms saw Petitioner that same day and recommended Petitioner undergo another epidural steroid injection. On May 17, 2013, Dr. Ahmad performed an epidural steroid injection at L4-L5 but Petitioner did not experience any significant relief (Petitioner's Exhibit 2).

Dr. Harms performed a second back surgery on June 4, 2013, and the procedure consisted of a laminotomy and discectomy at L4-L5 on the right side. Following the surgery, Petitioner continued to be seen by Dr. Harms who again ordered physical therapy (Petitioner's Exhibit 2).

When Dr. Harms saw Petitioner on November 11, 2013, Petitioner informed him that physical therapy was not helping. Dr. Harms opined that Petitioner should have a neurological consultation and he restricted Petitioner's lifting to no more than 10 pounds (Petitioner's Exhibit 2).

On December 3, 2013, Petitioner was seen by Dr. Kenneth Aronson, a neurologist, who performed nerve conduction studies at that time. The nerve conduction studies of the right lower extremity were normal; however, denervative changes were noted consistent with L5-S1 radicular symptoms (Petitioner's Exhibit 2).

On December 11, 2013, Petitioner was again seen by Dr. Harms and, because of Petitioner's continued pain symptoms, he recommended Petitioner work with a Rehabilitation Medicine doctor to see if some other non-operative measures could be taken. He opined that further surgery was not an option (Petitioner's Exhibit 2).

On January 20, 2014, Petitioner was seen by Dr. Victoria Johnson. Petitioner still had back pain as well as right leg pain that radiated to the ankle. Petitioner believed that he had reached a plateau. Dr. Johnson ordered a right SI joint injection which was subsequently performed by Dr. Ahmad on January 24, 2014. This injection did not relieve any of Petitioner's symptoms (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Dru Hauter, an occupational medicine specialist, on February 12, 2014. In connection with his examination of Petitioner, Dr. Hauter reviewed medical reports provided to him by Respondent. Dr. Hauter's impression was lumbar degenerative disc disease, lumbar congenital spinal stenosis and chronic back pain. Dr. Hauter opined that Petitioner's conditions were not related to any work injury, Petitioner's work restrictions were related to the spinal stenosis and not to the lumbar spine surgeries and that Petitioner was at MMI by March 1, 2013, which was prior to the injury Petitioner sustained while woodworking (Respondent's Exhibit 4; Deposition Exhibit 2).

Petitioner continued to be treated by Dr. Johnson who prescribed aquatic therapy and continued the 25 pound lifting restriction when she saw Petitioner on February 20, 2014. Petitioner continued to be seen by Dr. Johnson in April, May and June, 2014, and he continued aquatic therapy (Petitioner's Exhibit 2).

When Dr. Johnson saw Petitioner on June 10, 2014, she suggested referral to either a chiropractor or the Pain Treatment Center. On August 1, 2014, Petitioner was seen by Dr. Shabeera Rauther, he physician with the Department of Interventional Pain Center. Dr. Rauther opined that Petitioner had a possible piriformis syndrome and recommended either a caudal injection or a piriformis muscle injection (Petitioner's Exhibit 2).

Dr. Johnson again saw Petitioner on September 2, 2014, and she opined that Petitioner had a chronic pain syndrome and that not much more could be done for him. According to her record of that date, Dr. Rauther had previously suggested a spinal cord stimulator but Petitioner was not interested in obtaining one. Dr. Johnson also noted that no further surgery had been recommended (Petitioner's Exhibit 2).

Dr. Harms was deposed on October 7, 2013, and again on June 9, 2014, and his deposition testimony was received into evidence at trial. When Dr. Harms was deposed on October 7, 2013, he stated that when he performed the laminotomies on December 7, 2012, he opened up the spinal canal at both L1-L2 and L4-L5. Dr. Harms also removed a portion of disc material at L4-L5 that had come out of its normal space. The second surgery Dr. Harms performed on June 4, 2013, was limited to the L4-L5 level. He further testified that the hole did not close and when he operated for the second time on June 4, 2013, another piece of disc bulged out in that same area (Petitioner's Exhibit 16; pp 10, 22).

In regard to causality, when he was deposed, Dr. Harms reviewed a copy of Dr. Kornblatt's report of May 2, 2013. He agreed with Dr. Kornblatt's opinion that the disc pathology at L4-L5 was related to Petitioner's work activities, but that the L1-L2 spinal stenosis was not related to Petitioner's work activities; rather it was related to the degenerative condition of the spine (Petitioner's Exhibit 16; pp 20 – 21).

When Dr. Harms was re-deposed on June 9, 2014, he testified that the last time he saw Petitioner was on December 11, 2013, and that a 25 pound lifting restriction was appropriate. He reaffirmed his opinion that Petitioner's first surgery was work-related and that it set in place a chain of events that led to the second surgery (Petitioner's Exhibit 17; pp 5-7; 26-27).

On cross-examination, Dr. Harms agreed that Petitioner would have required "some type of back surgery" because of the degenerative conditions regardless of whether he sustained any work injuries. He was also questioned about Petitioner's woodworking activities of March, 2013, and agreed that it was "possible" that Petitioner reinjured his back while woodworking (Petitioner's Exhibit 17; pp 20-21).

Dr. Kornblatt was deposed on November 18, 2013, and his deposition testimony was received into evidence at trial. Dr. Kornblatt's testimony was consistent with his medical report and he reaffirmed his opinion that the stenosis at L1-L2 was not work-related but that the condition at L4-L5 was work-related, primarily because it would have required a traumatic event or repetitive traumatic events to cause the disc pathology at L4-L5. He further agreed that Petitioner's work restrictions would have been the same even without the surgical procedure that was performed at L1-L2. Dr. Kornblatt also opined that the second surgery was because of degenerative conditions

of the lumbar spine at L4-L5 and was thereby not work-related (Respondent's Exhibit 2; pp 10-14).

Dr. Hauter was deposed on August 4, 2014, and his deposition testimony was received into evidence at trial. Dr. Hauter's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner's back condition was caused by congenital deformities and degenerative changes and was not work-related. He further opined that Petitioner would have been at MMI on March 1, 2013, but that Petitioner had a re-injury over the weekend of March 12, 2013. On cross-examination, Dr. Hauter agreed that he had nothing more specific about the details of Petitioner's woodworking at home (Respondent's Exhibit 2; pp 9-12; 20-21).

Petitioner testified that he did not work between October 23, 2012, and November 16, 2012, and that he has not worked at all since November 30, 2012. Petitioner's treating physicians have had him either off work completely or subject to work restrictions which Respondent was unable to accommodate. Petitioner testified that he continues to be seen by Dr. Johnson and has a restriction of no lifting more than 20 pounds and no excessive bending and turning.

In regard to payment of temporary total disability benefits, Petitioner testified that he received a small amount sometime in May, 2013. According to the payment record tendered into evidence by Respondent, a payment in the amount of $1,205.35 was issued to Petitioner's counsel on May 9, 2013 (Respondent's Exhibit 3). The case was pre-tried before Arbitrator McCarthy on June 19, 2013, and, based on an agreement that an immediate payment of temporary total disability of 12 weeks would be made and, pending receipt of further information regarding Petitioner's second job earnings and treatment and restrictions in regard to the injury at L4-L5, temporary total disability benefits would be brought up to date and continued until Petitioner was at MMI. This understanding was confirmed in a letter from Petitioner's counsel to Respondent's counsel dated June 20, 2013 (Petitioner's Exhibit 12).

Petitioner's counsel subsequently wrote Respondent's counsel on August 1, 2013, and again referenced the pre-trial of June 19, 2013, and advised that Petitioner had not received any additional payment of temporary total disability benefits (Petitioner's Exhibit 15). According to Respondent's payment records, temporary total disability checks of $8,310.75 and $32,310.75 payable to Petitioner's counsel were issued on December 11, and December 26, 2013, respectively. Petitioner was then paid temporary total disability benefits of $739.83 per week from December 27, 2013, through February 27, 2014 (Respondent's Exhibit 3). Respondent then terminated payment of temporary total disability benefits based on Dr. Hauter's report.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested on October 11, 2012, and an accidental injury arising out of and in the course of his employment for Respondent on November 30, 2012, and that Petitioner's current condition of ill-being is, in part, causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive trauma injury that manifested itself on October 11, 2012, and the accident of November 30, 2012, was unrebutted. At trial, Respondent disputed accident; however, Respondent did not tender any lay testimony regarding same.

The records of Petitioner's treating chiropractor, Dr. Page, indicated that Petitioner began experiencing low back pain on October 1, 2012; however, Petitioner continued to engage in the repetitive activity through at least October 11, 2012.

Petitioner's treating physician, Dr. Harms, testified that Petitioner's low back condition was work-related and that the first surgery of December 7, 2012, was related to Petitioner's work activities in regard to the L4-L5 level. He did agree that the pathology observed at L1-L2 was not work-related.

Respondent's Section 12 examiner, Dr. Kornblatt, agreed that Petitioner's low back condition was work-related in regard to the pathology at L4-L5 but not at L1-L2 and that the surgery at L4-L5 performed on December 7, 2012, was causally related to Petitioner's work activities.

In regard to the second back surgery of June 4, 2013, Dr. Harms testified that this was causally related to Petitioner's work activities. Contrary to his prior opinion, Dr. Kornblatt opined that the surgery of June 4, 2013, was because of the degenerative changes in Petitioner's lumbar spine and was not work-related.

Respondent's second Section 12 examiner, Dr. Hauter, opined that none of Petitioner's lumbar spine conditions were related to his work and subsequently referenced what he described as another accident that occurred over the weekend of March 12, 2013, when Petitioner was woodworking.

The Arbitrator finds the opinions of Dr. Harms and Dr. Kornblatt to be consistent in regard to the issue of causality and the need for the surgery of December 7, 2012.

In regard to causality and the second surgery of June 4, 2013, the Arbitrator finds the opinion of Dr. Harms to be more persuasive than that of Dr. Kornblatt or Dr. Hauter.

The Arbitrator finds that there is insufficient evidence to find the Petitioner sustained some type of intervening accident while woodworking in March, 2013. Petitioner testified that he would work with very small objects such as towel racks and birdhouses that did not exceed three to four pounds. Further, at that time Petitioner was still under active medical care and was not at MMI.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and, with the exception of the treatment provided in regard to the surgery at L1-L2, Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibits 3, 4, 5 and 6 excluding those charges incurred for treatment pertaining to the surgery at L1-L2, as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit of $6,884.32 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

Dr. Harms has stated that further surgery is not an option for Petitioner.

Dr. Johnson has opined that as of the last time she saw Petitioner on September 2, 2014, that not much more could be done for him.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 95 weeks commencing October 23, 2012 through November 16, 2012, and December 3, 2012, through September 2, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physicians had Petitioner either off work completely or subject to restrictions that Respondent could not accommodate.

While the pathology at L1-L2 was not related to Petitioner's work activities, Respondent's Section 12 examiner, Dr. Kornblatt, opined that this condition had no effect on Petitioner's work restrictions.

Dr. Johnson indicated that on September 2, 2014, there was not much else that could be done for Petitioner. The Arbitrator thereby finds Petitioner to be at MMI as of that date.

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

The Arbitrator concludes that Respondent is liable for Section 19(k) penalties of $20,482.48, Section 19(l) penalties of $5,280 and Section 16 attorneys' fees of $5,152.49.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's conclusion of law in disputed issues (C) and (F), Respondent did not tender any lay testimony that disputed that Petitioner sustained either or a repetitive trauma injury that manifested itself on October 11, 2012, or an accidental injury on November 30, 2012.

Respondent's first Section 12 examiner, Dr. Kornblatt, opined in his report of May 2, 2013, that Petitioner's low back condition in regard to the pathology at L4-L5 was work-related and that Petitioner had work restrictions. This may have been the basis of Respondent's payment of two weeks temporary total disability benefits that Respondent issued on May 9, 2013. Respondent did not; however, pay any of the other past accrued temporary total disability benefits.

When the case was pre-tried on June 19, 2013, Petitioner's counsel agreed not to proceed with a 19(b) hearing because Respondent agreed to immediately pay Petitioner 12 weeks temporary total disability benefits and, thereafter, bring temporary total disability benefits up to date pending receipt of some additional information. In spite of this, no payment was made to Petitioner's counsel until December 11, 2013, 176 days after the pretrial.

The Arbitrator finds Respondent's delay of 176 days in paying Petitioner temporary total disability benefits, after it had agreed to do so, to be unreasonable and vexatious.

The total period of temporary total disability benefits owed as of December 11, 2013, was 57 weeks, October 23, 2012, through November 16, 2012, and December 3, 2012, through December 10, 2013. The total accrued temporary total disability benefits for that period of time, at the rate of $739.83 per week, was $42,170.31. Respondent is entitled to a credit of $1,205.35 for the payment made on May 9, 2013, making that the total amount of temporary total disability benefits owed was $40,964.96. The appropriate Section 19(k) penalties are 50% of that amount, $20,482.48.

The Section 19(l) penalties are $30.00 a day for 176 days, a total of $5,280.

The Section 16 attorneys' fees are $5,152.49 (20% of $25,762.48).

The Arbitrator declines to award penalties and attorneys' fees for medical expenses.

William R. Gallagher, Arbitrator

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

PRUNKARD, BRAD
Employee/Petitioner

Case# **12WC042798**

12WC042797

VERMILION ASSOCIATION OF SPECIAL EDUCATION
Employer/Respondent

15IWCC0678

On 11/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO & LICHTENBERGER
TODD D LICHTENBERGER ESQ
510 N VERMILION ST
DANVILLE, IL 61832

2904 HENNESSY & ROACH PC
PAUL N BERNARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brad Prunkard
Employee/Petitioner

v.

Vermillion Association of Special Education
Employer/Respondent

15IWCC0678

Case # 12 WC 42798

Consolidated cases: 12 WC 42797

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on September 24, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, November 30, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $38,411.74; the average weekly wage was $1,109.74.

On the date of accident, Petitioner was 54 years of age, married with 1 dependent child(ren).

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

Respondent shall be given a credit of $48,485.32 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $48,485.32.

Respondent is entitled to a credit of $6,884.32 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibits 3, 4, 5 and 6 excluding those charges incurred for treatment pertaining to the surgery at L1-L2, as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit of $6,884.32 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner's petition for prospective medical is denied.

Respondent shall pay Petitioner temporary total disability benefits of $739.83 per week for 95 weeks, commencing October 23, 2012, through November 16, 2012, and December 3, 2012, through September 2, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner penalties of $5,152.49, as provided in Section 16 of Act; $20,482.48, as provided in Section 19(k) of the Act; and $5,280.00, as provided in Section 19(l) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 3, 2014
Date

NOV 5 - 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent. In 12 WC 42797, the Application alleged that Petitioner sustained a repetitive trauma injury to the "Whole Body" from doing "labor/construction." The Application alleged a date of accident (manifestation) of October 11, 2012 (Arbitrator's Exhibit 2). In 12 WC 42798, the Application alleged that on November 30, 2012, Petitioner was bending over to pick up lumber and sustained an injury to the "Whole Body." (Arbitrator's Exhibit 3). Prior to being tried, these two cases were consolidated.

These cases were tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Petitioner's counsel also filed a petition for Section 19(k) and Section 19(l) penalties as well as Section 16 attorneys' fees. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner worked for Respondent as a maintenance custodian. Petitioner testified that his job involved a significant amount of heavy construction including lifting walls and other things he was building. On October 11, 2012, Petitioner stated that he experienced low back pain and "catches" in his back that he attributed to the work he was doing.

Prior to the manifestation date, Petitioner sought medical treatment from Dr. Gary Page, a chiropractor, on October 3, 2012. At that time, Petitioner complained of neck and low back pain. Petitioner stated that the neck pain had been present since February 27, 2012, and he attributed it to the activities of daily living. In regard to the low back pain, Petitioner stated that he began to experience it on October 1, 2012, at his place of employment. Dr. Page diagnosed Petitioner with a lumbosacral sprain/strain (Petitioner's Exhibit 1).

Petitioner continued to work and was again seen by Dr. Page on October 12, 2012. Dr. Page's record of that date again noted that Petitioner's low back pain began on October 1, 2012, and was caused by Petitioner's work activities (Petitioner's Exhibit 1).

Petitioner subsequently sought medical treatment at Carle Spine Institute on October 16, 2012, when he was seen by Dr. Zeeshan Ahmad. At that time, Petitioner complained of right buttock pain going down the leg which he had been experiencing for three to four months. Petitioner stated that virtually anything exacerbated the pain,especially prolonged standing. Dr. Ahmad authorized Petitioner to return to work with a 20 pound lifting restriction and that Petitioner be allowed to sit every two hours. He ordered an MRI scan (Petitioner's Exhibit 2).

An MRI scan of the lumbar spine was performed on October 23, 2012, which revealed multilevel degenerative disc disease and a severe spinal stenosis at L1-L2. Dr. Ahmad saw Petitioner on October 25, 2012, and reviewed the MRI scan. He opined that Petitioner's complaints of sciatic pain were more consistent with a disc herniation at L4-L5 on the right side. He recommended Petitioner have an epidural steroid injection and continued Petitioner's work restrictions (Petitioner's Exhibit 2).

On October 31, 2012, Dr. Ahmad gave Petitioner an epidural steroid injection at L4-L5. On November 16, 2012, a physician with Carle (whose signature illegible) authorized Petitioner to return to work but with lifting restrictions and Petitioner being permitted to sit every 30 minutes if needed (Petitioner's Exhibit 2).

Petitioner testified that he returned to work for Respondent and, on November 30, 2012, he was in the process of building wall with two by fours. He bent over to pick up the framework of a wall and experienced excruciating pain in his low back.

Petitioner was subsequently seen by Dr. Ahmad on December 3, 2012, who referred him to Dr. James Harms, an orthopedic surgeon, who evaluated Petitioner that same day. Dr. Harms also reviewed the MRI and opined that it revealed severe narrowing of the spinal canal at L1-L2 and almost as severe narrowing at L4-L5 but with a herniated disc. Dr. Harms authorized Petitioner to be completely off work and recommended surgery (Petitioner's Exhibit 2).

Dr. Harms performed surgery on December 7, 2012, and the procedure consisted of a laminotomy at L1-L2 bilaterally and a laminotomy at L4-L5 bilaterally. After the surgery, Petitioner received physical therapy and, on February 27, 2013, Dr. Harms released Petitioner to return to work with restrictions of no lifting, pushing or pulling anything in excess of 25 pounds (Petitioner's Exhibit 2).

When seen at physical therapy on March 5, 2013, Petitioner reported that he had no back pain but that it had ached for 24 hours after his last session. The Carle records indicated that on March 12, 2013, Petitioner called and advised that he woke up Monday morning with a sharp pain in his back and that he had been doing some woodworking that weekend (Petitioner's Exhibit 2).

At trial, Petitioner testified that he has a small workshop at his house where he does some woodworking. However, Petitioner stated that he builds small wooden objects such as birdhouses and towel racks and that the heaviest thing he might build would be no more than three to four pounds.

Petitioner continued to receive physical therapy. When Petitioner was seen by Dr. Harms on April 24, 2013, Petitioner advised that he had a flare-up of his back pain because of repetitive lifting he was required to do at physical therapy (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Michael Kornblatt, an orthopedic surgeon, on April 29, 2013. In connection with his examination of Petitioner, Dr. Kornblatt reviewed medical records provided to him by Respondent. In his report dated May 2, 2013, Dr. Kornblatt opined that the herniated disc at L4-L5 was caused by Petitioner's work activities but that the spinal stenosis at L1-L2 was not related to Petitioner's work activities. He further opined that the accident of November 30, 2012, was an aggravation of Petitioner's pre-existing condition at L4-L5 and that the surgery of December 7, 2012, at L4-L5 was appropriate. He further opined that Petitioner could work with restrictions of lifting occasionally up to 30 pounds and frequently up to 15 pounds (Respondent's Exhibit 2; Deposition Exhibit 2).

Petitioner continued to receive physical therapy and, on May 15, 2013, a second MRI scan of the lumbar spine was performed. This scan revealed a recurrent right paracentral extrusion versus free disc fragment at L4-L5. Dr. Harms saw Petitioner that same day and recommended Petitioner undergo another epidural steroid injection. On May 17, 2013, Dr. Ahmad performed an epidural steroid injection at L4-L5 but Petitioner did not experience any significant relief (Petitioner's Exhibit 2).

Dr. Harms performed a second back surgery on June 4, 2013, and the procedure consisted of a laminotomy and discectomy at L4-L5 on the right side. Following the surgery, Petitioner continued to be seen by Dr. Harms who again ordered physical therapy (Petitioner's Exhibit 2).

When Dr. Harms saw Petitioner on November 11, 2013, Petitioner informed him that physical therapy was not helping. Dr. Harms opined that Petitioner should have a neurological consultation and he restricted Petitioner's lifting to no more than 10 pounds (Petitioner's Exhibit 2).

On December 3, 2013, Petitioner was seen by Dr. Kenneth Aronson, a neurologist, who performed nerve conduction studies at that time. The nerve conduction studies of the right lower extremity were normal; however, denervative changes were noted consistent with L5-S1 radicular symptoms (Petitioner's Exhibit 2).

On December 11, 2013, Petitioner was again seen by Dr. Harms and, because of Petitioner's continued pain symptoms, he recommended Petitioner work with a Rehabilitation Medicine doctor to see if some other non-operative measures could be taken. He opined that further surgery was not an option (Petitioner's Exhibit 2).

On January 20, 2014, Petitioner was seen by Dr. Victoria Johnson. Petitioner still had back pain as well as right leg pain that radiated to the ankle. Petitioner believed that he had reached a plateau. Dr. Johnson ordered a right SI joint injection which was subsequently performed by Dr. Ahmad on January 24, 2014. This injection did not relieve any of Petitioner's symptoms (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Dru Hauter, an occupational medicine specialist, on February 12, 2014. In connection with his examination of Petitioner, Dr. Hauter reviewed medical reports provided to him by Respondent. Dr. Hauter's impression was lumbar degenerative disc disease, lumbar congenital spinal stenosis and chronic back pain. Dr. Hauter opined that Petitioner's conditions were not related to any work injury, Petitioner's work restrictions were related to the spinal stenosis and not to the lumbar spine surgeries and that Petitioner was at MMI by March 1, 2013, which was prior to the injury Petitioner sustained while woodworking (Respondent's Exhibit 4; Deposition Exhibit 2).

Petitioner continued to be treated by Dr. Johnson who prescribed aquatic therapy and continued the 25 pound lifting restriction when she saw Petitioner on February 20, 2014. Petitioner continued to be seen by Dr. Johnson in April, May and June, 2014, and he continued aquatic therapy (Petitioner's Exhibit 2).

When Dr. Johnson saw Petitioner on June 10, 2014, she suggested referral to either a chiropractor or the Pain Treatment Center. On August 1, 2014, Petitioner was seen by Dr. Shabeera Rauther, he physician with the Department of Interventional Pain Center. Dr. Rauther opined that Petitioner had a possible piriformis syndrome and recommended either a caudal injection or a piriformis muscle injection (Petitioner's Exhibit 2).

Dr. Johnson again saw Petitioner on September 2, 2014, and she opined that Petitioner had a chronic pain syndrome and that not much more could be done for him. According to her record of that date, Dr. Rauther had previously suggested a spinal cord stimulator but Petitioner was not interested in obtaining one. Dr. Johnson also noted that no further surgery had been recommended (Petitioner's Exhibit 2).

Dr. Harms was deposed on October 7, 2013, and again on June 9, 2014, and his deposition testimony was received into evidence at trial. When Dr. Harms was deposed on October 7, 2013, he stated that when he performed the laminotomies on December 7, 2012, he opened up the spinal canal at both L1-L2 and L4-L5. Dr. Harms also removed a portion of disc material at L4-L5 that had come out of its normal space. The second surgery Dr. Harms performed on June 4, 2013, was limited to the L4-L5 level. He further testified that the hole did not close and when he operated for the second time on June 4, 2013, another piece of disc bulged out in that same area (Petitioner's Exhibit 16; pp 10, 22).

In regard to causality, when he was deposed, Dr. Harms reviewed a copy of Dr. Kornblatt's report of May 2, 2013. He agreed with Dr. Kornblatt's opinion that the disc pathology at L4-L5 was related to Petitioner's work activities, but that the L1-L2 spinal stenosis was not related to Petitioner's work activities; rather it was related to the degenerative condition of the spine (Petitioner's Exhibit 16; pp 20 – 21).

When Dr. Harms was re-deposed on June 9, 2014, he testified that the last time he saw Petitioner was on December 11, 2013, and that a 25 pound lifting restriction was appropriate. He reaffirmed his opinion that Petitioner's first surgery was work-related and that it set in place a chain of events that led to the second surgery (Petitioner's Exhibit 17; pp 5-7; 26-27).

On cross-examination, Dr. Harms agreed that Petitioner would have required "some type of back surgery" because of the degenerative conditions regardless of whether he sustained any work injuries. He was also questioned about Petitioner's woodworking activities of March, 2013, and agreed that it was "possible" that Petitioner reinjured his back while woodworking (Petitioner's Exhibit 17; pp 20-21).

Dr. Kornblatt was deposed on November 18, 2013, and his deposition testimony was received into evidence at trial. Dr. Kornblatt's testimony was consistent with his medical report and he reaffirmed his opinion that the stenosis at L1-L2 was not work-related but that the condition at L4-L5 was work-related, primarily because it would have required a traumatic event or repetitive traumatic events to cause the disc pathology at L4-L5. He further agreed that Petitioner's work restrictions would have been the same even without the surgical procedure that was performed at L1-L2. Dr. Kornblatt also opined that the second surgery was because of degenerative conditions

of the lumbar spine at L4-L5 and was thereby not work-related (Respondent's Exhibit 2; pp 10-14).

Dr. Hauter was deposed on August 4, 2014, and his deposition testimony was received into evidence at trial. Dr. Hauter's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner's back condition was caused by congenital deformities and degenerative changes and was not work-related. He further opined that Petitioner would have been at MMI on March 1, 2013, but that Petitioner had a re-injury over the weekend of March 12, 2013. On cross-examination, Dr. Hauter agreed that he had nothing more specific about the details of Petitioner's woodworking at home (Respondent's Exhibit 2; pp 9-12; 20-21).

Petitioner testified that he did not work between October 23, 2012, and November 16, 2012, and that he has not worked at all since November 30, 2012. Petitioner's treating physicians have had him either off work completely or subject to work restrictions which Respondent was unable to accommodate. Petitioner testified that he continues to be seen by Dr. Johnson and has a restriction of no lifting more than 20 pounds and no excessive bending and turning.

In regard to payment of temporary total disability benefits, Petitioner testified that he received a small amount sometime in May, 2013. According to the payment record tendered into evidence by Respondent, a payment in the amount of $1,205.35 was issued to Petitioner's counsel on May 9, 2013 (Respondent's Exhibit 3). The case was pre-tried before Arbitrator McCarthy on June 19, 2013, and, based on an agreement that an immediate payment of temporary total disability of 12 weeks would be made and, pending receipt of further information regarding Petitioner's second job earnings and treatment and restrictions in regard to the injury at L4-L5, temporary total disability benefits would be brought up to date and continued until Petitioner was at MMI. This understanding was confirmed in a letter from Petitioner's counsel to Respondent's counsel dated June 20, 2013 (Petitioner's Exhibit 12).

Petitioner's counsel subsequently wrote Respondent's counsel on August 1, 2013, and again referenced the pre-trial of June 19, 2013, and advised that Petitioner had not received any additional payment of temporary total disability benefits (Petitioner's Exhibit 15). According to Respondent's payment records, temporary total disability checks of $8,310.75 and $32,310.75 payable to Petitioner's counsel were issued on December 11, and December 26, 2013, respectively. Petitioner was then paid temporary total disability benefits of $739.83 per week from December 27, 2013, through February 27, 2014 (Respondent's Exhibit 3). Respondent then terminated payment of temporary total disability benefits based on Dr. Hauter's report.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested on October 11, 2012, and an accidental injury arising out of and in the course of his employment for Respondent on November 30, 2012, and that Petitioner's current condition of ill-being is, in part, causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive trauma injury that manifested itself on October 11, 2012, and the accident of November 30, 2012, was unrebutted. At trial, Respondent disputed accident; however, Respondent did not tender any lay testimony regarding same.

The records of Petitioner's treating chiropractor, Dr. Page, indicated that Petitioner began experiencing low back pain on October 1, 2012; however, Petitioner continued to engage in the repetitive activity through at least October 11, 2012.

Petitioner's treating physician, Dr. Harms, testified that Petitioner's low back condition was work-related and that the first surgery of December 7, 2012, was related to Petitioner's work activities in regard to the L4-L5 level. He did agree that the pathology observed at L1-L2 was not work-related.

Respondent's Section 12 examiner, Dr. Kornblatt, agreed that Petitioner's low back condition was work-related in regard to the pathology at L4-L5 but not at L1-L2 and that the surgery at L4-L5 performed on December 7, 2012, was causally related to Petitioner's work activities.

In regard to the second back surgery of June 4, 2013, Dr. Harms testified that this was causally related to Petitioner's work activities. Contrary to his prior opinion, Dr. Kornblatt opined that the surgery of June 4, 2013, was because of the degenerative changes in Petitioner's lumbar spine and was not work-related.

Respondent's second Section 12 examiner, Dr. Hauter, opined that none of Petitioner's lumbar spine conditions were related to his work and subsequently referenced what he described as another accident that occurred over the weekend of March 12, 2013, when Petitioner was woodworking.

The Arbitrator finds the opinions of Dr. Harms and Dr. Kornblatt to be consistent in regard to the issue of causality and the need for the surgery of December 7, 2012.

In regard to causality and the second surgery of June 4, 2013, the Arbitrator finds the opinion of Dr. Harms to be more persuasive than that of Dr. Kornblatt or Dr. Hauter.

The Arbitrator finds that there is insufficient evidence to find the Petitioner sustained some type of intervening accident while woodworking in March, 2013. Petitioner testified that he would work with very small objects such as towel racks and birdhouses that did not exceed three to four pounds. Further, at that time Petitioner was still under active medical care and was not at MMI.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and, with the exception of the treatment provided in regard to the surgery at L1-L2, Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibits 3, 4, 5 and 6 excluding those charges incurred for treatment pertaining to the surgery at L1-L2, as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit of $6,884.32 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

Dr. Harms has stated that further surgery is not an option for Petitioner.

Dr. Johnson has opined that as of the last time she saw Petitioner on September 2, 2014, that not much more could be done for him.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 95 weeks commencing October 23, 2012 through November 16, 2012, and December 3, 2012, through September 2, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physicians had Petitioner either off work completely or subject to restrictions that Respondent could not accommodate.

While the pathology at L1-L2 was not related to Petitioner's work activities, Respondent's Section 12 examiner, Dr. Kornblatt, opined that this condition had no effect on Petitioner's work restrictions.

Dr. Johnson indicated that on September 2, 2014, there was not much else that could be done for Petitioner. The Arbitrator thereby finds Petitioner to be at MMI as of that date.

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

The Arbitrator concludes that Respondent is liable for Section 19(k) penalties of $20,482.48, Section 19(l) penalties of $5,280 and Section 16 attorneys' fees of $5,152.49.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's conclusion of law in disputed issues (C) and (F), Respondent did not tender any lay testimony that disputed that Petitioner sustained either or a repetitive trauma injury that manifested itself on October 11, 2012, or an accidental injury on November 30, 2012.

Respondent's first Section 12 examiner, Dr. Kornblatt, opined in his report of May 2, 2013, that Petitioner's low back condition in regard to the pathology at L4-L5 was work-related and that Petitioner had work restrictions. This may have been the basis of Respondent's payment of two weeks temporary total disability benefits that Respondent issued on May 9, 2013. Respondent did not; however, pay any of the other past accrued temporary total disability benefits.

When the case was pre-tried on June 19, 2013, Petitioner's counsel agreed not to proceed with a 19(b) hearing because Respondent agreed to immediately pay Petitioner 12 weeks temporary total disability benefits and, thereafter, bring temporary total disability benefits up to date pending receipt of some additional information. In spite of this, no payment was made to Petitioner's counsel until December 11, 2013, 176 days after the pretrial.

The Arbitrator finds Respondent's delay of 176 days in paying Petitioner temporary total disability benefits, after it had agreed to do so, to be unreasonable and vexatious.

The total period of temporary total disability benefits owed as of December 11, 2013, was 57 weeks, October 23, 2012, through November 16, 2012, and December 3, 2012, through December 10, 2013. The total accrued temporary total disability benefits for that period of time, at the rate of $739.83 per week, was $42,170.31. Respondent is entitled to a credit of $1,205.35 for the payment made on May 9, 2013, making that the total amount of temporary total disability benefits owed was $40,964.96. The appropriate Section 19(k) penalties are 50% of that amount, $20,482.48.

The Section 19(l) penalties are $30.00 a day for 176 days, a total of $5,280.

The Section 16 attorneys' fees are $5,152.49 (20% of $25,762.48).

The Arbitrator declines to award penalties and attorneys' fees for medical expenses.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Allgood,
Petitioner,

vs. NO: 10 WC 38659

15IWCC0681

State of Illinois, Decatur Correctional Center,
Respondent,

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Gallagher finding Petitioner sustained an accidental injury arising out of and in the course of her employment on August 1, 2008. As a result Petitioner permanently lost 10% of the use of her right hand and 10% of the use of her left hand, 12-1/2% of the use of the right arm and 12-1/2% of the use of the left arm. The Arbitrator further found that Petitioner failed to prove a causal relationship existed between Petitioner's thumb condition and the August 1, 2008 accident. The Issues on Review are whether Petitioner filed her claim within the statute of limitations period set forth in Section 6(d) of the Illinois Workers' Compensation Act, and if so, whether Petitioner sustained an accidental injury arising out of and in the course of her employment on August 1, 2008, whether a causal relationship exists between the August 1, 2008 accident and Petitioner's present condition of ill-being. The Commission, after reviewing the entire record, modifies the Arbitrator's decision and finds that while Petitioner filed her claim within the statute of limitations period set forth in Section 6(d) of the Act, Petitioner failed to prove that her current condition of ill-being is causally related to the alleged August 1, 2008 work accident.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

15IWCC0681

1. Petitioner testified in 2002 she was a staff nurse at Taylorville Correctional Center. Petitioner further testified that she was flipping three ring binders and punching pills out of blister packs twice a day when her original pain started developing. She has numbness and extreme pain in her hands which would radiate all the way up both arms all of the time. The right elbow was worse than the left.

2. On January 25, 2002 Petitioner began treating with Dr. Warach. The doctor noted that Petitioner is a 50 year old right-handed female with a history of onset around two years ago. She is reporting constant progressive aching and sharp pain, variable in intensity, involving both thumbs, right greater than left. Her pain is made worse by use of thumb and hand. At times, she awakens with a funny feeling involving the forearms along with coldness and pain in her hands. She feels her hand grip on the right side is weaker than normal. She also reports that the fingers on the right hand intermittently lock up involuntarily. She has noticed some bilateral wasting of the thenar regions of her hands. She reports that her work involves considerable repetitive wrist, hand and arm movements and that her symptoms are worse at work. Dr. Warach ordered bilateral wrist and hand x-rays an EMG/NCV of her upper extremities and prescribed wrist splints.

3. The February 22, 2002 EMG/NCV showed evidence of bilateral median compressive neuropathies at the wrist (bilateral carpal tunnel syndrome), which were deemed to be mild. It further showed right ulnar motor neuropathy at/about elbow segment (right cubital tunnel syndrome), which was mild.

4. Dr. Warrach reviewed Petitioner's EMG/NCV test, found that Petitioner's use of the bilateral wrist splints had provided some benefit and he opined that Petitioner may benefit from an orthopedic consultation. On March 11, 2002 Dr. Warach noted that Petitioner relates that her handwriting for the last ten years and her work as a nurse in general involves considerable repetitive use of her hands and arms. At her request, he completed a form for workers compensation.

5. Petitioner testified that in February/March of 2002 she believed that her carpal tunnel and cubital tunnel were based on her repetition at work. She knew she had a problem in 2002 after Dr. Warach said it was work-related and he completed a form for her to that effect. Petitioner testified that she went to Dr. Watson who told her she needed surgery and told her to let him know when she was ready. She said she asked if there were any exercises she could do for the condition and he told her no. Petitioner further testified that at that time she was not ready for surgery. While she knew she had a problem, she thought that she could work through it by trying to ease her hands and not do so much repetitive work. She also thought she could wait until it got worse.

6. During an April 5, 2002 follow up visit, Dr. Warach noted that Petitioner still has persistent constant aching pain in both of her thumbs and she denies any numbness. He further noted that when she saw Dr. Watson for an orthopedic consultation on March 19,

2002 he recommended surgery, but she does not wish to proceed with carpal tunnel release at this time.

7. Petitioner testified that in 2004 she switched jobs and she became the Director of Nurses at the Decatur Correctional Center. Her new work schedule was 8 a.m. to 4 p.m. with a half hour lunch break. While she was also given two 15 minute breaks, she never took them. She reported that at the new job she performed more administrative work than hands-on nursing. In her new job, everything was done on the computer. On average, she used a keyboard 4-6 hours a day. She said she performed secretarial duties herself along with doing a lot of assignments for the healthcare unit administrator. Specifically, she typed letters, filed and shredded. She sent e-mails and type reports and documents. She completed nursing evaluation sheets, daily healthcare unit reports for the wardens along with reports on overtime, discharges from the hospital, nurses, and discipline. She also put together schedules for offenders' visits and the nursing staff. She performed charting and wrote notes by hand. She wrote dietary and safety reports, communications for outside healthcare facilities, ran the chronic clinics every 3-4 months, scheduled people for clinics, made grievance reports, prepared for the offenders' education classes and helped the nurses when needed. She also worked at home on scheduling or training when she could not complete these tasks during the day.

8. Lori Cowger testified she is the healthcare unit administrator/public service administrator at Decatur Correctional Center. Petitioner was her supervisor for many years. Ms. Cowger testified that she reviewed Petitioner's PX3 exhibit and she testified that it was an accurate list of Petitioner's job duties. She further testified that she would agree that Petitioner's activities in a given day were numerous and varied. She did agree that Petitioner spend probably four to six hours per day at her computer.

9. Petitioner testified that roughly in May of 2008 she got a whole lot worse. She could no longer sleep at night because she was aching all the way up both arms. She thought that this was ridiculous and she was going to have to do something about this. She went to Dr. Saunders who referred her to Dr. Warach to conduct a repeat EMG. On June 30, 2008 Petitioner completed a employee report of accident in which she listed the date of injury as May 20, 2008 and indicated she needed to perform repetitive bilateral hand movements in order to do job. As a result she was experiencing numbness and pain. The June 30, 2008 Supervisor's Report indicated that Petitioner reported that due to paperwork, writing and computer keyboarding she has carpal tunnel syndrome in both hands and shooting pain and numbness up her arms.

10. On July 11, 2008 Petitioner followed up with Dr. Warach who noted that Petitioner is a 57 year old right-handed female who gave history of onset around 2000 of persistent progressive intermittent numbness and tingling of the entire bilateral hands, right greater than left, along with numbness and tingling that may radiate from her hand up to her neck. She also reported bilateral thumb pain along with constant aching of the right

elbow. She reported she has had experienced a significant exacerbation of her symptoms in May of 2008 without any other extraordinary provocation factors or causes. She tried wrist splints and the exacerbation subsided to baseline after about two weeks. Petitioner related her work involves considerable repetitive wrist, arm and hand movements with typing, computer work, handwriting and paperwork. Her EMG/NCV test on February 22, 2002 revealed bilateral carpal tunnel syndrome and right cubital tunnel syndrome, which was deemed mild at the time. She saw Dr. Watson for an orthopedic consult on March 19, 2002 and surgery was not pursued at that time. Dr. Warach ordered bilateral wrist and hand x-rays and an EMG/NCV test.

11. The July 11, 2008 x-rays demonstrated Petitioner had degenerative changes of the first carpometacarpal joint in the left wrist, degenerative changes in the right wrist along with degenerative changes in the left and right hands. Her right elbow x-ray was normal.

12. The August 1, 2008 EMG/NCV upper extremity study provides evidence of bilateral carpal and cubital tunnel syndromes, moderate in severity.

13. At the time of the November 18, 2014 Arbitration Hearing, Petitioner's attorney moved to amended Petitioner's date of accident from May 1, 2008 to August 1, 2008. Petitioner filed her Application for Adjustment of Claim on October 6, 2010 and listed August 1, 2008 as the date of accident.

14. Dr. Warach instructed Petitioner to obtain wrist splints, elbow pads, avoid leaning on her elbows and to obtain authorization from Respondent's workers' compensation provider to refer her to an orthopedic surgeon.

15. On September 10, 2008 Petitioner began treating with Dr. Greatting. He noted that Petitioner is a 57 year old female being evaluated as a result of experiencing pain, numbness and tingling in her bilateral wrists and arms. She reported this started back in 2002. She is a right handed nursing director of the correctional center of a women's jail. She reported she does a lot of typing and other activities that irritate her wrists. She said she went to a workers' compensation doctor who told her that she could seek treatment whenever she felt it was necessary. However, at that time, the pain, numbness and tingling were not that bad so she put it off. She decided that the pain is now bad enough that she needs to be evaluated. She reports that the pain is mostly in her thumb. All of the symptoms are the same bilaterally, except the right side is more severe than the left side. Dr. Greatting diagnosed her with severe osteoarthritis of the CMC joints of the thumbs bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. He recommended that she undergo surgery.

16. On May 6, 2009 Petitioner underwent surgery. Her post-operative diagnoses were right cubital tunnel syndrome, right carpal tunnel syndrome, right thumb carpometacarpal joint arthritis, left trigger thumb. On July 8, 2009 Petitioner underwent her second surgery. Her

post-operative diagnoses was left cubital tunnel syndrome, left carpal tunnel syndrome, left thumb carpometacarpal joint arthritis, left trigger thumb.

17. On June 29, 2009 Petitioner followed up with Dr. Greatting who commented that her right hand is doing very well. The numbness in her right hand has resolved and she feels she has good motion and strength. However, her right trigger thumb has not resolved with injection and she now has some triggering in her left thumb as well. On September 14, 2009, Dr. Greatting noted that Petitioner reports the numbness has resolved in her left hand and she has good strength. She is very happy with her results. He found that Petitioner had reached maximum medical improvement and he released her from his care with instructions to return as needed. It was subsequently decided that Petitioner needed additional treatment for her right thumb and on December 22, 2009 Petitioner underwent surgery to release her right trigger thumb.

18. Petitioner testified that the day Dr. Greatting released her she complained about her left elbow. On July 31, 2012 she retired. At the November 18, 2014, Arbitration hearing Petitioner testified that she still has pain and tingling in her hands off and on along with pain up her arms, but she has not been back to the doctor since her release. She also testified that she has had controlled hypertension for 25 years, hypothyroidism for 20 years, has been postmenopausal since the age of 45 and has smoked for 24 years.

19. On November 5, 2014, Dr. Warach, a neurologist, was deposed. He testified he does know what Petitioner's job is but he does not recall reviewing her written job description. Petitioner also did not tell him what percentage of the day she spent doing her duties. He also does not know how long she has held her various jobs and he has not seen her work. He opined that Petitioner's carpal tunnel and cubital tunnel were caused by or aggravated by her work. He testified that he is not an orthopedic surgeon and has not performed carpal tunnel release surgeries. He agreed that the fact that Petitioner is a female places her in a higher risk category for developing carpal tunnel syndrome. He further agreed that the older one gets the more likely they are to be at a higher risk factor for this condition. He stated that he is not familiar with hypertension being a factor for carpal tunnel. He agreed that a thyroid syndrome could be a contributing factor to developing carpal tunnel or cubital tunnel. He agrees that she has been a smoker and smoking can lead to the development of carpal and cubital tunnel. He thinks that while her health certainly predisposed her to carpal tunnel and cubital tunnel, her work was the instrumental thing that was provocative and causative. He stated that once you get the condition and you continue to do activities it is most often the fact that these repetitive activities could aggravate the situation. All of the activities she did at work shared a common mechanism of repetitive movement of her wrists and elbows. Based on her examination, her EMG and information from Dr. Watson, he agreed that Petitioner had bilateral CTS in 2002. He further opined that the second set of EMG/NCVs in 2008 showed a worsening or deteriorating condition from 2002.

20. The Commission notes that the Arbitrator indicated that Dr. Watson's March 19, 2002 record was not tendered into evidence at trial. However, Dr. Watson's March 19, 2002 record was contained in the record and it can be found at PX1, Dep. Ex RX1. More specifically, in his March 19, 2002 entry, Dr. Watson stated Petitioner is a 51 year old nurse who is complaining of bilateral hand pain and numbness. The worst pain is in her thumb and it radiates up her forearm. She has had symptoms for over a year. The repetitive tasks of writing that she does during the day as well as dispensing medication makes this worse. She has been using splints and medication. Her EMG indicates bilateral carpal tunnel syndrome and right cubital tunnel syndrome. We discussed treatment options including carpal tunnel release and she wants to avoid this for now.

21. Dr. Williams, an orthopedic surgeon, was deposed on August 13, 2014. He testified that last year he saw 5,200 patients in the office, performed 550 surgeries and 200 independent medical evaluations/record reviews. Of those 80% were evaluations and 20% were record reviews, Ninety were for Respondents and 10% were for Petitioners. Of the evaluatations, 30-40% of these involved the State of Illinois. He testified that risk factors for carpal tunnel syndrome and/or cubital tunnel are age, being female and being postmenopausal. He noted that greater than 60% of carpal tunnel cases are idiopathic in nature. He evaluated Petitioner on May 21, 2014. He discussed her job with her at length (Petitioner also testified that she spoke with Dr. Williams for approximately one half hour about her job duties.) Dr. Williams said he was also provided with a Healthcare Unit associated job duties record along with the Director of Nursing duties which he shared with Petitioner and which she marked the pertinent items that she performed. Dr. Williams said he felt Petitioner had bilateral CMC joint arthritis, bilateral carpal and cubital tunnel syndrome and bilateral trigger thumbs. He stated he did not believe her work duties were the cause of or an aggravation of her conditions. He based his opinions on the listed work duties, her medical records and her health history. He did not find her work duties to be either highly repetitive, or involving forceful gripping and/or pinching or vibration. Her body mass index (BMI) puts her in an increased risk for peripheral neuropathies. He also agreed that her hypertension and hypothyroidism were risk factors. He stated that, in short, she has numerous risk factors for developing peripheral neuropathies. He noted she retired on July 31, 2012 and when he saw her on May 21, 2014 she was at maximum medical improvement. In his June 5, 2014 independent medical report which was admitted at Respondent's exhibit RX1, Dr. Watson opined that Petitioner's problems could be attributed to 25 year history of hypertension or 20+ year history of hypothyroidism as well as her 18+ history of postmenopausal status more so than her work duties. Even her CMC joint arthritis would have been aggravating to her carpal tunnel. He opined that her condition could also be idiopathic, which is the best known cause of carpal tunnel. Dr. Williams opined that Petitioner's work duties appeared to be varied and there was nothing that required sustained, repetitive or forcible gripping and/or pinching, vibration or any impact to the hands. Furthermore, her job duties do not qualify for the NIOSH definition of repetitiveness of tasks.

The Commission notes that the initial issue is whether Petitioner filed her claim within the statute of limitations period set forth in Section 6(d) of the Illinois Workers' Compensation Act. Petitioner is claiming that her condition manifested itself on August 1, 2008. Petitioner filed her Application for Adjustment of Claim on October 6, 2010. The Commission notes that the Supreme Court held that the phrase "manifests itself" means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have been plainly apparent to a reasonable person. Peoria County Belwood Nursing Home v. Industrial Commission, 115 Ill.2d 524 (1987). This has become known as the *Peoria County* standard.

Since this standard was developed the Courts have dealt with the application of the same time and again. In the recent case of Deana Durand v. Industrial Commission, 224 Ill. 2d 53 (2006), the Supreme Court held that the Appellate Court's application of the *Peoria County* standard in several carpal tunnel syndrome cases provides useful insight regarding how to determine the manifestation date. Specifically, the Supreme Court referenced the Appellate Court's holding that the fact of the injury is not synonymous with the fact of discovery. Or stated otherwise, the date on which the employee's notice of a repetitive trauma injury is not necessarily the manifestation date. Rather, the date on which the employee became unable to work due to physical collapse or medical treatment helps determine the manifestation date. (See Deana Durand v. Industrial Commission, 224 Ill. 2d 53 (2006) citing to Oscar Mayer and Co v. Industrial Commission, 176 Ill. App. 3d at 611 (1988).The Appellate Court also held that the standard remains flexible. Just as they rejected the employee's contention that the date of discovery of the condition and it relationship to the employment necessarily fixed the date of accident, they rejected any interpretation of this opinion that would permit the employee to always establish the date of accident in a repetitive trauma case by reference to the last date of work (See Oscar Mayer and Co v. Industrial Commission, 176 Ill. App. 3d at 612 (1988)).

With these guidelines in mind, the Commission must view the individual facts in this case in relationship to the law. In this instance, the evidence demonstrates that Petitioner clearly knew she had bilateral carpal tunnel syndrome and right cubital tunnel in early 2002 and that the conditions were related to work. The same is demonstrated through Petitioner's history to Dr. Warach, the February 22, 2002 EMG/NCV findings, Dr. Warach's March 11, 2002 entry in which he stated Petitioner is relating her condition to work and she has asked him to complete a workers' compensation form and lastly Dr. Watson's March 19, 2002 record in which he again tied Petitioner's condition to work and he recommended surgery. In short, there is an abundance of evidence to support the fact that in early 2002 Petitioner not only discovered her condition but that she was well aware of her condition and knew that the same was related to her work. Thus, it is established that the onset of pain necessitated medical attention and the standard set forth in *Peoria County* is clearly met at this time. However, since the *Peoria County* standard was set forth, the Appellate and Supreme Courts have held that the application of the

standard remains flexible in nature. In applying this flexibility, the Appellate Court in Oscar Mayer and Co, Id. found that the evidence established that at the time the claimant underwent his first EMG he was informed that he had carpal tunnel syndrome but he refused surgery and treated with conservative methods over the next two years. In other words, just like the Petitioner in the case at bar, the claimant met the standard set forth in *Peoria County* in that he was well aware of his condition, knew that the same was related to his work and he also sought medical attention. A period of two years then went by for the claimant while his condition did not improve and he underwent a second EMG test that showed his condition was becoming progressively worse. Yet, again he chose not to undergo surgery and he still treated with conservative treatment. Again, this is similar to the Petitioner in the case at bar in that her second EMG also showed a progression of her condition in that the EMG now not only demonstrated bilateral carpal tunnel syndrome but it also now showed a bilateral cubital tunnel condition as opposed to the earlier cubital tunnel only on the right side. Where the two cases differ slightly is that the claimant in Oscar Mayer and Co., id has a third EMG test prior to consenting to surgery while Petitioner is this instance reached that point after the second EMG. Either way the employees fell into one of the two alternative criteria set forth by Professor Larson for fixing the date when the injury manifest itself to the point where the employees were no longer able to perform their jobs. Also, like the claimant in Oscar Mayer and Co., id, the Petitioner in this case returned back to work after the surgeries and worked for a period of time prior to retiring. As such this claim is factually dissimilar to the claimant in Consuelo Castaneda v. Industrial Commission, 231 Ill. App. 3d 734 (1992) in that there was an event (of Petitioner not being physically able to work and seeking medical treatment on that day) as opposed to a non-event (Claimant Cataneda being part of a general lay off and not seeking medical treatment on that day) that Petitioner chose as the manifestation date.

In summary, the Commission finds that the evidence supports a finding that the manifestation date in this case is August 1, 2008, the date in which Petitioner's physical condition broke down, Petitioner could no longer work and Petitioner sought medical treatment after a progression of her condition had been shown. The evidence in the case at bar shows that the facts in this case is most similar to facts set forth in and the manifestation date accepted by the Appellate Court in Oscar Mayer and Co., Id. In applying both the standard set down in *Peoria County* and the flexibility aspect established in Oscar Mayer and Co., Id , the Commission finds that the Arbitrator correctly held that the Petitioner proved that the manifestation date is August 1, 2008. Furthermore, having filed the Application for Adjustment of Claim on October 6, 2010, the Commission finds that Petitioner properly filed her Application for Adjustment of Claim within the three year statute of limitations period set forth in Section 6(d) of the Act. As such, the Commission affirms the Arbitrator's finding on the statute of limitations issue.

In terms of the causation issue, the Commission has reviewed the medical opinions set forth by Drs. Warach and William and finds that Dr. William's causation opinion is more persuasive than Dr. Warach's causation opinion.

In reviewing the evidence in the record, the Commission notes Petitioner's attorney did not seek testimony from the orthopedic specialist Dr. Watson or the surgeon Dr. Greatting. Rather, he sought a causation opinion from Dr. Warach, a neurologist, who conducted Petitioner's EMG/NCV test but is neither an orthopedic doctor nor a surgeon. When Dr. Warach is asked on cross-examination his bases for finding Petitioner's condition is causally related to the August 1, 2008 accident, he testifies that while he knows what Petitioner's job is, he has not reviewed any written job description for the Petitioner. He does not know how long she has held various jobs. He has not been to her job site or seen how she works and he is unaware of the percentage of time in the day that she spends performing her various job duties. Yet, he claims that all of her activities require common repetitive movement of her wrists/elbows. In other words, the Commission finds that Dr. Warach is relying strictly on Petitioner's history and is not providing the necessary foundational understanding needed to represent that Petitioner's work duties were repetitive in nature. Furthermore, when Dr. Warach is asked if Petitioner's age, sex along with her being postmenopausal, obese, having a thyroid condition and having smoked for a long duration factored into her developing carpal tunnel and/or cubital tunnel conditions, he concedes that these risk factors could play a part in Petitioner's development of these condition. Based on the above, the Commission finds that Dr. Warach qualifications are less than a specialist in this given area, that his causation opinion is strictly based on Petitioner's history rather than a strong foundational understanding of Petitioner's job duties and that there are other possible causes of Petitioner's condition that are not related to work.

In reviewing Dr. Williams' deposition, it is clear that, unlike Dr. Warach, Dr. Williams is an orthopedic specialist with extensive experience in performing upper extremity surgeries. When he is asked the basis for believing that Petitioner's condition is not causally related to her work duties, he indicates he was provided with Petitioner's job duty records from both the Healthcare Unit and as the Director of Nursing which he shared with Petitioner and further refined by having her indicate what activities she generally performed and he in turn codified the same in the first two pages of his evaluation report. Thus, he established that he had a thorough understanding of Petitioner's job tasks. Additionally, using his expertise along with Petitioner's health history, he noted that Petitioner had several increased risk factors for the development of carpal tunnel and/or cubital tunnel syndrome through her having a significantly long history of hypertension and hypothyroidism, being of advanced age and being postmenopausal. Lastly, he reviewed the physical mechanics of the job duties themselves and found that they were not highly repetitive in nature, did not involve forceful gripping, pinching or vibrating. In all, he provided a thorough understand of Petitioner's work duties and he provided three separate bases to support his position that Petitioner's

condition was not related to her employment. Given all of the above, the Commission assigns more weight to Dr. Williams' causation opinion than to Dr. Warach's causation opinion and reverses the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to the August 1, 2008 work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of August 1, 2008 and Petitioner's condition of ill-being, her claim for compensation is hereby denied.

SEP 3 - 2015

MB/jm

O: 7/16/15

43

Mario Basurto

David L. Gore

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Ann Holtz,
Petitioner,

vs.

Napa Distribution Center,
Respondent,

NO: 06 WC 4650

15IWCC0682

DECISION AND OPINION ON §8(A) PETITION

Petitioner filed a Petition under §8(a) of the Illinois Workers' Compensation Act requesting additional medical expenses since the decision of Arbitrator Tobin dated December 22, 2006 in which he found that as a result of accidental injuries arising out of and in the course of her employment on September 21, 2005 Petitioner was temporarily totally disabled for a period of 39-5/7 weeks, is entitled to $11,521.82 in medical expenses and is permanently partially disabled to the extent of 13% of a person as a whole. Neither party appealed this Decision and it became final. The sole issue now before the Commission is whether Petitioner is entitled to additional reasonable and necessary medical expenses under §8(a) of the Act. The Commission, after reviewing the entire record, denies Petitioner's request for additional medical expenses, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

- On May 15, 2014, Petitioner appeared pro se along with Respondent's attorney at Commissioner Donohoo's Review Hearing.

- At the May 15, 2014 Review Hearing, Petitioner testified that her back and legs still bothers her and she is having problems with her bladder. Since the November 17, 2006 Arbitration hearing she saw Drs. Kovalsky, Mehta, and Templer at Orthopedic Center of Southern Illinois and she received some injections which did not help her low back. She also saw a doctor at the Southern Illinois Pain Management where she received some injections in her groin and hip which did not help her condition.

- Petitioner submitted into evidence PXA, a Petition for Review, PX1, a November 27, 2012 letter from Dr. Asbery which was objected to on the grounds of hearsay but was admitted into the record, PX2, a February 10, 2011 and March 13, 2013 letter from Dr. Steele which were objected to on the grounds of hearsay but was admitted into the record, PX3, a letter from the Social Security Administration which was objected to on the grounds of relevance but was admitted into the record, PX4, a medical entry from Barnes-Jewish West County Hospital which was admitted into evidence at the arbitration hearing, PX5, a June 25, 2010 withdraw letter from Attorney Gary Bement, PX6, a perspective care letter from Dr. Perry which was objected to on the basis of reasonableness, necessity and causation but was admitted into the record.

- While Petitioner testified as to various prescription medications she is taking she did not submit any prescription bills into the record. Petitioner submitted into evidence PX7 a list of expenses, PX8, a list of bills paid out by Medicare, PX9, a list of unpaid bills, PX10, medical bills paid by Petitioner's spouse's insurance carrier, PX11, a letter from Orthopaedic Center of Southern Illinois regarding an unpaid balance of $2,699.10 which had been tendered for collection, PX12, a SLU statement, PX13, medical bills from Crossroads Community Hospital which had been tendered for collection, PX14, a paid account balance from St. Mary's Good Samaritan, PX15, a paid bill from Occupational Performance and REH, PX16, outstanding bills from SSM Healthcare, PX17, a bill from INMed Diagnostic, PX18 a paid bill from Southern Illinois Anesthesia, PX19, a paid bill from RS Medical, PX20, a paid bill from Hearthland Radiology, PX21 a paid bill for Southern Illinois Anesthesiology, LTD and PX22, a paid bill for Anesthesia Partners. Respondent's attorney objected to all of the medical bills on the basis of reasonableness, necessity and causation.

- Respondent submitted into evidence RX1, the December 22, 2006 Arbitration decision, RX2, a Petition for Review filed in February 2007 and with RX5, Respondent's October 11, 2007 Motion for the Dismissal of the Review with a subsequent Order of November 8, 2007 granting the withdraw, RX3 a receipt of the certified transcript filed on September 6, 2007, RX4, a copy of the September 6, 2007 Arbitration Transcript, RX6, Petitioner's Petition for Review under §19(h) and §8(a) filed on September 3, 2008, RX7, a Section 19(b) Petition for Immediate Hearing filed on December 6, 2011, RX8, Petitioner's Request for Hearing filed with the Commission for hearing on the May 30, 2012 Review Docket, RX9, Petitioner's Petition for Review under §8(a) filed on June 21, 2013, RX10, medical records from Dr. Froehling from February 12, 2007 to February 26, 2007, RX11, medical records from Orthopedic Center of Southern Illinois dated March 29, 2007 to April 1, 2008, RX12, medical records from Dr. Asbery dated May 15, 2008 to November 15, 2010, RX13, medical from Dr. Carpenter dated March 8, 2010 to October 11, 2010, RX14, medical records from Dr. Steele dated from November 30, 2010 to November 17, 2011, RX15, medical records from Southern Illinois Pain Management dated from June 6, 2012 to August 28, 2012, RX16,medical records from Laser Spine Institute dated from September 19, 2012 to January 16, 2013, RX17, January 16,

15IWCC0682

evidence deposition of Dr. Childers and RX18, April 1, 2014 evidence deposition of Dr. Bernardi.

The Commission notes, pursuant to RX6, that while Petitioner filed a Petition for Review under §19(h) and §8(a) on September 3, 2008, Petitioner never requested a hearing date or took further action regarding this filing. Subsequent to this filing, Petitioner's attorney withdrew as counsel of record. On June 21, 2013, Petitioner filed a Petition for Review under §8(a) in which she is seeking additional medical expenses which she alleges she incurred since the December 22, 2006 Arbitration decision was issued and which she alleges are related to her September 21, 2005 work accident. Based on a review of the record, it appears that Petitioner is claiming her current lumbar, bladder and reproductive system problems are causally related to the September 21, 2005 work accident. In support of the same Petitioner introduced PX1, a November 27, 2012 letter from Dr. Asbery which was objected to on the grounds of hearsay but was admitted into the record, PX2, a February 10, 2011 and March 13, 2013 letter from Dr. Steele which were objected to on the grounds of hearsay but was admitted into the record, Respondent, in turn introduced January 16, 2013 evidence deposition of Dr. Childers, a urologist, and RX18 an April 1, 2014 evidence deposition of Dr. Bernardi, a neurosurgeon, along with their reports. Having reviewed all of the above the Commission finds that the causation opinions of Drs. Bernardi and Childers should be assigned greater weight than the causation opinions of Drs. Asbery and Steele. Furthermore, as a result of such finding, the Commission further finds that Petitioner has failed to provide sufficient evidence to causally link her lumbar and bladder treatments to the September 21, 2005 accident. Lastly, the Commission notes that the record is devoid of any evidence that Petitioner's reproductive problems are causally related to the September 21, 2005 work accident. As such, the Commission finds Petitioner failed to meet her burden that she is entitled to additional medical expenses for medical treatments which she incurred after September 29, 2006 as was indicated in the Arbitrator's December 22, 2006 decision.

IT THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove she is entitled to any additional medical expenses under §8(a) of the Act, her claim for further compensation is hereby denied.

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

DATED: SEP 3 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm
O: 8/6/15

43

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 Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANICE DECKER,

Petitioner,

15IWCC0695

vs.

NO: 09 WC 46157 & O9 WC 46270

METHODE ELECTRONICS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, permanent partial disability, and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not sustain her burden of proving a compensable accident or causation to a current condition of ill being, and denies compensation.

Findings of Fact and Conclusions of Law

1. Petitioner testified she worked for Respondent since October of 1993. She worked for 14 years at the Golden plant, was laid off in 2006 when that plant closed, and returned to work at the Carthage plant in 2007 in the "mold room." Petitioner worked 40 hour weeks plus voluntary overtime. Respondent makes electronic automotive parts. The items with which she works are usually small, between about one inch and six-seven inches. Her job involves the extensive use of her hands and arms. She actually had a previous workers' compensation claim for carpal tunnel and cubital tunnel syndromes.

2. She worked for seven years at Golden in "truck pull," assembling a switch that opens car trunks. She would sit at a table reaching into a bin of parts in front of her. She looked down, picked up three parts at a time, and described intricate hand manipulation in assembling the part. She also turned her head to the right in order to gauge the spring. If she did not have enough strength to snap a piece in place she used a press.

15IWCC0695

3. Petitioner also testified that in that job she put together about 300 parts in an hour, which was the number expected of her. The baseline was 205 parts an hour, but she exceeded that baseline every day. Her compensation was partially based on the number of parts she assembled. Petitioner indicated that she would be looking down her entire eight-hour work day except 40 minutes during lunch and a break.

4. Petitioner went from truck pull to "keyless entry." The work there was "totally different;" "it was a wire harness." However, the amount of time she looked down remained the same as in her previous assignment. She again regularly exceeded her targets in assembly.

5. It appears from her testimony that Petitioner would take rubber sleeves from a "sleeving" bin on her left, put them on parts on the desk in front of her, and transfer them to the "empty" bin on her right. She would be sitting in a "higher chair" and the bins were about abdomen high. She would be "bent over" the desk at which she was sitting. There were also parts on a taller table on her left which was about at breast level and she reached out at about shoulder level. Petitioner again described a process of assembly which involved extensive hand manipulation and reaching both left and right. She looked down during the assembly process. She worked in keyless entry for only about a year.

6. From there she went to the "SMT room" where she assembled circuit boards. The board would come down a conveyor belt. She would turn around to her right and look down and turn six tabs to pull them out. She would use a magnifying glass to inspect the soldering and tiny parts of 1/8 inch. If she found a flaw she would have to fix it. She had a soldering iron. She was seated and always bent forward. She worked at that job for four-five years. "Just about the whole day" was spent with her "head down and moving it right to left." She returned to truck pull for her last year of employment at Golden as they were phasing out work at the plant.

7. The machines at the "mold room" in Carthage were big. She would stand and load a mass of wires onto a turntable that makes the molds. She had to smooth the mold using a hard plastic stick and a little metal punch. It took maybe 30 seconds to smooth it all down. She "would beat it," she "would poke it." She would have to press down hard with her thumbs and shoulders. It would be about abdomen high and she would be looking down to make sure "to make sure you get all those grooves."

8. Once she finished smoothing the mold, "the other girl would do her job on it," and once they put it all together Petitioner "would put a magnet on top and then" "step back because there is a light curtain." When the mold opened another worker would "grab that sprue and you have to lean all the way across the turn table." Petitioner would have to grab the sprue and pull it down with her right arm. She would bend over and twisted "at her waist with her right arm up and out." It was particularly awkward because she was short. She was "bent and stretched" when pulling down. When the part was completed they would "turn around" and put it in the fixture.

15IWCC0695

9. There were four stations on the molding machines and the workers would rotate between jobs every two hours. Work in two of the stations involved sitting down cleaning the parts and using an Exacto knife. In that job she would take the board out of the fixture from her right, trim off excess material with the Exacto knife, put a mark on it, and place it in a bin on her left. She would be "looking, inspecting." The team of four would perform that process for 1,000 parts a day. While working in the mold room, she noticed her neck "killed" her and her shoulders hurt, and low back hurt because she was too short; "you can only stretch your body so far."

10. Petitioner testified that on September 24, 2009, she was preparing to go to work when she became dizzy and could not walk. Her "head was killing" her. Her husband took her to an emergency room ("ER"). They gave her medicine for her dizziness. She was released from the ER but did not go to work that day. Her condition did not improve the next day and she returned to the ER. This time she was admitted. She "had a terrible headache," "all in her neck." They did tests but did not know what was wrong. Petitioner went to her general practitioner, Dr. Leimbach, and a chiropractor, Dr. King, whom she had seen previously because she "had been having back trouble all along and [her] neck where [she] would get a lump in" her neck and head pain; "he would always get it back."

11. Dr. Leimbach referred her to Dr. Marchiando. She continued to treat with Dr. King as well until he released her to work on November 11, 2009. She did not return to work because she "heard they were going to be terminating the 13th," so she took two vacation days because she did not want to reinjure her neck. Dr. Marchiando ordered MRIs and prescribed medication and physical therapy. Petitioner returned to Dr. Leimbach and complained of continued neck pain and shoulder pain. It appears he thought her pain was generated by arthritis and referred her to Dr. MacGregor, a neurosurgeon. Petitioner told her about her neck pain for a couple of years and her work activities. She also prescribed medication and physical therapy.

12. The physical therapy helped a little bit and Dr. MacGregor then prescribed cervical epidural steroid injections. They provided relief for probably five, six months. Then her pain started coming back. Her headaches and neck were "killing" her and she had a constant lump in her back "from the bulging disc." The headaches were the most worrisome symptom. Petitioner's symptoms got worse so she returned to Dr. MacGregor. She prescribed an MRI and medication. Thereafter, Dr. MacGregor recommended C4-5 fusion surgery, which was performed on November 16, 2012.

13. The surgery resolved the headaches and dizziness, and her arm/shoulder pain was much better. Dr. MacGregor released Petitioner without restriction of activities and from treatment on April 18, 2013. Petitioner was much better, but she was still stiff and can't turn her head as far as she used to. She takes two Aleve every morning and every evening for the arthritis. If she does not, the pain in her neck and shoulders return.

14. On cross examination, Petitioner agreed that all the parts she dealt with at Golden and Carthage were small and light, "but you are just busy." "You have them and are just assembling; you just can't imagine how fast."

15IWCC0695

15. The Golden plant was designed ergonomically, but she knew that she did her job "according to specs." She agreed that the activities she performed at Golden were all close to her body, but "looking down." The work involved in those jobs was also all within arm's reach. She did not remember whether she told Dr. MacGregor about pushing the wires in the mold room.

16. Petitioner acknowledged she saw Dr. King prior to the alleged date of manifestation "to get adjusted every now and then" for trouble in her back. She had back and neck pain for about two years. She did not look for employment after being released by Dr. MacGregor; she was retired. However, she did look for employment after being laid off by Respondent.

17. Petitioner testified that when she called work on September 24, 2009 she told them she thought she had vertigo, which was what she was told in the ER. She had no reason to dispute that in the ER she did not complain of neck pain. She did not dispute that she did not mention neck pain in her initial visit to Dr. Leimbach because he knew she had neck pain but attributed it to an ear condition.

18. Petitioner also indicated she did not mention that her work activities was a cause of her neck pain, because they told her a long time ago that there was no workers' compensation benefits available "or anything a long time ago." She agreed that when she initially stopped working for Respondent, she took FMLA leave because she thought her dizziness was based on vertigo and did not know her condition was work related.

19. When she reported her condition to Respondent in October of 2009 she identified neck pain. She initially reported via telephone that she went to a chiropractor, had issues with arthritis, and was taken off work. That was when she informed Respondent that she believed her condition of ill being was work related. She came to that conclusion because she realized her general condition of ill being was due to her neck condition, which Dr. King opined was related to her work activities.

20. Petitioner continued to treat with Dr. Leimbach after Dr. King released her. She thought he did not indicate that her November 2009 MRI was normal but rather showed a bulging disc. Petitioner agreed that she had been diagnosed with arthritis in her entire spine throughout her treatment. She did not see Dr. MacGregor until February 2011, about a year and a half after she stopped working for Respondent. Her symptoms were getting worse at that time, even though she was not longer exposed to the work activities.

21. Petitioner acknowledged that there were two eight-month lapses in her treatment with Dr. MacGregor. When she first returned to Dr. MacGregor on January 16, 2012, she did not recommend surgery or a repeat MRI. When Petitioner returned to her on September 20, 2012, Petitioner reported turning her head getting out of the shower, getting dizzy, and falling. She then returned to Dr. MacGregor because of the aggravation of her symptoms. Dr. MacGregor ordered another MRI after that return for treatment.

22. On redirect examination, Petitioner testified she only rotated jobs on the mold machine. The rest of her jobs did not involve rotation of job duties. The other jobs were performed eight, 10 hours a day. She believed her condition was related to her work activities when she started having dizziness. Initially, in September 2009 she was told her condition was vertigo. However, in October 2009, Dr. King indicated it was something different. She discussed the situation with Dr. King and he indicated her condition was related to repetitive motion as she noted in her accident report.

23. While Petitioner had pain previously, she was able to work until September 24, 2009, which was when the dizziness began. She continued to experience dizziness even when she was released to work. She stopped having dizziness with the medication, but she was still getting headaches. When she had dizziness in the shower she reached for the shower head and just bending her neck did something. She previously reported other instances of dizziness with motion.

24. Denise Orris was called to testify by Petitioner. She was currently Human Resources manager for Respondent. She worked for Respondent for 36 years, probably 30 years of which in Human Resources and involving workers' compensation issues. She indicted Petitioner reported waking up dizzy on September 24, 2009 and was diagnosed with vertigo at the ER. She saw her chiropractor on October 12, 2009 and x-rays of her back indicated she had "arthritis and repetitive motion stress to the area."

25. On cross examination, Ms. Orris testified Petitioner initially called in and requested FMLA leave for what she believed was vertigo. She called a couple of weeks later and informed Respondent that her chiropractor asked she call in and get an workers' compensation incident number for billing because he thought her condition was work related. At that time she did not mention repetitive stress or the neck problem.

26. In 2008, Respondent announced that the Golden plant would close eventually, with some people moving to Carthage, but then there would be a reduction at Carthage as well over several years. Employees received notices of their impending respective layoffs at least 60 prior to the date of the layoff. Petitioner did not report any injuries prior to such notification.

27. Ms. Orris was familiar with the Golden and Carthage plants and the "stations were set up ergonomically for the individual running it." The chairs are adjustable so the parts would be within reaching distance. All the parts are very small and lightweight.

28. On redirect, Ms. Orris agreed that when Petitioner initially called in she did not relate the supposed vertigo was work related and asked for FMLA leave. She made no indication of an intention to file a claim until she told the witness Dr. King had asked for a workers' compensation claim number. That was when she reported an alleged injury which was work related. At that time, Petitioner related the activities that caused some problems, which included stretching. Respondent was still conducting business and Petitioner could have applied for another position, but none was likely available.

15IWCC0695

29. Petitioner testified in rebuttal that despite Ms. Orris' testimony about the adjustability of the seats, she still had to move her arms as she previously testified. She had her arms right in front of her and was looking down and bent over, "reaching," because she had to inspect the parts and put them together.

30. The medical records indicated that on September 24, 2009, Petitioner presented to an ER because of dizziness; reporting symptoms of nausea, "sense of movement," "spinning, and decreased ability to stand/walk." Clinical impression was "dizziness," the "vertigo" box was not checked. Petitioner was discharged in improved condition. On September 27, 2009, Petitioner was admitted to hospital for observation and evaluation because if dizziness for two-three days and unspecified chest discomfort. There were no neurological defects except for dizziness and vertigo. Petitioner was discharged on September 29, 2009. At that time it was noted that Petitioner's head CT was negative and showed "no acute change," chest x-ray was normal, and EKG was stable. She would be given a "couple of days off work to regain her full strength and balance."

31. On September 30, 2009, Petitioner presented to Dr. Leimbach after her hospitalization for dizziness and upset stomach. Her stomach was better but she was still dizzy. Dr. Leimbach diagnosed vertigo and referred Petitioner to physical therapy for inner ear exercises.

32. On October 20, 2009, Petitioner presented to Dr. Marchiando, an ENT, who noted Petitioner episodes of symptoms were diminishing, but she was still unsure of herself and did not believe she could work in this condition. Her work requires her to move her head back and forth. Dr. Marchiando terminated meclizine and ordered an ENG test. The results were "consistent with positional nystagamus, which denotes a nonlocalizing lesion in the peripheral or central vestibular pathways."

33. Cervical and brain MRIs taken on November 23, 2009 were both interpreted as negative.

34. Petitioner had physical therapy through February 16, 2010 for dizziness and headaches. It was noted she had on 2-3/10 pain and 75% of the long-term goals had been met. She was discharged to a home exercise program.

35. On December 7, 2010, Petitioner called into Dr. Leimbach's office noting she felt "real dizzy again like last year." A head MRI taken December 9, 2010 appeared to be normal. A cervical MRI taken December 21, 2010 showed 2-3 mm focus of high T2 signal in the posterior aspect of the cervical spine which may represent a cyst versus gliosis, focal 33 mm posterior right paracentral disc protrusion versus small disc prolapse at C3-4 without cord compression or myeomalacia, and degenerative disc disease at C4-5 and C5-6.

36. On February 7, 2010, Petitioner presented to Dr. MacGregor for evaluation of neck complaints on referral from Dr. Leimbach. Petitioner reported she gets a knot in her neck and pain radiates into the right shoulder and arm. She stated she worked for Respondent and was "too short for the machine and had to continuously stretch and reach."

15IWCC0695

37. Dr. MacGregor reviewed the recent MRI and she agreed with the radiologist's report which indicated a 2-3 mm focus of high T2 signal in the posterior aspect of the cervical spine which may represent a cyst versus gliosis, focal 33 mm posterior right paracentral disc protrusion versus small disc prolapse at C3-4 without cord compression or myeomalacia, and degenerative disc disease at C4-5 and C5-6. Dr. MacGregor prescribed medication and physical therapy, but she could not recommend continued chiropractic manipulation. Petitioner would call if she was interested in cervical injections. They were administered on April 5, April 26, and May 17 of 2011. After the injections, Petitioner reported she felt a lot better and was doing okay. She would call if her condition worsened for additional injections.

38. On December 14, 2011, Dr. Zelby performed a medical examination on Petitioner, pursuant to section 12 of the Act. Dr. Zelby noted the September 14, 2011 MRI showed degenerative changes most prominent at C4-5 and C5-6, with large osteophytes effectively fusing the disc space at those levels. A November 23, 2009 MRI showed a straightening of the cervical spine with mild hypertrophy on the left at C4-5 and C6-7, with no stenosis or neural impingement. There were also anterior osteophytes at C4-5 more than C5-6 and C6-7. "MRI scans of the cervical spine from 12/16/10, 12/21/10, and 9/12/11 show no interval changes."

39. Dr. Zelby concluded that Petitioner had "a constellation of complaints that have no identifiable medical basis." The MRI studies show very modest degenerative findings which did not affect the nervous system. There was no basis to believe that Petitioner suffered any infirmity at all, either occupationally related or otherwise.

40. Dr. Zelby also concluded that Petitioner had been over treated, presumably based only on her subjective complaints. She needed no additional treatment. The concept of MMI was inapplicable because there is no objective infirmity and no objective evidence of any injury.

41. On January 16, 2012, Petitioner returned to Dr. MacGregor noting that her neck was much better. She took muscle relaxers when it acted up and was doing fine. She was hospitalized for two weeks for transverse myelitis. Dr. MacGregor though she should finish physical therapy before she would "consider a low back workup."

42. On September 20, 2012, Petitioner returned to Dr. MacGregor. She reported neck pain and stiffness and some dizzy spells. She noted that she became very dizzy a month previously when she bent over in the shower. Dr. MacGregor ordered a new MRI.

43. On October 11, 2012, Petitioner reported to Dr. MacGregor that she was feeling a little better with pain medication and was "doing well at this point." Dr. MacGregor reviewed the MRI taken October 9, 2012, which showed moderate-to-severe, left lateral recess neuroforaminal stenosis at L4-5 and some mild stenosis at C5-6. Dr. MacGregor informed Petitioner that at some point she would need decompression at C4-5, but her strength was good. They would follow up after the holidays, or sooner if her condition worsened.

15IWCC0695

44. Dr. Zelby testified by deposition on October 22, 2012. Petitioner reported an injury at work over a period of time and described being too short for machines on which she was working in her job. Petitioner felt this caused her to reach, stretch, and pull, which just destroyed her back over time. Respondent got new machines over the second half of 2009 which Petitioner believed were harder for her to use. She had chiropractic treatment, physical therapy, and injections for her neck which helped a little.

45. Dr. Zelby explained that because bone spurs functionally fused the disc space at C4-5 and C5-6, "it would sort of make that joint immobile and certainly make it a non-pain generator." The MRIs showed some degeneration changes but no evidence of any traumatic changes. There was no stenosis or spinal cord compression in any of the MRIs.

46. Dr. Zelby characterized the MRIs as "absolutely" normal. The MRIs did not correlate with Petitioner's subjective complaints. Her subjective complaints were medically inexplicable. There was no factual basis to support Petitioner's opinions about her employment or her condition. She had no infirmity and treatment was likely driven by her subjective complaints. "In the context if her objective findings on MRIs and her normal neurological exams," her work activities as described to him was not a cause of her symptoms.

47. On cross examination, Dr. Zelby testified he viewed the actual diagnostic films and not just the radiology reports. He agreed that Petitioner complained of pain in her neck, in her shoulder, and down her arms. She had mild degenerative changes from C4-C6. He did not "appreciate" a disc protrusion at C3-4; he saw no abnormality at that level. He would disagree with any opinion to the contrary. He agreed that degenerative disc disease can cause neck pain. A herniation would have to be so large to compress the nerves to cause pain down the arms.

48. Dr. Zelby disagreed the discs were fused "because the discs have either worn away or calcified and brought the two discs together." He explained Petitioner had osteophytes growing essentially along the anterior longitudinal ligament causing calcification. "So it wasn't that she had a collapse of the disc space and degeneration of bone fusing to bone. She actually had a bridge of bone going across the anterior longitudinal ligament with calcification of that ligament resulting in the autofusion." It probably caused a little loss of lateral flexion.

49. On November 11, 2012, Dr. MacGregor performed anterior cervical and arthrodesis and placement of interbody fusion devise and plating across C4-5 for cervical spinal stenosis and spondylosis.

50. Dr. MacGregor testified by Deposition on April 16, 2014. Dr. MacGregor testified that when she first saw Petitioner, she reported sharp neck pain radiating into her right shoulder and arm with some tingling. The symptoms were aggravated by any physical activity, worsened as the day went on, and Petitioner attributed her condition to her employment.

51. Petitioner reported she was placed at a different machine. She was too short for the machine and she had to continuously stretch to reach the machine. That "caused a knot in the back of her neck which radiated to the right shoulder and down the right arm." She reported some dizziness around September 2006. Petitioner also indicated she had "to pull a heavy piece of equipment down from above her head multiple times throughout her shift, and that's when the headaches and neck pain begins."

52. On examination, Petitioner exhibited some tenderness in the cervical spine at approximately C5-6, reduced cervical ROM, and some spasm. Dr. MacGregor thought the 2010 MRI showed sufficient pathology to be causally related to her neck pain. She recommended ESIs, medication, and PT, and she recommended against chiropractic adjustment.

53. Dr. MacGregor took x-rays which showed osteophyte development which was a way the body was trying to quasi-fuse vertebrae naturally. That process could be related to an overuse phenomenon but was more likely idiopathic in nature.

54. Petitioner's neck condition improved considerably with physical therapy and medication. When Petitioner presented on September 20, 2012, she reported she bent her head in the shower a month previously and felt very dizzy. When she got out of the shower she fell in the bathroom. Her neck was still very sore and she still had some dizzy spells. Dr. MacGregor ordered a new MRI.

55. Dr. MacGregor described the new MRI as showing a degenerative finding that had progressed to the point Dr. MacGregor thought she would benefit from surgery, which could be performed at Petitioner's convenience. Dr. MacGregor thought Petitioner's condition developed over time. While Petitioner did not report a singular event, "repeated events tend to cause the condition over time."

56. Dr. MacGregor testified that while the textbooks don't describe a connection between cervical findings and vertigo and dizziness, the longer she practices in neurosurgery she has found "there is a certain subset of patients who describe what they say is dizziness, vertigo, and it tends to be C4-5 and above" when they extend their necks. That description might not be a true dizziness, "because that is an inner ear thing," but may be due more to a change in sensation due to the neck condition.

57. Dr. MacGregor thought Petitioner had good result from surgery and she had not seen her since releasing her from treatment.

58. Dr. MacGregor was then asked a hypothetical question in which she was to assume Petitioner often worked for more than 40 hours a week, sometimes as many as 50 to 60 and always worked with her head bent down handling parts with her hands and arms repetitively. She had to snap parts together, sometimes forcefully with a press, and to reach and stretch to retrieve parts. Dr. MacGregor answered that it was certainly possible that such activity contributed to the development of Petitioner's cervical condition.

15IWCC0695

59. On cross examination, Dr. MacGregor testified that the osteophytic formation and "auto fusion" was part of degenerative disc disease and development of arthritis. She agreed that the osteophytes and degeneration was the cause of her problem and pain generator, but then she said you can't "necessarily say" it was the pain generator. Dr. MacGregor also agreed that some sort of movement in the cervical spine would be necessary to cause degeneration to the degree Petitioner had. Dr. MacGregor indicated she believed the MRIs showed a general advance of Petitioner's cervical degenerative disc disease.

60. Dr. MacGregor further testified that she would be surprised if a 62 year old patient did not have some degenerative findings at all levels. The fact that Petitioner stopped working for Respondent since October of 2009 would not "necessarily" change her causation opinion because it was not "as though she miraculously got better."

61. Dr. MacGregor agreed that the trauma Petitioner suffered in the bathroom accident increased her pain and she was doing pretty well before that. It was only after that incident that she took the MRI and recommended surgery. It was "possible" that the bathroom incident aggravated Petitioner's degenerative and caused the need for surgery.

62. Dr. MacGregor agreed that as a general rule a person with a repetitive trauma condition would generally improve after no longer being exposed to the repetitive activities. However, "once a certain level has been reached," "even stopping the activity won't necessarily make the symptoms go away on a permanent basis." Dr. MacGregor did not see an MRI taken in November 2011. She had no opinion regarding Dr. Leimbach's and Dr. Zelby's, interpretation that that MRI was normal.

63. On redirect examination, Dr. MacGregor testified she would not consider that Dr. Zelby's description of the November 2011 MRI would be considered normal. The loss of spine lordosis is generally a reaction to injury.

64. Dr. MacGregor noted that the surgery confirmed that C4-5 was the pain generator because Petitioner got better. Pathology in the C4-5 level would lead to radicular pain perceived as shoulder or deltoid pain, as well as pain across the trapezius area. In addition an osteophyte would certainly cause irritation of the nerve root.

65. Dr. MacGregor also posited that a portion of her vertigo and dizziness "may have been caused" by her C4-5 pathology. Her causation opinion would not change if Petitioner's work involved no heavy lifting because she based her opinion "purely on the repeated neck movement." The bathroom incident did not change her causal opinion because the "pain distribution had not changed." Ceasing the offending activity would not reverse the degeneration.

66. On re-cross examination, Dr. MacGregor testified that it was certainly possible that the November 2011 MRI showed simply age-related degenerative disc disease. The MRI taken after the shower incident showed a progression of Petitioner's condition. She agreed that Petitioner reported she was getting better prior to the shower incident.

15IWCC0695

The Arbitrator found Petitioner proved accident based on her unrebutted testimony about having to "work with her neck flexed for extended periods of time, in awkward positions and also required the repeated use of her hands and arms, in reaching and occasionally in forceful pushing." He also found the causation opinion of Dr. MacGregor persuasive.

The Commission concludes that Petitioner has not successfully sustained her burden of proving she sustained a compensable accident or causation to her current condition of ill being. Petitioner proved only that she looked down for extended periods, turned her head, and performed fine manual manipulation in her work activities. Those circumstances would likely be occasioned by almost anybody who performs extensive typing or does fine manual manipulation in their employment. The Commission cannot conclude that even rapid repetitive fine hand manipulation contributed to an alleged repetitive injury to Petitioner's cervical spine. Here, Petitioner did not establish that her job duties involved extensive overhead activity, despite her apparent statement to Dr. MacGregor to the contrary, or the need to exert substantial force which would affect her cervical spine. She specifically testified that all the parts were in front of her and generally at shoulder level or lower.

It is certainly possible that the incident in the shower was the proximate cause of Petitioner's condition, causing the need for surgery, but that conclusion is not necessary for the Commission to find that Petitioner did not prove a compensable repetitive traumatic work accident. Likewise, it is not necessary to accept the opinion of Dr. Zelby, that fundamentally Petitioner does not have any condition of ill-being. That conclusion would be in direct opposition to the opinion of Dr. MacGregor who opined that Petitioner would benefit from surgery as soon as she reviewed the 2012 MRI.

Petitioner's argument that she sustained an accident causing her cervical spinal condition is undermined by the fact that her condition did not improve in the years after she no longer worked for Respondent. In addition, the MRIs showed what certainly could be nothing more than a natural progression of her degenerative disc disease. It is noteworthy that Petitioner did not have surgery until more than three years after she last worked for Respondent. The fact that Petitioner's condition worsened during the years she was unemployed, certainly supports the premise that her ultimate condition and the need for surgery was the result of the natural progression of her underlying arthritic condition. There is simply nothing in the record before the Commission to suggest that Petitioner's condition is anything other than the natural progression of underlying spinal arthritis of a person in her mid 60s.

Finally, the causation opinion provided by Dr. MacGregor was equivocal. All she stated was that it was "certainly possible" that her repetitive neck movement may have contributed to the development of her spinal condition. She also testified that the initial pathology could have been simply a reflection of her underlying arthritis and the later MRIs showed a progression of that condition.

For the reasons stated above the Commission reverses the Decision of the Arbitrator, finds that Petitioner did not sustain her burden of proving a compensable accident or causation to a current condition of ill being, and denies compensation.

15IWCC0695

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated January 29, 2015 is reversed and compensation is denied.

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

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

DATED: SEP 9 - 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-8/5/15
46

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

Richard D. Thompson,
Petitioner,
vs.

Triopia C.U.S.D. #27,
Respondent.

15IWCC0683

NO: 14 WC 19219

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, 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 February 11, 2015 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: SEP 8 – 2015
KWL/vf
O-8/24/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0683

THOMPSON, RICHARD D
Employee/Petitioner

Case# 14WC019219

TRIOPIA C.U.S.D. #27
Employer/Respondent

On 2/11/2015, 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:

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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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0683

Richard D. Thompson
Employee/Petitioner

v.

Triopia C.U.S.D. #27
Employer/Respondent

Case # 14 WC 19219

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **December 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/19/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$51,009.51**; the average weekly wage was **$980.95**.

On the date of accident, Petitioner was **45** years of age, married, with **3** dependent children.

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

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

Respondent shall be given a credit of N/A for TTD, N/A for TPD, N/A for maintenance, and N/A for other benefits, for a total credit of N/A.

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE THAT HIS ACCIDENT AROSE OUT OF HIS EMPLOYMENT, ALL BENEFITS ARE DENIED.

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

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

Arbitrator Molly Dearing

February 7, 2015
Date

FEB 11 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0683

ARBITRATION DECISION

RICHARD THOMPSON
Employee/Petitioner

Case # 14 WC 19219

v.

TRIOPIA C.U.S.D #27
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was forty five years of age and employed by Respondent as a physical education teacher. In that capacity, Petitioner directs middle school and high school students in physical education class. He testified that on the date of accident, physical education class began at 8:30 a.m. The class convenes in the cafeteria, where Petitioner takes role, before the students change clothes in locker rooms. Petitioner testified that the middle school students change in a locker room located near the cafeteria, and once the middle school students are finished, the entire class walks together to the gym, at which point the high school students then enter a nearby locker room to change, leaving the middle school students to be supervised by Petitioner.

While awaiting the high school students to emerge from the locker room, a student ran up the wall, jumped, and attempted to touch high on the side wall, which excited the other students. Petitioner informed the students that he could accomplish that same maneuver, and he stated that he was challenged by the students to attempt to go higher. Petitioner testified that he wanted to prove to the students that he could do it. Petitioner testified that he participated in that activity with the students because he likes to challenge his students and because he wants to be a physical fitness role model for them. Petitioner testified that it is not unusual for him to participate in activities with the students, nor does it violate any policies in educating students. He sets the curriculum for the class and he stated that he generally demonstrates activities that are part of the curriculum. Petitioner indicated that the students running up the wall was not done at his instruction, and it was not part of his daily curriculum. He testified that the daily activity for that day was mat ball, a variation of kickball, which they would have played but for Petitioner's injury. Petitioner acknowledged that there were other ways in which to build rapport with his students and that he can be a positive role model to his students without running up a wall. He performed the maneuver twice and he described it as a "Bo Jackson move running up the wall." On the second attempt, Petitioner felt a pop in his ankle when he struck the wall. He landed on the ground on his foot, and he felt pain in his right lower leg. Petitioner then hobbled over to a chair and instructed the students to go get Principal Adam Dean, who came to the gym approximately 15 minutes later.

Petitioner was transported to Passavant Hospital where he underwent an MRI on December 20, 2013 which revealed a near full-thickness tear of the Achilles tendon. PX 1, 2. The same was

repaired on December 20, 2013 by Dr. Darr Leutz. Petitioner followed up with Dr. Leutz postoperatively and underwent a course of physical therapy at Passavant Hospital. PX 2.

Petitioner was released to return to work without restrictions on March 17, 2014. PX 1. Petitioner testified that his treatment concluded in March 2014, and he continues to perform home exercises.

Petitioner testified that he is not presently taking any pain medication for his injury and he has returned to his position as a physical education instructor. Because Petitioner's injury occurred immediately prior to the holiday break, Petitioner lost no time from work and he was paid his regular salary during this time. Petitioner also testified he was able to return to the same job as before his injury earning at least the same amount of money.

A Position Description for a Teacher at the Junior-Senior High School in the Physical Education Department was admitted as Petitioner's Exhibit 8 and indicates that the Teacher is to create a flexible subject matter program and class environment favorable to learning and personal growth, as well as establish effective rapport with pupils and motivate them to develop skills, attitudes and knowledge to provide a good foundation. PX 8.

Adam Dean testified at Arbitration. Mr. Dean is Principal of the Junior Senior High School that includes grades seven through twelve and he is Petitioner's supervisor. Mr. Dean testified that Petitioner's maneuver up the wall on the date of accident did not violate a District rule or policy. Mr. Dean testified that Petitioner often participates in classroom curriculum activities with his students, and Mr. Dean has observed Petitioner in class prior to the date of accident pitching to students while playing whiffle ball. Mr. Dean testified that he believed the activity that caused Petitioner's injury could "link up with his [employment] goals" of building rapport and motivating students, but that that running up a wall was not an activity that he would recommend. Mr. Dean did not exercise any disciplinary action as a result of the incident.

Dr. Liana Palacci reviewed Petitioner's medical records at the request of Respondent for review and assignment of an AMA impairment rating. Based upon Petitioner's physical examination that showed no evidence of motion deficits or palpatory findings, as well his normal active range of motion and no evidence of muscle atrophy or deformity, Dr. Palacci assigned an impairment rating of 1% loss of the right lower extremity or the equivalent of 1% of the whole person. RX 1.

CONCLUSIONS OF LAW

In regard to disputed issue (C), to obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred, *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989),

whereas the "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. Courts have recognized three general types of risks to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Id.* Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment, unless the employee was exposed to the risk to a greater degree than the general public. *Metropolitan Water Reclamation District of Greater Chicago,* 407 Ill. App. 3d at 1014.

In the present case, the Arbitrator finds that Petitioner's injury did not arise out his employment with Respondent, but rather, was resultant solely from actions personal to Petitioner. In so concluding, the Arbitrator finds it significant that the activity of running up a wall was initiated by the students and not by Petitioner, which suggests that the activity was not incidental to his employment. The Arbitrator also finds it significant that Petitioner controls the curriculum of his classroom and he acknowledged that running up a wall "Bo Jackson style" was not part of the daily curriculum for December 19, 2013. The class was instead scheduled to play mat ball and there was no evidence presented to suggest that running up a wall was ever a part of Petitioner's physical education curriculum for his students.

Moreover, Petitioner testified that he ran up the wall the second time, at which time he was injured, because he was challenged by students to go higher. The Arbitrator finds that performing such a maneuver at the coaxing of the students is indicative of horseplay rather than a risk incident to his employment, and suggests that Petitioner engaged in the activity of running up a wall on December 19, 2013 for solely personal reasons, e.g. to show off.

While Petitioner testified that he ran up the wall to build rapport with his students, to challenge them, and to provide them with a physical fitness role model, he himself acknowledged that there were other less risky means to accomplish that objective. Because Petitioner's mechanism of injury in this case was resultant from an activity not performed at his instruction or at his initiation, and was outside of the curriculum, the Arbitrator finds that in performing such a maneuver, he exposed himself to a risk that was outside the exercise of any of his duties for Respondent. The Arbitrator notes that the Commission has held similarly in *Simpson v. Lowe's of DeKalb*, 01 IIC 0540 (July 13, 2001) and *Roque v. Guerro*, 3 IIC 815 (November 19, 2003), and given that those cases were factually analogous to the matter at hand, the Arbitrator finds the Commission's holdings in those matters to be instructive in the present case. Therefore, the Arbitrator finds that Petitioner's injury suffered while running up a wall was a personal risk not connected with or incidental to his employment duties.

Based upon the foregoing, the Arbitrator finds that Petitioner's injury of December 19, 2013 did not arise out of his employment with Respondent. Claim is denied. The remaining issues of causal connection, medical benefits, and the nature and extent of the injury are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ 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

Tami M. Juergensen,
Petitioner,
vs.

15IWCC0685
NO: 08 WC 34384

D Construction 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 temporary total disability, causal connection, medical expenses, 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 May 13, 2014, 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: SEP 8 - 2015
DLG/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0685

JUERGENSEN, TAMI M
Employee/Petitioner

Case# **08WC034384**

D CONSTRUCTION INC
Employer/Respondent

On 5/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2122 McNAMARA PHELAN McSTEEN LLC
BRIAN C CICHON
3601 McDONOUGH ST
JOLIET, IL 60431

0075 POWER & CRONIN LTD
MARTIN DEELEY
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0685

Tami M. Juergensen
Employee/Petitioner

Case # 08 WC 34384

v.

Consolidated cases:

D Construction, 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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **8/20/13 and 11/15/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0685

FINDINGS

On **10/6/2007**, 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 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, the Petitioner earned $ **68,952.00** ; the average weekly wage was $ **1,326.00** .

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** children under 18.

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

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

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

ORDER

See attached decisions of Arbitrator

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

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

Signature of Arbitrator

December 5, 2014
Date

MAY 13 2014

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

Having considered the evidence presented at hearing, the Arbitrator finds that on October 6, 2007 Petitioner sustained an injury that arose out of the course of her employment. In support of this finding, the Arbitrator adopts the following facts and rules as described hereafter.

Petitioner testified that she was a laborer who on October 6, 2007 was working for D Construction. On this date she was directing traffic on a job site at the intersection of 143rd street and Parker in Homer Glen. While performing this job, she was struck by a vehicle that launched her onto the hood of the car and onto the ground. She testified that she was in shock after being struck by the car and felt pain to her knees, shoulder and neck. Her foreman on the job that day was a person named Ron and she reported the incident to him as per company protocol. After she reported the accident to Ron, she observed Ron call Orlando Duran, who she then spoke with to report this accident. She did not know at the time whether or not Orlando prepared a report. After verbally reporting the accident to Ron and Orlando she was not provided an opportunity or asked to prepare any other type of report or documentation. Petitioner attempted to follow up with Orlando Duran to further document this accident, but was never able to report it to him because she was never able to meet up with him when he was in his office.

With respect to Petitioner's claimed notice of accident, Respondent called Orlando Duran to testify. He testified that he was the safety manager at D Construction and that at the accident date he was the only person working in that capacity. He was responsible for up to 600 employees and was responsible for making sure that those employees had proper safety training and were aware of the accident reporting protocol. Orlando was the person who was responsible for reporting workers' compensation injuries to and coordinating benefits with the insurance company. Orlando did not recall Petitioner reporting an injury where she was struck by a car and stated that he didn't recall receiving a phone call from a foreman named Ron on the claimed injury date. He further testified that he did not know who the foreman was on the job in question. At the time of the accident he was not often in his office.

Orlando did recall speaking with Petitioner on one specific occasion when the police were called to a job site based upon an allegation that Petitioner struck a motor vehicle with a flag on November 8, 2009. Petitioner stated that she did speak with Orlando about this incident as well as the police but that this was a separate and distinct incident from her earlier claimed accident date. Petitioner stated that she did not say anything about being struck by a vehicle at that time because she was never specifically asked about her accident date and she had already reported that accident to her supervisor and Orlando. Petitioner was not injured as a result of the November 8, 2009 incident so there was no reason for her to fill out an accident report.

Petitioner stated that she did not seek immediate medical treatment for her injuries as she could not afford to miss work. Whether actual or perceived, Petitioner feared that if she were to report this accident as a workers' compensation injury that she would then be prevented by D Construction from being given work. As a result of this, she did not miss any time from work immediately after her accident and continued to work despite the fact that she was experiencing pain from the accident.

Petitioner's first medical visit after the accident date was with Dr. Mitchell on December 11, 2007. Petitioner saw Dr. Mitchell on this date because her pain had increased. She went to see Dr. Mitchell because she had seen him for prior treatment. Petitioner testified that the most recent previous treatment for which she had seen Dr. Mitchell was for bilateral knee pain and had an arthroscopy of both knees done on October 17, 2006. Petitioner had made a full recovery from that procedure and had been working in a full duty capacity after that surgery. Dr. Mitchell's medical records show that Petitioner reached MMI and was released from his care on February 1, 2007.

Petitioner did not make any mention to the doctor on December 11, 2007 that she had been struck by a car or that she had been injured at work. When asked why she did not report this to Dr. Mitchell at that time she stated that she couldn't afford to be off of work and that she felt that if she reported this as a workers' compensation injury that she would not be offered further work by D Construction. She further wanted to make sure that any bills incurred would be covered by insurance and she believed that if she told Dr. Mitchell that this was a workers' compensation injury that these bills would go unpaid. On this specific office visit, petitioner indicated that she was having shoulder pain and after being injected, was referred to Dr. Romeo for further treatment. Petitioner remained working during this time.

Petitioner's next medical visit was with Dr. Romeo on January 29, 2008. The purpose of this visit was to treat for the pain that she was having to her left shoulder. Again, Petitioner did not mention that she had been struck by a car nor did she state that she had suffered a work injury. Petitioner stated that she was continuing to work this time and for the same reasons that she did not mention this accident to Dr. Mitchell, she did not mention it to Dr. Romeo. She needed to work and was fearful that if she reported a workers' compensation injury that she would not be able to work further.

Petitioner's first mention of a work injury to a medical provider occurred when she saw Dr. Mitchell on June 26, 2008. On this date she complained of bilateral knee pain and gave Dr. Mitchell a history of being struck by a car while working as a flagger. She indicated to Dr. Mitchell that she has had consistent pain in her knees since that time and reported the injury at the time of the incident but did not seek medical attention for this pain until now. When asked why petitioner chose this time to seek medical attention and to report this to her doctor she stated that she had been laid off and was no longer working. She no longer had a fear of being restricted from work as a result of pursuing this treatment and could no longer deal with the pain that she was experiencing. Since the accident she had constant pain in her knees but continued to work through the pain because she could not afford to miss any time from work.

With respect to Petitioner's having sustained a work injury, in light of the evidence and testimony presented, the Arbitrator finds the testimony of the Petitioner to be credible. This Arbitrator acknowledges the fact that petitioner did not seek medical treatment immediately after the accident and did not make any mention of this accident to any medical provider despite seeing 2 separate medical providers subsequent to her accident. This fact alone does not defeat Petitioner's claim. The explanation provided by the Petitioner that she did not want to file a workers' compensation claim because she needed to continue to work and because she feared retribution from her employer, whether real or not, is a valid one. This believe of the Petitioner is consistent with her continuing to work until she could work no longer and consistent with the fact that though she did see medical providers, that she made no mention if this accident until later in her treatment. Further, the only direct testimony as to whether or not Petitioner was stuck by a vehicle is unrebutted. There is a discrepancy in the testimony as to whether Petitioner reported this injury on the accident date. This Arbitrator has considered the testimony of Mr. Duran that Petitioner did not report a work injury on the stated date. This Arbitrator

further believes that Mr. Duran does not have a recollection of speaking to Petitioner on the accident date about this injury. Petitioner testified that she did report her injury to her foreman on the accident date and that that foreman did call Orlando who subsequently spoke to Petitioner. This testimony is consistent with the stated reporting protocol at D construction.

The Arbitrator believes that Petitioner did speak to her supervisor and Orlando Duran in reporting this accident. It is consistent that Petitioner would have a valid recollection of this incident and the reporting as it is a unique event for her. It is also consistent that Mr. Duran would not be able to recall if he spoke with Petitioner on that date as it would not be unique to him. At the time he was the only safety manager working for Respondent and was responsible for up to 600 employees. Petitioner further did what she was told to do and followed company protocol in reporting this injury to her supervisor who then contacted the safety manager, who then spoke to Petitioner. The evidence would be clearer if there had been a contemporaneous documentation of this injury by the employer, but once Petitioner reported the injury, she cannot be responsible for how the employer chooses to deal with this information. The fact that she did not immediately treat medically is also consistent with the lack of information because without any immediate follow up for Petitioner there would be no need for any documentation as would be reported to an insurance company. In addition, the fact that Mr. Duran was not present at the site is consistent with the absence of this documentation. Once petitioner was given an opportunity be her employer to document this injury on September 24, 2008 she did so consistent with her testimony. The Arbitrator further notes that he had the opportunity to observe both the Petitioner and Mr. Duran testify over an extended period and that he finds Petitioner to have been credible in her testimony.

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

The Arbitrator incorporates by reference thereto the findings as set forth above.

The Arbitrator finds the Petitioner has not met her burden of proving that her present condition is causally connected to the alleged incident occurring on October 6, 2007. The Petitioner was involved in a non-occupational motor vehicle accident a few days before she was seen by Dr. Mitchell on October 17, 2006. (Respondent's Exhibit No. 14). At that time she complained of bilateral knee pain and numbness in her left upper extremity. (Id.). She was the back seat passenger in a vehicle that was involved in a T-Bone accident. (Id.). She saw Dr.

Mitchell on November 2, 2006. (Respondent's Exhibit No. 12). Dr. Mitchell reviewed her MRI and determined she had a right knee meniscal tear and recommended arthroscopic surgery. (Id.). She underwent arthroscopic surgery to her right knee on November 27, 2006. (Respondent's Exhibit No. 6). As a result of the October 2006 auto accident, the Petitioner underwent arthroscopic surgery to her left knee on January 10, 2007. (Respondent's Exhibit No. 5).

Dr. Mitchell testified by way of evidence deposition. (Respondent's Exhibit No. 17). Dr. Mitchell testified that MRI exams for the knees done on July 11, 2008 showed no change when compared to the MRI exams done prior to the accident in 2006. *Id* at 38-39, but that MRI results were not extremely accurate at measuring the difference between old and new meniscal injuries when that injury occurred in the same location on the meniscus. He felt that Petitioner's bilateral knee injuries were related to her October 6, 2007 accident. Dr. Mitchell testified that as a result of the surgeries he performed on the Petitioner's knees prior to the alleged work accident that the Petitioner would develop osteoarthritis. (Respondent's Exhibit No. 17 at Pg. 31). Dr. Mitchell testified that the whole focus of the December 11, 2007 exam was the Petitioner's left shoulder. (Respondent's Exhibit No. 17 at Pg. 35). Dr. Mitchell testified he had no idea whether or not the Petitioner's left upper extremity problems were related to her work. (Id. page 49).

Dr. Gleason testified by evidence deposition. (Respondent's Exhibit No. 16). Dr. Gleason examined the Petitioner on July 6, 2010. Dr. Gleason testified within a reasonable degree of medical and surgical certainty that the August 4, 2008 surgery to the right knee and the October 27, 2008 surgery to the left knee are not the result of any alleged accident occurring on October 6, 2007. *Id* at 37. Dr. Gleason testified that it was not until June 26, 2008 that the Petitioner had any complaints of bilateral knee pain. *Id* at 16-17. Dr. Gleason noted Dr. Mitchell's office note of December 11, 2007. If the Petitioner had suffered some type of trauma in October of 2007, she would have complained to Dr. Mitchell on December 11, 2007. *Id* at 25.

The Arbitrator notes and finds significant the following facts. The Petitioner's testimony and Dr. Mitchell's records regarding her surgeries and pre-existing condition for the alleged October 6, 2007 incident show that Petitioner did not report any knee problems until June of 2008, more than 8 months after the date of the alleged accident. The Arbitrator notes the Petitioner had no lost time after the October 6, 2007 alleged incident. The Arbitrator notes that Dr. Mitchell was unable to link her left shoulder problems to her employment and that no other evidence on the issue of causal connection relative to her left shoulder was presented by the Petitioner.. The Arbitrator further notes that Dr. Gleason has testified that the Petitioner's left shoulder problems and knee problems are not related to any employment duties in 2007.

The Arbitrator finds the Petitioner has not met her burden of a proving a causal connection between her subsequent surgeries and her employment duties during 2007. Compensation is denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☒ 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

Robin Thiering,
Petitioner,
vs.

15IWCC0686

NO: 08 WC 11926

Wal-Mart,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,800.00. 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: SEP 8 - 2015
KWL/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

15IWCC0686

THIERING, ROBIN
Employee/Petitioner

Case# **08WC011926**

WAL-MART
Employer/Respondent

On 1/31/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0529 GREG TUITE & ASSOC
119 N CHURCH ST
SUITE 407
ROCKFORD, IL 61101

0210 GANAN & SHAPIRO PC
COURTNEY M QUITTER
210 W ILLINOIS ST
CHICAGO, IL 60654

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

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

Corrected

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0686

Robin Thiering
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # **08** WC **11926**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Waukegan, IL**, on **September 27, 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **February 5, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**16,537.56**; the average weekly wage was $**318.03**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**6,024.77** for TTD, $**4,211.21** for TPD, $**-0-** for maintenance, and $**2,500.00** for other benefits, for a total credit of $**12,735.98**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $212.02/week for 28-2/7 weeks, commencing 2/5/2007 through 6/17/2007, 10/5/2007 through 10/18/2007, 11/15/2007 through 11/28/2007, and 12/10/2007 through 1/20/2008 as provided in Section 8(b) of the Act. Respondent shall be given a credit of $6,024.44 for temporary total disability benefits and $4,211.21 for temporary partial disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $190.82/week for 100.2 weeks, because the injuries sustained caused the 60% loss of the right foot, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $190.82/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of $2,500.00 for permanent partial disability benefits that have been paid.

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

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

Edward Lee
Arbitrator

1/30/14
date

JAN 31 2014

STATEMENT OF FACTS

Robin Thiering (hereinafter "Petitioner") worked for Wal-Mart (hereinafter "Respondent") as a fitting room associate. Her job duties included hanging clothes, returning clothes and answering the phone. On February 5, 2007, Petitioner suffered an injury to her right foot when she slipped and fell on ice while walking to her car.

Petitioner was taken by ambulance to Beloit Memorial Hospital where she came under the care of Dr. Sauer. She was diagnosed with a right tibia-fibula fracture with extension towards the ankle joint and a posterior malleolar fracture. She underwent surgery on February 6, 2007 consisting of fixation of the right ankle fracture with screws and a rod. Petitioner was discharged from the hospital on February 9, 2007. RX #2; PX #7.

On February 21, 2007, Petitioner saw Dr. Sauer in follow-up and was placed in a short leg cast. Initially, Petitioner testified she used a wheelchair. However, when she saw Dr. Sauer on March 27, 2007, Petitioner's cast was removed and she was instructed to start weight bearing. She was authorized to return to work light duty, performing sit down work only and no driving. Petitioner began attending physical therapy at Beloit Memorial Hospital on April 19, 2007. RX #2; PX #3.

On May 10, 2007, Petitioner saw Dr. McCarty for purposes of a second opinion. She complained of discomfort with weight bearing localized to the fracture site. Petitioner reported she was told the fracture was not healing and that it may be four to six months before the fracture healed. Dr. McCarty diagnosed traumatic fractures of the right distal tibia and fibula without evidence of significant progression of healing. He discussed the treatment options which included removal of the proximal screw, progressive weight bearing as comfort allowed and a bone stimulator. PX #5.

Petitioner next returned to Dr. Sauer on May 16, 2007 with complaints of pain around the fracture area and irritation around the proximal interlocking screw. She was instructed to progress to full weight bearing. Dr. Sauer recommended Petitioner continue physical therapy. RX #2; PX #3.

On June 13, 2007, Petitioner saw Dr. Sauer in follow-up. She complained of ankle swelling with activity but noted she could walk full weight bearing, was using a cane and could drive. Dr. Sauer ordered compression stockings and an ultrasound stimulator. He continued to recommend physical therapy and authorized Petitioner to return to work light duty performing sit down work only with limited standing and walking, four hours per day for six weeks. RX #2; PX #3.

Beginning on June 18, 2007, Petitioner testified she returned to work for Respondent, four hours per day or 20-25 hours per week. She testified she was sitting in a fitting room with her leg elevated where she would answer phones and occasionally wait on people.

On July 25, 2007, Petitioner returned to Dr. Sauer with complaints of numbness in the great and second toes, which Dr. Sauer noted could be due to her socks and shoes being too tight. Dr. Sauer instructed Petitioner to discontinue physical therapy and start a home exercise program. He authorized Petitioner to return to work light duty with limited standing and walking for two months, working four hours per day and five days per week for two months. RX #2; PX #3. Petitioner testified she worked in the fitting room answering phones during June, July and August.

Petitioner saw Dr. Sauer on August 28, 2007 after an incident when she was sitting at a desk, felt pain and heard a snap after pulling her leg back. Dr. Sauer prescribed pain medications. Petitioner then returned to Dr. Sauer on September 26, 2007 with complaints of pain along her leg. Dr. Sauer recommended she consider removal of the screws. Petitioner was otherwise authorized to return to work light duty with limited standing and walking, four hours per day or 20 hours per week for six weeks. She

testified in August and September she was given more responsibility which required her to walk more and wait on customers. Petitioner also described unpacking lingerie and stocking in the fitting room. RX #2; PX #3.

On October 5, 2007, Petitioner underwent a second surgery which consisted of removal of the screws from the tibia. Following the surgery, Petitioner was admitted overnight for post-operative nausea and vomiting. She was discharged the following day. Petitioner then returned to Dr. Sauer on October 8, 2007 at which time she was instructed to ambulate as tolerated. Dr. Sauer authorized Petitioner to return to work light duty with the same restrictions of working four hours per day. Petitioner testified she returned to work on October 15, 2007, performing seated work four hours per day. RX #2; PX #3.

Petitioner next saw Dr. Sauer on October 23, 2007 at which time she complained of soreness around the incisions. Dr. Sauer ordered physical therapy and authorized Petitioner to return to work light duty performing sit down work with limited standing and walking, four hours per day or 20 hours per week for four weeks. RX #2; PX #3.

On October 24, 2007, Petitioner resumed physical therapy at Beloit Memorial Hospital. She saw Dr. Sauer in follow-up on November 27, 2007 at which time he noted one wound remained open. Dr. Sauer referred Petitioner to the wound clinic and authorized her to return to work light duty six hours per day maximum and alternating sitting and standing for four weeks.

Petitioner began attending the wound clinic on November 27, 2007 at Beloit Memorial Hospital. At the time she saw Dr. Sauer on December 10, 2007, he noted the wound had turned into a deep ulcer and recommended excision of the ulcer. RX #2; PX #3.

On December 11, 2007, Petitioner underwent a third procedure consisting of excision of a right medial leg ulcer with debridement of soft tissue including skin and subcutaneous tissue and closure of the right leg wound. Following the procedure, Petitioner was authorized off work. RX #2; PX #3.

Petitioner returned to Dr. Sauer in follow-up on December 17, 2007. It was noted there were no signs of infection and Petitioner was instructed to complete the course of antibiotics. Petitioner next returned to Dr. Sauer on December 31, 2007 at which time the sutures were removed. RX #2; PX #3.

On January 14, 2008, Petitioner returned to Dr. Sauer for a recheck of the ankle wound. Dr. Sauer noted the wound was gradually closing and the amount of drainage had diminished. He authorized Petitioner to return to work performing sit down work with the right leg lifted, four hours per day for the next two weeks. Petitioner testified she returned to work in the fitting room on January 16, 2008. RX #2; PX #3.

On January 28, 2008, Petitioner saw Dr. Sauer and noted an improvement in pain. At that time, Dr. Sauer authorized Petitioner to return to work full duty but noted she may need to sit to rest at times over the next three weeks. There were no restrictions on the number of hours or days per week Petitioner was permitted to work. RX #2; PX #3.

Petitioner testified she continued to work for the store and began doing more work. She stated she began experiencing more pain and would go home in tears. She also indicated she was scheduled to work six days in a row and was being scheduled on weekends in 2008, while she was not scheduled to work on weekends in 2007. Petitioner testified she called in absent three times.

On January 31, 2008, Petitioner presented to Dr. Reinecke with concerns over continued swelling and numbness along the side of her foot and in the first and second toes. She also complained of her foot turning when she walked which made it more achy and sore. Dr. Reinecke diagnosed overpronation secondary to ankle injury and plantar fasciitis and explained to Petitioner that the thickness, swelling and

numb feelings were all expected after the type of injury and surgery since her foot was in a different position due to the injury. Dr. Reinecke recommended an orthotic. PX #11.

Petitioner returned to Dr. Reinecke on February 7, 2008 for purposes of casting for the orthotic. Dr. Reinecke noted Petitioner had questions regarding her foot position and wanted an explanation. Dr. Reinecke again explained the change in positioning of the foot and recommended an orthotic device to help support the foot and hopefully alleviate the irritation of the posterior tendon. PX #11.

On February 20, 2008, Petitioner presented to Dr. Sauer in follow-up. At that time, Dr. Sauer noted Petitioner was working full duty and was tolerating work without much difficulty. Dr. Sauer recommended an orthotic. Petitioner saw Dr. Reinecke on February 28, 2008 to pick-up the orthotic device. Petitioner then followed up with Dr. Reinecke again on March 11, 2008 at which time she reported no trouble with the orthotic but noted some soreness in the right leg. Dr. Reinecke recommended Petitioner work five hours per day. RX #2; PX# 3; PX #11.

Also on March 11, 2008, Petitioner saw Dr. Sauer in order to reassess work status. Petitioner reported she was working eight hours per day, six days straight and that she was having difficulty after five hours as well as tenderness at the fracture site. Dr. Sauer authorized Petitioner to return to work light duty working a maximum of five hours per day or 25 hours per week for eight weeks. RX #2; PX #3.

On March 31, 2008, Petitioner returned to Dr. Sauer with complaints of continued pain in the ankle and foot. She indicated her pain had gotten worse and she was having trouble tolerating five hours per day at work. Petitioner also reported she tried an orthotic but it did not help. Dr. Sauer ordered x-rays of the foot and ankle and a bone scan. He also referred Petitioner to Dr. Lang for a second opinion. Petitioner was otherwise authorized to return to work light duty five hours per day. RX #2; PX #3.

On April 3, 2008, Petitioner underwent a bone scan which demonstrated focus of activity in the distal tibia and to a much lesser extent the distal fibula which likely represented healing fractures. RX #2; PX #3.

On April 23, 2008, Petitioner testified she put in her two week notice at the store. She last worked for the store on May 4, 2008. RX #6; RX #9.

Petitioner saw Dr. Lang on June 9, 2008 for purposes of a second opinion. Dr. Lang felt there was nothing mechanical or structural to suggest or recommend further surgery as he suspected the bulk of Petitioner's symptoms were due to nerve pathology. He therefore recommended comprehensive evaluation and treatment with a pain management clinic. PX #13.

On June 18, 2008, Petitioner returned to Dr. Sauer with complaints of mild intermittent swelling of the foot. Dr. Sauer recommended a foot-ankle orthosis. RX #2; PX #3. Petitioner testified she still wears the orthosis all the time.

On August 14, 2008, Petitioner attended an IME with Dr. Holmes at the request of the Respondent. Dr. Holmes diagnosed a tib-fib fracture which resulted from the work accident and recommended a diagnostic ultrasound and EMG/NCV to determine whether there was nerve damage. He opined Petitioner's symptoms were causally related to the work accident. Dr. Holmes opined Petitioner could return to work in a sedentary or semi-sedentary position and anticipated MMI in three to six months. RX #10.

Petitioner next saw Dr. Sauer on October 1, 2008 with complaints of continued pain. Dr. Sauer recommended a CT scan, MRI and an EMG. He otherwise noted the claimant was completely off pain medications except Advil. He authorized the claimant off work and instructed her to follow-up three weeks after the EMG, MRI and CT scans. RX #2; PX #3.

On October 1, 2008, the claimant underwent a CT scan of the right lower leg which demonstrated healed fractures of the distal tibia and fibula with intermedullary rod within the tibia. RX #2; PX #3.

Petitioner underwent a MRI of the right ankle on October 10, 2008 which showed no bony, muscular or tendinous abnormality and mild soft tissue edema around the ankle. She also underwent a MRI of the right lower leg which showed subcutaneous soft tissue edema but no abnormal signal. RX #2; PX #3.

On October 13, 2008, Petitioner underwent an EMG/NCV which showed evidence of demyelinating and axonal neuropathy of the common peroneal nerve. However, it was noted Petitioner had 1+ bipedal edema during the examination which made testing difficult. It was also noted electrodiagnostic testing of the bilateral sural and saphenous nerves were undetectable. RX #2; PX #3.

Petitioner next saw Dr. Sauer on October 22, 2008 to review the test results. Dr. Sauer indicated his greatest concern was the possibility of a persistent nonunion of the tibial shaft fracture. He also noted nerve damage which may have occurred from the injury or due to entrapment in scar or irritation from hardware. Dr. Sauer instructed Petitioner to see Dr. Lang to confirm whether she had an ongoing nonunion of the tibia. He indicated if she had a bone grafting procedure, it may allow her to heal completely and improve her overall life. Dr. Sauer noted the alternative would be to leave her with a nonunion and ongoing pain with weightbearing. He indicated if Dr. Lang disagreed there was a nonunion then he was prepared to discharge her. PX #10.

On November 3, 2008, Petitioner returned to Dr. Lang with complaints of a significant amount of pain in her leg and difficulty walking. Dr. Lang felt adequate healing had taken place and noted he would not consider the fracture a nonunion. Instead, he felt the pain was neuropathic in nature and that pain medications may help Petitioner since her pain could not be reproduced with stressing of the leg. Dr. Lang also noted some patients benefited from rod removal and Petitioner could consider it. PX #13.

On February 9, 2009, Petitioner attended a repeat IME with Dr. Holmes who diagnosed a clear nonunion of the distal tibia status post tibial rodding which was directly related to the work accident. Dr. Holmes recommended surgery consisting of bone grafting which would give an 85-90% chance of healing. He further opined therapy would be useless and the tibia would not be stabilized by removing the rod. Dr. Holmes recommended an EMG when swelling was less and indicated a treatment plan for the nerve pain could be outlined. He opined Petitioner should either be off work or return to work in a strictly sedentary position. Dr. Holmes felt Petitioner would be at MMI within three to six months of bone grafting. RX #10.

On May 14, 2009, Petitioner underwent an EMG/NCV which was abnormal and showed evidence of right peroneal neuropathy at the ankle, mild peripheral polyneuropathy of the bilateral lower extremities, and mild posterior tarsal tunnel syndrome. PX #14.

Petitioner next presented to Dr. Blint at Rockford Orthopedic Associates on May 18, 2009. She complained of right leg, ankle and foot pain which was worse with pressure or standing on her leg. Dr. Blint diagnosed a closed tibia fracture and ordered a repeat MRI of the right leg. PX #14.

On May 29, 2009, Petitioner underwent a MRI of the right leg which demonstrated mild residual fracture deformities of the distal tibial and fibular shafts and mature osseous healing without osteomyelitis or other complications. PX #14.

Petitioner returned to Dr. Blint on June 8, 2009. At that time, Dr. Blint prescribed Neurontin and referred Petitioner to Dr. Bush for evaluation of tarsal tunnel syndrome. PX #14.

On June 11, 2009, Petitioner first saw Dr. Bush. She reported complaints of right foot, lower right leg and ankle pain. Dr. Bush diagnosed tarsal tunnel syndrome and neuritis. He instructed Petitioner to let the Neurontin take effect then return for a definitive plan. PX #14.

On July 9, 2009, Petitioner returned to Dr. Bush with complaints of pain and numbness on the medial aspect of the ankle. Dr. Bush diagnosed tarsal tunnel syndrome with right saphenous entrapment and neuritis of the right deep peroneal nerve. He prescribed Lidoderm. PX #14.

Petitioner next presented to Dr. Bush on August 6, 2009. At that time, Dr. Bush instructed the claimant to discontinue Neurontin due to side effects. He indicated he would not recommend surgery or injections due to a decrease in symptoms and recommended a brace. PX #14.

On August 18, 2009, Dr. Holmes prepared an IME addendum after reviewing the EMG/NCV and MRI report. He diagnosed a tibial nonunion, possible neuroma involving the peroneal nerve and overlying polyneuropathy. Dr. Holmes did not feel Petitioner had tarsal tunnel syndrome. He recommended use of a Lidoderm patch and a bone stimulator. Dr. Holmes noted the treatment options included bone grafting and immobilization and also indicated Petitioner may require decompression of the nerve or an attempt to release the neuroma. Dr. Holmes indicated he would not recommend rod removal. He noted Petitioner could take an additional three months to heal after bone grafting and if she did not heal after bone grafting, she could require full plating of the tibia. Overall, Dr. Holmes felt Petitioner would benefit from surgery. He opined she could return to work in a sedentary or semi-sedentary capacity with use of bracing and immobilization of the foot until a decision was made regarding surgery. Dr. Holmes felt Petitioner would be at MMI six months after surgery. RX #10.

Dr. Holmes saw Petitioner again on December 9, 2009. He diagnosed a nonunion and right peroneal nerve neuropathy. Dr. Holmes recommended a repeat CT scan and opined Petitioner could return to work light duty in a strictly sedentary position. RX #10.

On December 15, 2009, Petitioner underwent a repeat CT scan of the right leg which showed healed fractures of the tibia and fibula. RX #10.

On February 16, 2010, Dr. Holmes prepared an IME addendum after reviewing the updated CT scan. He opined the CT scan showed the fracture was not completely healed at one spot which could account for Petitioner's pain. Dr. Holmes indicated it may be helpful for Petitioner to undergo a re-evaluation to determine if she still has pain that may be from the potential continued nonunion of the tibia. RX #10.

Petitioner testified if she was going to have surgery, she wanted to treat with Dr. Holmes. She therefore requested a consultation with Dr. Holmes to discuss the surgery he was recommending. Petitioner attended a consultation with Dr. Holmes on April 15, 2010 at which time she testified she took paperwork for her SSDI case provided to her by her attorney for Dr. Holmes to fill out. Dr. Holmes noted Petitioner continued to have constant pain over the ankle and had developed ringworm on the top of her foot. He recommended a dermatology consultation which was unrelated to the work injury and pain management to resolve any pain prior to surgery. Dr. Holmes also completed a Physical Medical Source Statement which was required for Petitioner's SSDI case. He indicated Petitioner could sit for more than two hours, stand for five to ten minutes at a time, stand or walk less than two hours during an eight hour work day but sit for at least six hours, required a sitting position with the leg elevated and needed to use a cane, could not lift, twist, bend, crouch, squat or climb stairs or ladders. Dr. Holmes also recommended Petitioner be evaluated by a pain management doctor prior to returning to work. RX #10; PX #5.

On May 3, 2010, Petitioner presented to Dr. Jaworowicz at Medical Pain Management. She complained of pain starting in the right ankle and radiating to her knee and increased pain with any

activity. Petitioner reported her foot was cold and sensitive to touch. Dr. Jaworowicz diagnosed CRPS of the lower extremity, neuropathy and depression. He prescribed Topamax. PX #12.

On May 24, 2010, Petitioner last saw Dr. Jaworowicz. She reported trying the Topamax but woke up with shortness of breath, tremors and tachycardia. Dr. Jaworowicz noted Petitioner was not interested in a spinal cord stimulator. PX #12.

At the request of her attorney, Petitioner was evaluated by Dr. Coe on September 29, 2010. Dr. Coe diagnosed multiple fractures of the right ankle including a spiral intra-articular fracture of the right distal tibia, a fracture of the posterior malleolous and a fracture of the distal fibula. He opined there was a causal connection between the work injury and Petitioner's condition of ill-being. Dr. Coe opined Petitioner required additional treatment, including further pain management, possibly a spinal cord stimulator and a repeat right ankle surgery. He opined Petitioner required work restrictions including working in a primarily sedentary position with limited walking, kneeling, squatting and stair climbing, continued use of the right foot and ankle brace and a 10-lb lifting restriction. PX #6.

Also at the request of her attorney, Petitioner was evaluated by Susan Entenberg on May 2, 2011. Ms. Entenberg opined Petitioner was not able of performing her past work as a stocker and fitting room associate. She also felt Petitioner was not a good candidate for vocational rehabilitation and a stable labor market did not exist for her. Ms. Entenberg noted Petitioner had not performed a job search. She opined Petitioner did not have transferrable skills to a lighter occupation. PX #20.

On October 12, 2011, at the request of the Respondent, Ed Steffan of EPS Rehabilitation performed a labor market survey. He found 10 employers with 15 positions consistent with Petitioner's rehabilitation variables between $8.75-$13.00 per hour. Additionally, seven of nine employers had positions open and available at the time of his calls. The positions identified were located in the Rockford area. Mr. Steffan opined Petitioner should be able to obtain gainful employment based on the findings of the labor market survey and motivation of Petitioner to seek and secure employment. RX #11.

On November 15, 2011, Dr. Holmes prepared an IME addendum report. Dr. Holmes noted his opinions had not changed and he was still recommending the bone grafting procedure. He noted the bone grafting procedure would be considered a minor procedure and would probably require hospitalization for only one day after surgery. He further noted there was an 80-90% chance the procedure would improve Petitioner's condition. Dr. Holmes opined Petitioner could easily return to work in a sedentary capacity if not semi-sedentary or light duty. He otherwise recommended a FCE to determine work restrictions. RX #10.

On January 22, 2012, Susan Entenberg prepared an addendum report after reviewing the limited labor market survey. She felt the sedentary jobs identified in the labor market survey required basic computer skills, good communication, customer service skills and a light exertional level. She also felt the labor market survey did not consider the restrictions outlined by Dr. Holmes in the Physical Medical Source Statement dated April 15, 2010. Ms. Entenberg noted her opinions did not change as she felt Petitioner was not an appropriate candidate for vocational rehabilitation and a stable labor market did not exist for her. PX #20.

On May 11, 2012, Ed Steffan prepared an addendum report. Mr. Steffan noted although Petitioner was reporting difficulty with standing and walking, sedentary jobs are performed from a seated position. He further disagreed with Ms. Entenberg and felt Petitioner had transferrable skills from her prior work experience which she could use to pursue sedentary work. Mr. Steffan opined that based on the findings of his labor market survey and the reports of Dr. Holmes and Dr. Coe, Petitioner could pursue other positions besides those identified in the labor market survey, including a cashier,

switchboard operator, customer service representative, team assembler, security guard, monitor position, receptionist and information clerk. Mr. Steffan further opined that based on Petitioner's previous customer service experience, available physical capability and the labor market, there was an available and stable labor market which Petitioner could access if she was motivated to return to work. RX #11.

Petitioner underwent a FCE on September 17, 2012. The FCE was noted to be valid and demonstrated Petitioner had functional capabilities at the Light physical demand level. It was noted Petitioner previously worked as a fitting room attendant which was classified as a Light physical demand level occupation and Petitioner's current physical capabilities appeared to fall within the Light physical demand level but she failed to meet the expectations with floor to chair and above shoulder lifting. It was therefore recommended bending, stooping, stairs and right foot controls be performed on an occasional basis and balancing, squatting, and crouching be performed on a minimal basis. It was also recommended Petitioner not crawl at all. It was noted Petitioner was able to sit for 55 minutes with her right leg hanging down but as the assessment progressed, she requested a stool to elevate her leg and stated she experienced increased swelling and pain with prolonged sitting. It was therefore noted it would be important to consider the reports and behaviors if Petitioner was required to sit for extended periods of time. PX #19.

On September 29, 2012, Susan Entenberg prepared an addendum report after reviewing the FCE results. Ms. Entenberg's opinions remained the same that Petitioner was not an appropriate candidate for vocational rehabilitation and a stable labor market was not available. PX #20.

On October 31, 2012, Dr. Holmes prepared an addendum report after reviewing the FCE results. Dr. Holmes' opinions did not change regarding his prior surgical recommendations and he indicated if Petitioner did not undergo the bone grafting procedure, she would be at MMI. He otherwise opined Petitioner was capable of and able to return to work. Dr. Holmes could not provide a definite opinion regarding whether the fitting room associate position would be consistent with a sedentary position. However, he opined if the parties could find a job which was consistent with Petitioner's restrictions, she could return to work in those restrictions. RX #10.

On November 1, 2012, Ed Steffan prepared an addendum report after reviewing the FCE results and fitting room associate job description. Mr. Steffan's opinions did not change as he still felt there was a readily available and stable labor market Petitioner could access if she was motivated to use her physical capabilities to return to work. RX #11.

Susan Entenberg testified regarding her opinions on March 13, 2013. PX #20. Approximately 85% of the opinions Ms. Entenberg provides are at the request of the employee. Id at 34. Ms. Entenberg testified she did not feel Petitioner was a candidate for vocational rehabilitation and she did not feel a stable labor market existed for her. Id at 22, 24. She disagreed that Petitioner could perform the jobs identified in the labor market survey prepared by Ed Steffan. Id at 31. Ms. Entenberg testified she did not perform a labor market survey. Id at 35. Ms. Entenberg relied on the Physical Medical Source Statement prepared by Dr. Holmes in reaching her opinions. However, she acknowledged her report did not indicate that Dr. Holmes stated Petitioner could sit from 30-45 minutes up to two hours. Id at 37. She also admitted her report did not indicate that Dr. Holmes stated Petitioner could sit six hours out of an eight hour work day. Id at 38. Ms. Entenberg testified she relied on the doctors' opinions regarding work status and if Petitioner's work status was adjusted, it could impact her opinions. Id at 35-36. She admitted she did not review the November 15, 2011 report of Dr. Holmes and was therefore not aware Dr. Holmes felt Petitioner could return to work in a sedentary if not semi-sedentary or light duty capacity. Id at 49-50.

Ed Steffan testified regarding his opinions on June 5, 2013. RX #1. Approximately 60-70% of the opinions Mr. Steffan provides are at the request of the employee. Id at 5. Mr. Steffan testified regarding the labor market survey he performed. He used Petitioner's work history information as well as the opinions of Dr. Holmes and Dr. Coe and contacted 12 employers. Id at 8-9. Mr. Steffan testified 10 employers had 15 positions consistent with Petitioner's rehabilitation variables and seven employers had nine positions available. Id at 9. He also felt Petitioner could do jobs other than those identified in the labor market survey. Id at 17. Mr. Steffan opined a reasonably stable labor market exists for Petitioner. Id at 11, 20.

Mr. Steffan testified regarding the two subsequent reports he prepared. He explained Petitioner's prior work history was important and he considered it when rendering his opinions. RX #1 at 15. Mr. Steffan testified he believed Petitioner had transferrable skills which she acquired through her prior positions as a CNA and apartment demonstrator which she could use in a sedentary position. Id at 16-17. He concluded there is a readily available and stable labor market for Petitioner. Id at 20. Mr. Steffan acknowledged the Rockford labor market is smaller than the labor market of Chicago. Id at 11, 46. However, he explained the jobs he identified within Petitioner's restrictions were using his most conservative estimate and Petitioner has access to a labor market greater than just the town of Rockford. Id at 18. He further explained he did not list every possible job Petitioner could perform. Id at 55. Mr. Steffan testified the Physical Medical Source Statement is outdated as Dr. Holmes provided updated restrictions. Id at 54. He testified the updated restrictions do not preclude Petitioner from finding full-time employment. Id at 55.

Alicia Lawrence, store manager, testified on behalf of Respondent. Ms. Lawrence was the store manager on the accident date and during the time Petitioner worked for the store following the accident. She has worked for Respondent for a total of 18 years. Following the accident, Ms. Lawrence testified Petitioner returned to work with restrictions and the store was able to accommodate her restrictions with a position in the fitting room. Ms. Lawrence further confirmed Petitioner returned to work with a restriction on the number of hours she could work and the store was able to accommodate the restrictions with respect to Petitioner's hours.

Ms. Lawrence explained the employee schedules are generated by computer and there is no way for the computer to know whether an employee has a restriction on the number of hours she can work. Therefore, if the computer schedules an employee to work more than the number of hours allowed by their doctor, Ms. Lawrence explained the employee should tell the store so the hours can be adjusted. She further testified an employee's hours can be adjusted the same day she is scheduled to work provided the employee notifies the store of the issue. Ms. Lawrence recalled having one conversation with Petitioner regarding an issue with the number of hours she was being scheduled to work. She stated she told Petitioner to notify her if there was an issue with the hours so the schedule could be adjusted. Ms. Lawrence explained if Petitioner reported her hours or restrictions were not being accommodated, she would verify the restriction and adjust the hours. She confirmed Petitioner was not disciplined, punished or given fewer shifts to work due to her restrictions.

Ms. Lawrence testified Petitioner no longer works for the store because she turned in her resignation and quit. At the time she quit, Ms. Lawrence testified Petitioner's work restrictions were being accommodated and would have continued to be accommodated had she not quit. Ms. Lawrence explained there have been situations where employees with permanent restrictions have continued to work for the store and be accommodated since the date Petitioner quit.

With respect to her current condition, Petitioner testified she has to watch what she is doing to make sure she does not overdo it. She testified she is able to do laundry, watch TV, read, do puzzles and cook. Petitioner stated she is always has pain in her right leg and has problems with stairs. She is no longer able to dance, play with her five grandchildren or ice skate. Petitioner currently takes over the counter medications for pain. She last worked for the store on May 4, 2008 and has not attempted to returned to work since that time or performed a job search. She is not interested in undergoing additional surgery and is not currently seeing a doctor for her ankle.

With respect to (k), TTD benefits in dispute, the Arbitrator finds the following:

The Arbitrator finds Petitioner failed to prove she is entitled to additional TTD benefits. There is no dispute Petitioner quit working for Respondent when her work restrictions were being accommodated. Petitioner testified she put in her two week notice on April 23, 2008 and last worked for the store in May 2008. This was confirmed by Alicia Lawrence who was the store manager at the time of the accident and during the time Petitioner worked for the store. Ms. Lawrence confirmed Petitioner's work restrictions were accommodated during the time she worked for the store and would have continued to be accommodated had Petitioner not quit.

After Petitioner quit working for the store, she continued to be able to work light duty as indicated by both Dr. Holmes and Dr. Coe. On August 18, 2008, Dr. Holmes indicated Petitioner could return to work in a sedentary or semi-sedentary position. RX #10. Dr. Holmes indicated on February 9, 2009 Petitioner could either be off work or return to work in a sedentary position. On August 18, 2009, Dr. Holmes indicated Petitioner could return to work in a sedentary or semi-sedentary position. He stated on December 9, 2009 that Petitioner could work in a strictly sedentary position. On April 15, 2010, Dr. Holmes completed a Physical Medical Source statement in which he indicated Petitioner could sit for more than two hours and stand for five to ten minutes at a time, stand/walk less than two hours during an eight hour workday but could sit for at least six hours, required a seated position with her leg elevated and needed to use a cane and could not lift, twist, bend, crouch/squat or climb stairs/ladders. PX #5. The Arbitrator notes this is consistent with a sedentary or semi-sedentary position. The last doctor to see Petitioner was Dr. Coe on September 29, 2010. PX #6. Dr. Coe indicated Petitioner required work restrictions of a primarily sedentary position with limited walking, kneeling, squatting, stair climbing and a 10-lb lifting restriction. On November 15, 2011, Dr. Holmes indicated Petitioner could easily return to work in a sedentary if not semi-sedentary or light duty capacity. Dr. Holmes stated on October 31, 2012, Petitioner was capable of and able to return to work. RX #10. The medical evidence clearly demonstrates Petitioner continued to be able to work light duty after she quit. Furthermore, Ms. Lawrence testified Respondent would have continued to accommodate Petitioner's restrictions had she not quit.

Based on the foregoing, the Arbitrator finds Petitioner failed to prove she is entitled to additional TTD benefits.

With respect to (f) whether Petitioner's current condition of ill-being is causally related to the injury and (l) the nature and extent of the injury, the Arbitrator finds the following:

Petitioner is entitled to PPD benefits to the extent of 60% loss of use of the right foot and 15% man as a whole. Petitioner was diagnosed with a tibia-fibula fracture for which she underwent three surgical procedures consisting of fixation of the right ankle fracture with screws and rod, removal of the screws from the right tibia and excision of right medial leg ulcer with debridement of soft tissue including

skin and subcutaneous tissue and closure of leg wound. A fourth surgical procedure consisting of bone grafting in order to correct the nonunion of the fracture was recommended. Petitioner testified she does not wish to undergo another surgery. Following the third procedure, Petitioner was authorized to return to work full duty beginning on January 28, 2008. She was then given work restrictions of working five hours per day or 25 hours per week for eight weeks beginning on March 11, 2008 and returned to work for Respondent within the restrictions. Petitioner continued to work for Respondent within the work restrictions until she put in her two week notice on April 23, 2008. She last worked for the store on May 4, 2008. Petitioner testified she quit working for the store.

Although Petitioner wants the Arbitrator to ignore the fact she quit, it is undisputed Petitioner quit working for the store thereby removing herself from the labor force. The evidence establishes Petitioner's work restrictions were being accommodated at the time she quit and had she not quit, Respondent would have continued to accommodate her restrictions. The examining doctors of both Petitioner and Respondent established Petitioner could continue to work in a sedentary capacity. Furthermore, the testimony of the vocational experts, specifically Ed Steffan, establish there is a reasonable and stable labor market for Petitioner. Petitioner has made absolutely no attempt to return to work or look for a job. She has therefore failed to prove she is permanently and totally disabled.

The Arbitrator finds Petitioner's testimony that she was required to work outside of her restrictions unconvincing and not supported by the evidence based on the testimony of the witnesses and the evidence regarding Petitioner's work schedule.

The Arbitrator finds the testimony of Alicia Lawrence credible. Ms. Lawrence was the store manager on the accident date and during the time Petitioner worked for the store. She confirmed Petitioner returned to work with restrictions and the store was able to and did accommodate Petitioner's work restrictions until she quit working for the store. Although Petitioner testified she was required to work outside of the hourly restrictions placed by her doctor, Ms. Lawrence confirmed the store was aware of Petitioner's restriction on the number of hours she could work and accommodated the restriction. Ms. Lawrence explained the work schedules of the employees are generated by a computer and there is no way for the computer to know whether an employee has a restriction on the number of hours she can work. Therefore, if an employee has a restriction on the number of hours she can work and is scheduled to work more hours than the restriction allows, the store will adjust the hours so they are consistent with the restriction provided the employee alerts the store of the discrepancy. Ms. Lawrence stated the store is able to adjust the employee's hours the same day she is scheduled to work provided the employee notifies the store of the discrepancy. Ms. Lawrence recalled having one conversation with Petitioner regarding an issue with the number of hours she was scheduled to work. Ms. Lawrence testified she told Petitioner to notify her if there was an issue with the number of hours she was being scheduled so her hours could be adjusted. She further explained if Petitioner notified the store that her hours were not being accommodated, she would verify the restrictions and then adjust the hours accordingly. Ms. Lawrence confirmed Petitioner was not disciplined or given fewer shifts to work due to her restrictions. Furthermore, Ms. Lawrence testified Petitioner's work restrictions were being accommodated up until the time she quit and had Petitioner not quit, her restrictions would have continued to be accommodated.

The evidence regarding the days and hours Petitioner worked, specifically the work calendar and time clock archive, do not support Petitioner's contention that she was required to work outside her restrictions. PX #1, RX #8. Rather, the evidence demonstrates the store was accommodating Petitioner's work restrictions and complying with Petitioner's hourly restriction.

Immediately following the injury, Petitioner was authorized off work. On June 13, 2007, Dr. Sauer authorized Petitioner to return to work light duty with limited standing and walking, four hours per day for six weeks. RX #2; PX #3. Petitioner testified she returned to work on approximately June 18, 2007. The calendar confirms Petitioner worked a total of five days each week for the next six weeks. PX #1. Furthermore, the time clock archives confirm that for the next six weeks, Petitioner's hourly restrictions were also accommodated as she worked approximately 20 hours per week which equates to approximately four hours per day. RX #8:

6/16/2007-6/22/2007 = 20.24 hours worked; 5 days worked
6/23/2007-6/29/2007= 20.39 hours worked; 5 days worked
6/30/2007-7/6/2007 = 20.55 hours worked; 5 days worked
7/7/2007-7/13/2007 = 20.07 hours worked; 5 days worked
7/14/2007-7/20/2007= 20.15 hours worked; 5 days worked
7/21/2007-7/27/2007 = 19.99 hours worked; 5 days worked

Dr. Sauer next adjusted Petitioner's work restrictions on July 25, 2007. At that time, he authorized Petitioner to return to work light duty with limited standing and walking, four hours per day, five days per week, for two months. PX #3; RX #2. PX #1 confirms for the next two months, Petitioner worked five days per week, which is consistent with her work restrictions. The time clock archives also confirm that for the next eight weeks, Petitioner's hourly restrictions were accommodated as she worked five days each week for approximately four hours each day or 20 hours per week. RX #8:

7/28/2007- 8/3/2007 = 20.18 hours worked; 5 days worked
8/4/2007-8/10/2007 = 20.02 hours worked; 5 days worked
8/11/2007-8/17/2007 = 20.13 hours worked; 5 days worked
8/18/2007-8/24/2007 = 20.23 hours worked; 5 days worked
8/25/2007-8/31/2007 = 19.21 hours worked; 5 days worked
9/1/2007-9/7/2007 = 20.11 hours worked; 5 days worked
9/8/2007-9/14/2007 = 20.19 hours worked; 5 days worked
9/15/2007-9/21/2007 = 20.08 hours worked; 5 days worked

On September 26, 2007, Dr. Sauer authorized Petitioner to return to work light duty with limited walking and standing, 20 hours per week for six weeks. PX #3; RX #2. PX #1 indicates that for the next six weeks, Petitioner worked five days per week, consistent with the work restrictions. Additionally, the time clock archives also indicate the claimant worked five days each week and approximately 20 hours per week. RX #8:

9/22/2007-9/27/2007 = 20.10 hours worked; 5 days worked
9/29/2007-10/5/2007 = 16.35 hours worked; 5 days worked
10/6/2007-10/12/2007 = 0 hours worked
10/13/2007-10/19/2007 = 20.12 hours worked; 5 days worked
10/20/2007-10/26/2007 = 20.36 hours worked; 5 days worked

Petitioner returned to Dr. Sauer on October 23, 2007 at which time Dr. Sauer continued Petitioner's restrictions of sit down work with limited standing and walking, four hours per day and 20 hours per week for the next four weeks. PX #3; RX #2. PX #1 confirms Petitioner worked five days each week for the next four weeks. The time clock archive confirms Petitioner continued to work five days per week and approximately 20 hours per week. RX #8:

10/27/2007-11/2/2007 = 20.12 hours worked; 5 days worked
11/3/2007-11/9/2007 = 20.20 hours worked; 5 days worked

11/10/2007-11/16/2007 = 20.45 hours worked; 5 days worked

11/17/2007-11/23/2007 = 20.36 hours worked; 5 days worked

On November 27, 2007, Dr. Sauer authorized Petitioner to return to work light duty alternating sitting and standing, six hours per day for the next four weeks. PX #3; RX #2. PX #1 shows Petitioner continued to work five days per week for the next two weeks. The time clock archives also show Petitioner worked less than six hours per day or less than 30 hours per week for the next two weeks, which is again consistent with her work restrictions. RX #8:

11/24/2007-11/30/2007 = 22.01 hours worked; 5 days worked

12/1/2007-12/7/2007 = 27.36 hours worked.

Petitioner underwent surgery to her right lower leg on December 11, 2007 and was authorized off work following the procedure. She was then authorized to return to work light duty on January 14, 2008 performing sit down work and lifting her leg, four hours per day for two weeks. PX #3; RX #2. PX #1 shows Petitioner worked five days per week for the next two weeks. The time clock archives demonstrate Petitioner worked approximately four hours per day or 20 hours per week, which is again consistent with the work restrictions. RX #8:

1/12/2008-1/18/2008 = 12.26 hours worked; 3 days worked

1/19/2008-1/25/2008 = 20.61 hours worked; 5 days worked

Beginning on January 28, 2008, Dr. Sauer authorized Petitioner to return to work full duty and noted Petitioner may need to sit for periods to rest. PX #3; RX #2. Although Petitioner testified she began to work more during the month of January and was sometimes asked to work six days in a row, the Arbitrator does not find this is evidence that Respondent was not accommodating Petitioner's restrictions. Rather, PX #1 shows the entire time Petitioner worked for the store from February 5, 2007 through May 9, 2008, Petitioner worked six days in a row on one occasion from February 25, 2008 through March 1, 2008. During this period of time, Petitioner was authorized to work full duty and therefore, working six days in a row would not have been outside of her restrictions because Petitioner had no restrictions. Additionally, the time clock archives demonstrate during the time Petitioner was authorized to work full duty, she never worked more than 32.78 hours in one week. RX #8. The Arbitrator also finds Petitioner's testimony that she experienced more pain and would often go home in tears unconvincing. Again, the period of time Petitioner was referring to corresponds to when she was authorized to work full duty. Petitioner's testimony is also inconsistent with the medical records of Dr. Sauer on February 20, 2008 which indicate Petitioner was working full duty and tolerating work without much difficulty. PX #3; RX #2.

On March 11, 2008, Petitioner returned to Dr. Sauer who again authorized her to return to work light duty working a maximum of five hours per day or 25 hours per week for the next eight weeks. PX #3; RX #2. PX #1 demonstrates Petitioner continued to work five days per week. The time clock archive shows Petitioner continued to work within her hourly restriction of 25 hours per week until she quit working for the store. RX #8:

3/8/2008-3/14/2008 = 18.61 hours worked; 3 days worked

3/15/2008-3/21/2008 = 10.06 hours worked; 2 days worked

3/22/2008-3/28/2008 = 20.20 hours worked; 4 days worked

3/29/2008-4/4/2008= 23.10 hours worked; 5 days worked

4/5/2008-4/11/2008= 23.32 hours worked; 5 days worked

4/12/2008-4/18/2008= 20.32 hours worked; 5 days worked

4/19/2008-4/25/2008= 25.16 hours worked; 5 days worked

4/26/2008-5/2/2008= 16.21 hours worked; 4 days worked

5/3/2008-5/9/2008= 12.38 hours worked; 3 days worked

Based on the evidence contained in the work calendar and time clock archives, the Arbitrator finds Petitioner's testimony that she was being required to work more hours than allowed by her work restrictions, to be unconvincing. Instead, the Arbitrator finds the evidence establishes the opposite and shows Respondent was accommodating the hourly restrictions set forth by the claimant's treating doctor. When taken with the testimony of Ms. Lawrence who also confirmed the store was accommodating Petitioner's work restrictions, the Arbitrator finds the evidence proves Respondent was accommodating Petitioner's restrictions until the time she quit in May of 2008.

From a medical standpoint, the evidence shows Petitioner remained able to work in a sedentary or light duty capacity. Both the examining doctors of Petitioner and Respondent clearly felt Petitioner could return to work with restrictions. Dr. Holmes consistently opined Petitioner could return to work in a sedentary capacity, at a minimum. Petitioner first saw Dr. Holmes on August 14, 2008 for purposes of an IME at the request of the Respondent. Dr. Holmes opined Petitioner's condition was causally related to the work accident and opined she could return to work in a **sedentary or semi-sedentary** position. RX #10.

Petitioner saw Dr. Holmes a second time on February 9, 2009 for re-evaluation. Dr. Holmes recommended a bone grafting procedure which would give Petitioner an 85-90% chance of healing. He disagreed with the rod removal procedure suggested by Dr. Lang as he felt the procedure would not stabilize the tibia. Dr. Holmes opined Petitioner should be either off work or could work in a **strictly sedentary position.** On August 18, 2009, Dr. Holmes prepared an addendum to his report. He opined Petitioner would benefit from surgery and again recommended the bone grafting procedure. Dr. Holmes felt Petitioner had not yet reached MMI and therefore did not recommend a full duty return to work, but he did indicate Petitioner could work in a **sedentary or semi-sedentary capacity** until a decision was made regarding surgery. RX #10.

On December 9, 2009, Petitioner saw Dr. Holmes a third time. At that time, Dr. Holmes recommended a repeat CT scan and indicated Petitioner could return to work in a **strictly sedentary position.** Following the CT scan, Dr. Holmes prepared an addendum to his report in which he opined the fracture was not completely healed and recommended a re-evaluation to determine whether Petitioner still had pain from a continued nonunion of the tibia. RX #10.

Petitioner saw Dr. Holmes a fourth time on April 15, 2010. Petitioner admitted she requested a consultation with Dr. Holmes to discuss the surgery he was recommending. However, she also testified she took paperwork for Dr. Holmes to completed, specifically a Physical Medical Source Statement, which was provided by her attorney for purposes of her SSDI case. The Arbitrator finds this suspicious. Dr. Holmes recommended an unrelated consultation with a dermatologist for ringworm on her foot and an evaluation with a pain management doctor to resolve pain before surgery. Dr. Holmes completed the Physical Medical Source Statement in which he indicated Petitioner could **sit for more than two hours and stand for five to ten minutes at a time, stand/walk less than two hours during an eight hour workday but could sit for <u>at least</u> six hours, required a seated position with her leg elevated and needed to use a cane and could not lift, twist, bend, crouch/squat or climb stairs/ladders.** The Arbitrator finds the Physical Medical Source Statement indicative of Petitioner's ability to work and consistent with Dr. Holmes' prior opinions that Petitioner could work in a sedentary or semi-sedentary position. RX #10; PX #5.

On November 15, 2011, Dr. Holmes prepared an addendum report. Dr. Holmes' opinions regarding surgery did not change as he was still recommending the bone grafting procedure which he felt was a minor procedure and had an 80-90% chance of improving Petitioner's condition. Dr. Holmes otherwise opined Petitioner could return to work in a **sedentary, if not semi-sedentary or light duty capacity,** but recommended an FCE to determine restrictions. RX #10.

After reviewing the FCE results and a job description for a fitting room associate, Dr. Holmes prepared an addendum report dated October 31, 2012. His opinions regarding surgery did not change and Dr. Holmes stated if Petitioner did not undergo surgery, she would be at MMI. Although Dr. Holmes could not provide a definite opinion regarding whether the fitting room position would be consistent with a sedentary position, he opined **Petitioner was capable and able to return to work.** RX #10.

The opinions of Dr. Coe are consistent with the opinions of Dr. Holmes that Petitioner could return to work in a sedentary capacity. Dr. Coe examined Petitioner at the request of her attorney on September 29, 2010. Dr. Coe was also the last doctor who has seen Petitioner. He opined Petitioner **required work restrictions which included a primarily sedentary position with limited walking, kneeling, squatting, stair climbing and a 10-lb lifting restriction.** PX #6.

The opinions of Dr. Holmes and Dr. Coe are consistent as both doctors agreed Petitioner was capable of returning to work in a sedentary capacity at a minimum and therefore establish Petitioner remained able to work in a light duty capacity.

The opinions of Ed Steffan are more credible than the opinions of Susan Entenberg. Ms. Entenberg's opinions are biased as 85% of the vocational opinions she provides are at the request of the Petitioner. PX #20 at 34. Petitioner did not perform a job search and Ms. Entenberg did not perform a labor market survey. Id at 35. In reaching her opinions that there is no stable labor market for Petitioner and Petitioner is not a candidate for vocational rehabilitation, Ms. Entenberg relied largely on the Physical Medical Source Statement prepared by Dr. Holmes on April 15, 2010 for purposes of Petitioner's SSDI case, which has no relevance or bearing on the case at hand. However, Ms. Entenberg misread the physical capabilities indicated by Dr. Holmes. Specifically, Ms. Entenberg testified Petitioner could only sit for 30-45 minutes at a time and indicated this in her report. Id at 36. Her opinions were therefore based on this understanding. However, on cross-examination, Ms. Entenberg admitted she was not aware of and did not include in her report that Dr. Holmes stated Petitioner could sit 30-45 minutes up to two hours and she could sit **six** hours out of an eight hour workday. Id at 37-38.

Despite testifying she relied on the doctors' opinions regarding work status and admitted if work status was adjusted it could change her opinions, Ms. Entenberg admitted she was not aware of and did not review the November 15, 2011 report of Dr. Holmes. PX #20 at 35-36; 49-50. She was therefore not aware Dr. Holmes felt Petitioner could return to work in a sedentary if not semi-sedentary or light duty capacity. Ms. Entenberg was also not aware Dr. Holmes was recommending a minor surgery which had an 80-90% chance of improving Petitioner's condition. Id at 53. Ms. Entenberg therefore based her opinions on outdated information.

Furthermore, although she admitted she was aware of Dr. Coe's report and his opinions regarding work status, Ms. Entenberg completely disregarded and made absolutely no mention of Dr. Coe's opinions regarding work status in her report. PX #20 at 38-39. Ms. Entenberg's opinions are not credible and are therefore given little weight.

The opinions of Ed Steffan are more credible than the opinions of Ms. Entenberg. Mr. Steffan testified a readily available and stable labor market existed for Petitioner matching her rehabilitation variables. RX #1 at 11, 20. Mr. Steffan considered all information regarding Petitioner. Unlike Susan

Entenberg who only reviewed the initial reports of Dr. Holmes and the Physical Medical Source Statement, Mr. Steffan reviewed all of Dr. Holmes' reports. He testified he also considered the Physical Medical Source Statement which is used in SSDI cases, but felt it was outdated as Dr. Holmes prepared a subsequent report dated November 15, 2011 in which he again addressed Petitioner's work restrictions. Id at 54. Additionally, Mr. Steffan testified he also reviewed Dr. Coe's report, which is dated after the Physical Medical Source Statement, and also addressed Petitioner's work restrictions. Id at 8, 51. Mr. Steffan therefore considered all information regarding Petitioner's physical capabilities when rendering his opinions.

Unlike Ms. Entenberg, Mr. Steffan felt Petitioner had transferrable skills from her prior work as a CNA and apartment demonstrator which she could use in a sedentary position. RX #1 at 16-17. Also unlike Ms. Entenberg, Mr. Steffan performed a labor market survey in which he identified 10 employers with 15 positions consistent with Petitioner's rehabilitation variables. Id at 9. Mr. Steffan also identified seven employers with nine positions available within Petitioner's restrictions paying $8.75-$13.00/hour at the time the labor market survey was performed and which were located in the Rockford labor market. Id at 9-11. However, Mr. Steffan testified he felt Petitioner could perform other jobs than those listed in the labor market survey. Id at 17.

Following the labor market survey, Mr. Steffan prepared two additional reports in which he identified additional examples of positions Petitioner could access if she wanted to return to work which included 84,950 cashier positions, 4,206 switchboard operator positions, 66,640 customer service representative positions, 31,960 team assembler positions, 38,410 security guard positions, and 26,740 receptionist/information clerk positions. RX #1 at 18-19. Mr. Steffan explained he conservatively estimated 10% of the positions identified would be sit down, but believed a greater number would be available. Id at 18. Additionally, he testified he looked at the Bureau of Labor Statistics and identified in excess of 10,000 positions related to clerk and entry level unskilled positions which would be available to Petitioner. Id at 19. He therefore concluded there was a readily available and stable labor market for Petitioner. Id at 20.

When discussing the number of positions identified, Mr. Steffan explained he used the Chicago-Joliet-Naperville area. RX #1 at 18. He acknowledged the Rockford labor market is different and has less jobs available within the job positions he identified. Id at 11, 46. However, of the statistics related to the Rockford labor market which were presented to him at his deposition, Mr. Steffan testified there were jobs available within the positions he previously identified. Id at 48-49. Using the most conservative estimate of 10% and the information presented to him regarding the Rockford labor market, Mr. Steffan testified approximately 1000-1200 jobs would be available for Petitioner in the Rockford labor market alone. Id at 50. He further testified he did not list every possible job Petitioner could perform and Petitioner had access to a labor market greater than just the town of Rockford. Id at 55. Regardless, Mr. Steffan established there is a readily available and stable labor market for Petitioner. The Arbitrator therefore finds the testimony of Mr. Steffan to be credible and adopts his opinions over those of Susan Entenberg.

The Arbitrator notes Mr. Steffan was asked several questions on cross-examination regarding various factors which may preclude employment in a Social Security case, including the number of days per months a person could miss, the number of unscheduled breaks, non-exertional impairments, and being off task. RX #1, pgs. 35-41. The Arbitrator notes these are all factors considered by the Social Security Administration when evaluating a person's disability which have absolutely no relevance to the

case at hand. Inasmuch as this testimony was given from a Social Security Administration standpoint, the Arbitrator finds it irrelevant and gives it no weight.

Petitioner quit working for Respondent when her restrictions were being accommodated thereby removing herself from the labor force. Had Petitioner not quit, her restrictions would have continued to be accommodated. Both Dr. Holmes and Dr. Coe agreed Petitioner could continue to work at a minimum in a sedentary capacity. Petitioner wants the Arbitrator to ignore the fact she quit. Regardless of whether Petitioner quit, the testimony of the vocational experts, specifically Mr. Steffan, establishes there is a reasonable and stable labor market available for Petitioner. Petitioner has made absolutely no attempt to return to work or look for a job. For all these reasons, Petitioner failed to prove she is permanently and totally disabled. She is therefore entitled to PPD benefits to the extent of 60% loss of use of the right foot and 15% man as a whole.

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

Rhonda Mathews,

Petitioner,

vs. No. 10 WC 36298

Howe Developmental Center/State of Illinois,

15IWCC0691

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds that the Arbitrator erred in not admitting Petitioner's Exhibit 6 into evidence. The exhibit is a signed letter from Anne M. Mahalik, Director of Health Informatics for the Illinois Department of Human Services. The letter, dated July 15, 2010, is on the stationery of the Illinois Department of Human Services, Office of Developmental Disabilities. Ms. Mahalik stated she was aware of Petitioner's job duties in May of 2010. At one point, Petitioner reported she could no longer box records because her right knee hurt too badly. Petitioner then performed other duties within the department until the end of May 2010, when she was laid off. Ms. Mahalik did not witness a specific work accident or incident involving Petitioner. The Commission finds the letter from Ms. Mahalik has all the indicia of being genuine (see Ill. R. Evid. 901(a)) and, as an admission by a party opponent, is not hearsay (see Ill. R. Evid. 801(d)(2)).

Having carefully considered all the evidence presented, including Petitioner's Exhibit 6, the Commission agrees with the Arbitrator that Petitioner failed to prove her claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2014, is hereby corrected as stated herein, and otherwise affirmed and adopted.

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

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

DATED: SEP 8 - 2015
o-07/09/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

DISSENT

I respectfully dissent from the majority decision and would reverse the Arbitrator's decision in its entirety. Petitioner's unrebutted testimony was that her job duties for Respondent changed significantly in April 2010 upon notification that Respondent's facility was closing. Petitioner testified that at that time she was tasked with removing patient records from shelves, placing them in boxes and loading the boxes on a skid. Petitioner stated that she had to use a portable stairway to reach the shelved records above her head and had to bend and stoop in the process of retrieving, and boxing the records. Petitioner testified that by her estimate the boxes weighed between 40 and 50 pounds and that she stacked them four high on the skids. Petitioner further testified that in April she boxed between 200 and 250 records and another 250 records in May. Petitioner testified that during the course of this activity she developed pain and swelling in her right knee and that she reported her symptoms to Anne Mahalik, the Director of Health Informatics for the Illinois Department of Human Services, and Edward Cole, the supervisor of nursing and health information. Petitioner maintains that she notified Edward Cole before May 21, 2010 (her last day of work). Petitioner sought medical treatment on June 14, 2010 and was referred to Dr. Anthony Brown who performed surgery on her right knee August 18, 2010.

At hearing, Edward Cole testified on Petitioner's behalf. Mr. Cole testified that at the time Respondent's facility was closing, Petitioner was responsible for collecting approximately 400 medical records, boxing them and shipping them to other facilities. Cole testified that Petitioner moved 400 to 500 boxes of patient records weighing 20 to 30 pounds or more. Cole testified that Petitioner moved at least 70 percent of the boxes by herself. Mr. Cole testified that although he did not complete any workers compensation paperwork in regard to Petitioner's injury, he was aware of Petitioner's right knee injury and believed that she did report it.

At hearing petitioner also presented her Exhibit 6, a signed letter from Anne Mahalik, the Director of Health Informatics for the Illinois Department of Human Services. As indicated by the majority, the letter, dated July 15, 2010, is on the stationery of the Illinois Department of Human Services, Office of Developmental Disabilities. Ms. Mahalik stated that she was aware of Petitioner's job duties in May of 2010. Her letter states that Petitioner reported that she could no longer box records because her right knee hurt too badly. As stated by the majority, Ms. Mahalik's letter has all the indicia of being genuine and as an admission by a party opponent, is not hearsay and is admissible.

The evidence presented at hearing reflects that Petitioner was performing the duties assigned to her by her supervisors and Petitioner provided unrebutted testimony as to the physical demands of those duties which were corroborated by her supervisor Edward Cole. Furthermore, Cole testified to being aware of Petitioner's injury at the time of its occurrence. Additionally, the evidence presented demonstrates that Petitioner had no symptoms or treatment to her right knee prior to the accident and then the injury and onset of pain after the change in Petitioner's job duties. The evidence demonstrates that Petitioner was in a state of good health in regard to her right knee prior to her injury which changed immediately following the injury. The chain of events, and absence of any evidence of treatment to Petitioner's right knee prior to May 21, 2010, clearly establishes that Petitioner's condition of ill being is attributable to her work injury. Accordingly, I would reverse the decision of the Arbitrator and remand the matter for a determination of benefits.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MATTHEWS, RHONDA
Employee/Petitioner

Case# **10WC036298**

HOWE DEVELOPMENTAL CENTER
Employer/Respondent

15IWCC0691

On 4/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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SPRINGFIELD, IL 62794-9255

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

APR 17 2014

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0691

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

Rhonda Mathews
Employee/Petitioner

v.

Howe Developmental Center
Employer/Respondent

Case # **10** WC **36298**

Consolidated cases: **Chicago**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 10, 2014**. 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 _____

15IWCC0691

FINDINGS

On **05-21-10**, 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 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 $ **46,740.20**; the average weekly wage was $ **898.85**.

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

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

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

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

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

ORDER

The undersigned Arbitrator finds Petitioner did not prove that Petitioner sustained an accident that arose out of and in the course of her employment. This Arbitrator also finds that Petitioner did not prove her current condition of ill being is casually related to her work injury. Therefore, this Arbitrator makes no award in Petitioner's favor.

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

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

Signature of Arbitrator

04-16-14
Date

APR 17 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RHONDA MATHEWS, Employee/Petitioner,	)	
v.	)	10 WC 36298 Chicago
HOWE DEVELOPMENTAL CENTER, Employer/Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This action was pursued by the Petitioner under the Workers' Compensation Act ("WCA") seeking relief from her employer the Howe Developmental Center ("Howe"). On February 10, 2014, a hearing was held before Arbitrator Kurt Carlson at the Illinois Workers' Compensation Commission in Chicago, Illinois. Petitioner Rhonda Mathews was represented by counsel. Howe was represented by the Illinois Attorney General's Office. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner is currently retired, but had worked for the State of Illinois for approximately 35 years, thirty of which were spent at Tinley Park Mental Health Center, the last five years at Howe. As of May 21, 2010, she was a Health Information Assistant whose job duties included light filing and secretarial work. Petitioner testified that her job duties changed in April and May of 2010 when she was notified that Howe was closing. Her job then "became physical" and she boxed client's records by pulling them from the shelves, placing them in boxes and placing the boxes on skids or pallets. She climbed on a portable stairway and put the files in a small grocery cart, and then packed the boxes on skids. In April, she prepared 200 to 250 files to boxed. In

May, she prepared 250 boxes. She estimated that each box weighed 40 to 50 pounds. During the course of packing the boxes, she noticed pain and swelling in her right knee. She was "unable to stand" and took pain medications.

Petitioner claims she reported her injury to Ann Mahalic, the Director of Health Information for the State of Illinois, and nurse Edward Cole, Director of Nursing and Health Information. She later admitted that Ms. Mahalic was not her supervisor. Similar to the date of accident, she was not able to specify a notice date. However, she testified that she notified CareSYS of her injury on June 1, 2010, but also stated that she never filled out an injury form.

Petitioner last worked on May 21, 2010, electing to use vacation time. She retired as of June 1, 2010, the same day that Howe officially closed.

After her vacation, on June 14, 2010, Petitioner first sought medical attention with Dr. Sandra McGowan. The records that day that her right knee "shifts and swelling X 1 week was noted after doing a lot of packing and storing." An x-ray of her right knee the following day revealed a possible small right joint effusion with preservation medial lateral joint compartments and no evidence of acute trauma. On July 9, 2010 an MRI revealed a complex tear of the posterior horn of the medial meniscus, moderate knee joint effusion and a small baker's cyst.

Petitioner next saw Dr. Anthony Brown who performed a right knee arthroscopy medial menisectomy and chondroplasty. His records on June 28, 2010 state, "was doing a lot of boxing at work then noted swelling." Petitioner participated in physical therapy from August 19, 2010 through January 22, 2011.

On January 17, 2011, Dr. Brown released Petitioner from his care, while also recommending that Petitioner wear an unloader brace and use a stationary bike. Most of the Petitioner's medical bills were paid were paid through her husband's group health insurance.

Petitioner was not given any restrictions by Dr. Brown but testified that she continues to have problems walking up and down steps and has constant pain. She sleeps with her leg on a body pillow. She takes tylenol three to four times each day. She "can't move and do things like [she] used to." When she goes on longer shopping trips, she rides the motorized scooter approximately two to three times a month and has disabled parking sticker.

Ed Cole testified at the hearing that he was Petitioner's supervisor at Howe. He testified that he was Petitioner's supervisor at that time and that she was in charge of getting the medical records for the clients boxed and shipped to the clients' new housing location. He indicated that the work was "labor intensive." He further stated that Petitioner boxed 400 to 500 boxes, but he "can only guess." When he picked up one box that was half full, he estimated that it weighed 20 to 30 pounds. Petitioner did have assistance sometimes from others, but she moved about 70% of the boxes.

Mr. Cole was asked the question of whether Petitioner ever reported an injury to her right knee. His response was "I believe she did." However, he was not able to give a date and admitted that he did not fill out a workers' compensation packet with Howe's Workers' Compensation Coordinator. He did not have Petitioner fill out a notice of injury form nor did he fill out a supervisor's report form.

II. Conclusions of Law

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

E. Was timely notice given to the Respondent?

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

Petitioner bears the burden of proving that a repetitive motion led to her injury. She testified that she filled and moved approximately 450 to 500 boxes weighing about 40 to 50 pounds each in a two month period, using a portable stairway, a small grocery cart and a skid. Petitioner failed to identify a specific time, place or event of accident. In fact, her original application for adjustment of claim contained no date of accident until it was amended on the date of trial, nearly four years later. (ARB EX. #2) It is unclear from the record whether the Petitioner is claiming specific loss or repetitive trauma. The original application for adjustment of claims states "repetitive trauma" with no accident date. The request for hearing form has "repetitive trauma" crossed out. Under a repetitive trauma theory it is still necessary to determine a precise date of injury. Bellwood v. Industrial Commission, 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026 (1987). See also, Deana Durand v. Industrial Commission, 224 Ill. 2d 53, 308 Ill. Dec. 715, 862 N.E. 2d 918 (2006). While it is true that an amendment to the application for adjustment of claim may be properly made at any time to conform with the evidence already in the records, there must be evidence "already in the records." McLean Trucking Co. v. Industrial Commission, 96 Ill2d 213 (Ill. 1983). Declaring the accident date four years after the Petitioner's last day of work is not sufficient and constitutes a failure of proof in this matter. As a result, Respondent received no timely notice of this matter. Furthermore, Petitioner failed to identify what specific activity or repetitive activity injured her right knee. For instance, she neglected to testify as to any bending, stooping, or twisting motions, or any motions that would put undue pressure on her knee from filling and lifting boxes. Petitioner failed to make clear at what height(s) she was working, and whether this required any of the aforementioned movements of her right knee. Petitioner failed to prove that lifting the boxes caused her injury. Simply walking could have caused her injury or aggravated a pre-existing condition. Therefore, Petitioner did not

establish an accident or causal connection as she did not prove that her work duties were of such a repetitive nature that they would lead to her right knee injury.

This is particularly problematic for Petitioner as she has no medical evidence to support her claim of repetitive trauma. Additionally, Petitioner did not provide a causal connection opinion from any expert indicating that her injury was based on repetitive trauma. Also problematic for Petitioner, is the fact that she waited until June 14, 2010 to see a doctor for the first time. Those records suggest that her pain was only a week old, which would place the injury date on her vacation.

Therefore, based on all of the above, this Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of her employment. Notice was defective and casual connection unproved.

III. Conclusion

Therefore, based on the evidence present at trial, including Petitioner's testimony, as well as the parties' exhibits, the undersigned Arbitrator hereby finds that Petitioner's injury is not compensable. Additionally, although made unnecessary by the finding of non-compensability, this Arbitrator also finds that Petitioner did not prove causation. Accordingly, no award is made in Petitioner's favor.

ARBITRATOR KURT CARLSON

04-16-14

DATE

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Clifford L. Burris,

Petitioner,

15IWCC0697

vs.

NO: 13 WC 07982
13 WC 07984

Olin Brass & Steel,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. Petitioner, a 33-year-old "DC caster," sustained work-related repetitive trauma injuries to his right shoulder, right elbow and both hands manifesting on February 12, 2012 and January 16, 2013. Medical causation was not in dispute and Petitioner's treatment was authorized.

Dr. Paletta diagnosed right shoulder impingement syndrome with a partial thickness rotator cuff tear and posterior superior labral tear and right lateral epicondylitis. Dr. Paletta performed right shoulder arthroscopic surgery on October 1, 2013 consisting of extensive debridement of the shoulder joint; no surgical repair was required for the low-grade partial thickness tear. On January 15, 2013, Petitioner reported to Dr. Paletta that he no longer had any right shoulder complaints and was back to work, and Dr. Paletta opined that Petitioner reached maximum medical improvement. Dr. Paletta referred Petitioner to his partner Dr. Brown for hand treatment; Dr. Brown diagnosed bilateral carpal tunnel syndrome and performed bilateral releases in the spring of 2014. Petitioner subsequently returned to Dr. Paletta for continued right elbow complaints, and Dr. Paletta performed right elbow arthroscopic surgery on May 27, 2014. The surgery consisted of an ultrasound guided percutaneous fascitotomy and lateral epicondylectomy known as a "Tenex procedure," which is less invasive than a traditional lateral epicondylectomy. Dr. Paletta completely released Petitioner from care with no restrictions on August 6, 2014.

Petitioner successfully returned to his pre-injury job. He testified that currently he has constant shoulder pain, the severity of which depends upon the amount of work. He testified that overhead work is especially painful but a required activity of his job as a DC caster. Petitioner testified that he has ongoing pain, stiffness

15IWCC0697

and weakness in his right elbow, and that he experiences excruciating pain if he bumps his elbow.

In considering the issue of nature and extent of permanent disability, the Arbitrator noted that neither party offered an impairment report or opinion into evidence. The Arbitrator found Petitioner's testimony to be credible. The Arbitrator concluded that the evidence supported a an award of 12.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act and 15% loss of use of the right arm and 12.5% of each hand pursuant to §8(e) of the Act. The Arbitrator further awarded medical expenses and several periods of temporary total disability.

After considering all of the evidence, we modify the Arbitrator's award with respect to the right shoulder and elbow. We note that on January 15, 2014, Petitioner had no significant pain and was back to work without problems in his right shoulder. On examination, Dr. Paletta noted full and painless range of motion and normal rotator cuff strength. On August 6, 2014, Dr. Paletta noted that Petitioner was doing extremely well overall. Petitioner reported that his right elbow felt "good" and he denied any significant pain. Range of motion in the right elbow was full and he had normal strength on examination. He had no tenderness at the lateral epicondyle, radiocapitellar joint or radial tunnel. Dr. Paletta concluded that Petitioner's surgical outcome with respect to the right elbow was excellent. Petitioner was released from care without restrictions and did not return to Dr. Paletta after August 6, 2014. However, Petitioner testified at hearing that his residual symptoms were constant and severe. Petitioner claimed that he experiences pain, stiffness and weakness in the upper extremities that interferes with his daily activities. However, he admitted that he has no plans to return to Dr. Paletta. We find that Petitioner's testimony is not fully supported by the objective evidence. Relying on the credible medial record, we reduce the Arbitrator's award to 9% loss of use of the person as a whole under §8(d)2 and 10% of the right arm under §8(e) of the Act. All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 117.8 weeks, for the reason that the injuries sustained caused the 9% loss of use of the person as a whole pursuant to §8(d)2 of the Act, and 10% of the right arm and 12.5% of each hand pursuant to §8(e) of the Act.

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

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

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: SEP 9 - 2015
RWW/plv
0-8/4/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0697

BURRIS, CLIFFORD
Employee/Petitioner

Case# **13WC007982**
13WC007984

OLIN BRASS & COPPER
Employer/Respondent

On 11/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4620 ARMBRUSTER DRIPPS WINTERSCHEIDT
JOHN WINTERSCHEIDT
219 PIASA ST
ALTON, IL 62002

0299 KEEFE & DePAULI PC
MICHAEL KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0697

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Clifford Burris,
Employee/Petitioner

v.

Global Brass & Copper
Employer/Respondent

Case # **13** WC **007982**

Consolidated cases: **13 WC 007984**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **02/12/12 & 01/16/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**64,798.48**; the average weekly wage was $**1,162.13**.

On the date of accident, Petitioner was **33 & 34** years of age, *married* with **2** dependent children.

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

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

Respondent shall be given a credit of $**1,682.51** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,682.51**.

Respondent is entitled to a credit of $**572.90** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $211.66 to Petitioner, and $8,858.98 to the medical providers listed in Petitioner's Exhibit 15, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $572.90 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $774.75/week for 2 5/7 weeks, commencing 10/01/13-10/06/13, 04/04/14-04/06/14, 04/18/14-04/21/14, and 05/27/14 through 06/01/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $1,682.51 for temporary total disability benefits that have been paid.

Permanent Partial Disability: Person as a whole & specific loss

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

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 62.5 weeks, because the injuries sustained caused the 12 1/2% loss of the person as a whole referable to the right shoulder, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 85.45 weeks, because the injuries sustained caused the 15% loss of the right arm and 12 ½% of each hand, as provided in Section 8(e) of the Act.

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

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

Carl Lee 11/10/14

Signature of Arbitrator Date

NOV 17 2014

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

15IWCC0697

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CLIFFORD BURRIS,
Employee/Petitioner,

v. Case # 13 WC 007982

GLOBAL BRASS & COPPER, 13 WC 007984
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Case bearing Commission number 13 WC 007982 alleges repetitively traumatic injuries to Petitioner's right shoulder, bilateral hands, bilateral wrists and bilateral elbows with an alleged accident date of February 12, 2012. Case bearing Commission number 13 WC 007984 alleges repetitively traumatic injuries to Petitioner's right shoulder, bilateral hands, bilateral wrists and bilateral elbows with an alleged accident date of January 16, 2013. The matters were previously consolidated for trial under case number 13 WC 007982.

Petitioner is a right hand dominant, thirty-six-year-old machinist who has been employed as a "DC Caster" for Respondent's metal works for eight years. He works five days a week and works in excess of forty hours a week, on average. Overtime is mandatory, and as reflected by a wage statement that was produced by Respondent and entered in evidence as Petitioner's Exhibit 1, Petitioner worked overtime during every pay period from February 25, 2011 through February 10, 2012. (PX 1). Prior to February 2012, Petitioner had never injured, nor had he ever received medical treatment to his right shoulder, right elbow or hands.

Petitioner's job as a DC Caster is hand intensive and includes working with various machines and metals in the production of Respondent's metal works. As Respondent stipulated to causation of Petitioner's right shoulder surgery, right elbow surgery and bilateral carpal tunnel surgeries, Petitioner did not testify in detail about his day-to-day work duties.

In late 2011 and early 2012, Petitioner noticed pain and popping in his dominant, right shoulder, pain in his elbows and numbness and tingling in his hands. He reported the condition to his supervisor on February 12, 2012 and was sent to Respondent's medical department. Respondent's medical department's entry of February 21, 2012 references Petitioner's complaints of pain in his hand, elbow and shoulder and states that Petitioner's "job consists of repetitive work using pry bar to break crust from holding spout, raking metal forward out of the launder, skimming holding furnace. Throwing bags of cover." (PX 2; 02/21/12).

Respondent's medical department referred Petitioner to Respondent's company doctor whom he saw on March 2, 2012. The company doctor recorded Petitioner's complaints and noted Petitioner's repetitive work using a fifty to sixty pound pry bar to break crust from a holding furnace spout, raking metal out of a launder, skimming a holding furnace and throwing bags of cover. The company doctor diagnosed bilateral hand tingling and numbness, bilateral wrist and elbow pain and right shoulder pain with grinding sounds due to repetition of heavy casting work. Petitioner was instructed to see his personal physician. (PX 2; 03/02/12). Petitioner's workers' compensation claim was denied.

Petitioner saw his personal physician, Dr. Melissa Hollie on January 16, 2016. Dr. Hollie recorded a history of a painful pop in Petitioner's right shoulder about two weeks prior and complaints of Petitioner's inability to lift his right arm past the shoulder level without sharp pain. Dr. Hollie prescribed medication and ordered an MRI of the shoulder. (PX 3; 01/16/13).

The right shoulder MRI was preformed on January 22, 2013 and revealed frayed fibers and minimal partial undersurface tears at the distal, anterior end of the

supraspinatus tendon. (PX 4). As a result, Dr. Hollie referred Petitioner to Dr. Jesse Susi, whom Petitioner saw on February 19, 2013. Dr. Susi recorded Petitioner's work duties and the onset of Petitioner's shoulder complaints of about a year, with the complaints becoming progressively worse. He diagnosed rotator cuff tendinitis and bursitis, and prescribed medication. (PX 5).

Petitioner's complaints did not abate, and he returned to Dr. Hollie on March 6, 2013, at which time Dr. Hollie referred Petitioner to surgeon, Dr. George Paletta for treatment of the shoulder. (PX 3; 03/06/3).

Petitioner initially saw Dr. Paletta on March 20, 2013, when a history of right shoulder pain for a period of thirteen months was recorded. Dr. Paletta also noted that Petitioner's job as a caster involves a significant amount of repetitive work, with a combination of overhead work and work below the shoulder level. Dr. Paletta's record indicates that Petitioner first noted his symptoms in conjunction with his work in about February 2012 while working with a pry bar and performing overhead work tasks. After reviewing the MRI, Dr. Paletta diagnosed chronic impingement syndrome with subacromial bursitis with a possible small partial thickness rotator cuff tear. Petitioner was given a medrol dose pack and medication for pain, and was referred to physical therapy and an injection. Dr. Paletta opined that Petitioner's condition was either caused by or made symptomatic by his work activities, based upon the history of onset provided. (PX 6; 03/20/13).

On March 28, 2013, Petitioner underwent a right subacromial bursa injection with ultrasound guidance at the hands of Dr. Helen Blake. (PX 10; 03/28/13). The injection helped alleviate Petitioner's complaints for about two weeks before they returned to their pre-injection level. Therefore, Dr. Paletta preformed arthroscopic surgery on Petitioner's right shoulder on October 1, 2013 consisting of extensive debridement of a partial thickness articular sided rotator cuff tear and extensive debridement of the labrum, subacromial bursa and bursal sided partial thickness rotator cuff. (PX 8; 10/01/13 Op. Rpt).

Petitioner was excused from work and underwent physical therapy. (PX 9). Dr. Paletta released Petitioner from his care, with respect to his right shoulder, without restrictions on January 15, 2014. (PX 6; 01/15/14). As Petitioner was still experiencing pain in his right elbow and numbness and tingling in his hands, Dr. Paletta referred Petitioner to surgeon, Dr. David Brown for his bilateral hand complaints and ordered an MRI of the right elbow.

The MRI was preformed on January 28, 2014 and revealed proximal common extensor tendinitis without discrete tendon tear in the elbow with mild distal biceps insertional tendinosis/tendinitis without tendon tear. (PX 7). Following the MRI, Dr. Paletta referred Petitioner back to Dr. Blake, who administered a steroid injection in the right elbow on February 26, 2014. (PX 10; 02/26/14). The injection provided no relief.

By that time, Petitioner had already seen Dr. Brown who had initiated treatment of Petitioner's hands. (PX 11; 02/19/14). Therefore, Dr. Paletta delayed treatment of Petitioner's chronic lateral epcondylitis, until Petitioner completed his treatment with Dr. Brown for his hands. (PX 6; 03/26/14).

Dr. Brown recorded a history of Petitioner's work with hand tools, chipping guns and pry bars every day of his job with the gradual onset of numbness and tingling in his hands, right greater than left, with weakness and nocturnal paresthesia. As a result, he diagnosed bilateral carpal tunnel syndrome and ordered nerve conduction studies. (PX 11; 02/19/14). Petitioner saw Dr. Daniel Phillips on March 5, 2014 who preformed the nerve conduction studies that revealed moderate to severe sensory neuropathy on the right, mild to moderate sensory neuropathy on the left, and mild to moderate demyelinative ulnar neuropathy across the elbows. (PX 12). As a result, Dr. Brown recommended bilateral carpal tunnel release surgeries and conservative treatment for Petitioner's bilateral cubital tunnel syndrome. (PX 11; 03/05/14).

On April 4, 2014, Dr. Brown preformed right carpal tunnel release surgery and excused Petitioner from work following the procedure. On April 18, 2014, Dr. Brown preformed left carpal tunnel release surgery. (PX 13). Following a period of light duty

work restrictions and physical therapy, Dr. Brown released Petitioner from his care on June 11, 2014 without restrictions. (PX 11, 06/11/14; PX 14).

By that time, Petitioner had resumed treatment with Dr. Paletta for his right elbow. On May 27, 2014, Dr. Paletta performed surgery on the elbow consisting of an ultrasound guided percutaneous fasciotomy and lateral epicondylectomy, or Tenex procedure. (PX 8). Petitioner was excused from work and referred to physical therapy. (PX 9). After a period of light duty work restrictions, Petitioner was released from Dr. Paletta's care without restrictions on August 6, 2014. (PX 6; 08/06/14).

As a result of the medical treatment Petitioner received for his right shoulder, right elbow and bilateral hands, he has incurred medical bills in the amount of $104,959.62. Of that amount, Petitioner paid $211.66 personally, $572.90 was paid by Petitioner's medical insurance (for which Respondent claims a Section 8(j) credit), and a balance of $8,858.98 remains outstanding. (PX 15).

With respect to his dominant right shoulder, Petitioner experiences pain with the performance of his job duties, particularly when he works overhead. The degree of pain depends upon the nature of the work he is performing at the time, but his shoulder is painful all day. He has a decreased range of motion in his shoulder and a loss of strength in the extremity. He experiences difficulty lifting heavy objects with his right arm outstretched from his body.

With respect to his dominant right elbow, Petitioner experiences stiffness in the elbow and a stabbing pain. His right elbow is weaker than his left and if he bumps the operated elbow, he feels excruciating pain.

Petitioner experiences soreness and stiffness in both of his hands. He also feels occasional numbness and tingling in the hands and has a loss of grip strength. Given the fact that Petitioner is required to use his hands and arms on a repetitive basis to perform his day-to-day work activities, Petitioner testified that his job has become difficult.

CONCLUSIONS OF LAW

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

The parties stipulated that Petitioner's right shoulder surgery, right elbow surgery and bilateral carpal tunnel surgeries are causally connected to his work duties with Respondent. Respondent's objection to causation is based upon its dispute of the nature and extent of Petitioner's injuries, according to the Request for Hearing form. Therefore, I find that Petitioner's conditions of ill-being with respect to his right shoulder, right elbow and bilateral hands are causally related to his repetitively traumatic work duties with Respondent.

Issue G. What were Petitioner's Earnings?

Respondent produced, and Petitioner entered a wage statement in evidence, documenting Petitioner's earnings from February 25, 2011 through February 10, 2012. (PX 1). Petitioner testified that he works five days a week and, on average, works in excess of forty hours a week, as reflected by the wage statement. Overtime is mandatory, according to Petitioner, and he worked overtime during every pay period from February 25, 2011 through February 10, 2012. (PX 1).

The wage statement reflects Petitioner's gross pay for every pay period, and when added, those figures calculate to annul earnings of $64,798.48. The wage statement also documents "non overtime hours" "non overtime pay" and "overtime hours" for each pay period. To properly calculate the Petitioner's average weekly wage pursuant to Section 10 of the Act, Petitioner's overtime hours at his regular pay rate, must be included, as he was required to work overtime and did so regularly. However, to make this calculation, Petitioner's regular rate of hourly pay must be determined for each pay period by dividing the number of regular hours worked by his "non overtime pay" for that pay period because his regular rate of pay changed during the period documented by the wage statement. After doing so, the wage statement supports calculation of Petitioner's total earnings for all hours worked at his regular rate of pay to be $60,430.78. Dividing that number by fifty-two weeks generates an average weekly wage of $1,162.13. Therefore, I hereby find that

Petitioner's average weekly wage is $1,162.13, thereby yielding a temporary total disability rate of $774.75 and a permanent partial disability rate of $695.78 (maximum).

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

There is no evidence of unreasonable or excessive treatment found in the record. Therefore, Respondent is hereby ordered to pay Petitioner $211.66 for out-of-pocket medical expenses he has incurred for treatment of his work related conditions and Respondent is further ordered to pay the sum of $8,858.98 for outstanding medical bills listed in Petitioner's Exhibit 15, directly to the providers listed therein, pursuant to the Act's Medical Fee Schedule. Finally, Respondent is granted a Section 8(j) credit for the $572.90 paid by its group health medical insurer, and is hereby ordered to hold Petitioner harmless for that amount paid to the various medical providers listed in Petitioner's Exhibit 15.

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

Petitioner testified credibly throughout the Hearing. As reflected in his treatment medical records, he has a very repetitive, labor intensive job that requires strenuous use of his upper extremities on a daily basis. As a result of his injuries, he has a surgically repaired, dominant right shoulder, a surgically repaired dominant right elbow, a surgically repaired dominant right hand, a surgically repaired left hand, and significant residual complaints associated with each surgically addressed area of his body. At age thirty-six, with eight years of employment as a DC Caster for Respondent, Petitioner has many years of strenuous labor ahead of him throughout his employment life.

No permanent partial disability impairment report or opinion was submitted in evidence. Therefore, no weight is given to this factor in the determination of Petitioner's permanent partial disability.

Therefore, for the reasons stated herein, I find that Petitioner has incurred permanent partial disability in the amount of 12 ½% of the body as a whole referable to

the right shoulder, 15% of the right arm referable to the elbow and 12 ½% of each hand referable to the surgically repaired carpal tunnel syndrome. Therefore, Respondent is hereby ordered to pay Petitioner the sum of $695.78 per week, for a period of 147.95 weeks pursuant to Sections 8(d) 2, 8 (e) 9, and 8 (e) 10.

Edward Lee

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ 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

Alexander Kuznetsov,
Petitioner,
vs.

15IWCC0687
NO: 13 WC 7659

Pace Suburban Bus - Northwest Division,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2014, 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: SEP 8 - 2015
KWL/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0687

KUZNETSOV, ALEXANDER
Employee/Petitioner

Case# 13WC007659

PACE SUBURBAN BUS-NORTHWEST DIVISION
Employer/Respondent

On 11/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3254 PARAD LAW OFFICES PC
BORIS PARAD
910 SKOKIE BLVD SUITE 109
NORTHBROOK, IL 60062

1505 SLAVIN & SLAVIN
PAUL R POPOVIC
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0687

Alexander Kuznetsov
Employee/Petitioner

v.

Pace Suburban Bus - Northwest Division
Employer/Respondent

Case # **13** WC **7659**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 30, 2014 and August 28, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 22, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$46,800.00**; the average weekly wage was **$900.00**.

On the date of accident, Petitioner was **60** years of age, *single* with **no** dependent children.

ORDER

Because the accident did not arise out of employment, benefits are denied.

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

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

Signature of Arbitrator

November 16, 2014
Date

NOV 17 2014

ICArbDec p. 2

DISCUSSION

Petitioner testified that he is employed by Respondent as a bus operator. Petitioner testified his duties include serving passengers and providing a safe ride for them. Petitioner testified that on January 22, 2013, he performed an inspection of the bus at the end of the work day. Petitioner testified that after he completed the inspection, he raised his left leg to get back onto the bus when all of the sudden he felt pain in his left knee. Petitioner testified he then drove the bus to park it in the garage and then drove home. He notified his manager the following morning and was sent for medical care. Petitioner testified that he gets on and off the bus using the same stairs as the passengers. Petitioner underwent conservative treatment then arthroscopic surgery

consisting of repair of the meniscus and removal of loose bodies. Petitioner was off work and was not paid any benefits.

Petitioner has not carried his burden of proof that an accident arose out of the employment. Petitioner's testified that he raised his leg to get on the bus and felt knee pain. That testimony includes no evidence of increased risk due to employment.

Based upon the foregoing, Petitioner's claim is denied.

The remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN ACOSTA,

15IWCC0698

Petitioner,

vs. NO: 12 WC 10690

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of consolidation of claims, causation, and nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

This claim was initially consolidated with another claim Petitioner had against Respondent, 12 WC 10718, and then severed. Respondent's motion to re-consolidate the claims was denied. Respondent did not specifically preserve the issue of the denial of re-consolidation in its Petition for Review. However, it did object to the denial of re-consolidation at the beginning of the arbitration hearing and argues the issue in its brief.

There is no explanation in the record before the Commission why the cases were initially consolidated and then severed. Respondent argues that it had the absolute right to have the cases consolidated because they involved the same petitioner, same respondent, and the same alleged injured body part. It seems to base its assertion on Petitioner's accident reports in which he alleged injuring, among other body parts, his left shoulder in the report of the first accident, and his shoulders in the report of the second accident.

15IWCC0698

Respondent is not correct that Petitioner alleged the same body parts are injured in the different accidents. In this case, Petitioner's Application for Adjustment of Claim he alleged injury to the left upper extremity. In 12 WC 10718 Petitioner alleged injury to the body as a whole. After this claim has already been adjudicated to finality, the Commission sees no reason why this claim should be retried in consolidation with other claims alleging injuries to other body parts. Generally, consolidation is done in the interest of judicial/administrative economy. Consolidation at this point would seem to accomplish the opposite, judicial/administrative wastage. Therefore, the Commission rejects Respondent's argument and affirms the Decision of the Arbitrator in refusing to re-consolidate this case with 12 WC 10718.

Petitioner injured his left shoulder on March 7, 2011, while picking up debris from the roadway and throwing it on the bed of his pickup truck. The Commission affirms the Arbitrator's finding that that accident caused Petitioner's current condition of ill-being of the left shoulder. On 10/31/11, Dr. Treg Brown performed arthroscopic subacromial decompression of the left shoulder for impingement syndrome. On June 26, 2012, Dr. Brown performed closed manipulation of the left shoulder for adhesive capsulitis. On September, 4, 2012, Petitioner reported his range of motion and strength had returned. Dr. Brown noted the adhesive capsulitis was resolving well, Petitioner was at maximum medical improvement and released him to normal work activities and from further treatment. Petitioner had a Functional Capacity Evaluation ("FCE") a week after Dr. Brown released him to full activities. It rated Petitioner to be able to function at a medium physical demand level.

Petitioner testified his job involved very heavy labor. Currently, his left side is not as it was prior to the accident and he has less range of motion. He has discomfort with exertion and he hears cracks and pops. His shoulder condition affects how he can perform many of his jobs and can't do them as well or gets help. He has trouble lifting his hand over his head. He has difficulty prying out the side bars off the trucks to clean them in winter. He had been able to do that singlehanded without pain. His ability to climb ladders and climb on the truck is affected. He has difficulty and pain hooking up chains to tow vehicles, pushing, and throwing sticks on the truck. Changing tires cause pain in his shoulder. It hurts when he uses a sledgehammer.

The Arbitrator awarded Petitioner 12.5% loss of the person as a whole. The Arbitrator's interpretation of the FCE was that it showed "diminished strength" in the left shoulder, an interpretation which he mentioned twice. However, the FCE indicated 5/5 strength in all left shoulder maneuvers. In addition, it is unclear from the FCE exactly what percentage of his functional limitation is due to the shoulder condition. The majority of his impairment seems to emanate from his lumbar condition and associated leg symptoms, which are the subjects of other claims, which were not adjudicated at the instant hearing. In addition, when Dr. Brown released him from treatment on September 9, 2012, a week prior to the FCE, he noted that Petitioner reported his ROM and strength had returned and he released him to work without restrictions.

The Commission finds that Petitioner was released to full duty at a "very heavy labor" job with regard to his left shoulder condition. The fact that Petitioner testified it hurts when he uses a sledgehammer is instructive because it shows he actually can still use a sledgehammer. In looking at the entire record before us, the Commission finds that an award of 7.5% loss of the person as a whole is appropriate here and accordingly modifies the Decision of the Arbitrator.

15IWCC0698

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 37.5 weeks, as provided in §8(d) of the Act, for the reason that the injuries sustained caused the loss of 7.5% of the person as a whole.

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

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

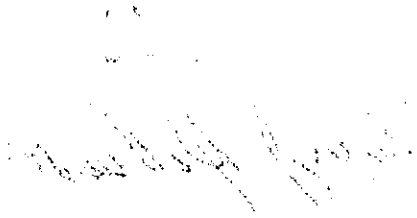
DATED: SEP 9 - 2015

Ruth W. White

Charles J. DeVriendt

Stephen J. Mathis

RWW/dw
O-8/5/15
46



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ACOSTA, KEVIN
Employee/Petitioner

Case# **12WC010690**

IL DEPT OF TRANSPORTATION
Employer/Respondent

15IWCC0698

On 10/7/2014, 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 0.04% 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:

0355 WINTERS BREWSTER CROSBY ET AL
THOMAS F CROSBY
111 W MAIN ST
MARION, IL 62959

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

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

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

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT - 7 2014

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0698

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kevin Acosta
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **12** WC **010690**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville, IL** , on **August 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 7, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$65,115.06**; the average weekly wage was $1,255.11 Max: $669.64.

On the date of accident, Petitioner was **48** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**. The Parties agree and stipulate Respondent will have credit for all medical bills paid by group insurance.

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

ORDER

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the man as a whole, as provided in Section 8(d) 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.

Edward Lee

Signature of Arbitrator

9/29/14

Date

OCT 7 - 2014

FINDING OF FACTS:

Testimony of Petitioner:
Kevin Acosta was a Highway Maintainer on March 7, 2011 and was on that date on road patrol tasked with the removal of dead animals and other debris from roads and road sides. While on Ill. Rt. 14 west of Mulkeytown he attempted to lift and throw a semi tractor tire weighing 50 to 75 pounds over the 7 foot sidewall into the rear of the IDOT dump truck. Immediately upon throwing the tire he experienced pain and a pulling sensation in his left shoulder. On the same day he was called to dispose of a television with glass tube that was on Rt. 148 near Zeigler. He was unable to lift the television and used the hydraulic lift to load it in the dump truck. Petitioner notified his supervisor of the shoulder injury on March 7, 2011. Petitioner continued to work without seeking medical care but the shoulder condition did not improve and Petitioner sought medical care a few weeks later for his left shoulder from Dr. McCain of Southern Illinois Medical Clinic Associated in Marion IL. Petitioner was prescribed a course of Physical Therapy at Occupational Rehab through June and July 2011 that did not resolve his shoulder restrictions and pain. Petitioner described he suffered a loss of strength in the shoulder and restriction in his range of motion despite the therapy. Dr. McCain referred Petitioner to Dr. Tregg Brown of Southern Illinois Orthopedics who continued conservative treatment and ordered more physical therapy. Petitioner's shoulder continued to be painful and movements restricted which resulted in Dr. Brown initiating a course of steroidal injections. In late August 2011 Dr. Brown informed Petitioner that if he showed no improvement after the second injection surgery would be the next treatment option. The injections did not improve the Petitioner's range of motion or shoulder pain. The day before his scheduled follow up appointment with Dr. Brown on 9/22/11 Petitioner was involved in a tractor rollover accident at work. Petitioner testified both of his shoulders were sore from gripping the steering wheel as the tractor rolled over but he did not experience and additional symptoms in his left shoulder. Petitioner informed Dr. Brown that the injections had not worked and surgery was scheduled for October 31, 2011.

As a result of the tractor roll over, Petitioner suffered a low back injury and was taken off work but continued to treat with Dr. Brown for his left shoulder. Dr. Brown only treated Petitioner's Left Shoulder and did not address any injury sustained in the tractor roll-over accident. Petitioner underwent a left shoulder surgical decompression on 10/31/11 and was prescribed physical therapy and lifting restrictions related to his left shoulder after the surgery. Petitioner was compliant with PT. Despite surgery and physical therapy Petitioner's left shoulder became weaker and lost range of motion. Petitioner describes the shoulder would "lock up". Petitioner received a second surgery for impingement syndrome in June of 2012 at the hand of Dr. Brown. After the second surgery Petitioner underwent an additional course of physical therapy to increase strength and range of motion.

Petitioner testified his strength and range of motion increased after the second surgery and physical therapy but that the shoulder continued to "pop" and his movement and strength did not return to his pre accident state. Dr. Brown discharged Petitioner from Physical Therapy in late August 2012 and placed him at MMI on 9/4/12. Petitioner was allowed to return to restricted work at IDOT on September 6, 2012. Later in September 2012 Petitioner underwent a functional capacity evaluation which tested the range of motion in his left shoulder. Petitioner is still employed as an IDOT Highway Maintainer.

Petitioner testified as to the current condition of ill-being to his left shoulder. Petitioner complains of decreased range of motion, cracking, popping and occasional catching in the shoulder with movement; decreased strength and pain with exertion. Petitioner explained that several of his job duties are more difficult or require him to seek help of co-employees due to his shoulder condition, these include: power washing trucks, Petitioner testified that he is unable to use his left arm to power wash for any extended period of time and must now ask for assistance from co-workers. Petitioner has difficulty using his left arm to pull himself up to the cab of trucks and tractors. Petitioner states he has to seek assistance to

remove the sideboards from IDOT salt trucks (2x12, 8 to 10 foot boards) he used to be able to lift them alone. Petitioner avoids using or asks for assistance in using crow bars and pry bars due to shoulder weakness and pain. Climbing ladders with the left arm overhead is difficult and painful. Dragging chains with his left arm is difficult as is over head throwing motions. Truck maintenance is difficult because of shoulder pain. Petitioner asks for assistance when assigned to work with a sledge hammer due to the onset of shoulder pain.

MEDICAL EVIDENCE

Respondent submitted an Illinois First Report of Injury form that documents a date of injury 3/11/11 where Mr. Acosta injured his left shoulder, left arm, and left side of his neck when throwing a semi tire into the back of a 3-ton truck.

On 6/7/11, Mr. Acosta was evaluated for a workers' compensation by Dr. Sean McCain his family doctor, where he reported left shoulder pain radiating down the arm and back rating pain at 7/10. Limited ROM secondary to pain, left, pt has weakness and pain with supraspinatus. The history notes he reported hurting his shoulder back in March but tried to continue working and it got worse. Plan: PT

An MRI of the left shoulder on 6/20/11 revealed signal abnormality in the distal supraspinatus tendon consistent with partial tear or tendinitis. There was no evidence of full thickness rotator cuff tear. A Type I acromion was noted with minimal degenerative change at the Left AC joint (images reviewed).

6/24/2011 Dr. McCain exam of Left shoulder: limited ROM secondary to pain.
Assessment: Rotator cuff syndrome NOS, PLAN: Reviewed the MRI and needs more PT will send to Ortho

On 7/21/11, consultation with Dr. Tregg Brown revealed his report of an injury on 3/7/11. There was pain with palpation over the greater tuberosity on examination with mild tenderness over the biceps tendon. He had 4/5 supraspinatus strength against resistance with 5/5 infraspinatus, subscapularis, deltoid, biceps, and triceps strength. Impingement signs were positive. MRI shows mild changes within the supraspinatus tendon near at insertion. Official report indicates tendinopathy versus partial tear. Pt was suspected to have a partial tear of the left supraspinatus tendon. General light duty was recommended.

8/8/11, Dr. McCain followed up with Mr. Acosta and continued left shoulder pain was described radiating down the arm, complaints of tingling, numbness, and weakness. Physical Therapy was continued.

On 8/11/11, a diagnostic Ultra Sound of the left shoulder by Dr. Tregg Brown revealed probable small partial thickness articular-sided supraspinatus tear and likely adhesion in the infraspinatus muscle.

On 8/25/11, Dr. Brown performed a left shoulder injection and prescribed perform home exercises with possible plan for surgery.

A 9/22/11 first report of injury form documents a date of injury of 9/21/11 whereby Mr. Acosta was mowing along the highway when the tractor caught the edge of a concrete culvert and tipped over on its side. He injured his waist, back, neck, and shoulders.

On 9/22/11 an evaluation by Dr. Brown reveals Mr. Acosta's report that his symptoms have been consistent since his last office visit with the pain going away but always coming back. He added that he had a subsequent injury rolling a tractor though he did not sustain any major injuries. HE was very sore and taken to the ER where x-rays were taken. Pt has a partial-thickness rotator cuff tear that has been

treated conservatively for months. His symptoms have been consistent since his last office visit. Dr. Brown gave him a steroid shot last visit. Symptoms returned rather rapidly. PLAN: Pt has exhausted all conservative treatment measures. Going on for several months now and I think his lifestyle and job requirements are not going to allow him to get the type of rests that he needs in order to get this injury to heal on its own. Recommending an arthroscopic rotator cuff repair with a subacromial decompression by arthroscopic surgery. ADDENDUM: The injection provided no relief. He is quite frustrated with his lack of improvement. IMPRESSION: Partial-thickness rotator cuff tear unresponsive to conservative measures.

On 9/23/11, Mr. Acosta followed up with Dr. McCain. He was assessed with Left shoulder pain. He was noted to have full ROM with pain and he complained of tingling, numbness and weakness. HPI: Trauma/injury: pt rolled over tractor on Wednesday, seen in ER. Pt is here for f/u left shoulder pain. Pt has seen Dr. Brown yesterday who scheduled surgery on left shoulder. Pt on 9/21/811 was working and tractor rolled. PT seen Dr. Brown on f/u after the recent accident and the plan was that needs surgery even before the accident on 9/21 surgery had been planned. Since this recent accident shoulder pain is about the same. The accident has not changed the outcome of this prior injury to his shoulder. Deposition testimony of Dr. McCain corroborated lack of any significant additional left shoulder complaints from the tractor rollover accident and confirmed post tractor accident Dr. McCain provided treatment for back injury only.

On 10/31/11, an operative report describes Dr. Brown's performance of arthroscopic subacromial decompression of the Left shoulder. The joint was visualized in sequential fashion with no abnormal synovitis, nor abnormal cartilage. In the subacromial space, a subacromial bursectomy and CA ligament release was performed. The anterior 8 mm of the acomion was taken off with a burr. The undersurface of the acromion was debrided down to a nice smooth surface ultimately creating a Type I acomion.

On 1/17/12, a follow up with Dr. Brown revealed Mr. Acosta's continued left posterior shoulder pain. A steroid injection into the trigger point in the infraspinatus was provided and continuation of PT.

On 2/15/12, a left shoulder follow up with Dr. Brown revealed continued left shoulder pain as well as weakness. The trigger point injection gave him a couple of days of relief but his symptoms had returned. He described burning pain in the posterior aspect of the shoulder. Struggles with overhead and external rotation. He continues to have supraspinatus and infraspinatus weakness at 4+/5. Complaints of pain with resisted external and resisted empty can testing.

On 2/22/12 an MRI/arthrogram of the left shoulder was performed and revealed supraspinatus tendinopathy. Dr. Brown's impression: a small tear of the labrum at the biciptal anchor.

On 4/25/2012 History: 5 ½ months out from subacromial decompression with continued limitation of function. PLAN: Dr. Brown recommending a closed manipulation. If we are unable to obtain all of his motion at that time we would immediately proceed to an arthroscopic lysis of adhesions.

6/15/2012 Dr. Brown's office recommends to PT to wait 6 weeks post manipulation for FCE to allow for possible lysis of adhesions.

6/26/2012 Dr. Brown, Southern Illinois Orthopedic Center: Operative Report Postoperative Dx: Left shoulder with adhesive capsulitis. Procedure: Closed manipulation of the left shoulder there was audible popping of scar tissue... manipulated with a posterior capsule stretch and again felt audible palpable lysis of adhesions. Upon completion, he had full internal and external rotation, forward elevation, and abduction in relation to the contralateral shoulder.

On 7/24/2012 post surgical follow up PLAN: physical therapy for continued strengthening, scapular stabilization, and stretching, f/u in six week

On 9/4/2012 Dr. Brown's impression: Postoperative adhesive capsulitis, resolving well. PLAN: Now considered MMI and can be released from our care.

9/11/2012 Functional Capacity Evaluation - WORK STRATEGIES SELECT Physical Therapy. Date of Report -9/11/2012 – Purpose of Assessment: FCE Type: Work Related; Determine ability to return to work

Climb Ladders – Occasional – Job Function: Not Met

Upper Extremity/SHOULDER:	NORM ROM	Left ROM
Flexion	180 degrees	150 degrees
Extension	60 degrees	40 degrees
Abduction	180 degrees	145 degrees
Internal Rotation	90 degrees	85 degrees
External Rotation	90 degrees	60 degrees

RESPONDENT'S IME: Orthopedic Sports Medicine & Spine Care Institute – Dr. James T. Doll

IME was performed on April 5, 2012. Dr. was given history that included both the March 7, 2011 tire throwing accident and the September 21, 2011 tractor roll over.

After review of all medical Dr. Doll performed a clinical examination and found:
On inspection of the left shoulder, surgical sites were well-healed. Limited range of motion was evident with a fairly solid end feel at the end range of motion. Approximate measurements were 0 degrees of external rotation, full internal rotation, 75 degrees of forward flexion and 60 degree of abduction. He reported pain during ROM and particularly at end of ROM. Hawkins and Neer's testing was attempted and reports of pain occurred. Tenderness was reported laterally along the deltoid musculature extending sown the poster lateral arm. Strength testing was reduced in the left shoulder, particularly external rotation and abduction at a rating of 4/5.

Dr. Doll, Respondent's IME, did not find intervening causation to the left shoulder injury from the tractor roll over. Dr. Doll concluded: "Given a thorough review of all of the information available to me, it is my opinion within a reasonable degree of medical certainty that his current Left shoulder condition is medically causally related to his 3/7/11 work injury."

G. IS PETITIONER'S CURRENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE INJURY?

Respondent contends that the shoulder injury sustained on March 7, 2011 when Petitioner threw a truck tire into the bed of the dump truck and felt immediate onset of pain in his left shoulder is not the cause of his current condition of ill-being because Petitioner suffered a later accident while working for Respondent when a tractor he was operating rolled over on September 21, 2011. At the time of the September 2011 tractor accident Petitioner had been treating with Dr. McCain and Dr. Tregg Brown for his shoulder injury for three months. Prior to the tractor rollover, Dr. Brown had discussed proceeding with the shoulder surgery in August 2011 because of the ineffectiveness of conservative treatment. Dr. McCain opined after the September tractor accident that the condition of the Petitioner's left shoulder had not changed from the state it was in before the tractor accident. Respondent's IME concluded that the March 7, 2011 accident, not the September 11, 2011 tractor rollover, was the cause of Petitioner's left shoulder injury. The Arbitrator finds that the March 7, 2011 accident was the cause of the condition of ill-being in Petitioner's left shoulder.

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

Pursuant to 820 ILCS 305/8.1b(b), in determining the level of permanent partial impairment, the Commission shall base its determination on the following factors:

(i) The reported level of impairment pursuant to a permanent partial impairment evaluation report in conformity with the most recent edition of the American Medical Association's Guidelines to Evaluation of Permanent 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 the treating medical records.

Under 820 ILCS 305/8.1(b) no single enumerated factor shall be the sole determination of disability.

In determining Mr. Acosta's permanent partial disability under 820 ILCS 305/8.1(b), the Arbitrator finds the following:

1. Neither party presented an impairment rating based upon the current edition of the AMA Guidelines. Therefore, the Arbitrator gives no weight to this factor.
2. Under 8.1b(b)(ii), the petitioner at the time of the occurrence was employed in a heavy work occupation as a highway maintainer for IDOT. Petitioner has testified that his range of motion and strength of his left shoulder is diminished since the March 7, 2011 accident. The FCE established Petitioner has objective evidence of limited range of motion and decreased strength in his left shoulder. Petitioner's testimony recited a number of job tasks he is not longer able to perform without assistance due to loss of strength/motion and shoulder discomfort. The Arbitrator finds that the difficulty in performing job tasks involving motion and strength of the left shoulder are consistent with the medical proof concerning the shoulder injury and surgeries. The inability of Petitioner to fully perform his pre-accident job duties without assistance demonstrates a significant disability which given Petitioner's age may affect future employment.
3. Under 8.1b(b)(iii) the age of Petitioner at the time of the accident was 48 given the permanent restrictions effecting the strength and ROM of the left shoulder in relationship with a probable long work life of heavy labor, the Arbitrator finds the age of Petitioner enhances the partial permanent impairment.
4. Under 8.1b(b)(iv) as to loss of future earning capacity there was evidence that Petitioner has to rely on the assistance of co-employees to do work he is regularly assigned. The Arbitrator finds Petitioner's diminished ability to perform heavy work might prevent Petitioner from obtaining other heavy work positions in the future and is an enhancing factor as to the nature and extent of the disability.
5. Under 8.1b(b)(v), the medical records corroborate Petitioner's testimony as to disability. The records of Dr. Tregg Brown and the FCE demonstrate that the shoulder injury continues to affect Petitioner's ROM and strength. The Arbitrator finds the records of the treating physician support Petitioner's complaints of reduced strength, loss of ROM of the left shoulder.

Considering all factors enunciated in 305/8.1b the Arbitrator finds Petitioner has sustained a permanent partial disability to the left shoulder in the amount of 62.5weeks representing 12.5% loss of use on a Man as a Whole basis.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carla Jarrett,

Petitioner,

15IWCC0696

vs.

NO: 08 WC 04239

State of Illinois, Department of Human Services,

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 all of the issues and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove that her bilateral carpal tunnel syndrome is causally related to her employment by Respondent. On the alleged date of manifestation, March 2, 2005, Petitioner was a 35-year-old caseworker in Jackson County. She filed an Application for Adjustment of Claim on January 31, 2008 alleging repetitive trauma to her neck and both upper extremities. The Arbitrator found that Petitioner's claim was supported by a preponderance of the evidence and awarded 5% loss of use of each hand pursuant to §8(e) along with outstanding medical expenses. Respondent timely appealed the Decision of the Arbitrator and argued that Petitioner failed to prove that her employment by Respondent caused repetitive trauma injuries.

Finding of Facts and Conclusions of Law

Petitioner began working as a caseworker for Respondent in 1991. Her job involved interviewing clients in her office or over the phone, completing paperwork and entering information into the computer. Sitting at her desk, Petitioner faced chairs intended for clients. At her right, adjacent to her desk, was a computer table; the entire configuration formed an "L" shape and Petitioner sat on a wheeled chair on a floor mat. Petitioner testified that "eventually" she obtained a wrist support for her keyboard but she did not recall whether she had it prior to March 2, 2005. She testified that she put her computer monitor on top of a box so that it was at the proper height. Petitioner's caseload varied; she

estimated that she interviewed between three and nine clients per day. She testified that some applications took half an hour to complete and some took two hours. During interviews, she would enter information into the computer, record medical histories, and complete paperwork.

Cynthia Canning was called by Respondent to testify at hearing. She is the Department of Human Services local office administrator for Jackson County. Her supervisor's report with respect to Petitioner's claim of injury is dated March 3, 2005. Ms. Canning testified that she is familiar with the job duties of a caseworker and she previously worked as a caseworker. She agreed that caseworkers file, answer the phone, write, type, and interview clients. She denied that any of these activities were continuous; rather each would be performed as needed. Ms. Canning testified that she saw Petitioner on a daily basis, however Petitioner had her own office and she did not observe Petitioner working every day.

Petitioner testified that her symptoms began in March of 2005. She noticed that her hands began tingling and falling asleep and she felt pain shooting up both of her arms. She completed a notice of injury report and sought medical attention with Dr. Bobell at Murphysboro Health Center on March 2, 2005. Dr. Bobell noted that Petitioner "thinks she has carpal tunnel" and complained of shooting pain from her fingers up to her shoulders that had gotten progressively worse. On referral from Dr. Bobell, Petitioner underwent an EMG/NCV study in April 2005 which reportedly returned normal results. Dr. Bobell recommended bracing, ice and anti-inflammatory medication. On October 19, 2005, Dr. Bobell referred Petitioner to a chiropractor, Dr. Womick, on Petitioner's request. Petitioner also had some physical therapy beginning in February of 2006 at Southern Illinois Healthcare. On March 2, 2006, Petitioner reported to Dr. Bobell that her pain decreased with physical therapy and she was no longer taking any medication. Dr. Bobell recommended braces and ergonomic office furniture. On May 26, 2006, Petitioner was discharged from physical therapy.

On May 21, 2007, Petitioner returned to Dr. Bobell and complained that her symptoms were worse. Petitioner reported that after one to two hours of work she experienced severe pain and tingling in both upper extremities. Petitioner reported that she had pain regardless of activity, but that it was worse while working. On exam, Phalen's maneuver testing was positive bilaterally and Tinels's sign was positive on the left. On Petitioner's request, Dr. Bobell referred Petitioner to an orthopedic surgeon, Dr. Haueisen at PremierCare and Dr. Bobell also took Petitioner off of work pending further work-up. Petitioner was examined by Dr. Haueisen on June 11, 2007 and she explained that her job required frequent typing, computer work, and completion of forms. She gave a history of developing numbness and tingling around March of 2005, left worse than right. She reported increased numbness with any activities where her hands were elevated, such as driving. She complained that occasionally she awoke at night with numbness in her hands. She reported that typing and "anything repetitive" increased her symptoms and she denied any benefit from using splints. On exam, Petitioner's Tinel's sign and Phalen's maneuver were positive bilaterally. Dr. Haueisen noted that the 2005 EMG/NCS was reportedly normal, and he ordered a new study. Dr. Haueisen opined that Petitioner could resume her regular job duties. After Petitioner became upset about being released to return to work, Dr. Haueisen issued restrictions indicating that Petitioner may type for one hour followed by fifteen minutes of rest.

On June 21, 2007, Dr. Haueisen reviewed the new EMG/NCS data and found evidence of mild bilateral carpal tunnel syndrome without cervical radiculopathy. He performed a diagnostic and therapeutic cortisone injection into the left carpal tunnel on June 29, 2007. On August 3, 2007 Petitioner

reported 90% relief of left-sided symptoms, including the pain in her neck and trapezius. Dr. Haueisen performed a right-sided injection and recommended that Petitioner resume working regular duty. When Petitioner returned on September 4, 2007, she reported complete relief of symptoms and Dr. Haueisen released her from care. Petitioner testified that she went off of work for unrelated medical reasons from November 19, 2007 through November 21, 2007 and from December 18, 2007 through July 1, 2010, approximately two and a half years in total. During this time, she did not seek any treatment for hand complaints.

At the request of Respondent, Dr. Naam examined Petitioner on September 8, 2008. Although there are no medical records to corroborate this history, she told Dr. Naam that she experienced a recurrence of symptoms several months earlier in June of 2008. Petitioner explained to Dr. Naam that she went off of work in December of 2007 due to her unrelated medical issues. Dr. Naam noted that Petitioner was a smoker and that her employment as a caseworker for Respondent involved typing on a keyboard, writing, filing, and talking on the phone. Dr. Naam reviewed Petitioner's EMG/NCS study and the medical records and performed a physical examination. He found no swelling or atrophy and that Petitioner had normal grip strength. She had positive Tinel's signs, Phalen's maneuver and nerve compression tests at the median nerves. Dr. Naam diagnosed mild bilateral carpal tunnel syndrome and minimal bilateral cubital tunnel syndrome with a congenital Madelung's deformity at both wrists. He believed that some of Petitioner's wrist pain was related to the Madelung's deformity. Dr. Naam opined that he found no medical causation between Petitioner's carpal tunnel syndrome and her employment because none of her job duties involved repetitive forceful use of the hands, exposure to vibrating tools or awkward hand positions. Furthermore, he noted that an exacerbation of symptoms occurred while she was off of work for a very significant period of time, strongly indicating that her symptoms are not caused or aggravated by her work activities.

On July 1, 2010, Petitioner returned to work after approximately two and a half years and resumed her regular work duties. On June 15, 2011, Petitioner returned to Dr. Bobell with hand complaints and requested a referral for surgical treatment. Petitioner underwent electrodiagnostic testing a final time on October 28, 2011; the results indicated moderately severe bilateral carpal tunnel syndrome. Petitioner testified that she went on a leave of absence, again for unrelated medical reasons, in April of 2013 and she never returned to work. Petitioner testified that Dr. Scott, a neurosurgeon, performed a right-sided carpal tunnel release in October 2013 and a left-sided carpal tunnel release in January 2014 but there are no surgical records in evidence.

Dr. Naam was deposed on February 25, 2014 and his testimony was offered into evidence by Respondent. Dr. Naam testified that he is a licensed hand surgeon at the Southern Illinois Hand Center and a clinical professor of hand surgery at Southern Illinois University in Springfield. Dr. Nam testified consistently with his report that his opinion to a reasonable degree of medical certainty is that Petitioner's carpal tunnel syndrome is not work-related. Dr. Naam testified that he reviewed a report regarding the ergonomics of Petitioner's work station and the only suggestion was with respect to Petitioner's computer screen height. Furthermore, Dr. Naam noted that Petitioner has personal risk factors for carpal tunnel syndrome such as obesity, smoking, and female gender. Dr. Naam additionally explained the congenital deformity present in Petitioner's wrists that he believed contributed to Petitioner's symptoms. Dr. Naam found it to be significant that Petitioner stopped working by December of 2007 and still experienced a recurrence of her symptoms. Dr. Naam believed that the timeline further supported his causal opinion.

15IWCC0696

After considering all of the evidence, we find that Petitioner failed to prove that her carpal tunnel syndrome is causally related to her employment by Respondent. Simply performing work that involves the use of the hands over a period of years is not factually sufficient to prove that the work places the employee at an increased risk of injury; medical causation must be proved by a preponderance of the evidence. We find that Petitioner failed to support her claim with sufficient credible medical opinion. There is no testimony from either Dr. Haueisen or Dr. Scott, and neither doctor issued causal opinions that are in evidence. Furthermore, we note the absence of any treatment records from Dr. Scott, Petitioner's surgeon. We are not persuaded by Dr. Bobell's diagnosis of a "work-related" carpal tunnel syndrome where her opinion is not supported by the preponderance of the evidence. We find the opinions of Dr. Naam to be credible and persuasive in this case. Dr. Naam is a board-certified hand surgeon and a professor of hand surgery. He routinely diagnoses and treats patients with carpal tunnel syndrome and he testified that while "awkward positioning" and repetitive motion could potentially be related to the development of carpal tunnel syndrome, the positioning would necessarily have to involve extremes of flexion and extension, which Petitioner's work did not. Furthermore, the credible evidence shows that Petitioner's work was varied clerical work that did not involve sustained repetitive motion. There is no evidence that Petitioner's work duties, nor the use of her workstation, exposed her to the types of forces that would place her at risk for repetitive injury. Furthermore, Dr. Naam had the opportunity to review an ergonomic study of Petitioner's workstation and he considered the significant personal risk factors in Petitioner's case. Furthermore, Dr. Naam concluded that the recurrence and persistence of Petitioner's symptoms while off of work for over two years is further evidence that her carpal tunnel syndrome is idiopathic and not caused or aggravated by her employment by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2015 is hereby reversed and Petitioner's claim is denied.

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

DATED:
RWW/plv SEP 9 - 2015
0-8/5/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Adella Jordan-Luster,
Petitioner,

vs. No: 10 WC 38101

15IWCC0703

State of Illinois/Sheridan Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, and the nature and extent of the permanent disability, and being advised of the facts and law, modifies the Arbitrator's award of permanent partial disability and otherwise affirms and adopts the October 24, 2014 Decision of Arbitrator Gerald Granada, which is attached hereto and made a part hereof.

Petitioner, a 55 year old State of Illinois employee, had been employed in various capacities by the Department of Corrections since 1986. She served first as a corrections officer, correctional counselor, case work supervisor, and then as assistant warden of programs from 2003 to her voluntary retirement in 2010. As assistant warden, Petitioner planned, organized and directed the overall program functions, including the medical and dental services, chaplaincy, clinical services, leisure time, academic and vocational school, library services and substance abuse treatment programs. She also conducted employee review hearings, during which she handwrote notes, which she typed up following the hearings. Petitioner testified that each hearing lasted 30-45 minutes, and she spent the same amount of time typing her reports after each hearing. She also conducted tours of the facility and used Folger Adams keys 10-15 times per workday to open secured doors. She testified that her normal workdays were 12 hours long, and she worked weekdays and alternate weekends.

Petitioner was assisted in her clerical duties as assistant warden by a secretary, but she assumed all typing and filing duties when her secretary left approximately six months before she reported her carpal tunnel syndrome on December 21, 2009. Petitioner testified that she typed a maximum of two continuous hours at a time and handwrote 45 continuous minutes at a time.

15IWCC0703

Petitioner sought treatment from Dr. Newcomer on December 21, 2009 after several months of bilateral hand numbness and weakness, right greater than left. She noted that she frequently dropped things and had to shake out her hands at night to return feeling. Dr. Newcomber noted that Petitioner attributed her complaints to her work duties. A February 11, 2010 EMG/NCS showed severe bilateral median nerve entrapment at the wrists. Dr. Newcomer performed bilateral carpal tunnel releases on March 19, 2010 (right hand) and May 19, 2010 (left hand). On June 21, 2010, Petitioner reported to Dr. Newcomber that she was asymptomatic with regard to her hand complaints.

Dr. Newcomer provided a narrative report on April 16, 2012, causally relating Petitioner's bilateral hand condition to her work activities as assistant warden. He based his opinions on assumptions that Petitioner spent 50-60% of her day typing on a computer and spent significant time signing documents and composing handwritten reports. The doctor opined that she aggravated her bilateral carpal tunnel syndrome condition, which ultimately led to her need for surgery.

Respondent obtained a §12 report from Dr. James Williams. Dr. Willams admitted that Petitioner's surgical releases were appropriate and medically necessary, but he found her condition was idiopathic, based upon her body mass index, high blood pressure, gender, age, and smoking history. Dr. Williams relied upon a scientific study performed by Dr. Ring and on the American Society for Surgery of the Hand's 2010 position statement, which definitively state that typing is not causally related to the development of carpal tunnel syndrome.

Arbitrator Granada found Dr. Newcomber's causation opinion more persuasive than Dr. Williams'. He noted that Dr. Newcomber opined that Petitioner's repetitive job duties aggravated her carpal tunnel syndrome condition, not that the activities caused the condition. He also noted that Dr. Williams failed to take into account Petitioner's increased workload caused by the loss of her secretary in 2009. The Arbitrator further found that Petitioner's complaints were supported by her medical history. He awarded Petitioner 15% loss of use of the right hand and 12.5% loss of use of the left hand.

After considering the entire record, and for the reasons set forth above, the Commission agrees with the Arbitrator's findings of accident arising out of and in the course of Petitioner's employment and causal connection between her bilateral carpal tunnel syndrome and repetitive work activities. However, the Commission finds the Arbitrator's award of permanent partial disability excessive under the facts as interpreted by the Commission. Petitioner voluntarily retired from her position with Respondent prior to her surgeries. At the time of hearing, she was employed as an adjunct professor at Lincoln College. She testified that she had difficulty inputting grades due to her hand pain. Although she previously typed 80 words per minute, she testified that she now must use the "hunt and peck" method. She also testified that she could not lift her grandchildren or groceries due to weakness in her hands. Based upon this evidence and Dr. Newcomber's medical report, indicating that Petitioner was asymptomatic as of June 21, 2010, the Commission finds that Petitioner suffered loss of use of 10% of each hand as a result of her work injury.

All else is affirmed and adopted.

15IWCC0703

IT IS THEREFORE ORDERED BY THE COMMISSION that the October 24, 2014 Decision of the Arbitrator is modified with regard to the award of permanent partial disability, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $644.72/week for a period of 41 weeks, as provided in Section 8(e)9 of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 10% loss of use of the right hand and 10% loss of use of the left hand.

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

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

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

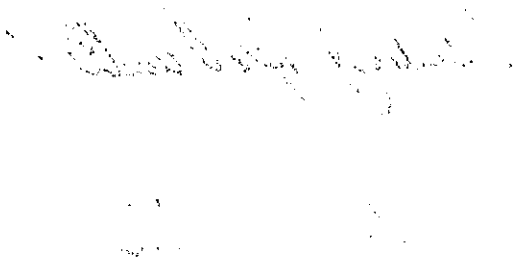
DATED: SEP 10 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-07/14/15
jdl/dak
68



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JORDAN-LUSTER, ADELLA
Employee/Petitioner

Case# 10WC038101

15IWCC0703

SHERIDAN CORRECTIONAL CENTER
Employer/Respondent

On 10/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN & MACIARIELLO
JULIO COSTA
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

5120 ASSISTANT ATTORNEY GENERAL
DAVID PAEK
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

OCT 24 2014

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Adella Jordan-Luster
Employee/Petitioner

v.

Sheridan Correctional Center
Employer/Respondent

Case # **10** WC **38101**

Consolidated cases: _____

15IWCC0703

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **9/12/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 15IWCC0703

On **12/21/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**95,736.00**; the average weekly wage was $**1,841.07**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $644.72/week for 56.375 weeks, because the injuries sustained caused the 15% loss of the right hand and 12.5% loss of the left hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

10/23/14
Date

OCT 24 2014

15IWCC0703

FINDINGS OF FACT

This case involves a Petitioner claiming a repetitive trauma bilateral carpal tunnel syndrome injury to her right and left hands from her employment with the Respondent with an alleged accident date of December 21, 2009. [Arb. Ex. 1.] The issues in dispute are: did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; is Petitioner's current condition of ill-being causally related to the injury; and what is the nature and extent of the Petitioner's injury. [Id.]

The Petitioner's Testimony

The Petitioner testified that she has been an Illinois Department of Corrections employee since 1986. She was a Correctional Officer at Stateville Correctional Center from 1986 to 1991. She became a Correctional Counselor I from 1991 to 1993. She was a Correctional Counselor II from 1993 to 1995 or 1996 at Joliet Correctional Center. From 1995 or 1996 to 2000, she was a Case Work Supervisor at Robinson Correctional Center. The Petitioner received a Ph.D. in criminology in 2000. From 2000 to 2003, she was the Assistant Warden of Programs at Pontiac Correctional Center. From 2003 to 2010, the Petitioner was the Assistant Warden of Programs at Sheridan Correctional Center ("Sheridan CC"), until her voluntary retirement in February of 2010.

As the Assistant Warden of Programs, the Petitioner's job consisted of several duties and responsibilities which are more fully set out in Respondent's Exhibit 2. The Petitioner would assist in the proper operation of Sheridan CC. [RX 2.] The Petitioner would also plan, organize and direct the overall program functions and program managers at Sheridan CC, including for medical and dental services, chaplaincy, clinical services, leisure time, academic and vocational school, library services and contractual substance abuse treatment programs. [Id.] The Petitioner would also supervise Sheridan CC employees and would be responsible for disciplining employees by conducting employee review hearings. The Petitioner testified that during these hearings, she would handwrite notes during the hearing and type reports afterwards. Each hearing took between 30-45 minutes and the Petitioner would type out reports for roughly 30-45 minutes. When asked to approximate how many reports she would do, the Petitioner could not and testified that it varied from 5-7 hearings at a time and did not specify a frequency.

The Petitioner also would conduct routine and unscheduled tours throughout Sheridan CC where she would walk to other buildings and areas of Sheridan CC and would routinely use Folger-Adams keys to open secured doors. She approximated that she would use these keys between 10-15 times per workday and that these keys were much larger and heavier than normal keys. The Petitioner confirmed that the CMS position description marked as Respondent's Exhibit 2 was accurate for her position as Assistant Warden of Programs.

The Petitioner testified that she would report to her immediate supervisor, Warden Michael Rothwell. She testified that on a typical workday, she would start work at around 6 a.m. and would finish by 6 p.m. She testified that she mostly worked Monday through Friday and every other weekend. She testified that her work hours were longer during weeks when she served as the Duty Warden.

The Petitioner testified that throughout the majority of her time as Assistant Warden from 2003 to June or July of 2009, she had a secretary who assisted with all of the Petitioner's clerical needs, which included typing out correspondence, and filing and preparing documents for signature. The Petitioner testified that Melva Sebby was her secretary when the Petitioner started her position at Sheridan CC in 2003 and that Sebby was her secretary for about 3 years. The Petitioner testified that Lori Boone was her secretary after Sebby and that she did not recall how long she did not have a secretary between Sebby and Boone. The Petitioner testified that Boone left 5-6 months before she reported her injury on December 21, 2009; as such, her secretary left sometime in June or July 2009. After her secretary left, the Petitioner had to do all of the clerical duties her secretary normally did herself in addition to her other duties.

The Petitioner testified that she was required to type a maximum of 2 continuous hours at a time as part of her job. The Petitioner testified that she was average or slightly above average in terms of typing force. The Petitioner testified that she was required to handwrite a maximum of 45 continuous minutes at a time as part of her job primarily when she would be taking notes during employee review hearings. She testified that she is not a forceful handwriter.

The Petitioner testified that her right hand started to hurt gradually starting in March or April of 2009. She first went to see Dr. Joseph Newcomer regarding her hands on December 21, 2009. [PX 1.] She testified that her left hand did not hurt initially, but started to hurt as she compensated for not using her right hand. The Petitioner is right hand dominant. On December 21, 2009, the Petitioner complained of an 8-9 month ongoing bilateral hand numbness and weakness with the right hand being worse than the left. [Id.] She complained of dropping objects and testified she needed to rest her hands frequently as a result of hand cramping. [Id.] Dr. Newcomer gave the Petitioner a clinical impression of bilateral carpal tunnel syndrome, right worse than left, and recommended an EMG nerve conduction study. [Id.] Dr. Newcomer noted that the Petitioner does a lot of writing and handles a vast amount of paperwork at work and opined that the Petitioner's carpal tunnel syndrome was likely a result of her work duties. [Id.] The Petitioner also gave written notice of her alleged work-related accident on December 21, 2009. [RX 1.]

15IWCC0703

On February 11, 2010, an EMG of the Petitioner's hands performed by Dr. Edward Pegg indicated severe bilateral median nerve entrapment at the wrist. [PX 1.]

On February 15, 2010, the Petitioner followed up with Dr. Newcomer regarding her EMG results. Dr. Newcomer noted that the Petitioner continued to have weakness, numbness and tingling in the median nerve distribution and confirmed the diagnosis of bilateral carpal tunnel syndrome. [PX 1.] Dr. Newcomer planned to proceed with decompression surgeries starting with the right hand. [Id.]

On March 19, 2010, the Petitioner underwent a right carpal tunnel release. [PX 1.] On May 19, 2010, the Petitioner underwent a left carpal tunnel release. [Id.]

On May 28, 2010, the Petitioner presented to Dr. Newcomer to have her sutures removed from her left hand. [PX 1.] Dr. Newcomer gave her a 10 pound lifting restriction. [Id.]

On June 21, 2010, the Petitioner presented to Dr. Newcomer who noted that the Petitioner was asymptomatic with regards to her hands and the Petitioner was to see Dr. Newcomer on an as needed basis. [PX 1.]

On April 16, 2012, Dr. Newcomer wrote a letter to the Petitioner's attorney providing a narrative report of the Petitioner's treatment with Dr. Newcomer. [PX 1.] Dr. Newcomer stated,

After reviewing your request and seeing that 50 to 60% of her day is comprised typing on the computer and spending a significant amount of time signing documents and composing handwritten reports, it is my opinion that is based on a reasonable degree of medical and surgical certainty that certainly the position that Miss Jordan-Luster had as a correction officer her entire career certainly aggravated the condition of ill-being for which she ultimately underwent carpal tunnel release. I can't definitively say that this was a direct causation the development of carpal tunnel syndrome but there is no question in my mind that certainly that type of work aggravated her condition which ultimately led to surgery. [PX 1.]

The Petitioner testified that she has had a history of problems in her fingers prior to her bilateral carpal tunnel syndrome, which are supported by her medical records. In October 2000, the Petitioner injured her right thumb while moving some heavy boxes. [RX 6.] Dr. Newcomer's impression was a right trigger thumb and the Petitioner received an injection. [Id.] In August 2003, Dr. Newcomer diagnosed the Petitioner with a symptomatic left ring finger triggering. [Id.] On September 23, 2003, Dr. Newcomer performed a left ring finger trigger release on the Petitioner. [Id.] On January 10, 2005, Dr. Newcomer performed a ganglion excision of the Petitioner's left ring finger. [Id.] On August 8, 2008, Dr. Newcomer performed a release of the Petitioner's left trigger thumb. [Id.] On February 16, 2009, the Petitioner presented to Dr. Newcomer complaining of right ring finger triggering. [Id.] Dr. Newcomer administered an injection to the Petitioner's right ring finger on that date.

The Petitioner testified that she had been a smoker for 30 years which included all of her time as an employee for the Respondent, but that she has recently quit. During that time, she would smoke approximately 7 cigarettes per day.

On April 17, 2013, the Petitioner was evaluated for an Independent Medical Exam at the request of the Respondent, which was performed by Dr. James Williams. [RX 9.] Dr. Williams conducted a physical examination of the Petitioner in addition to reviewing her medical records. Dr. Williams confirmed with the Petitioner that pictures taken of the Petitioner's work station were accurate depictions. [RX 4, Ex. 3.] Dr. Williams opined in his IME report that the Petitioner successfully underwent right and left carpal tunnel releases, which were appropriate and medically necessary. Dr. Williams indicated that the Petitioner had reached maximum medical improvement. Dr. Williams opined that given the Petitioner's other medical issues, including her increased body mass index and smoking history, that her carpal tunnel syndrome was idiopathic in nature. [RX 9.] Dr. Williams indicated that most carpal tunnel syndrome cases are idiopathic in nature. [Id.] He referred to and relied upon Dr. David Ring's April 2008 paper and the American Society for Surgery of the Hand's position statement in 2010, which definitively state that typing is not related to the development of carpal tunnel syndrome, to support his opinion. [Id.]

The Petitioner testified that she is currently an adjunct professor at Lincoln College in Bloomington, Illinois. She testified that she has difficulty in inputting grades due to pain in her hands. She testified that she can only type for 15-20 minutes continuously and requires a 5 minute break to rest her hands. She testified that she is not able to lift her grandchildren and cannot lift her groceries. The Petitioner testified that the pain in her hands has reduced her to hunt and peck typing whereas she was a proficient typer prior to her carpal tunnel releases. She testified that her right hand still hurts more than the left. She approximated that she used to be able to type 80 words per minute.

John Nunley's Testimony on behalf of the Respondent

15IWCC0703

The Respondent called John Nunley to testify on its behalf. Nunley testified that he is currently the Manager of the Addiction Recovery Unit for the Illinois Department of Corrections. Nunley has been a State of Illinois employee for the last 23 years. Nunley served as Assistant Warden of Operations at Sheridan CC from 2003 to September 2010. Nunley testified that he was appointed as Assistant Warden of Operations at the same time that the Petitioner was appointed as Assistant Warden of Programs at Sheridan CC and he and the Petitioner started working at Sheridan CC at the same time. Nunley testified that Sheridan was divided organizationally between Programs and Operations and that both he and the Petitioner reported directly to Warden Rothwell.Nunley testified that he had worked with the Petitioner previously at Robinson Correctional Center where the Petitioner was his immediate supervisor. Nunley testified that during his time at Sheridan CC as Assistant Warden of Programs, he shared a secretary with the Petitioner. Both Sebby and Boone served as Nunley's secretary as well as the Petitioner's secretary. Nunley testified that Sebby and Boone were devoted to the Petitioner 75% of their time and 25% to him. Nunley had another secretary dedicated solely to him named Monica Morris.

Nunley clarified that as Assistant Warden of Operations, he would typically work between 7 and ½ to 9 hours per workday and that he would serve as the Duty Warden 1-2 weeks every month during which his work hours were closer to 12 hours per day. Nunley testified that this work schedule also applied to the Petitioner. Nunley testified that he would refer all of the employees under his purview as Assistant Warden of Operations, including correctional officers, to the Petitioner for employee review hearings, and that the Petitioner would refer employees under her purview as Assistant Warden of Programs to him to conduct hearings.

The Deposition Testimony of Dr. John Newcomer

On November 15, 2013, the evidence deposition of Dr. Newcomer was taken. In his deposition Dr. Newcomer testified that the Petitioner's work duties "were an aggravating factor to the development of the carpal tunnel syndrome that ultimately required surgical treatment." [PX 2, 14:1-5.] Dr. Newcomer opined that despite any other contributing factors, that the Petitioner's job duties aggravated her condition to the point where she needed surgery. [PX 2, 20:21-21:1.] On cross-examination, Dr. Newcomer testified that he relied on information provided by the Petitioner's attorney regarding the Petitioner's job duties, including that the Petitioner "did a lot of keyboarding and handwriting as an assistant warden." [PX 2, 15:14-16:13.] Dr. Newcomer acknowledged that he did not review any documents laying out the Petitioner's job duties and responsibilities nor did Dr. Newcomer mention whether he had discussed the Petitioner's job duties and responsibilities with the Petitioner. In Dr. Newcomer's April 16, 2012 narrative report [PX 1], the information that 50 to 60% of the Petitioner's workday was comprised of typing on the computer and signing documents and composing handwritten reports, which Dr. Newcomer relied exclusively on in rendering his causation opinion, was supplied by the Petitioner's attorney and was not independently verified by Dr. Newcomer with the Petitioner. Dr. Newcomer testified that repetitive trauma can aggravate a condition of carpal tunnel and that the repetitive trauma does not have to be forceful. [PX 2, 16:14-21.] When asked whether he was aware of how frequently and for what duration the Petitioned typed, Dr. Newcomer could not answer. [PX 2, 17:2-7.]

The Deposition Testimony of Dr. James Williams

The deposition of Dr. Williams was taken on June 18, 2014. Dr. Williams testified that carpal tunnel syndrome can be multifactorial in cause and greater than 60% of cases are idiopathic in cause. [RX 4, 15:5-11.] Dr. Williams testified that the Petitioner's typing and handwriting activities at work did not cause or aggravate her bilateral carpal tunnel syndrome. [RX 4, 16:13-18.] Dr. Williams testified that whether a certain activity like handwriting or typing aggravates carpal tunnel syndrome symptoms does not necessarily establish a causal connection. [RX 4:42:22-43:3.] Dr. Williams based his opinion on the Petitioner's medical history which she provided to him, the medical records he reviewed, his physical examination of the Petitioner, as well has her medical comorbidities, including the Petitioner's increased body mass index, female gender, hypertension, post-menopausal status, and her smoking for 30 years. [RX 4, 16:19-17:3.] Dr. Williams testified that the Petitioner's bilateral carpal tunnel syndrome was caused by her other medical comorbidities or idiopathic in cause. [RX 4, 17:4-7.] Dr. Williams testified that it is generally accepted in the medical field that handwriting and typing activities do not cause carpal tunnel syndrome. [RX 4, 20:4-10.] In support for his opinion, Dr. Williams reasonably relied on a Mass General paper written by Dr. David Ring as well as the position statement for the American Society for Surgery of the Hand. [RX 4, 20:11-19; see also, RX 4, Defendant's Exhibit 4.]

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this findings, the Arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence from her treating physician. . Furthermore, the Arbitrator finds that Petitioner's testimony was consistent with the contemporaneous medical evidence and she testified consistently regarding the circumstances of her claim, particularly the repetitive nature of her work activities. Petitioner credibly testified that she had never exhibited CTS related symptoms until 2009. She testified that her pain gradually worsened and correlated the increase in symptomatic pain with the loss of her secretary. She testified that she had the same position for eight years and the only major alteration to her work schedule was the added duties she assumed when her secretary left. When the Petitioner was not typing for 2 hours per day, she would attend hearings, where she was consistently writing by hand for up to 45 minutes in one setting. After

15IWCC0703

Petitioner lost her secretary, her job duties would include filing and other clerical duties in addition to her regular duties as an assistant warden. Even Respondent's witness, Mr. Hunley confirmed that the secretary for the assistant warden position did about 75% of the work for the assistant wardens. Given the additional repetitive secretarial activities Petitioner was required to perform in addition to her regular job as an assistant warden, the Arbitrator concludes that the added secretarial work was sufficient to establish a claim for repetitive trauma. As such, the Arbitrator finds that the Petitioner sustained an repetitive trauma incident that manifested itself on December 21, 2009.

2. Based on the findings with regard to the issue of accident, the Arbitrator concludes that the Petitioner has met her burden of proof on the issue of causation. In support of this finding, the Arbitrator relies on the opinions of Petitioner's treating physician that the Petitioner's activities aggravated the Petitioner's conditions of carpal tunnel syndrome. While the Respondent's IME physician points to other factors, such as Petitioner's weight, gender and smoking as factors to consider, Petitioner's complaints related to her carpal tunnel syndrome did not begin until she took on the additional duties of her former secretary. Furthermore, Respondent's IME did not address the Petitioner's additional workload in his analysis of Petitioner's condition. Based on these factors, the Arbitrator concludes that the Petitioner's condition of bilateral carpal tunnel are related to the employment activities leading up to her claimed accident date of December 21, 2009.

3. With regard to the issue of the nature and extent of the Petitioner's injuries, the Arbitrator finds that the Petitioner has sustained injuries to both her hands requiring surgical intervention in the form of carpal tunnel release. Petitioner no longer works for the Respondent and currently works as an adjunct professor at Lincoln College. She still notices pain when typing, more in the right hand than the left. She also has difficulty in lifting heavy items, such as grandchildren and groceries. Based on the Petitioner's testimony and the medical evidence, the Arbitrator concludes that the Petitioner has sustained 15% loss of use of her right hand and 12.% loss of her left hand as a result of her work-related injuries.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ 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

BENNIE CASALINO,

Petitioner,

15IWCC0704

vs.

NO: 12 WC 44552

AREA ERECTORS,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the June 30, 2014 19(b) Decision of Arbitrator Doherty finding that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on November 21, 2012, that Petitioner's current condition of ill-being is causally related to his accidental injuries, that Respondent shall pay Petitioner temporary total disability benefits of $1,058.75 for 29-6/7 weeks for the period of December 05, 2012 through July 02, 2013, as provided in Section 8(b), and that that Respondent shall pay the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's right knee through July 02, 2013, pursuant to Section 8(a) and 8.2 of the Act. The issues presented on review are accident, notice, causal connection, medical expenses, and temporary total disability benefits. The Commission, after considering the entire record, reverses the Decision of the Arbitrator to find that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on November 21, 2012. As a result the Commission's findings herein, the Arbitrator's awards of medical expenses and temporary total disability benefits are hereby vacated.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1) Petitioner, a 39 year-old cement mason, testified he owns his own cement mason company, Northern American Structures, and that in October 2012 he turned in 80 hours for himself, as the only employee of his company, but that those hours could have been for months prior to that time. Petitioner testified that he could not recall what jobs he performed for his own company during that period of time, but he could recall the jobs he performed for Respondent in November of 2012. (T75-77).

2) Petitioner testified that on November 21, 2012, he arrived at Respondent's job site in Wheaton, Illinois, that it was early and dark out, that he was walking around a cement mixer, that he tripped over a pile of debris with his leg, that he went down with his right leg in front of him, that he caught himself with his face hitting the pavement, and that he heard a "pop" in his right knee. Petitioner initially denied any treatment to his right knee prior to November 21, 2012, and then testified he had right knee surgery approximately 10 years prior, for a torn meniscus, but that his right knee was "a brand new knee" afterwards with no treatment to the right knee until after November 21, 2012. (T7-12). Petitioner testified that his co-worker, Kenny Farmer, the laborer working with him, witnessed his fall, but that he did not say anything to Farmer at the time of his fall, although he had a tremendous amount of pain following the "pop" in his knee at the time of his fall. (T14-15).

3) Petitioner admitted that on the date of accident he said nothing to his foreman, Wally Kemp, or any other foreman, about his injury, and he did not call into Respondent's main office to report the injury. (T55-57). Petitioner further admitted that the first time he reported his injury to a supervisor at Respondent was on December 6, 2012, to Jeff Hardison. Petitioner admitted that he flagged Hardison down at the Wheaton job site, reported his injury, that Hardison was very cooperative and walked around and asked about where he was hurt, that he filled out paperwork, and that he sent him to Physicians Immediate Care. Petitioner admitted he did not tell his foreman on the jobsite at the Wheaton job that he got hurt in Wheaton, that he did not advise the foreman at the next jobsite he worked at in Arlington Heights, where he was subsequently sent by Respondent. Petitioner admitted he did not report the injury until December 6, 2012, after he had returned to the Wheaton jobsite from the Arlington Heights jobsite. (T77-82).

4) Petitioner testified that following his November 21, 2012 work injury, he waited two weeks until he sought medical treatment for his right knee because he had been sent to another jobsite of Respondent's, in Arlington Heights, and "you don't report an accident that happened on another job" even though it was the same employer. Petitioner also testified that he delayed seeking treatment for his right knee because the date of his injury was right before Thanksgiving, that everyone had left the job earlier, that his knee had swelled up but he could walk on it, and that he had had a

torn meniscus before and thought this time it could be nothing, but after two weeks of continued swelling he knew something was wrong. (T49-53);

5) Petitioner testified that in February 2011 he was treating with Dr. Templin for lower back pain, but had no major treatment for his low back from that date through December of 2012, and that he had prior low back pain but was able to work.

6) On direct examination, Petitioner testified that on November 26, 2012, he sought unrelated treatment with Dr. Daniel Co, his personal physician, and that he did not mention his right knee condition at that time because he was there for a different type of ailment. (T17). On cross examination, Petitioner testified he may have seen Dr. Co on November 26, 2012, but he did not recall it at all. (T58-59). The November 26, 2012 office visit note of Dr. Daniel Co reflects Petitioner sought treatment for a possible exposure to a sexually transmitted disease. The doctor noted that Petitioner's social history included exercising with P90X, Pilates, yoga, walking his dog, and working 3 days a week as a cement mason. On that date, Dr. Co's review of systems documented all were within normal limits, without joint pain, muscle weakness, or swelling of any extremities. Dr. Co's office visit notes also reflect a complete physical examination was conducted on that date. Petitioner's examination on that date indicated: a normal gait; normal colorization of skin; and, normal strength and tone of the bilateral upper extremities and bilateral lower extremities. Dr. Co's assessment was hypertension, and exposure to sexually transmitted disease, and a testing for same was recommended. (RX5).

7) Petitioner testified that on December 6, 2012 he was sent to Physicians Immediate Care after advising Jeff Hardison, Respondent's safety instructor, that he slipped and fell on debris on November 21, 2012, that he had swelling in his leg and that he needed medical treatment. Petitioner testified that at that time he was still having back pain but he was more worried about his knee. (T17-19).

8) Jeff Hardison, employed as Respondent's corporate safety director, testified that Respondent's safety program requires that employees immediately report a work injury to the employee's foreman, that the foreman contact him. He further testified that all employee handbooks contain guidelines for work injuries, that the employees sign off on the guidelines, that the employees also undergo a job orientation at the job site they are assigned to, and that the controlling contractors at the job site conduct an orientation with their guidelines, OSHA guidelines, and that Respondent also conducts a review of the site specific program with the employees(T137-140).

9) Hardison further testified that Petitioner had extensive job orientation and training when he began his employment with Respondent in October 2012. (T140-141). He testified that on December 6, 2012, while at the Wheaton job site, Petitioner approached him and reported a work-related injury that occurred at the Wheaton

jobsite approximately two weeks prior, that Petitioner said he slipped and hurt his knee, and that a laborer saw it. Hardison testified he asked Petitioner if he had reported the accident to his foreman, and Petitioner replied that he had not done so. Hardison testified he advised Petitioner that he was required to do so immediately following the injury. Hardison testified that he advised Petitioner that Respondent would provide him medical care at Physicians Immediate Care or Concentra, or a clinic by his home if he wanted. Hardison testified he conducted an investigation of the reported accident, but the environment had changed, and that whatever Petitioner said was there at the accident location was not there anymore. Hardison testified he completed an accident report, contained within RX1, on that date, December 06, 2012, and included a photo of the site where Petitioner reported his accident occurred. (T143-147).

10) Hardison testified Petitioner never reported to him that he had any difficulties involving his back, or any difficulty involving his back while lifting bags of grout, or carrying buckets of wet grout. (T147-149).

11) Hardison testified that while the Employee Incident Report indicates the date of notification of the injury was November 22, 2012, which was actually Thanksgiving Day, his first notification of this work injury was on December 6, 2012, when he issued his report. The Commission notes the parties clarified that "Jeff Hamilton" referenced in PX1, the Employee Incident Report and Patient Information Release completed by Petitioner, is actually "Jeff Hardison." (T165-167).

12) The December 6, 2012 Employee Injury Report & Information Release form, signed by Petitioner, reflects that on November 22, 2012 at approximately 7:20 a.m. he injured his knee at Wheaton, Illinois job, that he reported to Jeff Hamilton, that debris including rebar, foam, broken concrete were involved, that Ken Farmer witnessed his accident, that "our mixer was set up in area with debris, and I just walked around and slipped," and that he felt pain immediately. The Employee Injury Report also reflects that Petitioner previously injured this same part in February of 1998. (PX1). Petitioner admitted his December 6, 2012 written report of injury failed to mention anything about back pain or problems, and that he would not be surprised if the Physicians Immediate Care records did not contain reference to back complaints either. (T80-82).

13) The December 6, 2012 office visit note from Physician's Immediate Care reflects Petitioner was seen with complaints of right knee pain, with a date of injury of November 22, 2012. Petitioner provided a history that he was walking through some debris on a job two weeks ago, on November 22, 2012, when he tripped and had to catch himself from falling using his right leg. Petitioner further provided a history that he heard a "small snap" in his right knee, that he had some mild pain at that time but was able to finish the workday, that he had some minor pain in his knee with

some swelling later on that day, that he continued to work and perform his work duties thereafter, but over the prior two weeks he had noticed more pain in his right knee with prolonged standing, kneeling, and that he decided to have it evaluated. Petitioner further provided a history of having a prior right knee arthroscopy for a small meniscus tear, and that he was concerned he could have another tear. Petitioner denied locking or giving way. Petitioner's physical examination revealed a normal right knee exam other than very mild suprapatellar swelling and tenderness along the medial joint space, and a very mildly positive McMurray's test, with a negative apprehension test. It was further noted Petitioner had no pain with patellofemoral grinding, normal quad strength, full range of motion of the right knee, and with regard to his low back it was noted he had normal stability, muscle strength, and tone, with normal sensation in both lower extremities. X-rays of the right knee performed that date indicated mild degenerative joint disease, and he was diagnosed with a right knee sprain/strain. A hinged knee brace, ice, and light duty were recommended. (PX2).

14) Although Petitioner testified to a work-related injury on November 21, 2012, the date of accident recorded on Petitioner's December 6, 2012 Employee Injury Report, on the December 11, 2012 Employer's First Report of Injury, and recorded by the initial medical provider, Physician's Immediate Care, both on December 6, 2012 and December 13, 2012, is November 22, 2012. (PX1, PX2) Petitioner admitted on cross examination that November 22, 2012 was Thanksgiving Day, and that he did not work that day or the following three days, November 23, 24, or 25. Petitioner further testified on cross examination that he could not recall if he sought treatment with Dr. Co on the following Monday, November 26, 2012. (T59).

15) On December 13, 2012, Petitioner was seen in follow up at Physician's Immediate Care, at which time he reported he was doing much better, and had no pain in his knee. His physical examination was negative for tenderness, swelling, or joint line tenderness. The anterior drawer sign and McMurray's sign were both noted to be negative, and his range of motion and gait were both found to be normal. Petitioner's right knee sprain/strain was noted to have resolved. He was released to return to work full duty without restrictions, and released from care at maximum medical improvement as of that date. (PX2).

16) Petitioner testified that he received the December 13, 2012 full duty release to return to work from Physicians Immediate Care based upon his advising the examining doctor that he needed to get his job back, and asking that he be placed on full duty work. Petitioner denied he advised the doctor that he was doing much better or that he had no pain in his knee. (T22-32). Petitioner admitted that the last date he worked for Respondent was on December 7, 2012. (T84).

17) Petitioner testified that his back wasn't the problem following his November 21, 2012 work injury, as his back always hurting when he worked and it just gradually got worse and worse as the knee worsened, because he was limping, and his back then hurt even more. (T35).

18) Petitioner admitted he signed his Application for Adjustment of Claim with respect to his November 21, 2012 work injury on December 20, 2012, and that he sought medical treatment with his personal physician, Dr. Co, on the following day, December 21, 2012. (RX4, T82-83).

19) Petitioner testified he advised Dr. Co that he tripped and felt a "pop," and that he had back pain for few months, now worse with walking. Petitioner testified that he thought the back pain he was having was related to the knee pain, as it got a lot worse after the knee accident. (T35-36). The December 21, 2012 office visit note of Dr. Co reflects Petitioner was reported "he hurt his right leg and back at work and wants to see a [sic] Orthopedic Doctor. He hurt is [sic] on the November 21st." Petitioner also requested a note for restricted duty at work. Petitioner reported that while at work he tripped, caught himself, and felt a pop, and since then had been in pain. Petitioner advised Dr. Co that initially his knee was swollen, that he reported it to work a week later and was placed on light duty, and that he was then fired. Petitioner also advised Dr. Co that he had had back pain for a few months, which was worse with walking different from the knee pain. Dr. Co documented a past medical history of insomnia, restless leg syndrome, prostate issues, vitamin D deficiency, lumbago, GERD, exposure to STD, and hypertension. Dr. Co also documented a social history that Petitioner performed Pilates and yoga on a daily basis, that he was unable to perform his P90X exercises as a result of his knee, that he walks his dog, reads, watches TV, and works full time, three days a week as cement finisher. Dr. Co also documented a surgical history of a July 05, 2011 right knee arthroscopy. At the time of his December 21, 2012 examination Dr. Co noted a normal neurologic exam, a normal musculoskeletal exam in both upper and lower extremities, and diagnosed right knee pain. Dr. Co referred Petitioner to his prior orthopedic surgeon, Dr. Giridhar Burra, and authorized him off work. (PX3, RX5).

20) On January 31, 2013, Petitioner began treating with Dr. Burra, whom previously performed a right knee surgery ten years prior. Dr. Burra diagnosed a possible re-tear of the medial meniscus with patellofemoral pain versus patellar subluxation episode. Petitioner underwent an MRI of the right knee on February 9, 2013, suspicious for a meniscal tear. On February 19, 2013 Dr. Burra opined Petitioner's current condition of ill-being was causally related to his work-related injury of November 21, 2012 based upon , and on May 10, 2013 Dr. Burra performed an arthroscopy, revision partial medial meniscectomy and abrasion chondroplast of the medial femoral condyle. (PX4).

21) On May 6, 2013 Dr. Nikhil Verma conducted a Section 12 examination at Respondent's request, and subsequently reviewed additional treating records including Petitioner 2013 right knee surgical reports and intraoperative photos. (RX17). Dr. Verma testified that Petitioner's complaints of medial sided symptoms were consistent with most meniscectomy pain or changes related to his prior meniscectomy, and that there was no evidence that the November 21, 2012 incident Petitioner described to him caused or aggravated the condition of ill-being for which Dr. Burra was recommending surgery. Dr. Verma testified that the basis for his opinion was that Petitioner was seen five days after November 21, 2012 without any right knee complaints which one would expect with a significant knee injury such as a displacement meniscal tear. (RX18, T14-15).

Based upon a review of the record as a whole, the Commission reverses the Arbitrator's finding that Petitioner sustained an accidental injury arising out of and in the course of his employment with Respondent on November 21, 2012. The Commission relies upon the initial treating medical records from Dr. Co, which fail to list any right knee injury as of November 26, 2012, five days after Petitioner's alleged work injury, and upon the Commission's finding that Petitioner is lacking in credibility.

The Commission finds significant that Petitioner initially claimed a date of accident of November 22, 2012, which was Thanksgiving Day, and a day he did not work for Respondent. Petitioner reported a November 22, 2012 date of accident at the time he completed his Employee Report of Injury, and when he sought treatment at Physician's Immediate Care on December 6, 2012, and on December 13, 2012. Petitioner continued to claim a November 22, 2012 date of accident until December 20, 2012, the date he signed his Application for Adjustment of Claim in this matter. On that date, and on the day after when he sought treatment with Dr. Co, his personal physician, he alleged a new date of accident of November 21, 2012.

The Commission finds most significant that Petitioner sought treatment with Dr. Co on Monday, November 26, 2012, just five days after his alleged date of accident. At that time, Petitioner made absolutely no report of right knee complaints, or mention of a work-related injury. Although Petitioner's chief complaint at the time of his November 26, 2012 date of service was possible exposure to a sexually transmitted disease, Dr. Co, his personal physician, conducted a very thorough physical examination on that date, and specifically noted the following: 1) Petitioner was seen for a follow up of an acute condition; 2) Petitioner reported he was not having any symptoms; 3) Petitioner requested a STD testing. Dr. Co also recorded a fairly physical rigorous social history including exercising with a P90X program, performing Pilates and yoga, and walking his dog. Dr. Co also noted that Petitioner was working three days a week as a cement finisher. Upon review of Petitioner's systems, Dr. Co noted all were within normal limits. He documented no joint pain or muscle weakness, and no swelling of the extremities. Dr. Co's office note also reflects he conducted a full physical examination of Petitioner, specifically noting: a normal gait; normal colorization of skin; normal strength and

15IWCC0704

tone of both upper and both lower extremities. Dr. Co's assessment on that date was hypertension and exposure to an STD, and he recommended blood testing.

The Commission is unable to reconcile Petitioner's claim of significant, traumatic right knee injury resulting in a tear of the medial meniscus on November 21, 2012 with his November 26, 2012 physical examination findings, which were negative for any right knee pathology, and the lack of any right knee complaints or history of a right knee work-related injury. The Commission finds Petitioner to be lacking in credibility. The November 26, 2012 office visit note is void of any finding or complaint of right knee injury, swelling, antalgic gait, bruising, joint pain, abnormal strength or tone.

The Commission also finds suspect Petitioner's claim of a right knee injury at approximately 7:20 a.m. on November 21, 2012, as he continued working a full day, lifting significant weights at his physically demanding job as a cement mason, and he continued to work that job until December 6, 2012, when he reported his alleged injury to the safety person, Jeff Hardison. The Commission also finds significant that as of Petitioner's December 6, 2012 office visit at Physician's Immediate Care, his right knee physical examination had significantly changed from a completely normal examination on November 26, 2012, to swelling, tenderness, and a very positive McMurray's test.

Based on the evidence contained in the record, the Commission finds that the Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment with Respondent on November 21, 2012. Given the Commission's findings above, relative to accident, the Arbitrator's award of 29-6/7 week of temporary total disability, and medical expenses incurred in the care and treatment of Petitioner's right knee through July 03, 2013 is hereby vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 30, 2014 Decision is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits for the period of December 06, 2012 through July 02, 2013, for 29-6/7 weeks at the rate of $1,058.75 per week, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses incurred and related to Petitioner's right knee through July 03, 2013 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that since the Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on November 21, 2012, his claim for compensation is hereby denied.

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

DATED: SEP 10 2015
KWL/kmt
O-07/14/15
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

15IWCC0704

CASALINO, BENNIE
Employee/Petitioner

Case# **12WC044552**

13WC013173

AREA ERECTORS
Employer/Respondent

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
MICAELA M CASSIDY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0704

Bennie Casalino
Employee/Petitioner

v.

Area Erectors
Employer/Respondent

Case # **12** WC **44552**

Consolidated cases: **13 wc 13173**

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 **6/2/14**. 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 IN CASE 12 WC 44552

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

15IWCC0704

FINDINGS

On the date of accident, **11/21/12**, 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 through **7/2/13** ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$4,446.75**; the average weekly wage was **$1,588.13**.

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

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,058.75/week for 29-6/7 weeks, commencing 12/6/12 through 7/2/13, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's causally related medical treatment to his right knee through 7/2/13 pursuant to Sections 8 and 8.2 of the Act.

Penalties

No award of penalties or fees is made.

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 J. Doherty
Signature of Arbitrator

6/27/14
Date

ICArbDec19(b)

JUN 30 2014

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

15IWCC0704

CASALINO, BENNIE
Employee/Petitioner

Case# **13WC013173**

12WC044552

AREA ERECTORS
Employer/Respondent

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
MICAELA M CASSIDY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0704

Case # 13 WC 13173

Consolidated cases: 12wc44552

Bennie Casalino
Employee/Petitioner

v.

Area Erectors
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **6/2/14**. 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 IN CASE 13 WC 13173

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

15IWCC0704

FINDINGS

On the date of accident, **12/21/12**, 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. SEE DECISION

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

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

The parties stipulated that in the year preceding the injury, Petitioner earned $**7,495.95**; the average weekly wage was $**1,629.55**.

The parties stipulated that on the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

All remaining issues are moot and no findings are made.

ORDER

Based on the Arbitrator's finding of no accident and no causal connection, no award of benefits is made.

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 Gresty
Signature of Arbitrator

6/27/14
Date

ICArbDec19(b)

JUN 30 2014

FINDINGS OF FACT

Doa - 11/21/12 right knee case 12 WC 44552 and Doa 12/21/12 low back case 13 WC 13173- consolidated matters at trial.

Petitioner testified that he has worked 39 years as a cement mason. Petitioner testified that he belongs to a cement local in Bellwood, Illinois. Petitioner testified that he was hired by Respondent Area Erectors on 10/15/12 and that he worked at two job sites for Respondent in Wheaton and Morton Grove. Petitioner testified that on when he arrived at work on 11/21/12 he was not having any problems with his right knee. Petitioner underwent right knee surgery for a torn meniscus in 2002 but returned to work thereafter and worked for 10 years prior to 11/21/12 without additional treatment during that period.

Petitioner testified that on 11/21/12, he was at the Wheaton job site for Respondent performing his cement mason duties. Petitioner testified that he tripped over a pile of debris on the ground catching his left foot. As he fell, all of his weight was on his right knee and he felt a pop in the right knee. Petitioner testified that the accident was witnessed by a co-worker, Ken Farmer.

Petitioner testified that he had pain in his right knee but did not seek immediate medical attention for the right knee. Petitioner saw his family doctor, Dr. Co, on 11/26/12. Dr. Co's records dated 11/26/12 do not contain a mention of right knee pain. Rather, the records indicate that Petitioner was seen for a "... follow up visit. Note follow up for acute condition. He says that he isn't having any symptoms. He wants to be treated for STD. He says that he has been going through a lot the last couple of months. ..." RX 5. Petitioner testified that his right knee was painful but that he waited to get treatment to see if the pain would decrease. Petitioner testified that he also waited to get treatment as his accident occurred right before the Thanksgiving holiday and that he was off work over the holiday period.

Petitioner testified that his knee pain continued as of 12/6/12 so he reported his accident to Respondent. Specifically, Petitioner testified that he reported the accident to a supervisor Jeff Hardison on 12/6/12 and that paper work was completed. Petitioner completed an accident report on 12/6/12 listing an accident date of 11/22/12. He reported that he injured his right knee walking through debris on the Wheaton job site and that it was witnessed by Ken Farmer. PX 1. Ken Farmer completed a report on 12/6/12 stating that he witnessed Petitioner's accident on 11/22/12 on the Wheaton job. PX 1 b. A form 45 was completed on 12/11/12 by Christy Budziszek. The form 45 also lists an accident date of 11/22/12 on the Wheaton job and an injury to the right knee. PX 1.

Jeff Hardison testified at trial for Respondent. Mr. Hardison is a certified health and safety expert for Respondent. He testified that on 12/6/12, he was performing a random job site safety check when he had a conversation with Petitioner who advised that he was hurt on the Wheaton job site two weeks earlier. Petitioner pointed to the area where the accident occurred and stated that he hurt his knee. Petitioner conceded that he did not report the accident immediately to his foreman. Mr. Hardison testified that the accident environment had changed, that the debris was gone and that he was unable to perform a full investigation. Mr. Hardison offered Petitioner medical care from the company clinic at Physicians Immediate Care as it was located close to Petitioner's home. He did not interact with Petitioner after 12/6/12.

On cross, Mr. Hardison testified that he took a written statement from the witness Ken Farmer and that he recalls Mr. Farmer stating that the witnessed the accident. He further testified that employees are to report accidents immediately but that on occasion some workers wait to report injuries after realizing that the injury is not improving. Finally, he testified that although the accident report lists an accident date of 11/22/12, his first notice of the accident was on the report date of 12/6/12.

Christy Budziszek also testified for Respondent. She has worked for 10 years for Respondent in the capacity of a claims administrator. In that capacity, she obtains and processes injury report and sends reports to the insurance company. In this case, she administered Petitioner's claim. Ms. Budziszek testified that the accident was reported on 12/6/12 and that all of the reports indicated an accident date of 11/22/12 which was Thanksgiving day. She testified that she forwarded the accident reports to the carrier on 12/10/12.

Ms. Budziszek further testified that she received a return to work with restrictions from Petitioner's doctors at the company clinic on 12/10/12. She further testified that she received a follow up note dated 12/13/12 with a full duty return to work. She testified that Petitioner called her on 12/14/12 and she advised Petitioner that he had been replaced.

On 12/6/12 Petitioner was seen at Physicians Immediate Care as sent by Respondent's safety director for an evaluation of right knee pain. The records from the 12/6/12 visit indicate "Patient states he was walking through some debris while on the job about two weeks ago on 11/22/2012 when he tripped and had to catch himself from falling using his right leg. Patient heard a small snap in the right knee and had some mild pain at that time. He was able to finish the day and had some minor pain in that knee with some swelling later on that day. Patient continued to go to work and perform all of his duties but over the last two weeks has been noticing that he is having more pain in the right knee with prolonged standing, kneeling and decided he needed to come in and have it evaluated. Patient had a right knee arthroscopy several years ago with a small meniscal tear and was concerned that it could be another meniscal tear and that is why he came in. Patient has no locking and no giving way of the knee. He just has pain which seems to be generalized to the knee with prolonged walking and kneeling. Patient has no fevers, chills, no redness, no erythema and does complain of some mild swelling in the upper aspect of the knee. Patient has some complaints of feeling the knee is slightly unstable on standing mostly with possible hyperextensions but otherwise his knee is apparently stable. Patient rates the pain at 5/10 which comes and goes. Rest and keeping his leg elevated improves the pain. No other temporal factors. Patient has no other complaints at this time. Patient denies any non-work related incident or event correlating with the development of this condition." PX 2.

On exam was noted very mild suprapatellar swelling and tenderness along the medial joint space and a very mildly positive medial McMurray's test. X-rays revealed mild DJD. Petitioner was assessed with a right knee sprain and a hinged knee brace was applied. He was to elevate and apply ice as well as take ibuprofen. Petitioner was returned to work with restrictions until the recheck of 12/13/12.

Petitioner was rechecked at the clinic on 12/13/12. The notes indicate that Petitioner reported "he is doing much better and has no pain in the knee at the present time." Petitioner's physical exam of the right knee was normal. The assessment was right knee sprain/strain resolved. Petitioner was to advance to full duty without restrictions and released from care at MMI. PX 2.

Petitioner testified that on the day before the doctor's visit of 12/13/12, he spoke with a supervisor and was advised that he had been "fired." Petitioner also testified that he spoke with a union rep the day before the 12/13/12 doctor visit and was told that he had been "replaced" due to his restrictions. As a result, Petitioner testified that he requested the full duty release from Physicians Immediate on 12/13/12 so that he could retain his job. Petitioner denied telling the physicians that he was doing much better and that he had no pain in his right knee.

On 12/21/12 Petitioner returned to Dr. Co. The 12/21/12 notes indicate "The patient is a 56 year old male who presents for a follow up visit. The patient feels well with minor complaints (He hurt his right leg and back at work and wants to see Orthopedic Doctor. He hurt is [sic] on the November 21st). Note for "follow up for chronic condition." He also would like a note for restricted duty at work. At work, tripped, caught himself felt pop and since then he's been in pain. Initially swollen. Reported it to work a week later, placed on light duty and he was fired. Back pains for a few months, now worse with walking different from the knee pain. Stands or walks less than 30 minutes to get significant pain."

The review of the musculoskeletal system noted back pain and joint pain with no present muscle weakness. Physical exam of the right lower extremity revealed "normal strength and tone." The assessment was "knee pain and the current plan was a follow up in 4 months or as needed and a referral to orthopedics. Petitioner was taken off work. PX 3.

The first mention in the medical records of back pain in connection with any alleged accident in these matters is on the visit to Dr. Co on 12/21/12. Petitioner testified at trial that his back was "always hurting" while he was at work but that the back pain worsened after the right knee injury due to the fact that he was walking with a limp. Petitioner testified that he had prior back problems and those problems are reflected in the medical records submitted at trial.

Specifically, on May 10, 2006, the Petitioner underwent an MRI at Universal Open MRI and Diagnostic Center of Naperville, on referral from then-primary care physician Dr. Patricia O'Connor, which disclosed multilevel degenerative disc disease without stenosis, and an annular tear at L4-5 without stenosis. (RX15). Between November 2008 and February 2009, the Petitioner underwent chiropractic care for low back pain that extended down the legs, at Ondras Chiropractic. (RX14). On February 20, 2011, the Petitioner was seen for the first time by Dr. Cary Templin of Hinsdale Orthopedics. He reported low back pain to right groin and back of right thigh and knee for the past several weeks. He rated his pain as an 8 on a scale of 1-10. (RX6). On July 5, 2011, the Petitioner began treating with Dr. Co and reported joint pain to his back, elbows and knees. He reported he was a cement finisher, working two days per week. (RX5). Finally, on September 12, 2012, one month before starting work for Respondent, Petitioner was seen by Dr. Co again. At that visit he reported feeling pretty good, except for his back. He reported icing his back. He reported working 3 days per week as a cement finisher. He was prescribed Tramadol for back pain, and given a Lidoderm patch, also for back pain. Dr. Co characterized the Petitioner's low back condition/diagnosis as a chronic problem. (RX5).

On 1/31/13 Petitioner saw Dr. Burra for his right knee. Dr. Burra performed Petitioner's prior right knee arthroscopy partial medial meniscectomy in 2003. Dr. Burra diagnosed a right knee medial meniscal tear and performed arthroscopic surgery on the right knee on 5/10/13. PX 12. He further testified that the diagnosis was confirmed during surgery as reflected in the operative report and the operative pictures. PX 12. As a result, he disagreed with the Dr. Verma, Respondent's Section 12 physician, who opined 4 days before surgery that Petitioner did not show evidence of significant intra-articular pathology or internal

derangement based on objective examination and MRI scan. Based on the fact that Petitioner was asymptomatic for 10 years between right knee surgeries, the described mechanism of injury and the re-tear shown on MRI and at surgery, Dr. Burra opined that Petitioner's right knee condition was casually related to his accident in November 2012. PX 12. Dr. Burra last saw Petitioner for his right knee on July 2, 2013 following the surgery. Petitioner was discharged from his care on that date with a release to return to his prior employment duties. Dr. Burra testified that Petitioner was "completely asymptomatic" after the surgery. PX 12.

With regard to his back treatment, Petitioner saw Dr. Templin on the referral of Dr. Burra in February 2013. At his deposition, Dr. Templin testified that he originally saw Petitioner in February 2011 for back pain and no surgical recommendations were made at that time. He did not see Petitioner again until February 2013 when Petitioner complained of worsened low back pain with some pain extending into the legs. He noted Petitioner's report of "...some recent heavy activity at work in late 2012, repetitively lifting 80 pound bags of concrete that basically aggravated his back, with pain predominantly in the low back but some pain also extending into the legs. He rated his pain as an 8 out of 10 and also noted that he was – that he had some type of knee injury as well that he had seen Dr. Burra For. I think that's actually how he came back to see me." Dr. Templin opined that the type of activity described to him between October and December 2012 is the type that can aggravate DJD that Petitioner had. PX 11. He opined that such aggravation occurred. PX 11.

Petitioner testified that he advised Dr. Templin that he lifted heavy bags of concrete at work and that is why Dr. Templin noted that information. At his deposition on cross exam, Dr. Templin testified his opinion that Petitioner's back condition was related to repetitive lifting at work was based solely on the history provided by Petitioner. PX 11.

On 4/24/13, Dr. Templin released Petitioner to modified work with no lifting greater than 5 to 10 pounds, sitting, bending, kneeling standing as tolerated." PX 11. Dr. Templin opined that Petitioner can work full time within those restrictions at the time of his deposition. On 6/18/13, Dr. Templin referred Petitioner to Dr. Cheema for pain management as Petitioner complained of pain at 10/10 on that date. PX 11. Dr. Templin's last visit with Petitioner was on 9/9/13. Dr. Templin did not recommend any additional treatment or medication other than a referral to Dr. Cheema. He further testified that he did consider Petitioner's complaints of pain to exceed what he would expect given Petitioner diagnostic presentation. PX 11, p. 26.

Petitioner attended a Section 12 exam with Dr. Verma on 5/6/13, 4 days prior to his knee surgery on 5/10/13. Petitioner advised that he hurt his right knee at work after tripping on debris. As a result of the exam and the records reviewed by Dr. Verma, he noted that he did not "... see any evidence of intra-articular pathology other than the patient having had a prior meniscectomy and I felt his medial-sided symptoms were consistent with most meniscectomy pain or changes related to that prior meniscectomy." RX 18. He further noted that Petitioner's described incident did not cause or aggravate Petitioner's knee condition such that he would need the surgery recommended by Dr. Burra. Dr. Verma found no evidence of a significant injury to the knee on or about November 21, 2012. RX 18.

Petitioner began treatment with Dr. Cheema at the Holistic Science Pain Clinic on 6/21/13. The records reflect that Dr. Burra referred Petitioner to Dr. Cheema. His records of that visit indicate low back pain radiating to the groin. Dr. Cheema noted a decreased range of motion at the lumbar spine and loss of

lumbar lordosis. PX 6. Petitioner had one injection on 7/19/13. Between 6/21/13 and 4/16/14, Petitioner received Norco from Dr. Cheema based on ongoing complaints of low back pain. He did not receive any additional injections as he testified the one he received did not help his pain level. Although the records contain reference to a knee condition, the records note treatment for Petitioner's back complaints only.

Finally, with regard to Petitioner's low back complaints and treatment, Petitioner attended a Section 12 exam with Dr. Goldberg on 5/31/13. RX 21. Petitioner provided a history of repetitively lifting heavy bags of cement at the end of 2012 and developing back pain. The pain traveled into both of his thighs on the front side but did not go below the knees. He also offered that he had knee surgery a few weeks before the exam in May 2013. Dr. Goldberg was also aware that Dr. Templin treated Petitioner two years earlier in 2011 for reported low back pain that traveled into the right thigh and knee and his pain was 8/10. He also reviewed prior back treatment records from 2006, including x-rays showing DJD, Dr. Co records from 11/2/11, 5/15/12 and 11/26/12 indicating no lumbar complaints, and Dr. Co's record from 9/12/12 when Petitioner complained of back pain and he was given Tramadol. Dr. Goldberg also reviewed Petitioner's records for knee and back complaints after the accident in November 2012, including Dr. Co's note of 12/21/12 wherein Petitioner complained of increased back pain worse with walking after his knee injury.

Following his exam of Petitioner's lumbar spine showing him to be neurologically intact, Dr. Goldberg opined that Petitioner had "some degenerative disk disease but I don't think it was caused or aggravated by the work related accident in—around November 2012." His opinion is based on the fact that Petitioner had low back complaints which pre-dated the November 2012 accident and based on the fact that no mention of any work injury to the lumbar spine was made when he was seen by Dr. Co in November 2012, 12/6/12 or 12/13/12 at Physicians Immediate Care. RX 21, p. 15. On cross, Dr. Goldberg testified that lifting heavy bags of cement can "hypothetically" aggravate DJD.

At trial, Petitioner testified that his knee pain subsided about 6 weeks post surgery in 2013. He testified that he no longer has knee pain but only occasional knee pain flare ups. He testified that he has excruciating low back pain. Petitioner testified that he has difficulty getting out of bed in the morning. Petitioner uses ice and therapy to ease the pain in addition to Norco which he takes 3 to 5 pills per day.

Average weekly wage was placed at issue at trial. RX 2 is a recorded statement Petitioner gave to the insurance company dated 12/12/12. Petitioner did not mention any low back injury in the statement. Petitioner stated that as a cement mason he earned $41.65 per hour. He testified that for Respondent and when asked how many hours he worked per week he worked he normally worked on average "40 but recently we've been working 32, you know, 24 its been erratic I don't know how to answer that question. … in summer months we work, you know, 40 in the winter months we work 24 so. … the weather doesn't provide" [in the winter months]. PX 9 contains wage records from Respondent showing that between 10/2/12 and 11/18/12, Petitioner pay records from his time of hire to 11/21/12, Petitioner worked 105 hours, 14 days, and 2.8 weeks. His total earnings for that period is $4,446.75/2.8 weeks yields an AWW of $1,588.13.

CONCLUSIONS OF LAW

The foregoing findings of fact are incorporated into the following conclusions of law in both cases 12 WC 44552 and 13 WC 13173.

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 with Respondent? E. Was timely notice provided to Respondent? F. Is Petitioner's current condition of ill-being causally related to the injury?

With regard to the accident date of November 21, 2012 and Petitioner's right knee injury alleged in case **12 WC 44552**, the Arbitrator finds that Petitioner sustained an injury to his right knee on November 21, 2012 arising out of and in the course of his employment for Respondent and that his right knee condition through July 2, 2013 is causally related to the accident. The Arbitrator further finds that Respondent received proper and timely notice of that accident and injury.

The Arbitrator notes that Petitioner had a prior right knee surgery almost 10 years before this accident. However, Petitioner worked without treatment or symptom during that period up to the date of accident on 11/21/12. Petitioner credibly testified that he tripped over debris at the worksite on 11/21/12. Petitioner testified that he waited to report the injury or seek treatment over a holiday period while waiting to see if the pain and swelling subsided. When the symptoms continued, Petitioner reported is injury to Jeff Hardison on 12/6/12 as testified to by Mr. Hardison and accident reports were completed. Statements were given to the insurance company documenting the accident and the knee pain. PX 1. The Arbitrator further finds that the accident was witnessed by co-worker Ken Farmer as referenced in the accident reports.

Petitioner testified that he initially received treatment at Respondent's direction from Physician's Immediate Care. The Arbitrator notes those records contain a consistent accident history. The records from 12/6/12 note that exam revealed very mild suprapatellar swelling and tenderness along the medial joint space and a very mildly positive medial McMurray's test. X-rays revealed mild DJD. Petitioner was assessed with a right knee sprain and a hinged knee brace was applied. He was to elevate and apply ice as well as take ibuprofen. Petitioner was returned to work with restrictions until the recheck of 12/13/12.

Between 12/6/12 and the recheck of 12/13/12, Petitioner discovered he may have been replaced at the worksite due to his restrictions. Petitioner testified that when he returned to Physician's on 12/13/12, he reported no continued knee problems and requested a return to full duty in order to keep his job. When he called to return he was told he had been replaced and/or fired. On 12/21/12 Petitioner returned to his primary physician Dr. Co. The 12/21/12 notes indicate "The patient is a 56 year old male who presents for a follow up visit. The patient feels well with minor complaints (He hurt his right leg and back at work and wants to see Orthopedic Doctor. He hurt is [sic] on the November 21st). Note for "follow up for chronic condition." He also would like a note for restricted duty at work. At work, tripped, caught himself felt pop and since then he's been in pain. Initially swollen. Reported it to work a week later, placed on light duty and he was fired." Following the referral for orthopedic care for his knee, Petitioner saw Dr. Burra.

On 1/31/13 Petitioner saw Dr. Burra for his right knee. Dr. Burra performed Petitioner's prior right knee arthroscopy partial medial meniscectomy in 2003. Dr. Burra diagnosed a right knee medial meniscal tear and performed arthroscopic surgery on the right knee on 5/10/13. PX 12. He further testified that the diagnosis was confirmed during surgery as reflected in the operative report and the operative pictures. PX

12. As a result, he disagreed with the Dr. Verma, Respondent's Section 12 physician, who opined 4 days before surgery that Petitioner did not show evidence of significant intra-articular pathology or internal derangement based on objective examination and MRI scan. Based on the fact that Petitioner was asymptomatic for 10 years between right knee surgeries, the described mechanism of injury and the re-tear shown on MRI and at surgery, Dr. Burra opined that Petitioner's right knee condition was casually related to his accident in November 2012. PX 12. Dr. Burra last saw Petitioner for his right knee on July 2, 2013 following the surgery. Petitioner was discharged from his care on that date with a release to return to his prior employment duties. Dr. Burra testified that Petitioner was "completely asymptomatic" after the surgery. PX 12. Petitioner testified that his right knee subsided about 6 weeks after the surgery. The Arbitrator further finds that no treatment was rendered to Petitioner for his right knee after that date. To the extent any treatment was rendered or referenced in subsequent treatment records after July 2, 2013, it is not causally connected to the accident of 11/21/12.

In finding causal connection for the right knee, the Arbitrator places greater weight on the opinion of Dr. Burra and his operative findings than on the pre-surgical opinion of Dr. Verma. Based on the totality of the credible evidence at trial, the Arbitrator finds accident on 11/21/12, proper and timely notice, and causal connection for Petitioner's right knee injury and treatment through the MMI date of July 2, 2013.

With regard to the alleged accident of 12/21/12 and the alleged low back injury on that date in case **13 WC 13173,** the Arbitrator notes Respondent's dispute on the issues of whether Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act and to employment relationship based on the fact that Petitioner was no longer working for Respondent on the alleged date. However, the Arbitrator notes Petitioner's theory of accident and injury at trial which was that Petitioner's low back injury arose as a result of his altered gait due to the knee injury as well as reference to repetitive lifting during his period of employment. Petitioner first reported the back complaints to Dr. Co on 12/21/12. Thus, the Arbitrator notes Petitioner's reasoning for the alleged accident date to be valid under the Act.

Nevertheless, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injury to his low back which can be considered casually related to his employment with Respondent on any date under either theory of recovery. In so finding, the Arbitrator notes Petitioner's significant history of low back complaints and treatment as recently as 2 months prior to starting his employment with Respondent, the lack of low back complaints documented in the initial treating records of Dr. Co or Physician's Immediate Care and the lack of low back injury during his recorded statement. With regard to the first mention of low back complaints to Dr. Co on 12/21/12, the Arbitrator notes that Dr. Co referred to the low back condition as "chronic" referencing his prior treatment of Petitioner's complaints. In denying accident and causal connection, the Arbitrator further notes the inconsistent accident histories noted throughout the record. Specifically, the Arbitrator notes that on some occasions, at trial, and in records Petitioner reports back pain due to altered gait following his knee injury. On other occasions and records, Petitioner reports back injury from repetitive lifting of heavy cement bags. The Arbitrator notes that these inconsistencies detracted from Petitioner's credibility regarding the relationship between his low back complaints and any work related activity.

Finally, in denying accident and causal connection for the low back complaints, the Arbitrator places greater weight on the opinions offered by Dr. Goldberg over that of Dr. Templin and agrees with the basis of Dr. Goldberg's opinion as noted above in light of the record in its entirety.

In light of the findings on the issues of accident and causal connection, all other issues are moot and no findings are made on those issues in case 13 WC 13173. **No benefits are awarded in case 13 WC 13173.**

The remaining conclusions of law are made in case 12 WC 44552 only in connection with Petitioner's right knee injury.

G. What were Petitioner's earnings?

The parties differ in their calculation of the average weekly wage, Petitioner asserting that the correct amount is $1,588.13, while Respondent asserts that it is $1,016.40.

In *Sylvester v. Industrial Comm'n*, 197 Ill. 2d 225, 756 N.E.2d 822 (4th Dist. 2001), our supreme court noted that section 10 provides four methods of calculating average weekly wage: (1) by default, average weekly wage is "actual earnings" during the 52-week period preceding the date of injury, illness or disablement, divided by 52; (2) if the employee lost five or more calendar days during that 52-week period, "whether or not in the same week," then the employee's earnings are divided not by 52, but by "the number of weeks and parts thereof remaining after the time so lost has been deducted;" (3) if the employee's employment began during the 52-week period, the earnings during employment are divided by "the number of weeks and parts thereof during which the employee actually earned wages;" and (4) if the employment has been of such short duration or the terms of the employment of such casual nature that it is "impractical" to use one of the other three methods to calculate average weekly wage regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. *Sylvester*, 756 N.E.2d 822.

In this matter, the Arbitrator relies on the third method noted above in that Petitioner began his work for Respondent in October 2012. Using the wage figures in PX 9, between 10/21/12 and 11/18/12 Petitioner worked 105 hours, 14 days, or 2.8 weeks. His total earnings for that period were $4,446.75/2.8 weeks yields an AWW of $1,588.13 and a TTD rate of $1,058.75.

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

Based on the findings on the issues of accident and causal connection with regard to Petitioner's right knee injury, and on Respondent's liability dispute on the issue of medical expenses, the Arbitrator further finds that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's right knee through July 2, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

L. What temporary benefits are in dispute? TTD

Based on the findings on the issues of accident and causal connection with regard to Petitioner's right knee injury, and on Respondent's liability dispute on the issue of temporary total disability, the Arbitrator

further finds that Petitioner was temporarily and totally disabled for a period of 29-6/7 weeks commencing 12/6/12 through 7/2/13 pursuant to Section 8(b) of the Act. The finding is further based on the restricted duty and off work authorizations of Petitioner's treating physicians. Respondent shall receive credit for amounts paid, if any.

M. Should penalties or fees be imposed on Respondent?

To the extent Petitioner alleges he is entitled to penalties and fees under the Act, the Arbitrator finds that based on the record in its entirety, Respondent's conduct was not so unreasonable or vexatious so as to justify the imposition of penalties or fees under Sections 19(k), 19(l) or 16 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Doering,

Petitioner,

vs. NO: 13WC 23436

Keystone Steel & Wire,

15IWCC0702

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 13, 2014, 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.

15IWCC0702

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 $5,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 10 2015
o080415
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Dissent

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain his burden of proving that his bilateral carpal tunnel syndrome was related to his work activities, reversed the Decision of the Arbitrator, and denied compensation. The Arbitrator found that Petitioner sustained his burden of proving repetitive trauma work injuries and that July 8, 2013 was a proper date of manifestation of his bilateral carpal tunnel syndrome. July 8, 2013 was the date Petitioner testified he saw Dr. Hoffman after an EMG. However, at that time Dr. Hoffman's treatment note only indicated that Respondent had denied Petitioner's workers' compensation claim and referred him to a hand specialist, Dr. Rashid.

Petitioner testified that his symptoms began four or five years prior to his alleged date of manifestation. However, he did not report the alleged injuries until two months after he was terminated.

Petitioner relies on Dr. Rashid's causal connection opinion. Dr. Rashid saw Petitioner on only one occasion and opined that his bilateral carpal tunnel syndrome was caused by his work activities based exclusively on Respondent's job description that indicates Petitioner used his hands 66% of the work day. Dr. Rashid was unaware of Petitioner's recreational activities, which included riding a mountain bike, which is very stressful on hands and which he did every day for several years before the bike was stolen. She was also unaware that Petitioner worked on and off in a relative's auto service business for 10 years, an activity which can also be very hand intensive and stressful.

The job description, Respondent's Exhibit 11, actually says that the activity of "handling" which is described as "[s]eizing, holding, grasping, turning or otherwise working with hand(s), fingering not involved" must be done frequently. Frequently is defined as more than 33% but not more than 66%. Petitioner would be required to use his hands as described from a maximum of 66% down to as little as 34% during his shift. There is no information concerning the amount of force involved in the example activities listed which were "[r]emoves roll, tags roll, and secures end of roll, places wire carriers or spools, welds ends, and smooths weld, performs minor repairs to machine."

Mr. Jeff Klokkenga testified on behalf of Respondent. His testimony indicated that Petitioner's job was not very hand intensive or repetitive. Petitioner's job involved various activities which changed throughout the workday. The only aspect of the job that involved forceful hand activity was the use of pliers, which required 20 pounds of pressure. That activity was only performed infrequently. Mr. Klokkenga worked the machine upon which Petitioner alleges he was injured for six and a half years. He was the General Manager working the same shift as Petitioner. He testified that it required minimal or less than 5 pounds of force to cut the wire with bolt cutters. Welds were made by an automated machine wherein the wire would be placed into a clamp jaw and a button pushed. A screwdriver would only be used during the shift to insert it into a roll just to keep the roll from unravelling when a cut was made. An air grinder would be used once every two weeks for 10 minutes to grind out a link if that occurred. A machine operator would use button pliers 10 times per shift on average which would require 20 pounds of force. Other than using the air grinder once every two weeks for 10 minutes there would be no use of any type of vibratory tools. I would find that Mr. Klokkenga's description of the use of the hands for this job is more credible than that of Petitioner.

Petitioner proved only that his work involved between 34% and 66% use of his hands. In my opinion that is insufficient to prove a causal connection between those activities and the development of bilateral carpal tunnel syndrome. In looking at the entire record before the Commission, I would have found that Petitioner did not sustain his burden of proving a causal connection between his work activities and his bilateral carpal tunnel syndrome, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Ruth W. White

RWW/dw
O-8/4/15
46

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

DOERING, CHARLES
Employee/Petitioner

Case# **13WC023436**

KEYSTONE STEEL & WIRE
Employer/Respondent

15IWCC0702

On 11/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
4242 N KNOXVILLE AVE
PEORIA, IL 61614

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

15IWCC0702

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHARLES DOERING
Employee/Petitioner

v.

KEYSTONE STEEL & WIRE
Employer/Respondent

Case # 13 WC 23436

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GREGORY DOLLISON**, Arbitrator of the Commission, in the city of **PEORIA, ILLINOIS**, on **09/22/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0702

On the date of accident, **07/08/213**, 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 $**47,840.00**; the average weekly wage was $**920.00**.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $5,254.35, as provided in Section 8(a) of the Act, subject to the medical fee schedule. Inasmuch as the medical bills are to be paid consistent with the medical fee schedule, this may cause the total amount awarded to decrease to comply with the provisions of said schedule.

Respondent shall further authorize the prescribed treatment as recommended by Dr. Rashid.

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

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

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

Signature of Arbitrator

11/11/14
Date

ICArbDec19(b)

NOV 13 2014

STATEMENT OF FACTS:

15IWCC0702

Petitioner began his employment with Respondent, Keystone Steel & Wire, in March 1987. He was thereafter employed by Respondent for twenty-six years as a fence machine operator, making various barbed wire fencing. His job duties included welding, running fencing machines, quality assurance of the wire, cutting out rolls of wire, starting new rolls, repairing fencing, palletizing and labeling rolls of wire, and recording his daily production. He worked with hand held tools on a continuous basis, including cutting "nippers", hammers, pliers, sledgehammers, wrenches, hog ringers (industrial sized staple gun for securing the fence rolls), welders, hand held grinders, screwdrivers, vice grips, and bolt cutters. He worked on a full-time basis, often working double-shifts and mandatory Saturdays. He also frequently volunteered for Sunday overtime. Petitioner is right hand dominant.

Petitioner testified that he was able to operate all of Respondent's fencing machines. Keystone makes several different types of fence, requiring wire sizes ranging from 16 gauge (smallest) down to a 6 gauge which is similar to a stiff cable. Some wires were "high tensile" which made them much more difficult to manipulate and cut. Petitioner, due to his seniority, was able to select the higher paying production jobs, typically working with 12 ½ gauge wire on two different machines, number 99 and 109. These machines ran 12 ½ gauge "non-climb" fencing. The finished rolls were 660 feet long. Each roll had to be cut free from the machine with bolt cutters and snips. An overhead hoist was then used to move the wire roll into a pallet, where it was secured with a long screwdriver and staple gun, and then labeled. Petitioner's production records from 2012 and 2013 were subpoenaed. (PX 6) In an 8 hour shift, his roll production varied from 4 rolls to 75 rolls with an approximate average production of 40-50 rolls per 8 hour shift.

Petitioner testified that his job duties included machine maintenance and small repairs. This included removing jammed wire from the machines. This process required the operator to use a screwdriver and pliers to loosen machine parts for wire removal.

Respondent's Exhibit 11 is a Keystone job description and analysis. It includes a statement that the Petitioner's job includes "rarely" reaching above shoulder, at, or below height, and "frequently" seizing, holding, grasping, turning and working with hands. (RX 11, p.6) The analysis lists the job functions as operating the machines, placing wire carriers, using a butt-welder to join the new carrier to the old, using pliers to smooth that weld, pushing buttons and pulling levers, removing and tagging rolls of fencing, securing a pallet of wire rolls, production recording, performing minor repairs of machines, repairing wire in machines, and handling scrap by hand or with hoists. (RX 11, p.1)

Petitioner testified that the carrier wire that sat on top of the machine could last 2 hours or a whole day. When it ran out, he would have to climb up on a deck, remove the carrier lid which weighs about 20 pounds, use the overhead hoist to set in a new carrier of wire, use the bolt cutters to cut out the old carrier, and then weld the new wire to the old, and then use pliers to grind down the weld.

Petitioner testified that he used hand snippers, continuously. When his right dominant hand got fatigued, he would switch to his left hand. Using the snippers required force. The high tensile wire and 10 gauge and lower wire took considerable force to cut. Using the bolt cutters also required force and the use of both hands. Overhead work was required to change the carriers, to reach parts of the machines for repairs, and when re-stringing wire into the machines.

Petitioner testified that in approximately 2008 or 2009, he began to notice that he was losing strength in his arms and hands, that he was dropping things, numbness and tingling in his fingers, and that certain movements caused pain in his shoulders. These symptoms were worse after he worked long hours and overtime hours.

In 2009, Petitioner was suspended from employment for approximately one year. He returned to work in 2010 but was placed on probation. When he returned to employment, his symptoms were present again. Petitioner stated that he did not report the symptoms because of his probationary status and fear of losing his job. In March 2013, Petitioner left work early one day, triggering discipline and a drug test. He tested positive for an illegal substance and his employment was terminated on May 3, 2013. (RX 2)

Once terminated, Petitioner sought medical treatment for his shoulders and hands. He went to Dr. Daniel Hoffman at the recommendation of a friend. He first saw Dr. Hoffman on June 24, 2013. Petitioner gave a history of being a machine operator at Keystone for the last 26 years and developing pain in both shoulders and numbness in both hands "over the last few months." Dr. Hoffman provisionally diagnosed a rotator cuff tear and possible carpal tunnel syndrome. An MRI of the right shoulder and EMG study of both arms were ordered. (PX 5, p.12)

On July 1, 2013 Petitioner underwent a right shoulder MRI at the OSF Center for Health with a history of chronic nontraumatic shoulder pain and limited range of motion. The right shoulder MRI showed a partial thickness articular surface infraspinatus tendon tear with chronic rotator cuff tendinitis and degenerative spurring at the acromioclavicular joint. (PX 3)

On July 2, 2013 Dr. Edward Trudeau performed a bilateral upper extremity EMG-NCV. Dr. Trudeau diagnosed bilateral median neuropathies, moderately severe on both sides, right greater than left. (PX 4, p.6)

On July 8, 2013 Petitioner returned to Dr. Hoffman for his test results and diagnosis. That date, Dr. Hoffman diagnosed Petitioner with carpal tunnel syndrome and a rotator cuff tear and referred him to Great Plains Orthopedics. (PX 5, pgs. 9-10) Petitioner testified that it was that day that he learned of his diagnosis which he felt was work related. Immediately thereafter, Petitioner sent written notice to Respondent of his July 8, 2013 manifestation date.

On August 2, 2013, Petitioner presented to Great Plains Orthopedics where he saw Dr. Mary Elizabeth T. Rashid. Petitioner provided a history that he had bilateral hand and wrist pain for about five or six years as well as bilateral shoulder pain. He further told Dr. Rashid that his work as a machine operator caused the symptoms, especially his gripping and lifting. After performing an examination and reviewing the EMG study, Dr. Rashid diagnosed bilateral carpal tunnel syndrome. The doctor provided options including surgery versus injections. Petitioner opted for surgery. (PX 3)

On August 20, 2013, Petitioner returned to Great Plains Orthopedics where he saw Dr. Jeffrey R. Garst for bilateral shoulder pain, right worse that left. Petitioner provided that his symptoms had been going on for a few years and had been gradually getting worse. Petitioner also informed the doctor that he worked for Respondent for over twenty (20) years as a machinist. After an examination and reviewing diagnostic studies, Dr. Garst diagnosed 1.) right shoulder partial rotator cuff tear with impingement and acromioclavicular arthritis; and 2.) left shoulder impingement with acromioclavicular arthritis, possible rotator cuff tear. With respect to the right shoulder, Dr. Garst recommended an injection and therapy, and surgery if the symptoms persisted. Regarding the left shoulder, the doctor noted that any further recommendation would depend on a MRI. At that time, Petitioner provided he would wait and take same into consideration. (PX 3)

15IWCC0702

Petitioner's testified and medical documentation show that Petitioner sustained a right elbow dislocation playing football in high school and also sustained a softball injury regarding the right shoulder. Plant medical records for May 21, 1996 reflect Petitioner being seen for a softball injury occurring on May 19, 1996 with Petitioner alleging injury to the right shoulder and seeing Dr. Edward Smith for a possible torn right rotator cuff or fracture of the right shoulder. Petitioner returned on May 21 indicating that Dr. Smith diagnosed the condition as a sprain to the rotator cuff with no dislocation. Petitioner was off work for this condition from May 20 until returning May 28, 2006 for a non-occupational right shoulder sprain, rotator cuff. (RX 6) Petitioner testified the 1996 condition involved his left shoulder.

Petitioner testified that since his discharged from Respondent he obtained employment with Excalibur Service Plant for three (3) month. Records submitted show Petitioner filling out an application for same on September 4, 2013. The job description indicated that Petitioner would have to take heavily soiled areas that would have to be hand scrubbed if needed and sanitize parts. (RX 8) In addition, Petitioner testified in this position that he also would do packaging wherein he would take flap cardboard and fold it into boxes, making 30 to 50 boxes each shift, and use a knife to cut. Additionally, Petitioner stated that he would have to use an Allen wrench or T-wrench on occasion and acknowledged having an incident while changing an auger with a T-handle Allen wrench in September 2013.

Petitioner testified that he currently worked at DJ's Auto Service, a family owned business. Petitioner indicated that he worked there in an unofficial capacity. He has worked there on and off since he was sixteen (16) years old. Petitioner stated that he has worked at DJ's in 2014 "almost everyday." Petitioner provided that he answer phones, did some changing of tires, performed oil changes, and repaired head lamps. Petitioner denied doing any mechanical work or doing auto detailing.

Petitioner also testified that was hired by Nord Commercial Services in September 2013. Petitioner submitted a resume to Nord indicating that he had worked at DJ's Auto and Tire from June of 1990 through the date of application, and his duties consisted of oil change, tire repairs and sales, and auto detailing. (RX 12)

Petitioner testified that he rode a mountain bike on a daily basis for 3 to 3-1/2 miles per trip before it was stolen in 2013. His current complaints consisted of bilateral hand numbness and tingling. He provided that he has loss of grip strength and occasionally drops objects. With respect to his shoulders, he experiences sharp pains while attempting to lift "any amount of weight."

Jeff Klokkenga, General Supervisor of the Wire Mill, testified on behalf of Respondent. Mr. Klokkenga testified that he worked the same shift as Petitioner. He provided that Petitioner was aware of the rule to report all accidental injuries on the job or conditions, fill out a report, and be seen at the plant medical facility. Mr. Klokkenga provided that he saw Petitioner on a daily basis, and Petitioner never once complained to him about symptomatology relative to either hand or his shoulders nor did he attribute any condition to his work activity. Mr. Klokkenga testified that Petitioner worked with 12-1/2 gauge wire primarily and that same would require minimal force. He indicated that Petitioner would rarely need to reach above his shoulders to facilitate his duties. He indicated air tools would be rarely used, if at all; the staple gun with a trigger requiring less than 5 pounds of force would be utilized to make a weld; the use of pliers would be minimal; and there would be little, if any, vibration.

Mr. Klokkenga indicated that the job description was completed to comply with ADA requirements and analyze functions of the job. Mr. Klokkenga described that Petitioner would need to put the carrier lids on the top of the wire two to five times a shift. Restringing the wire through the machine would be less than one time a shift and pulling the hoist hook out of the top roll would be at shoulder height. The roll push-off lever would be at waist height.

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Dr. Rashid testified via deposition in this matter. Dr. Rashid testified that when she saw Petitioner on August 2, 2013, he described bilateral hand and wrist pain symptoms for five to six years. Petitioner described that he was a machine operator and that most of his symptoms occurred when he was performing those functions. Petitioner informed the doctor that his job required a significant amount of gripping and lfting. Dr. Rashid testified that after performing an examination and reviewing an EMG study, she diagnosed bilateral carpal tunnel syndrome and recommended surgery. The doctor testified that a causal relationship exists between his condition and the work he performed. Dr. Rashid indicated her opinion was based on what Petitioner "told me about his job description." (PX 1, pgs. 8-11)

During the deposition, Dr. Rashid was presented with a copy of Petitioner's job description previously mention above. (RX 11) After reviewing the job description specifically Item Number 16 titled handling, the doctor noted that frequent seizing, holding, grasping, and turning was required of Petitioner's job. She also noted that "frequent" was defined in the job description as occurring up to 66% of the shift. Based on the job description, Dr. Rashid opined that the work activities caused Petitioner's carpal tunnel and the need for her recommended surgeries. (PX 1, pgs 11-12)

On cross-examination, Dr. Rashid testified that that she did not review any of the plant medical records. The doctor agreed that it was unusual that Petitioner didn't report his symptoms or seek medical care for five or six years. (PX 1, pgs. 17-18) She agreed that a percentage of carpal tunnels are idiopathic in nature and that there are certain risk factors that make an individual susceptible to carpal tunnel in and of themselves; specifically, obesity and smoking. She also acknowledged that a mountain bike with braking devices could cause carpal tunnel. Dr. Rashid indicated if an individual had symptomatic carpal tunnel she would not anticipate them engaging in job duties of scrubbing and sanitizing pots and pans or cooking utensils as that would aggravate the condition. (PX 1, pgs. 19-22)

Dr. Garst was also testified by deposition in this matter. Dr. Garst testified that he is a board certified orthopedic surgeon, specializing in upper extremity pathology since 1989. Dr. Garst examined Petitioner's shoulders only. The doctor stated that he reviewed a right shoulder MRI report which showed a partial thickness rotator cuff tear. (PX 2, p.10) Dr. Garst testified that based on Petitioner's symptoms reported, the MRI report and his clinical examination he diagnosed Petitioner with 1.) right shoulder partial rotator cuff tear with impingement and acromioclavicular joint arthritis; and 2.) left shoulder impingement and acromioclavicular joint arthritis, possible rotator cuff tear. Dr. Garst recommended an injection and therapy for Petitioner's partial tear with impingement in the right shoulder. The doctor provided that if the shoulder didn't improve, then surgery would be recommended. (PX 2, p.13)

Dr. Garst generated a report at Petitioner's request dated October 31, 2013. In the report the doctor provided that a causal relationship existed between his job activities and Petitioner's shoulder conditions of ill-being. Dr. Garst wrote, "My history with regard to his work is somewhat vague. He was a machinist for Keystone and he did it for over 20 years. I do not know his exact job but I am familiar with other patients who have been machinists at Keystone and my experience has been that it is a relatively heavy job as it is usually described to me. In his record with our office, the patient described his job as a machine operator and apparently stated that it was very repetitive with lifting of 20-30 pounds. Given that history of being a machinist at Keystone, and having no other history of trauma or strenuous job which may cause a rotator cuff problem, my thought is that the job would be likely to cause his shoulder problems and rotator cuff problems." The doctor went on to state that it would be helpful to have more detail on the type of work Petitioner performed. (PX 2, dep #2)

Just prior to the deposition testimony, Dr. Garst was provided a copy Petitioner's job description. (PX 2, pgs. 17-18) Dr. Garst testified that same gave him a better understanding of the job requirements. He noted

15IWCC0702

there were discrepancies between what Petitioner told him about the job and the actual job description. (PX 2, p. 19). Dr. Garst provided that if Petitioner's job description as stated to him was accurate in the letter that it could have been a contributing factor to his shoulder condition. (PX 2, pgs, 20-21) When asked if "...would it affect your opinion at all regarding causation or aggravation if [Petitioner] had a right shoulder rotator cuff strain back in 1996 that resolved with a modest amount of conservative treatment from a softball playing injury?" Dr. Garst replied, "Well, it does send up a little bit of a red flag; although I don't think it changed my opinion overall, but if he had a shoulder injury from a softball injury, that can be a problem but...overall, I don't think it would change my opinion." (PX 2 p. 21)

On cross-examination, Dr. Garst provided that Petitioner told him he had problems in his left and right shoulders for five to six years. The doctor indicated that Petitioner advised him the pain intermittently interfered with his activities and his ability to sleep. Dr. Garst agreed that it would be unusual if an individual had shoulder symptoms for five to six years that were interfering with activities and interfered with his sleep that he did not seek medical care for that condition in the five to six preceding years. (PX 2, p. 23) The doctor testified that he was not aware that in May 1996, Petitioner was previously diagnosed with a possible torn rotator cuff. He stated that if Petitioner's May 1996 incident involved the right shoulder, the radiographic findings he reviewed could relate to same. (PX 2, p. 24).

Dr. Garst testified that the MRI also reported showing hypertrophic bone spurring at the AC joint. He was not aware Petitioner had a type III acromion. He indicated that if Petitioner did have a type III acromion this would be a congenital formation that would make him susceptible to developing impingement in the absence of any traumatic event. He stated impingement could result in a spur that causes a partial rotator cuff thickness tear. The doctor indicated an individual could have the MRI findings of the right shoulder and be asymptomatic. (PX 2, p. 26) He could not date how long the partial thickness tear had been present. He stated that it was possible that if a MRI was performed in the year 2000 in light of the 1996 history of injury, it could have revealed the same thing. (PX 2, p. 27) The doctor stated that if the job description was accurate as defined in Respondent's Exhibit No. 11, "...it would send up a red flag with regards to his job causing shoulder problems." (PX 2, pgs. 30-31) Relative to the AC arthritis, he indicated this would not be an unusual MRI finding for an individual of Petitioner's stated age; it could have been part of the normal aging process; and, it would not be unusual for an individual of that age to have impingement syndrome. (PX 2, p. 32)

Petitioner was evaluated at Respondent's request by Dr. J. S. Player, a board certified orthopedic surgeon, on October 7, 2013. In addition to preparing a report, Dr. Player also testified via deposition in this matter. In addition to reviewing the job description Dr. Player reviewed all relevant medical records including the MRI films of the right shoulder. Dr. Player testified the MRI films were of diagnostic quality and showed a Bigliani type III acromion, degenerative arthritis, and hypertrophic degenerative arthritis in the AC joint. The doctor indicated that the Bigliani type III acromion was congenital or developmental which causes stalactites to hang down from the roof of the acromion and impinge and rub against the upper surface of the rotator cuff. Dr. Player stated that this in and of itself could result in a partial thickness tear of the rotator cuff. Dr. Player testified that the rotator cuff is at risk only during above shoulder level or overhead motions of the upper extremity. (RX 1, pgs. 13-15) Dr. Player also found it unusual that if an individual was symptomatic relative to the shoulder for five or six years he would anticipate them voicing complaints and seeking medical care. Dr. Player testified that almost all partial thickness tears are degenerative in nature. (RX 1, p. 16)

Dr. Player testified that based upon his exam, review of records, and viewing the MRI films he felt Petitioner had very mild bilateral shoulder impingement syndrome. The doctor noted in the medical record a diagnosis of sprain to the rotator cuff in 1996. He felt the Bigliani type III acromion in and of itself could cause impingement and lead to the partial thickness tear evident on the MRI. Based upon his review of the records, examination, and the MRI films the doctor indicated that a causal relationship does not exist between Petitioner's complaints relative to the right shoulder as Petitioner had congenital or developmental factors that

15IWCC0702

are known to cause partial thickness rotator cuff tears as documented on the MRI and that the job description did not indicate repetitive work above shoulder level. (RX 1, pgs. 17-18)

With respect to Petitioner's bilateral hand conditions, Dr. Player diagnosed mild to moderate bilateral carpal tunnel syndrome. He opined that the vast majority of carpal tunnels in the area of 80 to 85% are idiopathic in nature. (RX1, pg 24.) Dr. Player testified that prior to becoming a doctor, he worked as fence machine operator for Northwestern Steel & Wire in the Sterling/Rock Falls area. (RX 1, pgs. 24, 25) Dr. Player testified that in his opinion, a casual relationship does not exist between Petitioner bilateral hand conditions and his employment duties with Respondent. Dr. Player stated, "...although the work activities at some times can be repetitive, they are not forcefully repetitive. The gauge of the wire is just not great enough and would not conform with the type of work activities that would be known to cause carpal tunnel syndrome, primarily because they are just not forcefully repetitive." (RX 1, pgs. 25-26) Dr. Player testified that in his experience cutting 12 gauge wire is easy and can be done with scissors. (RX 1, p. 35) Dr. Player also testified that Petitioner had other risk factors for carpal tunnel consisting of a BMI over 30 (being a body mass index). The doctor noted Petitioner as being 5 feet 9 inches, 225 pounds which would equal a body mass index of 31.5. He stated that anything over 30 was considered obese and a predisposing factor for carpal tunnel as it would lead to greater constriction of the body against the median nerve and the carpal tunnel as the wrist gets fat. As to cigarette consumption, the doctor noted Petitioner had smoked for 15 to 20 years (although he quit three weeks prior to seeing Dr. Player), and nicotine on the nerve is known to predispose individuals to carpal tunnel. Dr. Player further noted Petitioner gave a history of an avid mountain biker riding and the positioning of his hands on the handlebars is known to cause carpal tunnel. (RX 1, pgs. 26-28) Lastly, Dr. Player indicated that if an individual was truly symptomatic relative to carpal tunnel he would not anticipate them working in packaging or scrubbing pots and pans as those activities would result in symptomatology. (RX 1, pgs 31-32)

In Support of the Arbitrator's decision regarding (B) Was there an employee-employer relationship, (C) Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent, (D) What was the date of accident, and (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The evidence is clear that Petitioner's last date of work with Respondent was April 21, 2013 and that Petitioner was terminated for unrelated reasons effective May 2, 2013. Petitioner alleges repetitive trauma to both hands and both upper extremities with a date of manifestation of July 8, 2013. The Arbitrator notes that case law has held for repetitive trauma that the date of manifestation or accidental injury can be found for a date beyond which the employee actually worked for the employer. Therefore, the Arbitrator must determine whether Petitioner proves accidental injury and causation on the theory of repetitive trauma.

Petitioner began his employment with Respondent, Keystone Steel & Wire, in March 1987. He was employed by Respondent for twenty-six years as a fence machine operator, making various barbed wire fencing. His job duties included welding, running fencing machines, quality assurance of the wire, cutting out rolls of wire, starting new rolls, repairing fencing, palletizing and labeling rolls of wire, and recording his daily production. He worked with hand held tools on a continuous basis, including cutting "nippers", hammers, pliers, sledgehammers, wrenches, hog ringers, welders, hand held grinders, screwdrivers, vice grips, and bolt cutters. He worked on a full-time basis, often working double-shifts and mandatory Saturdays. He also frequently volunteered for Sunday overtime. Petitioner is right hand dominant but he testified that his right hand often became fatigued so he performed several of his job duties with his left hand as well.

Petitioner testified that he was able to operate all of Respondent's fencing machines. Keystone makes several different types of fence, requiring wire sizes ranging from 16 gauge (smallest) down to a 6 gauge which is similar to a stiff cable. Some wires were "high tensile" which made them much more difficult to manipulate and cut. Petitioner, due to his seniority, was able to select the higher paying production jobs, typically working

15IWCC0702

with 12 ½ gauge wire on two different machines, number 99 and 109. These machines ran 12 ½ gauge "non-climb" fencing. The finished rolls were 660 feet long. Each roll had to be cut free from the machine with bolt cutters and snips. An overhead hoist was then used to move the wire roll into a pallet, where it was secured with a long screwdriver and staple gun, and then labeled. Petitioner's production records from 2012 and 2013 show that in an 8 hour shift, his roll production varied from 4 rolls to 75 rolls with an approximate average production of 40-50 rolls per 8 hour shift.

Petitioner testified that his job duties included machine maintenance and small repairs. This included removing jammed wire from the machines. This process required the operator to use a screwdriver and pliers to loosen machine parts for wire removal.

Respondent's Exhibit 11 is a Keystone job description and analysis. It includes a statement that the Petitioner's job includes "rarely" reaching above shoulder, at, or below height, and "frequently" seizing, holding, grasping, turning and working with hands. The analysis lists the job functions as operating the machines, placing wire carriers, using a butt-welder to join the new carrier to the old, using pliers to smooth that weld, pushing buttons and pulling levers, removing and tagging rolls of fencing, securing a pallet of wire rolls, production recording, performing minor repairs of machines, repairing wire in machines, and handling scrap by hand or with hoists.

Petitioner testified that the carrier wire that sat on top of the machine could last 2 hours or a whole day. When it ran out, he would have to climb up on a deck, remove the carrier lid which weighs about 20 pounds, use the overhead hoist to set in a new carrier of wire, use the bolt cutters to cut out the old carrier, and then weld the new wire to the old, and then use pliers to grind down the weld.

Petitioner testified that he used hand snippers, continuously. When his right dominant hand got fatigued, he would switch to his left hand. Using the snippers required force. The high tensile wire and 10 gauge and lower wire took considerable force to cut. Using the bolt cutters also required force and the use of both hands. Overhead work was required to change the carriers, to reach parts of the machines for repairs, and when re-stringing wire into the machines.

Petitioner testified that in approximately 2008 or 2009, he began to notice that he was losing strength in his arms and hands, that he was dropping things, numbness and tingling in his fingers, and that certain movements caused pain in his shoulders. These symptoms were worse after he worked long hours and overtime hours.

Petitioner sought medical treatment for his shoulders and hands. He first saw Dr. Hoffman on June 24, 2013. Petitioner gave a history of being a machine operator at Keystone for the last 26 years and developing pain in both shoulders and numbness in both hands "over the last few months." Dr. Hoffman provisionally diagnosed a rotator cuff tear and possible carpal tunnel syndrome. An MRI of the right shoulder when performed on July 1, 2013 showed a partial thickness articular surface infraspinatus tendon tear with chronic rotator cuff tendinitis and degenerative spurring at the acromioclavicular joint. On July 2, 2013, a bilateral upper extremity EMG-NCV was performed showing bilateral median neuropathies, moderately severe on both sides, right greater than left.

Ultimately, Petitioner came under the care of Dr. Mary Elizabeth T. Rashid. Petitioner provided a history that he had bilateral hand and wrist pain for about five or six years as well as bilateral shoulder pain. He further told Dr. Rashid that his work as a machine operator caused the symptoms, especially his gripping and lifting. Dr. Rashid performed an examination and reviewed the EMG study. Dr. Rashid diagnosed bilateral carpal tunnel syndrome. The doctor provided options including offered surgery versus injections. Petitioner opted for surgery.

Dr. Rashid testified via deposition in this matter. Dr. Rashid testified that a causal relationship exists between his bilateral hand conditions and the work he performed. During the deposition, Dr. Rashid was presented with a copy of Petitioner's job description. After reviewing the job description specifically Item Number 16 titled handling, the doctor noted that frequent seizing, holding, grasping, and turning was required of Petitioner's job. She also noted that "frequent" was defined in the job description as occurring up to 66% of the shift. Based on the job description, Dr. Rashid opined that the work activities caused Petitioner's carpal tunnel and the need for her recommended surgeries.

Respondent's Section 12 examiner, Dr. Player, testified that in his opinion, a casual relationship does not exist between Petitioner bilateral hand conditions and his employment duties with Respondent. Dr. Player stated, "...although the work activities at some times can be repetitive, they are not forcefully repetitive. The gauge of the wire is just not great enough and would not conform with the type of work activities that would be known to cause carpal tunnel syndrome, primarily because they are just not forcefully repetitive." Dr. Player also testified that Petitioner had other risk factors for carpal tunnel consisting of a BMI over 30, cigarette consumption, and Petitioner history of being an avid mountain biker.

A review of Respondent's own job description, clearly demonstrates that the fence machine operator position is hand intensive. At least 66% of the work time, Petitioner was handling wire and hand tools. Clearly, the tasks of cutting wire and using pliers to grind off welds would require forceful gripping. The Arbitrator also finds the opinion of Dr. Rashid persuasive.

Based upon the above, the Arbitrator finds that Petitioner sustained a repetitive trauma accident which manifested itself on July 8, 2013. For purposes of this claim, an employment relationship is found for that manifestation date. Petitioner's job termination and the circumstances surrounding it have no relevance to the compensability of this claim. Finally, the Arbitrator finds that a causal relationship exists between Petitioner's bilateral carpal tunnel syndrome and his work activities for Respondent.

With respect to Petitioner's bilateral shoulder conditions, the Arbitrator finds that Petitioner failed to prove that he sustained a repetitive trauma claim relative to either shoulder or that a causal relationship exists between any condition of ill-being in his shoulders and his past employment duties with Keystone Steel & Wire. Based upon the job description and the testimony of Petitioner and Mr. Klokkenga, the Arbitrator does not find Petitioner's job duties to entail repetitive lifting of 20 to 30 pounds as he so advised Dr. Garst and furthermore that the job did not require repetitive use of the arm above shoulder level. Petitioner's claim for any prospective medical relative to the shoulders is also hereby denied.

In Support of the Arbitrator's decision regarding (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 and (K) Is Petitioner entitled to any prospective medical care, the Arbitrator notes as follows:

Petitioner's Exhibit 7 is a compilation of outstanding medical charges from Great Plains Orthopedics (Dr. Garst & Dr. Rashid), Dr. Hoffman, Dr. Trudeau and the facility Memorial Medical Center where the nerve study was performed, and from OSF St. Francis Medical Center and radiology for the right shoulder MRI.

Having found the issues of accident and causal connection in favor of Petitioner with respect to Petitioner's bilateral hand condition of ill-being, the Arbitrator awards the following medical expenses:

Great Plains Orthopedics	$100.00
Dr. Daniel Hoffman	$490.00

15IWCC0702

Dr. Edward Trudeau	$3,822.00
Memorial Medical Center	$842.35

Based on the above, the Arbitrator finds that Respondent shall pay $5,254.35 for reasonable and necessary medical services pursuant to Section 8(a) of the Act. Said expenses shall be paid consistent with medical fee schedule. The Arbitrator further finds that Respondent shall authorize the prospective medical care as prescribed by Dr. Rashid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ 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

Katherine Diaz,

Petitioner,

15IWCC0688

vs.

NO: 14 WC 8678

Dog In Suds,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical expenses, penalties and fees, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 January 9, 2015, is hereby affirmed and adopted.

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

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

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

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

DATED: SEP 8 - 2015
DLG/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

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

15IWCC0688

DIAZ, KATHERINE
Employee/Petitioner

Case# **14WC008678**

DOG IN SUDS
Employer/Respondent

On 1/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0391 HANLON SCANLON
PATRICK C ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

15IWCC0688

KATHERINE DIAZ
Employee/Petitioner

Case #14 WC 8678

v.

DOG IN SUDS
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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 29, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☐ Prospective medical care?

FINDINGS

- On February 7, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained 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 $8,440.28; the average weekly wage was $159.25.
- At the time of injury, the petitioner was 32 years of age, single with one child under 18.
- The petitioner agreed that the respondent paid $2,502.50 in temporary total disability benefits and that the respondent agreed to reimburse Medicaid for their payments of medical expenses for the petitioner at Alexian Brothers through March 17, 2014.
- The parties agreed that the petitioner is entitled to temporary total disability benefits from February 8, 2014, through March 7, 2014.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $159.25/week for 5-1/7 weeks, from February 8, 2014, through March 15, 2014, which is the period of temporary total disability for which compensation is payable.
- The medical care rendered the petitioner for her lumbar spine through March 15, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine after March 15, 2014, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for lumbar epidural steroid injections is denied.
- The petitioner's request for penalties and fees is denied.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Robert E. Williams

Signature of Arbitrator

January 8, 2015
Date

JAN 9 - 2015

FINDINGS OF FACTS:

The petitioner, an assistant dog groomer, fell in a puddle of water on February 7, 2014. She sought emergency care the next day at Northwest Community Hospital for injuries to her upper back, ribs and thoracic spine. Chest x-rays were negative and the petitioner was discharged with a diagnosis of an upper back and rib contusion. She sought care for back pain on February 10th at Alexian Brothers Medical Group. Dr. Ishvari Panarker at Alexian Brothers noted sharp back pain, no radiation of her pain, tenderness of the left paraspinal region, limited left flexion, lateral flexion and extension and normal sensation, straight-leg raise and motor hamstring quadriceps strength of her legs. The doctor's assessment was low back pain and lumbago for which he prescribed medication. She followed up with Dr. Panarker on the 12th and reported improved upper back symptoms and pain down her left thigh that started the prior night. The doctor's physical examination was sharp non-radiating back pain, tenderness of the left paraspinal region and iliolumbar region, limited left flexion, lateral flexion and extension, pain with motion and some improvement. Dr. Lauren Katz-Pham at Alexian Brothers saw the petitioner on the 14th and noted sharp back pain with no radiation, tenderness of the left paraspinal region and iliolumbar region, tenderness throughout the mid and lower back, limited left flexion, lateral flexion and extension and pain with motion. The doctor's assessment was low back pain and thoracic spine pain. Dr. Panarker noted the petitioner's report of continuing back pain on the 17th and the 24th and a little worsening pain on March 3rd. She was released for work with a one-pound lifting restriction on February 17th, prescribed physical therapy on March 3rd and received care for abdominal pain on March 3rd at Alexian Brothers.

On March 10th, the petitioner had no tenderness of her left paraspinal region or the iliolumbar region and an improved range of motion. The doctor noted a limited region of tenderness over L3 to L4. On March 17th, the petitioner reported to Dr. Katz-Pham lifting 20 pounds two days earlier causing a flare-up of her sharp back pain that prevents her from returning to work that week. Dr. Pham indicated that the petitioner was to be off of work for an additional week. On April 3rd, the petitioner reported a continued inability to work due to the flare-up of her back pain.

At the respondent's request, Dr. Julie Wehner evaluated the petitioner on June 16th and opined that an MRI on March 6, 2014, showed minimal spinal stenosis at L4-5 due to a mild diffuse disc bulge and mild degenerative facet hypertrophy, that she had reached maximum medical improvement and that she could perform full-duty work.

Dr. Jeffrey Lindahl at Alexian Brothers saw the petitioner on July 3rd and noted the petitioner had no tenderness and a normal range of motion. His diagnosis was backache, unspecified. The petitioner reported continued low back pain to Dr. Kath-Pram on October 21st and to Dr. Lukasz Chebes at Alexian Brothers on November 25th. Dr. Katz-Pham noted only tenderness over L4-L5. Dr. Chebes noted decreased range of motion of her lumbar spine due to discomfort and mild tenderness of posterior elements at the intercristal line. He recommended lumbar epidural steroid injections.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her lumbar spine through March 15, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine after March 15, 2014, was not reasonable or necessary and is denied. On March 10, 2014, the petitioner had no sharp back pain and no tenderness in

her left paraspinal or iliolumbar region. On March 15, 20014, the petitioner lifted around 20 pounds resulting in a return in her back symptoms.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her lumbar spine through March 15, 2014, was causally related to the work injury. The petitioner sustained a back strain and had no neurological deficits and only limited tenderness over L3 to L4 when she treated on March 10, 2014. The doctor noted that she was ready to return to work. The petitioner's current condition of ill-being with her lumbar spine is due to an injury on or about March 15, 2014, while lifting a box of toys. The petitioner's injury while lifting a box of toys supersedes the petitioner's prior strain to her lumbar spine on February 7, 2014. The opinions of Dr. Katz-Pram are conjecture and are of no probative value.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The respondent shall pay the petitioner temporary total disability benefits of $159.25/week for 5-1/7 weeks, from February 8 through March 15, 2014, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the lumbar epidural steroid injections recommended by Dr. Chebes are reasonable medical care necessary to relieve the effects of the work injury. The petitioner's request for lumbar epidural steroid injections is denied.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that she is entitled to penalties and fees. The petitioner's request for penalties and fees is denied.

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

Charles Love,

Petitioner,

vs. NO: 13 WC 7832

15IWCC0699

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 October 28, 2014, 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: SEP 1 0 2015
TJT:yl
o 9/1/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

LOVE, CHARLES
Employee/Petitioner

Case# **13WC007832**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

15IWCC0699

On 10/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0062 TEPLITZ & BELL
JOEL M BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
DEREK FULLSTROM
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

15IWCC0699

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

Charles Love
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **13** WC **7832**

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **August 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

O. ☐ Other ____

15IWCC0699

FINDINGS

On **April 9, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**1,186**; the average weekly wage was $**61,672.00**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**31,289.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**31,289.52**.

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

ORDER

Petitioner has failed to prove his current condition is causally related to this accident.

Petitioner was paid TTD from 4/10/2012 – 1/11/2013; no further TTD is owed.

Petitioner has suffered a cervical strain and low back strain. Petitioner is awarded 1% of a man for said injuries and Respondent shall pay Petitioner 5 weeks of PPD at a rate of **$695.78**/week.

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

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

Signature of Arbitrator

10/29/14
Date

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on August 7, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record. The case relates to an accident date of August 7, 2014, a date which post-dates the September, 2011 AMA guidelines amendment to the Act. Neither side has submitted an AMA rating.

FACTUAL HISTORY

Petitioner was 43 years old with two dependents and worked for the Chicago Transit Authority (CTA) as a bus operator. On April 9, 2012 he was involved in an accident while driving the bus. Petitioner testified that he made a stop at 50th Street then proceeded on his route in the left lane. He stated that as he was approaching an intersection to make a left turn, another vehicle struck the bus. Petitioner testified that he was traveling at a slow rate of speed. He testified that when the other vehicle struck the bus his neck jerked but he felt okay. He stated that he pulled the bus into the terminal and called control. He subsequently made another phone call and waited for his supervisor to arrive. Petitioner testified that when his supervisor arrived they discussed the accident. He testified that 10-15 minutes later he felt shooting pain in his neck and requested an ambulance.

Petitioner testified that he was transported by ambulance to Holy Cross Hospital. He stated he treated at Access Medical with a nurse practitioner two days later. He was given Vicodin and referred to physical therapy but he testified the therapy made his pain

worse. Petitioner stated he was subsequently referred to the Rush Pain Center. He was again referred to physical therapy but testified that the therapy caused him too much pain. Petitioner testified he continued to get Vicodin from the nurse practitioner at Access Medical.

Petitioner testified that he subsequently treated with Dr. Toupin at Access Medical but Dr. Toupin stopped seeing him after a functional capacity evaluation. He testified that he next treated with Dr. Guzman. Dr. Guzman recommended physical therapy. Petitioner continues to see Dr. Guzman every two or three months to renew his prescriptions. Petitioner testified he takes Tramadol, Xanax, Norco, Vicodin, and Ibuprofen.

Petitioner testified that he is not currently employed by the CTA. He stated he was discharged in October of 2013. Petitioner testified that he is not currently working and he has not sought employment. He testified that before he worked for the CTA he drove a school bus. He stated that before the accident he felt fine and loved to work. Petitioner testified that he had prior injuries to his low back and neck from a motor vehicle accident in his personal vehicle in 2010. Petitioner testified that he missed three weeks of work due to those injuries. He stated that he completed physical therapy and returned to work full duty.

On cross-examination Petitioner agreed that he worked out of the Kedzie garage on the date of injury. He testified that the route he was driving on the date of accident was his normal route. Petitioner testified that at the time of the accident there were passengers on the bus but none of them were injured. He stated that the damage to the bus consisted only of scratches. He stated the bus did not have to be towed and it

was fully operational after the accident. Petitioner stated the other vehicle involved in the accident was also able to drive away after the accident.

Petitioner testified that he treated with several doctors and was truthful and honest with each one. Petitioner also agreed testified that he had treatment for his thyroid during the course of his treatment for this incident.

Petitioner further testified that at the time of the accident he was approaching an intersection. He did not recall whether the light was green or red. He also did not recall if there was a separate turn lane or if traffic was clear. Petitioner testified that he was going approximately 30 miles per hour at the time of the accident. He subsequently stated he may have been going 15-20 miles per hour or 10 miles per hour.

FINDINGS/ANALYSIS

F. Causal Connection

The Petitioner's current complaints are not related to this incident. The Petitioner was involved in a low impact motor vehicle accident over two years ago. Petitioner allegedly suffered injuries to his neck and back. The current accident involved a very very low impact fender-scratcher between a large full size bus being driven by the Petitioner and a passenger car driven by a motorist. Video evidence shows another vehicle braking as it comes into contact with the right front end of the bus as the bus is also braking. At most, the vehicles are traveling at 10 miles per hour and are almost stopped for the turn when the collision occurs. Petitioner and the several passengers onboard can be seen and none of them move any more than they would if the bus was merely routinely braking for a service stop or red light. The video goes on to show

Petitioner walking around, talking on his cell phone, sitting down, talking to passersby, moving the bus, and gesturing with his hands and arms for approximately an hour following the incident. There is no indication that Petitioner is in any pain whatsoever or that he suffered any injury at all. None of the passengers suffered any injury as a result of this incident. The Arbitrator finds that the nature and mode of the accident is wholly insufficient to have caused the type and nature of the injuries that Petitioner currently complains of. Medical evidence overwhelmingly supports this conclusion as well.

The medical records are devoid of any causal connection showing that the injuries, if any, are more than a very minor sprain or strain. There is no independent objective medical evidence or medical testimony to support Petitioner's assertion that his current condition is related to the 4/09/2012 incident. Petitioner initially treated at Holy Cross Hospital. He subsequently treated with Naythea Johnson, a nurse practitioner. Ms. Johnson's treatment records are void of any objective findings. They merely state Petitioner's subjective complaints and what prescriptions he was given. Of interest, on 5/02/2012 there is a note that an emergency room nurse practitioner contacted Ms. Johnson because she suspected Petitioner was drug seeking. Likewise, Petitioner testified that he continues to see Dr. Guzman every two or three months to get multiple prescriptions refilled.

The testimony and medical findings of IME, Dr. Michael Kornblatt are persuasive and corroborated by the description and video of the accident. Petitioner's allegations and complains defy a commonsense analysis of the accident. Petitioner underwent an independent medical examination (IME) with Dr. Michael Kornblatt on 10/08/2012. Dr. Kornblatt noted that Petitioner was uncooperative during the exam. He further noted

multiple Waddell's signs and significant symptom magnification. Dr. Kornblatt diagnosed Petitioner with cervical mechanical neck pain and lumbar mechanical low back pain with a history of minor cervical strain and lumbar strain which had resolved. Dr. Kornblatt felt that no further treatment was needed as Petitioner presented without any objective findings to justify his ongoing subjective complaints. In addition, Dr. Kornblatt stated that Petitioner reached maximum medical improvement within 3-4 weeks of this minor incident or May 9, 2012 at the latest.

Lastly, Petitioner's testimony and demeanor in court lacked credibility. His sudden severe pain an hour after a minor fender-scratcher is difficult to believe. Petitioner's lack of effort to obtain employment or return to work, his exaggerated pain symptoms and his attempts at trying to obtain prescriptions for pain-killer medication indicate an underlying lack of veracity.

The Arbitrator finds that the Petitioner suffered a minor sprain/strain to his neck and back but said injuries healed. The Petitioner's current condition/complains are not causally related to his work accident.

K. TTD

The Arbitrator finds that Temporary total disability benefits were appropriately paid from 4/10/2012 until 1/11/2013 when benefits were appropriately terminated based on Dr. Kornblatt's 12/28/2012 IME addendum. No further TTD is owed the Petitioner.

L. Nature and Extent

The Petitioner has suffered a minor and short-lived cervical strain and low back strain. The Arbitrator finds that the Petitioner has sustained injuries to the extent of 1% loss of man as a whole.

The Arbitrator has considered that pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

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

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

Petitioner was 43 years old at the time of his accident and worked as a bus driver. Petitioner failed to reenter the job market of his own accord. Neither side has submitted an AMA rating. All of the medical records indicate a diagnosis of either strain or pain and there is no medical evidence of injury beyond this diagnosis. Petitioner has never been assigned permanent restrictions. His in court testimony of his current complaints is not credible or supported by medical opinions or objective medical findings.

Petitioner underwent an MRI of his lumbar spine, which revealed congenital spinal stenosis but was otherwise unremarkable. He also underwent an MRI of his

cervical spine, which Dr. Kornblatt reviewed and found no evidence of a herniated disc or spinal stenosis.

In addition, Petitioner underwent a functional capacity evaluation (FCE) on 9/05/2012, which was invalid. The FCE summary indicates that Petitioner demonstrated inconsistent performance with self-limiting behaviors throughout testing. The report noted that self-limiting behavior, elevated pain complaints in relation to therapist observation and inconsistent testing has been associated with a conscious attempt to effect results of the test.

Following the FCE, Petitioner's own treating physician, Dr. Toupin, discharged him, noting that he appeared to be altering his actions to skew exam results to capitalize on benefits from this incident. Prior to this visit, Dr. Toupin also noted inconsistencies in Petitioner's stated abilities. For instance, on 8/03/12, he noted that Petitioner stated he could not move his neck at all in any direction, but as Dr. Toupin left the room Petitioner was turning his head to follow the doctor more than he stated he could.

Furthermore, Dr. Kornblatt indicated that Petitioner suffered only strain injuries to his cervical and lumbar spine and reached MMI within 3-4 weeks of the incident.

Although Petitioner testified he continues to see Dr. Guzman periodically, he does so only for prescription refills. While, Petitioner relies on a PCE form completed by Dr. Guzman on 8/09/2013 indicating Petitioner is still off work, that form merely lists diagnoses of neck pain and back pain. There is nothing to indicate what said pain is attributed to nor is there any mention of a treatment plan. The nature and type of accident are also wholly inconsistent with Petitioner account of his pain and disability.

Amended Date

Ketki Steffen

Signature of Arbitrator Ketki Shroff Steffen

10/25/14

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell Rosiak,

Petitioner,

15IWCC0694

vs.

NO: 06 WC 30029
12 WC 28370

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner worked as a truck driver for Respondent for four years prior to the first accident on May 12, 2006. On that date, Petitioner slipped while retrieving his bag from one of Respondent's trucks and injured his left ankle and knee. Petitioner denied any pre-exiting left knee or ankle problems or prior injuries to those areas. However, the medical records show that Petitioner had a prior history of gout in the lower extremities. Petitioner continued to receive medical treatment for gout in the lower extremities subsequent to the May 12, 2006 accident, and he also admitted that he was diagnosed with diabetes in 2010 and suffers from diabetic neuropathy. The Arbitrator found that the May 12, 2006 accident caused left knee and left ankle sprains but that there was no clear evidence supporting causal connection between the May 12, 2006 accident and the need for Petitioner's 2011 left knee and left ankle surgeries. The Arbitrator awarded 5% loss of use of the left foot and 7.5% of the left leg under §8(e) of the Act.

After considering all of the evidence, we modify the Arbitrator's award to 5% loss of use of the left leg and 3% of the left foot. Dr. Strugala at Midland Orthopaedic Associates examined Petitioner's left knee and left ankle sprains on referral from MercyWorks, but no orthopedic problem was found. Petitioner's condition is multifactorial involving his weight and history of gout and arthritis. Dr. Strugala released Petitioner to return to full duty work on June 26, 2006, although Petitioner clearly remained symtpomatic. Dr. Nelson, an orthopedic surgeon who evaluated Petitioner at the request of Dr. Strugala, concluded that Petitioner's ongoing symptoms as of September of 2006 were most likely related to gout and arthritis.

Furthermore, the Arbitrator did not find any causal connection between Petitioner's low back condition and the May 12, 2006 accident. The Arbitrator found that the evidence showed that Petitioner made some complaints of upper back pain secondary to twisting as he tried to avoid falling off the truck, but that Petitioner's low back pain complaints did not begin until late September of 2006. Petitioner was referred to Dr. Wehner for his lumbar complaints and was examined on November 29, 2006. Dr. Wehner found Petitioner to have "a wide variety of pain complaints that do not fit into any specific clinical pattern." Petitioner's lumbar MRI indicated mild spinal stenosis at L4-L5 that Dr. Wehner described as pre-existing. After Petitioner's EMG returned normal results, Dr. Wehner released Petitioner from care on January 10, 2007.

On June 4, 2012, Petitioner was again working full duty for Respondent after returning in January of 2012 from medical leave. Petitioner testified that on the date of accident he was driving the garbage truck through residential alleyways containing speed bumps when all of a sudden he felt as though he had been paralyzed. Petitioner testified that he was removed from the truck by emergency medical services and taken to the emergency room via ambulance. Petitioner was referred to Dr. Phillips at Midwest Orthopaedics at Rush. Dr. Phillips due to the severity of Petitioner's symptoms since the date of accident, Dr. Phillips performed a lumbar laminectomy and fusion surgery on August 1, 2012. The Arbitrator found that Petitioner sustained a compensable accidental injury to his low back on June 4, 2012 and his current condition of ill-being is casually related to the accident. The Arbitrator found that Petitioner sustained the loss of use of 35% of the person as a whole pursuant to §8(d)2 of the Act. Although the Arbitrator found that the June 4, 2012 accident contributed to the need for surgery, there was no question that Petitioner had a pre-existing chronic low back condition. Dr. Phillips opined that despite the pre-existence of Petitioner's lumbar problems, the accident significantly worsened Petitioner's functional condition and symptomatology.

After considering all of the evidence, we modify the Arbitrator's award to 25% loss of use of the person as whole pursuant to §8(d)2 of the Act. Petitioner was 52-years-old on June 4, 2012 and was not able to return to his regular employment under permanent restrictions from Dr. Phillips. The Arbitrator found that there was some impact on Petitioner's future earning capacity, although Petitioner offered no evidence that has made any effort to reenter the labor market. We note the medical evidence showing that Petitioner had recurrent flare-ups of low back pain for many years, beginning with a 1998 back injury. Petitioner underwent lumbar injections in 2008, 2009, and 2011 prior to the June 4, 2012 accident. Merely two months before the accident, Petitioner reported an exacerbation of low back pain radiating down his anterior thighs to his ankles and he received another injection. In conclusion, after modifying the award of the Arbitrator as stated above, else is otherwise affirmed and adopted.

15IWCC0694

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $480.00 per week for a period of 15.76 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 5% loss of the left leg and 3% loss of the left foot. Respondent shall further pay to Petitioner the sum of $695.78 for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 25% loss of the person as a whole.

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

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

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: SEP 2 - 2015
RWW/plv
0-8/11/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0694

ROSIAK, RUSSELL
Employee/Petitioner

Case# **12WC028370**

09WC035952
06WC030029

CITY OF CHICAGO
Employer/Respondent

On 10/3/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN 3RD FL
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60602

15IWCC0694

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

Russell Rosiak
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 12 WC 028370

Consolidated cases: 06 WC 30029; 09 WC 35952

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **8-19-2014**. 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 **6-4-2012**, 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 lumbar spine condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**63,856.00**; the average weekly wage was $**1228.00**.

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

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

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

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

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

ORDER SEE ATTACHED ORDER

Respondent shall pay Petitioner temporary total disability benefits of $818.66/week for 72 1/7 weeks, commencing 6-6-12 through October 23, 2013 (the date of the functional capacity evaluation), as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner $695.78 per week for a period of 175 weeks because Petitioner has suffered 35% loss of use of the person as a whole under Section 8(d)2 of the Act.

See pages 22-24 of the attached decision for the Arbitrator's medical award.

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

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

Molly C Mason
Signature of Arbitrator

10/3/14
Date

OCT 3 - 2014

Russell Rosiak v. City of Chicago
06 WC 30029, 09 WC 35952 and 12 WC 28370 (consolidated)

Arbitrator's Findings of Fact Relative to All Cases

Petitioner, a driver for Respondent's Department of Streets and Sanitation, alleges three work accidents, all of which are in dispute. The alleged accident dates are **May 12, 2006** (06 WC 30029), **April 3, 2009** (09 WC 35952) and **June 4, 2012** (12 WC 28370).

Petitioner testified he began working for Respondent four years before his claimed accident of May 12, 2006. T. 17. During those four years, he drove various vehicles, including boom-equipped "clam" trucks (used for tree removal) and salt trucks. T. 18-19. He regularly performed lifting. The objects he lifted could weigh up to 200 pounds. T. 19. He sometimes had to climb into the backs of trucks to free "stuck material." T. 20.

Petitioner testified he was able to perform all of his required duties prior to the accident of May 12, 2006. He injured his back on one occasion, about four years before the accident, but only required one injection. T. 20-21. He denied having any problems with his knees or ankles before May 12, 2006. T. 20. Before that date, he saw various doctors at the Hammond Clinic for multiple medical issues. T. 21.

Records in PX 14 reflect that Petitioner underwent left foot X-rays on November 4, 2005, with the interpreting radiologist noting no abnormalities. PX 14, p. 474. Records in the same exhibit reflect that Petitioner underwent right ankle X-rays on April 19, 2006 due to "possible gout," with the radiologist comparing the films to previous X-rays taken on September 7, 2003. The radiologist noted mild soft tissue swelling about the ankle and no erosive changes. PX 14, pp. 473, 481.

Petitioner testified that, as of **May 12, 2006**, he worked as an MTD driver for the forestry division. T. 17. On that date, he drove a work crew to various locations to trim trees. At the end of his shift, he went into a building and was waiting to punch out when he realized he had left his bag in his assigned truck. He walked back out to the parking area, climbed onto the truck, grabbed his bag and turned, at which point his foot "got caught and slipped." He testified the soles of his shoes were slippery due to walking in oil and anti-freeze. In order to avoid landing on a chip, he grabbed the handle of the truck door and it "yanked [him] back." He reported the incident to his foreman, who told him to wait and see how he felt the next day. T. 21.

Petitioner testified he talked with his foreman again the following day, a Saturday, and received instructions to see his primary care physician. On May 13, 2006, he went to the Hammond Clinic. The handwritten note of that date reflects that Petitioner reported a sudden onset of pain in his left knee and the entire left side of his body after stepping out of his truck the previous day. The provider, whose signature is not legible, noted left knee swelling and

mild spasm. He prescribed Vicodin, ice applications and left knee X-rays. PX 14, p. 320. The X-rays showed no fractures, dislocations or other bony abnormalities. PX 14, p. 391.

On May 15, 2006, Petitioner went to MercyWorks and saw Dr. Arnold for a "work comp initial visit." The doctor noted that Petitioner was in a wheelchair. He also noted that Petitioner complained of pain in his knees, ankles and left upper back secondary to a "torsional" work accident of May 12, 2006 in which Petitioner's feet slipped off the steps of a truck, causing him to twist his ankles.

On examination, Dr. Arnold noted marked swelling and a decreased range of motion in the left ankle, a mild to moderate effusion in the left knee and tenderness to palpation in the left upper back region.

Dr. Arnold diagnosed a left knee torsional injury and strains of the left ankle and left upper back. He took Petitioner off work and prescribed a left knee MRI. PX 17, p. 3.

The MRI, performed on May 19, 2006, showed a small joint effusion, moderate chondromalacia of the patella and mild lateral chondromalacia. PX 14, p. 532.

Petitioner returned to MercyWorks on May 24, 2006 and saw Dr. Sheth. On left knee examination, the doctor noted mild swelling, tenderness in the patellar area and pain with flexion and extension. On left ankle examination, he noted diffuse mild swelling and pain with range of motion. He described the back strain as "resolved." After reviewing the MRI, he recommended therapy and instructed Petitioner to remain off work. PX 17, p. 4.

Petitioner began attending therapy at Chatham Physical Therapy the same day. After three sessions, he returned to MercyWorks on June 1, 2006 and complained to Dr. Arnold of persistent left knee and left ankle pain. The doctor prescribed Hydrocodone. He instructed Petitioner to stay off work and see Dr. Maday.

On June 2, 2006, Petitioner saw Dr. Strugala (Dr. Maday's partner) at Midland Orthopaedic Associates. A handwritten history form dated June 2, 2006 (which appears to bear Petitioner's signature) sets forth an account of the May 12, 2006 accident that is consistent with Petitioner's testimony. The account reflects that Petitioner pulled his leg, ankle and the left side of his back when his foot got caught on the truck step and then came off the step. PX 14, p. 432.

Dr. Strugala noted that Petitioner was stepping off of a truck on May 12, 2006 when he caught his right foot and fell off the bottom step, twisting his left knee and ankle. He further noted that Petitioner complained of significant left ankle pain and swelling and pain over the anterior aspect of the left knee and thigh. He indicated Petitioner was using a crutch to walk.

On left knee examination, Dr. Strugala noted a trace effusion, a 10-degree flexion contracture, medial and lateral joint line tenderness, tenderness over the patella, no laxity and

good strength with extension. On left ankle examination, the doctor noted swelling, greatest over the lateral aspect, and tenderness, greatest over the ATFL.

Dr. Strugala interpreted the left knee MRI as showing a small joint effusion and mild chondromalacia of the patella but no meniscal or ligamentous tear.

Dr. Strugala diagnosed a left lateral ankle sprain and a left knee sprain. He provided Petitioner with an air cast ankle splint and instructed Petitioner to transition off the crutch. He also recommended continued therapy. He released Petitioner to seated sedentary work. PX 14, p. 347.

Petitioner continued attending therapy thereafter. On June 23, 2006, he returned to Dr. Strugala and reported improvement. The doctor noted that he was still experiencing pain and using the air splint but was "requesting return to work." He recommended a patellar knee sleeve (PX 14, p. 523) and continued therapy. He indicated it would be safe for Petitioner to resume full duty on June 26, 2006. PX 14, p. 348.

Petitioner also saw Dr. Sheth at MercyWorks on June 23, 2006, with the doctor noting Dr. Strugala's full duty release. PX 17, p. 6.

On July 11, 2006, Petitioner saw Dr. Lewis at MercyWorks. The doctor described Petitioner as "working regular job and going to physical therapy" twice weekly. On examination, he noted swelling of the left leg and ankle with tenderness of the patellar tendon and lateral malleolus. He instructed Petitioner to continue full duty and therapy and to follow up with Dr. Strugala. PX 17, pp. 6-7.

On July 21, 2006, Petitioner returned to Dr. Strugala and complained of ongoing left knee pain. On left knee examination, the doctor noted pain with flexion beyond 110 degrees. On left ankle examination, the doctor noted no swelling, mild tenderness over the peroneal tendon and good strength. He injected both of Petitioner's knees with Depomedrol and Lidocaine. He instructed Petitioner to continue therapy and allowed him to continue full duty. PX 14, p. 349.

At the next visit, on August 11, 2006, Dr. Strugala noted that Petitioner's left ankle problem was largely resolved but that he was still experiencing left knee pain. He recommended a series of Synvisc injections for the knee. PX 14, p. 350. He administered these injections on August 29, September 8 and September 15, 2006. On September 15, 2006, he noted that Petitioner reported no improvement. On September 22, 2006, he recommended that Petitioner see his partner, Dr. Nelson, for a surgical consultation. He also noted that Petitioner had recently started experiencing pain in his right knee and both ankles due to favoring his left knee. PX 14, p. 354.

Petitioner first saw Dr. Nelson on September 26, 2006. The doctor noted that Petitioner twisted his left knee and ankle while getting out of a truck on May 12, 2006 and underwent

conservative care, including Synvisc injections, thereafter. He also noted that Petitioner experienced a "severe flare-up of pain in both knees, ankle and back" a week before being seen and had been started on Colchicine. He further noted that Petitioner had a history of gout for which he regularly took Allopurinol.

On initial examination, Dr. Nelson noted a left knee effusion. He also noted that, while Petitioner appeared to have a 10-degree flexion contracture, he was able to extend Petitioner's left leg fully when Petitioner was lying on a table. He also noted tenderness in the left ankle. He attributed Petitioner's recent flare-up to gout rather than meniscal pathology. He prescribed screening lab work, to check for arthritis and gout, along with a left ankle MRI. PX 14, pp. 355, 525. The MRI, performed on September 30, 2006, was unremarkable. PX 14, pp. 533-534.

At the next visit, on November 7, 2006, Dr. Nelson described both the laboratory studies and the left ankle MRI as normal. He noted that Petitioner complained of thigh, knee and calf pain. He recommended a lumbar spine MRI, noting that Petitioner reported having a "fair amount of back pain for several days after his accident." He allowed Petitioner to continue working. PX 14, pp. 356, 526.

Petitioner also saw Dr. Arnold at MercyWorks on November 7, 2006. The doctor noted complaints relative to the left knee, left thigh, left ankle and lower back. He also noted the upcoming lumbar spine MRI. He recommended a Doppler ultrasound of both legs and released Petitioner to limited duty. PX 17, p. 11.

The lumbar spine MRI, performed on November 16, 2006, showed a circumferential contained disc herniation with mild central canal stenosis at L1-L2, no significant abnormalities at L2-L3 or L3-L4, a circumferential contained disc herniation with significant central spinal canal and moderate left neural foraminal stenosis at L4-L5 and a posterior-central contained disc herniation abutting the transversing bilateral S1 nerve roots and thecal sac at L5-S1. PX 14, pp. 535-536.

On November 20, 2006, Dr. Arnold of MercyWorks noted the MRI results and indicated that the Doppler ultrasound was negative. He continued the work restrictions and referred Petitioner to Dr. Wehner. PX 17, p. 12.

When Petitioner next saw Dr. Nelson, on November 28, 2006, the doctor described the intervening lumbar spine MRI as showing a herniation at L4-L5 causing some central canal stenosis and moderate left neural foraminal stenosis and a herniation at L5-S1 causing some pressure on the nerve root. He recommended pain management. He noted that Petitioner was "currently on a light duty status." He found this to be reasonable. PX 14, p. 357.

Petitioner also saw Dr. Arnold on November 28, 2006. The doctor noted that Petitioner was awaiting an epidural steroid injection and a visit to Dr. Wehner. He continued the work restrictions. PX 17, p. 12.

Petitioner first saw Dr. Wehner on November 29, 2006. A "new patient questionnaire" in Dr. Wehner's chart reflects that Petitioner provided a consistent history of the May 12, 2006 work accident and complained of pain in his back, both legs and left ankle. The questionnaire also reflects a history of gout in the right ankle. On a separate form, a nurse or other employee documented a history of right elbow surgery at age 21.

Dr. Wehner described Petitioner's gait as normal. She indicated Petitioner could "move about the room quite well." On examination, she noted extension to 20 degrees, negative straight leg raising, no pain with axial compression or light palpation and some pain with axial rotation.

Dr. Wehner interpreted the lumbar spine MRI as showing "some mild spinal stenosis at L4-L5." She described this as a pre-existing condition. She described Petitioner as having a "wide variety of pain complaints that do not fit into any specific clinical pattern." She recommended EMG testing of both lower extremities. She indicated Petitioner would be at maximum medical improvement for his back if the EMG proved to be negative. She found Petitioner capable of light duty pending the EMG. PX 28, pp. 13-14.

On December 4, 2006, Petitioner returned to MercyWorks and saw Dr. Arnold. The doctor noted that Petitioner's gait was normal but that he was still complaining of low back pain. He placed the epidural steroid injection on hold, ordered an EMG of both lower extremities and released Petitioner to restricted duty. PX 17, p. 12.

On December 18, 2006, Petitioner saw Dr. Shah at Mercy Hospital and underwent EMG testing. Dr. Shah noted a history of a fall in May 2006 and a history of low back pain and bilateral leg pain, left greater than right. On examination, he noted a decreased range of motion in both legs, muscle power that was difficult to assess secondary to complaints of pain and normal sensation. He described the EMG examination as essentially within normal limits. PX 14, p. 528.

Petitioner returned to Dr. Nelson on December 19, 2006. The doctor noted that Petitioner underwent an EMG and saw "a spine doctor who put a hold on the pain management." Dr. Nelson released Petitioner from care on a PRN basis, noting that Petitioner was scheduled to return to Dr. Wehner. PX 14, p. 358.

On December 27, 2006, Dr. Wehner wrote to Dr. Arnold indicating she was awaiting the EMG results. She noted that Petitioner "was initially off six weeks and then returned to work on one specific instrument that did not vibrate." She indicated that Petitioner then tried driving a clam operator for 1 ½ months but worsened due to the vibration of this vehicle. She stated that Petitioner was now on light duty and taking Lyrica and Vicodin. PX 28, p. 15.

On January 5, 2007, Dr. Wehner wrote to Dr. Arnold, referencing the negative EMG results. She described Petitioner's gait as normal and indicated that straight leg raising was negative.

Dr. Wehner noted that Petitioner continued to complain of pain in his back and left knee as well as numbness in both legs. Based on Petitioner's reported beer intake and smoking history, she theorized that the leg numbness stemmed from "some type of peripheral neuropathy." She indicated that neither the MRI nor the EMG provided an explanation for the numbness. She indicated Petitioner could continue the Lyrica but was otherwise at medical maximum improvement. She found Petitioner capable of resuming full duty. PX 28, p. 16.

Petitioner saw Dr. Wehner again on January 10, 2007. Dr. Wehner wrote to Dr. Arnold the same day, indicating that Petitioner attempted to resume full duty but was told he "could not take the Lyrica and drive the truck." Dr. Wehner indicated she advised Petitioner to take the Lyrica only at night for one week and then discontinue it. She also indicated she told Petitioner to stop drinking and smoking. She released Petitioner from care on a PRN basis. PX 28, p. 17.

A note in the MercyWorks chart reflects that Petitioner spoke with a nurse on February 14, 2007 and asked that his case be re-opened. The nurse indicated she discussed this with the Committee on Finance "and they agreed for a referral for a specialist." The nurse noted she relayed this to Petitioner and told him to call back with the name of the specialist he wanted to see. A subsequent note, dated April 26, 2007, reflects that a Dr. Tansey called MercyWorks, indicating Petitioner wanted to see him for a second opinion concerning his left leg, but that the Committee on Finance declined to authorize the referral. The note reflects that Petitioner was "treating for a right shoulder injury" as of April 26, 2007. PX 17, pp. 13-14. A third note, dated July 25, 2007, reflects that Petitioner called in and requested a referral to Dr. Nelson. A nurse case manager indicated she would pass Petitioner's request along to the Committee on Finance. PX 17, p. 14.

Records in PX 17 reflect Petitioner reported injuring his right shoulder at work on April 20, 2007 and underwent conservative care for that injury at MercyWorks until May 7, 2007, at which point Dr. Sheth released him to full duty. PX 17, pp. 15-17.

Petitioner testified he resumed his regular MTD [motor truck driver] job after Dr. Wehner released him to full duty. T. 26. Petitioner did not indicate exactly when he resumed full duty. He indicated he continued performing full duty until his second claimed work accident of **April 3, 2009.** During the interval between his return to work and this accident, he continued undergoing care at the Hammond Clinic. On June 15, 2007, he saw Dr. Hanlon at the clinic, provided a history of the accident and complained of lower back pain, left knee pain and bilateral ankle pain and "giving way." The doctor prescribed physical therapy. PX 14, pp. 505-506. On July 31, 2007, Dr. D'Angelo of the clinic imposed temporary restrictions of ground level work, no lifting over 20 pounds, no clam machine operation and no driving of clutch vehicles. PX 14, p. 510. On May 20, 2008, Petitioner underwent a repeat left knee MRI. The history

section of the MRI report reflects that Petitioner had been experiencing intermittent left knee pain ever since a work injury two years earlier in which he slipped down the steps of a truck and twisted his knee. The MRI showed mild osteoarthritis throughout the knee and a "suspected tiny inner margin radial tear in the body of the lateral meniscus." PX 17, pp. 90-91. Petitioner also underwent three lumbar epidural steroid injections, in August, October and early December 2007, and a fourth injection on July 8, 2008. He underwent a repeat lumbar spine MRI on August 31, 2008. This scan showed mild congenital spinal stenosis and a right paracentral disc herniation at L4-L5 compressing the thecal sac and the right L5 nerve root. PX 12. He underwent a right knee MRI on October 20, 2008, with the radiologist noting a minimal joint effusion and a small horizontal tear to the posterior middle horn and lateral meniscus. PX 9. PX 17, p. 88. He underwent an L4-L5 interlaminar lumbar epidural steroid injection on October 28, 2008. PX 15, pp. 220-221.

Petitioner did not testify to being involved in any car accidents but several treatment records in evidence reflect that he was rear-ended in a 3-car accident on February 6, 2009. On February 8, 2009, he saw Dr. DiFilippo at the Hammond Clinic, provided a history of the rear-end collision and complained of headaches as well as neck and back stiffness. The doctor administered a Toradol injection and took Petitioner off work for two days. PX 14, pp. 213-214. Petitioner returned to Dr. DiFilippo on February 19, 2009, at which time the doctor ordered cervical and lumbar spine MRIs. PX 14, p. 211.

Petitioner underwent the recommended lumbar spine MRI on March 12, 2009. This study showed degenerative disc disease at L1-L2, L4-L5 and L5-S1, mild central canal stenosis at L4-L5 and L5-S1 and a central disc protrusion at L1-L2 that the radiologist described as "not significantly changed." PX 13. PX 17, p. 94. A cervical spine MRI, performed the same day, showed a left paracentral and lateral disc protrusion with left neuroforaminal narrowing at C5-C6, a moderate central disc protrusion and broad-based disc bulging at C7-T1 and a "lesser degree of degenerative changes in the remainder of the cervical spine." PX 17, p. 95.

At the hearing, Petitioner had some difficulty recalling the type of vehicle he was operating at the time of his claimed **April 3, 2009** work accident. T. 28. After reviewing PX 1, a report he prepared concerning the accident, he recalled that the accident occurred after he backed his truck into a muddy area while delivering a load of wood chips to a greenhouse. He had to get out of the truck and unchain a gate in order to complete the delivery. He was swinging the gate to close it, he slipped on some rocks and fell, landing on a pile of sharp, broken cement. T. 30. The concrete jabbed his left ankle and leg, the left side of his back and his right elbow. T. 30. He lay on the ground for a while and then radioed his foreman for assistance. After a substitute driver arrived, he was taken to MercyWorks.

The MercyWorks records of April 3, 2009 reflect that Petitioner reported slipping on mud earlier that day, while closing a gate, falling onto his knees and then onto his back. The records also reflect that Petitioner reported hurting his right wrist "while trying to stop the fall." A separate handwritten note, apparently authored by Petitioner, reflects that Petitioner landed on broken cement. Petitioner was diagnosed with contusions of the right wrist, both knees and

the lumbar spine. He was released to full duty and instructed to apply ice and take Ibuprofen and Flexeril. PX 17, p. 109.

Petitioner returned to MercyWorks on April 6, 2009 and complained of pain in his lower back and both knees. The examining provider, Dr. Mejia, noted positive straight leg raising bilaterally. Dr. Mejia diagnosed a lumbar spine strain and bilateral knee strains. He released Petitioner to light duty with no driving, no lifting over 15 pounds, minimal climbing and walking and no repetitive bending, stooping, squatting, pushing, jerking, twisting or bouncing. PX 17, pp. 103-104. At the next visit, on April 13, 2009, Dr. Mejia recommended therapy and continued the previous work restrictions. PX 17, p. 101.

On April 27, 2009, Dr. Mejia reviewed the 2008 bilateral knee MRI results, continued the restrictions and scheduled Petitioner to see Dr. Maday on May 6, 2009. PX 2, p. 4. PX 17, pp. 99-100. It does not appear that Petitioner saw Dr. Maday at that time. A MercyWorks progress note dated May 6, 2009 reflects that the case was being denied per the Committee on Finance. PX 2, p. 2.

On November 11, 2009, Petitioner saw Dr. Kondamuri at the Surgical Hospital of Munster. The doctor noted that Petitioner complained of neck pain of two years' duration and lower back pain since 2003, with that pain extending "beyond his bilateral knees into his ankle and foot on the right side and up to the mid-leg on his left side." The doctor indicated that Petitioner described his back pain as having worsened secondary to driving a truck at work.

Dr. Kondamuri described Petitioner's gait as normal and straight leg raising as negative. He recommended a bilateral L4 transforaminal epidural steroid injection, which he performed two days later. PX 14, pp. 163-164.

Petitioner testified he could not recall whether he lost time from work due to his claimed work accident of April 3, 2009. [No lost time is claimed in 09 WC 35952.] He was able to recall that he resumed full duty at some point after that accident and continued performing full duty until his third accident of March 29, 2010. T. 34. [It is not clear whether Petitioner filed a claim for this accident. The Arbitrator discusses the treatment Petitioner underwent after this accident because that treatment bears on causation-related issues in the last case, 12 WC 28370.] After reviewing an accident report he prepared (PX 3), Petitioner testified that, on March 29, 2010, he was walking around outside one of Respondent's garages, trying to find his assigned garbage truck, when he slipped and fell. T. 36. After he got up, he initially noted hand soreness. He began driving and then noticed that he was having difficulty using the gas and brake pedals because his ankles were "real swollen." He called his foreman and requested a relief driver but no one was available. He managed to finish the workday and then met with his foreman, who completed a report and allowed him to go to MercyWorks. T. 37-38. He was also experiencing knee problems. T. 38.

The MercyWorks records reflect that Petitioner saw Dr. Diadula on March 29, 2010. The doctor described the work accident of that date as follows:

> "The patient is a 50-year-old male, a motor truck driver, who states that while he was walking he did not see the hole because there was a big board around it. He tripped on the board and then fell in the hole. He hit his right wrist against the back of the truck. When he went down to the ground, the knees hit the rim and the ankles went down behind him."

Dr. Diadula noted that Petitioner complained of 10/10 pain in his right wrist, both knees and both calves, 9/10 pain in his right ankle and 10/10 pain in his left ankle. He also noted a history of a meniscal tear in 2008 and a back injury in 2009.

On initial examination, Dr. Diadula noted right wrist swelling, with no abrasions or ecchymoses, a complaint of numbness in the right fifth digit, tenderness in the infrapatellar area of the right knee and quadriceps, slight swelling in the right calf, swelling of the left knee with no abrasions or ecchymoses, left calf tenderness with no swelling abrasions or ecchymoses and tenderness and swelling of both ankles.

Dr. Diadula obtained X-rays of the right wrist, both knees and both ankles. He indicated that none of these X-rays showed fractures on preliminary reading. PX 11.

Dr. Diadula diagnosed multiple contusions of the right wrist and both knees, bilateral ankle sprains, right worse than left, and bilateral calf strains. He took Petitioner off work and prescribed Extra Strength Tylenol or Vicodin. He instructed Petitioner to wear a wrist brace, ankle supports and knee braces, if available. PX 17, pp. 18-19.

Petitioner returned to MercyWorks on April 2, 2010 and again saw Dr. Diadula. The doctor indicated that the final X-ray reports did not document any fractures. He again noted a complaint of right wrist pain which was "now radiating to the right elbow and right shoulder," along with a complaint of numbness in the right fourth and fifth digits. He also noted complaints referable to both knees, both calves and both ankles. He continued the medications and instructed Petitioner to remain off work and see Dr. Maday for his knees. PX 17, p. 19.

Petitioner continued seeing Dr. Diadula at MercyWorks thereafter, while also seeing the following doctors at Dr. Diadula's referral: Dr. Maday (for the knees), Dr. Heller (for the right wrist) and Dr. Perns for his ankles. On April 14, 2010, Dr. Maday obtained a history of a fall at work on March 30, 2010, with Petitioner indicating he struck both knees on the ground. Dr. Maday noted that Petitioner had recently undergone bilateral knee MRIs but that he did not have the films or reports. He took Petitioner off work, recommended a home exercise program and indicated he would try to obtain the MRI results. On April 21, 2010, after reviewing the knee MRIs (PX 10), he diagnosed bilateral knee pain, a right knee lateral meniscus tear and a left knee cartilaginous injury. He recommended a right knee arthroscopy and partial lateral meniscectomy. Dr. Kucharzyk recommended bilateral knee surgery on June 16, 2010, noting that Petitioner was awaiting a second opinion examination "by his work comp carrier."

Coventry, Respondent's utilization review provider, deemed right knee surgery medically necessary but Respondent did not authorize it based on a causation opinion rendered by Dr. Raab, a Section 12 examiner, on June 21, 2010. On April 23, 2010, Dr. Heller noted that Petitioner struck his right arm against a truck in a work fall of March 29, 2010. He indicated Petitioner was complaining of right elbow pain and burning and tingling extending to the right little finger. He also obtained a history of right elbow surgery many years earlier. He indicated that Petitioner "seems to have post-traumatic right elbow ulnar neuritis from striking his elbow against a truck." He recommended a right upper extremity EMG. The first EMG was aborted at Petitioner's request. On May 10, 2010, Dr. Heller noted that the EMG had not been completed. He recommended an elbow pad and instructed Petitioner to avoid prolonged elbow flexion. He released Petitioner from care on a PRN basis. On September 3, 2010, Petitioner saw Dr. Altamimi at the Hammond Clinic for multiple complaints, including lower back and left leg pain. Dr. Altamimi noted a history of a fall at work in 2006. He also noted that Petitioner was using a cane, wearing a back support and taking opioids per his personal physician. He indicated Petitioner refused to undergo another EMG at that time to evaluate his pain and reported leg weakness. PX 14, pp. 49-51. Dr. Levin examined Petitioner on October 12, 2010, in connection with the March 29, 2010 accident. He recommended an EMG to evaluate the right elbow and found Petitioner to be at maximum medical improvement with respect to his ankles. He found no causal relationship between the March 29, 2010 accident and the ankle condition. RX 3. On December 3, 2010, Dr. Levin issued a second report in which he opined that Petitioner's right wrist pain was "coming from referred pain at the elbow." RX 4. Petitioner was able to complete an EMG on January 6, 2011. It showed an "advanced stage of ulnar CMAP demyelination" and bilateral pathology involving the C6 and C7 nerve roots, with the examiner, Farshad Barkhordar, D.C., indicating he could not rule out early diabetic neuropathy. In his report, Barkhordar noted that Petitioner had been diagnosed with diabetes in March 2010. PX 17, pp. 26-28. Based on the EMG, Dr. Diadula opined that Petitioner's right wrist condition was not work-related. On January 14, 2011, Dr. Diadula discussed the various causation-related opinions with Petitioner and released Petitioner to full duty, "per the IME," commenting as follows: "if patient is off work, it is due to a non-work-related condition." PX 17, p. 25.

Petitioner testified he took a medical leave of absence from Respondent between January 17, 2011 and January 17, 2012. He testified that, during that year, he underwent repeat lumbar spine MRIs and surgery on both ankles and both knees. He indicated that Dr. Karcrzyk, a physician associated with the Hammond Clinic, performed these surgeries. T. 42-43. The surgeries took place at Franciscan Physicians Hospital.

Records in PX 21 reflect that Petitioner saw Dr. Mark Chang on April 26, 2011 for what is described as a return visit. Dr. Chang described Petitioner as returning "with new information" and continuing to experience "a lot of neck pain, right arm pain and numbness and tingling in both fingers." He noted he had last seen Petitioner for similar symptoms in March 2009. He also noted that Petitioner had been off work since March 2010 secondary to a motor vehicle accident of February 6, 2009. He described a recent cervical spine MRI as showing a moderate left C5-6 disc herniation, broad base bulging at C6-C7 and a broad base herniation at C7-T1. He described a recent EMG as showing "bilateral C6 and C7 radiculopathies."

Dr. Chang noted that Petitioner was "scheduled for lumbar spine surgery," pending a repeat lumbar spine MRI. He indicated Petitioner should remain off work pending the results of this MRI. He also indicated he discussed the possibility of cervical spine surgery with Petitioner, noting that such surgery would be "fairly extensive." PX 21, p. 6.

A lumbar spine MRI performed on May 13, 2011 showed "multi-level degenerative changes with a central disc protrusion and annular tear at L5-S1 and small central disc protrusion at T12-L1 along with mild to moderate central spinal canal stenosis." PX 18, p. 21.

On October 11, 2011, Petitioner underwent a left S1 transforaminal epidural injection and a right S1 transforaminal epidural injection at Franciscan Physicians Hospital. Dr. Desari administered these injections. PX 15, pp. 189-190. An accompanying patient data form, apparently completed by Petitioner, reflects complaints of bilateral hip pain radiating down the right leg and across the left knee and ankle. The form reflects that Petitioner rated his current pain level at 7/10.

Petitioner testified he resumed working for Respondent in January 2012. When he returned to work, he was assigned to drive a newer garbage truck in the 16th ward. His duties consisted of pre-checking the truck, to make sure the hopper was empty and the flippers and lights were working, driving laborers to various alleys, and dumping loads of garbage. He testified there was "a lot of heavy garbage," including downed trees in his assigned area. Petitioner testified he was able to perform his assigned duties until **June 4, 2012**, when he sustained another accident.

Records in PX 15 reflect that Petitioner was admitted to Franciscan Physicians Hospital on April 3, 2012 due to an "exacerbation of low back pain radiating down the anterior thighs to his knees and lateral ankles." The admitting history reflects that Petitioner's current symptoms were similar to those he had experienced in October 2011, when he underwent a lumbar epidural steroid injection. Petitioner reported obtaining about two months of pain relief following that injection. Petitioner rated his current back pain level at 8/10. The admitting nurse indicated that Petitioner appeared "extremely uncomfortable" and was "walking very stiffly in a forward flexed position." The nurse noted that Petitioner had been seen in the Emergency Room in January, at which time he was given a Medrol Dose-Pak due to increased low back and leg pain.

Dr. Dasari administered a left S1 transforaminal epidural steroid injection and a right S1 transforaminal epidural steroid injection on April 10, 2012. PX 15, pp. 77-78. An accompanying patient data form, apparently completed by Petitioner, reflects that Petitioner underwent an injection that provided temporary relief, returned to work in January 2012 and was experiencing back and leg pain when driving his truck and getting in and out of the truck. PX 15, pp. 80-84.

Petitioner testified that, on **June 4, 2012**, a "superhero" garbage man on his crew somehow put the contents of ten alleys into the truck he was driving. The contents included heavy items such as desks and dressers. Petitioner testified that, as he was driving the overloaded truck over speed bumps and potholes in the alleys, his back started to tingle. He adjusted the air seat but the seat "just kept slamming." He resumed driving and went over a few more bumps, at which point his back "locked up," causing him to feel as if he were paralyzed. T. 44-48. He could not bend his left leg. T. 48. He called his foreman and reported that he had hit some bumps and was unable to move his left leg. The foreman came to the scene, as did the ward boss, paramedics and firefighters, who had to extricate him from the truck. T. 48-49. He was taken to Holy Cross Hospital via ambulance. T. 48-49.

The Holy Cross Emergency Room records of June 4, 2012 reflect that Petitioner was driving a garbage truck earlier that day when he hit a few bumps, struck his left knee against the dashboard and "began having severe back pain radiating to L knee." PX 16, p. 7. The triage nurse also noted a history of chronic back pain and herniated disc and bilateral knee and ankle surgeries. PX 16, p. 7. The examining physician, Dr. Elmosa, noted moderate lumbar spine tenderness, moderate diffuse left knee tenderness, a full range of left knee motion, no laxity and negative straight leg raising bilaterally. PX 16, p. 8. Dr. Elmosa obtained lumbar spine and left knee X-rays. The lumbar spine X-rays showed degenerative arthritic changes with possible degenerating intervertebral discs at L4-L5 and L5-S1. PX 16, p. 13. Petitioner was given Dilaudid and Valium for pain. At discharge, Petitioner was given a prescription for Hydrocodone and was instructed to follow up with Dr. Schiappa. PX 16, p. 16.

Petitioner testified he sought follow-up care at MercyWorks. He saw Dr. Anderson there on June 6, 2012. Dr. Anderson recorded a consistent history of the June 4, 2012 accident and noted that Petitioner complained of 10/10 pain in his lower back radiating down his left leg beyond the knee "but with most pain at the left knee area." Dr. Anderson also noted a "significant history of chronic lower back pain." He reviewed Petitioner's past medical records, noting that Petitioner had undergone bilateral knee and ankle surgery while on leave and that a doctor had discussed a lumbar fusion with him during this same period. He noted that Petitioner reported "working with chronic lower back pain" since returning to work in January 2012.

Dr. Anderson noted that Petitioner was using a crutch to walk and appeared to be in moderate distress secondary to left-sided lower back pain. On lumbar spine examination, he noted tenderness from L1 to S1, left greater than right, restricted forward bending and positive straight leg raising on the left. He noted no warmth or effusion on left knee examination.

Dr. Anderson diagnosed a lumbar strain, history of degenerative disc disease and left radiculopathy. He instructed Petitioner to apply ice, decrease the Hydrocodone and continue taking Skelaxin and using Lidoderm patches. He took Petitioner off work and instructed him to present his MRI reports at the next visit. PX 18, p. 5.

At the next visit, on June 13, 2012, Dr. Anderson noted that Petitioner was now using two crutches and complaining of 9/10 lower back pain, left greater than right and "down left leg to ankle." He also noted that Petitioner planned to see Dr. Frank Phillips at Rush. He refilled the Hydrocodone prescription, arranged for Petitioner to undergo a lumbar spine MRI and kept Petitioner off work.

The MRI, performed on June 18, 2012, demonstrated "multi-level vertebral column curvature/alignment abnormalities, degenerative disc disease and facet arthropathy, with associated central spinal canal stenosis and neural foraminal narrowing," along with "moderate diffuse atrophy of the paraspinal musculature. PX 18, p. 12.

On June 20, 2012, Dr. Anderson reviewed the MRI results. He again noted that Petitioner was using crutches and planned to see Dr. Phillips. He kept Petitioner off work and discharged him from care "per company protocol." PX 18, p. 6.

Petitioner first saw Dr. Phillips on June 26, 2012. Following this evaluation, Dr. Phillips sent a lengthy letter to Dr. Anderson of MercyWorks. In this letter, Dr. Phillips noted a "long history of back problems" dating back to 2009 and recently aggravated on June 4, 2012 "while working on a truck for six hours, bouncing around." He noted that Petitioner complained of severe axial back pain in a sciatic distribution radiating down his left leg. He further noted that Petitioner was using crutches to walk. He described Petitioner's bilateral knee problems as another "significant pain generator."

Dr. Phillips described Petitioner as standing with a kyphotic posture and being unable to heel or toe walk. He indicated that, on initial examination, he noted "obvious lumbar tenderness to palpation with paralumbar spasm" and reduced flexion and extension. He interpreted the June 18, 2012 lumbar spine MRI as showing "advanced disc degenerative changes primarily at L4-L5 and L5-S1," some disc desiccation and a central disc protrusion at L1-L2, moderate stenosis at L2-L3, facet hypertrophy and severe stenosis at L3-L4, facet hypertrophy, diffuse bulging and severe stenosis at L4-L5 and a small, non-compressive central disc prolapse at L5-S1. He described lumbar spine X-rays taken that day as showing "advanced disc degenerative changes at L4-L5 and L5-S1 where is complete bone-on-bone disc space collapse."

Dr. Phillips described Petitioner as becoming "more and more disabled, particularly after the recent aggravation of his symptoms related to the truck driving this year." He indicated that Petitioner's very severe stenosis was limiting his ability to walk or even stand upright. He further indicated that Petitioner was "unable to function" in his current state and needed surgery. He recommended a lumbar laminectomy across the stenotic levels, from L1 down to S1, and a fusion at L4 to S1 to address Petitioner's "severe axial back pain as well as the advanced disc degenerative changes." He anticipated having to perform "considerable facet removal," given the severity of the stenosis at L4-L5. PX 18, pp. 7-9; PX 19, pp. 29-30. He took Petitioner off work, pending this surgery. PX 19, p. 28.

On August 1, 2012, Dr. Phillips performed surgery consisting of posterior spinal decompression of levels L3-L4, L4-L5 and L5-S1, with laminectomy and bilateral foraminotomies and a posterior fusion at L4-L5 with instrumentation and pedicle screws. PX 19, pp. 31-34.

Following the surgery, Petitioner returned to Dr. Phillips on August 15, 2012. On that date, Dr. Phillips noted that Petitioner was "still in a considerable amount of pain" and was relying on crutches. Dr. Phillips encouraged Petitioner to increase his activity level and begin walking on a regular basis. After Petitioner reported some bilateral leg weakness, especially when attempting to stand, Dr. Phillips provided him with a walker "in exchange for the crutches." Dr. Phillips indicated that Petitioner's reported leg weakness was "not neurological because when he is tested he has 5/5 strength in [both] lower extremities."

Dr. Phillips refilled Petitioner's Norco, discontinued the Valium and started Petitioner on Flexeril. He obtained lumbar spine X-rays and later interpreted them as confirming "an L4 to sacrum fusion construct," appropriate placement of the pedicle screws and adequate decompression. He was able to visualize posterolateral bone from L4 to S1. PX 19, p. 24.

Dr. Phillips noted that Petitioner presented a letter indicating he had been scheduled to attend an IME on August 20, 2012. Dr. Phillips indicated that Petitioner was "still too fresh post-operative to be undergoing any kind of physical examination." PX 19, p. 27. He issued a letter indicating that Petitioner was still in pain and recovering from surgery. He stated that Petitioner "should not be scheduled for an IME at this time as it will be a disservice to both the patient and the examiner." PX 19, p. 25.

Dr. Phillips instructed Petitioner to remain off work for the time being. PX 19, p. 26.

At Respondent's request, Petitioner saw Dr. Graf for a Section 12 examination on September 1, 2012. In his lengthy report of the same date, Dr. Graf indicated he obtained a history from Petitioner, examined Petitioner's thoracic/lumbar/sacral spine and reviewed multiple treatment records (from 2009 through June 26, 2012) and lumbar spine MRI reports along with a City of Chicago Injury on Duty report dated June 8, 2012. Dr. Graf referenced records indicating Petitioner saw a spinal surgeon, Dr. Talman, at some point while he was on medical leave, between January 17, 2011 and January 17, 2012, with that physician recommending a lumbar fusion. Dr. Graf indicated that the recommended fusion could not be performed at that point because Petitioner "had no more medical leave time available" and thus had to return to work in January 2012.

Dr. Graf described Petitioner as obese, based on a height of 6 feet and a weight of 274 pounds. He indicated that Petitioner seemed to have difficulty getting out of a chair but exhibited a normal gait. He indicated that Petitioner could stand on his heels and toes and refused to attempt squatting secondary to left knee pain.

On thoracic/lumbar/sacral spine examination, Dr. Graf noted no paraspinal spasm or pain to palpation. He deferred forward bending and extension secondary to the recent surgery.

He described distracted sitting straight leg raising and supine straight leg raising as negative bilaterally.

Dr. Graf indicated that, because he perceived Petitioner as targeting an accident of 2009 and because he had only been provided with records from 2009 through June 26, 2012, he was unable to render an opinion as to whether the accident of June 4, 2012 caused an exacerbation. He asked that the missing records be sent to him along with Petitioner's imaging studies. He stated that, regardless of causation, Petitioner was currently totally disabled. He further stated it would be reasonable for Petitioner to undergo three months of therapy following the recent fusion. RX 5.

Petitioner returned to Dr. Phillips on September 4, 2012. On that date, Dr. Phillips sent Coventry a letter indicating Petitioner was still having some axial back pain but was "actually doing reasonably well." Dr. Phillips also indicated that Petitioner was "still using crutches for reasons that are unclear." He instructed Petitioner to stop using the crutches within the next week or two. He noted that Petitioner reported walking three to four blocks at a time. He obtained repeat X-rays, which showed good positioning of the surgical hardware and bone formation. He instructed Petitioner to return in a couple of months, at which point he anticipated prescribing formal therapy. PX 19, p. 23.

On October 15, 2012, Dr. Graf issued a lengthy addendum, after reviewing additional information consisting of MercyWorks records dating back to May 15, 2006, two reports from Dr. Raab, Dr. Phillips' operative report of August 1, 2012, Dr. Phillips' post-operative notes through September 4, 2012 and various lumbar spine MRI and X-ray films from 2011 and June 18, 2012.

Based on his previous examination, record review, Petitioner's history, a MercyWorks note of June 6, 2012 indicating Petitioner reported "working with chronic low back pain" and Dr. Phillips' initial note, referencing a long history of back pain dating to an injury in 2009, Dr. Graf opined that Petitioner's low back pain pre-dated June 6, 2012 and "bears no relation to driving over a speed bump."

Petitioner testified that Respondent discontinued paying temporary total disability and medical benefits following Dr. Graf's examination. T. 51. The Request for Hearing form in this case shows that Respondent paid no temporary total disability benefits. Arb Exh 3.

Petitioner returned to Dr. Phillips on November 6, 2012. The doctor again described Petitioner as doing reasonably well. He noted that Petitioner was still experiencing back pain, "particularly as the day goes on." On examination, he noted 40 degrees of flexion and 30 degrees of extension. Repeat X-rays confirmed the fusion construct but showed that the posterolateral bone was "not yet incorporated." Dr. Phillips indicated he was going to have Petitioner start therapy in about three weeks "just to give the fusion some more time to consolidate." He anticipated that Petitioner would reach maximum medical improvement

about eight months post-fusion. PX 19, p. 22. He continued to keep Petitioner off work. PX 19, p. 20.

Petitioner returned to Dr. Phillips on January 17, 2013, having started physical therapy in the interim. Dr. Phillips noted that Petitioner had "little in the way of back pain" but complained of pain in the area of the coccyx, especially after sitting for a while. He noted that Petitioner described his work injury as involving a prolonged period of "jarring in his truck," resulting in a possible tailbone injury. On examination, he noted tenderness toward the coccygeal area and a good range of lumbar spine motion. Repeat X-rays confirmed the fusion construct and showed some posterolateral bone. Dr. Phillips prescribed a donut pillow to use when sitting. He referred Petitioner to Dr. King, a pain specialist, for evaluation for possible coccygeal injections. He instructed Petitioner to stay off work and continue therapy. PX 19, p. 19.

On February 26, 2013, Petitioner underwent a caudal epidural steroid injection at Franciscan Physicians Hospital. Dr. Dasari administered this injection. The doctor's procedure report lists the following diagnoses: failed back surgery syndrome, lumbar radicular pain and coccydynia. PX 15, pp. 33-34. An accompanying history form, apparently completed by Petitioner, reflects a history of low back pain dating back to 2006, a work accident on June 8, 2012 and a multi-level fusion on August 1, 2012. PX 15, pp. 36-38. Petitioner testified he ended up using his group insurance to undergo the February 26, 2013 injection. T. 56.

Petitioner returned to Dr. Phillips on March 19, 2013 and reported improvement following an injection by a local pain physician a month earlier. Dr. Phillips noted that Petitioner was "anxious to try some therapy as he is feeling much better since the injection and his therapy prior was limited by his discomfort." On examination, Dr. Phillips noted about 60% of lumbar range of motion. Repeat X-rays showed adequate decompression, good positioning of the pedicle screw instrumentation and some posterolateral bone, "more robust on the right." Dr. Phillips recommended that Petitioner do an additional month of therapy now that he was feeling better. He indicated that, in the interim, Petitioner could return to light duty with no lifting over 30 pounds, no repetitive bending and no commercial garbage truck driving "because of the jarring involved." He indicated Petitioner should return for new X-rays in about three months. He further indicated that a functional capacity evaluation might be appropriate at that point, depending on the X-ray results. PX 19, p. 15.

Dr. Phillips testified by way of evidence deposition on May 21, 2013. PX 29. Dr. Phillips testified he attended medical school in South Africa, did an orthopedic surgery residency at the University of Chicago Hospital and then underwent fellowship training in spine surgery at Case Western. PX 29 at 5. He initially practiced spine surgery at the University of Chicago but has been affiliated with Rush University during the last ten years. PX 29 at 5. He obtained board certification in orthopedic surgery in 1997 and was re-certified in 2007. He has published many book chapters and articles in peer-reviewed publications. Phillips Dep Exh 1.

Dr. Phillips testified that Petitioner provided a history of "intermittent back and leg pain since 2009" at the initial appointment of June 26, 2012. Petitioner also related that, most recently, he had suffered an acute flare-up of his pain on June 4, 2012, while "bouncing around" in a work truck for six hours. PX 29 at 6. As of June 26, 2012, Petitioner was relying on a crutch to walk and could not walk any significant distance. PX 29 at 7. His gait was unsteady and he stood with a kyphotic posture, meaning he was leaning forward. PX 29 at 7. He had a limited range of motion, particular in extension, and decreased strength in the L4-L5 distribution. PX 29 at 7.

Dr. Phillips testified he reviewed a lumbar spine MRI of June 18, 2012. This MRI showed "advanced degenerative changes really throughout the lumbar spine." Dr. Phillips opined that Petitioner's severe symptoms were consistent with this imaging study. Petitioner had failed conservative care and was essentially nonfunctional so he recommended surgery. PX 29 at 8. The surgery he performed on August 1, 2012 consisted of a laminectomy or decompression from L3 down to S1 and then a fusion at L4-S1 with screws. PX 29 at 9.

Dr. Phillips testified that Petitioner's condition as of June 26, 2012 required him to be off work. PX 29 at 10, 20.

Dr. Phillips testified that Petitioner's leg symptoms improved postoperatively. Petitioner continued to have back pain but it was improved. PX 29 at 11. Large, overweight individuals such as Petitioner can experience more back pain postoperatively but their size "probably shouldn't compromise the long-term result." PX 29 at 12.

Dr. Phillips testified that, on January 17, 2013, he prescribed therapy and referred Petitioner to Dr. King for possible coccygeal injections. On that date, he continued to keep Petitioner off work. PX 29 at 14. On a form dated January 17, 2013, he answered "yes" in response to a question asking whether the diagnosis and treatment were causally related to the work accident. PX 29 at 14.

Dr. Phillips testified he last saw Petitioner on March 19, 2013. Petitioner was doing "okay" at that point. He had improved since undergoing an injection by a local pain physician. He wanted to try additional therapy so the doctor prescribed another month of therapy. PX 29 at 15. He also released Petitioner to light duty. PX 29 at 16. He understands that Petitioner works as a garbage truck driver for the City of Chicago. PX 29 at 16. Petitioner is scheduled to return to him in June 2013. PX 29 at 16.

Dr. Phillips testified Petitioner may have told him he hit some speed bumps in alleys on June 4, 2012. He is familiar with alley speed bumps and has had an occasion to drive over them. The sciatic pain Petitioner had in his left leg after the June 4, 2012 accident seemed to more of an acute manifestation.

Dr. Phillips testified he based part of his causation opinion on the fact that Petitioner was able to work before the June 4, 2012 accident. PX 29 at 19. He operated on Petitioner's

back to address the symptoms that, by history, Petitioner developed after the June 4, 2012 accident.

Dr. Phillips testified his surgical charges were reasonable and consistent with the charges of other surgeons in the Chicago area. PX 29 at 21.

Dr. Phillips testified he skimmed Dr. Graf's two reports. He is aware that Dr. Graf identified complaints of back pain dating back to 2006. PX 29 at 22. He (Dr. Phillips) has prepared IME reports of his own. PX 29 at 22. He did not study Dr. Graf's reports in any detail but he saw nothing in them that caused him to change his own opinions. PX 29 at 24.

Under cross-examination, Dr. Phillips acknowledged that the lumbar spine MRI report of June 18, 2012 references an earlier MRI of November 16, 2006. PX 29 at 25. He further acknowledged he has not seen the films or reports concerning either the 2006 MRI or the two lumbar spine MRIs performed in 2011. PX 29 at 25. He is not sure whether Petitioner used the phrase "chronic pain" at the initial visit in June 2012 but Petitioner readily indicated he had been experiencing back and leg pain since 2009. PX 29 at 25.

Dr. Phillips testified that his initial note of June 26, 2012 is in the form of a letter directed to Dr. Anderson. He believes Dr. Anderson referred Petitioner to him. PX 29 at 25-26. He did not review any of Dr. Anderson's records prior to examining Petitioner on June 26, 2012. PX 29 at 26. Nor did he review any other prior records. The only prior care he is aware of is that summarized by Dr. Graf in his IME reports. PX 29 at 26. Petitioner indicated he had sustained a back injury or aggravation in 2009 but he did not describe the circumstances of this injury. PX 29 at 26. The lumbar spine films he obtained on June 26, 2012 showed degenerative changes. Petitioner's spinal stenosis is certainly degenerative in nature. PX 29 at 27. His operative report of August 1, 2012 reflects post-operative diagnoses of stenosis at three levels and spondylolisthesis at L4-L5 and L5-S1. He also documented a dural defect. That defect was not degenerative in nature. Such defects typically result from injections, not acute injuries. PX 29 at 27.

Dr. Graf testified by way of evidence deposition on August 19, 2013. RX 7. Dr. Graf is a board certified orthopedic surgeon and fellowship-trained spine surgeon. RX 7 at 4-5. Graf Dep Exh 1. He also holds board certification in independent medical evaluations. RX 7 at 5. He devotes about 10 to 15% of his practice to medical-legal reviews. RX 7 at 7. He did not independently recall Petitioner. RX 7 at 7-8. He relied on his reports to testify. RX 7 at 8-9.

Dr. Graf testified that one of the reports he reviewed in connection with his own evaluation revealed that Dr. Talman had offered Petitioner a spinal fusion before the June 2012 accident, during a period when Petitioner was off work and undergoing knee surgery. RX 7 at 15. Per this report, Petitioner did not undergo the fusion at that time because he was running out of medical leave time. RX 7 at 15.

Dr. Graf testified that Petitioner's verbal account of the June 4, 2012 work accident was consistent with both a written accident report and the MercyWorks records. RX 7 at 16.

Dr. Graf testified that Petitioner's lumbar spine radiographic studies were consistent with "advanced disc degenerative changes," not an acute process. RX 7 at 17.

Dr. Graf testified he is familiar with the surgery Dr. Phillips performed because he performs similar surgeries all the time. RX 7 at 19.

Dr. Graf opined that Petitioner's lumbar spine condition pre-existed the June 4, 2012 accident and was not causally related to that accident. RX 7 at 21. Dr. Graf also found no causal relationship between Petitioner's lumbar spine condition and the general demands of his job. RX 7 at 21. The surgery Dr. Phillips performed was not necessitated by the June 4, 2012 accident because the same surgery had been recommended to Petitioner before the accident. RX 7 at 21. Petitioner's obesity could possibly have increased his disc degeneration. RX 7 at 22.

Under cross-examination, Dr. Graf conceded he did not ask Petitioner how long he had been back to work before the June 4, 2012 accident. RX 7 at 23. He is aware that Petitioner drove a garbage truck. He has seen but never driven such a truck. RX 7 at 23. In his opinion, the June 4, 2012 accident caused no symptoms whatsoever. RX 7 at 24. The surgery Dr. Phillips performed was necessary but unrelated to the June 4, 2012 work accident. RX 7 at 24-25.

On redirect, Dr. Graf testified there was nothing in the medical records that would lead him to conclude Petitioner's truck driving duties caused his symptoms. RX 7 at 25.

Under re-cross, Dr. Graf indicated he did not know how long Petitioner drove a garbage truck for Respondent. Petitioner told him he had been off work for a long instance and then had started back again before the accident. RX 7 at 26.

Itemized billing in PX 30 reflects Petitioner underwent physical therapy at ATI from August 22, 2013 through September 27, 2013. Petitioner testified he had to switch from NovaCare to ATI and undergo therapy there because the therapy at NovaCare was not being paid for. T. 53.

At Dr. Phillips' recommendation, Petitioner underwent a functional capacity evaluation at ATI on October 23, 2013. T. 52. The evaluator, Jason Lemley, ATC, CWcHP, rated the evaluation as valid "based upon the objective data that was collected and the formulas using that data." Lemley indicated that Petitioner demonstrated physical abilities consistent with a light physical demand level, meaning he could occasionally lift 17 pounds from chair to floor level, 23 pounds from desk to chair level and 19 pounds above shoulder level. He described Petitioner's motor truck driver job with Respondent as typically falling within a medium physical demand level, with occasional lifting up to 50 pounds. He noted that he did not receive a specific job description prior to the evaluation. Lemley also noted that he

recommended Petitioner follow up with his physician based on his ongoing complaints of lower back pain with activities such as squatting, bending, walking and extended sitting. PX 27.

On November 6, 2013, Dr. Phillips wrote a note addressed "to whom it may concern" indicating he had reviewed the functional capacity evaluation and felt the results to be a "reasonable representation" of Petitioner's physical demand level. Dr. Phillips also indicated he believed the restrictions outlined in the evaluation were "likely to be in effect permanently." PX 19, p. 104.

Petitioner testified that Respondent never offered him light duty per the functional capacity evaluation. T. 52. He further testified he has been off work since June 4, 2012.

Petitioner testified he continues to experience pain and swelling in his left ankle and cramping in his left calf. T. 53-54. His left knee "snaps" at times and he feels as if there is something floating inside the knee. He underwent a repeat left knee MRI and was told it did not show any remaining problem. T. 54. He underwent carpal and cubital tunnel releases at Hammond Clinic within the last year. T. 54-55. His activities are very limited secondary to his back pain. He avoids bending. He applies Lidoderm lotion to his back and knees. He also takes prescription pain medication.

Petitioner testified that PX 8, a written job description, does not accurately describe the lifting he was required to perform as a motor truck driver. PX 8 states a motor truck driver is required to lift 35 pounds but he was required to lift 200 pounds. T. 57.

Under cross-examination, Petitioner acknowledged receiving a settlement equivalent to 6% loss of use of the person in a case numbered 87 WC 34499. That case involved an accident he sustained while driving a dump truck for Consolidation Excavating. T. 58. He suffers from diabetic neuropathy. T. 58. He underwent several examinations at Respondent's request. T. 59. He provided the examining physicians with accurate information. T. 59.

[CONT'D]

Russell Rosiak v. City of Chicago
12 WC 28370 (consolidated with 06 WC 30029 and 09 WC 35952)

Arbitrator's Credibility Finding

Petitioner provided detailed testimony concerning the duties he performed between January 17, 2012 and his claimed accident of June 4, 2012. Petitioner also provided a wealth of detail concerning the events leading up to the accident. The Arbitrator found him credible.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on June 4, 2012 arising out of and in the course of his employment?

The Arbitrator finds that Petitioner met his burden of proof on the issue of accident in 12 WC 28370. Petitioner's testimony concerning the circumstances of this accident was not only detailed. It was uncontradicted. Petitioner indicated that, on June 4, 2012, a "superhero" on his crew loaded an unusually large number of heavy items, including pieces of furniture, into the back of his truck. As Petitioner (who is not a small individual) was driving the fully loaded truck over bumps and potholes, along his usual route, he struck his knees against the dashboard and developed back and leg symptoms which worsened to the point that he became immobile. Paramedics were called to the scene, as was Petitioner's foreman. The accident report is consistent with Petitioner's testimony. Petitioner identified two witnesses, laborers A. Nelson and A. Travis, in this report. Respondent did not call either of these witnesses. Petitioner's foreman signed the report. Respondent stipulated to timely notice and sent Petitioner to its clinic, MercyWorks, for treatment.

Petitioner sustained an accident on June 4, 2012 arising out and in the course of his employment.

Did Petitioner establish a causal connection between the accident of June 4, 2012 and his current claimed lumbar spine condition of ill-being?

The Arbitrator finds that Petitioner's current lumbar spine condition of ill-being is multi-factorial and that the accident of June 4, 2012 was a cause of that condition. The Arbitrator further finds that the accident contributed to the need for the lumbar spine laminectomy and fusion Dr. Phillips performed on August 1, 2012.

There is no question that Petitioner had an extensive history of low back pain prior to the June 4, 2012 accident. He had undergone a lumbar spine injection as recently as April 2012 and some records (specifically, Dr. Chang's 2011 note and the MercyWorks note of June 6, 2012) suggest that lumbar spine surgery came under discussion while he was off work in 2011. However, the evidence also shows that Petitioner resumed his regular truck driving duties for

Respondent in January 2012, after his medical leave expired, and continued performing those duties until the June 4, 2012 accident. Petitioner had to be extricated from his work truck after the accident. By the time he saw Dr. Phillips, on June 26, 2012, he was essentially "non-functional" due to his pain levels and inability to walk. In the Arbitrator's view, the accident of June 4, 2012 caused Petitioner's pre-existing degenerative condition to worsen and significantly reduced his function. Petitioner was able to live and work with his pain between January 17, 2012 and the accident but was not able to do so thereafter.

Although neither Dr. Phillips nor Dr. Graf reviewed all of the records pre-dating the June 4, 2012 accident, the Arbitrator finds Dr. Phillips' causation-related opinions more persuasive overall. Dr. Phillips testified he believed Petitioner was referred to him by Dr. Steven Anderson (of MercyWorks), a physician of Respondent's, not Petitioner's, selection. Dr. Graf was not credible when he testified, under cross-examination, that the June 4, 2012 accident resulted in no symptoms whatsoever. Dr. Graf also readily conceded that he devotes 10 to 15% of his practice to medical-legal consulting and that the surgery Dr. Phillips performed was reasonable and necessary.

Is Petitioner entitled to temporary total disability benefits?

In 12 WC 28370, Petitioner claims he was temporarily totally disabled from June 5, 2012, the day after the accident, through the hearing of August 19, 2014. Arb Exh 3.

In reliance on Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010), as well as the MercyWorks records and Dr. Phillips' records and testimony, the Arbitrator finds that Petitioner was temporarily totally disabled from June 6, 2012 (the day Dr. Anderson of MercyWorks took Petitioner off work) through October 23, 2013, the date of the functional capacity evaluation, a period of 72 1/7 weeks. When Dr. Phillips gave his deposition, he indicated he recommended another month of therapy when he saw Petitioner in March 2013. He also indicated he planned to see Petitioner again in June 2013. No June 2013 treatment note is in evidence. It appears that Petitioner did not start the recommended therapy until August 2013, at which point he switched from NovaCare to ATI due to payment issues. He finished the therapy in September 2013 and underwent the evaluation about a month later. Dr. Phillips commented on the evaluation in November 2013 but did not recommend any additional care at that time.

The Arbitrator finds that Petitioner's lumbar spine condition stabilized as of the functional capacity evaluation. Per Interstate Scaffolding, temporary total disability benefits are awardable during a period of instability. Petitioner did not testify to looking for alternative work within the restrictions of the evaluation and did not seek vocational rehabilitation or maintenance. Arb Exh 3.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims a number of bills from various providers.

The Arbitrator awards Petitioner the outstanding charges of $32,405.34 from Rush University Medical Center for services provided in connection with Petitioner's lumbar spine surgery, subject to the fee schedule. The Arbitrator notes that the total hospital charges were $101,266.69 but that the hospital allowed a substantial patient discount of $68,861.35. PX 19. None of the Rush University Medical Center charges were covered by Petitioner's wife's group carrier. PX 22.

The Arbitrator awards Petitioner the bill in the amount of $8,079.40 from University Anesthesiologists, S.C. PX 20. This bill relates to anesthesia services provided during the August 1, 2012 lumbar spine surgery. The Arbitrator has previously found that Petitioner established causation vis-à-vis this surgery and Dr. Graf conceded the surgery was reasonable.

The Arbitrator declines to award Dr. Chang's bill in the amount of $242.50 (PX 21) because Dr. Chang treated Petitioner for cervical, not lumbar complaints, and the dates of treatment shown on the bill pre-date the accident of June 4, 2012.

The Arbitrator declines to award Petitioner any of the charges enumerated on the Blue Cross Blue Shield EOB forms in PX 22 other than those from Rush University Medical Center – see above. The vast majority of the charges relate to treatment Petitioner underwent prior to the June 4, 2012 accident. A few of the charges relate to a surgical procedure Petitioner underwent at Franciscan Physicians Hospital on October 9, 2012 but there is no evidence indicating this procedure was back-related.

The Arbitrator awards the NovaCare physical therapy bill of $8,655.00 (PX 23) for services rendered between December 6, 2012 and February 21, 2013, subject to the fee schedule. This bill is not supported by therapy records but it is supported by Dr. Phillips' records (which include therapy prescriptions) and deposition testimony.

The Arbitrator awards Petitioner medical expenses in the amount of $322.00 from Radiological Physicians, Ltd. relating to the lumbar spine MRI of June 18, 2012, subject to the fee schedule. PX 24.

The Arbitrator awards the University Pathologists, S.C. bill in the amount of $638.25 (PX 25), subject to the fee schedule. This bill relates to pathology services provided at Rush University Medical Center in connection with the lumbar spine surgery of August 1, 2012. The Arbitrator has previously found that Petitioner established causation vis-à-vis this surgery and Dr. Graf conceded that Petitioner required the surgery.

The Arbitrator awards the Palmer & Zavala, S.C. charges in the amount of $390.00 (PX 26), subject to the fee schedule, for the inpatient consultations performed by Dr. Casimir on August 2, 3 and 4, 2012, during Petitioner's post-surgical course.

The ATI bill (PX 30) includes charges for physical therapy performed between August 22,

2013 and September 23, 2013 and a functional capacity evaluation performed on October 23, 2013. The therapy bill is not supported by accompanying records but it does show that the therapy was prescribed by Dr. Phillips. At his deposition, in May of 2013, Dr. Phillips testified he prescribed one more month of therapy when he last saw Petitioner in March 2013. Based on Petitioner's testimony that he had to switch therapy providers to ATI due to lack of payment to NovaCare, the Arbitrator finds it reasonable to infer that this additional month of therapy did not take place until August and September 2013.

The Arbitrator awards the ATI bill in the amount of $9,780.57, subject to the fee schedule.

What is the nature and extent of the injury?

The Arbitrator notes that Petitioner did not seek either a wage differential award or vocational rehabilitation.

This case is post-amendatory, since Petitioner's accident occurred after September 1, 2011. The Arbitrator thus considers all of the factors set forth in Section 8.1b of the Act. The Arbitrator notes that neither party offered an AMA impairment rating into evidence. The Arbitrator views Petitioner as an older individual, since he was 52 as of the June 4, 2012 accident. The valid functional capacity evaluation of October 23, 2013 showed that Petitioner was functioning at a light physical demand level and was thus not able to resume his medium duty garbage truck driver job. Dr. Phillips indicated that he viewed the functional capacity evaluation as a fair measure of Petitioner's work ability. He also indicated that the restrictions set forth in the evaluation are likely permanent. Petitioner credibly testified that Respondent did not offer him light duty work after the evaluation. Respondent did not call any witness to contradict this testimony. There is thus evidence that the accident affected Petitioner's future earning capacity.

The Arbitrator, having considered all of the foregoing, awards permanency in 12 WC 28370 equivalent to 35% loss of use of the person as a whole, or 175 weeks of compensation, under Section 8(d)2 of the Act. The Arbitrator awards permanency at the applicable maximum rate of $695.78 per week based on the stipulated average weekly wage of $1,228.00. Arb Exh 3.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0694

ROSIAK, RUSSELL
Employee/Petitioner

Case# **06WC030029**

09WC035952
12WC028370

CITY OF CHICGO
Employer/Respondent

On 10/3/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
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0766 HENNESSY & ROACH PC
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15IWCC0694

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Russell Rosiak
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **06** WC **30029**

Consolidated cases: **09WC35952;12WC28370**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **8-19-2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5-12-2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to left ankle and left knee strains but failed to establish a causal relationship between the accident of May 12, 2006 and his current claimed lumbar spine condition of ill-being.

In the year preceding the injury, Petitioner earned $**41,600**; the average weekly wage was $**800**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services. [Petitioner did not place medical expenses at issue in 06 WC 30029. Arb Exh 1. T. 7-8.]

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

Respondent shall be given a credit of $**4,143.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,143.72**.

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

ORDER SEE ATTACHED ORDER

Respondent shall pay Petitioner temporary total disability benefits of $533.33/week for 6 weeks, commencing 5-15-06 (the day Dr. Arnold took him off work) through 6-25-06 (the day before Dr. Strugala released him to full duty at his request), as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $480/week for 8.35 weeks, because the injuries sustained caused the 5% loss of the left foot, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $480/week for 16.125 weeks, because the injuries sustained caused the 7.5% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Molly C Mason
Signature of Arbitrator

10/3/14
Date

OCT 3 - 2014

Russell Rosiak v. City of Chicago
06 WC 30029, 09 WC 35952 and 12 WC 28370 (consolidated)

Arbitrator's Findings of Fact Relative to All Cases

Petitioner, a driver for Respondent's Department of Streets and Sanitation, alleges three work accidents, all of which are in dispute. The alleged accident dates are **May 12, 2006** (06 WC 30029), **April 3, 2009** (09 WC 35952) and **June 4, 2012** (12 WC 28370).

Petitioner testified he began working for Respondent four years before his claimed accident of May 12, 2006. T. 17. During those four years, he drove various vehicles, including boom-equipped "clam" trucks (used for tree removal) and salt trucks. T. 18-19. He regularly performed lifting. The objects he lifted could weigh up to 200 pounds. T. 19. He sometimes had to climb into the backs of trucks to free "stuck material." T. 20.

Petitioner testified he was able to perform all of his required duties prior to the accident of May 12, 2006. He injured his back on one occasion, about four years before the accident, but only required one injection. T. 20-21. He denied having any problems with his knees or ankles before May 12, 2006. T. 20. Before that date, he saw various doctors at the Hammond Clinic for multiple medical issues. T. 21.

Records in PX 14 reflect that Petitioner underwent left foot X-rays on November 4, 2005, with the interpreting radiologist noting no abnormalities. PX 14, p. 474. Records in the same exhibit reflect that Petitioner underwent right ankle X-rays on April 19, 2006 due to "possible gout," with the radiologist comparing the films to previous X-rays taken on September 7, 2003. The radiologist noted mild soft tissue swelling about the ankle and no erosive changes. PX 14, pp. 473, 481.

Petitioner testified that, as of **May 12, 2006**, he worked as an MTD driver for the forestry division. T. 17. On that date, he drove a work crew to various locations to trim trees. At the end of his shift, he went into a building and was waiting to punch out when he realized he had left his bag in his assigned truck. He walked back out to the parking area, climbed onto the truck, grabbed his bag and turned, at which point his foot "got caught and slipped." He testified the soles of his shoes were slippery due to walking in oil and anti-freeze. In order to avoid landing on a chip, he grabbed the handle of the truck door and it "yanked [him] back." He reported the incident to his foreman, who told him to wait and see how he felt the next day. T. 21.

Petitioner testified he talked with his foreman again the following day, a Saturday, and received instructions to see his primary care physician. On May 13, 2006, he went to the Hammond Clinic. The handwritten note of that date reflects that Petitioner reported a sudden onset of pain in his left knee and the entire left side of his body after stepping out of his truck the previous day. The provider, whose signature is not legible, noted left knee swelling and

mild spasm. He prescribed Vicodin, ice applications and left knee X-rays. PX 14, p. 320. The X-rays showed no fractures, dislocations or other bony abnormalities. PX 14, p. 391.

On May 15, 2006, Petitioner went to MercyWorks and saw Dr. Arnold for a "work comp initial visit." The doctor noted that Petitioner was in a wheelchair. He also noted that Petitioner complained of pain in his knees, ankles and left upper back secondary to a "torsional" work accident of May 12, 2006 in which Petitioner's feet slipped off the steps of a truck, causing him to twist his ankles.

On examination, Dr. Arnold noted marked swelling and a decreased range of motion in the left ankle, a mild to moderate effusion in the left knee and tenderness to palpation in the left upper back region.

Dr. Arnold diagnosed a left knee torsional injury and strains of the left ankle and left upper back. He took Petitioner off work and prescribed a left knee MRI. PX 17, p. 3.

The MRI, performed on May 19, 2006, showed a small joint effusion, moderate chondromalacia of the patella and mild lateral chondromalacia. PX 14, p. 532.

Petitioner returned to MercyWorks on May 24, 2006 and saw Dr. Sheth. On left knee examination, the doctor noted mild swelling, tenderness in the patellar area and pain with flexion and extension. On left ankle examination, he noted diffuse mild swelling and pain with range of motion. He described the back strain as "resolved." After reviewing the MRI, he recommended therapy and instructed Petitioner to remain off work. PX 17, p. 4.

Petitioner began attending therapy at Chatham Physical Therapy the same day. After three sessions, he returned to MercyWorks on June 1, 2006 and complained to Dr. Arnold of persistent left knee and left ankle pain. The doctor prescribed Hydrocodone. He instructed Petitioner to stay off work and see Dr. Maday.

On June 2, 2006, Petitioner saw Dr. Strugala (Dr. Maday's partner) at Midland Orthopaedic Associates. A handwritten history form dated June 2, 2006 (which appears to bear Petitioner's signature) sets forth an account of the May 12, 2006 accident that is consistent with Petitioner's testimony. The account reflects that Petitioner pulled his leg, ankle and the left side of his back when his foot got caught on the truck step and then came off the step. PX 14, p. 432.

Dr. Strugala noted that Petitioner was stepping off of a truck on May 12, 2006 when he caught his right foot and fell off the bottom step, twisting his left knee and ankle. He further noted that Petitioner complained of significant left ankle pain and swelling and pain over the anterior aspect of the left knee and thigh. He indicated Petitioner was using a crutch to walk.

On left knee examination, Dr. Strugala noted a trace effusion, a 10-degree flexion contracture, medial and lateral joint line tenderness, tenderness over the patella, no laxity and

good strength with extension. On left ankle examination, the doctor noted swelling, greatest over the lateral aspect, and tenderness, greatest over the ATFL.

Dr. Strugala interpreted the left knee MRI as showing a small joint effusion and mild chondromalacia of the patella but no meniscal or ligamentous tear.

Dr. Strugala diagnosed a left lateral ankle sprain and a left knee sprain. He provided Petitioner with an air cast ankle splint and instructed Petitioner to transition off the crutch. He also recommended continued therapy. He released Petitioner to seated sedentary work. PX 14, p. 347.

Petitioner continued attending therapy thereafter. On June 23, 2006, he returned to Dr. Strugala and reported improvement. The doctor noted that he was still experiencing pain and using the air splint but was "requesting return to work." He recommended a patellar knee sleeve (PX 14, p. 523) and continued therapy. He indicated it would be safe for Petitioner to resume full duty on June 26, 2006. PX 14, p. 348.

Petitioner also saw Dr. Sheth at MercyWorks on June 23, 2006, with the doctor noting Dr. Strugala's full duty release. PX 17, p. 6.

On July 11, 2006, Petitioner saw Dr. Lewis at MercyWorks. The doctor described Petitioner as "working regular job and going to physical therapy" twice weekly. On examination, he noted swelling of the left leg and ankle with tenderness of the patellar tendon and lateral malleolus. He instructed Petitioner to continue full duty and therapy and to follow up with Dr. Strugala. PX 17, pp. 6-7.

On July 21, 2006, Petitioner returned to Dr. Strugala and complained of ongoing left knee pain. On left knee examination, the doctor noted pain with flexion beyond 110 degrees. On left ankle examination, the doctor noted no swelling, mild tenderness over the peroneal tendon and good strength. He injected both of Petitioner's knees with Depomedrol and Lidocaine. He instructed Petitioner to continue therapy and allowed him to continue full duty. PX 14, p. 349.

At the next visit, on August 11, 2006, Dr. Strugala noted that Petitioner's left ankle problem was largely resolved but that he was still experiencing left knee pain. He recommended a series of Synvisc injections for the knee. PX 14, p. 350. He administered these injections on August 29, September 8 and September 15, 2006. On September 15, 2006, he noted that Petitioner reported no improvement. On September 22, 2006, he recommended that Petitioner see his partner, Dr. Nelson, for a surgical consultation. He also noted that Petitioner had recently started experiencing pain in his right knee and both ankles due to favoring his left knee. PX 14, p. 354.

Petitioner first saw Dr. Nelson on September 26, 2006. The doctor noted that Petitioner twisted his left knee and ankle while getting out of a truck on May 12, 2006 and underwent

conservative care, including Synvisc injections, thereafter. He also noted that Petitioner experienced a "severe flare-up of pain in both knees, ankle and back" a week before being seen and had been started on Colchicine. He further noted that Petitioner had a history of gout for which he regularly took Allopurinol.

On initial examination, Dr. Nelson noted a left knee effusion. He also noted that, while Petitioner appeared to have a 10-degree flexion contracture, he was able to extend Petitioner's left leg fully when Petitioner was lying on a table. He also noted tenderness in the left ankle. He attributed Petitioner's recent flare-up to gout rather than meniscal pathology. He prescribed screening lab work, to check for arthritis and gout, along with a left ankle MRI. PX 14, pp. 355, 525. The MRI, performed on September 30, 2006, was unremarkable. PX 14, pp. 533-534.

At the next visit, on November 7, 2006, Dr. Nelson described both the laboratory studies and the left ankle MRI as normal. He noted that Petitioner complained of thigh, knee and calf pain. He recommended a lumbar spine MRI, noting that Petitioner reported having a "fair amount of back pain for several days after his accident." He allowed Petitioner to continue working. PX 14, pp. 356, 526.

Petitioner also saw Dr. Arnold at MercyWorks on November 7, 2006. The doctor noted complaints relative to the left knee, left thigh, left ankle and lower back. He also noted the upcoming lumbar spine MRI. He recommended a Doppler ultrasound of both legs and released Petitioner to limited duty. PX 17, p. 11.

The lumbar spine MRI, performed on November 16, 2006, showed a circumferential contained disc herniation with mild central canal stenosis at L1-L2, no significant abnormalities at L2-L3 or L3-L4, a circumferential contained disc herniation with significant central spinal canal and moderate left neural foraminal stenosis at L4-L5 and a posterior-central contained disc herniation abutting the transversing bilateral S1 nerve roots and thecal sac at L5-S1. PX 14, pp. 535-536.

On November 20, 2006, Dr. Arnold of MercyWorks noted the MRI results and indicated that the Doppler ultrasound was negative. He continued the work restrictions and referred Petitioner to Dr. Wehner. PX 17, p. 12.

When Petitioner next saw Dr. Nelson, on November 28, 2006, the doctor described the intervening lumbar spine MRI as showing a herniation at L4-L5 causing some central canal stenosis and moderate left neural foraminal stenosis and a herniation at L5-S1 causing some pressure on the nerve root. He recommended pain management. He noted that Petitioner was "currently on a light duty status." He found this to be reasonable. PX 14, p. 357.

Petitioner also saw Dr. Arnold on November 28, 2006. The doctor noted that Petitioner was awaiting an epidural steroid injection and a visit to Dr. Wehner. He continued the work restrictions. PX 17, p. 12.

Petitioner first saw Dr. Wehner on November 29, 2006. A "new patient questionnaire" in Dr. Wehner's chart reflects that Petitioner provided a consistent history of the May 12, 2006 work accident and complained of pain in his back, both legs and left ankle. The questionnaire also reflects a history of gout in the right ankle. On a separate form, a nurse or other employee documented a history of right elbow surgery at age 21.

Dr. Wehner described Petitioner's gait as normal. She indicated Petitioner could "move about the room quite well." On examination, she noted extension to 20 degrees, negative straight leg raising, no pain with axial compression or light palpation and some pain with axial rotation.

Dr. Wehner interpreted the lumbar spine MRI as showing "some mild spinal stenosis at L4-L5." She described this as a pre-existing condition. She described Petitioner as having a "wide variety of pain complaints that do not fit into any specific clinical pattern." She recommended EMG testing of both lower extremities. She indicated Petitioner would be at maximum medical improvement for his back if the EMG proved to be negative. She found Petitioner capable of light duty pending the EMG. PX 28, pp. 13-14.

On December 4, 2006, Petitioner returned to MercyWorks and saw Dr. Arnold. The doctor noted that Petitioner's gait was normal but that he was still complaining of low back pain. He placed the epidural steroid injection on hold, ordered an EMG of both lower extremities and released Petitioner to restricted duty. PX 17, p. 12.

On December 18, 2006, Petitioner saw Dr. Shah at Mercy Hospital and underwent EMG testing. Dr. Shah noted a history of a fall in May 2006 and a history of low back pain and bilateral leg pain, left greater than right. On examination, he noted a decreased range of motion in both legs, muscle power that was difficult to assess secondary to complaints of pain and normal sensation. He described the EMG examination as essentially within normal limits. PX 14, p. 528.

Petitioner returned to Dr. Nelson on December 19, 2006. The doctor noted that Petitioner underwent an EMG and saw "a spine doctor who put a hold on the pain management." Dr. Nelson released Petitioner from care on a PRN basis, noting that Petitioner was scheduled to return to Dr. Wehner. PX 14, p. 358.

On December 27, 2006, Dr. Wehner wrote to Dr. Arnold indicating she was awaiting the EMG results. She noted that Petitioner "was initially off six weeks and then returned to work on one specific instrument that did not vibrate." She indicated that Petitioner then tried driving a clam operator for 1 ½ months but worsened due to the vibration of this vehicle. She stated that Petitioner was now on light duty and taking Lyrica and Vicodin. PX 28, p. 15.

On January 5, 2007, Dr. Wehner wrote to Dr. Arnold, referencing the negative EMG results. She described Petitioner's gait as normal and indicated that straight leg raising was negative.

Dr. Wehner noted that Petitioner continued to complain of pain in his back and left knee as well as numbness in both legs. Based on Petitioner's reported beer intake and smoking history, she theorized that the leg numbness stemmed from "some type of peripheral neuropathy." She indicated that neither the MRI nor the EMG provided an explanation for the numbness. She indicated Petitioner could continue the Lyrica but was otherwise at medical maximum improvement. She found Petitioner capable of resuming full duty. PX 28, p. 16.

Petitioner saw Dr. Wehner again on January 10, 2007. Dr. Wehner wrote to Dr. Arnold the same day, indicating that Petitioner attempted to resume full duty but was told he "could not take the Lyrica and drive the truck." Dr. Wehner indicated she advised Petitioner to take the Lyrica only at night for one week and then discontinue it. She also indicated she told Petitioner to stop drinking and smoking. She released Petitioner from care on a PRN basis. PX 28, p. 17.

A note in the MercyWorks chart reflects that Petitioner spoke with a nurse on February 14, 2007 and asked that his case be re-opened. The nurse indicated she discussed this with the Committee on Finance "and they agreed for a referral for a specialist." The nurse noted she relayed this to Petitioner and told him to call back with the name of the specialist he wanted to see. A subsequent note, dated April 26, 2007, reflects that a Dr. Tansey called MercyWorks, indicating Petitioner wanted to see him for a second opinion concerning his left leg, but that the Committee on Finance declined to authorize the referral. The note reflects that Petitioner was "treating for a right shoulder injury" as of April 26, 2007. PX 17, pp. 13-14. A third note, dated July 25, 2007, reflects that Petitioner called in and requested a referral to Dr. Nelson. A nurse case manager indicated she would pass Petitioner's request along to the Committee on Finance. PX 17, p. 14.

Records in PX 17 reflect Petitioner reported injuring his right shoulder at work on April 20, 2007 and underwent conservative care for that injury at MercyWorks until May 7, 2007, at which point Dr. Sheth released him to full duty. PX 17, pp. 15-17.

Petitioner testified he resumed his regular MTD [motor truck driver] job after Dr. Wehner released him to full duty. T. 26. Petitioner did not indicate exactly when he resumed full duty. He indicated he continued performing full duty until his second claimed work accident of **April 3, 2009.** During the interval between his return to work and this accident, he continued undergoing care at the Hammond Clinic. On June 15, 2007, he saw Dr. Hanlon at the clinic, provided a history of the accident and complained of lower back pain, left knee pain and bilateral ankle pain and "giving way." The doctor prescribed physical therapy. PX 14, pp. 505-506. On July 31, 2007, Dr. D'Angelo of the clinic imposed temporary restrictions of ground level work, no lifting over 20 pounds, no clam machine operation and no driving of clutch vehicles. PX 14, p. 510. On May 20, 2008, Petitioner underwent a repeat left knee MRI. The history

section of the MRI report reflects that Petitioner had been experiencing intermittent left knee pain ever since a work injury two years earlier in which he slipped down the steps of a truck and twisted his knee. The MRI showed mild osteoarthritis throughout the knee and a "suspected tiny inner margin radial tear in the body of the lateral meniscus." PX 17, pp. 90-91. Petitioner also underwent three lumbar epidural steroid injections, in August, October and early December 2007, and a fourth injection on July 8, 2008. He underwent a repeat lumbar spine MRI on August 31, 2008. This scan showed mild congenital spinal stenosis and a right paracentral disc herniation at L4-L5 compressing the thecal sac and the right L5 nerve root. PX 12. He underwent a right knee MRI on October 20, 2008, with the radiologist noting a minimal joint effusion and a small horizontal tear to the posterior middle horn and lateral meniscus. PX 9. PX 17, p. 88. He underwent an L4-L5 interlaminar lumbar epidural steroid injection on October 28, 2008. PX 15, pp. 220-221.

Petitioner did not testify to being involved in any car accidents but several treatment records in evidence reflect that he was rear-ended in a 3-car accident on February 6, 2009. On February 8, 2009, he saw Dr. DiFilippo at the Hammond Clinic, provided a history of the rear-end collision and complained of headaches as well as neck and back stiffness. The doctor administered a Toradol injection and took Petitioner off work for two days. PX 14, pp. 213-214. Petitioner returned to Dr. DiFilippo on February 19, 2009, at which time the doctor ordered cervical and lumbar spine MRIs. PX 14, p. 211.

Petitioner underwent the recommended lumbar spine MRI on March 12, 2009. This study showed degenerative disc disease at L1-L2, L4-L5 and L5-S1, mild central canal stenosis at L4-L5 and L5-S1 and a central disc protrusion at L1-L2 that the radiologist described as "not significantly changed." PX 13. PX 17, p. 94. A cervical spine MRI, performed the same day, showed a left paracentral and lateral disc protrusion with left neuroforaminal narrowing at C5-C6, a moderate central disc protrusion and broad-based disc bulging at C7-T1 and a "lesser degree of degenerative changes in the remainder of the cervical spine." PX 17, p. 95.

At the hearing, Petitioner had some difficulty recalling the type of vehicle he was operating at the time of his claimed **April 3, 2009** work accident. T. 28. After reviewing PX 1, a report he prepared concerning the accident, he recalled that the accident occurred after he backed his truck into a muddy area while delivering a load of wood chips to a greenhouse. He had to get out of the truck and unchain a gate in order to complete the delivery. He was swinging the gate to close it, he slipped on some rocks and fell, landing on a pile of sharp, broken cement. T. 30. The concrete jabbed his left ankle and leg, the left side of his back and his right elbow. T. 30. He lay on the ground for a while and then radioed his foreman for assistance. After a substitute driver arrived, he was taken to MercyWorks.

The MercyWorks records of April 3, 2009 reflect that Petitioner reported slipping on mud earlier that day, while closing a gate, falling onto his knees and then onto his back. The records also reflect that Petitioner reported hurting his right wrist "while trying to stop the fall." A separate handwritten note, apparently authored by Petitioner, reflects that Petitioner landed on broken cement. Petitioner was diagnosed with contusions of the right wrist, both knees and

the lumbar spine. He was released to full duty and instructed to apply ice and take Ibuprofen and Flexeril. PX 17, p. 109.

Petitioner returned to MercyWorks on April 6, 2009 and complained of pain in his lower back and both knees. The examining provider, Dr. Mejia, noted positive straight leg raising bilaterally. Dr. Mejia diagnosed a lumbar spine strain and bilateral knee strains. He released Petitioner to light duty with no driving, no lifting over 15 pounds, minimal climbing and walking and no repetitive bending, stooping, squatting, pushing, jerking, twisting or bouncing. PX 17, pp. 103-104. At the next visit, on April 13, 2009, Dr. Mejia recommended therapy and continued the previous work restrictions. PX 17, p. 101.

On April 27, 2009, Dr. Mejia reviewed the 2008 bilateral knee MRI results, continued the restrictions and scheduled Petitioner to see Dr. Maday on May 6, 2009. PX 2, p. 4. PX 17, pp. 99-100. It does not appear that Petitioner saw Dr. Maday at that time. A MercyWorks progress note dated May 6, 2009 reflects that the case was being denied per the Committee on Finance. PX 2, p. 2.

On November 11, 2009, Petitioner saw Dr. Kondamuri at the Surgical Hospital of Munster. The doctor noted that Petitioner complained of neck pain of two years' duration and lower back pain since 2003, with that pain extending "beyond his bilateral knees into his ankle and foot on the right side and up to the mid-leg on his left side." The doctor indicated that Petitioner described his back pain as having worsened secondary to driving a truck at work.

Dr. Kondamuri described Petitioner's gait as normal and straight leg raising as negative. He recommended a bilateral L4 transforaminal epidural steroid injection, which he performed two days later. PX 14, pp. 163-164.

Petitioner testified he could not recall whether he lost time from work due to his claimed work accident of April 3, 2009. [No lost time is claimed in 09 WC 35952.] He was able to recall that he resumed full duty at some point after that accident and continued performing full duty until his third accident of March 29, 2010. T. 34. [It is not clear whether Petitioner filed a claim for this accident. The Arbitrator discusses the treatment Petitioner underwent after this accident because that treatment bears on causation-related issues in the last case, 12 WC 28370.] After reviewing an accident report he prepared (PX 3), Petitioner testified that, on March 29, 2010, he was walking around outside one of Respondent's garages, trying to find his assigned garbage truck, when he slipped and fell. T. 36. After he got up, he initially noted hand soreness. He began driving and then noticed that he was having difficulty using the gas and brake pedals because his ankles were "real swollen." He called his foreman and requested a relief driver but no one was available. He managed to finish the workday and then met with his foreman, who completed a report and allowed him to go to MercyWorks. T. 37-38. He was also experiencing knee problems. T. 38.

The MercyWorks records reflect that Petitioner saw Dr. Diadula on March 29, 2010. The doctor described the work accident of that date as follows:

> "The patient is a 50-year-old male, a motor truck driver, who states that while he was walking he did not see the hole because there was a big board around it. He tripped on the board and then fell in the hole. He hit his right wrist against the back of the truck. When he went down to the ground, the knees hit the rim and the ankles went down behind him."

Dr. Diadula noted that Petitioner complained of 10/10 pain in his right wrist, both knees and both calves, 9/10 pain in his right ankle and 10/10 pain in his left ankle. He also noted a history of a meniscal tear in 2008 and a back injury in 2009.

On initial examination, Dr. Diadula noted right wrist swelling, with no abrasions or ecchymoses, a complaint of numbness in the right fifth digit, tenderness in the infrapatellar area of the right knee and quadriceps, slight swelling in the right calf, swelling of the left knee with no abrasions or ecchymoses, left calf tenderness with no swelling abrasions or ecchymoses and tenderness and swelling of both ankles.

Dr. Diadula obtained X-rays of the right wrist, both knees and both ankles. He indicated that none of these X-rays showed fractures on preliminary reading. PX 11.

Dr. Diadula diagnosed multiple contusions of the right wrist and both knees, bilateral ankle sprains, right worse than left, and bilateral calf strains. He took Petitioner off work and prescribed Extra Strength Tylenol or Vicodin. He instructed Petitioner to wear a wrist brace, ankle supports and knee braces, if available. PX 17, pp. 18-19.

Petitioner returned to MercyWorks on April 2, 2010 and again saw Dr. Diadula. The doctor indicated that the final X-ray reports did not document any fractures. He again noted a complaint of right wrist pain which was "now radiating to the right elbow and right shoulder," along with a complaint of numbness in the right fourth and fifth digits. He also noted complaints referable to both knees, both calves and both ankles. He continued the medications and instructed Petitioner to remain off work and see Dr. Maday for his knees. PX 17, p. 19.

Petitioner continued seeing Dr. Diadula at MercyWorks thereafter, while also seeing the following doctors at Dr. Diadula's referral: Dr. Maday (for the knees), Dr. Heller (for the right wrist) and Dr. Perns for his ankles. On April 14, 2010, Dr. Maday obtained a history of a fall at work on March 30, 2010, with Petitioner indicating he struck both knees on the ground. Dr. Maday noted that Petitioner had recently undergone bilateral knee MRIs but that he did not have the films or reports. He took Petitioner off work, recommended a home exercise program and indicated he would try to obtain the MRI results. On April 21, 2010, after reviewing the knee MRIs (PX 10), he diagnosed bilateral knee pain, a right knee lateral meniscus tear and a left knee cartilaginous injury. He recommended a right knee arthroscopy and partial lateral meniscectomy. Dr. Kucharzyk recommended bilateral knee surgery on June 16, 2010, noting that Petitioner was awaiting a second opinion examination "by his work comp carrier."

Coventry, Respondent's utilization review provider, deemed right knee surgery medically necessary but Respondent did not authorize it based on a causation opinion rendered by Dr. Raab, a Section 12 examiner, on June 21, 2010. On April 23, 2010, Dr. Heller noted that Petitioner struck his right arm against a truck in a work fall of March 29, 2010. He indicated Petitioner was complaining of right elbow pain and burning and tingling extending to the right little finger. He also obtained a history of right elbow surgery many years earlier. He indicated that Petitioner "seems to have post-traumatic right elbow ulnar neuritis from striking his elbow against a truck." He recommended a right upper extremity EMG. The first EMG was aborted at Petitioner's request. On May 10, 2010, Dr. Heller noted that the EMG had not been completed. He recommended an elbow pad and instructed Petitioner to avoid prolonged elbow flexion. He released Petitioner from care on a PRN basis. On September 3, 2010, Petitioner saw Dr. Altamimi at the Hammond Clinic for multiple complaints, including lower back and left leg pain. Dr. Altamimi noted a history of a fall at work in 2006. He also noted that Petitioner was using a cane, wearing a back support and taking opioids per his personal physician. He indicated Petitioner refused to undergo another EMG at that time to evaluate his pain and reported leg weakness. PX 14, pp. 49-51. Dr. Levin examined Petitioner on October 12, 2010, in connection with the March 29, 2010 accident. He recommended an EMG to evaluate the right elbow and found Petitioner to be at maximum medical improvement with respect to his ankles. He found no causal relationship between the March 29, 2010 accident and the ankle condition. RX 3. On December 3, 2010, Dr. Levin issued a second report in which he opined that Petitioner's right wrist pain was "coming from referred pain at the elbow." RX 4. Petitioner was able to complete an EMG on January 6, 2011. It showed an "advanced stage of ulnar CMAP demyelination" and bilateral pathology involving the C6 and C7 nerve roots, with the examiner, Farshad Barkhordar, D.C., indicating he could not rule out early diabetic neuropathy. In his report, Barkhordar noted that Petitioner had been diagnosed with diabetes in March 2010. PX 17, pp. 26-28. Based on the EMG, Dr. Diadula opined that Petitioner's right wrist condition was not work-related. On January 14, 2011, Dr. Diadula discussed the various causation-related opinions with Petitioner and released Petitioner to full duty, "per the IME," commenting as follows: "if patient is off work, it is due to a non-work-related condition." PX 17, p. 25.

Petitioner testified he took a medical leave of absence from Respondent between January 17, 2011 and January 17, 2012. He testified that, during that year, he underwent repeat lumbar spine MRIs and surgery on both ankles and both knees. He indicated that Dr. Karcrzyk, a physician associated with the Hammond Clinic, performed these surgeries. T. 42-43. The surgeries took place at Franciscan Physicians Hospital.

Records in PX 21 reflect that Petitioner saw Dr. Mark Chang on April 26, 2011 for what is described as a return visit. Dr. Chang described Petitioner as returning "with new information" and continuing to experience "a lot of neck pain, right arm pain and numbness and tingling in both fingers." He noted he had last seen Petitioner for similar symptoms in March 2009. He also noted that Petitioner had been off work since March 2010 secondary to a motor vehicle accident of February 6, 2009. He described a recent cervical spine MRI as showing a moderate left C5-6 disc herniation, broad base bulging at C6-C7 and a broad base herniation at C7-T1. He described a recent EMG as showing "bilateral C6 and C7 radiculopathies."

Dr. Chang noted that Petitioner was "scheduled for lumbar spine surgery," pending a repeat lumbar spine MRI. He indicated Petitioner should remain off work pending the results of this MRI. He also indicated he discussed the possibility of cervical spine surgery with Petitioner, noting that such surgery would be "fairly extensive." PX 21, p. 6.

A lumbar spine MRI performed on May 13, 2011 showed "multi-level degenerative changes with a central disc protrusion and annular tear at L5-S1 and small central disc protrusion at T12-L1 along with mild to moderate central spinal canal stenosis." PX 18, p. 21.

On October 11, 2011, Petitioner underwent a left S1 transforaminal epidural injection and a right S1 transforaminal epidural injection at Franciscan Physicians Hospital. Dr. Desari administered these injections. PX 15, pp. 189-190. An accompanying patient data form, apparently completed by Petitioner, reflects complaints of bilateral hip pain radiating down the right leg and across the left knee and ankle. The form reflects that Petitioner rated his current pain level at 7/10.

Petitioner testified he resumed working for Respondent in January 2012. When he returned to work, he was assigned to drive a newer garbage truck in the 16th ward. His duties consisted of pre-checking the truck, to make sure the hopper was empty and the flippers and lights were working, driving laborers to various alleys, and dumping loads of garbage. He testified there was "a lot of heavy garbage," including downed trees in his assigned area. Petitioner testified he was able to perform his assigned duties until **June 4, 2012**, when he sustained another accident.

Records in PX 15 reflect that Petitioner was admitted to Franciscan Physicians Hospital on April 3, 2012 due to an "exacerbation of low back pain radiating down the anterior thighs to his knees and lateral ankles." The admitting history reflects that Petitioner's current symptoms were similar to those he had experienced in October 2011, when he underwent a lumbar epidural steroid injection. Petitioner reported obtaining about two months of pain relief following that injection. Petitioner rated his current back pain level at 8/10. The admitting nurse indicated that Petitioner appeared "extremely uncomfortable" and was "walking very stiffly in a forward flexed position." The nurse noted that Petitioner had been seen in the Emergency Room in January, at which time he was given a Medrol Dose-Pak due to increased low back and leg pain.

Dr. Dasari administered a left S1 transforaminal epidural steroid injection and a right S1 transforaminal epidural steroid injection on April 10, 2012. PX 15, pp. 77-78. An accompanying patient data form, apparently completed by Petitioner, reflects that Petitioner underwent an injection that provided temporary relief, returned to work in January 2012 and was experiencing back and leg pain when driving his truck and getting in and out of the truck. PX 15, pp. 80-84.

Petitioner testified that, on **June 4, 2012**, a "superhero" garbage man on his crew somehow put the contents of ten alleys into the truck he was driving. The contents included heavy items such as desks and dressers. Petitioner testified that, as he was driving the overloaded truck over speed bumps and potholes in the alleys, his back started to tingle. He adjusted the air seat but the seat "just kept slamming." He resumed driving and went over a few more bumps, at which point his back "locked up," causing him to feel as if he were paralyzed. T. 44-48. He could not bend his left leg. T. 48. He called his foreman and reported that he had hit some bumps and was unable to move his left leg. The foreman came to the scene, as did the ward boss, paramedics and firefighters, who had to extricate him from the truck. T. 48-49. He was taken to Holy Cross Hospital via ambulance. T. 48-49.

The Holy Cross Emergency Room records of June 4, 2012 reflect that Petitioner was driving a garbage truck earlier that day when he hit a few bumps, struck his left knee against the dashboard and "began having severe back pain radiating to L knee." PX 16, p. 7. The triage nurse also noted a history of chronic back pain and herniated disc and bilateral knee and ankle surgeries. PX 16, p. 7. The examining physician, Dr. Elmosa, noted moderate lumbar spine tenderness, moderate diffuse left knee tenderness, a full range of left knee motion, no laxity and negative straight leg raising bilaterally. PX 16, p. 8. Dr. Elmosa obtained lumbar spine and left knee X-rays. The lumbar spine X-rays showed degenerative arthritic changes with possible degenerating intervertebral discs at L4-L5 and L5-S1. PX 16, p. 13. Petitioner was given Dilaudid and Valium for pain. At discharge, Petitioner was given a prescription for Hydrocodone and was instructed to follow up with Dr. Schiappa. PX 16, p. 16.

Petitioner testified he sought follow-up care at MercyWorks. He saw Dr. Anderson there on June 6, 2012. Dr. Anderson recorded a consistent history of the June 4, 2012 accident and noted that Petitioner complained of 10/10 pain in his lower back radiating down his left leg beyond the knee "but with most pain at the left knee area." Dr. Anderson also noted a "significant history of chronic lower back pain." He reviewed Petitioner's past medical records, noting that Petitioner had undergone bilateral knee and ankle surgery while on leave and that a doctor had discussed a lumbar fusion with him during this same period. He noted that Petitioner reported "working with chronic lower back pain" since returning to work in January 2012.

Dr. Anderson noted that Petitioner was using a crutch to walk and appeared to be in moderate distress secondary to left-sided lower back pain. On lumbar spine examination, he noted tenderness from L1 to S1, left greater than right, restricted forward bending and positive straight leg raising on the left. He noted no warmth or effusion on left knee examination.

Dr. Anderson diagnosed a lumbar strain, history of degenerative disc disease and left radiculopathy. He instructed Petitioner to apply ice, decrease the Hydrocodone and continue taking Skelaxin and using Lidoderm patches. He took Petitioner off work and instructed him to present his MRI reports at the next visit. PX 18, p. 5.

At the next visit, on June 13, 2012, Dr. Anderson noted that Petitioner was now using two crutches and complaining of 9/10 lower back pain, left greater than right and "down left leg to ankle." He also noted that Petitioner planned to see Dr. Frank Phillips at Rush. He refilled the Hydrocodone prescription, arranged for Petitioner to undergo a lumbar spine MRI and kept Petitioner off work.

The MRI, performed on June 18, 2012, demonstrated "multi-level vertebral column curvature/alignment abnormalities, degenerative disc disease and facet arthropathy, with associated central spinal canal stenosis and neural foraminal narrowing," along with "moderate diffuse atrophy of the paraspinal musculature. PX 18, p. 12.

On June 20, 2012, Dr. Anderson reviewed the MRI results. He again noted that Petitioner was using crutches and planned to see Dr. Phillips. He kept Petitioner off work and discharged him from care "per company protocol." PX 18, p. 6.

Petitioner first saw Dr. Phillips on June 26, 2012. Following this evaluation, Dr. Phillips sent a lengthy letter to Dr. Anderson of MercyWorks. In this letter, Dr. Phillips noted a "long history of back problems" dating back to 2009 and recently aggravated on June 4, 2012 "while working on a truck for six hours, bouncing around." He noted that Petitioner complained of severe axial back pain in a sciatic distribution radiating down his left leg. He further noted that Petitioner was using crutches to walk. He described Petitioner's bilateral knee problems as another "significant pain generator."

Dr. Phillips described Petitioner as standing with a kyphotic posture and being unable to heel or toe walk. He indicated that, on initial examination, he noted "obvious lumbar tenderness to palpation with paralumbar spasm" and reduced flexion and extension. He interpreted the June 18, 2012 lumbar spine MRI as showing "advanced disc degenerative changes primarily at L4-L5 and L5-S1," some disc desiccation and a central disc protrusion at L1-L2, moderate stenosis at L2-L3, facet hypertrophy and severe stenosis at L3-L4, facet hypertrophy, diffuse bulging and severe stenosis at L4-L5 and a small, non-compressive central disc prolapse at L5-S1. He described lumbar spine X-rays taken that day as showing "advanced disc degenerative changes at L4-L5 and L5-S1 where is complete bone-on-bone disc space collapse."

Dr. Phillips described Petitioner as becoming "more and more disabled, particularly after the recent aggravation of his symptoms related to the truck driving this year." He indicated that Petitioner's very severe stenosis was limiting his ability to walk or even stand upright. He further indicated that Petitioner was "unable to function" in his current state and needed surgery. He recommended a lumbar laminectomy across the stenotic levels, from L1 down to S1, and a fusion at L4 to S1 to address Petitioner's "severe axial back pain as well as the advanced disc degenerative changes." He anticipated having to perform "considerable facet removal," given the severity of the stenosis at L4-L5. PX 18, pp. 7-9; PX 19, pp. 29-30. He took Petitioner off work, pending this surgery. PX 19, p. 28.

On August 1, 2012, Dr. Phillips performed surgery consisting of posterior spinal decompression of levels L3-L4, L4-L5 and L5-S1, with laminectomy and bilateral foraminotomies and a posterior fusion at L4-L5 with instrumentation and pedicle screws. PX 19, pp. 31-34.

Following the surgery, Petitioner returned to Dr. Phillips on August 15, 2012. On that date, Dr. Phillips noted that Petitioner was "still in a considerable amount of pain" and was relying on crutches. Dr. Phillips encouraged Petitioner to increase his activity level and begin walking on a regular basis. After Petitioner reported some bilateral leg weakness, especially when attempting to stand, Dr. Phillips provided him with a walker "in exchange for the crutches." Dr. Phillips indicated that Petitioner's reported leg weakness was "not neurological because when he is tested he has 5/5 strength in [both] lower extremities."

Dr. Phillips refilled Petitioner's Norco, discontinued the Valium and started Petitioner on Flexeril. He obtained lumbar spine X-rays and later interpreted them as confirming "an L4 to sacrum fusion construct," appropriate placement of the pedicle screws and adequate decompression. He was able to visualize posterolateral bone from L4 to S1. PX 19, p. 24.

Dr. Phillips noted that Petitioner presented a letter indicating he had been scheduled to attend an IME on August 20, 2012. Dr. Phillips indicated that Petitioner was "still too fresh post-operative to be undergoing any kind of physical examination." PX 19, p. 27. He issued a letter indicating that Petitioner was still in pain and recovering from surgery. He stated that Petitioner "should not be scheduled for an IME at this time as it will be a disservice to both the patient and the examiner." PX 19, p. 25.

Dr. Phillips instructed Petitioner to remain off work for the time being. PX 19, p. 26.

At Respondent's request, Petitioner saw Dr. Graf for a Section 12 examination on September 1, 2012. In his lengthy report of the same date, Dr. Graf indicated he obtained a history from Petitioner, examined Petitioner's thoracic/lumbar/sacral spine and reviewed multiple treatment records (from 2009 through June 26, 2012) and lumbar spine MRI reports along with a City of Chicago Injury on Duty report dated June 8, 2012. Dr. Graf referenced records indicating Petitioner saw a spinal surgeon, Dr. Talman, at some point while he was on medical leave, between January 17, 2011 and January 17, 2012, with that physician recommending a lumbar fusion. Dr. Graf indicated that the recommended fusion could not be performed at that point because Petitioner "had no more medical leave time available" and thus had to return to work in January 2012.

Dr. Graf described Petitioner as obese, based on a height of 6 feet and a weight of 274 pounds. He indicated that Petitioner seemed to have difficulty getting out of a chair but exhibited a normal gait. He indicated that Petitioner could stand on his heels and toes and refused to attempt squatting secondary to left knee pain.

On thoracic/lumbar/sacral spine examination, Dr. Graf noted no paraspinal spasm or pain to palpation. He deferred forward bending and extension secondary to the recent surgery.

He described distracted sitting straight leg raising and supine straight leg raising as negative bilaterally.

Dr. Graf indicated that, because he perceived Petitioner as targeting an accident of 2009 and because he had only been provided with records from 2009 through June 26, 2012, he was unable to render an opinion as to whether the accident of June 4, 2012 caused an exacerbation. He asked that the missing records be sent to him along with Petitioner's imaging studies. He stated that, regardless of causation, Petitioner was currently totally disabled. He further stated it would be reasonable for Petitioner to undergo three months of therapy following the recent fusion. RX 5.

Petitioner returned to Dr. Phillips on September 4, 2012. On that date, Dr. Phillips sent Coventry a letter indicating Petitioner was still having some axial back pain but was "actually doing reasonably well." Dr. Phillips also indicated that Petitioner was "still using crutches for reasons that are unclear." He instructed Petitioner to stop using the crutches within the next week or two. He noted that Petitioner reported walking three to four blocks at a time. He obtained repeat X-rays, which showed good positioning of the surgical hardware and bone formation. He instructed Petitioner to return in a couple of months, at which point he anticipated prescribing formal therapy. PX 19, p. 23.

On October 15, 2012, Dr. Graf issued a lengthy addendum, after reviewing additional information consisting of MercyWorks records dating back to May 15, 2006, two reports from Dr. Raab, Dr. Phillips' operative report of August 1, 2012, Dr. Phillips' post-operative notes through September 4, 2012 and various lumbar spine MRI and X-ray films from 2011 and June 18, 2012.

Based on his previous examination, record review, Petitioner's history, a MercyWorks note of June 6, 2012 indicating Petitioner reported "working with chronic low back pain" and Dr. Phillips' initial note, referencing a long history of back pain dating to an injury in 2009, Dr. Graf opined that Petitioner's low back pain pre-dated June 6, 2012 and "bears no relation to driving over a speed bump."

Petitioner testified that Respondent discontinued paying temporary total disability and medical benefits following Dr. Graf's examination. T. 51. The Request for Hearing form in this case shows that Respondent paid no temporary total disability benefits. Arb Exh 3.

Petitioner returned to Dr. Phillips on November 6, 2012. The doctor again described Petitioner as doing reasonably well. He noted that Petitioner was still experiencing back pain, "particularly as the day goes on." On examination, he noted 40 degrees of flexion and 30 degrees of extension. Repeat X-rays confirmed the fusion construct but showed that the posterolateral bone was "not yet incorporated." Dr. Phillips indicated he was going to have Petitioner start therapy in about three weeks "just to give the fusion some more time to consolidate." He anticipated that Petitioner would reach maximum medical improvement

about eight months post-fusion. PX 19, p. 22. He continued to keep Petitioner off work. PX 19, p. 20.

Petitioner returned to Dr. Phillips on January 17, 2013, having started physical therapy in the interim. Dr. Phillips noted that Petitioner had "little in the way of back pain" but complained of pain in the area of the coccyx, especially after sitting for a while. He noted that Petitioner described his work injury as involving a prolonged period of "jarring in his truck," resulting in a possible tailbone injury. On examination, he noted tenderness toward the coccygeal area and a good range of lumbar spine motion. Repeat X-rays confirmed the fusion construct and showed some posterolateral bone. Dr. Phillips prescribed a donut pillow to use when sitting. He referred Petitioner to Dr. King, a pain specialist, for evaluation for possible coccygeal injections. He instructed Petitioner to stay off work and continue therapy. PX 19, p. 19.

On February 26, 2013, Petitioner underwent a caudal epidural steroid injection at Franciscan Physicians Hospital. Dr. Dasari administered this injection. The doctor's procedure report lists the following diagnoses: failed back surgery syndrome, lumbar radicular pain and coccydynia. PX 15, pp. 33-34. An accompanying history form, apparently completed by Petitioner, reflects a history of low back pain dating back to 2006, a work accident on June 8, 2012 and a multi-level fusion on August 1, 2012. PX 15, pp. 36-38. Petitioner testified he ended up using his group insurance to undergo the February 26, 2013 injection. T. 56.

Petitioner returned to Dr. Phillips on March 19, 2013 and reported improvement following an injection by a local pain physician a month earlier. Dr. Phillips noted that Petitioner was "anxious to try some therapy as he is feeling much better since the injection and his therapy prior was limited by his discomfort." On examination, Dr. Phillips noted about 60% of lumbar range of motion. Repeat X-rays showed adequate decompression, good positioning of the pedicle screw instrumentation and some posterolateral bone, "more robust on the right." Dr. Phillips recommended that Petitioner do an additional month of therapy now that he was feeling better. He indicated that, in the interim, Petitioner could return to light duty with no lifting over 30 pounds, no repetitive bending and no commercial garbage truck driving "because of the jarring involved." He indicated Petitioner should return for new X-rays in about three months. He further indicated that a functional capacity evaluation might be appropriate at that point, depending on the X-ray results. PX 19, p. 15.

Dr. Phillips testified by way of evidence deposition on May 21, 2013. PX 29. Dr. Phillips testified he attended medical school in South Africa, did an orthopedic surgery residency at the University of Chicago Hospital and then underwent fellowship training in spine surgery at Case Western. PX 29 at 5. He initially practiced spine surgery at the University of Chicago but has been affiliated with Rush University during the last ten years. PX 29 at 5. He obtained board certification in orthopedic surgery in 1997 and was re-certified in 2007. He has published many book chapters and articles in peer-reviewed publications. Phillips Dep Exh 1.

Dr. Phillips testified that Petitioner provided a history of "intermittent back and leg pain since 2009" at the initial appointment of June 26, 2012. Petitioner also related that, most recently, he had suffered an acute flare-up of his pain on June 4, 2012, while "bouncing around" in a work truck for six hours. PX 29 at 6. As of June 26, 2012, Petitioner was relying on a crutch to walk and could not walk any significant distance. PX 29 at 7. His gait was unsteady and he stood with a kyphotic posture, meaning he was leaning forward. PX 29 at 7. He had a limited range of motion, particular in extension, and decreased strength in the L4-L5 distribution. PX 29 at 7.

Dr. Phillips testified he reviewed a lumbar spine MRI of June 18, 2012. This MRI showed "advanced degenerative changes really throughout the lumbar spine." Dr. Phillips opined that Petitioner's severe symptoms were consistent with this imaging study. Petitioner had failed conservative care and was essentially nonfunctional so he recommended surgery. PX 29 at 8. The surgery he performed on August 1, 2012 consisted of a laminectomy or decompression from L3 down to S1 and then a fusion at L4-S1 with screws. PX 29 at 9.

Dr. Phillips testified that Petitioner's condition as of June 26, 2012 required him to be off work. PX 29 at 10, 20.

Dr. Phillips testified that Petitioner's leg symptoms improved postoperatively. Petitioner continued to have back pain but it was improved. PX 29 at 11. Large, overweight individuals such as Petitioner can experience more back pain postoperatively but their size "probably shouldn't compromise the long-term result." PX 29 at 12.

Dr. Phillips testified that, on January 17, 2013, he prescribed therapy and referred Petitioner to Dr. King for possible coccygeal injections. On that date, he continued to keep Petitioner off work. PX 29 at 14. On a form dated January 17, 2013, he answered "yes" in response to a question asking whether the diagnosis and treatment were causally related to the work accident. PX 29 at 14.

Dr. Phillips testified he last saw Petitioner on March 19, 2013. Petitioner was doing "okay" at that point. He had improved since undergoing an injection by a local pain physician. He wanted to try additional therapy so the doctor prescribed another month of therapy. PX 29 at 15. He also released Petitioner to light duty. PX 29 at 16. He understands that Petitioner works as a garbage truck driver for the City of Chicago. PX 29 at 16. Petitioner is scheduled to return to him in June 2013. PX 29 at 16.

Dr. Phillips testified Petitioner may have told him he hit some speed bumps in alleys on June 4, 2012. He is familiar with alley speed bumps and has had an occasion to drive over them. The sciatic pain Petitioner had in his left leg after the June 4, 2012 accident seemed to more of an acute manifestation.

Dr. Phillips testified he based part of his causation opinion on the fact that Petitioner was able to work before the June 4, 2012 accident. PX 29 at 19. He operated on Petitioner's

back to address the symptoms that, by history, Petitioner developed after the June 4, 2012 accident.

Dr. Phillips testified his surgical charges were reasonable and consistent with the charges of other surgeons in the Chicago area. PX 29 at 21.

Dr. Phillips testified he skimmed Dr. Graf's two reports. He is aware that Dr. Graf identified complaints of back pain dating back to 2006. PX 29 at 22. He (Dr. Phillips) has prepared IME reports of his own. PX 29 at 22. He did not study Dr. Graf's reports in any detail but he saw nothing in them that caused him to change his own opinions. PX 29 at 24.

Under cross-examination, Dr. Phillips acknowledged that the lumbar spine MRI report of June 18, 2012 references an earlier MRI of November 16, 2006. PX 29 at 25. He further acknowledged he has not seen the films or reports concerning either the 2006 MRI or the two lumbar spine MRIs performed in 2011. PX 29 at 25. He is not sure whether Petitioner used the phrase "chronic pain" at the initial visit in June 2012 but Petitioner readily indicated he had been experiencing back and leg pain since 2009. PX 29 at 25.

Dr. Phillips testified that his initial note of June 26, 2012 is in the form of a letter directed to Dr. Anderson. He believes Dr. Anderson referred Petitioner to him. PX 29 at 25-26. He did not review any of Dr. Anderson's records prior to examining Petitioner on June 26, 2012. PX 29 at 26. Nor did he review any other prior records. The only prior care he is aware of is that summarized by Dr. Graf in his IME reports. PX 29 at 26. Petitioner indicated he had sustained a back injury or aggravation in 2009 but he did not describe the circumstances of this injury. PX 29 at 26. The lumbar spine films he obtained on June 26, 2012 showed degenerative changes. Petitioner's spinal stenosis is certainly degenerative in nature. PX 29 at 27. His operative report of August 1, 2012 reflects post-operative diagnoses of stenosis at three levels and spondylolisthesis at L4-L5 and L5-S1. He also documented a dural defect. That defect was not degenerative in nature. Such defects typically result from injections, not acute injuries. PX 29 at 27.

Dr. Graf testified by way of evidence deposition on August 19, 2013. RX 7. Dr. Graf is a board certified orthopedic surgeon and fellowship-trained spine surgeon. RX 7 at 4-5. Graf Dep Exh 1. He also holds board certification in independent medical evaluations. RX 7 at 5. He devotes about 10 to 15% of his practice to medical-legal reviews. RX 7 at 7. He did not independently recall Petitioner. RX 7 at 7-8. He relied on his reports to testify. RX 7 at 8-9.

Dr. Graf testified that one of the reports he reviewed in connection with his own evaluation revealed that Dr. Talman had offered Petitioner a spinal fusion before the June 2012 accident, during a period when Petitioner was off work and undergoing knee surgery. RX 7 at 15. Per this report, Petitioner did not undergo the fusion at that time because he was running out of medical leave time. RX 7 at 15.

Dr. Graf testified that Petitioner's verbal account of the June 4, 2012 work accident was consistent with both a written accident report and the MercyWorks records. RX 7 at 16.

Dr. Graf testified that Petitioner's lumbar spine radiographic studies were consistent with "advanced disc degenerative changes," not an acute process. RX 7 at 17.

Dr. Graf testified he is familiar with the surgery Dr. Phillips performed because he performs similar surgeries all the time. RX 7 at 19.

Dr. Graf opined that Petitioner's lumbar spine condition pre-existed the June 4, 2012 accident and was not causally related to that accident. RX 7 at 21. Dr. Graf also found no causal relationship between Petitioner's lumbar spine condition and the general demands of his job. RX 7 at 21. The surgery Dr. Phillips performed was not necessitated by the June 4, 2012 accident because the same surgery had been recommended to Petitioner before the accident. RX 7 at 21. Petitioner's obesity could possibly have increased his disc degeneration. RX 7 at 22.

Under cross-examination, Dr. Graf conceded he did not ask Petitioner how long he had been back to work before the June 4, 2012 accident. RX 7 at 23. He is aware that Petitioner drove a garbage truck. He has seen but never driven such a truck. RX 7 at 23. In his opinion, the June 4, 2012 accident caused no symptoms whatsoever. RX 7 at 24. The surgery Dr. Phillips performed was necessary but unrelated to the June 4, 2012 work accident. RX 7 at 24-25.

On redirect, Dr. Graf testified there was nothing in the medical records that would lead him to conclude Petitioner's truck driving duties caused his symptoms. RX 7 at 25.

Under re-cross, Dr. Graf indicated he did not know how long Petitioner drove a garbage truck for Respondent. Petitioner told him he had been off work for a long instance and then had started back again before the accident. RX 7 at 26.

Itemized billing in PX 30 reflects Petitioner underwent physical therapy at ATI from August 22, 2013 through September 27, 2013. Petitioner testified he had to switch from NovaCare to ATI and undergo therapy there because the therapy at NovaCare was not being paid for. T. 53.

At Dr. Phillips' recommendation, Petitioner underwent a functional capacity evaluation at ATI on October 23, 2013. T. 52. The evaluator, Jason Lemley, ATC, CWcHP, rated the evaluation as valid "based upon the objective data that was collected and the formulas using that data." Lemley indicated that Petitioner demonstrated physical abilities consistent with a light physical demand level, meaning he could occasionally lift 17 pounds from chair to floor level, 23 pounds from desk to chair level and 19 pounds above shoulder level. He described Petitioner's motor truck driver job with Respondent as typically falling within a medium physical demand level, with occasional lifting up to 50 pounds. He noted that he did not receive a specific job description prior to the evaluation. Lemley also noted that he

recommended Petitioner follow up with his physician based on his ongoing complaints of lower back pain with activities such as squatting, bending, walking and extended sitting. PX 27.

On November 6, 2013, Dr. Phillips wrote a note addressed "to whom it may concern" indicating he had reviewed the functional capacity evaluation and felt the results to be a "reasonable representation" of Petitioner's physical demand level. Dr. Phillips also indicated he believed the restrictions outlined in the evaluation were "likely to be in effect permanently." PX 19, p. 104.

Petitioner testified that Respondent never offered him light duty per the functional capacity evaluation. T. 52. He further testified he has been off work since June 4, 2012.

Petitioner testified he continues to experience pain and swelling in his left ankle and cramping in his left calf. T. 53-54. His left knee "snaps" at times and he feels as if there is something floating inside the knee. He underwent a repeat left knee MRI and was told it did not show any remaining problem. T. 54. He underwent carpal and cubital tunnel releases at Hammond Clinic within the last year. T. 54-55. His activities are very limited secondary to his back pain. He avoids bending. He applies Lidoderm lotion to his back and knees. He also takes prescription pain medication.

Petitioner testified that PX 8, a written job description, does not accurately describe the lifting he was required to perform as a motor truck driver. PX 8 states a motor truck driver is required to lift 35 pounds but he was required to lift 200 pounds. T. 57.

Under cross-examination, Petitioner acknowledged receiving a settlement equivalent to 6% loss of use of the person in a case numbered 87 WC 34499. That case involved an accident he sustained while driving a dump truck for Consolidation Excavating. T. 58. He suffers from diabetic neuropathy. T. 58. He underwent several examinations at Respondent's request. T. 59. He provided the examining physicians with accurate information. T. 59.

[CONT'D]

Russell Rosiak v. City of Chicago
06 WC 30029

Arbitrator's Credibility Assessment

Petitioner's account of his May 12, 2006 work accident was detailed and supported by the histories that appear in the Hammond Clinic and MercyWorks records.

There was a slight discrepancy between Petitioner's account of his pre-accident state of health (T. 20) and his treatment records, with one record showing that Petitioner underwent a work-up for gout in his right ankle in April 2006. Overall, however, there is no evidence indicating Petitioner underwent any significant care for his knees or ankles before the accident.

The Arbitrator found Petitioner credible.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on May 12, 2006 arising out of and in the course of his employment by Respondent?

The Arbitrator finds that Petitioner met his burden of proof on the issue of accident. Petitioner testified he was injured at the end of his workday, when he returned to his assigned truck in order to retrieve a bag. He credibly testified he climbed onto the truck, grabbed his bag, turned in order to start his descent and then lost his footing. He attributed this to a build-up of oil, anti-freeze and other substances on his shoes. As he fell, he grabbed onto a door handle in order to avoid landing on a chip and was "yanked back."

Respondent maintains it is unclear whether the accident occurred before or after Petitioner punched out for the day. In fact, Petitioner testified he realized his bag was missing while he and his co-workers were sitting in a building, waiting to punch out. T. 17. Regardless, the Appellate Court has held that the term "employment" contemplates not only actual work time but a reasonable time before commencing and after concluding actual employment. Christman v. Industrial Commission, 159 Ill.App.3d 479, 482 (3rd Dist. 1987). Petitioner was in Respondent's yard, retrieving a necessary item, when the accident took place.

The Arbitrator finds that Petitioner established a compensable work accident of May 12, 2006.

Did Petitioner establish a causal connection between his accident of May 12, 2006 and his current condition of ill-being?

The Arbitrator finds that the accident of May 12, 2006 resulted in left ankle and left knee sprains which remained symptomatic after Petitioner resumed full duty (at his own

request) in late June 2006. The Arbitrator finds that Petitioner failed to establish a causal connection between the accident and his claimed current lumbar spine condition of ill-being. The MercyWorks records show that, following the accident, Petitioner complained of pain in his left upper back, secondary to twisting as he tried to avoid falling off the truck. Those records also show that Dr. Sheth viewed the back problem as having resolved on May 24, 2006. It was much later, in late September 2006, that Petitioner began voicing lower back complaints. He attributed these complaints to the accident but the medical evidence does not support a finding of causation between the May 12, 2006 accident and Petitioner's current lumbar spine condition of ill-being.

Is Petitioner entitled to temporary total disability benefits?

The Arbitrator, having found that Petitioner established a compensable accident and causation as to left ankle and left knee sprains, and in reliance on the MercyWorks records, finds that Petitioner was temporarily totally disabled from May 15, 2006 through June 25, 2006, a period of 6 weeks, with Respondent receiving credit for the $4,143.72 in benefits it paid. Arb Exh 1. The Arbitrator awards these benefits at the rate of $533.33 per week based on the stipulated average weekly wage of $800.00. Arb Exh 1.

The MercyWorks records show that Dr. Arnold took Petitioner off work on May 15, 2006. Dr. Strugala subsequently released Petitioner to sedentary duty but there is no evidence indicating Respondent provided same. Dr. Strugala's records show that, on June 23, 2006, Petitioner reported improvement and asked to be allowed to resume full duty. Dr. Strugala agreed and permitted Petitioner to return to truck driving, albeit with the use of a left patellar knee sleeve, as of June 26, 2006.

What is the nature and extent of the injury?

Based on the foregoing causation-related findings, as well as the results of the left ankle and left knee MRIs performed in 2006, the Arbitrator finds that Petitioner established permanency equivalent to 5% loss of use of the left foot, or 8.3 weeks of permanency, and 7.5% loss of use of the left leg, or 16.125 weeks of permanency, under Section 8(e) of the Act. The left ankle MRI was negative and the left knee MRI showed an effusion and chondromalacia but no ligament tears. Petitioner underwent conservative care, consisting of an air splint for the ankle and a sleeve and injections for the knee. While Petitioner ultimately underwent left ankle and left knee surgeries, those surgeries did not take place until 2011 (after other events, including work accidents of April 3, 2009 and March 29 or 30, 2010 in which Petitioner claimed to have fallen, striking both knees in the process) and there is no clear evidence linking the need for either of these surgeries with the May 12, 2006 accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☒ 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

Michael Holmes,

Petitioner,

vs. NO: 13 WC 34006

15IWCC0701

Elite Staffing,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015, 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.

15IWCC0701

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

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

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

DATED: SEP 10 2015
TJT:yl
o 8/24/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

HOLMES, MICHAEL
Employee/Petitioner

Case# **13WC034006**

ELITE STAFFING
Employer/Respondent

15IWCC0701

On 1/5/2015, 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:

3068 SCROGGINS LAW OFFICE
MORGAN SCROGGINS
1506 JOHNSON RD SUITE 200
GRANITE CITY, IL 62040

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD BOX 446
EDWARDSVILLE, IL 62025

15IWCC0701

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MICHAEL HOLMES
Employee/Petitioner

v.

ELITE STAFFING
Employer/Respondent

Case # 13 WC 34006

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Belleville**, on **September 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0701

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

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**17,166.00**; the average weekly wage was $**330.10**.

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

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

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

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

ORDER

Respondent shall provide Petitioner with worker's compensation benefits to include prospective medical treatment for Petitioner's right shoulder injury pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

12/12/14
Date

ICArbDec19(b)

JAN 5 - 2015

ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner, MICHAEL HOLMES, now age 48, was employed by the Respondent, ELITE STAFFING, on August 2, 2013, and was working as a laborer.

On August 2, 2013, Petitioner was working as a laborer on the line. On the day in question, his shift started at 6:00 p.m. After returning to the line from lunch, a supervisor stopped Petitioner and told him to get a pair of safety glasses from the office. He was told to hurry because the line is stopped until he returned. He went to the restroom before returning. While in the restroom, Petitioner slipped and fell when he turned around on the wet floor. As a result of the fall, he injured his right shoulder.

The Petitioner slipped on a wet floor. This particular bathroom was the only one available to employees. It contained five urinals and three stalls. Since the employees had just returned from their lunch break, the floors were in more disarray. There was water and urine all about the floors from multiple employees urinating and washing their hands. Employees must wash their hands prior to returning to the floor. The janitor, Ed Harris, was notified of the incident when Mr. Dressler came to the break room to get him. The last time the bathroom was cleaned was 7:30 p.m., prior to the 8:00 p.m. break. The employees, per Mr. Harris, like to destroy a bathroom.

Further, the Petitioner testified that he was working on an "assembly line". The "line" stopped while he was getting his glasses and using the restroom. As a part of his working condition, the Petitioner had to hurry in and out of the bathroom, to return to the line so it could keep running.

When Petitioner returned to the line, his right shoulder hurt really bad. He then reported the incident to the line supervisor. The supervisor sent him to the office and they had him clock out and fill out the incident report. The main supervisor then took him back to the bathroom and showed him the floor. The floor was damp but had been cleaned. You could still see the mop streaks.

The Petitioner was transported by Ambulance to Anderson Hospital. They took X-rays of his shoulder. He was diagnosed with right shoulder pain, bruise, and degenerative at the glenohumeral joint. The Petitioner had delays in medical treatment because the Respondent would not approve treatment. On October 24, 2013, Petitioner was directed to obtain an MRI of the right shoulder due to the continuous pain. On November 21, 2013, the MRI revealed a rotator cuff tear with soft tissue edema. On December 12, 2013, Petitioner's doctor agreed with the MRI and felt the tear was acute in nature.

The Arbitrator finds the Petitioner still requires medical treatment for his right shoulder and accordingly orders Respondent to pay for such reasonable and necessary prospective medical benefits.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HARRIET NUZZO,

Petitioner,

vs. NO: 11 WC 37634

METROPOLITAN PIER & EXPOSITION AUTHORITY, **15IWCC0706**

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, while affirming and adopting the remainder of the Arbitrator's Decision, modifies the Decision to find that the Petitioner reached maximum medical improvement as of November 7, 2011. Based on this finding, the Petitioner is not entitled to further TTD or medical expenses after that date.

The Arbitrator specifically found there was a causal relationship between Petitioner's accident and post-concussion syndrome, aggravation of pre-existing degenerative cervical spine condition, and a right shoulder sprain which led to surgical repair. The Arbitrator also

specifically found the following conditions were not causally related to the accident: headache, cognitive deficits, cervical fracture and carpal tunnel syndrome.

Dr. Karen Levin examined Petitioner at Respondent's request on November 7, 2011 pursuant to §12 of the Act. (Rx3). Dr. Levin found that Petitioner's subjective complaints were out of proportion to any true hard findings on examination. She noted Petitioner would not allow her to perform a complete examination based on subjective complaints. In order to determine if a true neurologic deficit existed with Petitioner, Dr. Levin referred Petitioner to Dr. Landre for neuropsychological evaluation.

Following her neuropsychological evaluation of Petitioner, Dr. Landre issued a December 15, 2011 report. (Rx5). Her conclusion was that Petitioner appeared to have an uncomplicated concussion and possible soft tissue injury to her arm. She indicated that Petitioner's evaluation reflected mostly normal cognitive functioning, with a few exceptions that were likely attributable to non-injury related factors. Emotional assessment suggested a moderately severe mental disorder with a strong tendency to react to stress by developing somatic complaints. There was no evidence indicating any cognitive or psychological problems related to the September 15, 2011 accident, with Petitioner appearing to be at or near her baseline level of cognitive functioning. Dr. Landre opined that psychologically speaking, injuries of this nature are not known to produce somatoform disorders, and that Petitioner's complaints likely evidenced some level of exaggeration, given the significantly elevated scores on over-reporting detection testing. From a neurologic standpoint, Dr. Landre did not believe Petitioner had any impairments that precluded her from returning to unrestricted work duties or driving a vehicle.

The Petitioner clearly sustained a head trauma on the accident date. However, we believe the level of complaints and the variety of injuries she claims as a result of the trauma is exaggerated. The Commission finds no evidence to support an ongoing, causally related post-concussion syndrome after November 7, 2011.

While we agree that the accident may have aggravated preexisting cervical degeneration at the time of the accident, we do not find Petitioner's ongoing cervical complaints after November 7, 2011 credible. The objective information from MRI and CT Scans indicated a degenerative cervical condition with no evidence of acute trauma. (Px3). Additionally, an April 11, 2012 EMG indicated no evidence of cervical radiculopathy. (Px4). Despite a lack of objective evidence of radiculopathy, Dr. Abusharrif performed multiple cervical epidurals in mid-2013, none of which provided any relief to Petitioner. We rely upon the opinions of Dr. Levin and Dr. Landre as being more persuasive than the opinions of Petitioner's treating physicians, because in our view these physicians relied more significantly on objective information and data as opposed to Petitioner's subjective complaints. This is important in a case where the claimant's/patient's credibility is questionable with regard to the subjective complaints.

Similarly, while she may have suffered a right shoulder strain at the time of the accident, any relationship of that strain to the accident also ended as of November 7, 2011. We note that the January 4, 2012 right shoulder MRI reflected nothing beyond bursitis and moderate AC joint hypertrophy. The Commission believes that the October 29, 2012 right shoulder surgery, based on a review of the records of Dr. Daniel Troy (Px4), was performed based on the Petitioner's subjective complaints and subjective responses during examination. The surgical report itself (Px6) reflects no significant findings whatsoever, noting only diffuse hypertrophic bursitis in the subacromial space. The report specifically noted overall pristine appearing rotator cuff with minimal articular surface fraying at the supraspinatus insertion, overall pristine appearing bicep tendon, no apparent degenerative changes of the glenoid or humeral head, and slight labrum fraying. After brief improvement, Petitioner's right shoulder condition regressed. Prior to the surgery, on September 18, 2012, as well as after examining Petitioner on February 25, 2013, Dr. Brian Cole believed Petitioner had "significant pain with a high level of impairment subjectively more than objectively", and opined that her right shoulder pain was of unknown etiology. His records make it clear that he did not anticipate any significant relief would be obtained via shoulder surgery, and his opinion turned out to be quite accurate. (Px7).

A review of all of the evidence leads us to conclude that Petitioner's subjective complaints were exaggerated, and the exaggeration of the complaints is what led to right shoulder surgery being performed. Several medical records reflect Petitioner complaining of complete inability to raise her arm, and had severe pain complaints with any movement, along with episodes of crying. Based on the objective evidence, there is no real support for such severe complaints. For these reasons and the reasons noted above, we specifically find that the surgery is not related to the September 15, 2011 accident.

Respondent's credit for previous payment of awarded medical bills is only applicable to the bills actually paid. Respondent is not entitled to use any claimed overpayment of a medical bill as credit against other unpaid medical expenses, or any other awarded benefits. If Respondent believes there was an overpayment of any paid bills pursuant to the medical fee schedule, the remedy is to address this directly with the provider, not to attempt to credit such claimed overpayment against other owed bills or other workers' compensation benefits.

Based on the credit Respondent is entitled to exceeding the benefits awarded, the Commission finds that the proper bond required in this matter is the minimum of $100.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $919.84 per week for a period of 7-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses listed and contained in Petitioner's Exhibit 1 that were incurred prior to

15IWCC0706

and including November 7, 2011, but not those incurred subsequent to November 7, 2011, pursuant to §§8(a) and 8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including any and all awarded medical expenses that were previously paid; any medical credit is limited as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $50,465.93 under §8(j) of the Act, based on previous payments of TTD and permanency advances; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 10 2015
TJT: pvc
O 07/14/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

NUZZO, HARRIET
Employee/Petitioner

Case# 11WC037634

METROPOLITAN PIER & EXPOSITION AUTHORITY
Employer/Respondent

15IWCC0706

On 8/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
WILLAIM A LOWRY ESQ
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0706

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)/8(a)

Harriet Nuzzo
Employee/Petitioner
v.
Metropolitain Pier and Exposition Authority
Employer/Respondent

Case # 11 WC 37634

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

15IWCC0706

FINDINGS

On the date of accident, **September 15, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**71,727.76**; the average weekly wage was $**1,379.38**.

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

Respondent ***has, in part*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**37,965.93** for TTD, $**0** for TPD, $**0** for maintenance, and $**12,500.00** for other benefits, for a total credit of $**50,465.93**.

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

ORDER

Temporary Total Disability

Respondent shall pay **Petitioner** temporary total disability benefits of **$919.84** per week for 117-5/7 weeks, commencing **September 16, 2011** through **December 17, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$50,465.93** for compensation benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $55,177.56, as provided in Sections 8(a) and 8.2 of the Act as set forth below.

Respondent shall be given a credit for all medical benefits that have been paid.

Penalties

Respondent shall pay to Petitioner penalties of $**0**, as provided in Section 16 of the Act; $**0**, as provided in Section 19(k) of the Act; and $**0**, as provided in Section 19(l) of the Act.

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

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

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

Signature of Arbitrator

August 21, 2014

Date

AUG 25 2014

FINDINGS OF FACT

Petitioner worked for Respondent, Metropolitan Pier and Exposition Authority, as a union carpenter, since 2001 or 2002. Before the accident, she was working full duty and was able to perform her physically demanding and heavy job tasks, which included lifting, construction work and moving airwalls. Petitioner testified that before the accident, she did not have problems with her head, neck or right shoulder. Petitioner is right handed. She denied prior right arm injuries. Later, on Cross-Examination, Petitioner admitted that she had treatment with a chiropractor for neck pain in the past.

On September 15, 2011, Petitioner was moving airwalls with other employees of Respondent when she heard a big noise and something hit her head. Petitioner testified that all she remembers is going down. She fell to the floor. She went with a co-worker to the first aid department and she got sick and was throwing up. At this time, Petitioner had head pain and her head was "all messed up." Petitioner was taken by ambulance to Mercy Hospital. The medical records establish that there was no loss of consciousness, but Petitioner was dazed and saw stars after being struck on the head. There was no testimony as to whether Petitioner was wearing a hardhat and this is not mentioned in the medical records, either.

At Mercy, Petitioner had a work-up for a head injury. The history was of a heavy object dropping from the ceiling and hitting her in the head. There was no loss of consciousness, although the patient had vomited once. She was at the hospital from 10:16 am to 1:02pm. The physical exam was largely negative and Petitioner was neurologically intact. No complaints or deficits regarding the neck or upper extremities were noted, although the indication for a CT scan of the neck was blunt head trauma and neck pain. The neck CT was negative for acute pathology. Degenerative disc disease was noted at several levels. A head CT was negative for acute pathology, although a minimal questionable soft tissue abrasion over the right forehead was noted. Petitioner was prescribed medication and instructed to follow up with MercyWorks, or her personal physician. While the admitting history describes a "major head injury", the Arbitrator notes that Petitioner was discharged less than 3 hours after presenting to the emergency room. (Pet. Ex 2)

Apparently, a lay-off was going to take place at Respondent around the time of the accident. Petitioner had not received formal notice of the layoff at the time of the accident.

Petitioner was next seen at Christ Hospital in the emergency room on September 17, 2011, with ongoing complaints of headache, dizziness, constant pressure on the right side of the head, nausea and vomiting, two days after being struck on the head with a sprinkler that fell 45 feet. While the HPI notes: "Pt. denies other complaints", the physical examination by the attending physician documents diffuse tenderness to palpation of the neck. The examination of the head was said to be atraumatic and the neck had normal range of motion. The upper extremity exam was said to be normal. A neck CT was performed and was negative for acute pathology, but showed DDD at several levels. The head CT was said to be unremarkable. Petitioner was discharged home with a diagnosis of closed head injury with concussion, persistent cephalgia. Tylenol, Ibuprofen and Zofran were prescribed and Petitioner was to follow up with her PCP. (ResEx. 2)

Petitioner followed up with her PCP, Dr. Zorub, on September 19, 2011. She had complaints of headache, dizziness, loss of balance, nausea and neck pain. Dr. Zorub's office called 911 and petitioner was transported to Christ Hospital, via ambulance.

Petitioner was admitted at Christ Hospital and was seen by several physicians. The headache and dizziness complaints seemed to be the primary concern, but slight neck pain and discomfort in the shoulders was noted by Dr. Campanella. Petitioner's neurological exam was said to be non-focal. When Petitioner was discharged on September 20, 2011, it was noted that her headache had significantly improved and there was no lightheadedness or dizziness. The patient denied neck pain at discharge. The diagnosis was headache, secondary to concussion from direct head trauma. The records from Christ Hospital do not reveal any bruising or other signs of trauma to the body, right shoulder, head or neck, besides a mention of some superficial tenderness at the right frontotemporal area by Dr. Shams. (PetEx. 5)

Petitioner continued treatment with Dr. Zorub, who charted a left sided headache, along with dizziness, on September 26, 2011. When Petitioner was seen on October 17, 2011, right sided headache and dizziness was charted, along with right shoulder and upper arm complaints. The physical exam regarding the upper extremities appears to have been negative (5/5). Dr. Zorub recommended physical therapy, which was discontinued, secondary to non-attendance, on January 9, 2012. Petitioner continues to see Dr. Zorub (through February 18, 2013, per PetEx. 9) Dr. Zorub kept Petitioner off work.

A further Head CT was performed on October 18, 2011 and was interpreted as unchanged from the September 17, 2011 study. Petitioner then began treatment with Dr. Leslie Schaffer, a neurosurgeon, on a referral from Dr. Zorub. At the first visit, on October 26, 2011, the neurologic exam was benign. Dr. Shaffer diagnosed "post traumatic syndrome" that should resolve over time (up to 2 years, per Petitioner's testimony). Petitioner saw Dr. Shaffer through December 14, 2011. She was referred for an ortho consult and Dr. Troy was recommended. Dr. Schaffer kept Petitioner off of work. (PetEx. 3)

Petitioner first saw Dr. Troy on December 30, 2011. The chart note from that day is a little bizarre, with a history of a fall at work on November 15, 2011. Petitioner had complaints of pain of the right shoulder and of intermittent tingling going to her right upper extremity. The physical exam revealed some inconsistencies in movement and it was limited due to Petitioner's crying and complaining of pain. There were shoulder complaints, along with cervical paraspinal to trapezius complaints of pain. Dr. Troy recommended a shoulder MRI and continued therapy and medication. The MRI was performed on

January 4, 2012 and showed hypertrophy of the acromioclavicular joint and bursitis, without evidence of a rotator cuff tear. Petitioner was seen by Dr. Troy on January 13, 2012 and a steroid injection was performed on the right shoulder. Full passive range of motion of the shoulder was noted, although active range of motion was said to be limited by pain. When petitioner was seen on February 10, 2012, improvement was noted, although cervical issues were noted. Dr. Troy was considering an FCE for return to work at the next visit. An FCE was ordered on March 9, 2012, apparently to establish a baseline before work hardening. When Dr. Troy saw Petitioner on May 4, 2012, she had pain, tingling and numbness in the right wrist and her shoulder symptoms had worsened. Dr. Troy thought there might be traumatically induced carpal tunnel syndrome (from what trauma?) and recommended another steroid injection. An EMG/NCV study was done on April 11, 2012. The study showed bilateral median nerve mononeuropathy and no evidence of cervical radiculopathy. When Petitioner was seen on June 29, 2012, surgery of the right shoulder was scheduled. Petitioner was kept off work by Dr. Troy during this time. (PetEx. 4)

Petitioner was seen for an IME by Dr. Brian Cole on August 20, 2012 at Respondent's request. Dr. Cole's diagnosis was: "AC joint pain of the right shoulder with subjective and supratentorial symptoms well proportion to the objective findings. Lot of what is going on appears to be neuropsychological related to her right shoulder pain." Dr. Cole thought that the condition was causally related to the accident. He was not strongly supportive of the recommended arthroscopic procedure and suggested concurrent pain management if the procedure was done. He thought that Petitioner was capable of no more than sedentary work. An addendum was issued (dated August 20, 2012, too) and Dr. Cole stated that surgery should be the last option for the patient. Her subjective complaints were way out of proportion to the objective findings. He clarified his causal connection opinion to state that he could not categorically state that the AC joint pain was traumatically induced, but there was no evidence of prior shoulder pain and she developed the AC joint pain soon after the injury, thus relating the treatment to the injury. (PetEx. 7) The term "supratentorial" means that the problems were in the patient's head, as opposed to being objectively verifiable.

Dr. Troy performed right shoulder surgery on October 29, 2012. The procedure was: 1. Diagnostic glenohumeral arthroscopy with labral debridement; 2. Subacromial decompression; and 3. Postop pain injection of Marcaine with epi to the subacromial space. The Post Operative Diagnosis was: "1. Overall pristine appearing rotator cuff with minimal articular surface fraying of the supraspinatus insertion. Overall pristine appearing biceps tendon superior labrum anterior and posterior insertion , no apparent degenerative changes of the glenoid or humeral head. There is slight fraying of the labrum. 2. Diffuse hypertrophic bursitis in the subacromial space." (PetEx. 6)

Petitioner had follow up care with Dr. Troy through April 26, 2013. Dr. Troy thought that the patient was having atypical pain when she was seen on March 29, 2013. Decreased range of motion, apparently as compared to the time of surgery, was noted on February 22, 2013. Petitioner told Dr. Troy that she thought that the surgery helped. When Petitioner was last seen by Dr. Troy on April 26, 2013, it was noted that pain complaints were keeping her out of therapy. Therefore the shoulder was not progressing. Petitioner was treating with Dr. Curtin and Dr. Troy thought an ESI to the cervical spine should be performed. After the ESI, therapy would be instituted. (PetEx. 11)

Petitioner was seen by Karen F. Levin, M.D., a neurologist, at the request of Respondent for an IME on November 7, 2011. Dr. Levin thought that Petitioner's symptoms were out of proportion to any true hard findings on examination. Petitioner did not allow a full examination so that this opinion could be certain. Dr. Levin recommended MRI of the brain, with and without contrast, MRI of the Cervical Spine, an ENG

and neuropsychological testing by Dr. Nancy Landre. Dr. Levin strongly suspected that no true neurologic problem would be found, but deferred further recommendations until the results were known.

The MRI of the brain was done without contrast only on November 22, 2011, and showed no evidence of acute intracranial abnormality. The brain MRI with contrast was never done. The MRI of the C-spine was also done on November 22, 2011 and showed degenerative findings similar to the prior studies, with no evidence of fracture or malalignment. (ResEx. 4) The ENG, apparently, was never done.

Petitioner underwent neuropsychological testing by Nancy Landre, Ph.D. on December 12, 2011. Dr. Landre's diagnosis was: Probable Undifferentiated Somatoform Disorder-Rule out Somatic Malingering. The study was said to show mostly normal cognitive functioning and impaired emotional functioning. Dr. Landre reported that injuries of this nature are not known to produce Somatoform Disorders. There might also have been some exaggeration of symptoms by the patient. Dr. Landre thought that Petitioner was capable of driving and returning to work from a neuropsychological standpoint. Somatoform is a psychological disorder involving physical complaints for which no organic or physiological explanation is found and which there is a strong likelihood that psychological factors are involved. (ResEx. 5)

Petitioner also had treatment with Dr. Jeffrey Curtin, a neurologist. Petitioner testified that she is currently treating with Dr. Curtin for a cervical spine condition and he is keeping her off work. The first visit with Dr. Curtin was March 12, 2013. Dr. Curtin diagnosed post-concussion syndrome (r/o subdural hematoma, occipital neuralgia, cervical cephalgia), neck pain (r/o fracture, herniated disc, anterolisthesis, spondylosis, stenosis, nerve impingement, ventral cord flattening) and parasthesias (r/o cervical radiculopathy, brachial plexus injury, inflammation/scar tissue) . A review of the prior films and Gabapentin were recommended. Physical therapy was to be discontinued, pending further work-up. A script for a repeat Cervical CT scan was issued March 15, 2013. (PetEx. 8)

Petitioner was again seen by Dr. Cole at the request of Respondent on February 25, 2013. The examination was limited by complaints of pain. The patient had significant pain, with a high level of impairment, more subjectively than objectively. The diagnosis was right shoulder pain of unknown etiology. Petitioner was not at MMI. She needed six weeks more therapy. She could not return to work. (PetEx. 7)

Petitioner was seen by Dr. Curtin on April 5, 2013. The chart notes: "still has bruising R forehead", with continued neck and shoulder complaints and severe pain with palpation over the right occipital notch. A Cervical Spine CT was performed on April 10, 2013 and it showed similar degenerative findings with significant foraminal stenosis on the right at C4-5 and C5-6, with no severe central canal stenosis. A letter from Dr. Curtin of October 31, 2013 states that Petitioner suffered a cervical fracture near the facet line. This, combined with the multi-level DDD results in cervical radiculopathy in the arms, as well as cevicogenic headaches secondary to occipital neuralgia. She was said to be unable to work. (PetEx.10)

Dr. Cole examined Petitioner for an impairment rating on August 26, 2013. Petitioner had a great deal of subjective complaints and limitations. Dr. Cole thought that Petitioner was at MMI regarding her shoulder condition. The impairment rating was 3% upper extremity. (ResEx. 9)

Petitioner began pain management treatment with Dr. Abusharif on May 8, 2013. The Petitioner at that time wrote that she has seizures. The remainder of her complaints and the physical exam were consistent with prior exams. A cervical ESI was performed, with no relief. A second ESI was performed on June 24, 2013, with no relief. A third ESI was performed on August 26, 2013, again with no relief of

symptoms. A stellate ganglion block was done on September 13, 2013 with a resulting 20% reduction in pain for two to three days. Dr. Abusharrif recommended symptomatic treatment for the neck and the shoulder. (PetEx. 12)

Petitioner has been involved in a job search through SOAR Research. (PetEx. 14) She has not worked since the accident. Petitioner is receiving disability payments from her union. Maintenance benefits were suspended due to non-cooperation with vocational rehab. Petitioner has not been told that she is at MMI by Dr. Curtin or Dr. Abushariff. Petitioner will cooperate with vocational efforts and will appear for IME's. Petitioner fell at a mall in January of 2013 and had some treatment for her right arm. X-rays of the right shoulder and elbow showed no acute findings. Her condition does not appear to have changed after the fall. (PetEx. 13)

Petitioner testified that she is not the same as she used to be. Her head hurts all the time. She does not remember things. Her stomach bothers her due to the medication that she takes. Her neck hurts all the time. She drops things when using her right hand. She has trouble lifting with her right arm.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Petitioner was evasive in some of her testimony. The Arbitrator does not ascribe this to malingering or to secondary gain motivations.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment by Respondent on September 15, 2011when she was struck on the head by an object that fell from a significant height (a sprinkler, sprinkler head, or sprinkler coupling). She may have suffered further trauma from the airwall that she was moving, or the bar that she was using to move the airwall although the initial medical records do not document multiple severe trauma that one would expect had the wall crushed Petitioner. Further, there was no bruising or swelling consistent with having been struck by the bar. The accident occurred while Respondent's employees were moving airwalls, and a risk incident to this task being done by a carpenter is that one might be struck by an overhead object. Thus, the accidental injuries arose out of and in the course of Petitioner's employment by Respondent.

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

Petitioner's testimony and the medical records establish that there is a causal connection between the accidental injuries and Petitioner's current condition of ill-being, to wit: post-concussion syndrome, aggravation of pre-existing degenerative cervical spine condition and right shoulder sprain, leading to surgical repair.

Petitioner testified that she had no problems with her head, right shoulder or neck before the accident. She was able to perform her job. With the exception of some chiropractic treatment for the neck, there was no evidence of any past injuries or treatment regarding these body parts.

At the time of trial, there was no active treatment for the post-concussion syndrome condition. Indeed, there is no clear medical opinion relating Petitioner's current complaints of headache and not remembering things to the accident. Dr. Curtin does say that Petitioner does have occipital neuralgia, but does not relate this condition to the accident. Dr. Levin recommended testing to confirm that there were no true neurologic problems because the symptoms were way out of proportion to the hard neurologic findings, but the ENG and the brain MRI with contrast were not done. Dr. Levin did not comment on the tests that were performed after her examination of Petitioner. Dr. Landre, Phd., found moderately severe mental disorder that was likely unrelated to the accident. Dr. Landre did not think that there were appreciable cognitive deficits. Petitioner has failed to prove that her current complaints of headaches and cognitive deficits are related to the accident. Assuming that Petitioner has a somatoform disorder, there is no proof regarding causal connection. Any such finding would be speculative.

The medical records support a finding of causal connection regarding an aggravation of Petitioner's degenerative cervical spine condition. Petitioner testified that Dr. Curtin found a fracture in her cervical spine and Dr. Curtin mentions this in his October 31, 2013 letter. This is probably the old avulsed fracture from the superior articular facet of C6 shown on the CT of April 10, 2013. Dr. Curtin does not relate this condition to the accident, so the Arbitrator declines to do so. Petitioner continues under the care of Dr. Curtin and Dr. Abusharif, according to her testimony and the medical records. She has not been released from care and has not been found to be at MMI regarding her cervical spine condition. The Arbitrator finds that the accident of September 15, 2011 has aggravated Petitioner's degenerative cervical spine condition, which remains symptomatic and disabling as of the date of the arbitration hearing.

The accidental injuries of September 15, 2011 also resulted in a right shoulder sprain, which led to surgical repair by Dr. Troy on October 29, 2012. Petitioner has not been released from care by Dr. Troy, because the cervical spine condition was hampering PT for the shoulder. Dr. Troy deferred to Dr. Curtin and Dr. Abusharif. Dr. Cole opined that there was a causal connection between the accident and Petitioner's right shoulder condition and thought that surgery should be the last option for the patient. Dr. Cole found Petitioner to be at MMI as of August 26, 2013. Previously, Dr. Cole said that Petitioner needed 6 weeks more therapy, as of February 25, 2013. That therapy was never done. The Arbitrator finds that there is a causal connection between the accident and Petitioner's right shoulder condition, which remains disabling and not at MMI as of the date of the arbitration hearing.

The Arbitrator finds that there is no causal connection between the accidental injuries of September 15, 2011 and Petitioner's carpal tunnel syndrome condition. There is no evidence of any trauma to the hands from the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's Exhibit Number 1 was the claimed bills. Respondent's Exhibit Number 10 was a Fee Schedule Analysis of Bills, which, unfortunately, does not correlate with Petitioner's Exhibit Number 1. Respondent's Exhibit 12 is the TTD, PPD and medical paid by Respondent's TPA. Respondent is entitled to a credit for all bills paid. The award for bills is made pursuant to Sections 8 (a) and 8.2 of the Act, so the Respondent can take reductions for the negotiated rate, or the Fee Schedule, as applicable. The bills will be addressed in the order that they are set forth in Petitioner's Exhibit 1.

Dr. Curtin: $1,500.00. Submitted bill is $575.00. **Award: $575.00**

High Technology, Inc.: $540.00? Not listed on PetEx. 1. **Award: 0**

Dr. Cole: 0 Balance. **Award: 0**

Advanced Orthopedic and Spine: $1,140.00. The 2 page bill of 11/26/2013 shows a balance of $1,140.00, but does not itemize the services for the unpaid amount. The bill for therapy services of March 7, 2013 is awarded. **Award: $211.00**

Midwest Orthopedic Consultants, SC: $23,323.20. The 22 page bill submitted is dated 12/18/2012 and does not reflect the payments that were made by the TPA as shown on Respondent's Exhibit 12. The bills for services rendered for the right shoulder and cervicalgia conditions are properly Respondent's liability. There is no causal connection for any treatment regarding carpal tunnel syndrome. **Award: 0.** The Parties need to verify whether there are unpaid bills for the shoulder and cervical spine condition set forth on the exhibit. If they cannot, then there has been a failure of proof regarding this claimed bill.

Dr. Abusharif Pain Treatment Centers: $11,063.00. **Award: $11,063.00**

Pain Treatment Surgical Suites: $17,957.25. **Award: $17,957.25**

Christ Hospital: $23,096.00. Bills for mammogram related charges of 11/26/2012 and 11/09/2011 are obviously unrelated and are not awarded. **Award: $22,399.00**

Advocate Medical Group: $925.00. The bills total $1,123.00. **Award: $925.00**

Dr. Schaffer: 0 Balance. **Award: $0**

Oaklawn Radiology : $488.44. Charges for mammogram read are not awarded. **Award: $208.44**

Midwest Diagnostic: $60.00. **Award: $60.00**

Cardiology Group: $18.00. **Award: $18.00**

Neurologic Associates: 0 Balance. **Award: $0**

City of Chicago EMS: $840.00. **Award: $840.00**

Oak Lawn F.D.: $745.00. **Award: $745.00**

Medco: $76.95. **Award: $76.95**
Prescription: $31.62. **Award: $31.62**

ACL Laboratories: $67.30. **Award: $67.30**

Total Bills Awarded, subject to credit for payments made and pursuant to Sections 8(a) and 8.2:
$55,177.56

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner made a claim for prospective medical care on the Request for Hearing form, but the only evidence of same is that she remains under the care of Drs. Curtin and Abusharif and she has not been found to be at MMI by these physicians and Dr. Troy. A note from Dr. Abusharif indicates that there will be a need for periodic treatment for "permanent nerve damage".

Because a specific plan for prospective medical treatment has not been made, the Arbitrator declines to make such an award.

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

Petitioner claimed 104-5/7 weeks of TTD for the time period of 9/15/2011 to 9/15/2013. Respondent claimed that, assuming liability for accident, the correct period of TTD would be 43-5/7 weeks.

First, no TTD is awarded for 9/15/2011, as this was the accident date and Petitioner was working on that date. Therefore, she was not temporarily and totally disabled on that date.

Second, the date of trail was 12/17/2013 and Petitioner was obviously claiming TTD through that date and Respondent agreed that TTD was intermittently owed through the trial date, if liability attached. The time period of 9/16/2011 to 12/17/2013 is 117-5/7 weeks. This amount is awarded, based upon the Arbitrator's findings regarding accident and causal connection above. Petitioner is still under the care of Dr. Curtin and Dr. Abusharif and the deferred care of Dr. Troy. She is not at MMI and she has not been released to return to work with respect to her cervical and right shoulder conditions. The Arbitrator does

not find Petitioner's vocational efforts to be so lacking that she is not entitled to compensation for the disputed time periods.

Therefore, Petitioner is entitled to have and receive from Respondent the amount of $919.84/week for the period of 117-5/7 weeks for TTD. Respondent is entitled to a credit in the amount of $50,465.93 to be applied against this award.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner is not entitled to Penalties and Attorney's Fees, even though the Arbitrator has awarded TTD and medical expenses as set forth above. The medical issues in this case are very complicated, such that an award of penalties is not appropriate. Petitioner has not shown that any delay in payment of benefits was without good and just cause. The Arbitrator finds that Respondent's disputes regarding compensation benefits were not unreasonable or vexatious.

The claim for penalties and fees is, therefore, denied.

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

Patricia Burrola,

Petitioner,

vs. NO: 08 WC 16484

15IWCC0700

Sam's Club,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary 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 November 13, 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.

15IWCC0700

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

DATED: SEP 10 2015
TJT:yl
o 9/1/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURROLA, PATRICIA
Employee/Petitioner

Case# **08WC016484**

15IWCC0700

SAM'S CLUB
Employer/Respondent

On 11/13/2013, 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:

0293 KATZ FRIEDMAN EAGLE ET AL
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MELISSA McENDREE
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0700

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

Patricia Burrola
Employee/Petitioner

v.

Sam's Club
Employer/Respondent

Case # **08WC 16484**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **October 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. [ ] 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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **4/9/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner established causation as to non-surgical lumbar spine and bilateral arm/shoulder conditions and as to a cervical spine condition which ultimately required a three-level fusion. See the attached conclusions of law for more specific causation-related findings.

In the year preceding the injury, Petitioner earned $**21,490.56**; the average weekly wage was $**413.28**.

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

Petitioner ***has in part*** received reasonable and necessary medical services.

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

Respondent shall be given a credit of $**2,519.01** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**2,519.01**.

ORDERS

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $275.52/week for 61 3/7 weeks, from April 10, 2008 through August 31, 2008 (16 1/7 weeks) and from October 22, 2009 through September 3, 2010 (45 2/7 weeks), as provided in Section 8(b) of the Act, with Respondent receiving credit for the $2,519.01 in temporary total disability benefits it paid prior to trial.

Medical Benefits

See pages 30-32 of the attached conclusions of law for the Arbitrator's medical award.

Permanent Partial Disability: Person as a Whole

For the reasons set forth in the attached credibility assessment and conclusions of law, the Arbitrator declines to award permanent total disability benefits, as requested by Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of $247.97/week for 200 weeks, because the injuries sustained caused the 40% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

15IWCC0700

Molly C Mason
Signature of Arbitrator

11/13/13
Date

NOV 13 2013

Patricia Burrola v. Sam's Club
08 WC 16484

15IWCC0700

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent in September of 2003. At that point she worked at a Respondent store in Florida. After a stint as a cashier, she moved on to a position in the meat department. She ultimately transferred to a meat department job at a Respondent store in the Chicago area.

Petitioner testified her duties involved preparing chickens for rotisserie cooking, wrapping meat and preparing deli trays. She worked 8 hours per day, 40 hours per week. She was on her feet about 7 hours each workday.

Petitioner testified she regularly lifted boxes of chicken. Each box contained about 10 5-pound chickens. She lifted these boxes off of a pallet and onto a flatbed. The boxes were stacked about 6 feet high. She is 5 feet, 2 inches tall.

Petitioner testified she prepared between 20 and 40 boxes of chicken per day. In order to get the chickens ready to be cooked on a rotisserie, she had to place five chickens on a skewer and place the skewers on a rack. This involved bending and reaching above shoulder level.

The parties agree that Petitioner sustained an accident while working for Respondent on April 9, 2008. Petitioner denied having any neck or low back problems prior to this accident. She testified the accident occurred around 2:40 PM, near the end of her shift. She went into the bakery area to get some gloves and slipped, falling backward and landing on the cement floor. After she landed, she realized the floor was wet. Petitioner offered into evidence a video of the accident. PX 18. The Arbitrator watched this video twice during the hearing and twice following the hearing. The video shows Petitioner at something of a distance but she can be seen in the upper right portion of the screen. She turns to her right to walk into a room and abruptly falls backward to the floor. Her feet appear to go out from under her. Her arms go out to the side. Shortly after she lands, she rolls to her right, sits up and gets to her feet. Her back is to the viewer at this point. She can be seen placing a hand on her lower back and slowly making her way to a nearby bakery rack.

Petitioner testified she disagrees with Section 12 examiner Dr. Bernstein's statement that the video shows her sliding backward. She did not slide backward. Her feet slipped out from under her, causing her to fall backward to the ground.

Petitioner testified she initially sought treatment at the Emergency Room at St. Mary of Nazareth Hospital. Records in PX 1 reflect that Petitioner arrived at the Emergency Room at about 8:52 PM on August 9, 2008. The Emergency Room physician, Dr. Svingen, recorded the following history:

"49 y o female slipped on water and fell directly backwards onto butt/back. ?LOC, states she was 'out of it.' Now c/o pain 'all over' – head to toe. Unable to specify a site."

Dr. Svingen noted that Petitioner had undergone a hysterectomy and bladder surgery about two months earlier.

A separate handwritten triage history reflects that Petitioner complained of "body aches s/p slip & fall on wet floor – onset 3 PM." This history also reflects that Petitioner denied losing consciousness.

Dr. Svingen ordered X-rays of the cervical and lumbar spine. The cervical spine X-rays showed "mild to moderate degenerative arthritis mainly involving the lower cervical levels" and "minimal degenerative spondylolisthesis at C4-C5." The interpreting radiologist noted "no definite evidence of fracture." The lumbar spine X-rays showed "a mild degree of degenerative arthritis involving various levels of the lumbar spine."

Dr. Svingen also ordered a CT scan of the head. This scan, performed without contrast, was negative.

Dr. Svingen prescribed Flexeril and Motrin. When he discharged Petitioner from the Emergency Room, he instructed her to seek follow-up care in 1-2 days. PX 1-2.

Petitioner returned to the same Emergency Room at about 5:50 PM on April 10, 2008, with triage personnel noting a complaint of "BRB [bright red blood] from R ear s/p fall 4/9." A The Emergency Room physician, Dr. Halpern, noted that Petitioner complained of a headache and neck pain as well as bleeding from her ear. Dr. Halpern noted the results of the radiographic studies performed the day before. He noted no ear bleeding on examination. He diagnosed a concussion, prescribed Tylenol #3 and instructed Petitioner to follow up with her family physician, Dr. Villalobos. PX 1.

Documents in the Commission file reflect that Petitioner retained counsel on April 11, 2008 and filed an Application for Adjustment of Claim on April 14, 2008.

Petitioner testified she saw Dr. Slusarenko following her Emergency Room visits. Records in PX 2 reflect that Petitioner first saw Dr. Slusarenko on April 11, 2008. A history form bearing that date reflects that, at about 3 PM on April 9, 2008, Petitioner slipped on a wet floor at work. The mechanism of injury is described as follows: "R foot slipped out from under her & fell flat on back. Hit back of head. Patient got herself up. Patient dazed. Doesn't know if lost consciousness." The history also reflects that Petitioner complained of headaches, blurred vision, neck pain traveling to her shoulders and down into her hands, middle and low back pain traveling to the right calf, right hand and wrist pain and right foot pain. PX 2.

Dr. Slusarenko ordered X-rays of the cervical spine and right hand. The cervical spine X-rays showed straightening and loss of the normal cervical lordosis "possibly indicating the presence of muscular spasm or soft tissue injury" and "anterior marginal changes with narrowing from C 4-5-6-7 compatible with the presence of osteophytosis and disc pathology." The right hand X-rays showed no evidence of fracture, dislocation or significant joint space narrowing. PX 2.

On April 12, 2008, Petitioner returned to Dr. Slusarenko, with the doctor noting complaints of cephalgia, blurred vision, cervical pain radiating to the shoulder and hands, right hand pain, middle back pain and acute thoracolumbar pain traveling to the right calf. He described Petitioner's right hand as "edematous and very tender to palpation."

On April 14, 2008, Dr. Slusarenko noted the same complaints along with "grip strength weakness of the right hand." Two days later, Dr. Slusarenko noted little improvement. He referred Petitioner to Dr. Osman, a neurologist. He continued seeing Petitioner on a very regular basis thereafter through July 24, 2009. His bills reflect that his treatment consisted of ultrasound, TENS, diathermy, massage, hot packs and manipulation. PX 17.

Petitioner first saw Dr. Osman on April 16, 2008. The doctor's note of that date documents the referral from Dr. Slusarenko. Dr. Osman noted that Petitioner slipped and fell on a wet floor at work on April 9, 2008, hitting the back of her head and "supporting herself" with her arms on impact.

Dr. Osman noted complaints to many parts of the body, including the head, neck, shoulders, arms, hands and low back, with the low back pain radiating to the right leg and foot. He also noted that Petitioner noticed blood coming out of her right ear and nose, as well as swelling of the gums and face, after the accident.

On examination, Dr. Osman noted cervical, thoracic, lumbar, trapezius and occipital spasm, "all worse on the right." He also noted positive straight leg raising at 30 degrees on the right and 60 degrees on the left. He diagnosed cervical and lumbar radiculopathy, cervical, thoracic and lumbar strains and "multiple soft tissue trauma and injury." He agreed with Dr. Slusarenko's recommendation of physical and chiropractic therapy. He renewed the Naprosyn and Flexeril. PX 2.

Petitioner returned to Dr. Osman on April 30, 2008 and reported worsening pain, especially on the right side. On re-examination, Dr. Osman again noted cervical, thoracic, lumbar and trapezius spasm, tenderness and limitation in range of motion, "all worse on the right side." He also noted positive straight leg raising on the right at 55 degrees and on the left at 65 degrees. He described the sensory examination as "inconclusive." He performed EMG/NCV testing. He found the test results to be compatible with right C5-C6-C7 radiculopathy and right L4-L5-S1 radiculopathy. He gave Petitioner Vicodin and Flexeril. PX 2.

At Dr. Slusarenko's recommendation, Petitioner underwent a cervical spine MRI on May 12, 2008. The interpreting radiologist, Dr. Kuritza, noted some degenerative changes at multiple discs, posterior disc bulges at C3-C4 and C4-C5, with no associated stenosis, and 3 to 4 mm posterior disc herniations at C5-C6 and C6-C7 with mild stenosis and bilateral neuroforaminal narrowing. PX 2.

Petitioner returned to Dr. Osman on May 14, 2008 and voiced a new complaint of right ankle swelling. The doctor described this swelling as having "persisted since the fall." The doctor's examination findings were essentially unchanged. He recommended ongoing physical therapy and chiropractic care. He prescribed Naprosyn and Flexeril. PX 2.

On May 20, 2008, Dr. Slusarenko referred Petitioner to Dr. Hassan (a/k/a Dr. Abdellatif) for pain management. In his records, Dr. Slusarenko describes Dr. Hassan as a "board certified anesthesiologist."

On May 21, 2008, Dr. Hassan administered cervical epidural injections and bilateral occipital nerve blocks at Rogers Park One Day Surgical Center. PX 4.

On June 27, 2008, Dr. Slusarenko noted that Petitioner remained significantly symptomatic and could not return to work.

On July 7, 2008, Petitioner underwent treatment at the Emergency Room at Norwegian American Hospital for facial swelling and a lump on her forehead. Petitioner indicated she was taking pain medication secondary to a back injury. The Emergency Room physician diagnosed a skin infection secondary to allergy and discharged Petitioner with instructions to follow up with her own physician. RX 6.

On July 23, 2008, Petitioner returned to Dr. Osman. Dr. Osman noted that Petitioner "underwent two cervical epidural injections by Dr. Hassan, with good response in the first injection and a limited response in the second injection." He noted that Petitioner's low back and right leg pain had worsened recently. His examination findings remained the same. He prescribed Flexeril and recommended that Petitioner continue physical therapy and chiropractic care. PX 2.

At Respondent's request, Petitioner saw Dr. Avi Bernstein, a spine surgeon, for a Section 12 examination on July 31, 2008. In his report of the same date, he described Petitioner as a "poor historian." He indicated that Petitioner slipped and fell at work on April 9, 2008, falling backward "and then slamming down to the floor, striking her head." He described the subsequent care, noting that Petitioner responded favorably only to the first of Dr. Hassan's two injections. He noted that Petitioner complained of neck and low back pain of equal severity. He also noted that Petitioner complained of radicular symptoms in the right arm and right leg.

Dr. Bernstein described Petitioner as "somewhat uncooperative" on examination. He described Petitioner's gait as "slow and guarded," with the guarding appearing to be "somewhat histrionic." He indicated Petitioner put forth incomplete effort on right arm and right leg examination.

Dr. Bernstein described cervical spine X-rays as showing advanced degenerative changes from C5 to C7 and "relatively good maintenance of the remaining discs." He interpreted the cervical spine MRI of May 12, 2008 as showing "advanced degenerative change from C5 to C7 with disc osteophyte complexes" and "an element of spinal stenosis" at those levels. He noted no clear cut cord compression or spinal cord signal changes.

Dr. Bernstein noted that, after he examined Petitioner, he viewed an in-store video of the accident. He described the video as showing Petitioner "slid[ing] backwards in a fall onto her buttock, rolling up her back." He indicated that the video did not show Petitioner striking her head or neck on the floor. He described Petitioner as "get[ting] up without any difficulty."

Dr. Bernstein stated that Petitioner's presentation "suggests symptom magnification and exaggeration." He reiterated that the MRI showed only pre-existing degeneration and "no evidence of an acute injury."

Dr. Bernstein addressed work status and treatment needs as follows:

> "At this point, I feel that [Petitioner] is capable of performing light duty work activity with a 20-lb. lifting restriction and avoidance of repetitive bending, lifting or twisting. It would be helpful to obtain an FCE to further evaluate [her] functional abilities as well as further assess her validity."

RX 2.

On August 21, 2008, Petitioner underwent a polyps biopsy at Saint Mary of Nazareth Hospital. Six days later, Petitioner underwent an upper endoscopy with biopsy at the same hospital. PX 1.

Petitioner testified that someone associated with Respondent sent her a letter directing her to return to work. She recalled returning to work as a greeter at Respondent's store in September of 2008. Initially, she was provided with a chair and could sit or stand as needed while greeting customers. She worked about five to six hours per day as a greeter. After about two weeks, "someone from corporate" visited the store and saw her using the chair. After this visit, her supervisor, who she referred to as "Coach Frank," told her she could no longer use the chair because there was no "letter of accommodation" on file. Petitioner testified she continued working as a greeter, without a chair, for about two more weeks. During this interval, she had difficulty standing. She would try to support her weight by leaning on something but was told that she could not lean while greeting. Eventually, she went to a

couple of supervisors (known as "coaches" in Respondent parlance) and told them she could not continue working.

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On September 30, 2008, Dr. Sistino of Affiliated Health Care Associates sent a note by facsimile to Respondent's personnel department stating: "please allow [Petitioner] a chair to sit 10 minutes per hour of work." Two days later, Dr. Sistino completed and signed a Respondent form indicating that Petitioner had "requested an accommodation under Wal-Mart's Accommodation in Employment policy." Dr. Sistino indicated that Petitioner was continuing to undergo treatment and that she had difficulty standing and sitting for extended periods. He indicated Petitioner "must change positions 10 minutes/hour."

On October 7, 2008, Petitioner returned to Dr. Hassan, with the doctor noting complaints of 10/10 pain in the neck and back, along with frequent headaches. He referred Petitioner to Dr. Kane for an orthopedic evaluation. He instructed Petitioner to continue therapy with Dr. Slusarenko. PX 3.

Petitioner testified that she saw Dr. Kane for a foot problem on October 7, 2008. By this time, she was no longer working.

On October 22, 2008, Petitioner returned to Dr. Osman. The doctor noted he had last seen Petitioner on July 23, 2008. He also noted that Petitioner had been "found to have a torn ligament in [her] right foot" and was scheduled to undergo surgery for that problem the following week. He indicated that Petitioner still complained of severe neck pain radiating to her right shoulder. He described Petitioner's "other symptoms" as "about the same." Petitioner reported that she had derived some relief from Flexeril but was now out of this medication.

Dr. Osman described his examination findings as essentially the same. He prescribed Flexeril and recommended that Petitioner "continue current management." PX 2.

On October 22, 2008, Dr. Sistino of Affiliated Health Care Associates signed a two-page group disability form entitled "attending physician's statement of functionality." This form reflects that Dr. Hassan took Petitioner off work on October 15, 2008 and that Petitioner was continuing to participate in a "multi-disciplinary program with pain specialist and chiropractors."

On October 24, 2008, Petitioner saw Dr. Singh at Dr. Hassan's referral. Dr. Singh noted that Petitioner fell at work on April 8, 2008. He also noted that Petitioner complained of neck and back pain as well as severe right shoulder pain and numbness and tingling into the right hand.

On examination, Dr. Singh noted 4/5 right deltoid strength with an "exquisitely positive impingement sign of the right shoulder." He also noted positive median nerve compression testing and positive Tinel's and Phalen's at the right wrist.

Dr. Singh reviewed the lumbar spine MRI. He indicated the MRI demonstrated some degenerative changes but no evidence of stenosis.

Dr. Singh indicated he lacked the EMG report, the cervical spine MRI report and various X-ray reports. He suspected that Petitioner's main source of pain was impingement of the right shoulder. He prescribed a right shoulder MRI and right shoulder X-rays. He indicated Petitioner was currently "in too much pain to work." He deferred pain management to Dr. Hassan. PX 2.

Petitioner underwent the recommended right shoulder MRI on October 24, 2008. The radiologist noted some mild hypertrophic spurring of the acromioclavicular joint. He described the rotator cuff as intact but indicated there was "some mild inflammatory fluid surrounding the distal supraspinatus tendon, probably with mild tendinitis and/or bursitis." PX 2, 8.

On October 29, 2008, Petitioner underwent a repair of the anterior talofibular ligament of the right ankle and a repair of the calcaneofibular ligament of the right ankle, performed by John Kane, DPM, at Rogers Park One Day Surgery Center. PX 4.

Petitioner testified she was no longer working as a greeter as of her October 29, 2008 right ankle surgery. Petitioner further testified she has not worked in any capacity or looked for work since her last day as a greeter.

Petitioner returned to Dr. Singh on November 7, 2008 and again complained of severe right shoulder pain.

Dr. Singh indicated he reviewed MRIs of the right shoulder, cervical spine and lumbar spine, along with the EMG report. He injected the right subacromial bursa. Following the injection, Petitioner reported that "90% of her pain was still there, radiating from her neck to her arm."

Dr. Singh concluded that Petitioner "has a surgical condition of her neck." He recommended a fusion at C5-6 and C6-7. He recommended non-operative care of the lumbar spine and indicated Petitioner might need some right shoulder therapy following the fusion, depending on her post-operative symptoms. PX 2.

Petitioner testified she did not undergo the recommended cervical fusion at that time. Instead, she continued undergoing conservative care with Drs. Slusarenko, Osman and Hassan.

On December 16, 2008, Petitioner saw Dr. Hassan and complained of severe pain in her neck, back, both shoulders and leg, along with severe headaches. Dr. Hassan recommended she follow up with Dr. Kane for her ankle, continue therapy with Dr. Slusarenko, see Dr. Montella for a "surgery consultation for bilateral shoulder, cervical spine and hip" and undergo a functional capacity evaluation. PX 2.

On January 20, 2009, Petitioner returned to Dr. Hassan. The doctor noted complaints of 10/10 pain in the neck, both shoulders and lower back. He recommended continued therapy, a lumbar epidural steroid injection and a left shoulder MRI. PX 3.

Petitioner underwent the recommended left shoulder MRI on January 27, 2009. The interpreting radiologist noted prominent supraspinatus tendinosis, no discrete rotator cuff tears and osteoarthritic changes with inferior spurring of the acromioclavicular joint. PX 10.

On January 23, 2009, Dr. Hassan administered trigger point injections and an L5 facet block. PX 3.

Petitioner returned to Dr. Osman on January 28, 2009. The doctor noted that Petitioner reported "temporary and limited benefit" from lumbar epidural injections. On examination, he noted considerable lumbar spasm and stiffness and positive straight leg raising bilaterally. He renewed Petitioner's Flexeril prescription.

On January 30, 2009, Petitioner saw Dr. Morganstern, an orthopedic surgeon affiliated with Gold Coast Orthopaedics. Dr. Morganstern noted that, on April 9, 2008, Petitioner slipped on a wet floor at work and "flew through the air," landing on her back. He indicated that Petitioner "struck her head and sustained injuries to her right foot, lower back, cervical spine and both shoulders." He also indicated that Petitioner denied injuring her neck, back or shoulders prior to April 9, 2008.

On right shoulder examination, Dr. Morganstern noted active forward flexion to 80 degrees, with passive to 90, and active abduction to 70 degrees, with passive to 80. He also noted a positive impingement sign and 3+/5 strength. He noted relatively similar findings on left shoulder examination. On lumbar spine examination, he noted positive straight leg raising bilaterally.

Dr. Morganstern diagnosed "bilateral shoulder impingement syndrome." He reviewed the shoulder MRIs. He recommended that Petitioner undergo bilateral shoulder arthroscopies, with the right shoulder to be addressed first. He instructed Petitioner to stay off work and continue therapy. PX 6.

Petitioner returned to Dr. Kane on February 17, 2009. Dr. Kane noted a significantly improved range of right ankle motion. He obtained X-rays which showed the surgical hardware to be in good position. He instructed Petitioner to continue therapy. PX 2.

Petitioner also saw Dr. Hassan on February 17, 2009, with the doctor noting complaints of 10/10 pain in the head and neck. The doctor also noted that Petitioner reported decreased anxiety secondary to taking Klonopin.

On March 4, 2009, Petitioner saw Dr. Naveed, a neurologist, at Dr. Hassan's referral. Dr. Naveed noted that Petitioner "fell on her back" in April 2008, injuring her neck. He also noted that Petitioner complained of "pain in both hands, neck pain radiating to the arm and forearm and lower back pain radiating to the lower extremities, right more than left." He indicated that Petitioner derived little benefit from epidural injections.

On motor examination, Dr. Naveed noted weakness, numbness and tingling in the lower extremities, decreased sensation in the left lateral leg, weakness in the upper extremities and a decreased range of neck motion. He found Petitioner's symptoms consistent with cervical and lumbosacral radiculopathy. He performed EMG testing. He found the upper extremity testing consistent with mild bilateral distal median neuropathy as well as bilateral C5-C6 cervical radiculopathy. He found the lower extremity testing consistent with bilateral L5-S1 lumbosacral radiculopathy. PX 10.

On March 9, 2009, Petitioner returned to Dr. Morganstern and complained of progressive bilateral shoulder pain, rated 6/10. Dr. Morganstern addressed causation as follows:

> "Again, these symptoms are a direct result of a work-related slip and fall while the patient was at work on April 9, 2008. Again, at the time of the fall, the patient attempted to try to catch herself by placing her hands behind her body. When the patient struck her lower back on the ground, the patient also struck her arms and hands under her full body weight, causing injury to both shoulders."

Dr. Morganstern again recommended arthroscopy of both shoulders for impingement syndrome. He indicated these surgeries were "pending insurance approval." He instructed Petitioner to remain off work. PX 6.

On May 5, 2009, Dr. Hassan noted that Petitioner complained of 10/10 low back pain and neck pain radiating to both arms. He referred Petitioner to Dr. Michael for a cervical spine evaluation, to Dr. Ralfi for a functional capacity evaluation and to Dr. Giannoulias for a bilateral shoulder evaluation. PX 3.

On June 12, 2009, Dr. Sistino of Affiliated Health Care Associates issued a letter indicating that Petitioner had reached a plateau and required a "more aggressive form of treatment." He indicated Petitioner was suspending her care at Affiliated Health Care Associates. PX 2.

Petitioner saw Dr. Michael, a neurosurgeon, on June 15, 2009. Dr. Michael's note of that date reflects that Petitioner slipped on a wet floor at work in April of 2008. Dr. Michael described the mechanism of injury as follows:

"She slipped and her right lower extremity flew up before her, causing her to land backward on her back. She placed her arms behind her in an attempt to break her fall and thus landed on her arms on her low back. Subsequently, she suffered neck pain, headaches, mid-back and low back pain. She has buttocks pain."

Dr. Michael indicated that Petitioner's "worse pain is in her neck." He indicated Petitioner had undergone therapy and two cervical spine injections, "to no avail." He also indicated Petitioner had undergone lumbar spine therapy and one lumbar epidural injection, again "to no avail."

Dr. Michael indicated that Petitioner was currently taking Alprazolam, Vicodin, Celebrex, Sertraline, Carisoprodol, Gabapentin and Omeprazole. He also noted that Petitioner was using a Lidocaine patch.

Dr. Michael described Petitioner's examination as "unremarkable." He noted no motor, sensory or reflex abnormalities.

Dr. Michael interpreted the cervical spine MRI as showing a small central herniation at C3-C4 with larger, more significant herniations at right C4-C5 and central C5-C6 and C6-C7.

Dr. Michael did not note any significant pathology on the lumbar spine MRI.

Dr. Michael indicated that Petitioner "never had cervical spine complaints" prior to her work accident. He indicated that, while the degenerative cervical spine changes likely predated this accident, the accident "clearly and unequivocally" aggravated them. He stated Petitioner could either learn to live with her pain or could consider surgery, "namely anterior cervical discectomy and fusion." He noted that Petitioner wished to proceed with surgery and that he planned to seek approval. He recommended only continued conservative care for Petitioner's low back complaints. He indicated he would not consider performing any lumbar spine surgery "until well after [Petitioner] has recovered from her cervical spine." PX 7.

At Dr. Hassan's referral, Petitioner saw Dr. Giannoulias of G & T Orthopaedics on June 22, 2009. Dr. Giannoulias indicated that Petitioner fell at work on April 8, "slipping forward and landing on both arms." Petitioner complained of bilateral shoulder pain.

On bilateral shoulder examination, Dr. Giannoulias noted some tenderness over the acromioclavicular joints and CA ligament, elevation to 150 degrees, external rotation to 80 degrees, internal rotation to the upper lumbar spine, "not much pain with abduction and internal rotation" and no significant crepitation. He interpreted the shoulder MRIs as showing "bilateral AC joint arthrosis as well as rotator cuff tendinopathy." He noted no rotator cuff tears or glenohumeral arthrosis. He told Petitioner he would try to avoid surgery. He injected both subacromial spaces. He indicated Petitioner might be a candidate for decompression and

distal clavicle repair if the injections failed to relieve her symptoms. He released Petitioner to work with no climbing, overhead activity or pushing/pulling. PX 8.

At Dr. Hassan's recommendation, Petitioner underwent a functional capacity evaluation at Best Practice Physical Therapy on June 25, 2009. The evaluator, Gerard Alleje, P.T., rated Petitioner's deli cutter-slicer job as light based on the Dictionary of Occupational Titles. Alleje found Petitioner incapable of returning to this job.

Alleje included the following comments in his report:

> "Ms. Burrola came walking into the facility with her trunk bent slightly at her waist around 15 degrees. She has subjective complaints of pain on her neck, low back, shoulders, right wrist/hand and right ankle. Ms. Burrola was cooperative during her FCE testing and even when she was complaining of pain she still attempted to do all tasks requested of her by tester. Mr. Burrola's vital signs were within normal limits before, during and after the FCE testing. There were a few sections of the FCE that she just could not do even after multiple attempts."

Alleje found Petitioner incapable of returning to any form of work, based on the strength classifications as established by the Dictionary of Occupational Titles. He described Petitioner as "not capable of lifting anything at all" but then indicated her "maximum carrying capacity is 5 pounds." PX 21.

Petitioner returned to Dr. Michael on July 6, 2009, with the doctor reiterating her treatment options and indicating he was continuing to await approval of the recommended cervical spine surgery. PX 7. There is no indication that Petitioner returned to Dr. Michael after July 6, 2009.

Petitioner returned to Dr. Giannoulias on July 13, 2009 and complained of right shoulder pain. On right shoulder examination, the doctor noted pain with elevation and internal rotation, a positive impingement sign and "signs of weakness with elevation and external rotation." He noted that Petitioner expressed a desire to proceed with surgery. He indicated he would schedule the surgery as soon as possible. PX 8.

Petitioner did not end up undergoing shoulder surgery with Dr. Giannoulias. On September 3, 2009, she saw Dr. Silver, an orthopedic surgeon affiliated with Illinois Bone & Joint. Petitioner testified she was referred to Dr. Silver by Dr. Strongin. Dr. Silver's history reflects that Petitioner slipped on a wet floor at work, "landing upon her outstretched arms, jamming her shoulders."

On initial examination, Dr. Silver noted minimal motion bilaterally, with approximately 45 degrees of forward flexion and lateral abduction in each shoulder with no internal rotation bialaterally. He also noted positive impingement signs and positive Hawkins and drop arm testing bilaterally.

Dr. Silver described Petitioner's shoulder MRIs as "consistent with inflammation of her rotator cuffs with impingement consistent with her clinical picture."

Dr. Silver recommended bilateral shoulder arthroscopic surgery. He prescribed Mobic and Vicodin.

On October 1, 2009, Dr. Silver wrote to Jessica Whiteside of Claims Management and indicated Petitioner's shoulders "are deteriorating." He indicated Petitioner would end up permanently disabled if he did not obtain approval for arthroscopic surgery. He also indicated he was providing Petitioner with Darvocet, Mobic and Omeprazole pending surgery. PX 9.

Dr. Silver performed a right shoulder arthroscopy at Peterson Surgery Center on October 3, 2009. In his operative report of that date, Dr. Silver described the glenohumeral arthroscopy as "normal, including the labrum, the articular surfaces, the subscapularis and biceps tendon and the articular surface of the rotator cuff." He noted the presence of "obvious rotator cuff impingement." He performed a subacromial decompression, arthroscopic debridement and arthroscopic distal clavicle resection. At the conclusion of the surgery, he instructed Petitioner to wear a sling, avoid any lifting, use a Polar ice machine and remain off work. PX 10.

On October 17, 2009, Dr. Silver wrote to Jessica Whiteside again, indicating that Petitioner pre-operative pain had resolved and that he planned to perform a left shoulder arthroscopy. He also indicated that Petitioner would start therapy shortly and remained temporarily disabled.

On October 22, 2009, Dr. Slusarenko issued a "final report" indicating he last saw Petitioner on July 22, 2009, at which time Petitioner remained symptomatic and unable to work.

On October 22, 2009, Petitioner saw Dr. Malek. Records in PX 10 describe Dr. Malek as a board certified neurosurgeon.

In his initial note, Dr. Malek indicated Petitioner was referred to him by Dr. Hassan.

Dr. Malek's initial history reflects that Petitioner slipped on a wet floor at work on April 9, 2008, "landing on her buttocks and back [and] trying to break her fall by using her hands." The history also reflects that Petitioner had previously had a box fall on her hand but had recovered from that injury.

Dr. Malek noted that Petitioner complained of pain in her right shoulder, neck and back, with her neck and back pain radiating to her extremities. He also noted that Petitioner had undergone multiple injections with Dr. Hassan and right shoulder surgery with Dr. Silver.

On examination, Dr. Malek noted positive straight leg raising bilaterally, paraspinal tenderness, an antalgic gait, pain with manipulation of both shoulders and negative Waddell signs.

Dr. Malek indicated he reviewed lumbar spine MRIs dated October 3, 2007 and March 12, 2009. He indicated the 2007 MRI was done in the course of a work-up for a tumor. He interpreted that MRI as negative. He interpreted the 2009 MRI as showing desiccation at L2-L3, L3-L4, L4-L5 and no distinct herniations.

Dr. Malek interpreted the cervical spine MRI of May 12, 2008 as showing herniations at C5-C6 and C6-C7. He interpreted the cervical spine MRI of March 12, 2009 as showing "complete reversal of the normal cervical lordosis, focal kyphosis and disc herniation, especially at C4-C5, C5-C6 and C6-C7."

Dr. Malek attributed the majority of Petitioner's symptoms to pathology at C4-C5, C5-C6 and C6-C7. He noted that the two cervical spine MRIs documented progression. He recommended a repeat cervical spine MRI. He found it likely that Petitioner would require a fusion of C4-C7. He indicated he needed to review the EMG.

Dr. Malek recommended that Petitioner stay off work, continue seeing Dr. Silver and return to him following the repeat cervical spine MRI. PX 10.

The repeat cervical spine MRI, performed on October 23, 2009, showed reversal of the usual cervical curvature, hypertrophic spurring at multiple levels and posterior disc protrusions/herniations at the C4-C5, C5-C6 and C6-C7 levels, indenting the thecal sac. The interpreting radiologist noted no significant spinal stenosis. PX 10.

Petitioner returned to Dr. Malek on November 5, 19 and 20, 2009. On all of these dates, the doctor noted that Petitioner remained symptomatic. He discussed the option of surgery and the risks and potential benefits of a 3-level fusion. He instructed Petitioner to stay off work. PX 10.

Between November 16 and December 11, 2009, Petitioner underwent right shoulder therapy at ATI. In a discharge summary dated January 7, 2010, the therapist stated that Petitioner "demonstrated minimal progress with overall function and strength due to c/o pain in other areas, including left shoulder/cervical spine." The therapist also indicated that Petitioner was being discharged due to upcoming cervical spine surgery. PX 9.

Dr. Malek performed a three-level anterior discectomy and fusion at Provena Saint Joseph Medical Center on December 15, 2009. During the surgery, Dr. Malek placed PEEK cages

at the three operated levels, C4-C5, C5-C6 and C6-C7. He accomplished the fusion via plating and multiple screws. PX 11.

Following the surgery, Petitioner returned to Dr. Malek on December 23, 2009. The doctor noted that Petitioner's incision looked good but that she still had some pain. He directed Petitioner to shift to a soft neck collar, to be used as needed, and to stay off work. At the next visit, on January 8, 2010, Dr. Malek described his examination as negative. He instructed Petitioner to stay off work and start therapy about six weeks post-op. PX 5.

On January 21, 2010, Dr. Silver wrote to Jessica Whiteside again, indicating that he planned to hold off on performing a left shoulder arthroscopy due to Petitioner's recent cervical spine surgery.

On February 12, 2010, Petitioner returned to Dr. Malek, with the doctor indicating that Petitioner's neck was doing "pretty well" but that her lower back was bothering her. He recommended cervical spine therapy and continued to keep Petitioner off work. He indicated he would address the lumbar spine later, upon referral. PX 5.

Between February 22, 2010 and March 23, 2010, Petitioner underwent additional right shoulder therapy at ATI. On February 22, 2010, a representative of ATI wrote to Petitioner's counsel indicating that workers' compensation was denying payment for the treatment. On March 19, 2010, following a repeat lumbar spine MRI, Dr. Malek prescribed lumbar spine therapy. PX 5, 13.

On April 23, 2010, Dr. Malek noted that Petitioner was continuing to have "primarily low back pain." He recommended additional therapy followed by a functional capacity evaluation. He continued to keep Petitioner off work. PX 5.

In May of 2010, Petitioner underwent work conditioning at ATI. Petitioner was discharged from work conditioning on May 28, 2010 due to upcoming left shoulder surgery. In her discharge report, the therapist found Petitioner to be functioning at a sedentary duty level. PX 13.

On May 14, 2010, Petitioner saw Dr. Fisher of the Illinois Bone & Joint Institute. Dr. Fisher noted that Petitioner complained chiefly of right proximal lateral thigh pain and bilateral buttock pain along with bilateral anterior knee pain. He also noted that Petitioner attributed all of these complaints to a slip and fall accident two years earlier. He indicated Petitioner reported slipping forward, landing on her buttocks and hands. He noted Petitioner described her neck and arms as "way, way better" since a fusion. He also noted Petitioner had recently undergone right shoulder surgery and was awaiting left shoulder surgery.

Dr. Fisher described Petitioner as walking with an antalgic gait with the aid of a cane.

On lumbar spine examination, Dr. Fisher noted tenderness at the paraspinous muscles at S1, approximately 90% of a full range of motion and tenderness over the right greater trochanter along the IT band. On bilateral leg examination, Dr. Fisher noted 5/5 strength, normal sensation and reflexes and negative straight leg raising. On bilateral knee examination, Dr. Fisher noted tenderness over the patellar tendons and no tenderness over the medial and lateral joint lines.

Dr. Fisher interpreted the March 18, 2010 lumbar spine MRI as showing mild degenerative changes and a far left intraforaminal disc herniation at L4-L5 resulting in moderate left neural foraminal stenosis.

Dr. Fisher diagnosed right trochanteric bursitis, degenerative changes of the lumbar spine, anterior knee pain and a left L4-5 intraforaminal disc herniation "without left L4 radicular symptoms." Dr. Fisher recommended that Petitioner continue therapy and follow up with Dr. Silver. He administered a right trochanteric bursa injection. He noted that Petitioner reported significant improvement in her right lateral thigh symptoms five minutes after this injection. He released Petitioner from care on a PRN basis. RX 7.

On June 11, 2010, Dr. Silver operated on Petitioner's left shoulder. In his operative report of that date, he described the labrum, subscapularis and biceps tendons and the articular surfaces of the rotator cuff as normal. He debrided superior surface rotator cuff fraying. Following the surgery, he instructed Petitioner to avoid lifting anything and use an ice machine for three to four days. PX 10.

Following the left shoulder surgery, Petitioner returned to Dr. Silver on June 24, 2010. The doctor recommended that Petitioner stay off work, continue using a CPM machine at home and begin therapy. PX 10.

Petitioner underwent an initial therapy evaluation at Rapid Rehab of Illinois on July 1, 2010. The evaluator, Lindsay Moses, DPT, noted that Petitioner complained of 8/10 pain in her left shoulder radiating down her left arm. She also noted that Petitioner is right-handed. PX 12.

On July 22, 2010, Dr. Silver wrote to Jessica Whiteside. He indicated Petitioner was making progress in therapy and had regained about 160 degrees of forward flexion of the left shoulder. He released Petitioner to right-handed work and indicated Petitioner should continue her therapy and medication. PX 10.

In a summary dated August 19, 2010, therapist Sherman noted that Petitioner's left rotator cuff strength had regressed. Sherman noted that Petitioner "has multiple areas of pain including cervical spine (post fusion) which may be causing radicular symptoms." PX 12.

Petitioner returned to Dr. Malek on August 20, 2010 and indicated she had aggravated her neck and low back while performing left shoulder therapy. The doctor placed therapy on

hold and prescribed plain X-rays of the cervical spine in order to evaluate the fusion. He described Petitioner as "quite antalgic." PX 5.

Petitioner returned to Dr. Silver on August 24, 2010. The doctor noted that Petitioner's forward flexion had increased to 180 degrees. He recommended continued therapy. He indicated Petitioner could use her left arm below shoulder level with no lifting. PX 10.

On September 3, 2010, Dr. Malek recommended that Petitioner undergo a repeat lumbar spine MRI, based on her persistent low back complaints. He indicated Petitioner was "doing a lot better with the neck." PX 5.

On September 10, 2010, Petitioner returned to Dr. Malek, following a lumbar spine MRI of September 8, 2010. Dr. Malek interpreted the MRI as showing some straightening of the normal lumbar lordosis and bulging discs at multiple levels, with "no focal extrusion." He indicated he told Petitioner she was not a candidate for low back surgery, commenting: "she has not done the physical therapy well and at this point I don't think any surgery on her low back would be of use." He recommended a functional capacity evaluation with validity testing. PX 5.

On September 21, 2010, Dr. Silver indicated Petitioner had regained full lateral abduction. He released Petitioner to work with no lifting over 5 pounds. PX 10.

Petitioner continued attending therapy at Rapid Rehab of Illinois through October 18, 2010. PX 12.

On October 28, 2010, Dr. Silver noted that Petitioner had "regained good strength in her shoulders" and could resume normal work "with regard to her shoulders only" as of November 1, 2010. PX 10.

At the request of her attorney, Petitioner saw Dr. Coe for an examination on March 22, 2011. Dr. Coe's examination report (Coe Dep Exh 2) sets forth the following history:

> "[Petitioner] states that on April 9, 2008, at approximately 3:00 PM, she slipped and fell on a wet floor. [Petitioner] states that she was wearing steel-toed safety shoes at the time of this accident. She states that she fell onto her back, landing on her buttocks. She states that she spread her arms out behind her to 'break her fall.'"

Dr. Coe indicated he reviewed various treatment records, Dr. Bernstein's July 31, 2008 report and the accident video in connection with his examination. [The Arbitrator notes that Dr. Coe's report contains no reference to the treatment rendered by Dr. Morganstern, Dr. Giannoulias or Dr. Singh.] He described Dr. Slusarenko's chiropractic care as leading to little improvement. He

described the injections administered by Dr. Hassan as providing only temporary symptomatic relief.

Dr. Coe noted that, as of his examination, Petitioner was seeing her family physician, Dr. Sundaresa, for medication for her neck and back. [Dr. Sundaresa's records are not in evidence.]

Dr. Coe stated that Petitioner denied having any neck, back or shoulder injuries or symptoms prior to the accident of April 9, 2008.

Dr. Coe noted that Petitioner complained of neck soreness and stiffness, bilateral shoulder stiffness and weakness and lower back pain radiating into both thighs. Petitioner indicated she limped and relied on a cane to walk.

On cervical spine examination, Dr. Coe noted a well-healed 2-inch right anterior surgical scar, tender trigger points bilaterally, a negative Spurling sign and a limited range of motion. On right shoulder examination, Dr. Coe noted a well-healed arthroscopic scar and slight tenderness over the acromioclavicular joint. On left shoulder examination, Dr. Coe noted a well-healed arthroscopic scar and no tenderness over the acromioclavicular joint. He also noted limited abduction, forward elevation and internal rotation bilaterally.

Dr. Coe described Petitioner's gait as slightly unsteady and broad-based. He indicated she used a cane but was able to walk without it. On lumbar spine examination, he noted tenderness over the right sacroiliac joint and right-sided facet joints, limited flexion, limited extension and limited lateral bending. He described straight leg raising as full bilaterally at 90 degrees in both the seated and recumbent positions.

Dr. Coe described distraction signs, including axial loading and pelvic torsion, as negative.

Dr. Coe indicated the accident video showed a "sudden and unguarded fall," with Petitioner "slipping and falling onto her back with her arms outstretched," striking her lower, mid and upper back. He indicated that Petitioner was able to get to her feet and then rested, bracing herself on racks.

Dr. Coe opined that the accident aggravated an underlying degenerative lumbar disc condition, causing chronic lumbar pain. He also opined that the accident resulted in an upper back contusion and neck strain "with aggravation of cervical degenerative disc disease and degenerative arthritis causing chronic cervical discogenic and myofascial pain." He further opined that Petitioner "forcefully threw back both shoulders" when she fell, "causing injuries to both shoulders with the development of bilateral shoulder subacromial impingement syndromes."

Dr. Coe found a causal relationship between the work accident and Petitioner's current symptoms and state of impairment. He indicated the injury caused "permanent partial

disability to the person as a whole with additional disability to both arms." He found Petitioner to be in need of physician follow-up and analgesic medication.

On November 2, 2011, Petitioner consulted Dr. Rock at Resurrection's pain center. Dr. Rock noted a three-year history of lower back pain secondary to slipping on a wet floor at work. He diagnosed "chronic pain syndrome with facetogenic low back pain." He administered lumbar facet joint injections on November 2, 2011. On November 23, 2011, Dr. Rock noted that these injections provided only ten days of relief. He performed right-sided facet joint radiofrequency rhizotomies. PX 14.

On April 10, 2012, Petitioner underwent a functional capacity evaluation at Elite Physical Therapy. The evaluator, David O'Connell, P.T., recorded the following history:

> "[Petitioner] reports she was injured while working as a deli processor at Sam's Club on April 9, 2008. She reports that she went to get gloves and slipped on the floor. She fell onto her sacral area and twisted her back and neck. She also reports that she reached her arms out behind her and felt her shoulders 'pop.'

O'Connell noted that Petitioner complained of constant neck and back pain as well as right ankle stiffness.

O'Connell rated the evaluation as valid. He described Petitioner as putting forth "an overall full and consistent effort." He found Petitioner to be functioning at a sedentary level of work, "indicative of a maximum/occasional 2-hand lift/carry of 10 pounds from knee to chest level." He went on to say that "this is a general category and [Petitioner] exhibited severe functional limitations above and beyond this category description." Specifically, he noted that Petitioner was unable to perform constant standing, frequent stooping/bending, frequent twisting, occasional squatting/kneeling, frequent bilateral reaching and frequent lifting of 25 pounds. He did not have a formal description of Petitioner's job but indicated that Petitioner was unable to return to her previous full duty work activities.

O'Connell noted that Petitioner failed the bell curve analysis of maximum grip strength testing. He indicated this testing had "limited reliability due to [Petitioner's] history of cervical radiculopathy and upper extremity surgeries." PX 15.

Dr. Coe gave a deposition on behalf of Petitioner on September 21, 2012. Dr. Coe testified he achieved board certification in occupational medicine in 1991. PX 16 at 5. He examined Petitioner on March 22, 2011 but did not issue his report until several months later, after he had an opportunity to view the accident video. PX 16 at 6.

Dr. Coe testified at length concerning his review of the treatment records. He found the 2008 and 2009 EMG results to be "pretty similar." The 2008 EMG showed primarily right-sided

problems while the 2009 EMG showed bilateral problems. PX 16 at 18-19. The 2009 bilateral results were indicative of "worsening over time." PX 16 at 19. The first EMG was performed only two weeks after the accident and it can take up to three months before an EMG is fully accurate. PX 16 at 19.

Dr. Coe testified he found Dr. Silver's operative reports significant because Dr. Silver described "obvious rotator cuff impingement," i.e., "pinching of the tendons of the rotator cuff."

Dr. Coe testified that, of the many physicians who saw Petitioner, only Dr. Bernstein found Petitioner to be malingering. None of the treaters described symptom magnification. PX 16 at 26.

Dr. Coe testified that Dr. Malek noted improvement following the cervical spine surgery and did not view Petitioner as a candidate for lower back surgery. PX 16 at 29.

Dr. Coe opined, to a reasonable degree of medical certainty, that the treatment Petitioner underwent through September 2010 was reasonable and necessary. PX 16 at 30.

Dr. Coe testified that Petitioner was "quite cooperative" during his examination. Petitioner complained of localized tenderness and stiffness in her neck. Dr. Coe indicated he used a goniometer to measure Petitioner's cervical spine range of motion. Petitioner had stiffness in all the directions he tested, consistent with her three-level fusion. PX 16 at 34. Petitioner also exhibited "mild residual stiffness" in both shoulders. PX 16 at 36. The shoulder impingement signs were negative. Petitioner exhibited mild, 4+/5, weakness of the right shoulder. PX 16 at 36. Petitioner exhibited a broad-based gait, not a limp. Petitioner's gait is typically seen in individuals who have persistent lower back pain. Petitioner brought a cane to the examination but was able to walk without the cane. Dr. Coe noted a limited range of lumbar spine motion. PX 16 at 39. Dr. Coe carried out all five Waddell tests. All of these tests were negative. PX 16 at 39.

Dr. Coe opined that the work accident aggravated a previously asymptomatic degenerative cervical spine condition and brought about the need for the surgery Dr. Malek performed on December 15, 2009. PX 16 at 42. The stiffness resulting from the surgery is a factor causing myofascial pain. PX 16 at 43. Petitioner's myofascial pain is likely chronic and permanent. PX 16 at 43.

Dr. Coe further opined that the work accident aggravated a previously asymptomatic degenerative lumbar spine condition, causing both acute and chronic lower back pain. PX 16 at 43. Petitioner's lower back pain is permanent. It has not responded to conservative treatment. PX 16 at 44.

Dr. Coe also found causation as to Petitioner's bilateral shoulder condition, citing the mechanism of injury Petitioner described, i.e., throwing her arms backward to try to break her

fall. Dr. Coe opined that this mechanism could "jar" the shoulders and stress the acromioclavicular joints. PX 16 at 44. The work accident brought about the need for the shoulder surgeries Dr. Silver performed. PX 16 at 44-45.

Dr. Coe testified he did not see Petitioner strike her head or neck when he watched the video. Petitioner appeared to have struck her buttocks, her lower back and her mid-back. PX 16 at 45. The accident was a "sudden slip and fall" that could have jarred the spine and jerked or twisted the neck. PX 16 at 45-46.

Under cross-examination, Dr. Coe acknowledged that the lumbar spine MRI of September 8, 2010 showed no disc herniations. PX 16 at 53. He looked only at the MRI reports, not the scans. PX 16 at 54. The radiologist who interpreted the September 8, 2010 MRI noted improvement. PX 16 at 55. In his capacity as an occupational medicine physician, he treats patients who have neck, low back and shoulder pain. PX 16 at 57. He cannot prescribe surgery because he is not a surgeon. PX 16 at 58. He refers patients to surgeons as appropriate. PX 16 at 58-59. He conducted all five Waddell tests but discussed only two of the tests in his report. PX 16 at 60. When he testified concerning Petitioner's range of motion, he compared Petitioner's range with that of the "population normals." He did not break the range down with respect to age, weight or gender. PX 16 at 62. Therapy can improve range of motion but would provide limited improvement for Petitioner's neck, since Petitioner had a three-level fusion. PX 16 at 63. Petitioner has moderate neck stiffness but "actually had a pretty good range of motion considering" the fusion. PX 16 at 63. He did not address the issue of work restrictions in his report because, when he examined Petitioner, she told him she was not working and had applied for disability benefits. PX 16 at 65. He is not sure whether Petitioner told him she hit her head when she fell. PX 16 at 67. Petitioner described stretching her arms out behind her when she fell. PX 16 at 67. To his recollection, the video showed Petitioner's arms stretched out to the side. PX 16 at 69. He does not believe that Dr. Silver saw the video of the accident. PX 16 at 70. Petitioner's initial upper back complaints were "equally likely to have been arising from her shoulders." PX 16 at 71. No one really looked at Petitioner's shoulders until June of 2009. PX 16 at 71. Different forces on the shoulders with different degrees of arthritis in each shoulder could end up causing impingement. PX 16 at 72. If Petitioner in fact underwent treatment for her neck, back or shoulders before the accident, he would want to know about that. PX 16 at 72-73. He did not review Dr. Rock's records. PX 16 at 73.

On redirect, Dr. Coe testified that the treatment Dr. Rock provided in 2011 would not affect the opinions he has already rendered in this case. PX 16 at 74. Dr. Rock simply provided additional treatment for the type of pain he previously described. Dr. Rock's treatment, as described by Petitioner's counsel, is appropriate and reasonable for facet joint pain. If Petitioner extended her arms backward when she fell, with the arms actually making contact with the floor, that could have jarred her shoulders. PX 16 at 75.

At Respondent's request, Dr. Bernstein re-examined Petitioner on September 27, 2012. He noted that Petitioner had undergone injections, an EMG, right ankle surgery, bilateral

shoulder surgery and a three-level cervical anterior fusion since his previous examination of July 31, 2008. He also noted that Petitioner had recently undergone multiple injections and a rhizotomy by Dr. Rock.

Dr. Bernstein described Petitioner as slightly overweight and deconditioned. He noted that she "sighs constantly through the evaluation." He indicated she initially walked with a marked right-sided limp but, after trying to walk on her heels and toes, began walking relatively normally. He stated he asked Petitioner to bend "and she provided no effort whatsoever, bending about 10 degrees at the waist."

On cervical spine examination, Dr. Bernstein noted some limitation of range of motion consistent with a three-level fusion. He indicated Petitioner lacked about 20 degrees of rotation bilaterally and about 30 degrees of lateral bending.

Dr. Bernstein noted normal strength, sensation and reflexes in Petitioner's legs. He described straight leg raising as completely negative.

Dr. Bernstein indicated he reviewed the MRI and EMG reports along with the operative reports of Drs. Malek and Rock. With respect to the cervical spine MRI report, Dr. Bernstein indicated he had "no confidence whatsoever" in Dr. Kuritza's reading. Dr. Bernstein indicated that, although he did not review the cervical spine MRI films, the report suggested typical degenerative changes without evidence of a disc herniation.

Dr. Bernstein addressed causation as follows:

> "This patient has had cervical spine surgery for a variety of degenerative findings in the cervical spine. Based on my prior evaluation of the patient and my prior review of her cervical MRI scan in 2008, it is my opinion that her surgery was not causally related to the alleged work incident, of a slip and fall. Furthermore, I note that this patient is alleging two shoulder surgeries, neck surgery, multiple low back procedures and right ankle and foot surgery to this slip and fall. It is inconceivable that these diffuse complaints and this diffuse treatment are reasonably causally related to the alleged incident."

Dr. Bernstein found Petitioner to be at maximum medical improvement. He found Petitioner capable of functioning at a sedentary duty level, based on the functional capacity evaluation. He indicated that, if Petitioner was motivated, she could certainly function at the light physical demand level. RX 3.

Records in PX 14 reflect that Dr. Rock performed additional procedures at Resurrection Medical Center on February 23, April 11 and October 29, 2012 but the records are incomplete.

It appears that Dr. Rock administered right transforaminal epidural steroid injections on February 23 and October 29, 2012.

Dr. Bernstein testified on behalf of Respondent at a deposition conducted on March 19, 2013. Dr. Bernstein testified he is a fellowship-trained spine surgeon. He is board certified in orthopedic surgery. Bernstein Dep Exh 1.

Dr. Bernstein testified he first examined Petitioner on July 31, 2008. On that date, Petitioner indicated she slipped at work on April 9, 2008, falling backward onto her right leg and striking her head on the floor. RX 1 at 7. Petitioner claimed that she ruptured one of her eardrums as a result of this fall. RX 1 at 7. Petitioner complained of neck pain radiating into both arms and low back pain radiating down her right leg into her foot. RX 1 at 7-8.

Dr. Bernstein testified he reviewed treatment records and a video of the accident in connection with his examination. He had only a "minimal" recollection of the video. He testified the history Petitioner provided to him was "not really" consistent with the video in that the video showed Petitioner "basically squat down and lean backwards into a rolling maneuver onto the floor." He would not describe Petitioner as having fallen. He saw no evidence that Petitioner struck her head. RX 1 at 9.

Dr. Bernstein testified that Petitioner was "somewhat uncooperative" and very guarded in her movement during his examination. Petitioner put forth "an incomplete effort." RX 1 at 9, 11. He did pinwheel testing for sensation and Petitioner had "decreased sensation involving all the digits of the right hand except for the small finger." Petitioner also had diminished reflexes throughout her upper and lower extremities. RX 1 at 10.

Dr. Bernstein testified that Petitioner's cervical spine X-rays and MRI of May 12, 2008 showed advanced degenerative changes from C5 to C7. He did not note any spinal cord signal changes or spinal cord compression. RX 1 at 11-12. The changes he observed were chronic and unrelated to the work accident. If the accident aggravated these changes, it did not aggravate them in such a way as to require substantial treatment or surgery. RX 1 at 12. Petitioner was not a surgical candidate, based on the MRI, because there was no evidence of nerve root or spinal cord compression. RX 1 at 12. He did not recommend any care. He found Petitioner to be at maximum medical improvement as of the date of his examination. RX 1 at 13. He felt Petitioner could perform light duty, with no lifting over 20 pounds. He believed a functional capacity evaluation would be useful. RX 1 at 13-14.

Dr. Bernstein testified he re-examined Petitioner years later. None of the records he reviewed in connection with the re-examination prompted him to change the opinions he had voiced earlier. Petitioner did not complain of shoulder pain when he examined her in 2008 and he could not imagine how Petitioner could have injured her shoulders in the incident he witnessed on video. RX 1 at 16. Petitioner did not begin treatment for her shoulders until about a year and a half after the accident. He cannot link this treatment to the accident. RX 1 at 17. He is also unable to link Dr. Rock's care to the accident. Dr. Rock performed a rhizotomy

and this procedure "is an effective tool in the management of low back pain." RX 1 at 18. Petitioner still complained of low back pain at the re-examination. RX 1 at 18. His re-examination findings were similar to his original examination findings. RX 1 at 19.

Dr. Bernstein testified he was unable to rely on Dr. Kuritza's interpretation of the cervical spine MRI performed on October 23, 2009. He was also unable to rely on the lumbar spine MRI report of March 12, 2009. RX 1 at 20.

Dr. Bernstein testified that the neck surgery Petitioner underwent was "probably for diffuse degenerative changes." He could not link the need for this surgery to the accident. He was also unable to causally relate the other surgeries and treatment Petitioner underwent. RX 1 at 20-21. He noted that the functional capacity evaluation showed Petitioner to be capable only of sedentary duty. He felt Petitioner could perform light duty, with lifting up to 20 pounds, if Petitioner was at all motivated. RX 1 at 21. He would have continued the restrictions he recommended at his original examination. He did not recommend any additional treatment.

Dr. Bernstein testified that, "at the most," the accident "aggravated a degenerative condition causing some pain complaints." The accident did not bring about the need for cervical spine surgery or low back treatment. RX 1 at 22.

Under cross-examination, Dr. Bernstein testified he charges $1,000 per hour for deposition time. He conducts examinations for legal cases about 100 to 200 times per year. He now charges $1,200 for each examination. RX 1 at 24. He currently gives about 60 to 70 depositions annually. RX 1 at 24. He initially examined Petitioner at the request of Jessica Whiteside of Claims Management. RX 1 at 25. At the initial examination, he reviewed an MRI scan of May 12, 2008 and X-rays. At his re-examination, he reviewed only MRI and X-ray reports. He was not provided with the scans. He reviewed the heading of Dr. Silver's operative reports. He is a spine specialist so he does not delve deeply into shoulder issues. RX 1 at 26. He has no opinion concerning the reasonableness and necessity of the surgeries Dr. Silver performed. RX 1 at 26. He would have expected Petitioner to complain of shoulder pain within a week of the accident in order for the shoulder treatment to be causally related to the accident. RX 1 at 27. Hypothetically, a complaint of neck pain radiating through the shoulders could relate to a shoulder condition. RX 1 at 27. Dr. Kuritza is a radiologist whose reports he has seen hundreds of times. He does not know Dr. Kuritza. RX 1 at 27-28. He has no reason to dispute Dr. Malek's post-operative diagnoses. RX 1 at 29. He did not review Dr. Malek's treatment from a "standard of care" perspective and is in no position to criticize that care. RX 1 at 29. It was reasonable for Dr. Malek to perform the surgery. RX 1 at 29. He is aware that none of the treating physicians found Petitioner to be magnifying her symptoms. RX 1 at 30. He reviewed the video in connection with his first examination, in July of 2008. He has not re-reviewed the video since then but has some independent recollection of it. RX 1 at 31. The video did not show Petitioner slipping or falling. Rather, Petitioner's motion "looked like a manipulated maneuver." Petitioner could be seen "sitting down and rolling backwards." He recalls the video because Petitioner's manipulation "was so flagrant." RX 1 at 32. It is his habit to view a video after an examination. RX 1 at 32. The restrictions he recommended on July 31,

2008 are related to the accident or "at least related to the subjective complaints" Petitioner voiced during the examination, "to the extent that those were valid." RX 1 at 33. Petitioner had stenosis in her cervical spine before the accident. It is possible for a whiplash-type injury to aggravate pre-existing cervical spine stenosis. RX 1 at 34. He is aware that Petitioner's functional capacity evaluation was found to be valid. RX 1 at 34-35. His opinion that Petitioner can perform light rather than just sedentary duty is based on his interpretation of Petitioner's level of motivation. RX 1 at 35. He spent about 20 minutes examining Petitioner in 2012. RX 1 at 35. The functional capacity evaluator would have spent more time than this with Petitioner. RX 1 at 36. Petitioner told him that her right ankle surgery stemmed from the accident. RX 1 at 37-38. However, Petitioner did not list this surgery in the form she completed in connection with his 2012 re-examination. RX 1 at 38-39.

On redirect, Dr. Bernstein testified he dictates his report the same day he performs an examination. RX 1 at 39. He believes that some of the conditions Petitioner had as of the 2012 functional capacity evaluation were not related to the accident. RX 1 at 39-40. He did not observe any whiplash-type injury in the video. RX 1 at 40. He looks through treatment records in the presence of an examinee but it is not his practice to watch a video during an examination. RX 1 at 41. He devotes most of his time to treatment, not examinations. RX 1 at 42. He sees thousands of patients per year. He performs about 250 to 300 surgeries per year. RX 1 at 42. His methodology is the same, whether he is examining a patient for treatment or for Section 12 purposes. RX 1 at 42-43. He recommends treatment or testing to about 20% of the individuals he examines in legal cases. RX 1 at 43. He finds causation as to the need for treatment about 20% of the time. RX 1 at 43-44.

At her attorney's request, Petitioner met with Susan Entenberg, a certified rehabilitation counselor, on April 9, 2013. Entenberg described Petitioner as pleasant and cooperative but "an extremely poor historian." Entenberg noted that Petitioner reported graduating from high school, obtaining an associate's degree in approximately 1988 and taking classes in various subjects, including early childhood education, computers and business, in the 1980s and early 1990s. Entenberg also noted that Petitioner speaks both English and Spanish. She indicated that Petitioner began working for Respondent in 2003 and previously worked at Advocate Medical Center, Head Start and Misericordia. She described Petitioner as having "very limited computer skills."

Entenberg indicated that Petitioner underwent extensive care and several surgeries following her work accident of April 9, 2008. Petitioner reported that she was currently using a cane and taking Lyrica, Flexeril and Omeprazole per her primary care physician, Dr. Sundarasen. [The Arbitrator again notes that this doctor's records are not in evidence.]

Entenberg noted that Petitioner complained of right foot pain and swelling, intermittent neck pain, weakness and numbness in both hands and constant right-sided lower back pain radiating down the right leg and occasionally down the left leg as well. Entenberg indicated that Petitioner denied any shoulder problems.

Entenberg described Petitioner's average day as consisting of very sedentary activities, including twelve hours of lying down.

Entenberg described Petitioner's previous deli processor job for Respondent as unskilled and medium in terms of the level of exertion required.

Based on her interview of Petitioner and her review of Petitioner's records and 2012 functional capacity evaluation, Entenberg found Petitioner incapable of resuming her former job for Respondent. She noted that Petitioner would be unable to resume this job even if consideration were given only to the restrictions Dr. Bernstein recommended on July 31, 2008. Entenberg further opined that Petitioner "is a very poor candidate for vocational rehabilitation, with no stable labor market available to her." She noted that the 2012 functional capacity evaluation limited Petitioner to "less than sedentary work, due to the need for only occasional sitting." Entenberg Dep Exh 2.

Susan Entenberg gave a deposition on behalf of Petitioner on June 24, 2013. Entenberg testified she has worked in the field of vocational rehabilitation since 1975. She achieved certification in 1978. PX 20 at 5-6. She has a contract with the Social Security Administration Office of Disability Adjudication Review. She testifies before administrative law judges as to the kind of work an applicant might be able to perform. PX 20 at 7.

Entenberg testified she met with Petitioner at the request of Petitioner's counsel. She charged $720 for her evaluation of Petitioner. PX 20 at 8. As of the evaluation, Petitioner was 54 years old and living with her adult son. Petitioner reported obtaining an associate's degree in liberal arts in 1988. PX 20 at 8-9.

Entenberg testified she relied on the 2012 functional capacity evaluation in part because Dr. Bernstein recommended that such an evaluation be done to determine Petitioner's validity. The evaluation was valid. PX 20 at 10. Based on the demands of the job Petitioner performed for Respondent, along with the functional capacity evaluation, Entenberg opined that Petitioner could not resume her former job. PX 20 at 12-13. The evaluation showed Petitioner to be at a "less than sedentary" level of function and capable of only limited sitting. Petitioner would not meet the requirements of a sedentary job, which involves sitting for up to one third of the day. PX 20 at 14. The evaluation also showed that Petitioner is capable of only "minimal occasional standing." PX 20 at 16. Petitioner has a "decent" educational history but no transferable skills and very limited computer skills. Petitioner was also "an extremely poor historian." She had a lot of difficulty with dates. She even had difficulty recalling her address and telephone number. PX 20 at 18. There is no reasonably stable labor market for Petitioner's services. Petitioner would have to be able to function at a higher level from a physical standpoint in order to be marketable. PX 20 at 19. Retraining is not an option because it would involve extensive sitting. PX 20 at 19.

Under cross-examination, Entenberg acknowledged that the 2012 functional capacity evaluation does not reflect a prescribing doctor. The report also shows Petitioner to be

functioning at a sedentary level. She relies on the expertise of the evaluator since she is not qualified to perform a functional capacity evaluation. PX 20 at 22-23. A person who has a sedentary job has to be able to sit for prolonged periods. PX 20 at 24. Petitioner told her she spends most of each day lying down. PX 20 at 25. Petitioner could not work as a bank teller or front desk clerk. Those jobs are actually light, not sedentary. PX 20 at 25-27. Petitioner told her she did not perform any job search because she cannot sit or stand for long. Petitioner told her she does not feel like a reliable worker at this point. PX 20 at 28. In this case, given the medical records, she does not believe it is speculative to say Petitioner cannot work, despite the fact that Petitioner did not search for work. PX 20 at 28. Since she is not a doctor, she cannot say which of Petitioner's physical conditions are preventing her from resuming work. At one point in her life, Petitioner was probably trainable but now she may not be, in part because of the difficulty she has with communication. If Petitioner were physically capable of sedentary duty, she would want Petitioner to get "up to speed on a computer." PX 20 at 30.

In addition to the exhibits previously discussed, Respondent offered into evidence a labor market survey prepared by Workfinders USA. The survey is dated June 21, 2013. The author is not identified. The survey reflects that Workfinders USA approached 280 prospective employers and limited its search to sedentary positions with no lifting. The survey lists seven jobs that were open as of the initial contact, with the hourly wage for those jobs ranging from $8.25 to $13.75 per hour. The identified positions are a customer service representative, a reception position at a college, a sales representative position, two bank teller positions, a front desk position at a health club, a telephone operator at a hotel and a guest service agent at a hotel spa. The unidentified author indicates that "so long as [Petitioner] is able to drive and has an attitude of wanting to work, these opportunities present a great opportunity for her to secure employment." RX 4.

In addition to the exhibits previously discussed, Petitioner offered into evidence multiple bills from numerous providers totaling $538,355.97. PX 17. Respondent objected to these bills on the basis of liability, reasonableness and necessity and an alleged violation of the "two doctor" rule.

Petitioner testified that lower back spasms affect her legs and neck spasms affect her hands and arms. These spasms are excruciating. Petitioner testified she also experiences neck pain and right-sided low back pain that radiates down her legs. This pain can be sharp and throbbing at times. The intensity varies, depending on her medication. Activity can aggravate the pain but the pain can also come on spontaneously. She uses a 4-prong cane daily for support. She sits on a chair while showering because she is unable to bend. She is able to dress herself but wears clothes that are easy to put on. She wears slip-on rather than tie shoes. Her sons and grandchildren provide assistance when she has to put socks on. She leaves the house two to four times weekly. She walks with a cane when she is outside her house. On a good day, she can walk a couple of blocks but this tires her out. She experiences "pins and needles" in her toes. She takes Lyrica twice daily and Flexeril three times daily. She took Lyrica but not Flexeril before testifying. Flexeril makes her feel groggy. When she has to go out or sit for an extended period, she applies a pain patch. Dr. Rock prescribed the patches. She is able to

stand for about an hour. No position is comfortable for her. She is most comfortable when she lies down. She sometimes sleeps on a futon that has boards in it. Dr. Hassan recommended this to her. She switches between the futon and a conventional bed at night. On average, she sleeps 3 to 5 hours per night. Lifting a gallon of milk would aggravate her neck. Her son puts milk in small containers for her. She lives on the second floor and has difficulty with stairs. She lives with her son and he assists her with stairs. The neck and shoulder surgeries she underwent helped in the sense that they resulted in improved neck and arm motion. As a result of the surgeries, she can wash her hair on her own, do some cooking and lift 2-pound weights.

Under cross-examination, Petitioner testified it is difficult for her to watch the video of her accident. She believed she hit her head when she fell but, on re-viewing the video, realized this did not happen. She was able to get up and walk away after she fell. She took a leave of absence from work from January 2008 until shortly before the accident. She had only been back at work a few days when the accident occurred. In the past, she worked at an Advocate clinic, answering the telephone, filing records, delivering charts and arranging appointments. She also worked as a teacher's aide in a Head Start program. She could not recall when she did this. She attended college for two years. She studied early childhood education. She did not recall undergoing treatment for a hernia in 2008. Dr. Hassan's office scheduled her to see different doctors. Dr. Hassan referred her to an orthopedic surgeon based on her MRI results.

On redirect, Petitioner testified she took a leave from work in early 2008 because she underwent a total hysterectomy and a pelvic "sling" procedure.

[CONT'D]

15IWCC0700

Arbitrator's Credibility Assessment

Petitioner's presentation was unusual. She appeared significantly deconditioned. As the hearing progressed, she began mumbling rather than answering questions directly. At times, she lapsed into Spanish as she tried to think of how to express something in English. Susan Entenberg aptly described her as a very poor historian.

In his initial examination report of July 31, 2008, Dr. Bernstein indicated that the accident video (PX 18) shows Petitioner "sliding backward in a fall onto her buttock, rolling up her back" with no direct impact to the head or neck. RX 2. At his deposition, almost five years later, Dr. Bernstein went so far as to say that the video, which he had not looked at since his examination, shows Petitioner voluntarily sitting or squatting down and then rolling backward. He testified the video shows a "manipulative" maneuver rather than a legitimate slip and fall.

The Arbitrator, having viewed the accident video several times, disagrees with Dr. Bernstein's assessment. The exact mechanism of injury is not easy to determine, because Petitioner is seen from a significant distance and from the rear rather than the side, but the video appears to show an involuntary and abrupt fall, with Petitioner's feet going up in front of her, rather than a controlled squat and roll. Petitioner's arms shoot out to the side as she lands.

Dr. Bernstein strongly suggests that Petitioner "faked" her fall. The Arbitrator finds this very unlikely. The Arbitrator notes that Respondent stipulated to accident.

Dr. Bernstein also noted symptom magnification and lack of effort in his examination reports. RX 2-3. Interestingly, however, he consistently recommended work restrictions and ultimately agreed with the need for cervical spine surgery. With the exception of Dr. Malek, who at one point implied Petitioner did not fully cooperate with therapy, none of Petitioner's many treating physicians noted symptom magnification or lack of cooperation. Both of Petitioner's functional capacity evaluations were found to be valid.

The Arbitrator notes discrepancies in the histories in Petitioner's voluminous treatment records. The initial Emergency Room records reflect that Petitioner reported falling backward but they do not reflect that Petitioner reported striking her head or attempting to support all of her body weight with her arms. Subsequent records contain significantly more detail but the details are not always consistent. The Arbitrator has taken the inconsistencies into consideration in addressing the disputed issues in this case.

Did Petitioner establish a causal connection between the undisputed accident of April 9, 2008 and her various claimed conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between her work fall of April 9, 2008 and her current cervical spine condition of ill-being. The Arbitrator further finds that the accident led to the need for the cervical spine surgery Dr. Malek performed in December of 2009. In so finding, the Arbitrator relies in part on the accident video (PX 18), which shows a quick, backward fall. The Arbitrator finds it plausible that this fall could have given rise to an unusual jerking of the head and cervical spine complaints even if Petitioner did not strike her head against the floor. The Arbitrator also relies on Dr. Malek's history and records. The Arbitrator further notes that Dr. Bernstein acknowledged under cross-examination that a flexion-extension head movement could aggravate the type of cervical spine stenosis Petitioner had before the accident. To the extent that Petitioner had stenosis, it was not disabling, as evidenced by Petitioner's successful performance of fairly strenuous job duties for Respondent. Petitioner credibly denied having any cervical spine problems before the accident. The voluminous treatment records do not reference any such problems.

The Arbitrator further finds that the work fall resulted in a non-surgical lumbar spine condition that merited an initial course of therapy and an MRI scan. There is no indication Petitioner had lumbar spine complaints before the accident. In 2007, not long before the accident, Petitioner underwent a lumbar spine MRI in connection with a gynecological/abdominal work-up. This MRI, unlike the one performed shortly after the accident, was negative. The Arbitrator notes, however, that a subsequent MRI, performed in 2010, showed improvement, as Dr. Coe conceded.

The Arbitrator further finds that Petitioner established a causal connection between the work fall and right hand and bilateral shoulder contusions or strains, with those conditions warranting initial evaluation, radiographic studies and conservative care through July 31, 2008. Very shortly after the fall, Dr. Slusarenko noted that Petitioner's right hand was swollen and tender. He also noted bilateral upper extremity radicular complaints and neck pain radiating to both shoulders.

The Arbitrator finds, however, that Petitioner failed to establish causation as to the bilateral shoulder surgery that Drs. Morgenstern and Giannoulias recommended and that Dr. Silver ultimately performed. Dr. Giannoulias found causation as to both shoulders, and ultimately recommended surgery, but he mistakenly assumed that Petitioner "slipped forward, landing on both arms." PX 8. Petitioner's shoulder MRIs did not show any acute findings and Dr. Silver did not document any discrete tears in his operative reports. Dr. Silver did not testify and his office notes address causation in only a cursory fashion. Dr. Silver assumed that Petitioner landed on her outstretched arms, "jamming her shoulders," but the video shows Petitioner's arms going out to the side.

The Arbitrator is not persuaded by Dr. Coe's opinion that the accident led to the need for the shoulder surgeries Dr. Silver performed. Dr. Coe is not an orthopedic surgeon. Dr. Coe did not explain how a backward fall, with the arms going out to the side, could result in aggravation of pre-existing impingement syndrome.

Finally, the Arbitrator notes that Petitioner's counsel indicated at the hearing that he was not claiming causation as to the right ankle condition which necessitated surgery in October 2008. Dr. Coe did not address the right ankle at any point in his report or deposition.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims outstanding medical bills in excess of half a million dollars. PX 17.

At the outset, the Arbitrator notes that some of the bills in PX 17, such as the bill from Advocate Illinois Masonic Medical Center for Emergency Room services provided on April 28, 2010 and the bill from Hind General Hospital, are not supported by medical records. Other bills, such as those from Delaware Place MRI, Paulina Anesthesia and Rogers Park One Day Surgery Center, include charges for right ankle treatment, despite Petitioner's stipulation that she is not claiming causation as to the right ankle. Still other bills, such as those stemming from treatment rendered at St. Mary of Nazareth's Emergency Room in June of 2008, relate to general health conditions such as facial swelling and abdominal pain. [The facial swelling that Petitioner experienced on June 19, 2008 was potentially related to her pain medication but Petitioner failed to clearly establish this.]

Based on the foregoing causation-related findings and the information noted in the preceding paragraph, the Arbitrator awards the following medical expenses, subject to the fee schedule:

Affiliated Healthcare (Dr. Slusarenko) 4/11/08 – 7/30/08 (with Respondent receiving credit for a $1,375.88 payment made in July of 2011 – see letter confirming this payment in PX 17)	$ 7,765.00 (minus $1,375.88)
Associated Anesthesiologists of Joliet 12/15/09, anesthesia for cervical spine surgery	$ 2,156.00
ATI Physical Therapy 11/16/09 – 12/11/09, therapy [The Arbitrator declines to award the $400.00 in non-emergency transportation charges reflected in the ATI bill for this period – Petitioner offered no evidence in support of these charges.]	$ 1,939.44
Bassam Osman, M.D. 4/16/08 – 7/23/08 (bill in PX 17 shows $0 balance)	$ 0.00

Diversified Emergency Services		
4/9/08	$	0.00
(bill in PX 17 shows $0 balance)		
Joliet Radiological		
12/15/09	$	0.00
(bill in PX 17 shows $0 balance)		
Lakeshore Open MRI		
5/12/08, cervical spine MRI	$	1,845.30
Michel Malek, M.D.		
2/26/09 – 9/10/10	$	62,203.00
MRI Lincoln Imaging Center		
12/29/09, cervical X-rays	$	225.00
8/20/10, cervical X-rays	$	225.00
NuWave Monitoring		
12/15/09, intra-operative monitoring	$	1,675.00
OP Tech		
12/15/09, cervical collar	$	353.01
Orthofix, Inc.		
12/16/09, bone stimulator	$	4,995.00
Paulina Anesthesia (anesthesia at Rogers Park One Day Surgery)		
5/21/08	$	1,080.00
7/2/08	$	1,080.00
Preferred Open MRI		
12/10/09	$	216.00
Prescription Partners		
10/22/09, Dr. Malek	$	1,190.48
11/5/09, Dr. Malek	$	1,186.79
Pro Clinics (Dr. Hassan)		
5/20/08 – 7/15/08	$	17,101.18
Provena St. Joseph Medical Center		
12/15/09 – 12/16/09, inpatient, cervical spine surgery	$	101,507.85

Rogers Park One Day Surgery		
5/21/08, injection	$	6,709.00
7/2/08, injection	$	6,676.82
Rogers Park One Day Surgery		
5/21/08, physician charges	$	225.00
7/2/08, physician charges	$	225.00
St. Mary & Elizabeth Medical Center		
4/9/08, Emergency Room	$	2,969.50
4/10/08, Emergency Room (bill in PX 17 shows $0 balance)	$	0.00
United Surgical Assistants		
12/15/09	$	17,911.40
Village Imaging Professionals		
4/9/08, cervical and lumbar spine X-rays (bill in PX 17 shows $0 balance)	$	0.00

The Arbitrator declines to award any expenses relating to treatment rendered by Drs. Slusarenko, Osman and Hassan (a/k/a Abdellitif) after July 31, 2008, the date of Dr. Bernstein's first examination. While the Arbitrator disagrees with Dr. Bernstein's assessment of the video, the Arbitrator finds the date of the doctor's first examination to be an appropriate cut-off point for the initial course of conservative care. The records show that Petitioner derived little lasting benefit from this care.

The Arbitrator views Dr. Slusarenko as Petitioner's first choice of physicians. Records in PX 2 reflect that Dr. Slusarenko referred Petitioner to Drs. Osman and Hassan, with Dr. Hassan, in turn, referring Petitioner to several physicians, including, ultimately, Dr. Malek. Petitioner did not exceed her choice of physicians with respect to Dr. Malek. He was within the chain of referrals from her first choice. For the reasons previously stated, the Arbitrator finds the care provided by Dr. Malek, including the three-level fusion, to be related, reasonable and necessary. Post-operative records reflect that Petitioner reported significant pain relief following the fusion. Petitioner's examiner, Dr. Coe, acknowledged that Petitioner obtained a good surgical result.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from April 10, 2008 through August 31, 2008 and from October 7, 2008 through September 10, 2010. Respondent stipulated Petitioner was temporarily totally disabled from April 10, 2008 through June 14, 2008. The parties agree Respondent paid $2,519.04 in temporary total disability benefits. Arb-

Exh 1.

In addressing the issue of temporary total disability, the Arbitrator notes that Dr. Bernstein did not examine Petitioner until July 31, 2008 and that he recommended significant work restrictions in his report of that date. RX 2. Petitioner credibly testified that the work she performed for Respondent was outside those restrictions. Petitioner also testified that Respondent provided her with accommodated work as a greeter in September of 2008. She did not identify the exact period of time during which she performed this work. She attributed her inability to continue greeting to Respondent's decision to take away her chair but the Arbitrator notes she was beginning to experience right ankle problems during this time frame. She does not link these problems to the work accident. She underwent a significant right ankle surgery on October 29, 2008. She also began active shoulder treatment at about the same time, while continuing to undergo care for her neck and back. The Arbitrator has previously found the bilateral shoulder surgical work-up and surgeries to be unrelated to the work accident. Dr. Singh found Petitioner to be a candidate for a cervical fusion on November 7, 2008 but, for reasons that remain unclear, Petitioner did not pursue this course of care until she began seeing Dr. Malek on October 22, 2009.

In short, the issue of temporary total disability is no less problematic than the other issues presented in this case.

Based on the previous causation-related findings and the foregoing chronology, the Arbitrator finds that Petitioner was temporarily totally disabled from April 10, 2008 through August 31, 2008, a period of 16 1/7 weeks, and from October 22, 2009 through September 3, 2010 (the day on which Dr. Malek recommended another lumbar spine MRI and found that Petitioner was "doing a lot better" with respect to her neck), a period of 45 2/7 weeks. The Arbitrator finds that Petitioner reached maximum medical improvement with respect to her causally related surgical cervical spine condition of ill-being on September 3, 2010. The entire temporary total disability award consists of 61 3/7 weeks. Respondent is to receive credit for the $2,519.04 in temporary total disability benefits it paid prior to trial.

What is the nature and extent of the injury? Is Petitioner permanently and totally disabled?

Petitioner claims permanent total disability benefits from September 11, 2010 forward. Arb Exh 1. In making this claim, Petitioner relies, in part, on Dr. Malek's last note, dated September 10, 2010, finding that Petitioner was not a candidate for low back surgery and recommending a functional capacity evaluation.

Based in part on the foregoing causation findings, the Arbitrator declines to award permanent total disability benefits in this case. Some of Petitioner's most significant complaints involve her lower back and lower extremities. No physician viewed Petitioner as a candidate for lower back surgery. The therapist who performed the 2012 functional capacity evaluation attributed Petitioner's limited ability to stand to lower back and right ankle

complaints. Petitioner did undergo a significant right ankle surgery several months after her work accident but did not claim causation as to her right ankle. Dr. Coe did not mention the right ankle in his report or testimony.

While Susan Entenberg viewed Petitioner as essentially unemployable, she conceded that the 2012 functional capacity evaluation showed Petitioner to be capable of sedentary duty, that Petitioner never looked for work and that Petitioner is a very poor historian and communicator. It appears to the Arbitrator that Petitioner long ago gave up any notion of returning to the workplace.

Having found that Petitioner established causation as to a significant cervical spine condition that ultimately required a three-level fusion, and noting that Respondent's examiner, Dr. Bernstein, consistently recommended work restrictions, the Arbitrator awards permanency equivalent to 40% loss of use of the person as a whole, or 200 weeks of compensation, under Section 8(d)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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Matheson,
Petitioner,

vs. 12 WC 10757

Keene Technology, Inc.,
Respondent.

15IWCC0708

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, and temporary total disability, and being advised of the facts and law, reverses the September 26, 2014 Section 19(b) decision of Arbitrator Falcioni. After considering the record as a whole, and for the reasons set forth below, the Commission finds that Petitioner failed to prove that he suffered an accident in the course of and arising out of his employment as a service technician and also failed to prove that his current condition of ill-being is causally related to that accident. Petitioner's claim is therefore denied.

Petitioner began working for Respondent in 2011 as a service technician, servicing rewinders and underwinders for the paper industry nationwide. His job involved lifting a 50 pound toolbox and working in awkward positions throughout the day. Petitioner testified that he traveled to Respondent's clients' facilities to service their machines and that his last three-day job was completed on January 27, 2012 at the James Hardy facility, where he made repairs on an elevated machine. Petitioner described climbing scaffolding and lifting his toolbox over his head onto the machine. After three days on that job, Petitioner was unable to continue working due to his back complaints.

Petitioner acknowledged a history of low back pain beginning in 1990 when he treated with Dr. Gahl. In 2005, he received a spinal cord stimulator implant. He testified this provided relief until he aggravated his back condition with a 2007 work injury while working for another employer. He received nerve blocks and injections, which did not suffice to relieve the problems, and in 2008, Dr. Citow performed fusion surgery at L5-S1. Petitioner testified that post-operatively he was released without restrictions, but admitted he suffered intermittent back spasms and bilateral leg pain after the surgery. He testified he was able to continue working and was unconcerned with the job requirements when he accepted the position of service technician with Respondent. He testified that, although the toolbox was equipped with wheels, he had to lift it several times a day during the course of travel or servicing customers' equipment. He described lifting machine parts weighing up to 75 pounds, climbing scaffolding, bending, twisting, and kneeling. The job at James Hardy required all of these activities, and Petitioner testified that after three days, he was unable to continue working because "my back was gone." Petitioner testified to pain in his right leg, groin and low back. Petitioner admitted to suffering from residual pain at 1-2/10 from his prior lumbar fusion, for which his primary care physician, Dr. Gray, prescribed Norco. Petitioner admitted he might have regularly phoned Dr. Gray's office for medication refills in 2010-11, but asserted that this new pain constituted a "drastic change" in his condition, causing his pain level to increase to 10/10 and his leg pain to move from the left to right leg and groin. Petitioner testified that his current right leg pain is different from any he suffered before this accident in that it travels down his entire leg to his foot. Before this accident, according to Petitioner, his leg pain stopped at his knee and was intermittent.

Petitioner solicited a §12 evaluation from Dr. Jeffrey Coe, who is board certified in occupational medicine. Dr. Coe reported that Petitioner described occasional flare-ups of back and right SI joint pain before this incident, though he denied having any prior right leg pain. Dr. Coe reviewed an MRI performed on May 26, 2010 that showed degenerative disc space narrowing at L4-5, the level above his 2008 fusion. Dr. Coe opined that Petitioner could currently work at the light physical demand level, but should not go back to his service technician job, which was medium demand. The doctor causally related Petitioner's work activities as service technician to the breakdown in his lumbar spine. However, Dr. Coe did not review any medical records from before this accident except for the 2010 MRI. Dr. Coe testified at deposition that he based his opinion on Petitioner's report that he had no right leg pain prior to this incident. If Petitioner had reported right leg pain prior to this incident, Dr. Coe admitted that might affect his causation opinion.

Respondent offered the opinion of Dr. Edward Goldberg of Midwest Orthopaedics at Rush. Dr. Goldberg, a spine surgeon, reviewed Petitioner's medical records from 2006 to the present and found numerous prior right sided complaints. In 2006, Petitioner was admitted to the hospital with complaints of right flank pain. In 2007, he received epidural steroid injections on the right side at L5-S1 on July 26 and August 10 and was prescribed Duragesic patches on July 12 for low back pain radiating to his right lower extremity. On August 28, 2007, Dr. Asner noted that Petitioner complained of right leg radicular pain. Dr. Citow noted the same complaint on September 28, 2007 and eventually performed a fusion at L5-S1 on August 6, 2008. He returned Petitioner to work full duty on January 30, 2009. Dr. Goldberg noted that Petitioner had an MRI on May 26, 2010 and a CT scan on June 14, 2010 that showed his healed fusion at L5-S1 and a laminectomy defect at L4-5. Petitioner reported right leg complaints in May and

15IWCC0708

September of 2010. Late in 2011, Petitioner had tried to get his Norco refilled early, indicating his pain was increasing even prior to his alleged date of accident, and his symptoms after the alleged work incident were the same as before the accident.

Dr. Goldberg noted the lack of any specific incident and observed the Petitioner was already seeing Drs. Gahl and Gray for low back and right leg complaints, including ongoing use of both anti-inflammatory and narcotic pain medication. Noting that Petitioner's pre-existing complaints indicated a pain generator at the same level as following this alleged accident, Dr. Goldberg concluded there was no causal connection between Petitioner's lumbar condition and his work activities in January 2012, and further opined that the heavy lifting involved in Petitioner's job with Respondent would not have aggravated his low back condition, because there was no instability at either L5-S1 or L4-5.

The Arbitrator found Petitioner's expert's causation opinion more persuasive than Dr. Goldberg's and adopted Dr. Coe's opinion that Petitioner's pre-existing back condition was aggravated by his repetitive work activities and awarded Petitioner 133-4/7 weeks of temporary total disability. The Commission views the evidence differently.

The Commission notes overwhelming evidence of pre-existing low back and right leg pain generated by the progressive degeneration or adjacent level failure of the disc at L4-5. Petitioner's testimony that he had never suffered right-sided lower extremity pain prior to January 2012 lacks credibility, as the record is clear that such complaints waxed and waned for several years preceding the alleged accident in this case. Petitioner had sufficiently serious low back pain that a spinal cord stimulator was implanted in 2005 and removed in 2008, when Dr. Citow performed a fusion surgery at L5-S1. Dr. Citow did return Petitioner to work full duty on January 30, 2009, but Petitioner continued to suffer low back and bilateral leg pain and remained on Norco and steroids from that time to the date of accident in this case. In June 2010, Petitioner advised Dr. Gray that he was trying to get on disability. Dr. Gahl noted on April 10, 2012 that Petitioner had at one time been approved for Social Security Disability, but chose instead to attempt to return to the work force. Petitioner told Dr. Gray's nurse on February 1, 2012 that Dr. Citow's release to return to work after his L5-S1 fusion was really for a trial period to see if he could perform a job. At that time, Petitioner told the nurse, he suspected that he would be unable to ever hold a job again. Petitioner's own suspicions regarding his ability to return to the workforce, in addition to his treating physicians' concerns and his long history of waxing and waning back and right leg pain, support the Commission's finding that Petitioner's medical condition pre-existed his alleged work accident.

The Commission finds Dr. Goldberg's opinions persuasive and supported by the prior medical records. The Commission finds that Petitioner failed to prove that an accident arising out of and in the course of his employment with Respondent occurred on January 27, 2012 and also failed to prove that that his current condition is causally related to his work activities. Having so found, the Commission reverses the Arbitrator's Decision. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision is reversed and the Arbitrator's award of 133-4/7 week of temporary total disability is vacated.

15IWCC0708

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 Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: SEP 10 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-07/15/15
jdl/dak
68

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ 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

Bennie Casalino,
Petitioner,
vs.

15IWCC0705
NO: 13 WC 13173

Area Erectors,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, penalties, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 2014 is hereby affirmed and adopted.

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

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

The 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: SEP 10 2015
KWL/vf
O-7/14/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0705

CASALINO, BENNIE
Employee/Petitioner

Case# **13WC013173**
12WC044552

AREA ERECTORS
Employer/Respondent

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
MICAELA M CASSIDY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0705

Bennie Casalino
Employee/Petitioner

v.

Area Erectors
Employer/Respondent

Case # 13 WC 13173

Consolidated cases: 12wc44552

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 **6/2/14**. 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 IN CASE 13 WC 13173

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

FINDINGS

On the date of accident, **12/21/12**, 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. SEE DECISION

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

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

The parties stipulated that in the year preceding the injury, Petitioner earned $**7,495.95**; the average weekly wage was $**1,629.55**.

The parties stipulated that on the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

All remaining issues are moot and no findings are made.

ORDER

Based on the Arbitrator's finding of no accident and no causal connection, no award of benefits is made.

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 Sweeley
Signature of Arbitrator

6/27/14
Date

ICArbDec19(b)

JUN 30 2014

15IWCC0705

FINDINGS OF FACT

Doa - 11/21/12 right knee case 12 WC 44552 and Doa 12/21/12 low back case 13 WC 13173- consolidated matters at trial.

Petitioner testified that he has worked 39 years as a cement mason. Petitioner testified that he belongs to a cement local in Bellwood, Illinois. Petitioner testified that he was hired by Respondent Area Erectors on 10/15/12 and that he worked at two job sites for Respondent in Wheaton and Morton Grove. Petitioner testified that on when he arrived at work on 11/21/12 he was not having any problems with his right knee. Petitioner underwent right knee surgery for a torn meniscus in 2002 but returned to work thereafter and worked for 10 years prior to 11/21/12 without additional treatment during that period.

Petitioner testified that on 11/21/12, he was at the Wheaton job site for Respondent performing his cement mason duties. Petitioner testified that he tripped over a pile of debris on the ground catching his left foot. As he fell, all of his weight was on his right knee and he felt a pop in the right knee. Petitioner testified that the accident was witnessed by a co-worker, Ken Farmer.

Petitioner testified that he had pain in his right knee but did not seek immediate medical attention for the right knee. Petitioner saw his family doctor, Dr. Co, on 11/26/12. Dr. Co's records dated 11/26/12 do not contain a mention of right knee pain. Rather, the records indicate that Petitioner was seen for a "... follow up visit. Note follow up for acute condition. He says that he isn't having any symptoms. He wants to be treated for STD. He says that he has been going through a lot the last couple of months. ..." RX 5. Petitioner testified that his right knee was painful but that he waited to get treatment to see if the pain would decrease. Petitioner testified that he also waited to get treatment as his accident occurred right before the Thanksgiving holiday and that he was off work over the holiday period.

Petitioner testified that his knee pain continued as of 12/6/12 so he reported his accident to Respondent. Specifically, Petitioner testified that he reported the accident to a supervisor Jeff Hardison on 12/6/12 and that paper work was completed. Petitioner completed an accident report on 12/6/12 listing an accident date of 11/22/12. He reported that he injured his right knee walking through debris on the Wheaton job site and that it was witnessed by Ken Farmer. PX 1. Ken Farmer completed a report on 12/6/12 stating that he witnessed Petitioner's accident on 11/22/12 on the Wheaton job. PX 1 b. A form 45 was completed on 12/11/12 by Christy Budziszek. The form 45 also lists an accident date of 11/22/12 on the Wheaton job and an injury to the right knee. PX 1.

Jeff Hardison testified at trial for Respondent. Mr. Hardison is a certified health and safety expert for Respondent. He testified that on 12/6/12, he was performing a random job site safety check when he had a conversation with Petitioner who advised that he was hurt on the Wheaton job site two weeks earlier. Petitioner pointed to the area where the accident occurred and stated that he hurt his knee. Petitioner conceded that he did not report the accident immediately to his foreman. Mr. Hardison testified that the accident environment had changed, that the debris was gone and that he was unable to perform a full investigation. Mr. Hardison offered Petitioner medical care from the company clinic at Physicians Immediate Care as it was located close to Petitioner's home. He did not interact with Petitioner after 12/6/12.

On cross, Mr. Hardison testified that he took a written statement from the witness Ken Farmer and that he recalls Mr. Farmer stating that the witnessed the accident. He further testified that employees are to report accidents immediately but that on occasion some workers wait to report injuries after realizing that the injury is not improving. Finally, he testified that although the accident report lists an accident date of 11/22/12, his first notice of the accident was on the report date of 12/6/12.

Christy Budziszek also testified for Respondent. She has worked for 10 years for Respondent in the capacity of a claims administrator. In that capacity, she obtains and processes injury report and sends reports to the insurance company. In this case, she administered Petitioner's claim. Ms. Budziszek testified that the accident was reported on 12/6/12 and that all of the reports indicated an accident date of 11/22/12 which was Thanksgiving day. She testified that she forwarded the accident reports to the carrier on 12/10/12.

Ms. Budziszek further testified that she received a return to work with restrictions from Petitioner's doctors at the company clinic on 12/10/12. She further testified that she received a follow up note dated 12/13/12 with a full duty return to work. She testified that Petitioner called her on 12/14/12 and she advised Petitioner that he had been replaced.

On 12/6/12 Petitioner was seen at Physicians Immediate Care as sent by Respondent's safety director for an evaluation of right knee pain. The records from the 12/6/12 visit indicate "Patient states he was walking through some debris while on the job about two weeks ago on 11/22/2012 when he tripped and had to catch himself from falling using his right leg. Patient heard a small snap in the right knee and had some mild pain at that time. He was able to finish the day and had some minor pain in that knee with some swelling later on that day. Patient continued to go to work and perform all of his duties but over the last two weeks has been noticing that he is having more pain in the right knee with prolonged standing, kneeling and decided he needed to come in and have it evaluated. Patient had a right knee arthroscopy several years ago with a small meniscal tear and was concerned that it could be another meniscal tear and that is why he came in. Patient has no locking and no giving way of the knee. He just has pain which seems to be generalized to the knee with prolonged walking and kneeling. Patient has no fevers, chills, no redness, no erythema and does complain of some mild swelling in the upper aspect of the knee. Patient has some complaints of feeling the knee is slightly unstable on standing mostly with possible hyperextensions but otherwise his knee is apparently stable. Patient rates the pain at 5/10 which comes and goes. Rest and keeping his leg elevated improves the pain. No other temporal factors. Patient has no other complaints at this time. Patient denies any non-work related incident or event correlating with the development of this condition." PX 2.

On exam was noted very mild suprapatellar swelling and tenderness along the medial joint space and a very mildly positive medial McMurray's test. X-rays revealed mild DJD. Petitioner was assessed with a right knee sprain and a hinged knee brace was applied. He was to elevate and apply ice as well as take ibuprofen. Petitioner was returned to work with restrictions until the recheck of 12/13/12.

Petitioner was rechecked at the clinic on 12/13/12. The notes indicate that Petitioner reported "he is doing much better and has no pain in the knee at the present time." Petitioner's physical exam of the right knee was normal. The assessment was right knee sprain/strain resolved. Petitioner was to advance to full duty without restrictions and released from care at MMI. PX 2.

Petitioner testified that on the day before the doctor's visit of 12/13/12, he spoke with a supervisor and was advised that he had been "fired." Petitioner also testified that he spoke with a union rep the day before the 12/13/12 doctor visit and was told that he had been "replaced" due to his restrictions. As a result, Petitioner testified that he requested the full duty release from Physicians Immediate on 12/13/12 so that he could retain his job. Petitioner denied telling the physicians that he was doing much better and that he had no pain in his right knee.

On 12/21/12 Petitioner returned to Dr. Co. The 12/21/12 notes indicate "The patient is a 56 year old male who presents for a follow up visit. The patient feels well with minor complaints (He hurt his right leg and back at work and wants to see Orthopedic Doctor. He hurt is [sic] on the November 21st). Note for "follow up for chronic condition." He also would like a note for restricted duty at work. At work, tripped, caught himself felt pop and since then he's been in pain. Initially swollen. Reported it to work a week later, placed on light duty and he was fired. Back pains for a few months, now worse with walking different from the knee pain. Stands or walks less than 30 minutes to get significant pain."

The review of the musculoskeletal system noted back pain and joint pain with no present muscle weakness. Physical exam of the right lower extremity revealed "normal strength and tone." The assessment was "knee pain and the current plan was a follow up in 4 months or as needed and a referral to orthopedics. Petitioner was taken off work. PX 3.

The first mention in the medical records of back pain in connection with any alleged accident in these matters is on the visit to Dr. Co on 12/21/12. Petitioner testified at trial that his back was "always hurting" while he was at work but that the back pain worsened after the right knee injury due to the fact that he was walking with a limp. Petitioner testified that he had prior back problems and those problems are reflected in the medical records submitted at trial.

Specifically, on May 10, 2006, the Petitioner underwent an MRI at Universal Open MRI and Diagnostic Center of Naperville, on referral from then-primary care physician Dr. Patricia O'Connor, which disclosed multilevel degenerative disc disease without stenosis, and an annular tear at L4-5 without stenosis. (RX15). Between November 2008 and February 2009, the Petitioner underwent chiropractic care for low back pain that extended down the legs, at Ondras Chiropractic. (RX14). On February 20, 2011, the Petitioner was seen for the first time by Dr. Cary Templin of Hinsdale Orthopedics. He reported low back pain to right groin and back of right thigh and knee for the past several weeks. He rated his pain as an 8 on a scale of 1-10. (RX6). On July 5, 2011, the Petitioner began treating with Dr. Co and reported joint pain to his back, elbows and knees. He reported he was a cement finisher, working two days per week. (RX5). Finally, on September 12, 2012, one month before starting work for Respondent, Petitioner was seen by Dr. Co again. At that visit he reported feeling pretty good, except for his back. He reported icing his back. He reported working 3 days per week as a cement finisher. He was prescribed Tramadol for back pain, and given a Lidoderm patch, also for back pain. Dr. Co characterized the Petitioner's low back condition/diagnosis as a chronic problem. (RX5).

On 1/31/13 Petitioner saw Dr. Burra for his right knee. Dr. Burra performed Petitioner's prior right knee arthroscopy partial medial meniscectomy in 2003. Dr. Burra diagnosed a right knee medial meniscal tear and performed arthroscopic surgery on the right knee on 5/10/13. PX 12. He further testified that the diagnosis was confirmed during surgery as reflected in the operative report and the operative pictures. PX 12. As a result, he disagreed with the Dr. Verma, Respondent's Section 12 physician, who opined 4 days before surgery that Petitioner did not show evidence of significant intra-articular pathology or internal

derangement based on objective examination and MRI scan. Based on the fact that Petitioner was asymptomatic for 10 years between right knee surgeries, the described mechanism of injury and the re-tear shown on MRI and at surgery, Dr. Burra opined that Petitioner's right knee condition was casually related to his accident in November 2012. PX 12. Dr. Burra last saw Petitioner for his right knee on July 2, 2013 following the surgery. Petitioner was discharged from his care on that date with a release to return to his prior employment duties. Dr. Burra testified that Petitioner was "completely asymptomatic" after the surgery. PX 12.

With regard to his back treatment, Petitioner saw Dr. Templin on the referral of Dr. Burra in February 2013. At his deposition, Dr. Templin testified that he originally saw Petitioner in February 2011 for back pain and no surgical recommendations were made at that time. He did not see Petitioner again until February 2013 when Petitioner complained of worsened low back pain with some pain extending into the legs. He noted Petitioner's report of "...some recent heavy activity at work in late 2012, repetitively lifting 80 pound bags of concrete that basically aggravated his back, with pain predominantly in the low back but some pain also extending into the legs. He rated his pain as an 8 out of 10 and also noted that he was – that he had some type of knee injury as well that he had seen Dr. Burra For. I think that's actually how he came back to see me." Dr. Templin opined that the type of activity described to him between October and December 2012 is the type that can aggravate DJD that Petitioner had. PX 11. He opined that such aggravation occurred. PX 11.

Petitioner testified that he advised Dr. Templin that he lifted heavy bags of concrete at work and that is why Dr. Templin noted that information. At his deposition on cross exam, Dr. Templin testified his opinion that Petitioner's back condition was related to repetitive lifting at work was based solely on the history provided by Petitioner. PX 11.

On 4/24/13, Dr. Templin released Petitioner to modified work with no lifting greater than 5 to 10 pounds, sitting, bending, kneeling standing as tolerated." PX 11. Dr. Templin opined that Petitioner can work full time within those restrictions at the time of his deposition. On 6/18/13, Dr. Templin referred Petitioner to Dr. Cheema for pain management as Petitioner complained of pain at 10/10 on that date. PX 11. Dr. Templin's last visit with Petitioner was on 9/9/13. Dr. Templin did not recommend any additional treatment or medication other than a referral to Dr. Cheema. He further testified that he did consider Petitioner's complaints of pain to exceed what he would expect given Petitioner diagnostic presentation. PX 11, p. 26.

Petitioner attended a Section 12 exam with Dr. Verma on 5/6/13, 4 days prior to his knee surgery on 5/10/13. Petitioner advised that he hurt his right knee at work after tripping on debris. As a result of the exam and the records reviewed by Dr. Verma, he noted that he did not "... see any evidence of intra-articular pathology other than the patient having had a prior meniscectomy and I felt his medial-sided symptoms were consistent with most meniscectomy pain or changes related to that prior meniscectomy." RX 18. He further noted that Petitioner's described incident did not cause or aggravate Petitioner's knee condition such that he would need the surgery recommended by Dr. Burra. Dr. Verma found no evidence of a significant injury to the knee on or about November 21, 2012. RX 18.

Petitioner began treatment with Dr. Cheema at the Holistic Science Pain Clinic on 6/21/13. The records reflect that Dr. Burra referred Petitioner to Dr. Cheema. His records of that visit indicate low back pain radiating to the groin. Dr. Cheema noted a decreased range of motion at the lumbar spine and loss of

lumbar lordosis. PX 6. Petitioner had one injection on 7/19/13. Between 6/21/13 and 4/16/14, Petitioner received Norco from Dr. Cheema based on ongoing complaints of low back pain. He did not receive any additional injections as he testified the one he received did not help his pain level. Although the records contain reference to a knee condition, the records note treatment for Petitioner's back complaints only.

Finally, with regard to Petitioner's low back complaints and treatment, Petitioner attended a Section 12 exam with Dr. Goldberg on 5/31/13. RX 21. Petitioner provided a history of repetitively lifting heavy bags of cement at the end of 2012 and developing back pain. The pain traveled into both of his thighs on the front side but did not go below the knees. He also offered that he had knee surgery a few weeks before the exam in May 2013. Dr. Goldberg was also aware that Dr. Templin treated Petitioner two years earlier in 2011 for reported low back pain that traveled into the right thigh and knee and his pain was 8/10. He also reviewed prior back treatment records from 2006, including x-rays showing DJD, Dr. Co records from 11/2/11, 5/15/12 and 11/26/12 indicating no lumbar complaints, and Dr. Co's record from 9/12/12 when Petitioner complained of back pain and he was given Tramadol. Dr. Goldberg also reviewed Petitioner's records for knee and back complaints after the accident in November 2012, including Dr. Co's note of 12/21/12 wherein Petitioner complained of increased back pain worse with walking after his knee injury.

Following his exam of Petitioner's lumbar spine showing him to be neurologically intact, Dr. Goldberg opined that Petitioner had "some degenerative disk disease but I don't think it was caused or aggravated by the work related accident in—around November 2012." His opinion is based on the fact that Petitioner had low back complaints which pre-dated the November 2012 accident and based on the fact that no mention of any work injury to the lumbar spine was made when he was seen by Dr. Co in November 2012, 12/6/12 or 12/13/12 at Physicians Immediate Care. RX 21, p. 15. On cross, Dr. Goldberg testified that lifting heavy bags of cement can "hypothetically" aggravate DJD.

At trial, Petitioner testified that his knee pain subsided about 6 weeks post surgery in 2013. He testified that he no longer has knee pain but only occasional knee pain flare ups. He testified that he has excruciating low back pain. Petitioner testified that he has difficulty getting out of bed in the morning. Petitioner uses ice and therapy to ease the pain in addition to Norco which he takes 3 to 5 pills per day.

Average weekly wage was placed at issue at trial. RX 2 is a recorded statement Petitioner gave to the insurance company dated 12/12/12. Petitioner did not mention any low back injury in the statement. Petitioner stated that as a cement mason he earned $41.65 per hour. He testified that for Respondent and when asked how many hours he worked per week he worked he normally worked on average "40 but recently we've been working 32, you know, 24 its been erratic I don't know how to answer that question. ... in summer months we work, you know, 40 in the winter months we work 24 so. ... the weather doesn't provide" [in the winter months]. PX 9 contains wage records from Respondent showing that between 10/2/12 and 11/18/12, Petitioner pay records from his time of hire to 11/21/12, Petitioner worked 105 hours, 14 days, and 2.8 weeks. His total earnings for that period is $4,446.75/2.8 weeks yields an AWW of $1,588.13.

CONCLUSIONS OF LAW

The foregoing findings of fact are incorporated into the following conclusions of law in both cases 12 WC 44552 and 13 WC 13173.

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 with Respondent? E. Was timely notice provided to Respondent? F. Is Petitioner's current condition of ill-being causally related to the injury?

With regard to the accident date of November 21, 2012 and Petitioner's right knee injury alleged in case **12 WC 44552**, the Arbitrator finds that Petitioner sustained an injury to his right knee on November 21, 2012 arising out of and in the course of his employment for Respondent and that his right knee condition through July 2, 2013 is causally related to the accident. The Arbitrator further finds that Respondent received proper and timely notice of that accident and injury.

The Arbitrator notes that Petitioner had a prior right knee surgery almost 10 years before this accident. However, Petitioner worked without treatment or symptom during that period up to the date of accident on 11/21/12. Petitioner credibly testified that he tripped over debris at the worksite on 11/21/12. Petitioner testified that he waited to report the injury or seek treatment over a holiday period while waiting to see if the pain and swelling subsided. When the symptoms continued, Petitioner reported is injury to Jeff Hardison on 12/6/12 as testified to by Mr. Hardison and accident reports were completed. Statements were given to the insurance company documenting the accident and the knee pain. PX 1. The Arbitrator further finds that the accident was witnessed by co-worker Ken Farmer as referenced in the accident reports.

Petitioner testified that he initially received treatment at Respondent's direction from Physician's Immediate Care. The Arbitrator notes those records contain a consistent accident history. The records from 12/6/12 note that exam revealed very mild suprapatellar swelling and tenderness along the medial joint space and a very mildly positive medial McMurray's test. X-rays revealed mild DJD. Petitioner was assessed with a right knee sprain and a hinged knee brace was applied. He was to elevate and apply ice as well as take ibuprofen. Petitioner was returned to work with restrictions until the recheck of 12/13/12.

Between 12/6/12 and the recheck of 12/13/12, Petitioner discovered he may have been replaced at the worksite due to his restrictions. Petitioner testified that when he returned to Physician's on 12/13/12, he reported no continued knee problems and requested a return to full duty in order to keep his job. When he called to return he was told he had been replaced and/or fired. On 12/21/12 Petitioner returned to his primary physician Dr. Co. The 12/21/12 notes indicate "The patient is a 56 year old male who presents for a follow up visit. The patient feels well with minor complaints (He hurt his right leg and back at work and wants to see Orthopedic Doctor. He hurt is [sic] on the November 21st). Note for "follow up for chronic condition." He also would like a note for restricted duty at work. At work, tripped, caught himself felt pop and since then he's been in pain. Initially swollen. Reported it to work a week later, placed on light duty and he was fired." Following the referral for orthopedic care for his knee, Petitioner saw Dr. Burra.

On 1/31/13 Petitioner saw Dr. Burra for his right knee. Dr. Burra performed Petitioner's prior right knee arthroscopy partial medial meniscectomy in 2003. Dr. Burra diagnosed a right knee medial meniscal tear and performed arthroscopic surgery on the right knee on 5/10/13. PX 12. He further testified that the diagnosis was confirmed during surgery as reflected in the operative report and the operative pictures. PX

12. As a result, he disagreed with the Dr. Verma, Respondent's Section 12 physician, who opined 4 days before surgery that Petitioner did not show evidence of significant intra-articular pathology or internal derangement based on objective examination and MRI scan. Based on the fact that Petitioner was asymptomatic for 10 years between right knee surgeries, the described mechanism of injury and the re-tear shown on MRI and at surgery, Dr. Burra opined that Petitioner's right knee condition was casually related to his accident in November 2012. PX 12. Dr. Burra last saw Petitioner for his right knee on July 2, 2013 following the surgery. Petitioner was discharged from his care on that date with a release to return to his prior employment duties. Dr. Burra testified that Petitioner was "completely asymptomatic" after the surgery. PX 12. Petitioner testified that his right knee subsided about 6 weeks after the surgery. The Arbitrator further finds that no treatment was rendered to Petitioner for his right knee after that date. To the extent any treatment was rendered or referenced in subsequent treatment records after July 2, 2013, it is not causally connected to the accident of 11/21/12.

In finding causal connection for the right knee, the Arbitrator places greater weight on the opinion of Dr. Burra and his operative findings than on the pre-surgical opinion of Dr. Verma. Based on the totality of the credible evidence at trial, the Arbitrator finds accident on 11/21/12, proper and timely notice, and causal connection for Petitioner's right knee injury and treatment through the MMI date of July 2, 2013.

With regard to the alleged accident of 12/21/12 and the alleged low back injury on that date in case **13 WC 13173**, the Arbitrator notes Respondent's dispute on the issues of whether Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act and to employment relationship based on the fact that Petitioner was no longer working for Respondent on the alleged date. However, the Arbitrator notes Petitioner's theory of accident and injury at trial which was that Petitioner's low back injury arose as a result of his altered gait due to the knee injury as well as reference to repetitive lifting during his period of employment. Petitioner first reported the back complaints to Dr. Co on 12/21/12. Thus, the Arbitrator notes Petitioner's reasoning for the alleged accident date to be valid under the Act.

Nevertheless, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injury to his low back which can be considered casually related to his employment with Respondent on any date under either theory of recovery. In so finding, the Arbitrator notes Petitioner's significant history of low back complaints and treatment as recently as 2 months prior to starting his employment with Respondent, the lack of low back complaints documented in the initial treating records of Dr. Co or Physician's Immediate Care and the lack of low back injury during his recorded statement. With regard to the first mention of low back complaints to Dr. Co on 12/21/12, the Arbitrator notes that Dr. Co referred to the low back condition as "chronic" referencing his prior treatment of Petitioner's complaints. In denying accident and causal connection, the Arbitrator further notes the inconsistent accident histories noted throughout the record. Specifically, the Arbitrator notes that on some occasions, at trial, and in records Petitioner reports back pain due to altered gait following his knee injury. On other occasions and records, Petitioner reports back injury from repetitive lifting of heavy cement bags. The Arbitrator notes that these inconsistencies detracted from Petitioner's credibility regarding the relationship between his low back complaints and any work related activity.

Finally, in denying accident and causal connection for the low back complaints, the Arbitrator places greater weight on the opinions offered by Dr. Goldberg over that of Dr. Templin and agrees with the basis of Dr. Goldberg's opinion as noted above in light of the record in its entirety.

In light of the findings on the issues of accident and causal connection, all other issues are moot and no findings are made on those issues in case 13 WC 13173. **No benefits are awarded in case 13 WC 13173.**

The remaining conclusions of law are made in case 12 WC 44552 only in connection with Petitioner's right knee injury.

G. What were Petitioner's earnings?

The parties differ in their calculation of the average weekly wage, Petitioner asserting that the correct amount is $1,588.13, while Respondent asserts that it is $1,016.40.

In *Sylvester v. Industrial Comm'n*, 197 Ill. 2d 225, 756 N.E.2d 822 (4th Dist. 2001), our supreme court noted that section 10 provides four methods of calculating average weekly wage: (1) by default, average weekly wage is "actual earnings" during the 52-week period preceding the date of injury, illness or disablement, divided by 52; (2) if the employee lost five or more calendar days during that 52-week period, "whether or not in the same week," then the employee's earnings are divided not by 52, but by "the number of weeks and parts thereof remaining after the time so lost has been deducted;" (3) if the employee's employment began during the 52-week period, the earnings during employment are divided by "the number of weeks and parts thereof during which the employee actually earned wages;" and (4) if the employment has been of such short duration or the terms of the employment of such casual nature that it is "impractical" to use one of the other three methods to calculate average weekly wage regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. *Sylvester*, 756 N.E.2d 822.

In this matter, the Arbitrator relies on the third method noted above in that Petitioner began his work for Respondent in October 2012. Using the wage figures in PX 9, between 10/21/12 and 11/18/12 Petitioner worked 105 hours, 14 days, or 2.8 weeks. His total earnings for that period were $4,446.75/2.8 weeks yields an AWW of $1,588.13 and a TTD rate of $1,058.75.

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

Based on the findings on the issues of accident and causal connection with regard to Petitioner's right knee injury, and on Respondent's liability dispute on the issue of medical expenses, the Arbitrator further finds that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's right knee through July 2, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

L. What temporary benefits are in dispute? TTD

Based on the findings on the issues of accident and causal connection with regard to Petitioner's right knee injury, and on Respondent's liability dispute on the issue of temporary total disability, the Arbitrator

further finds that Petitioner was temporarily and totally disabled for a period of 29-6/7 weeks commencing 12/6/12 through 7/2/13 pursuant to Section 8(b) of the Act. The finding is further based on the restricted duty and off work authorizations of Petitioner's treating physicians. Respondent shall receive credit for amounts paid, if any.

M. Should penalties or fees be imposed on Respondent?

To the extent Petitioner alleges he is entitled to penalties and fees under the Act, the Arbitrator finds that based on the record in its entirety, Respondent's conduct was not so unreasonable or vexatious so as to justify the imposition of penalties or fees under Sections 19(k), 19(l) or 16 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle L. Hankins,
Petitioner,

vs. No: 11WC 23890

State of Illinois/Illinois Veterans Home--Quincy,
Respondent.

15IWCC0709

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, and nature and extent of the permanent disability, and being advised of the facts and law, modifies the Arbitrator's award of permanent partial disability and otherwise affirms and adopts the August 4, 2014 Decision of Arbitrator William Gallagher, which is attached hereto and made a part hereof.

Petitioner, a 39 year old care plan registered nurse, had been employed by Respondent since 1993. She alleged that on April 7, 2011, she was leaving her office to attend a meeting when she slipped and fell on a wet floor. Petitioner testified that she bumped her right elbow on the register outside her door and landed on her buttocks and both hyper-extended hands. At hearing on April 2, 2014, Petitioner amended her application for adjustment to include the allegation of injury to her right elbow. The application originally filed alleged injury to both hands, neck and back. She also sought penalties and fees.

15IWCC0709

Respondent did not dispute accident or causal connection regarding Petitioner's left hand injury. However, it argued that Petitioner's right elbow condition was not causally related to her April 7, 2011 slip and fall. No one witnessed Petitioner's accident, but several co-workers heard her call for help and responded immediately thereafter. Petitioner introduced the testimony of two co-workers and a family member, two of whom testified that her elbow was red and swollen on the day of the accident. Respondent argued that Petitioner had completed three reports of accident on that date: a home incident report, a workers' compensation notice of injury, and a workers' compensation claim form. All three described Petitioner's fall and complaints of bilateral hand and wrist pain, but omitted any reference to her right elbow. Respondent notes that Petitioner's initial consultation with Dr. Moore on the date of accident included complaints of pain in both wrists, back and neck, but "No other pains in the shoulders or elbows." Although Petitioner did not specify an elbow injury, she did complaint of right wrist pain, radiating to her thumb, and on April 15, 2011, Dr. Moore noted that Petitioner probably suffered median nerve compression at her elbow or wrist. An EMG performed on April 19, 2011 indicated right ulnar neuropathy with compression at the cubital tunnel.

Respondent moved to reopen proofs when it learned after the hearing on April 2, 2014 that one of Petitioner's witnesses was not scheduled to work on the date of the accident. Arbitrator Gallagher granted Respondent's motion, and proofs were re-opened for additional testimony on May 14, 2014. At that hearing, Respondent offered the testimony of its HR assistant, who testified that Petitioner's witness had requested April 7, 2011 off work due to family illness. The witness testified that, although she wasn't scheduled to work that day, she had come into the building to retrieve some items that had fallen out of her purse on the day before. She denied having deliberately misled the Arbitrator at her first appearance when she represented that she was at work that day and said she had merely forgotten that she was off work, but still present, on the date of Petitioner's accident.

Petitioner offered the causation opinion of her §12 examiner Dr. Jeffrey Williams in support of her allegation of causal connection between her accident and right cubital tunnel. The doctor opined that Petitioner's right cubital tunnel could have been caused by her fall, if she struck the inside of her right elbow at the "funny bone" on the register as she fell. Dr. Williams admitted on cross-examination at his deposition that the cubital tunnel condition was mild and could have been chronic. He also listed several medical causes of cubital tunnel. Although he admitted on cross-examination at his deposition that he would have expected Petitioner to complain immediately of elbow pain if she had struck her elbow, he found her immediate complaints of pain in both wrists radiating from the fingers up both arms to be consistent with her diagnoses of left carpal and right cubital tunnel.

Arbitrator Gallagher found that Petitioner's right cubital tunnel was causally related to her fall on April 7, 2011. Based upon his conclusion that both her left carpal and right cubital tunnel conditions were causally related to Petitioner's work accident, Arbitrator Gallagher awarded Petitioner medical expenses related to treatment of both injuries, including surgical releases, temporary total disability for 39-3/7 weeks, and permanent partial disability of 15% loss of use of the left hand for Petitioner's left carpal tunnel syndrome injury and 15% loss of use of the right arm for her cubital tunnel injury. The Arbitrator declined to award Petitioner penalties and fees.

15IWCC0709

After considering the entire record, and for the reasons set forth above, the Commission affirms the Arbitrator's findings of accident arising out of and in the course of Petitioner's employment and causal connection between the aggravation of her left carpal tunnel syndrome, right cubital tunnel, and her slip and fall on April 7, 2011. However, the Commission finds the Arbitrator's award of permanent partial disability excessive under the facts as interpreted by the Commission.

Petitioner testified that her left hand is still weak and a bit achy, and she complained of occasional right elbow pain. Keyboarding caused her some discomfort, and she occasionally felt some pain in her right elbow when lifting a grandchild. Based upon these relatively minor complaints of occasional discomfort, and upon her doctors' records indicating resolution of her symptoms following her surgeries and release to return to work with no restrictions, the Commission finds that her permanent partial disability is 10% loss of use of the left hand for her left carpal tunnel syndrome and 10% loss of use of the right arm for her right cubital tunnel syndrome.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the August 4, 2014 Decision of the Arbitrator is modified with regard to the award of permanent partial disability, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $916.41 per week for a period of 39-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64/week for a period of 45.8 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 10% loss of use of the left hand and 10% loss of use of the right arm.

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 injuries.

15IWCC0709

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

DATED: SEP 10 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/04/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANKINS, MICHELLE L
Employee/Petitioner

Case# **11WC023890**

ILLINOIS VETERANS HOME-QUINCY
Employer/Respondent

15IWCC0709

On 7/16/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST PO BOX 2475
SPRINGFIELD, IL 62705

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4993 ASSISTANT ATTORNEY GENERAL
ANDREW SUTHARD
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

JUL 17 2014

RONALD A. RABBIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michelle L. Hankins
Employee/Petitioner

v.

Illinois Veterans Home - Quincy
Employer/Respondent

Case # 11 WC 23890

Consolidated cases: n/a

15IWCC0709

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 14, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On April 7, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $71,999.72; the average weekly wage was $1,374.61.

On the date of accident, Petitioner was 39 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $23,301.54 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $23,301.54.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $916.41 per week for 39 3/7 weeks commencing April 7, 2011, through October 14, 2011; January 13, 2012, through February 6, 2012, and August 17, 2012, through October 18, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 68.7 weeks because the injury sustained cause the 15% loss of use of the left hand and 15% loss of use of the right arm, as provided in Section 8(e) of the Act.

Petitioner's petition for penalties and attorneys' fees is denied.

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

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

William R. Gallagher, Arbitrator

July 11, 2014
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on April 7, 2011. According to the Application, Petitioner fell on a wet floor and landed on her "bottom" and her hyperextended hands sustaining injuries to the left hand/wrist, right hand/wrist, neck and upper back. When this case was tried, Petitioner's counsel made a motion to amend the Application to include the right elbow. This motion was granted by the Arbitrator. Respondent disputed liability on the basis of accident and causal relationship; however, the primary liability dispute was in regard to the alleged injury to the right elbow. Petitioner's counsel also filed a petition for Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees

This case was initially tried in Quincy on April 2, 2014. Shortly thereafter, Respondent's counsel filed a motion to reopen proofs (Arbitrator's Exhibit 5). Counsel for Petitioner and Respondent discussed this motion with the Arbitrator via conference telephone call on May 6, 2014. The Arbitrator granted the motion and additional evidence was heard in Springfield on May 14, 2014.

Petitioner has worked for Respondent since 2003 and, at the time of the accident, Petitioner's job title was MDS Coordinator. Petitioner is an RN and her job duties include management of the medical charts, participating in care planning, etc. Petitioner testified that on April 7, 2011, she was walking out of her office to go to a care plan meeting when she slipped and fell on a wet floor. When Petitioner fell, she landed on both of her extended hands which caused her to experience pain in both wrists/hands. Petitioner also testified that when she fell, she struck her right elbow on a radiator there was attached to the wall adjacent to the area where she sustained the fall. Petitioner described the impact to her right elbow as being to the "funny bone" and that she noted swelling in that area shortly thereafter. Petitioner also experienced some pain in the back and neck as well, but the symptoms subsequently resolved.

The primary dispute in this case was whether Petitioner did, in fact, injure her right elbow when she sustained the work-related accident on April 7, 2011. The accident was not witnessed; however, a number of co-workers heard Petitioner fall and came to provide assistance to her shortly thereafter.

Jeanette Quesenberry testified on behalf of the Petitioner and stated that she worked for Respondent as a housekeeper for approximately 11 years. At the time Petitioner fell, Quesenberry was in a room used by housekeeping. After she heard which she described as a "bang" she observed Petitioner laying on the ground leaning back against the radiator. Petitioner complained of pain in the left hand and Quesenberry observed swelling and redness of the right elbow.

Subsequent to the trial of this case in Quincy, Respondent's counsel determined that Quesenberry did not work on the date of the accident, April 7, 2011. This was the basis for Respondent's counsel filing the motion to reopen proofs (Arbitrator's Exhibit 5). Respondent's counsel subpoenaed Quesenberry and she testified again in Springfield on May 14, 2014. Quesenberry testified that she did not work on April 7, 2011; however, she testified that she was at Respondent's facility on that date even though she was not working. Her explanation was that on

the preceding day her purse (which was located in the storage area used by housekeeping) got knocked over spilling its contents under a metal table. When Quesenberry discovered this, she gathered up what she thought were all of its contents and left Respondent's facility at approximately 3 PM. The following day, April 7, 2011, Quesenberry determined that not all of the contents of her purse had been recovered and that she was lacking various things including her drivers' license, credit cards, etc. Quesenberry returned to Respondent's facility, retrieved the items from under the metal table and it was while she was there that she heard Petitioner fall.

Keitha Stark, Respondent's HR Coordinator, testified on behalf of the Respondent on May 14, 2014. She identified one exhibit that confirmed that Quesenberry did not work on April 7, 2011, and another exhibit which was an employee absence request prepared by Quesenberry requesting the day off because of an ill family member (Respondent's Exhibits 12 and 13). Quesenberry confirmed that she requested the day off because her fiancé's granddaughter was ill.

Felicia Kindhart, a c-worker, testified on behalf of the Respondent. Kindhart is also an RN and shares an office with Petitioner. At the time Petitioner sustained the fall, Kindhart was on the phone and heard Petitioner yell "hey." She observed Petitioner laying on the floor and observed another employee named Brenda assist Petitioner to get up off the floor. She testified that Petitioner complained of hurting all over, in particular, her left wrist. Petitioner did not show Kindhart her right elbow.

Lynn Alderton, Petitioner's immediate supervisor, also testified on behalf of the Respondent. Alderton's office is in another building and she was there at the time of Petitioner's accident. She confirmed that another supervisor, Lynette Carpenter, completed the Supervisor's Report of Injury (Petitioner's Exhibit 1).

Brenda Langan testified by deposition, on behalf of the Respondent. Langan is also an employee of Respondent and was in her office at the time of Petitioner's accident and she responded after hearing a noise in the hall. She confirmed that Kindhart was also present and that they provided assistance to Petitioner. She stated that Petitioner complained of her hands hurting. She did not observe Quesenberry at that time; however, she did testify that she was only present for just a few minutes. She also confirmed that there was a heating register adjacent to the area where Petitioner fell (Respondent's Exhibit 14).

Cary Veile testified on behalf of the Petitioner at trial. Veile works for Respondent as a housekeeper and is Petitioner's sister-in-law. She did not witness the accident, but she was at Petitioner's residence either that same evening or the next evening and observed that Petitioner's right elbow was red and swollen.

On the day of the accident Petitioner prepared three reports, a Home Incident Report, a Workers' Compensation Employee's Notice of Injury and a Workers' Compensation Claim. All of these reports described Petitioner's slip and fall on the wet floor and that Petitioner had complaints in both wrist/hands. There was no specific reference to any injury to the right elbow (Petitioner's Exhibit 1).

Petitioner initially sought medical treatment at Quincy Medical Group where she was seen by Dr. Travis Moore on April 7, 2011. The medical record indicated that Petitioner fell on a wet floor and landed on both of her wrists. Petitioner complained of pain in both wrist as well as some tingling of the left thumb. She did not complain of pain in either shoulder or elbow. A wrist splint was prescribed for the left hand and a 10 pound lifting restriction was imposed (Petitioner's Exhibit 1).

Dr. Moore saw Petitioner on April 11, 2011, and her right wrist/hand pain and improved but her left wrist/hand symptoms had worsened. Dr. Moore authorized Petitioner to be off work and noted that an EMG might be necessary. When seen on April 15, 2011, Dr. Moore ordered an EMG which was performed on April 19, 2011. Both nerve conduction studies and an EMG were performed by Dr. Linda Johnson on that date. In her record, she noted that Petitioner had throbbing numbness and tingling worse in the left hand and burning in the right hand since April 7, 2011. The nerve conduction studies revealed moderately severe left median neuropathy and right ulnar neuropathy at the cubital tunnel (Petitioner's Exhibit 3). Dr. Moore saw Petitioner again on April 25, 2011, and referred her to Dr. George Crickard. Dr. Crickard saw Petitioner on April 26, 2011, and he reviewed the nerve conduction studies and EMG. He opined Petitioner had left carpal tunnel syndrome that was asymptomatic before the fall and that carpal tunnel release on the left hand was indicated.

Petitioner was subsequently seen by Dr. Steven Dement on April 28, 2011, and Petitioner continued to complain of bilateral hand/wrist symptoms including the right thumb and little finger. He opined that the little finger symptoms were because of the ulnar neuropathy but had no explanation for the right thumb symptoms. He prescribed a wrist brace and recommended Petitioner undergo an MRI scan. An MRI scan was performed on May 7, 2011, which revealed some osteoarthritis of the right thumb. Dr. Crickard saw Petitioner on May 12th, 2011, and she was wearing wrist braces on both hands at that time (Petitioner's Exhibit 2).

Dr. Crickard referred Petitioner to Dr. Ethan Philpott, who saw Petitioner on July 27, 2011. Dr. Philpott noted that Petitioner had sustained a fall in which she struck the palms of both hands which caused an exacerbation of carpal tunnel syndrome of the left hand. In regard to the right upper extremity, he noted that Dr. Crickard previously performed right carpal tunnel surgery several years ago. Petitioner complained of burning/numbness going from the dorsal first web space to the posterior forearm. Dr. Philpott opined Petitioner had carpal tunnel syndrome of both hands and cubital tunnel syndrome on the right side. He noted that a cubital tunnel release on the right side might be appropriate. In his office note of August 29, 2011, Dr. Philpott noted that Petitioner needed a left carpal tunnel release and right cubital tunnel release (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on August 3, 2011. In connection with his examination, Dr. Williams reviewed various medical records provided to him by Respondent. Dr. Williams opined that the accident of April 7, 2011, could have aggravated Petitioner's pre-existing carpal tunnel syndrome condition in the left hand/wrist and that surgery was indicated. He also opined that the right cubital tunnel syndrome was a new condition and that it could have been related to the accident of April 7, 2011, and that Petitioner was a candidate for a right cubital tunnel release (Petitioner's Exhibit 8).

On January 13, 2012, Dr. Philpott performed an open left carpal tunnel release. Petitioner remained under Dr. Philpott's care following the surgery and he released her to return to work on February 6, 2012. There are some handwritten notes contained at the bottom of Dr. Philpott's office record of April 24, 2012, which (although somewhat difficult to decipher) indicated that on April 7, 2011, Petitioner fell with both outstretched hands and hit elbow on a register (Petitioner's Exhibit 6).

Petitioner then had a dispute of some nature with Dr. Philpott regarding some complaints she had of shoulder pain. There was no indication that this was alleged to be a work-related condition. In any event, according to Dr. Philpott's record, Petitioner made a "seen" [scene] in the lobby and he declined to see her thereafter (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Mark Greatting, an orthopedic surgeon, on June 13, 2012. According to Dr. Greatting's record of that date, Petitioner provided a history of slipping and falling on a wet floor on April 7, 2011, landing on both of her outstretched wrists and striking the posteromedial aspect of her right elbow on a heating/air-conditioning register. Dr. Greatting noted that Petitioner had undergone left carpal tunnel surgery but still had tenderness in the area of the surgical incisions and numbness/tingling in the ring and little finger of the left hand. Petitioner also had complaints of numbness/tingling of the ring and little finger of the right hand which she did not have prior to the accident, but developed afterwards. Dr. Greatting opined that "Based on her history I think she sustained some direct trauma to her ulnar nerve the time she fell and I think this is directly related to the injury." (Petitioner's Exhibit 7).

Dr. Greatting performed an open right cubital tunnel release on Petitioner on August 7, 2012. Subsequent to the surgery, Petitioner remained under Dr. Greatting's care and he restricted her from working until the office visit of October 18, 2012, when he opined that she was at MMI (Petitioner's Exhibit 7).

Petitioner's counsel took the deposition of Respondent's Section 12 examiner, Dr. Williams, on October 31, 2013. Dr. Williams' testimony was consistent with his medical reports and he reaffirmed his opinions regarding causality of both the left carpal tunnel syndrome and right cubital tunnel syndrome. Dr. Williams agreed that the medical records pertaining to treatment Petitioner received shortly after the accident and the witness statements he reviewed did not specifically reference that Petitioner struck her elbow or that she had any complaints to same (Petitioner's Exhibit 11; pp 18-20; 26-28).

As noted herein, Petitioner previously had right carpal tunnel surgery performed some years ago. This was a workers' compensation case which was settled for 15% loss of use of the right hand. A copy of the settlement contract was received into evidence at trial (Respondent's Exhibit 9).

At trial Petitioner testified that she still experiences pain and aching in her left hand and that its grip strength is less than what was previously. Petitioner still has pain/tenderness in her right elbow. Petitioner was able to return to work at her regular job for Respondent; however, she did state that keyboarding does cause her to experience some discomfort.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent on April 7, 2011, when she fell injuring her left hand and right elbow.

In support of this conclusion the Arbitrator notes the following:

There was no apparent dispute that Petitioner sustained a slip and fall on a wet floor on the Respondent's premises. While the fall was not witnessed, various individuals responded to Petitioner's request for assistance immediately afterward.

There was likewise no dispute that Petitioner injured her left hand when she sustained the fall. The primary dispute was whether Petitioner injured her right elbow when she sustained the fall.

Petitioner testified that she struck her right elbow on a radiator when she fell. Petitioner's testimony was corroborated by two witnesses, Jeanette Quesenberry and Cary Veile.

As noted herein, Quesenberry testified both on April 2, 2014, in Quincy and again on May 14, 2014, in Springfield. While her explanation of being on Respondent's premises but not working on April 7, 2011, is rather remarkable, Quesenberry had nothing to gain by giving false testimony. She stated that she observed some swelling and redness of Petitioner's right elbow shortly after the accident.

Cary Veile, who was admittedly Petitioner's sister-in-law, also observed swelling and redness of Petitioner's right elbow either the evening of the accident or the following evening.

Respondent's witness, Felicia Kindhart, stated that Petitioner complained of hurting all over; however Petitioner's primary complaint was her left wrist. Kindhart testified she was unaware of an injury to Petitioner's right elbow. Merely not pointing out an injury is not equivalent to denying an injury to the right elbow existed.

Respondent's witness, Brenda Langan, testified that Petitioner injured her hands and confirmed that there was a register adjacent to the area where Petitioner fell. She was only present for a few minutes thereafter.

While the medical records pertaining to treatment Petitioner received shortly after the accident did not specifically reference Petitioner's having struck her right elbow at the time of the fall, Petitioner did have left and right hand/wrist symptoms. Further, when the nerve conduction studies and EMG were performed on April 19, 2011, it was noted that Petitioner had bilateral hand symptoms since April 7, 2011.

While the various reports prepared shortly after the accident did not contain any specific reference to the Petitioner having struck her right elbow, they all consistently noted that Petitioner had complaints to both wrists/hands.

Respondent did produce evidence of Petitioner having undergone carpal tunnel surgery, on the right hand prior to the accident of April 7, 2011; however, no evidence was tendered that demonstrated that her right cubital tunnel syndrome was related to that prior surgery or any other pre-existing condition.

At best, the preceding evidence indicates that, at the time of the accident of April 7, 2011, the primary focus of Petitioner's complaints were the left hand and, to a lesser extent, the right hand and not the right elbow.

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

The Arbitrator concludes that Petitioner's condition of ill-being in regard to both the left hand and right elbow are related to the accident of April 7, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner's left carpal tunnel syndrome was related to the accident of April 7, 2011.

In regard to the right elbow, Petitioner's treating doctor, Dr. Geatting, and Respondent's Section 12 examining doctor, Dr. Williams, both opined that Petitioner's right cubital tunnel syndrome was related to the accident of April 7, 2011.

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

The Arbitrator concludes that all the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 39 3/7 weeks commencing April 7, 2011, through October 14, 2011; January 13, 2012, through February 6, 2012; and August 17, 2012, through October 18, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner was authorized to be off work by her treating physicians during aforementioned periods of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the left hand and 15% loss of use of the right arm.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained an injury which resulted in the left carpal tunnel syndrome and right cubital tunnel syndrome, both of which required surgery. Petitioner still has complaints referable to both areas consistent with the injury she sustained.

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

The Arbitrator concludes Petitioner is not entitled to Section 19(k) or Section 19(l) penalties as well as Section 16 attorneys' fees.

In support of this conclusion the Arbitrator notes the following:

Respondent's denial of the right elbow condition was neither in bad faith nor vexations. It is further noted that the proposed Decision submitted by Petitioner did not award penalties or attorneys' fees.

William R. Gallagher, Arbitrator

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

MARTIN GONZALEZ,

Petitioner,

vs.

NO: 11 WC 49015

15IWCC0711

ROMAN'S SEMI TRUCK REPAIR,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Illinois Workers' Compensation Commission on remand from the Circuit Court of Cook County. The Arbitrator initially filed a Decision and Opinion regarding this case on January 15, 2013. Timely Petition for Review was filed by the Respondent, and on October 18, 2013 the Commission issued a decision affirming and adopting the decision of the Arbitrator with further explanation as to the basis of the decision, with one Commissioner dissenting. After the Commission, pursuant to Section 19(f) of the Act, issued a corrected decision on November 6, 2013, the Respondent filed a Notice of Appeal to the Circuit Court.

On June 11, 2014, the Circuit Court, Judge Robert Lopez Cepero presiding, issued an order vacating the October 18 and November 6, 2013 decisions of the Commission, and remanding the case back to the Commission with instructions "for further proceedings consistent with Supreme Court Rules 408 & 411." On September 10, 2014, a second order was issued by the Circuit Court denying the Petitioner's Motion to Reconsider, and this time remanding the case to the Commission "for further proceedings consistent with Illinois Rules of Evidence 408 & 411." The Commission, after considering the remand order from the Circuit Court, and being advised of the facts and law, affirms and adopts our prior decision of November 6, 2013, which is attached hereto and made a part hereof.

15IWCC0711

The case at bar involved an altercation at work between the Petitioner and another employee of the Respondent. The Petitioner alleged injuries as a result of this altercation.

Rule 408 of the Illinois Rules of Evidence states as follows:

> **Compromise and Offers to Compromise**
>
> (a) Prohibited Uses. Evidence of the following is not admissible on behalf of any party, when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction:
>
> (1) furnishing or offering or promising to furnish – or accepting or offering or promising to accept – a valuable consideration in compromising or attempting to compromise the claim; and
>
> (2) conduct or statements made in compromise negotiations regarding the claim.
>
> (b) Permitted Uses. This rule does not require the exclusion of any evidence otherwise discoverable merely because it is presented in the course of settlement negotiations. This rule also does not require exclusion if the evidence is offered for purposes not prohibited by subdivision (a). Examples of permissible purposes include proving a witness' bias or prejudice; negating an assertion of undue delay; establishing bad faith; and proving an effort to obstruct a criminal investigation of prosecution.

Rule 411 of the Illinois Rules of Evidence states as follows:

> **Liability Insurance**
>
> Evidence that a person was or was not insured against liability is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This rule does not require the exclusion of evidence of insurance against liability when offered for another purpose, such as proof of agency, ownership, or control, or bias or prejudice of a witness.

The Commission finds that neither of these evidentiary rules is applicable to bar evidence in this case. It appears that the Circuit Court raises the issue based on evidence submitted and allowed by the Arbitrator regarding facts surrounding Petitioner's unrelated May 2011 workers' compensation claim (11 WC 26053), including both documentary evidence and testimony.

Because the case at bar involved an altercation between co-workers, the Arbitrator's duty was to determine the reason for the altercation, i.e. whether it arose out of the employment, as well as to determine, per Illinois law, whether the Petitioner was the aggressor or not.

15IWCC0711

It was the Petitioner's allegation that the altercation was based on the Respondent, via Petitioner's supervisor and co-workers, essentially attempting to pressure him into settling his May 2011 workers' compensation claim. Testimony and documentary evidence regarding interactions between Petitioner and Respondent in this regard was therefore highly relevant to the issue of compensability in this case, and the admission into evidence of the testimony and documents was proper to show motive of fight. The testimony and documents at issue were solely related to the resolution of a separate case, not the case at bar. They were not substantive to the settlement or resolution of this case.

In *Control Solutions, LLC v. Elecsys*, 2014 IL App (2d) 120251; 13 N.E.3d 302; 2014 Ill. App. LEXIS 423; 382 Ill. Dec. 889 (2014), the Appellate Court noted that prior to official promulgation of the Illinois Rules of Evidence in January, 2011, Illinois courts routinely held that matters relating to offers of compromise and negotiations for settlement were generally inadmissible. Two justifications were offered for the rule: 1) negotiations and compromises do not constitute admissions of liability and are therefore irrelevant, and 2) admitting evidence of negotiations and compromises violates public policy by discouraging litigants from settling their disputes without the need for trial.

The Court stated: "For Rule 408 to apply, the communications must concern a claim actually in dispute as to the validity or amount at the time of the negotiations, or an apparent difference of opinion, *and the communications must relate to that claim* (emphasis added). Id. at 38; 313; 24.

Here, the communications in question relate to "negotiations" regarding an entirely different claim than the case at bar. As noted, they relate to alleged improper attempts to urge the Petitioner to try to settle an entirely different claim that led to the altercation at issue. We see no basis to find that Rule 408 applies to any of the applicable testimony and documentation in this case. Respondent's efforts to "convince" the Petitioner to settle his prior 2011 claim are not something the Commission considers to be an "attempt to compromise" a claim.

The purpose of these evidentiary rules is to avoid prejudice to a party. Evidentiary errors committed at administrative hearings are harmless where the objecting party fails to demonstrate how the error prejudiced his case. *Lebajo v. Department of Pub. Aid*, 210 Ill. App. 3d 263, 155 Ill. Dec. 70, 569 N.E.2d 70 (1 Dist. 1991). We fail to see any reasonable argument that the discussion of resolution of a separate case prejudiced the Respondent in this case.

Additionally, we note that this case involves a review by an administrative body, not a jury. The finder of fact was the Arbitrator, and is now the Commission. The Commission does not view this evidence for any purpose other than a reason why the Petitioner and his co-worker were involved in an altercation.

Rule 411 specifically states that the rule does not require exclusion of evidence of insurance against liability when offered for another purpose. While the rule uses "such as" language in giving examples of other purposes, the use of that language does not restrict "other purposes" to only those stated examples. Here, the purpose was solely to show the reasons and motives for the altercation that is the basis of the current claim. The purpose was not to show

15IWCC0711

whether anyone acted negligently or otherwise wrongfully. Thus, Rule 411 does not require the exclusion of any of the evidence submitted in this case.

Additionally, a specific exception noted in Rule 411 involves the use of evidence to show potential bias and prejudice of a witness. Here, the Respondent's witnesses claimed that there was no communication with the Petitioner about his prior workers' compensation claim at the time of the altercation. The evidence Respondent takes issue with, i.e. insurance coverage was presented for the specific purpose of showing the bias and prejudice of Respondents witnesses. Thus, we fail to see how Rule 411 is applicable to bar any evidence in this case.

Evidence regarding the reasons for the altercation between Petitioner and his co-worker, Adrian, was integral to the determination of whether the incident arose out of and in the course of the Petitioner's employment. It was also integral to the determination of whether the Petitioner was the aggressor in the altercation. Settlement discussions and/or documentation from a separate case have no prejudicial impact on the case at bar. Indeed, such discussions and/or documentation are the key indices that are available to determine these noted issues.

No evidence was ever presented, documentary or testimonially, regarding the value of any alleged settlement demand or offer. How this evidence could be considered prejudicial to Respondent within the meaning of Rules 408 and 411 is unclear to the Commission. The Commission, as an administrative body charged with administering the Illinois Workers' Compensation Act, clearly recognizes that the basis for submission of this evidence was to prove only the motive for the altercation Petitioner was involved in, and not to prove the content of any settlement negotiations or communications from 11 WC 26053. Similarly, we clearly recognize that whether the Respondent was or was not insured at the time of that separate claim is irrelevant to the case at bar. There was no prejudice to Respondent based on the admission of the disputed evidence.

The Commission hereby affirms our prior decision, and attaches and incorporates our prior decision as part of this decision on remand. The case is remanded to the Arbitrator for further proceedings consistent with this decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission filed November 6, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical bills in evidence and related prospective medical care recommended by Dr. Sreeram under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is 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.

15IWCC0711

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 14 2015
TJT: pvc
O 07/14/15
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent with the Majority's affirming and adopting the Arbitrator's decision. The Arbitrator improperly admitted evidence and allowed testimony which was highly prejudicial to the Respondent. Specifically information regarding settlement discussions and information regarding the insurance status of the Respondent pertaining to a prior workers' compensation lawsuit that was filed by Petitioner against the Respondent. Rule 408 of the Illinois Rules of Evidence establishes that settlement offers and conduct or statements made in compromise of negotiations regarding claims are not admissible. ILCS Evid. Rule 408. The Arbitrator also allowed into evidence documents pertaining to whether or not Respondent was insured for a prior workers' compensation matter. Rule 411 of the Illinois Rules of Evidence establishes that whether or not someone is insured is not admissible upon whether or not the person acted wrongly. ILCS Evid. Rule 411. The Respondent was extremely prejudiced by the evidence regarding prior settlement discussions and the admission of Respondent's insurance status in the prior claim. This testimony and these records were improperly admitted and the admission of such incompetent evidence warrants a reversal and a remand for a new hearing.

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Verhonda Rozier,

Petitioner,

15IWCC0720

vs.

NO: 13WC034350

East St. Louis School District #189,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2015, is hereby affirmed and adopted.

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

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

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

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: SEP 17 2015
o091015
DLG/ge
045

David L. Gore

Mario Basurto

Stephen Mathis

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

15IWCC0721

ROZIER, VERHONDA
Employee/Petitioner

Case# **13WC034350**

EAST ST LOUIS SCHOOL DISTRICT #189
Employer/Respondent

On 3/20/2015, 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:

4463 GALANTI LAW OFFICE PC
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

0810 BECKER HOENER THOMPSON ET AL
RODNEY THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

15IWCC0720

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Verhonda Rozier
Employee/Petitioner

v.

East St. Louis School District #189
Employer/Respondent

Case # **13** WC **034350**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 29, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0720

FINDINGS

On **09/06/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,211.32**; the average weekly wage was **$543.88**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** children under 18.

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

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

Respondent shall be given a credit of **$5,886.84** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$5,886.84**.

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

ORDER

Respondent shall pay to Petitioner **15-4/7 weeks** of temporary total disability in accordance with Section 8(b) of the Act, representing the periods of time from **9/20/13** to **9/22/13** and **10/15/13** to **1/28/14** at the rate of **$362.55/week**. Pursuant to the stipulation of the parties, Respondent shall be given a credit of $5,886.84 for temporary total disability benefits previously paid.

Respondent shall pay reasonable and necessary medical services in the amount of **$489.00** to Regeneration Orthopedics for medical treatment provided to Petitioner on 10/17/13 and 11/7/13. Respondent shall be given a credit for any and all bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

Petitioner has failed to prove that her current condition of ill-being in her lumbar spine, left knee, and neck are causally related to her accident. Petitioner's claim for prospective medical care 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 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

March 17, 2015
Date

MAR 20 2015

Verhonda Rozier v. East St. Louis School District 189, 13 WC 34350 (19(b))

Findings of Fact and Conclusions of Law

An Application for Adjustment of Claim was filed in this matter alleging that Petitioner sustained an accident arising out of and in the course of her employment with Respondent on September 6, 2013. (AX 2) The disputed issues are: causal connection; medical bills; prospective medical care; and temporary total disability benefits. Petitioner was the sole witness testifying at her hearing.

The Arbitrator finds:

As reflected in RX 4, Petitioner has a long documented history of low back and neck pain prior to her work accident herein.

On July 31, 2000, Petitioner was seen by her family physician, Dr. Srinivsarao Yaganti. Petitioner complained of a headache and strain on the back of her head and upper part of her neck.

On April 9, 2002, Dr. Yaganti noted complaints of left knee pain. Petitioner reported a history of falling the previous November when she slipped on wax. Her left knee locked up and it hurt to bend down. Physical examination revealed mild tenderness on the medial aspect of the left knee joint. She asked to be taken off work. Dr. Yaganti recommended she obtain an x-ray and he prescribed Paxil and Xanax.

X-rays of Petitioner's right hip were obtained on April 5, 2005. They revealed degenerative changes with small bony density adjacent to the superolateral aspect of the acetabulum and adjacent to the greater trochanter of the femur.

On April 7, 2005, Petitioner returned to Dr. Yaganti with complaints of low back pain, right buttock pain, hip pain, and right shoulder pain. She reported that she slipped and fell at work. She had difficulty walking and a lot of pain in her lower back. Dr. Yaganti diagnosed her with osteoarthritis, referred her to a physical therapist, was taken off work, and recommended x-rays be obtained. She was also prescribed Demerol, Darvocet, and Ibuprofen 600 mg for pain.

On April 20, 2005, Petitioner returned to Dr. Yaganti for a follow-up. It was noted that she was still having back pain in the sacral area and she was having paralumbar muscle spasms. Vertebral stiffness and tenderness were noted. Dr. Yaganti recommended Petitioner continue physical therapy, prescribed Vicodin, and advised her to quit smoking. She was kept off work through May 4, 2005.

Petitioner returned to Dr. Yaganti on May 4, 2005 with complaints of low back pain and right buttock pain. She had been undergoing physical therapy and chiropractic treatment. Her pain radiated into her right buttock. She was advised to do stretching exercises and avoid lifting heavy weights. Dr. Yaganti prescribed Petitioner Flexeril. He also recommended she get an MRI and see a "Workmen's Compensation doctor."

On May 10, 2005, Petitioner was treated by Dr. Benjamin Laux for chiropractic treatment. He noted her primary complaints were in her lumbar spine and she reported pain as a 9 out of a scale of 10. Physical examination revealed sciatic pain, mechanical spine pain, facet syndrome, myalgia, and mild degenerative joint disease. A sprain/strain injury was noted. Spinal manipulation was recommended three times a week for three weeks.

On June 19, 2005, an MRI of Petitioner's lumbar spine was obtained at Mid-America Imaging. It revealed mild degenerative disc disease of the L5-S1 disc.

Petitioner was seen by Dr. Yaganti on April 2, 2007. It appears he reviewed her 2005 lumbar MRI and noted multiple level degenerative disc disease, especially at L5-S1. She reported intermittent lower back pain and Dr. Yaganti noted a history of degenerative disc disease. It was noted Petitioner was also struggling with quitting smoking. Physical examination revealed vertebral stiffness.

Petitioner followed up with Dr. Yaganti on July 10, 2007. She reported that she had fallen down steps on June 4, 2007 with left ankle pain since then. She also reported intermittent low back stiffness as well as right hip stiffness. She had been taking Vicodin on a regular basis was advised to take Vicodin 5/500 every six hours and was also prescribed Meloxicam.

On October 18, 2007, Petitioner followed up with Dr. Yaganti. She reported that she had not taken her medication for more than two days and was experiencing lower back pain. She could not sit or stand for too long without getting lower back pain, mostly on the right side. She was prescribed Vicodin for pain and Meloxicam for arthritis.

Petitioner was seen by Dr. Yaganti on April 2, 2008. He noted that she had a history of degenerative disc disease of the lumbar spine. She reported that while opening a car door, she slipped and fell, hurting her lower back. She was given a prescription of Vicodin on March 4, 2008. Physical exam revealed vertebral stiffness and muscle spasms in the lower lumbar spine. Dr. Yaganti recommended she discontinue Meloxicam.

On June 3, 2008, Petitioner complained of right sided lower back pain and muscle spasms. Dr. Yaganti noted vertebral stiffness and lumbar muscle spasms. He advised her to avoid prolonged standing or sitting. She was to avoid lifting or carrying heavy objects. He also recommended she perform low back stretching exercises.

On September 22, 2008, Petitioner returned to Dr. Yaganti and reported having back pain for the past four days.

Petitioner saw Dr. Yaganti on December 23, 2008. He noted that she had missed two appointments and was non-complaint with her medications. She complained of neck pain, right shoulder pain and occasional paresthesia in the right hand. It was noted that she could not go to work the previous week. Petitioner reported occasional back pain and was taking Flexeril for muscle spasms. Physical examination revealed some neck stiffness and trapezius and sternomastoid muscle spasms. Dr. Yaganti recommended an x-ray of the right shoulder and cervical spine. He also advised her to apply a heating pad to her affected areas, get a massage for her neck, and take Vicodin for pain.

On December 30, 2008, an x-ray of Petitioner's cervical spine was obtained at Memorial Hospital. It revealed a loss of disc height at C4-5 consistent with moderate discogenic degenerative changes. Endplate degenerative changes were also noted at C5-6 and C6-7 as well.

On January 21, 2009, an MRI of Petitioner's cervical spine revealed a small central ventral extradural deformity on the thecal sac at C6-7. Broad-based right-sided disc herniation was present at C5-6 partially occluding the entrance to the right neural foramen.

On February 26, 2009, Petitioner was evaluated by orthopedic surgeon, Dr. Christopher Heffner, for an evaluation of her herniated cervical disc. She reported that she fell in 2004 and that she believed she may have injured her neck at that time but did not have significant neck problems until October of 2008. She reported posterior neck pain with radiation into her right upper extremity. She had difficulty holding her arm down and had to reach above her head to gain some relief. It was noted that she was taking Vicodin, had high blood pressure, smoked less than a pack of cigarettes a day, and was 188 pounds. Dr. Yaganti reviewed the cervical spine MRI and diagnosed her with a herniated cervical disc at C5-6 significantly to the right side. He noted some adjacent level disease at C4-5 and C6-7, but opined the significant and symptomatic problem was C5-6 which produced radiculopathy. He recommended physical therapy, traction, and anti-inflammatory medication.

Petitioner followed up with Dr. Yaganti on April 9, 2009. He noted she was treating with Dr. Heffner for neck pain and was scheduled for surgery in June. She

reported pain and tingling all the time in her hands. He opined that before surgery, she could obtain a steroid injection form a pain management physician. She was prescribed Lortab and Gabapentin.

On June 2, 2009, Petitioner was seen by Dr. Yaganti. He noted some neck pain radiating down her right side as well as lower back pain. She had difficulty turning around and had pain in her fingers, affecting her daily activities. She was receiving traction and was doing exercises for her neck pain. Petitioner experienced a lot of panic and anxiety. She was referred to a pain management physician and advised to increase her Lortab dosage for pain. Dr. Yaganti noted that Dr. Heffner recommended surgery for her neck.

Petitioner followed up with Dr. Yaganti on July 17, 2009. She reported significant neck pain radiating into her right arm as well as low back pain. She had been off work since June 15, 2009. She was prescribed Lortab for severe pain and Neurontin.

On July 23, 2009, Dr. Heffner noted Petitioner had continued posterior neck pain, but it had gotten better after being off work during the summer. She was having more significant lower back pain across her hips and into her buttock and thigh on both sides. Straight leg raises caused back pain bilaterally at approximately 30 degrees. Dr. Heffner noted Petitioner was not tolerating Voltaren so he prescribed Mobic. He also recommended an MRI of her lumbar spine and physical therapy for her lumbar area.

On August 4, 2009, an MRI of the Petitioner's lumbar spine was obtained. Dr. James Farn interpreted the images and noted they revealed mild degenerative disc disease with slight noncompressive disc bulging at L5-S1.

Petitioner followed up with Dr. Heffner on September 3, 2009. She continued to have posterior neck pain with radiation into her right shoulder and upper arm as well as lower back. She had missed physical therapy due to pain in her neck and back. He reviewed her lumbar MRI and noted mild degenerative disc disease at L5-S1. Her neck pain was not improving so Dr. Heffner recommended surgery.

On September 11, 2009, Petitioner called Dr. Heffner's office and stated that she had taken off work because of pain. She requested an off work slip from Dr. Heffner, which was provided to her.

Petitioner was seen by Dr. Heffner on September 29, 2009. He noted that she continued to have complaints of pain in her posterior neck, radiating down into her right shoulder and down her right arm and fingers. He recommended a C5-6 anterior cervical discectomy and fusion.

On October 5, 2009, Petitioner was seen by Dr. Yaganti. He noted that she was to undergo surgery the following day. Lumbar degenerative disc disease and cervical

radiculopathy were noted. Dr. Yaganti prescribed Neurontin for upper extremity pain and Cymbalta for radicular pain.

On October 6, 2009, Petitioner underwent surgery with Dr. Heffner. His pre-operative diagnosis was cervical spondylosis and herniated cervical disc. He performed an anterior C5-6 cervical discectomy with decompression, anterior C5-6 cervical interbody fusion, and anterior C5-6 trabecular metal interbody spacer fixation. His post-operative diagnosis was cervical spondylosis and herniated cervical disc.

Petitioner was attended by Dr. Yaganti at Memorial Hospital on October 6, 2009. He noted she had undergone a C5-6 anterior cervical discectomy and fusion, was in a cervical collar, and had some discomfort. He recommended continued morphine for pain.

X-rays of Petitioner's cervical spine were obtained on October 7, 2009. They revealed changes of anterior interbody fusion at C5-6 with satisfactory positioning. There was stable disc space narrowing at C4-5 and anterior osteophyte formation at C4-5, C5-6, and C6-7.

Petitioner was seen by Dr. Heffner on October 14, 2009. He noted that she was very pleased and that she did not have any neck pain. She even stated that her lower back pain had improved. She was allowed to resume some light housework and could drive when she was no on medication. A soft collar was ordered for her to wear when sleeping.

X-rays of Petitioner's cervical spine were obtained o November 5, 2009. They showed an intervertebral disc spacer/surgical material had been placed at C5-7. Osteophytic spurring was present at C4-5, C5-6, and C6-7. The intervertebral disc spacer/surgically implanted material superimposed the anterior superior endplate of C6 to a greater degree than on the previous examination.

Petitioner followed up with Dr. Heffner on November 6, 2009. He reported posterior neck and interscapular pain probably related to distraction. He opined she could gradually increase her activities and begin physical therapy.

Dr. Heffner allowed her to return to work without restrictions on December 7, 2009.

On February 2, 2010, Petitioner followed up with Dr. Yaganti. He noted that Petitioner rarely had neck pain, but she was still getting lower back pain and had vertebral stiffness. He prescribed Meloxicam and Lortab and recommended she apply a heating pad and performs stretching exercises for her lower back.

On February 25, 2010, Dr. Heffner noted posterior neck pain that Petitioner believed was somewhat new. She reported that her neck pain had virtually resolved but in the past few weeks she noticed a component of posterior neck pain that was not previously a problem. She had pain with turning her neck to the right side and with extension of her neck. Dr. Heffner opined he believed she had distraction pain and some adjacent level facet joint pain which should resolve over time. He recommended x-rays and the use of a TENS unit for symptomatic relief.

Petitioner was seen by Dr. Heffner on April 15, 2010 and reported neck pain which was different from prior to surgery. She was prescribed Mobic by Dr. Heffner.

X-rays of the cervical spine were obtained on April 12, 2010. Disc space narrowing was present at C4-5 and anterior spurring was seen at C4, C5, C6, and C7. Loss of cervical lordosis was also noted in the mid cervical spine.

On August 25, 2010, Petitioner returned to Dr. Yaganti. She complained of right lower back pain, and a history of a cervical herniation. She was taking Meloxicam 7.5 mg. per day for arthritis in her neck and back. Vertebral stiffness and tenderness were noted, along with muscle spasms in the lower lumbar spine. She was also taking Aspirin and Vicodin 7.5/500 mg. for pain. She was advised to avoid prolonged sitting or standing and to stretch her lower back.

Petitioner returned to Dr. Yaganti on December 23, 2010 with complaints of neck pain, back pain, right hip pain, and muscle spasms among other complaints. She had muscle spasms in both her neck and low back. She was advised to take Flexeril and Lortab, her dosage of Meloxicam was changed to 15 mg. per day, and she was told to apply a heating pad and perform back stretching exercises.

On May 3, 2011, Dr. Yaganti noted Petitioner complained of neck pain and lower back pain and spasms. She had been non-compliant with her medications though. He advised her to avoid prolonged sitting and standing, to perform lower back stretching exercises, apply a heating pad, and take Lortab for severe pain. He discontinued Flexeril and advised her to stop taking NSAIDs.

A June 20, 2011 radiology report was prepared after images were obtained of Petitioner's cervical spine. The report showed mild cervical levoscoliosis. An intervertebral disc spacer/surgical material was placed at C5-6. The orientation of the intervertebral disc spacer showed a mild amount of increased clockwise rotation on the AP view when compared to the previous exams. Decreased disc height with osteophytic spurring was re-identified at C4-5. Additional osteophytic spurring was also present at C5-6 and C6-7. A small amount of posterior bony spurring was seen at C5-6 and there was some superior endplate sclerosis which appeared unchanged.

Petitioner followed up with Dr. Yaganti on June 22, 2011. He noted that she was taking Ibuprofen, an NSAID, and told her to discontinue taking it as well as Meloxicam. Vertebral stiffness was noted as well as neck muscle spasms. He advised her to avoid prolonged sitting and standing and to do her lower back stretching exercises.

When Petitioner followed up with Dr. Yaganti on September 14, 2011, he noted that she had continued low back pain and had recently hurt her back when moving some furniture. On January 10, 2012, Petitioner reported back pain along with hypertension, anxiety, and tiredness. Petitioner missed work for several days prior to seeing Dr. Yaganti.

On February 29, 2012, Dr. Yaganti noted low back pain and neck muscle spasms. She had the same complaints when she followed up with him on March 21, 2012. He noted that she continued to have paralumbar muscle spasms. On May 4, 2012, Dr. Yaganti noted she was taking Lortab for her chronic neck and lower back pain.

Petitioner was seen by Dr. Yaganti on August 9, 2012. She was having neck pain and lower back pain and was taking hydrocodone every six hours for severe pain. When she followed up with him on December 28, 2012, she reported low back pain that radiated to the back of the right thigh. She also experienced muscle spasms in the neck and lower back as well as occasional headaches. She was prescribed Flexeril for muscle spasms and Meloxicam. She was advised not to take NSAIDs when taking Meloxicam.

On April 9, 2013, Petitioner returned to Dr. Yaganti. Among her complaints were neck pain and lower back pain and stiffness. It was noted that she did not do much exercise.

Petitioner was seen at the Emergency Room at Memorial Hospital on August 28, 2013. She reported that she was walking up steps when she fell forward, landing on her knee. She reported back pain, stating she believed she twisted it when she tried to catch herself. X-rays revealed no acute fracture. Mild degenerative joint disease was noted. She was prescribed Tramadol and Norflex for pain. (PX 1)

X-rays of the thoracic spine were obtained on August 28, 2013. They revealed prior interbody spacer at C5-6 and a change in appearance compared to April 12, 2010. Multilevel degenerative changes in the cervical spine were visualized.

On September 12, 2013 Petitioner presented to the emergency room at Memorial Hospital at approximately 8:40 p.m. She gave a history of right low back and left knee pain that started a week before. She said that she tripped and jolted her body and landed on her left knee. She said that since that time she had been having "chronic" low back pain that had been bothering her. She claimed it went down in her right leg. She had taken Tramadol and Flexeril without relief. She said that she had been

prescribed Vicodin before. She told the emergency room personnel that she had had previous neck surgery. She was examined and the clinical impression initially was left knee contusion, low back strain, chronic high blood pressure and hyperkalemia. She was prescribed Vicodin 5-500. She was told to follow up with Dr. Yaganti with regard to her blood pressure and her potassium level. She was released to return to work on September 13, 2013. (PX 1)

X-rays were taken of Petitioner's left knee and were unremarkable. X-rays were taken of her low back as well, and they were reported as unremarkable. Those x-rays were compared to x-rays that had been taken at Memorial Hospital on August 28, 2013.

On September 20, 2013, Dr. Yaganti prepared a hand-written note stating that Petitioner had been treated by him from September 16, 2013 through September 20, 2013 and was released to return to work with no restrictions on September 23, 2013.

On September 26, 2013, Petitioner saw Dr. Anwar Khan upon referral by Dr. Yaganti. She gave a history that on September 6, 2013 she was walking with a mentally challenged student. The student stepped out in front of her and she fell down, landing on her left knee. She said she noticed some swelling of the knee and used some ice. She continued to work. She was off that weekend and when she returned to work on September 13, 2013 she noticed pain and discomfort and went to the emergency room. She complained that her left knee felt as if it was going to give out underneath her and that it felt as though the bones were "shifting" in the knee joint. She was having pain and discomfort on the right side of the low back. She reported no history of any radiation of pain from the back to the lower extremities. She gave a past history of having cervical spine fusion including a fusion on October 6, 2009. She had some soreness along the medial joint line of the left knee and she had some loss of range of motion of the low back. She felt pain and discomfort on the right side of her lower back when bending. Diagnoses by Dr. Khan included lumbago and pain in the left knee joint. He told her to use a heating pad to the right side of the low back. He said that the lower back physical examination was fairly unremarkable. She was advised to get an MRI scan of her left knee. Dr. Khan did not address her ability to work. (PX 4)

On October 9, 2013, Petitioner underwent an MRI of her left knee at Elite Imaging. This revealed a large, multiloculated, medial popliteal cyst that protruded between the gastrocnemius medial head and semimembranosus tendon. She had a small effusion above her kneecap.

On October 10, 2013, Petitioner saw both Dr. Ashley Eavenson and Mr. Corey Voss, a physical therapist with Dr. Eavenson's office. She gave Mr. Voss a history that she was taking a student to a bathroom when she tripped over the student's foot. She said that she fell onto her hands and knees with most of her weight on her left knee.

She said that later that afternoon she began limping around and reported the event to the principal. She went home and placed ice on the knee. She told Mr. Voss that her doctor told her to go to the emergency room. She acknowledged that she had an MRI of her left knee and that she had been released to return to work. However, she said that she was not working at that time. She complained of low back pain over the right lumbar spine and into her right buttock. She said she had trouble lifting her right leg. Examination revealed that she was 5'3" tall and weighed 186 pounds. She was tender over the right lumbar paraspinal muscles and sciatic notch. Bilateral lower extremity strength was 4/5. She demonstrated positive valgus stress test on the left knee and positive straight leg raising bilaterally. It was at 40 degrees on the left and 30 degrees on the right. She had some slight swelling of the medial left knee at 1+. His assessment was possible left MCL sprain and lumbar disc protrusion. Physical therapy was initiated. (PX 3)

On October 14, 2013, she saw Dr. Ashley Eavenson, a chiropractor with Mr. Voss' office. She said that her low back and left knee was still very sore. Petitioner began ultrasound, electrical muscle stimulation and some moist heat and cold packs. Petitioner also saw Mr. Voss on October 14, 2013 and he continued her physical therapy program. (PX 3)

On October 15, 2013, she saw Dr. Ashley Eavenson again. She said that she felt about the same and Dr. Eavenson reviewed the MRI of her left knee. She gave her gentle manipulation of her lumbar spine and told her to go see Dr. Gornet for her back and Dr. Choi for her left knee. She was taken off work. She also saw Mr. Voss the same date. (PX 3)

An MRI of Petitioner's lumbar spine was obtained at MRI Partners of Chesterfield on October 15, 2013. The L3-4 disc revealed minimal central canal stenosis that was congenital in etiology. At L4-5 there was mild loss of disc signal and height with a diffuse annular disc bulge. There was moderate central canal stenosis and minimal bilateral neuroforaminal stenosis. At L5-S1 there was a minimal loss of disc signal and height with a minimal diffuse disc bulge and mild central canal stenosis. Again, there was mild bilateral neuroforaminal stenosis. (PX 2)

Petitioner returned to Dr. Ashley Eavenson on October 17, 2013. She was still having pain in her lower back and left knee. She was manipulated once again and was told to stay off work. She noted that she was scheduled to see Dr. Gornet and had seen Dr. Choi that same date. She has also saw Mr. Voss the same day. (PX 3)

On October 17, 2013, Petitioner saw Dr. Luke Choi with Regeneration. She stated that she had been suffering from GERD, asthma, depression, high blood pressure and high cholesterol in the past. She has undergone a disc removal and fusion in her neck.

She said that she was off work at the time. She told Dr. Choi that she was walking a student from the bathroom back to the classroom when she tripped over the student's foot, landing directly onto her left knee. She said that she was still having pain and a sense of weakness in the left knee. She denied any prior issues with the left knee. Examination revealed that she had full extension and flexion to approximately 120 degrees with some moderate guarding. She had diffuse tenderness but it was mostly localized in the peripatellar region. X-rays were taken of the left knee and they were negative. He reviewed the MRI report of her left knee. His impressions were left knee peripatellar contusion due to a fall and left knee MRI findings of a popliteal cyst. He recommended conservative treatment. He gave her a six day course of a Medrol dose pak and a ten day course of Naproxen. He told her to continue with the physical therapy by Mr. Voss. He wanted to see her again in two weeks. He released her to return to work on a full duty basis as of October 17, 2013. (PX 4)

Petitioner returned to Dr. Mark Eavenson for evaluation on October 21, 2013. She said that the Prednisone was helping her knee but was not helping her back. He examined her and then gave her some chiropractic manipulation of the lumbar spine. He said that she was to "continue restrictions." There were no restrictions placed on Petitioner at that time though as Dr. Choi had released her to return to work. She also saw Mr. Voss on October 21, 2013 and underwent her normal course of physical therapy. (PX 3)

On October 22, 2013 she returned to see Dr. Ashley Eavenson. She said that she felt much better with regard to her knee but that her back was still bothering her. Treatment was as before. She also saw Mr. Voss the same day. (PX 3)

Petitioner returned to see Dr. Ashley Eavenson on October 24, 2013. She said that her knee was feeling better but her back was still bothering her. She was given gentle manipulation of the lumbar spine and told to continue with the therapy through Mr. Voss. She also noted that she was to "continue restrictions." She was scheduled to see Dr. Gornet. She saw Mr. Voss on October 24, 2013 for more physical therapy.

On October 28, 2013 she returned to see Dr. Mark Eavenson. Petitioner said that she would start to feel better but when she started to do the laundry or other activities around the house it would aggravate her left knee pain and her right SI pain. Treatment by Dr. Eavenson was as before. She also saw Mr. Voss that date and treatment was as before. (PX 3)

On October 29, 2013 Petitioner returned to Dr. Ashley Eavenson. She said that her low back was feeling much better and she was still tender over the inside of her left knee. Treatment continued as before with regard to her lumbar spine and right SI joint. Mr. Voss apparently took care of her left knee. (PX 3)

Petitioner followed up with Dr. Ashley Eavenson on October 30, 2013. She said that her lower back was bothering her. She underwent treatment and was told to continue with restrictions, whatever those were. She also saw Mr. Voss on the same date. (PX 3)

On October 31, 2013, Petitioner was evaluated by Dr. Matthew Gornet. She complained of low back pain with pain to the right side, right buttock and hip and down the right leg to her knee. She also complained of neck pain on both sides. She said that on September 6, 2013 she was walking a mentally challenged child from the bathroom and the child moved in front of her. She tripped over the child. She fell to the ground, landing on her left knee. Petitioner said that while she was falling, she twisted to try to avoid the child and allegedly hurt her back. She said that she had a history of low back pain that was on a "chronic low level." She also told Dr. Gornet she had a "more significant episode" two to three years ago. She noted that she had previous surgery on her neck. The neck pain that she had went into both shoulders and her right arm. Examination revealed a mild decrease in biceps strength at 4/5. Dr. Gornet noted that her right EHL strength was 4/5. X-rays revealed a trapezoidal cage at C5-6 with what appeared to be a failed fusion with flexion/extension films. Lumbar spine films revealed no evidence of instability with the exception of L5-S1. Dr. Gornet reported some "mild translation" with flexion and extension films. He reviewed the MRI scan of her low back. He said that there was a subtle disc protrusion to the left at L5-S1 and centrally as well. She had facet arthropathy resulting in a lateral recess stenosis at L4-5 and L5-S1. It was his opinion that "at a minimum" the event of September 6, 2013 aggravated her underlying condition of facet arthritis at L5-S1 and might have caused a new injury to her disc at that level. He wanted her to wean off of the narcotics and recommended further physical therapy and chiropractic services. She was referred to Dr. Boutwell for facet blocks and epidural steroid injections. He took her off work. (PX 5)

On November 4, 2013 Petitioner returned to see Dr. Ashley Eavenson. She was again adjusted and was told to continue "restrictions" imposed by Dr. Gornet. She also saw Mr. Voss the same day for physical therapy. (PX 3)

Petitioner returned to see Dr. Luke Choi for her knee on November 7, 2013. She said she had made significant improvement in the pain in her knee. She only had mild discomfort in the knee. Examination of the knee revealed some mild tenderness along the inferior pole of the patella. It was otherwise negative. Diagnosis was left knee pre-patellar contusion and left knee MRI findings of popliteal cyst. He did not recommend any formal treatment for her knee. He thought that she could be treated conservatively with modifying her activities and taking over-the-counter non-steroidal anti-inflammatories as needed. (PX 4)

On November 25, 2013 Petitioner saw Dr. Kayleah Boutwell on referral by Dr. Gornet. She underwent a right-sided L4-5 epidural steroid injection. After the injection she said that her pain level was 0/10. (PX 6)

Petitioner returned to Dr. Boutwell on December 9, 2013 and underwent a right-sided L5-S1 epidural steroid injection. Again, her pain score after the injection was 0/10. (PX 6)

Petitioner followed up with Dr. Boutwell again on December 23, 2013. She underwent a right-sided L4-5 median nerve branch block. For a third time, her post procedure pain level was 0/10. (PX 6)

On December 23, 2013, Petitioner saw Dr. Frank Petkovich at Respondent's request. (RX 3, dep. ex. 2) Petitioner advised the doctor that on September 6, 2013 a child was walking in front of her and she tripped and fell over the child and landed on her left knee. Petitioner explained to the doctor that she had some pain in her left knee all weekend but it gradually became somewhat better. She said that she returned to work on the following Monday and developed pain in her low back, primarily on the right side. It became worse as the week progressed. She then outlined her medical treatment since that time, noting that she had been seen by Dr. Anwar Khan, Dr. S. Yaganti, Memorial Hospital, Dr. Eavenson and Mr. Voss, Dr. Gornet and then Dr. Boutwell. She said that Dr. Boutwell had provided her with four injections. She said she also saw Dr. Luke Choi regarding her knee. She was complaining of less discomfort in her left knee but persistent pain in her low back, primarily on the right side. She said she had not worked since September 26, 2013.Petitioner also reported that she had some pain in her neck when she was seen by Dr. Gornet on October 31, 2013 and that she had developed some pain in her neck shortly after the accident but that, at present, her neck pain was much improved. Dr. Petkovich reviewed Petitioner's medical records as part of the examination. (RX 3, dep. ex. 2)

Petitioner acknowledged having low back pain before September 6, 2013 but she felt her pain after that accident was more severe and persistent. She also denied any problems with her left knee before the accident. She acknowledged mild residual cervical pain prior to the work accident. (RX 3, dep. ex. 2)

Physical examination revealed that she was 5'3" tall and weighed 181 pounds. She had a well-healed, right anterior cervical scar from her prior neck surgery. Range of motion of her neck was mildly limited, consistent with her surgery. Range of motion of her lumbar spine was limited bilaterally. She had tenderness to touch in the right lumbar paraspinous area. Dr. Petkovich reviewed the MRI of Petitioner's lumbar spine taken on October 15, 2013. He interpreted it as showing degenerative disc changes at L4-5 and L5-S1 with some disc desiccation and degenerative disc bulging. Petitioner

also had some spinal stenosis at L4-5 and L5-S1 with some lateral recess stenosis and facet joint degenerative changes. He took x-rays of her cervical spine which revealed the prior anterior cervical discectomy and fusion at C5-6. In his report he stated that there appeared to be a lack of fusion at that level. His diagnoses were contusion of the left knee, degenerative disc disease at C5-6 with pseudarthrosis and muscular lumbar strain with underlying degenerative disc disease at L4-5 and L5-S1. (RX 3, dep. ex. 2)

Dr. Petkovich was of the opinion that Petitioner's left knee condition had resolved. With regard to Petitioner's cervical spine, he opined that any injury she might have sustained to that had resolved as well. Finally, with regard to her lumbar spine, Dr. Petkovich opined that Petitioner had sustained a muscular strain at the time of the injury; however, her lumbar spine condition had not improved since then. He recommended that she undergo physical therapy. He concluded that she could return to work, provided that she not lift more than twenty pounds. He anticipated she would be able to return to work eventually. (RX 3, dep. ex. 2)

Petitioner next underwent radiological studies on March 31, 2014, prior to her visit with Dr. Gornet. This included a lumbar myelogram and post-myelogram CT scan. The myelogram revealed some disc space narrowing at L4-5. There was no definite nerve root impingement signs or evidence of a herniated disc. The CT scan showed a broad-base disc bulge at L4-5 with some flattening of the ventral aspect of the dura. Facet changes at that level could create some foraminal stenosis. At L5-S1 the facet changes were greater. There was a mild disc bulge at that level. Facet arthropathy was more advanced on the right than the left. There was bilateral foraminal encroachment. (PX 2)

On March 31, 2014 she returned to Dr. Gornet. He noted that she had tried to return to work but her pain was severe. He referenced a CT scan that showed severe facet arthritis at L5-S1. He said that this was consistent with her symptoms. He wanted her to undergo surgery. (P 5)

In April of 2014 Petitioner was hospitalized for a brain aneurysm and underwent surgery. (RX 3, dep. ex. 3)

On May 21, 2014 Petitioner was examined a second time at Respondent's request by Dr. Frank Petkovich. (RX 3, dep. ex. 3) Petitioner indicated that she was not working. She had, however, returned to work on a light duty basis in January of 2014 and worked for several weeks before she stopped. At the time of her evaluation with Dr. Petkovich, Petitioner was taking Tramadol and Meloxicam. Examination revealed that she walked with a slow heel to toe gait. She was using a cane in her right hand. He noted that she had recently undergone brain surgery for an aneurysm prior to this visit and had been released from the hospital approximately 1 1/2 weeks earlier. She had

mild loss of cervical range of motion and of lumbar range of motion. She was tender in the right paralumbar area. Sensation was intact in all extremities. Reflexes were intact in all extremities. There was no atrophy of the legs. She could stand on her heels and toes. She had negative straight leg raising bilaterally. He reviewed reports of the myelogram/CT scan and found no evidence of any acute findings but lots of evidence of degenerative disc disease at L4-5 and L5-S1. His diagnoses on that occasion were muscular lumbar strain, muscular cervical strain, left knee contusion, prior cervical fusion at C5-6 and degenerative disc disease at L4-5 and L5-S1.

Dr. Petkovich opined that Petitioner suffered a muscular lumbar strain, a cervical strain, and left knee contusion as a result of the September 6, 2013 work accident. He thought she had minimal subjective complaints. He believed that she was at maximum medical improvement (MMI) and could return to work without restrictions. He stated that the surgery recommended by Dr. Gornet was not related to the event of September 6, 2013. He said that the surgery would be to the results of the degenerative disc disease at L4-5 and L5-S1. (RX 3)

On May 29, 2014 Petitioner saw Dr. Gornet again. He thought that she had a failed fusion at C5-6. His review of the CT scan showed severe arthritis at L5-S1 with a small annular tear of the disc at that level on the left side. He thought that the accident caused an aggravation of her prior arthritic changes. He believed that her past history was of a chronic low level back pain and that the event of September 6, 2013 significantly aggravated her condition making her severely symptomatic. She was off work and was told to wean off narcotic medication.

Petitioner returned to Dr. Gornet on September 22, 2014. He reviewed Dr. Petkovich's report of May 2014 and felt that it was in error in that it concluded that there had not been any lasting symptoms due to the aggravation of her pre-existing arthritic condition in her low back and her failed fusion at C5-6. He said that she tried and failed conservative treatment and that she needed a spinal fusion at L5-S1. Dr. Gornet also thought that she needed to undergo repeat cervical spine surgery to attempt fusion at that level as well. He thought that the injury aggravated her arthritic conditions of her facet joints, particularly on the right side. This, in turn, caused her symptoms which caused her need for surgery. Petitioner was off work at that time. (PX 5)

Dr. Gornet was deposed on November 6, 2014. (PX 7) He testified that Petitioner had an aggravation of her pre-existing cervical spine and lumbar spine conditions of ill-being. He stated that she needed an anterior/posterior fusion at L5-S1 and that she needed to have a repeat fusion of her cervical spine at C5-6. He stated that both of these surgeries were required as a result of the accident of September 6, 2013. He stated that also she had the prior arthritic conditions in the lumbar spine and the prior failed fusion

in the neck, the event of September 6, 2013 aggravated those pre-existing arthritic conditions, causing her to have symptoms, which in turn, caused the need for the current surgery. Dr. Gornet did not review any of Petitioner's medical records prior to her September 6, 2013 work accident, including the August 28, 2013 emergency room report. Moreover, he was not aware of the extent of her treatment for her low back and neck conditions or whether she missed any work due to those conditions prior to September 6, 2013. (PX 7)

Dr. Petkovich was deposed on December 1, 2014. He testified that Petitioner suffered a muscular lumbar strain, a cervical strain, and left knee contusion as a result of the September 6, 2013 work accident. However, he testified that there was no aggravation or acceleration of her pre-existing cervical spine or pre-existing lumbar spine conditions due to the accident. He thought she had minimal subjective complaints. He believed that she was at maximum medical improvement (MMI) and could return to work without restrictions. He said that the surgery recommended by Dr. Gornet was not related to the event of September 6, 2013. He said that the surgery would be to the results of the degenerative disc disease at L4-5 and L5-S1. (RX 3)

Dr. Petkovich testified that he was aware Petitioner had previous complaints of low back pain, but he was not aware of how long she experienced those complaints. He stated that he was aware that she at least had significant low back pain approximately one week before her alleged worked accident when she reported to the emergency room and x-rays were obtained. (RX 3)

At her hearing held on January 29, 2015, Petitioner testified that she began working for Respondent on December 21, 1998. She was 52 years of age at the time of the Hearing and worked as an Auxiliary Aide for Respondent.

Petitioner testified that on September 6, 2013 she was working at Mason Clark Middle School where she was assisting a student to the restroom and on the way back to the classroom she tripped over the student's foot and fell. Petitioner testified that she fell really hard and used her hands to try and keep from falling and to keep the student from falling. Petitioner fell forward. She finished her work day and did not seek immediate medical attention as she believed it was a Friday and that she would probably be okay by Monday.

According to Petitioner she ended up reporting to Memorial emergency room on September 12, 2013 because "she believed" she was having back problems and pain that day. She acknowledged having been seen at Memorial ten days before because she had been involved in another accident when she fell up some steps. Petitioner explained that it was her first day back to work after the summer vacation and her daughter was incarcerated so Petitioner was taking her grandson to the day care. Petitioner was on

her way to the car, had the diaper bag and was reaching back to close the door when she stumbled to the floor.

Petitioner was asked if she had a history of chronic low back pain to which she replied she "believed" she had arthritis. She also acknowledged some previous falls.

Petitioner testified that after she was seen at the emergency room, she followed up with Dr. Yaganti, her primary care doctor, who then referred her to Dr. Khan for her knee. She also saw Dr. Eavenson, a chiropractor, who referred her to Dr. Choi for her knee and then Dr. Gornet for her back.

Petitioner could not recall what dates she was taken off work by Dr. Eavenson but that whatever was in the records was probably correct. She underwent physical therapy and injections for her knee and Dr. Gornet prescribed injections for her back. They would help for a few days and then the pain would return. Petitioner agreed that Dr. Gornet has recommended surgery on both her back and neck which she would like to have done. She remains off work.

Petitioner acknowledged that she suffered a brain aneurysm in April of 2014. Petitioner had to undergo surgery due to the aneurysm and was left with weakness on her left side that requires the cane. She is still under doctor's care for her aneurysm and remains off work for that condition also.

On cross-examination Petitioner could not recall reporting whether she had any neck pain when seen at the emergency room on September 12th. She did recall the knee pain and low back pain. Petitioner also denied having any left knee pain before the accident and specifically could not recall reporting knee pain to Dr. Yaganti in 2002 or telling him she had hurt her left knee after falling in November of 2001.

Petitioner testified that the last time she saw Dr. Choi for her left knee was in February of 2013. She was supposed to return but then had the brain aneurysm and hasn't done so. She could not recall if her prior low back complaints went back to 2005 because she cannot recall that far back anymore. She could not recall having any low back treatment in 2007 because she simply cannot remember. She did recall being prescribed back pain medication in 2008, including hydrocodone in 2012. She also recalled treating with Dr. Heffner for her neck because he did the surgery on her neck in 2009. She recalled mentioning low back pain to him during that time also. Petitioner also could not recall if she had right hip and low back pain for which she saw Dr. Yaganti. She couldn't remember if she was having muscle spasms in her low back in 2011. She did recall having lots of neck muscle spasms during that time.

Petitioner recalled having ongoing low back pain in 2013. She wasn't sure if she was prescribed back pain medication for the August 28th accident because she may

have had some already. She thought she probably had some pain medication available on the day of her accident at work but she never took it before going to work.

Petitioner believed her neck pain began in 2008. Petitioner also believed she hurt her right side/hip in a work accident in 2005. Petitioner denied any further injuries to her left knee, low back, or neck since September 6, 2013.

On redirect examination Petitioner explained that she was not trying to be evasive in her answers; rather, she was trying to answer all questions to the best of her ability/memory.

The Arbitrator concludes:

1. **With regard to disputed issue F, "Is Petitioner's current condition of ill-being causally related to the injury?":**

   Petitioner sustained a compensable accident on September 6, 2013 when she tripped over a student whom she was attempting to assist. She experienced low back pain, primarily on the right side, as well as left knee pain. While the Arbitrator finds it difficult to conclude that Petitioner injured her neck at the time of the accident as early treatment records and Petitioner's accident report don't indicate neck pain associated with the accident and there was no mention of neck pain until Petitioner presented to Dr. Gornet, Respondent's examining physician, Dr. Petkovich, felt she had sustained a cervical strain at the time of the accident.

   The record reveals that Petitioner had pre-existing low back and neck conditions dating back to the early 2000s. The record is clear that Petitioner continuously received treatment for her low back and neck conditions for nearly ten years before the work accident. This treatment included prescriptions for narcotic pain medication, muscle relaxers, chiropractic treatment, physical therapy, and a cervical fusion in 2009. Petitioner missed work due to her low back and neck pain and was prescribed pain medication for these symptoms up to the time of her work accident.

   The medical records of Dr. Yaganti and Dr. Heffner, as well as the reports and testimony of Dr. Petkovich, all relate a relationship between Petitioner's current condition of ill-being and her complaints and symptoms prior to her September 6, 2013 work accident. Petitioner had a significant history of pre-existing lumbar degenerative disc disease and pre-existing degenerative changes at C5-6. Dr. Petkovich was aware that Petitioner presented to the emergency room on August 28, 2013 with chronic low back complaints, necessitating x-rays. Dr. Petkovich

testified that the work accident did not aggravate or accelerate her pre-existing conditions.

Petitioner received continuous treatment for her low back condition for nearly ten years before the work accident. Most significantly, she received treatment for a low back injury nearly a week prior to the work accident. On August 28, 2013, Petitioner presented to the emergency room with low back pain after falling on stairs. X-rays were negative for acute fracture, but did show mild degenerative changes. Those same x-rays were compared with the x-rays obtained after the accident on September 12, 2013. The x-rays studies of September 12, 2013 showed no remarkable findings and mild degenerative disc disease. These findings were equivalent to the findings of August 28, 2013. At the time of the work accident, Petitioner's medications included Tramadol, which was prescribed to her for her low back pain.

Dr. Gornet testified that he had not reviewed any records concerning care or treatment to Petitioner prior to September 6, 2013. Specifically, he was not aware that she appeared at the emergency room of Memorial Hospital on August 28, 2013. He also stated that he was not aware of how long she had been having low back or leg pain before the work accident and what type of treatment she had received for it. He reiterated that it was his opinion that the event of September 6, 2013 aggravated her pre-existing degenerative disc disease and degenerative joint disease in the lumbar spine and aggravated the prior failed fusion in the cervical spine; however, he opined that this "aggravation" was based solely on her symptomatology following the event of September 6, 2013. Dr. Gornet did admit though that Petitioner's degenerative radiological changes occurred prior to the accident and that some of her physical findings could have been attributable to those changes. Dr. Gornet also relied upon Petitioner's history to him when he formed his opinion that she aggravated or exacerbated her pre-existing low back and neck conditions. Dr. Gornet testified that there was no indication that Petitioner's medical condition after the current event was similar to her medical condition prior to the accident. However, he never reviewed any of her earlier treatment records and it appears he was unaware of Petitioner's brain aneurysm in 2014 as it is not reflected in his office notes.

Petitioner's unrelated general health condition has made it difficult for Petitioner to recall many things. As Petitioner testified (and as the Arbitrator believes) she was not trying to be evasive. She was slow in answering some questions and, as she stated, she simply could not recall certain things anymore which, unfortunately, renders her a poor historian. Thus, the Arbitrator has had to place great weight on the medical records in evidence. Petitioner testified that she did

have chronic low back pain prior to her work accident, but was unable to recall the general duration of her low back pain and the extent of her treatment. The records speak for themselves.

As a result of Petitioner's difficulty with recollection the Arbitrator concludes that Dr. Gornet's opinions are unpersuasive. Dr. Gornet relied upon Petitioner to relay an accurate history of her condition and complaints when he formulated his causation opinion. He also failed to independently review Petitioner's earlier treatment records. The Arbitrator finds the testimony of Dr. Petkovich and records of Dr. Yaganti and Dr. Heffner more persuasive on this point and concludes that Petitioner's current condition of ill-being in her left knee, low back, and neck is not related to the event of September 6, 2013.

Respondent's examining physician, Dr. Petkovich, concluded that Petitioner may have sustained a cervical strain. As for the cervical strain and left knee injury, the doctor was of the further opinion that Petitioner had reached maximum medical improvement as of the December 23, 2013. Accordingly, Petitioner has failed to prove that her condition of ill-being in her left knee and cervical spine after December 23, 2013 is causally related to her work accident. Petitioner's low back condition is causally related until the time of Dr. Petkovich's second examination in 2014. At that time he felt she was at maximum medical improvement. Petitioner failed to establish causal connection beyond that date.

2. **With regard to disputed issue J, "Were the medical services that were provided to Petitioner reasonable and necessary?" "Has Respondent paid all appropriate charges for all reasonable and necessary medical services?":**

Liability for medical bills flows from the Arbitrator's causation determination as set forth above.

As discussed above, the Arbitrator finds the testimony of Dr. Petkovich more persuasive on this issue. Dr. Petkovich opined that at the time of his evaluation of Petitioner on December 23, 2013, the condition of her left knee had resolved. Additionally, with regard to her cervical spine, he opined that any injury she might have sustained to that had resolved as well. With regard to her lumbar spine, Dr. Petkovich opined that she had sustained a muscular strain at the time and he recommended physical therapy. After a second evaluation of Petitioner on May 21, 2014, Dr. Petkovich opined Petitioner had reached MMI with respect to her lumbar strain, cervical strain, and left knee contusion, and could return to work without restrictions. He said that the surgery recommended by Dr. Gornet was not related to the event of September 6, 2013. He opined that the surgery would be due to her pre-existing degenerative disc disease at L4-5 and L5-S1. He

further opined that any surgery to repair the failed cervical fusion was not related to the event of September 6, 2013. Therefore, the Arbitrator concludes that Petitioner should be awarded medical bills incurred with regard to her neck and left knee through December 23, 2013 and she should be awarded the physical therapy bills incurred for her low back through May 21, 2014. The treatment provided to Petitioner by Dr. Gornet from March 31, 2014 through September 22, 2014 was related to Petitioner's pre-existing lumbar degenerative disc disease and failed cervical fusion and not reasonable and necessary to relieve her of any conditions that were a result of the work accident.

At trial, Petitioner submitted into evidence a Medical Bills Checklist which shows $735.00 in outstanding balances owed to Petitioner's medical providers. The parties did not dispute the treatment provided to Petitioner with respects to her left knee condition. As such, the Arbitrator finds that Respondent shall pay the outstanding balance of $489.00 owed to Regeneration Orthopedics for the reasonable and necessary treatment provided by Dr. Choi on October 17, 2013 and November 7, 2013. The Arbitrator further finds that Respondent is not liable to pay MFG Spine, L.L.C., the outstanding balance of $246.00 because the treatment provided to Petitioner on May 29, 2014 and September 22, 2014 were not reasonable and necessary with respect to Petitioner's work-related condition.

3. **With regard to disputed issue K, "What temporary benefits are in dispute? (TTD)", the Arbitrator finds as follows:**

Petitioner is awarded temporary total disability benefits from September 20, 2013 through September 22, 2013 and October 15, 2013 through January 28, 2014. Respondent stipulated to that period of time. Petitioner is not awarded any temporary total disability benefits thereafter (ie., March 13, 2014 - January 29, 2015). In so concluding the Arbitrator relies upon her causation determination set forth above.

4. **With regard to disputed issue O, "Is Petitioner entitled to prospective medical treatment?", the Arbitrator finds as follows:**

Petitioner's claim for prospective medical care is denied. The Arbitrator concludes that based upon the preponderance of the credible evidence and her causation determination discussed above, any further treatment recommended to Petitioner, including the surgeries proposed by Dr. Gornet, is not related to the accident of September 6, 2013.

****

15IWCC0720

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ABIGAIL MAGADAN,

Petitioner,

vs.

NO: 05 WC 48591
05 WC 48592

S.P. RICHARDS CO.,

Respondent.

15IWCC0712

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, First District. Pursuant to the Appellate Court's Order dated December 23, 2013, the Commission's August 10, 2011 Decision (11 IWCC 0783) was affirmed in part, reversed in part, and remanded for further proceedings.

The Appellate Court has remanded this matter back to the Commission for 1) entry of an award of temporary total disability (TTD) benefits from October 15, 2008, to February 22, 2010; 2) a determination of the appropriate amount of medical expenses associated with claimant's right shoulder condition; and, 3) further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The parties appeared before Commissioner Michael J. Brennan on August 27, 2015. The parties stipulated that the medical expenses relating to the right shoulder total $69,681.34. Pursuant to the Appellate Court's Order, and the stipulation of the parties, the Commission finds that Petitioner is entitled to medical expenses of $69,681.34. The Commission further awards Petitioner TTD benefits from October 15, 2008 through February 22, 2010, representing 70-6/7 weeks. All else is affirmed and adopted pursuant to the Appellate Court's Order.

15IWCC0712

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 Respondent shall pay to the Petitioner the sum of $468.00 per week for a period of 70-6/7 weeks, October 15, 2008 through February 22, 2010, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $69,681.34 for medical expenses under §8(a) of the Act.

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

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

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

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

DATED: SEP 15 2015

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
D: 9-1-15
052

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Yard,
Petitioner,
vs.

NO: 08WC 2386

Freeman United Coal Mining Company,
Respondent,

15IWCC0722

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,000.00. 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: SEP 17 2015
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DLG/ge
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YARD, DAVID
Employee/Petitioner

Case# **08WC002386**

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

15IWCC0722

On 2/11/2015, 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

15IWCC0722

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID YARD
Employee/Petitioner

Case # 08 WC 2386

v.

Consolidated cases: _____

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing,** Arbitrator of the Commission, in the city of **Springfield**, on **December 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Disease, Causation and Sections 1(d)-f of the Occupational Disease Act**

FINDINGS

On **August 27, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,089.84**; the average weekly wage was **$1,059.42**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $635.65/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Molly Dearing

February 7, 2015
Date

FEB 11 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID YARD
Employee/Petitioner

v. Case #08 WC 002386

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner was 62 years of age at the time of Arbitration. He graduated from high school and attended community college in Springfield, Illinois. After high school, Petitioner worked for approximately four months at Allis-Chalmers in Springfield as a radial driller operator before going to work at Circle Steel Corporation for five and a half years as a laborer and overhead crane operator.

Petitioner began working for Respondent in May 1977. He worked in the coal mine for 30 years and 8 months with the last 29 years being underground. In addition to pure coal dust, Petitioner was regularly exposed to silica dust, roof bolting glue fumes, diesel fumes and trowel. He began as a laborer for Respondent and he worked in that position for approximately six months shoveling on the downside of the airlocks on the slope. He testified that there was significant dust in that position, and required he wear goggles and a respirator. Petitioner changed the filters in the respirator approximately four times per day to prevent it from becoming clogged and he emptied dust from his goggles approximately every 20 minutes.

Thereafter, he bid into a laborer position on the surface as a repair trainee and then as a repairman, where he worked for approximately one year before returning underground. As a repairman, he repaired mining equipment and serviced it underground, and he frequently worked around belt transfer points. Petitioner next worked as a shuttle car operator, which involved transferring coal from the face where it is cut to the best for transfer out of the mine. Petitioner then became a continuous miner operator, which runs the machine that cuts the coal from the face. Petitioner testified that the area around the continuous miner and the face is some of the dustiest areas in the plant. For a short period, Petitioner was a timberman constructing mine roof supports before he moved into a belt repair position, which maintains belt transfer points and establishes belt moves. Petitioner testified that he was constantly exposed to dust around the belts where coal is moving. He continued in belt repair until he bid to a utility man position, which he described as being a jack-of-all-trades and can include anything from running a miner to roof bolting. While roof bolting, Petitioner was exposed to silica dust and the roof bolting glue fumes. Petitioner became a mine examiner in September 2004, where he remained until the mine closed. A mine examiner monitors the working areas of the mine, belts and travel ways to identify hazardous areas to ensure compliance and report necessary corrections. Petitioner testified that all of his positions have involved manual labor.

Petitioner last day of work in the coal mine was on August 27, 2007 at Respondent's Crown II mine, as he had taken two vacation days prior to the mine's closure on August 29, 2007. He was 55 years old at that time and working as a mine examiner. On that day, Petitioner was exposed to and breathed coal dust. Petitioner testified that but for the mine closing, he would have reported for his next shift. He testified that he was experiencing health issues, including breathing problems, leading up to the closure of the mine. Petitioner testified that he had been contemplating leaving the mine at the time it closed. He testified that Respondent was having difficulty with ventilation at the mine, and he was continuing working to see "what was going to happen." He testified that he turned 55 years of age on June 11, 2011, and since he already had 30 years in the mine, he had contemplated quitting because of his health.

Petitioner applied for the panel at the recommendation of the UMWA District Office. He applied for a position of gob hauler because he was confident he would not be recalled to that position, and he did not want to return to the mining industry because of his breathing difficulties. After the mine closed, Petitioner exercised and received a full retirement pension from the mine, which severed his recall rights with the company.

After leaving the mine, Petitioner went to work at Allied Municipal Supply Company in Taylorville. He worked in the sign shop where he prepared signs by wiping them down and affixing reflective material to the sign plank. He worked there from December 2007 until May 2008 and he earned $10.00 per hour. Allied Municipal Supply Company was his sole employment after leaving the mine.

Petitioner testified that he smoked a pack a week for six months to a year when he was a teenager, but has not smoked since he was 18. He suffers from borderline hypertension, and he has a 10-pound weight restriction on his left hand from an injury in the mine. Petitioner testified that he first started noticing breathing problems in 1998. He was working as a utility man at that time. As he was loading the bolter with glue bolts, he had trouble breathing and he would have to sit down and have the bolters load their own machine. He testified that from the time he first noticed the breathing problems until the time he left the mine, his problems got worse, and have further worsened since leaving the mine. Petitioner sought treatment with Dr. Glennon Paul upon referral from his primary care physician, Dr. Gill, and at the instruction of Petitioner's counsel. Dr. Paul prescribed him breathing medications, and he presently utilizes a bronchodilator once daily or as needed, and an Albuterol inhaler a couple of times per day. Petitioner testified that his breathing problems affect his daily life, as they make everything slower and he knows "not to push it." He testified that he used to like to swim, but he became severely winded years ago while swimming and had to be brought back to shore by his wife. He has not swam since that time. Petitioner currently plays guitar, works crossword puzzles, and reads. He testified that he would refuse a position in a coal mine if it were offered to him today because he feels unable to perform the work of a coal miner due to his breathing difficulties.

Petitioner testified that, from time to time, he underwent screenings by NIOSH for coal workers' pneumoconiosis. Following the screenings, NIOSH would write to him to reveal the findings. He did not bring any of those letters with him to Arbitration. Petitioner underwent a breathing test and chest x-ray in May 2007, and he received a letter from NIOSH before the mine closed. Petitioner testified that the Department of Labor presented that letter to Respondent because he was intended on exercising his Part 90 rights in which Respondent would have been required to accommodate him in a position within a certain dust level. He was unsure as to whether

his position as a mine examiner was within the Part 90 requirement as he separated from his employment with Respondent soon thereafter.

Petitioner identified Petitioner's Exhibit No. 16 as the standard hourly and daily wage rates from the National Bituminous Coal Wage Agreement. His current class would have been grade 5 as a mine examiner and his rate of pay as of January 1, 2014 would have been $28.41 an hour. Petitioner testified that the National Bituminous Wage Agreement was between UMWA and Respondent. He stated that Respondent ceased to exist on September 1, 2007 and is no longer doing business. Petitioner testified that there is no other union mine in Illinois, and he acknowledged that there was no job for him with Respondent at the wage rate identified.

Petitioner was seen by Dr. Robert Cohen on October 3, 2008 upon referral by the U.S. Department of Labor for a Black Lung Evaluation. PX 2, 8. Dr. Cohen is a senior attending physician at Stroger Hospital of Chicago and is the Medical Director of the Pulmonary Physiology and Rehabilitation Section. He is also the Medical Director of the Black Lung Clinic of Stroger Hospital and the National Coalition of Black Lung Respiratory Disease Clinics. Dr. Cohen has been a B-reader since 1998. PX 2.

Dr. Cohen testified that the spirometry he performed as part of his examination was within the limits of normal. Dr. Cohen performed a B-reading of Petitioner's chest x-ray dated October 1, 2007. He interpreted the film as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in all lung zones. He made an identical interpretation of a chest x-ray dated August 14, 2008. PX 2.

Dr. Cohen testified that Petitioner has coal workers' pneumoconiosis, which he opined is related to exposures while coal mining. Dr. Cohen also diagnosed Petitioner with chronic cough, which he also related to Petitioner's years of exposure in the coal mine. Dr. Cohen testified that, by definition, an individual with coal worker's pneumoconiosis has some impairment in their lungs irrespective of whether it can measured by spirometry. Dr. Cohen testified that lung scarring indicates that those parts of the lungs are damaged and therefore, those areas would represent areas of impairment. Dr. Cohen further testified that coal workers' pneumoconiosis is a permanent condition without a cure, and can present symptoms of shortness of breath despite normal pulmonary function testing. He explained that an individual with coal workers' pneumoconiosis can have a lobe of the lung surgically removed and still have normal pulmonary function testing within the range of normal. Dr. Cohen stated that besides coal dust, there are many other exposures in the coal mine environment that can damage the lungs, including rock dust, hydraulic equipment, and exposure to diesel exhaust. Dr. Cohen recommended that Petitioner avoid any further exposure to coal mine dust or any other toxic exposures from the coal mine without risking his health, though he acknowledged that Petitioner's coal workers' pneumoconiosis may not progress even with additional exposure. Dr. Cohen did not indicate the presence of emphysema in his interpretation of the film, nor did he find any disease process in Petitioner other than pneumoconiosis. PX 2.

Dr. Cohen testified that Petitioner had a normal resting and exercise pulmonary function test at the time of his examination in 2008, and as such, he did not have a physical limitation at that time. Dr. Cohen testified that because coal workers' pneumoconiosis is a slow, chronically progressive disease, his disease may be limiting Petitioner's physical activities. Dr. Cohen testified that serial or further pulmonary function testing could be performed to determine whether his pneumoconiosis is limiting his activities. PX 2.

Dr. Cohen testified that the criteria for determining the presence of chronic bronchitis is whether an individual has a productive cough on most days of the week for three months a year for two years. He testified that although Petitioner complained of a history of dyspnea on exertion for approximately ten years and coughing with phlegm, he did not quite meet the criteria for a diagnosis of chronic bronchitis. Dr. Cohen testified the Petitioner has a chronic cough, which he opined was related to Petitioner's 31 years of exposure to coal mine dust. PX 2.

Dr. Cohen testified that Petitioner reported exertion as the only aggravant of his shortness of breath. Dr. Cohen testified that shortness of breath itself is a non-specific complaint and can be due to many different etiologies. One of the most common causes in the United States population of shortness of breath is deconditioning. At the time Dr. Cohen examined Petitioner, he had a BMI of 32.7 which was obese. Dr. Cohen testified that the presence of cough itself is not considered an objective determinant of pulmonary impairment. Petitioner was not taking and, according to the history Dr. Cohen obtained from him, had never taken breathing medication. PX 2.

Petitioner did not report to Dr. Cohen that he left mining because of a pulmonary problem or concern, and Petitioner did not inform Dr. Cohen that he left mining on the advice of a physician because of a pulmonary problem or concern. He did not relate to Dr. Cohen any problem in performing the duties of his last job in the mine. Dr. Cohen testified that more likely than not coal workers' pneumoconiosis will not progress once the exposure ceases. Dr. Cohen testified that the exercise testing on Petitioner was normal in a sense that it would be what he would expect of a normal healthy 56 year old man of Petitioner's height and weight. The exercise testing did not provide to Dr. Cohen an explanation for Petitioner's complaint of shortness of breath. The testing did not reveal a ventilatory limit to exercise. It did not reveal a pulmonary cause for his complaint of dyspnea. From a pulmonary function standpoint, the exercise testing would indicate Petitioner is capable of heavy manual labor. PX 2.

Dr. Glennon Paul is the Medical Director of St. John's respiratory therapy and Clinical Assistant Professor of Medicine at SIU Medical School. Dr. Paul is a senior physician at the Central Illinois Allergy and Respiratory Clinic. Dr. Paul has been board certified in allergy, immunology and asthma since 1974. Dr. Paul testified that he reads approximately 5,000 chest x-rays per year and he interprets about the same number of pulmonary function tests. In his practice, he has had occasion to treat coal miners for coal mine-induced lung disease dating back to the 1970s, but the vast majority of his work was performed for coal companies, including Respondent. PX 1.

Dr. Paul testified by way of evidence deposition on June 30, 2014, and he saw Petitioner seven times prior to that time. Dr. Paul testified that Petitioner had coal workers' pneumoconiosis, chronic bronchitis and sinusitis which were caused or aggravated by his work as a coal miner. Dr. Paul testified that if Petitioner were to return to the work environment of the coal mine, it would endanger his health in the form of an increased potential for worsening of his coal workers' pneumoconiosis, chronic bronchitis and sinusitis. Dr. Paul testified that based on his pulmonary diagnoses and Petitioner's clinical presentation, he did not have the pulmonary capacity to perform the manual labor of a coal miner on a full time basis. PX 1.

Dr. Paul initially saw Petitioner on July 9, 2012. Petitioner reported to Dr. Paul that he left mining due to a layoff in 2007, and he related symptoms of cough, wheezing and shortness of breath. Dr. Paul did not have any medications listed and he did not particularly ask Petitioner about medications. Dr. Paul testified that he performed pulmonary function studies on Petitioner, whichi

revealed no obstruction. A methacholine challenge test was administered, which was normal, and ruled out the presence of asthma. PX 1.

On July 30, 2012, Dr. Paul's assessment continued to be sinusitis, bronchitis and coal workers' pneumoconiosis. Petitioner was last seen on April 8, 2014, at which time he reported to Dr. Paul that his shortness of breath had resolved. A physical examination of the chest was normal, and Dr. Paul's only assessment on that date was joint deformity of the right hand with pain on movement, though he acknowledged that his record might have been mistaken about which hand was affected. Dr. Paul testified that April 18, 2013 was the most recent visit in which Petitioner presented with an overt pulmonary problem. Dr. Paul saw Petitioner on July 17, 2013, August 15, 2013, November 21, 2013, and the last visit of April 8, 2014. PX 1.

Dr. Henry K. Smith, board certified radiologist and NIOSH B-reader, interpreted chest x-ray dated May 7, 2007 as positive for pneumoconiosis, profusion 1/1 with P/S opacities in all lung zones. He made an identical interpretation of chest x-ray dated October 1, 2007. PX 4.

At the request of counsel for Respondent, Dr. Jerome F. Wiot reviewed chest x-rays of Petitioner and testified by way of evidence deposition on September 18, 2009. Dr. Wiot was the Past President of the American Board of Radiology and served as an examiner for the Board. Dr. Wiot was also the Past President of the American College of Radiology and as a member of the Task Force on Pneumoconiosis, he helped to develop the weekend symposium which eventually became the modern day B-reader program. Dr. Wiot sat on the faculty at the outset of the B-reader program. Dr. Wiot has been a B-reader since the program's inception and he has been board certified in radiology since 1959. RX 1.

Dr. Wiot reviewed Petitioner's chest x-rays dated October 1, 2007, and August 14, 2008. Dr. Wiot testified that the films were of diagnostic quality. His interpretation of the films was that there was no evidence of coal workers' pneumoconiosis. Dr. Wiot testified that the film of October 1, 2007 was quality 2, underexposed. He explained that the concern regarding underexposed film is overreading, as underexposure results in every vessel standing out and a reader must take care to not over interpret the vessels as changes. Dr. Wiot testified that for the purposes of determining radiographically significant workers' pneumoconiosis, he prefers not to have medical records of the patient, and once a diagnosis is made, entries and treatment records regarding normal physical examinations of the chest, pulmonary function testing, and complaints of shortness of breath mean nothing. He testified that the scarring and emphysematous areas of coal workers' pneumoconiosis cannot perform the function of normal, healthy lung tissue, and by definition, if a person has the disease, there would be impairment in the function of their lungs at the site of the scar tissue, regardless of whether it could be measured by pulmonary function testing. Dr. Wiot testified that an individual can have coal workers' pneumoconiosis and still have normal physical examinations of the chest, normal pulmonary function testing, and normal arterial blood gas testing. Dr. Wiot testified that coal workers' pneumoconiosis is permanent, has no cure, and the only treatment for the disease to remove the affected individual from further coal dust exposure, though he stated that most coal workers' pneumoconiosis will not progress after the exposure ceases. RX 1.

Dr. David Rosenberg conducted a review of medical records and films regarding Petitioner at the request of Respondent's counsel, and he testified by way of evidence deposition on November 1, 2013. After he graduated from medical school, Dr. Rosenberg did a pulmonary fellowship at the National Institute of Health in Bethesda, Maryland. Dr. Rosenberg is board

certified in pulmonary disease, internal medicine and occupational medicine. Dr. Rosenberg has been a B-reader since July 2000. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians and the American College of Occupational and Internal Medicine. Dr. Rosenberg presently has patients who he treats for coal workers' pneumoconiosis. RX 2.

Dr. Rosenberg interpreted Petitioner's chest x-ray taken of October 1, 2007 as having minimal changes of micronodularity, category 1/0 in the mid and upper lung zones with Q/Q opacities. There was also some prominence in the left pulmonary artery. The chest x-ray taken on August 14, 2008 revealed Q/Q opacities with a profusion of 1/0. There was prominence of the right hilum. Dr. Rosenberg found both films to be quality 2, being light. RX 2.

Dr. Rosenberg reviewed the spirometry performed as part of Dr. Cohen's examination. He testified that same did not reveal an obstruction, and Petitioner's lung volumes revealed no restriction. Dr. Rosenberg testified that Petitioner's diffusion capacity was normal. Dr. Rosenberg agreed with Dr. Cohen's testimony that exercise testing is the gold standard for assessment of cardiopulmonary function. Petitioner's work capacity was normal, and he had no ventilatory limit revealed by the exercise testing. Dr. Rosenberg agreed with Dr. Cohen's testimony that the results of the exercise testing were what he would expect of a normal, healthy, 56-year-old male. The objective testing did not explain Petitioner's complaint of shortness of breath. Dr. Rosenberg testified that based upon the results of his testing, Petitioner was capable of heavy manual labor. RX 2.

Dr. Rosenberg concluded that Petitioner had a very minimal degree of simple coal workers' pneumoconiosis related to past coal mine dust exposure. He had no associated impairment and/or disability with his pulmonary function tests, exercise evaluation and blood gases being normal. Dr. Rosenberg testified that most patients with simple disease have preserved lung function. He testified that, on microscopic basis, if scar tissue is laid down in normal structures, in a theoretical sense, that area would not be functioning properly. Dr. Rosenberg testified that in less than 10% of cases, coal workers' pneumoconiosis can progress after one has left the mine. Dr. Rosenberg testified that if one has coal workers' pneumoconiosis and wants to have the least possible chance of any further progression of the disease, he should minimize the exposure to coal dust. He explained that the American Thoracic Society maintains that a coal miner who has a number of years of coal mining experience may have low levels of continued exposure. Dr. Rosenberg testified that a cough is not considered an objective determinant of pulmonary impairment. RX 2.

Petitioner underwent a chest x-ray on May 7, 2007 as part of the NIOSH screening program. The chest x-ray was interpreted by two B-readers, Dr. John E. Parker and Dr. William P. Meseroll, as positive for pneumoconiosis, category 1/0 with opacities in all lung zones. A third B-reader, Dr. Robert B. Harrison, interpreted the chest x-ray as negative for pneumoconiosis. NIOSH sent Petitioner a letter dated August 13, 2007 advising him that his x-ray showed enough coal workers' pneumoconiosis to be eligible for the option to work in a low dust area of a mine, which empowered Petitioner with the option to work in a job in a mine where the concentration of dust was not more than one milligram per cubic meter of air. RX 5. The Mine Safety Health Administration also sent a letter to Respondent dated August 15, 2007, advising him that his medical examination indicated the Petitioner had a sufficient degree of pneumoconiosis allowing him to exercise the option to work in a low dust area of the mine with a concentration of respirable dust of not more than one milligram per cubic meter. PX 9.

Medical records of Springfield Clinic were admitted into evidence. On February 9, 2000, Petitioner underwent a chest x-ray for reported chest pain. The x-ray demonstrated the lungs to be clear. The impression was no acute pulmonary disease. On July 24, 2001, Petitioner underwent another chest x-ray, which failed to demonstrate any infiltrates, pneumothoraces or definite pulmonary disease. PX 10, RX 3.

Petitioner was seen on July 8, 2004 at the Springfield Clinic complaining of soreness in his right shoulder, wrist and elbow. On that date, his lungs were clear without wheezing or rhonchi noted. He had no shortness of breath at rest. Petitioner underwent a preoperative chest x-ray on May 29, 2008. Same was interpreted as revealing the lungs to be clear with normal pulmonary vascular pattern and no pleural fluid. Petitioner underwent a myocardial perfusion study on October 29, 2008, with the indication for same being COPD and dyspnea. There was no fixed or reversible myocardial perfusion abnormalities. The left ventricular ejection fraction was normal at 73%. Petitioner was seen by Dr. Max Hammer on June 13, 2008, for another discussion regarding his hernia. Review of systems pulmonary revealed no pulmonary symptoms. PX 11, RX 3.

Petitioner was seen on October 21, 2008 to discuss possible sleep apnea. Dr. Gill noted that Petitioner had fractured his left hand seven years prior and was presently having problems gripping things. He has a lot of pain in his left hand from arthritis. Upon examination, Petitioner had obvious deformity of the left hand and some wasting of the intraosseous muscles. He also gave a history of being involved in a motor vehicle accident many years prior that resulted in a plate and pin in the right ankle. He had also been evaluated for plantar faciitis and been prescribed insoles. He related that he still had pain in his feet when he walked. When discussing Petitioner's symptoms with him and his wife, Petitioner reported progressive shortness of breath for some time, which Petitioner believed was due to coal workers' pneumoconiosis though Dr. Gill noted the possibility of a cardiac etiology. Petitioner was seen in follow up on October 31, 2008. His lungs were clear on examination. Petitioner's stress test that day showed no reversible ischemia, and it showed preserved ejection fraction. The doctor noted he had obvious limitation of activities with his left hand because of previous injury to left hand. He had weakness of grip in the left hand and muscle wasting. PX 11, RX 3.

Petitioner presented to Dr. Gill on July 22, 2012. On a Patient History & Review of Systems of that date, Petitioner checked the box for shortness of breath, but not for cough. Petitioner reported to Dr. Gill long-standing shortness of breath related to coal worker' pneumoconiosis. Petitioner presented Dr. Gill with a letter from the U.S. Department of Labor dated August 2007 that notes he had pneumoconiosis and was eligible for rights afforded to him under that Act. A physical examination of the chest revealed the lungs to be clear. Dr. Gill's impression was pneumoconiosis and he referred him to Dr. Paul for management. PX 12, RX 3.

Petitioner filed for Social Security Disability on January 9, 2009 with an alleged date of disability of May 5, 2008. The Disability Determination Transmission indicated Petitioner's primary diagnosis is traumatic arthritis in the left hand and a secondary diagnosis is status post umbilical hernia repair. RX 4.

June Blaine performed a vocational assessment on Petitioner's behalf on October 14, 2013 and prepared a report dated January 31, 2014 enumerating her findings. PX 9. Ms. Blaine is a rehabilitation counselor that works with individuals with either an occupational disease or work-

related injury to assess their ability to work, as well as their earning and return to work potential. She has been performing those services for 31 years. PX 3.

In completing her vocational assessment, Petitioner's counsel instructed Ms. Blaine to assume that Petitioner could not return to work in a coal mine due to work-related lung disease, but that he had no limit to the level of work he could perform, and to construe any physical limitations to employment most strongly in favor of the Respondent. When she did her vocational assessment, she assumed Petitioner had no physical limitations other than he could no longer work as a coal miner. PX 3.

Ms. Blaine testified that Petitioner's work history prior to 1977, when he began working for Respondent, did not provide him skills for a current job search. She testified that his coal mining work and the skills he obtained therefrom were specific for working in the coal mine. Ms. Blaine administered the Wide Range Achievement, Revision 4. On this testing, he scored above high school in all phases which was word read, sentence comprehension and math computation. Ms. Blaine testified that Petitioner had another job for a short amount of time after the mine closed, which indicated he was able to earn at least $10.00 per hour. Ms. Blaine considered Petitioner's age, lack of computer skills, his education level, as well as the 9% unemployment level in his county. Based on that information, Ms. Blaine did not think Petitioner presented with skills that would allow him to earn a wage greater than $10.00 per hour. PX 3.

Ms. Blaine testified that she did not ask Petitioner any specific information regarding his medical history, given the assumptions she was given from Petitioner's counsel. Ms. Blaine did not ask Petitioner any questions related to his breathing, nor did she review any of his medical records. Ms. Blaine testified that when she is asked to be involved as a vocational expert in cases pending before the Workers' Compensation Commission, she customarily asks the attorney for the Application for Adjustment of Claim, and a medical, employment and educational history. Ms. Blaine testified that when she is working with an injured worker, she is generally looking at any limitations on their ability to function based on an orthopedic condition or injury. She could not recall the last time an attorney, other than Petitioner's counsel, retained her as a vocational expert and gave her no medical to review. Ms. Blaine was not aware that Petitioner applied for and was awarded Social Security Disability. She did not know the date he claimed the disability began or the basis for the award. Ms. Blaine had no opinion on whether Petitioner was capable of performing his last job in the coal mine but for his diagnosis of coal workers' pneumoconiosis. Ms. Blaine was not aware of Petitioner's medical condition other than what Petitioner's counsel asked her to assume which was that he had coal workers' pneumoconiosis and had no physical limitations. Ms. Blaine did not know how extensive Petitioner's job search was or if he looked for any work after he left the assigned job. Petitioner did not ask Ms. Blaine for help in job placement. If the assumption that Petitioner was unable to return to work in the coal mine because of his diagnosis of coal workers' pneumoconiosis was incorrect, Ms. Blaine testified that her opinion could change. PX 3.

CONCLUSIONS OF LAW

In regards to the issues of disease and causal connection, pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public."

The Arbitrator finds that Petitioner suffers from coal workers' pneumoconiosis that was caused and aggravated by exposures during his thirty one years of coal mining employment. In so concluding, the Arbitrator finds significant the findings of the two of the independent readers from NIOSH, Dr. John E. Parker and Dr. William P. Meseroll, who interpreted the May 7, 2008 x-ray as positive for pneumoconiosis, category 1/0 with opacities in all lung zones. RX 5. As they corroborate the findings of the two NIOSH B-readers, the Arbitrator finds the opinions of Drs. Paul, Cohen, and Smith to be persuasive, and notes that Respondent's expert, Dr. Rosenberg, also interpreted Petitioner's chest x-rays of October 1, 2007 and August 14, 2008 as positive for coal workers' pneumoconiosis related to Petitioner's coal mine employment. RX 2. Although Dr. Wiot found no evidence of coal workers' pneumoconiosis, his opinion is outweighed by the preponderance of the medical evidence.

In addition to coal worker's pneumoconiosis, Dr. Paul diagnosed Petitioner with chronic bronchitis and sinusitis (PX 1, 14), and Dr. Cohen assessed Petitioner with a chronic cough. PX 2. The Arbitrator finds that Petitioner does not suffer from chronic bronchitis, sinusitis or a chronic cough. In so concluding, the Arbitrator notes that Dr. Cohen testified that he made the diagnosis of chronic cough upon Petitioner's history alone and he further stated that Petitioner "does not meet criteria for a diagnosis of Chronic Bronchitis". PX 2. Moreover, the Arbitrator finds no symptomatology in Petitioner's treating records prior to 2008 supportive of those diagnoses. Thereafter, Petitioner reported to Dr. Gill on October 21, 2008 that he "has been short of breath for some time", though he did not report any similar complaints again until 2012. PX 11, 12. As of his last treatment visit with Dr. Paul on April 8, 2014, Petitioner reported that his shortness of breath had resolved, a physical examination of the chest was normal, and Dr. Paul's only assessment on that date was joint deformity of the hand with pain on movement. The Arbitrator finds the absence of any persistent symptomatology consistent with chronic bronchitis, sinusitis or a chronic cough probative, as is the lack of any complaints prior to his date of accident or filing of his claim.

Based upon the foregoing, the Arbitrator finds that Petitioner suffers from coal workers' pneumoconiosis that arose out of and in the course of his employment with Respondent, and is causally related to his exposures while mining coal. The medical evidence supports this diagnosis, and the medical opinions of Drs. Paul, Cohen and Rosenberg indicate that Petitioner's exposures in the mine would contribute to, aggravate or exacerbate these conditions. PX 1, 2, RX 2.

In regard to disputed issue (L), Section 1(e) of the Workers' Occupational Diseases Act defines the term "disablement" as "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment...." 820 ILCS 310/1(e). As such, a claimant can establish "disablement" by showing "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body" or alternatively, by showing an inability to earn "full wages at work in which the employee was engaged when last exposed to the hazards of the occupational disease..." *Id.* The Illinois Supreme Court has held that a claimant is considered disabled from earning full wages at work in which he was engaged when last exposed to the hazards of the disease when he can no longer work without endangering his life or health. *Owens-Corning Fiberglass Corp. v. Industrial Comm'n*, 66 Ill. 2d 247, 252 (1977). The Commission has recognized that even in the absence of measurable impairment, a diagnosis of coal workers' pneumoconiosis equates to disability under the Act. *See Eubanks v. Consolidation Coal Co.*, 08 IWCC 1515 (2008); *Samuel v. FW*

Electric, 08 IWCC 1296 (2008); *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (2008); *Brooks v. Consolidation Coal Co.*, 07 IWCC 1693 (2007); *Chrostoski v. Freeman United Coal Mining Co.*, 07 IWCC 226 (2007).

In this case, Dr. Paul testified that based on Petitioner's diagnoses of coal workers' pneumoconiosis, that Petitioner can have no further exposure in a coal mine without endangering his health by the worsening of that condition. Dr. Paul testified that, given his pulmonary diagnoses and his clinical presentation, Petitioner does not have the pulmonary capacity to perform the manual labor of a coal miner on a full-time basis. PX 1. Petitioner's other expert physician, Dr. Cohen, on the other hand, opined that Petitioner has normal resting and exercise cardiopulmonary function tests, and that he "does not have significant impairment." PX 2. Dr. Rosenberg similarly testified that, although Petitioner had simple coal workers' pneumoconiosis, he did not have any associated impairment or disability, as his "pulmonary function tests, exercise evaluation and blood gases being normal." However, Dr. Rosenberg acknowledged that those parts of the lung damaged by coal workers' pneumoconiosis cannot function as healthy lung tissue, though he downplayed the related functional loss as occurring on a microscopic, theoretical basis. He further stated that individuals can have low levels of exposure without likely progressing the disease, but stated that to avoid further progressing the disease, one should have minimal exposure. RX 2. Dr. Rosenberg and Dr. Wiot acknowledged that a coal miner may have radiographically significant coal workers' pneumoconiosis, yet have normal pulmonary function tests, normal blood gases, normal physical examination of the chest, and no symptoms. Dr. Rosenberg further testified that one can lose an entire lobe of lung with surgery and still have values within the normal range on spirometry, and lose up to one third of lung capacity due to injury or disease yet still be within the normal range. Being within the normal range does not mean that the lungs are free from injury or disease. RX 2.

The Arbitrator concludes that Petitioner's coal workers' pneumoconiosis causes disablement in accordance with Section 1(e) of the Act in that it creates at least some impairment in the function of the lungs by virtue of the disease and presents a risk to his health should he return to a coal mine environment. The testimony of Dr. Cohen, Dr. Paul, Dr. Wiot and Dr. Rosenberg all concur that by definition, coal workers' pneumoconiosis results in some impairment in the function of the lungs at the site of the damage. In addition to the preponderance of the expert testimony, the Arbitrator finds it significant of Petitioner's disablement that, due to his condition, should he return to coal mining employment, he would have the option to work in a low-dust area where the concentration of respirable dust is not more than one milligram per cubic meter of air. PX 9. Therefore, as Petitioner cannot return to mining without risking the progression or aggravation of his condition, the Arbitrator concludes that he has proven disablement within the meaning of the Act.

To be entitled to a wage differential award pursuant to Section 8(d)1, a claimant must prove a partial incapacity that prevents him from pursuing his usual and customary line of employment, and an impairment in earnings. 820 ILCS 305/3(d)1; *Dawson v. Freeman United Coal Mining Company*, 382 Ill. App. 3d 581, 586 (5th Dist. 2008). "A wage differential calculation presumes that but for his injuries, a claimant would have been in full performance of his duties." *Id.* The claimant must therefore show that, "but for his injury, he would have continued his mining career." *Id.*

In this case, Petitioner last mined coal on August 27, 2007, two days prior to the closure of Respondent's Crown II mine. Although he testified that he did not want to return to the mining industry because of his breathing difficulties, Petitioner testified that he would have continued to work for Respondent as a coal miner had the mine continued to operate. After the mine closed, Petitioner exercised and received a full retirement pension from the mine, which severed his recall

rights with the company. While Petitioner testified that he contemplated leaving the mine at the time it closed due to his breathing difficulties, Petitioner did not inform Dr. Cohen or Dr. Paul that he was unable to perform the duties of his last position in the mine, or that he left the mine because of a pulmonary problem or concern, which the Arbitrator finds probative. Moreover, Dr. Cohen opined that from a pulmonary function standpoint, Petitioner's exercise testing indicated Petitioner was capable of heavy manual labor, and Dr. Rosenberg also opined that Petitioner was capable of heavy manual labor. PX 1.

While the testimony of June Blaine is the only vocational rehabilitation opinion present in the record, the Arbitrator gives little weight to Ms. Blaine's opinion as they are based upon incorrect assumptions and information. *Dozer v. Savage Manufacturing & Sales*, 142 Ill. 2d 176, 195-196 (1990)(If an expert's opinion lacks a factual basis, the opinion deserves little weight). Ms. Blaine was instructed by Petitioner's counsel to assume that Petitioner was no longer able to work as a coal miner due to his coal workers' pneumoconiosis, even though no physician opined that he was medically precluded from mining coal and Dr. Cohen opined that Petitioner was capable of heavy manual labor. PX 2. Further, Ms. Blaine was asked to assume that Petitioner did not have any other work restrictions, though Petitioner had limitations with respect to his left hand, as evidenced in the medical records of Springfield Clinic and his Social Security records.

In light of the aforementioned evidence, Petitioner has failed to prove that, but for his injuries, he would have been in full performance of his duties as a coal miner. Therefore, Petitioner is not entitled to a wage differential pursuant to Section 8(d)1. *See Dawson v. Freeman United Coal Mining Company*, 382 Ill. App. 3d 581, 586 (5th Dist. 2008). While Petitioner has failed to prove a wage differential, the Arbitrator nonetheless finds that Petitioner is permanently and partially disabled under Section 8(d)2 by virtue of his occupationally related coal workers' pneumoconiosis, and credible associated residual complaints and limitations to the extent of 10% of the person as a whole.

In regard to disputed issue (O), or timely disablement pursuant to Section 1(f) of the Act, Petitioner's last injurious exposure occurred on August 27, 2007. His coal workers' pneumoconiosis was discovered by virtue of x-rays taken by NIOSH on May 7, 2007, and those results were conveyed to Petitioner by way of a letter dated August 15, 2007. PX 9, RX 5. Petitioner filed his present claim on January 17, 2008 (Arb. X 2), well within two years of his last exposure. Therefore, the Arbitrator finds that Petitioner's disability was timely pursuant to Section 1(f) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ 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

Zader Garner,

Petitioner,

15IWCC0690

vs.

NO: 10 WC 32074

Manteno Veteran's Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical expenses, prospective medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 January 21, 2015, is hereby affirmed and adopted.

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

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

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

DATED: SEP 8 - 2015
DLG/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

15IWCC0690

GARNER, ZADER
Employee/Petitioner

Case# 10WC032074

MANTENO VETERAN'S HOME
Employer/Respondent

On 1/21/2015, 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:

1427 BERG & BERG
JOHN BERG
2100 W 35TH ST
CHICAGO, IL 60609

5132 ASSISTANT ATTORNEY GENERAL
STACEY R LASKIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 21 2015

RONALD A. RASSIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

15IWCC0690

Zader Garner
Employee/Petitioner

v.

Manteno Veteran's Home
Employer/Respondent

Case # 10 WC 32074

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 6, 2010, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $35,469.50; the average weekly wage was $682.09.

On the date of accident, Petitioner was 27 years of age, *married* with 1 dependent child.

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

Respondent shall be given a credit of $60,156.56 for TTD[1], $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $60,156.56.

Respondent is entitled to a credit of $49,388.52 under Section 8(j) of the Act, and the parties have further stipulated that "medical bills will not be paid twice and that the Respondent will get credit for any payments made." *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $454.73/week for 123 & 1/7th weeks, commencing August 1, 2012 through December 10, 2014, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 6, 2010 through December 10, 2014, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall receive credit of $60,156.56 for temporary total disability benefits paid from January 12, 2010 through July 31, 2012. *See* AX1.

Medical Benefits

Respondent shall pay reasonable and necessary medical services from EQMD, Illinois Neurospine, the SC, and ATI totaling $10,590.08 that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $49,388.52 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

As stipulated by the parties, "medical bills will not be paid twice and that the Respondent will get credit for any payments made." *See* AX1.

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[1] The parties stipulated that Respondent is entitled to this credit for temporary total disability benefits paid from January 12, 2010 through July 31, 2012. AX1.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of a low back fusion as prescribed by Dr. Michael pursuant to Section 8(a) of the Act.

Penalties

As explained in the Arbitration Decision Addendum, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act 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.

Signature of Arbitrator

January 20, 2015
Date

JAN 21 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0690

ARBITRATION DECISION *ADDENDUM*

19(b) & 8(a)

Zader Garner
Employee/Petitioner

v.

Manteno Veteran's Home
Employer/Respondent

Case # **10** WC **32074**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from August 1, 2012 through December 10, 2014, whether she is entitled to prospective medical care in the form of a fusion surgery, and whether Petitioner is entitled to penalties and attorney's fees under Sections 19(k), 19(l) and 16 of the Act. Arbitrator's Exhibit[2] ("AX") 1.

Background

Petitioner testified that on January 6, 2010 she was employed by Respondent as a "VNAC," which is essentially a certified nurse's assistant. On this date, she explained that she was getting a patient up. She described him as a "one assist" which means that one person could perform this task. She used a "Sara lift" which is a belted machine to help Petitioner up. She testified that she secured the belt around the patient. His legs were against the machine, but then his legs gave out and she eased him down.

Petitioner testified that she hurt herself at that time, but she did not think much of it. She explained that while she was helping another patient, she felt pain in her back and pain shooting down her left leg. Petitioner testified that she then spoke with the charge nurse to inform her that she needed to go to the emergency room. Petitioner then called her child's father and went to the Riverside emergency room.

Before this injury, Petitioner testified that she had a prior back injury in 2008. She testified that she was able to return to work after physical therapy. She also had an injury in 2005, but believed that was a shoulder injury.

Medical Treatment

Petitioner testified that she underwent a body scan and gave a history at the emergency room. She was also referred to another doctor at the Oak Clinic and understood that she was diagnosed a muscle strain.

The medical records reflect that she went that same day to Riverside Medical Center emergency room for treatment. PX1 at 5-15. Petitioner reported that "that while at work this am was assisting a patient on a lift – patient started to slide off so she caught patient and eased him tot he(sic) floor – states she felt a 'pull' in her middle back section – states had similar injury to back approx 2 years ago." *Id.* The emergency room physician diagnosed Petitioner with back pain, instructed her to follow up with a doctor within 3-5 days, and discharged her with work restrictions with no lifting over 15 pounds, no repeated banding/twisting, and no pushing/pulling

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

over 15 pounds. *Id.*

Petitioner was then examined by a Certified Physician's Assistant, Brent Huffines ("P.A. Huffines") on January 11, 2010 at Riverside Corporate Health Services ("Riverside clinic"). PX2 at 94-97. She reported a consistent mechanism of injury and pain in the middle back radiating into the left leg and knee. *Id.* On examination, Petitioner had mild tenderness to palpation in the left and right paraspinal areas. *Id.* P.A. Huffines diagnosed Petitioner with a thoracic and lumbar sprain, and administered a toradol injection. *Id.* He also placed her on work restrictions including no lifting over five pounds and no pushing, pulling, bending or climbing. *Id.*

On January 22, 2010, Petitioner returned to the Riverside clinic and saw Dr. Alyce Jackson ("Dr. Jackson"). PX1 at 26; PX2 at 98-101. Dr. Jackson noted that Petitioner had been off work due to restrictions per her job, and that she returned for a follow up evaluation of her mid-back pain. *Id.* On examination, Dr. Jackson noted moderate tenderness in the right paraspinal area, and moderate restriction of thoracic rotation on the right. *Id.* She diagnosed Petitioner with a thoracic sprain and administered trigger point injections into the right mid-thoracic paraspinals region. *Id.* Dr. Jackson maintained Petitioner's work restrictions and ordered physical therapy. *Id.*

Petitioner began physical therapy at Riverside on February 9, 2010. PX1 at 30-33. She reported a prior injury in October, 2008 after which she went through a course of physical therapy and had pain medications. *Id.* She felt better for several months, but reported that she never felt 100%. *Id.*

Petitioner returned to Dr. Jackson on January 29, 2010 reporting no change in her condition. PX2 at 102-103. Dr. Jackson maintained her work restrictions and diagnosis. *Id.* She continued to follow up at Riverside through March 29, 2010 during which time she treated for mid-low back pain and was kept on light duty. PX2 at 104-115. Petitioner was discharged from physical therapy at Riverside on April 20, 2010. PX1 at 88-90. Petitioner returned to the Riverside clinic one last time on May 3, 2010 at which time she was released to regular work. PX2 at 116-118.

Petitioner then saw Dr. Ronald Michael ("Dr. Michael") at Illinois Neurospine Institute on June 7, 2010. PX3 at 121-123. She reported a consistent mechanism of injury and symptoms including low back pain with bilateral leg pain, right worse than left, and difficulty walking, sitting or standing. *Id.* Dr. Michael diagnosed Petitioner with nonspecific lumbar radiculitis and ordered a lumbar MRI. *Id.* He also placed her off work. *Id.*

Petitioner underwent the recommended lumbar MRI and returned to Dr. Michael on June 21, 2010. PX3 at 124-125. He reviewed Petitioner's MRI and noted a very small L5-S1 bulge and an L4-L5 bulge. *Id.* He recommended a series of three epidural steroid injections and kept Petitioner off work. *Id.*

Petitioner underwent the recommended injections on September 21, 2010, November 30, 2010 and December 14, 2010. PX3 at 128-130. When she returned to Dr. Michael on December 27, 2010 and February 28, 2011, he recommended either further conservative treatment including facet and caudal blocks, or learning to live with her pain. PX3 at 131-134. He kept her off work. *Id.*

On March 8, 2011, Petitioner had a bilateral L4-5 facet block and caudal blocks. PX3 at 135-136. Pre- and post-operatively, he diagnosed her with L4-5 and L5-S1 bulging discs and lumbar radiculitis. *Id.* When she returned to see him on April 4, 2011, she reported that her low back and leg pain continued. PX3 at 137-138. Dr. Michael diagnosed Petitioner with bulging discs at L4-5 and L5-S1. *Id.* He recommended a lumbar discogram and kept her off work through July 25, 2011. PX3 at 139-142.

15IWCC0690

Petitioner underwent the discogram on August 9, 2011. PX3 at 143-144. She also had a post-discogram CT scan which the interpreting radiologist noted showed "mild diffuse disk bulge(s)" at L4-5 and L5-S1 and a Dallas Grade 4 annular tear. PX3 at 145-146. He concluded that the MRI showed degenerative changes involving the lumbar intervertebral disks as described, no significant spinal canal or neural foraminal stenosis, and prominent epidural fat particularly at the L5 level extending to the sacrum. *Id.*

When she returned to Dr. Michael on August 22, 2011, he recommended surgery in the form of either a disc decompression and biacuplasty, or a posterior lumbar fusion. PX3 at 147-148. Petitioner opted for the intermediate option including decompression and biacuplasty at L4-5, and L5-S1. *Id.*

First Section 12 Examination & Addendum Report – Dr. Lim

On July 7, 2012, Petitioner presented to Dr. Richard Lim for an independent medical evaluation at Respondent's request. RX2. Petitioner reported a consistent mechanism of injury and pain complaints mostly in the low back and some pain radiating into the legs with numbness and tingling. *Id.*

Dr. Lim noted that Petitioner tested positive for three out five Waddell signs and that light touching her lumbar spine with palpation in the midline caused excruciating pain. *Id.* Dr. Lim reviewed radiographs, MRI reports, and CT scans and noted that the findings were consistent with degenerative disc disease. *Id.* He noted his review of Petitioner's prior MRI scans and found no significant change from 2005 to 2011 and, thus, he could not identify any acute injury to the lumbar spine having occurred in 2010[3]. *Id.*

Ultimately, he diagnosed Petitioner with myofascial pain syndrome and opined that her MRI scans were normal. *Id.* He indicated that he could not identify an acute injury to Petitioner's lumbar spine causally related to the 2010 work accident. *Id.* Dr. Lim also concluded that Petitioner seemed to have reached maximum medical improvement in 2011 based on lack of recent treatment and that the recommended biacuplasty and decompression surgeries would likely be ineffective based on his positive Waddell findings. *Id.*

Dr. Lim indicated that he did not have a job description for review and that Petitioner may require work restrictions based on her subjective complaints. *Id.* He recommended a functional capacity evaluation to determine Petitioner's abilities. *Id.*

Respondent offered a written job description and a form entitled "Demands of the Job" into evidence. RX7; RX8. These documents indicate that the "VNAC" position required lifting up to 41-50 pounds from four-to-six hours per day, with help available to perform lifting. *Id.*

Dr. Lim issued an addendum report dated July 27, 2012 in which he states that he reviewed the position description. RX3. Dr. Lim opined that, based on his review, Petitioner should be able to return to work full duty. *Id.*

Petitioner's temporary total disability benefits were suspended effective July 31, 2012 in a letter sent the same date from Respondent's workers' compensation insurance carrier. RX4.

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[3] Dr. Lim refers to an October 6, 2010 accident, but initially noted a January 6, 2010 accident date in his report. It appears that the reference to October is a typographical error.

15IWCC0690

Continued Medical Treatment

Petitioner continued to follow up with Dr. Michael through January 21, 2013 and request the decompression and biacuplasty surgery during which time he kept her off work. PX3 at 149-164.

When Petitioner saw Dr. Michael on April 20, 2013, she reported continued low back and bilateral leg pain, worse on the left. PX3 at 165-166. On this date, Dr. Michael noted that Petitioner opted for the fusion surgery. *Id.*

Deposition Testimony – Dr. Michael

Petitioner called Dr. Michael as a witness and he gave testimony at an evidence deposition on October 9, 2013. PX3 at 187-271. Dr. Michael is a board certified neurosurgeon. PX3 at 190-193. Dr. Michael testified about Petitioner's lumbar spine condition, medical treatment, and he rendered various opinions. *See generally* PX3 at 187-235.

Dr. Michael discussed the results of Petitioner's discogram which showed a Dallas Grade 4 annular tear at both L4-L5 and L5-S1. PX3 at 201. He also testified about Petitioner's post-discogram CT scan which showed dye leaking all the way through the annulus to just below the ligament. PX3 at 203. Based on these tests, he determined that Petitioner had two pathologic discs at L4-5 and L5-S1. PX3 at 204. Ultimately, Dr. Michael opined that Petitioner's L4-L5 and L5-S1 disc problems were causing her back and leg pain which was connected to the accident at work she described to him. PX3 at 205-206.

Continued Medical Treatment

Petitioner continued to follow up with Dr. Michael through November 5, 2014 during which time he continued her medication management and kept her off work. PX3 at 167-179A. In the interim, on October 2, 2014, Petitioner underwent a functional capacity evaluation at ATI. PX3 at 180-186. The evaluating physical therapist found the results to be valid and Petitioner was released to work at the light/medium physical demand level with desk-to-chair lifting at 43.4 pounds, chair-to-floor lifting at 28 pounds, and above-shoulder lifting at 47.8 pounds occasionally. *Id.*

Petitioner testified that her restrictions were not accommodated by Respondent. She signed up for a work program in Kankakee County to try to find other work and sedentary work. Petitioner testified that she is attending Olivette University and will graduate this spring with a degree in Psychology and minor in Biology. Petitioner only has one class left.

Second Section 12 Examination – Dr. Lim

On December 4, 2013, Petitioner presented to Dr. Richard Lim for a second independent medical evaluation at Respondent's request. RX5. At this time, Petitioner reported pain in the thoracolumbar region/upper lumbar area, and in the lumbosacral junction. *Id.*

Dr. Lim found that Petitioner's symptoms were consistent with pre-existing discogenic low back pain and myofascial type back pain. *Id.* He stated that "[i]n light of her history of pre-existing spinal pathology, I cannot apportion 100 percent of her symptoms to be related to her work-related injury. It is impossible to state with any degree of confidence that all of her symptoms are related to her work-related injury." *Id.* Dr. Lim further

noted his finding that Petitioner presented with 3/5 Waddell signs suggesting a significant non-organic source of her pain. *Id.* He also noted that her physical findings did not clearly support her presence of axial back pain. *Id.* He reiterated that his Waddell's findings during Petitioner's exam were "highly suspicious for nonorganic source of pain." *Id.*

Ultimately, Dr. Lim opined that surgery was ill-advised, particularly in a patient so young with Waddell's findings, and that it was not causally related to her accident at work. *Id.* He noted that Petitioner's last MRI confirmed normal hydration of the discs, although discogenic changes were noted, and his belief that the majority of Petitioner's symptoms were pre-existing to her work-related injury. *Id.* Thus, he placed Petitioner at maximum medical improvement in accordance with his prior report from July of 2012 and indicated that she could return to work full duty. *Id.*

Additional Information

Since the accident. Petitioner explained constant nagging back pain, shooting pain down both legs, numbness and tingling, pain so severe that it sometimes wakes her up at night. In her daily life, Petitioner testified that she cannot play volleyball or interact with her daughter the way that she used to do.

Petitioner testified that she wants the recommended surgery so that her issue is resolved. On cross examination, Petitioner testified that at one point she scheduled the surgery, but then had an anxiety attack and cancelled the surgery. She explained that her mother had heart surgery and did not survive it. Petitioner also testified that she has a difficult time sleeping due to her pain.

15IWCC0690

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being in the low back is causally related to the injury sustained at work as claimed. In so concluding, the Arbitrator finds that Petitioner's testimony is credible as it is consistently supported by the medical records and her reports to the Section 12 examiner, and also finds that the opinions provided her treating physicians are more persuasive than those provided by Respondent's Section 12 examiner, Dr. Lim.

To recover in a preexisting condition case, a claimant need only establish a causal connection between his work-related injury and claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)). As in this case, even where an employee has a pre-existing condition that renders him more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)).

The medical records reflect that Petitioner immediately reported symptoms in the mid-back when she sought medical attention on the date of accident radiating into the left leg and knee. She also reported a similar incident two years earlier. Petitioner testified that she had no medical attention for the back during this period of time. Her testimony is uncontroverted.

She subsequently began physical therapy on February 9, 2010 and also reported her prior injury in October, 2008. By June 7, 2010, Petitioner saw Dr. Michael and reported a consistent mechanism of injury and symptoms including low back pain with bilateral leg pain. He reviewed her MRI and noted a very small L5-S1 bulge and an L4-L5 bulge. Petitioner underwent epidural steroid injections on September 21, 2010, November 30, 2010 and December 14, 2010, and on March 8, 2011, she had a bilateral L4-5 facet block and caudal blocks. Dr. Michael then recommended that Petitioner undergo a discogram—a medically controversial diagnostic test—and post-discogram CT scan on August 9, 2011.

The CT scan showed "mild diffuse disk bulge(s)" at L4-5 and L5-S1 and a Dallas Grade 4 annular tear. By August 22, 2011, Dr. Michael recommended surgery in the form of either a disc decompression and biacuplasty, or a posterior lumbar fusion. Petitioner initially opted for the intermediate option including decompression and biacuplasty at L4-5, and L5-S1, but testified that she cancelled the surgery because of an anxiety attack recalling the death of her mother due to a surgery. Petitioner testified that she wishes to undergo the recommended fusion surgery because she can no longer live with her symptoms. Dr. Michael continues to recommend that surgery.

While Respondent's Section 12 examiner, Dr. Lim, ultimately opined that Petitioner's symptoms were non-organic in nature or due to her pre-existing lumbar spine condition, he also explained that he could not attribute 100% of her symptoms to the pre-existing condition. He seems to have based the majority of his opinions on his Waddell's findings during his two examinations of Petitioner.

However, there is no evidence in this record to support Dr. Lim's conclusion that Petitioner, a young woman of 27 at the time of her injury, had the same, if any, symptoms in the low back or radiating into her lower extremities before her lifting injury at work. Moreover, Dr. Lim does not explain how Petitioner's post-discogram CT scan showing Grade 4 annular tears at the levels of the small disc bulges are due to some pre-existing condition or non-organic pain generators instead of the tears and bulges. Thus, the Arbitrator finds the opinions of Dr. Michael in conjunction with Petitioner's credible testimony in light of all of the medical evidence to be more persuasive than those of Dr. Lim.

Based on all of the foregoing, the Arbitrator finds that Petitioner's current low back condition of ill-being is causally related to her injury at work on January 6, 2010 as claimed.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's lumbar spine condition is causally related to her accident at work relying on Petitioner's credible testimony as well as the opinions of her treating physician, Dr. Michael. The medical bills submitted into evidence from EQMD, Illinois Neurospine, the SC, and ATI totaling $10,590.08 are for the reasonable and necessary medical treatment rendered to Petitioner to address her back condition.

Thus, the Arbitrator awards these medical bills incurred by Petitioner that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. As stipulated by the parties, "medical bills will not be paid twice and that the Respondent will get credit for any payments made."

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work as claimed and that the opinions of Dr. Michael are persuasive given the record as a whole. Thus, the Arbitrator awards the recommended prospective medical care in the form of a lumbar fusion as prescribed by Dr. Michael pursuant to Section 8(a) of the Act as it is reasonable and necessary to alleviate Petitioner from the effects of her injury at work.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the disputed period beginning August 1, 2012 through December 10, 2014.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

In this case, the record reflects that Petitioner was undergoing active medical treatment and placed off work through by Dr. Michael as it related to her back condition during this period of time. There is no evidence in the record that Petitioner was able to work during this period of time.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Based on the record as a whole, the Arbitrator finds that no penalties or attorney's fees should be imposed on Respondent. In so concluding, Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k) (Lexis 2010).

Section 19(l) provides in pertinent part:

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment

of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l) (Lexis 2010).

Also, Section 16 of the Act provides for an award of attorney fees where an employer, its agent, or insurance carrier "has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee... or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier." 820 ILCS 305/16 (Lexis 2010).

Given the evidence, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's injury at work resulted in the continuing symptoms in the back and legs as alleged. Respondent required Petitioner to submit to two Section 12 examinations throughout her treatment. Respondent also promptly provided its Section 12 examiner with requested information including her job description and Dr. Lim issued his reports after which Respondent promptly took action in writing to terminate benefits. Respondent's conduct was not unreasonable, vexatious and/or in bad faith.

Based on all of the foregoing and the totality of the evidence, the Arbitrator denies Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES SZYMCZAK ,

Petitioner,

vs. NO: 08 WC 40737

EDMAR HEATING & COOLING,

15IWCC0693

Respondent.

DECISION AND OPINION ON REVIEW

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

According to the Request for Hearing form, Respondent stipulated to an average weekly wage of $1,646.24, resulting in a maximum TTD rate of $1,096.27. Despite the stipulation, Respondent issued Petitioner weekly TTD benefits of $780.04, not $1,096.27. The TTD underpayment occurred from February 22, 2012 through May 08, 2012, representing 77 days. Therefore, the Commission awards Petitioner Section 19(l) penalties of $2,310.00 for the underpayment of TTD benefits.

15IWCC0693

The Commission further finds Petitioner is entitled to Section 19(l) penalties of $2,610.00 for the non-payment of TTD from December 19, 2012 through March 15, 2013, representing 87 days. Dr. Bernstein had Petitioner off work during this period for his undisputed work-related injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,096.27 per week for a period of 126 weeks (February 22, 2012 through July 22, 2014), that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $346,211.86 for medical expenses under §8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $4,920.00 as provided in Section 19(l) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for radioablation as prescribed by Dr. Kurzydlowski.

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.

15IWCC0693

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

DATED: SEP 9 - 2015

MJB/tdm
O: 7/14/15
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

SZYMCZAK, CHARLES
Employee/Petitioner

Case# **08WC040737**

15IWCC0693

EDMAR HEATING & COOLING CO
Employer/Respondent

On 11/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0247 HANNIGAN & BOTHA
RICHARD D HANNIGAN
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Charles Szymczak
Employee/Petitioner

v.

Edmar Heating & Cooling Co.
Employer/Respondent

Case # **08** WC **40737**

15IWCC0693

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 22, 2014 and August 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 20, 2006**, 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 $**85,604.48**; the average weekly wage was $**1,646.24**.

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

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

Respondent shall be given a credit of $**76,738.90** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**76,738.90**.

Respondent is entitled to a credit of $**11,211.38** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,097.49** per week for **126** weeks commencing **February 22, 2012** through **July 22, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **February 22, 2012** through **July 22, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $**346,211.86** for medical services, as provided in Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall be entitled to a credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Respondent shall authorize and pay for radiofrequency ablation as prescribed by Dr. Kurzydlowski.

Petitioner's claim for penalties and attorneys' fees is denied, because Petitioner has not proved that Respondent's conduct was unreasonable.

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

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

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

Signature of Arbitrator

November 5, 2014
Date

NOV 5 - 2014

PROCEDURAL HISTORY

This matter was tried on June 15, 2009 pursuant to Section 19(b). The prior Arbitrator found that Petitioner failed to prove that there was a causal connection between the injury and the need for medical treatment.

On May 28, 2010, the Illinois Worker's Compensation Commission entered a Decision reversing the Decision of the Arbitrator and finding that Petitioner sustained his burden of proof in that there was a causal connection and further awarded the medical expenses incurred, as well as the discogram and fusion surgery.

On November 24, 2010, the Decision of the Commission was affirmed by the Circuit Court.

On December 21 2011, The Appellate Court affirmed.

This matter now appears before this Arbitrator pursuant to Petitioner's 19(b), 8(a) and petitions for penalties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner periodically saw Dr. Perlmutter (Px. 4). On August 16, 2010 and April 20, 2011 Dr. Perlmutter was prescribing an MRI and a fusion at the L4–5 level (Px. 4 pg. 7-8). That MRI was performed on May 11, 2011 and revealed severe central canal stenosis with impingement of the roots of the cauda equine at L3-4, facet arthrosis, ligamentum flavun thickening and prominence of the epidural fat. There was mild to moderate bilateral foraminal stenosis at that level. There was moderate to severe central canal stenosis with bilateral sub articular stenosis at L4–5 along with moderate to severe left and moderate right for a foraminal

stenosis at that level (Px.7 pg.56). Dr. Perlmutter reviewed the findings of the MRI on June 6, 2011 with the petitioner. He again prescribed a fusion from L3 through L5. Dr. Perlmutter continued to see the petitioner through January 6, 2012 (Px.7 pg.11-26).

The parties agreed to allow Petitioner to have his treatment with Dr. Avi Bernstein (Px.5). Surgery was performed on February 22, 2012 at Lutheran General Hospital. The surgery was an L3-L5 lumbar laminectomy, L3-L5 posterior spinal fusion, L3-L5 posterior lumbar interbody fusions, L3–4 and L4–5 discectomies, implantation bullet cages x4, segmental fixation using expedient titanium system, right iliac crest bone graft, local bone graft, infused BMP, mastergraft and running and triggered EMGS. (Px.5 pg. 419-423).

Postoperatively Petitioner developed night sweats as evidenced in the medical records of Dr. Neville. (Px. 7). On March 2, 2012, Petitioner went to Dr. Bernstein regarding the night sweats and was sent over to Dr. Neville's office. Dr. Neville noted that the patient had been taking up to 12 Norco daily since the surgery. Although night sweats had been present for 3 to 4 years they were worse since he was hospitalized. The doctor suspected that the night sweats were related to the high dosage of Norco. The doctor changed his medication. He also noted that Petitioner had anemia which could possibly have been related to surgical blood loss. (Px.7 pg.30-34) The doctor opined that the eteology of the night sweats was unclear but possibly related to the hyperhidrosis worsened by the inflammatory stress of the recent surgery. The anemia is likely related to operative blood loss (Px.7 pg.21-23). On March 15, 2012 Dr. Neville again indicated that the petitioner's down trending blood levels and the inflammatory response was likely related to the recent surgery (Px.7 pg.20). That opinion was again repeated on April 2, 2012 by Dr. Neville (Px.7 pg.14). Petitioner last saw Dr. Neville on June 14, 2012. The doctor noted that the lab results continued to improve and the anemia was related to the surgery (Px.7 pg.5).

Petitioner also treated concurrently with Dr. Bernstein. On April 2, 2012, Dr. Bernstein prescribed physical therapy three times a week for four weeks. Petitioner was sent to Athletico. Prior to June 11, 2012 Athletico's medical records do not note any complaints by the petitioner regarding the left shoulder. On June 11, 2012, the Athletico records show that Petitioner was extremely sore in the left leg, middle back, and near his shoulder blade following their last session. The patient thought it might be from the shuttle which is an exercise the petitioner was doing and surgery. (Px.10A pg.51). On June 18, 2012, the therapist at Athletico noted the patient reported left-sided back pain from his shoulder blade to sacrum. He stated that he has constant left heel pain which began following the last session. When his pain medication wears off he reports that his heel pain intensifies (Px.10A pg.54). On June 28, 2012, Petitioner reported that he was still experiencing discomfort in the left lower back as well as the left shoulder. He was wading and swimming in the water when he felt

symptoms in his left shoulder and stopped immediately. He was instructed that if the pain does occur in the shoulder he should defer those exercises (Px.10A pg.63). On June 29, 2012, Petitioner reported at Athletico that he had mild discomfort in the left shoulder, upper extremity and lower extremity while doing an exercise which involved sitting on the Swiss ball. At that time, that exercise was deferred due to the shoulder soreness (Px. 10A pg.64). On July 2, 2012, the patient continued to express to Athletico discomfort over the supraspinatus region of the left shoulder. They performed exercises with emphasis on posturing to decrease stress over the shoulder (Px.10A pg.65). On July 5, 2012, Athletico reported to Dr. Bernstein that the patient was having complaints of left shoulder soreness which may possibly be supraspinatus tendinitis. They indicate this was evident at last week's appointment (Px.10A pg. 67-69).

Petitioner testified that he never receive treatment for his left shoulder nor voiced complaints of left shoulder pain until he was having therapy at Athletico beginning June 18, 2012. Dr. Bernstein's history of July 9, 2012 notes that Petitioner had an issue with his left sternomanubrial joint and left shoulder which has been problematic since the time of his accident. Dr. Bernstein referred the petitioner to Dr. Bresch and had athletic: limit the various exercises that would involve the left shoulder (Px.5 pg. 434).

Petitioner saw Dr. Bresch on August 6, 2012. He stated that his left arm pain occurred in June of 2006 and that since that time he is had increasing pain in the left shoulder joint and trouble raising his arm overhead (Px. 8 pg. 56-55). Petitioner testified that he did tell Dr. Bresch that he injured the shoulder during the accident of June 20, 2006, that that was not true and that he can't explain why he said it that way to the doctors. Dr. Bresch prescribed an MRI of the left shoulder which was performed on September 1, 2012 (Px. 6 pg.3-4). On September 6, 2012, Dr. Bresch reviewed the MRI with the petitioner and prescribed surgery which would include left shoulder arthroscopic, subacromial decompression and rotator cuff repair. That surgery was set for October 5, 2012. Dr. Bresch had Petitioner off of work has did Dr. Bernstein (Px.8 pg.54, Px.5 pg. 433). On October 5, 2012, Petitioner underwent left shoulder arthroscopic with subacromial decompression and rotator cuff repair with Dr. Bresch at Illinois Sports and Orthopedic Surgery Center (Px. 9 pg.17-18). The doctor noted that there was a significant undersurface fraying of the rotator cuff with a buttonholed type extension up through the full thickness tear. On October 22, 2012, Dr. Bresch prescribed physical therapy for the left shoulder. He started therapy for the left shoulder at Athletico on October 26, 2012. That therapy went through November 20, 2012. Dr. Bresch still had Petitioner off of work. On May 9, 2013, Dr. Bresch indicated that Petitioner still complained of joint pain muscle cramps muscle weakness stiffness and arthritis and had ongoing cervical complaints. He was to follow-up with Dr. Bresch after he was seen by the spine specialist and Dr. Bresch had him off of work (Px. 8 pg. 16-17).

On October 4, 2012, Dr. Bernstein noted that Petitioner was having increasing symptoms in the lower extremities but was doing well regarding the low back. Work hardening was canceled so that he could pursue left shoulder surgery. Dr. Bernstein prescribed an MRI of the lumbar spine (Px. 5 pg. 205). An MRI of the lumbar spine was performed on October 19, 2012 and the findings were appropriate for one who had undergone Petitioner's surgery (Px.6 pg.5). Dr. Bernstein reviewed that MRI on October 29, 2012 and noted no other pathology other than the surgery. The patient was complaining of variable numbness in the lower extremity which the doctor could not explain on a radiographic basis (Px. 5 pg. 204). Dr. Bernstein recommended that the patient follow-up with him at the conclusion of his shoulder therapy. On December 10, 2012, Petitioner saw Dr. Bernstein who noted that the shoulder surgery was going well. He prescribed no work until further notice (Px. 5 pg. 6). On January 14, 2013, Dr. Bernstein continued the patient off of work and noted that he was benefiting from use of the H-wave on a daily basis (Px. 5 pg. 6). On March 11, 2013, Athletico records show that the pain was 6–8/10 in the low back and left leg (Px. 5 pg. 33-36). On March 18, 2013, Athletico records show that the patient still had pain in the back and left leg. (Px. 5 (38-41). On April 15, 2013, Dr. Bernstein placed a hold on physical therapy and prescribed a CT scan of the lumbar spine (Px. 5 pg. 3). He had the CT scan July 12, 2013 at Lutheran General Hospital (Px.5 pg.31). On July 18, 2013, Dr. Bernstein reviewed the scan with Petitioner. Dr. Bernstein's records indicate that the CT scan demonstrates a beautifully healed fusion. There is no other pathology of the lumbar spine. He prescribed no work, an updated MRI and provided Petitioner with a handicap placard (Px.5 pg. 201). The MRI was performed on August 16, 2013 (Px. 6 pg. 8-9). On September 3, 2013, Dr. Bernstein reviewed the MRI with Petitioner. The doctor felt that the MRI was benign and that is far as he was concerned Petitioner was at maximum medical improvement but due to the continued pain complaints which cannot be explained on the basis of a radiographic study he needed to work with chronic pain management. Dr. Bernstein testified that he never released Petitioner to return to work (Px.35 pg.12) and that Petitioner suffered from a failed back surgery. On March 3, 2014, Dr. Bernstein referred or a trial of lumbar epidural steroid injections as well as an anesthetic injection of the hardware for diagnostic purposes (Px. 5 pg. 161 duplicate # at end of exhibit5). The referral was to Dr. Noren. Dr. Kurzydlowski is associated with Dr. Noren and saw Ppetitioner on April 8, 2014. The doctor noted Petitioner's complaints of low back pain and left leg pain. The doctor prescribed injections into the hardware (Px. 5 pg 154-155). This was performed on April 28, 2014 at Illinois Sports Medicine and Orthopedic Surgery Center (Px. 36 pg. 23). On May 7, 2014, Dr. Kurzydlowski met with Petitioner and noted he had a couple days relief from the hardware injection. His diagnosis was post laminectomy syndrome, lumbar and spinal stenosis, lumbar pain. The doctor opined that since the patient did not sustain prolonged relief from the hardware injection he suspected the pain was on the left and from the facet joints below the fusion (Px. 36 pg. 15-19). On June 9, 2014, Dr. Kurzydlowski performed a left median nerve

branch block at L4, L5 and S1 (Px. 36 pg. 27). The patient advised that this provided significant relief. Based upon that, Dr. Kurzydlowski prescribed a radiofrequency ablation. That has yet to be performed but it is Petitioner's desire to have the procedure.

Neither Dr. Bernstein nor Dr. Kurzydlowski has released Petitioner to return to work. Dr. Kurzydlowski continues to treat Petitioner.

Dr. Tonino testified on April 14, 2014 (Px. 34). His practice is limited to treatment of the knees and shoulders. Dr. Tonino reviewed records and performed a physical examination. He found loss of external rotation of the left shoulder, internal rotation of the left shoulder, and minimal discomfort with rotator cuff testing. He noted that the patient had some winging of the left shoulder blade. He currently would restrict him to no lifting over 20 pounds, and no overhead or repetitive use of the left upper extremity. He further indicated that Petitioner would benefit from a functional capacity evaluation after the petitioner's low back has healed. He testified that the left shoulder condition was indirectly related to the injury he sustained on June 20, 2006. Although Petitioner did not injure the shoulder directly at the time of the injury, he did experience the left shoulder complaints while in physical therapy for his low back accident which occurred on June 20, 2006.

Dr. Levin opined that there was no causal connection.

Based upon the evidence in this case, the Arbitrator finds: that Petitioner's current condition of ill-being is causally related to the accident; that Petitioner has been under physicians' reasonable and necessary medical care and authorized off of work since his surgery of February 22, 2012; that as it pertains to his low back Petitioner has yet to achieve maximum medical improvement; and that Petitioner is entitled to the claimed temporary total disability benefits, the claimed past medical benefits, and the claimed prospective medical benefits.

The Arbitrator further finds that Respondent's disputes have been reasonable, and therefore Petitioner is not entitled to sanctions.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0719

Tabatha White,
Petitioner,
vs.

NO: 12WC 5050
12WC 5051

Helia Healthcare,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,000.00. 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: SEP 17 2015
o091015
DLG/ge
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0719

WHITE, TABATHA
Employee/Petitioner

Case# **12WC005050**

12WC005051

HELIA HEALTHCARE
Employer/Respondent

On 3/4/2015, 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:

0874 FREDERICK & HAGLE
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15IWCC0719

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

TABATHA WHITE,
Employee/Petitioner

v.

HELIA HEALTHCARE,
Employer/Respondent

Case # **12** WC **5050**

Consolidated cases: **12 WC 5051**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Urbana**, on **2/13/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/3/11 and 12/29/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident on **12/3/11**.

In the year preceding the injuries, Petitioner earned $**17,688.84**; the average weekly wage was $**340.17**.

On the date of accidents, Petitioner was **28** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 16-5/7 weeks, commencing 6/14/12 through 10/8/12, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for treatment of her right shoulder/neck, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $330.00/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

3/3/15
Date

MAR 4 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 28 year old CNA, sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 12/3/11 and 12/29/11. Petitioner was hired by respondent in June 2011. Her duties included helping the residents with their daily needs such as feeding, showering and dressing. On 12/3/11 respondent was short handed. While attempting to lift a resident from a lying to a sitting position petitioner sustained an injury to her right shoulder. She felt a pop in her right shoulder and immediate pain. (This is the injury related to case 12 WC 5050).

Following the injury petitioner reported it to her charge nurse, who was her supervisor. She was told to call the Administrator, Mrs. Henson. Mrs. Henson and the HR representative came in and administered a drug test. They also told her to go to Convenient Care for a 2nd drug test and examination.

On 12/5/11 petitioner presented to Dr. Chen at Carle Occupational Medicine. She had tenderness both anteriorly and over the suparspinatus area. She was unable to abduct comfortably. Forward flexion or flexion across the elbow increased the pain anteriorly. Petitioner demonstrated tenderness over the short head of the biceps, without evidence of a complete rupture. Tenderness was noted over the trapezius and supraspinatus musculature. Petitioner was assessed with a right shoulder strain. Dr. Chen referred petitioner to physical therapy. She underwent a course of physical therapy from 12/16/11 through 1/15/12. Petitioner was restricted to light duty with lifting restriction of 10 pounds, no overhead lifting, and little use of her right hand.

On 12/23/11 petitioner followed up with Dr. Chen. She reported that her shoulder symptoms were slightly better. She stated that therapy had been helpful. Dr. Chen assessed a right shoulder strain that was improving. He continued petitioner in therapy.

On 12/29/11 petitioner returned to Occupational Medicine. She was seen by Virginia Brown, RN. She gave a history of exacerbating her right shoulder symptoms when she was in a room standing with an another employee and a patient started to fall out of a lift, and she instinctively grabbed at the patient. She stated that her pain was much worse than her previous injury. She reported that it was difficult to raise her arm, and her pain was fairly intense. She complained of some tingling radiating down her arm into the fingertips. Petitioner was assessed with a right shoulder strain with exacerbation of pain secondary to a new injury. Petitioner was given a shot of Toradol and prescribed Robaxin. Her restrictions were changed. She was restricted to no lifting, pushing or pulling over 10 pounds. She was instructed to avoid overhead work, and do nothing repetitive. She was to do mostly left hand work. (This is the injury related to case 12 WC 5051).

On 1/10/12 petitioner returned to Dr. Chen. She complained of pain in the right shoulder and trapezius area and into the neck. She also reported some tingling down the right upper extremity. She stated that her right shoulder pain was no better. She was again assessed with a right shoulder strain. Dr. Chen wanted to rule out internal derangement. He ordered an MRI of the right shoulder. She was restricted from lifting over 10 pounds, instructed to avoid twisting or bending and avoid overhead activities, left hand only work, and no patient transfers.

On 1/18/12 petitioner underwent an MRI of the right shoulder. It was a negative. A trace of fluid was noted within the subacromial space.

On 1/23/12 petitioner returned to Dr. Chen. She reported that her symptoms were really not improved. Dr. Chen examined petitioner, reviewed the MRI, and assessed a right trapezius area and cervical area myofascial pain. Petitioner's physical therapy was transferred to a more convenient location. She was continued on light duty work.

On 2/28/12 petitioner returned to Occupational Medication and was seen by Dr. Sutter. She reported that her neck pain had increased. She thought it was from the exercises she was doing for her shoulder. She stated that it was worse than her shoulder pain. Dr. Sutter examined petitioner and assessed a neck strain. He ordered an MRI of the cervical spine. She was restricted from lifting over 5-10 pounds; no twisting at the neck; no overhead work; and left hand work mostly.

On 3/6/12 petitioner followed-up with Dr. Chen. She reported increasing pain in the neck for a few days. She reported that the pain seemed to have gotten worse after some manipulation treatment in therapy. Dr. Chen examined petitioner and assessed right sided neck and trapezius area symptoms. Dr. Chen authorized petitioner off work until Thursday.

On 3/7/12 petitioner underwent an MRI of the cervical spine. The impression was mild straightening of the normal cervical lordosis and equivocal minimal upper cervical posterior paraspinal muscle edema. No cervical degenerative disc disease.

On 3/8/12 petitioner returned to Dr. Chen. She reported that her neck pain was slightly improved. She also stated that her right shoulder continued to hurt and radiate down toward the lateral side of the arm. Petitioner reported that overall she thought she was getting better. Petitioner complained of subjective numbness on the lateral deltoid region, and first three finger numbness on the right associated with certain movements, including holding up a telephone for about 5 minutes or bending the wrist. Following an examination and review of the cervical MRI, Dr. Chen was of the opinion that petitioner was likely having soft

tissue and musculoskeletal spasm and swelling. Dr. Chen authorized petitioner off work. He believed petitioner had a mild form of carpal tunnel syndrome.

On 3/13/12 petitioner followed-up with Dr. Chen. She was still complaining of symptoms in the right trapezius area. She stated that the therapy had caused her symptoms to flare up. Dr. Chen noted that the MRIs of the right shoulder and neck were normal. Following an examination petitioner was assessed with myofascial pain in the right trapezius muscle group. Petitioner was referred to the pain clinic for possible trigger point injections. She was also dispensed a TENS unit and Norco. Petitioner was restricted to 5 pound material handling, no bending or twisting at the neck, no overhead work, and no repetitive right shoulder movements. She was instructed to take frequent breaks to stretch.

On 3/19/12 petitioner returned to Dr. Chen. She stated that her symptoms had flared up again. She stated that she was back working and over the course of the evening, her symptoms get worse. She was assessed with a trapezius area sprain. He again recommended the trigger point injections. He restarted petitioner in therapy and took her off work.

On 3/30/12 petitioner follows-up with Dr. Chen with complaints of persistent pain in the neck with difficulty with movements across the neck causing pain and headaches. She did not have the classic impingement symptoms on rotation, even though rotation was uncomfortable for her. Forward flexion markedly increased her neck pain and headaches. She had generalized discomfort in the upper trapezius muscle groups and the cervical area bilaterally. She had functional range of motion across both shoulder areas, no upper extremity numbness or tingling; and history of headaches, but not as bad as these. Dr. Chen believed the headaches were superficial. He again recommended trigger point injections. He assessed cervical neck pain and upper trapezius myofascial pain with resultant headaches. Petitioner was restricted to 5 pound material handling, no bending or twisting at the neck, alternate sitting and standing as she needs to. He restricted her from patient transfers.

On 4/5/12 petitioner returned to Dr. Chen. She stated that her headaches were getting worse. She stated that respondent had been good with her restrictions. Dr. Chen took petitioner off work due to her headaches until 4/12/12. He stated that she could return to work with the same restrictions on that date.

On 4/10/12 petitioner presented to Dr. Shabeera Rauther at the Department of Interventional Pain Center for trigger point injections. Dr. Rauther performed an injection that day.

On 4/19/12 petitioner returned to Dr. Chen. She stated that the benefits of the injection lasted for about two days. On 4/19/12 she complained of pain in the shoulder and neck at an 8/10. He examined petitioner and

assessed right shoulder pain. He referred her to Sports Medicine for possible shoulder injections. He continued her restrictions.

That same day respondent did 1 hour and 15 minutes of video surveillance from 9:00 am to 5:00 pm. Petitioner was seen using her right hand without any discomfort. She was also seen using it to carry light items, smoking and use her cell phone in excess of 5 minutes, driving with her right hand, and carrying things with her right hand.

On 4/30/12 petitioner presented to Dr. Kolb at Orthopedics of Illinois on the referral of Dr. Chen for treatment of her right shoulder. Petitioner reported that her symptoms continued to worsen. She localized the majority of her discomfort to the superior aspect of the shoulder and stated that it radiates proximally into the lateral aspect of the neck. She rated her pain at a 7/10. She stated that she had been off work for about a week after she was placed on restrictions that respondent could not accommodate. Following an examination and review of the imaging studies, Dr. Kolb assessed a trapezial muscle strain of the right shoulder. He performed a subacromial injection into the right shoulder for therapeutic and diagnostic reasons. Dr. Kolb was of the opinion that if petitioner got significant relief then a majority of the pain could be coming from her right shoulder and need to be addressed surgically.

On 5/3/12 petitioner underwent a Section 12 examination performed by Dr. Mark Levin, at the request of the respondent. Petitioner provided a consistent history of the accident, and her treatment to date. She stated that Dr. Kolb gave her a cortisone injection in her right shoulder the past week. She rated her neck pain as a 2/10. She reported that her shoulder was about 50% better, but she still had pain over the trapezius and scapular area being a 5-6/10. Petitioner reported that she was able to do things and pick things up, but felt that she could not carry her groceries. She stated that she drives minimally, but does not use her right hand when she drives. She also stated that she cannot use her cell phone, or her right hand to smoke. Petitioner reported that she is doing no carrying with the right hand. She stated that her right shoulder hurts when she tries to reach behind her. Petitioner stated that she was told to remain on light duty, but had been taken off work last Thursday by her company.

Dr. Levin performed a physical examination and record review. Based on the totality of his Section 12 examination Dr. Levin noted petitioner had subjective complaints of pain which were out of proportion to objective findings. He noted that her initial complaints of pain related to the alleged work injury appeared to have been shoulder pain, but subsequent testing was negative for any objective shoulder pathology. He noted that during therapy she had neck complaints for which she underwent a MRI of the cervical spine that was negative. Dr. Levin was of the opinion that petitioner's subjective complaints of pain did not fit with any

objective pathology from an alleged occurrence preventing her from returning to work. He was further of the opinion that her diagnosis was subjective complaints of pain out of proportion to objective findings of her cervical spine and right shoulder. Dr. Levin was of the opinion that he found no objective orthopedic pathology which would prevent her from returning to work and recommended that petitioner return to full duty work. He did not believe she needed any further treatment related to the injury on 12/3/11.

After completing his examination and report, Dr. Levin reviewed a video surveillance of petitioner, and still pictures dated 4/19/12. He believed the video showed petitioner doing activities including driving with her right hand, using her right hand for holding and carrying her child, as well as lifting up when she got up from a position in front of her garage. He also viewed her smoking with the right hand in a normal fashion. Dr. Levin also noted that the video showed activities contrary to what petitioner subjectively reported she was capable of performing.

On 5/21/12 petitioner followed up with Dr. Kolb. Dr. Kolb noted that petitioner reported that the injection provided at least 60% improvement initially, but since that time she stated that her pain had worsened to the point it was before the injection. She complained of pain along the anterolateral aspect of the shoulder that is reproduced with any type of overhead activities. Dr. Kolb recommended an arthroscopic intervention with debridement, subacromial decompression, and a possible biceps tenotomy. He continued her work restrictions of Dr. Chen.

On 6/14/12 petitioner underwent a right shoulder arthroscopy with extensive debridement of inflamed bursal tissues, partial thickness rotator cuff tendon tearing, and arthroscopic biceps tenotomy. This procedure was performed by Dr. Kolb. The postoperative diagnosis was right shoulder impingement syndrome, and biceps tendinopathy. Petitioner followed up post-operatively with Dr. Kolb.

On 6/25/12 petitioner returned to Dr. Kolb. Petitioner was not doing well and was seen at the emergency room the night before for a possible infection. Dr. Kolb was of the opinion that petitioner had developed cellulitis and continued her on the Keflex she was given at the emergency room. Petitioner was continued off work.

On 7/2/12 petitioner followed-up with Dr. Kolb. He noted that her cellulitis had resolved. He believed petitioner was making good overall progress. He prescribed a course of physical therapy. He continued her off work.

On 8/6/12 petitioner returned to Dr. Kolb. He noted that she was doing quite well. She reported that she was at least 65-70% better than she was before surgery. She complained of occasional achiness in the shoulder.

She stated that she was improving. Dr. Kolb noted that respondent had denied physical therapy. He released petitioner to work with no overhead lifting and no lifting over 5 pounds.

On 10/8/12 petitioner followed-up with Dr. Kolb. She reported that she was improved 50% from her last visit. She also complained of neck pain with occasional radicular complaints to the posterior and superior aspects of the shoulder. Petitioner stated that she was not taking any pain medications. Dr. Kolb released petitioner to work without restrictions. He continued her in physical therapy. He released her on an as needed basis.

On 8/23/13 the evidence deposition of Dr. Kolb, an orthopedic surgeon, was taken on behalf of petitioner. Dr. Kolb testified that in surgery the biceps tendon was found to have an abnormal appearance where it insert onto the top of the glenoid, and that finding was consistent with an injury to that area. This was treated by doing a biceps tenotomy. He also removed inflamed tissue from the petitioner's subacromial space and debrided a very small partial thickness rotator cuff tendon tear. Dr. Kolb opined that surgery was the only reasonable plan of action at the time he saw her. Dr. Kolb opined that petitioner sustained an injury to her right shoulder as a consequence of a December 2011 work injury; that the mechanism of injury would be consistent with his findings clinically, diagnostically and surgically; that the need for surgery was causally related to a 12/3/11 work injury; that the injury that occurred on 12/29/11 possibly exacerbated the injury of 12/3/11; and that petitioner could work her regular duty without restrictions. Dr. Kolb opined that the pop petitioner heard when she sustained her injury on 12/3/11was consistent with the bicep tendon injury.

On cross-examination Dr. Kolb was of the opinion that when lifting a patient up out of a bed, the biceps tendon would certainly be stressed at the shoulder and the elbow. Dr. Kolb opined that narrowing is not consistent with overhead lifting. Dr. Kolb was of the opinion that MRI's aren't always going to show what is going on in the shoulder. He opined that biceps tendon pathology of the shoulder is often times very difficult to diagnose radiographically and sometimes clinically.

On 10/2/13 the evidence deposition of Dr. Levin, an orthopedic surgeon, was taken on behalf of the respondent. He opined that petitioner had subjective complaints of pain, without any objective orthopedic pathology from the alleged work occurrence. Dr. Levin attempted to comment on Dr. Kolb's operative report which he had been handed that day. Petitioner made a Ghere objection which the arbitrator sustains. All of Dr. Levin's opinions based on his review of the operative report are stricken.

On 9/30/14 petitioner presented to Dr. Levin for an AMA impairment rating, at the request of the respondent. He noted that petitioner still gets intermittent pain and stiffness in her right shoulder and difficulty

snapping her bra. He also noted that she had occasional popping of the shoulder, but denied any numbness or tingling. Dr. Levin noted that petitioner was able to do all activities and has elected not to look for any new work. Petitioner noted that three years ago she was diagnosed with fibromyalgia and treats for this condition. Petitioner takes Aleve for her shoulder complaints, 3-4 times a week. An examination revealed tenderness across her bilateral trapezius, which she related to her fibromyalgia; no pain to palpation over the acromioclavicular or sternoclavicular joints bilaterally; some tenderness over the anterior aspect of the shoulder with no pain in the left shoulder; decrease with overhead reaching with her right arm by 10 degrees, abduction on the right decreased by 20 degrees, and extension on the right decreased by 10 degrees. Following a physical examination and record review he provided a 10% upper extremity impairment, or 6% whole person impairment, with respect to the injury petitioner sustained to her right shoulder on 12/3/11.

On 11/5/14 the second evidence deposition of Dr. Levin was taken on behalf of respondent. Dr. Levin opined that he had no problem with the surgery petitioner underwent, he did not see any findings on the MRI of the shoulder that correlate with the findings on the operative report being related to an alleged work injury in December 2011. Dr. Levin agreed that the reason for the surgery was continued subjective discomfort with lack of improvement, and it was totally appropriate in that situation to do an arthroscopy and surgical procedures to see what may be there. However, he opined the operative findings were not causally related to her accident.

On cross examination Dr. Levin admitted that sometimes there are operative findings that may not correlate with the MRI findings. Dr. Levin testified that he had no problem if a patient keeps complaining to do surgery. Dr. Levin was of the opinion that petitioner's subjective reports have varied all over the place, and after having had surgery performed, subjectively improved.

Respondent offered into evidence records from judici.com Coles County, IL regarding petitioner. Petitioner did not object. These records show that petitioner was convicted of misdemeanor retail theft under $150 in 2009. On 2/17/10 petitioner entered a guilty plea and got 2 years of supervision. On 7/11/12 her supervision was terminated/satisfied. Petitioner testified that when she applied for work with respondent she did not include this on her employment application because she thought that when she agreed to supervision and completed that period that it would no longer be part of her record, and she thought that if she did mark it she would not be considered for the job. She testified that she did not intend to deliberately misrepresent herself. Petitioner testified that she disclosed this to Mrs. Henson during her job interview and still got the job. Petitioner further testified that when she was hired she told Mrs. Henson that she needed weekends off because she was serving weekends in Cole County jail for driving on a suspended license. Petitioner testified that Mrs. Henson gave a few weekends off until her sentence was done.

Petitioner testified that after she underwent the surgery by Dr. Kolb she felt a lot better, but not 100%. Currently she has trouble snapping her bra in the back by herself and for that reason she wears a sports bra. She testified that she has a hard time shaving, and does not lift. She stated that her husband helps her lift things. She stated that her range of motion was the thing most affected by the surgery.

Petitioner testified that from the date of injury to surgery, she stayed within her restrictions. She stated that she had limitations but could use her arm. She stated that lifting caused her problems. Petitioner denied that she told Dr. Chen that she had difficulty holding a phone. She also denied that she told Dr. Levin that she could not use her right hand to drive. She stated that she told him that she had difficulty driving. She further stated that she could hold her cell phone pre-surgery, but not for 30 minutes. She testified that she could also use her right hand to smoke pre-surgery. She denied that she told Dr. Levin that she was unable to smoke with her right hand. She testified that she told him she tried to avoid smoking with her right hand.

Jo Blaker, a CNA with respondent, was called as a witness on behalf of respondent. She testified that her job was that of CNA scheduler. In 2011 she scheduled petitioner for work after her injury. She scheduled her for 1 person assist, passing ice water, feeding in the dining room, passing trays, doing vitals, answering phones, and filing. She testified that when petitioner was on restricted duty she stated that she could not do the work, and continued to get new restrictions, until the point where she could not lift over 5 pounds.

Blaker testified that in March or April of 2012 she saw petitioner at the company Easter Egg Hunt. She stated that petitioner was there with her husband and children. She stated that she observed petitioner running around pointing out Easter eggs to her kids, and laughing and joking. She testified that petitioner looked fine to her. She testified that petitioner was terminated before her surgery. She also stated that temporary total disability benefits for petitioner were terminated after respondent's Section 12 examination.

On cross-examination Blaker testified that she did not work alongside petitioner, and only assisted petitioner in the dining room or helped out when there was a shortage. She testified that she worked on the floor everyday for about 10 minutes from 12/11 to 6/12. She testified that she did not know what petitioner's restrictions were at the time of the Easter Egg Hunt. She stated that the Easter Egg Hunt lasted a few hours. Blaker testified that she discussed her concerns with Jane Flewelling in HR and Mrs. Henson, and no actions were taken that she knows of.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that on 12/3/11 and 12/29/11 petitioner sustained accidental injuries to her right shoulder that arose out of and in the course of her employment by respondent. On 12/3/11 while petitioner was

attempting to lift a resident from a lying to a sitting position she felt a pop in her right shoulder and immediate pain. Petitioner was placed on light duty. While working light duty on 12/29/11 petitioner exacerbated her right shoulder symptoms when she instinctively grabbed a patient that started to fall out of a lift.

Beginning 12/29/11 petitioner was restricted from lifting, pulling or pushing over 10 pounds, overhead work, and anything repetitive. She was also instructed to do mainly left hand work. She was assessed with a right shoulder strain. On 1/10/12 Dr. Chen ordered an MRI of the right shoulder which was negative, except for a trace of fluid within the subacromial space. He modified petitioner's restrictions. She was restricted from lifting over 10 pounds, and doing patient transfers. She was instructed to avoid twisting, bending and overhead activities, and do only left handed work.

Petitioner continued to complain that her symptoms were not improving and reported that she had neck pain from the exercises she was doing in physical therapy. This resulted in new restrictions related to the neck that included no lifting over 5-10 pounds, twisting at the neck, and overhead work. She was continued on mostly left hand work. An MRI of the cervical spine was performed. The impression was negative.

By 3/8/12 petitioner was improving, but her right shoulder continued to hurt. She reported to Dr. Chen that she had numbness on the lateral deltoid region and numbness of the first three fingers on the right with certain movements including holding a telephone for about 5 minutes, or bending the wrist. Dr. Chen assessed carpal tunnel syndrome, but did not make an casual connection opinion with respect to this diagnosis.

Despite no objective findings to support petitioner's subjective complaints, on 3/19/12 she reported to Dr. Chen that her symptoms worsened while she was working. On 3/30/12 Dr. Chen was of the opinion that petitioner's headaches were superficial. The arbitrator notes that prior to 12/3/11 petitioner's medical history was significant for severe migraine headaches that resulted in a significant amount of medical treatment. Dr. Chen restricted petitioner to 5 pounds of material handling, no bending or twisting at the neck, and alternating standing and sitting as needed. He also restricted her from doing patient transfers. On 4/5/12 petitioner was taken off work because of her headaches until 4/12/12, after which she could return to work with her prior restrictions.

On 4/19/12 petitioner reported to Dr. Chen that the benefits of the injection she had on 4/10/12 lasted only 2 days. She rated her pain on that day as 8/10. He continued her current restrictions. However, that same day, respondent performed about an hour and 15 minutes of video surveillance of petitioner. After having viewed this surveillance video, the arbitrator finds the petitioner's behavior and actions on the video are totally inconsistent with a person who rated her pain that day as a 8/10. Petitioner appeared to be in no distress or

discomfort and was clearly performing activities that she told Dr. Chen she could not do such as lifting, twisting, bending, pulling, and talking on her cell phone in excess of 5 minutes without any visible signs of discomfort. Thereafter, petitioner continued to report that her symptoms were worsening.

When petitioner presented to Dr. Levin on 5/3/12, she reported that she drives minimally, but does not use her right hand when she drives. She also reported that she cannot use her cell phone, or smoke with her right hand. She reported that she does no carrying with her right hand. The arbitrator finds these claims all inconsistent with what was depicted on the video surveillance of petitioner on 4/19/12. Dr. Levin was of the opinion that petitioner's subjective complaints of pain were out of proportion to the objective findings. Dr. Levin believed petitioner was capable of working full duty and did not require any further treatment.

Petitioner was continued on light duty by Dr. Chen. On 5/21/12 Dr. Kolb continued Dr. Chen's restrictions. On 6/14/12 Dr. Kolb performed a right shoulder arthroscopy with extensive debridement of imflamed bursal tissues, partial thickness rotator cuff tendon tearing, and arthroscopic biceps tenotomy. His postoperative diagnosis was right shoulder impingement syndrome, and biceps tendinopathy. Petitioner showed significant improvement in her symptoms postoperatively, and released to light duty work on 8/6/12 and to full duty work on 10/8/12.

Dr. Kolb testified that in surgery the biceps tendon was found to have an abnormal appearance where it inserts on to the top of the glenoid, and that finding was consistent with an injury to that area. This was treated by doing a biceps tenotomy. He also removed inflamed tissue from the petitioner's subacromial space and debrided a very small partial thickness rotator cuff tendon tear. Dr. Kolb opined that surgery was the only reasonable plan of action at the time he saw her. Dr. Kolb opined that petitioner sustained an injury to her right shoulder as a consequence of a December 2011 work injury; that the mechanism of injury would be consistent with his findings clinically, diagnostically and surgically; that the need for surgery was causally related to a 12/3/11 work injury; that the injury that occurred on 12/29/11 possibly exacerbated the injury of 12/3/11; and that petitioner could work her regular duty without restrictions. Dr. Kolb opined that the pop petitioner heard when she sustained her injury on 12/3/11was consistent with the bicep tendon injury. He further opined that when lifting a patient up out of a bed, the biceps tendon would certainly be stressed at the shoulder and the elbow. Dr. Kolb was of the opinion that MRI's aren't always going to show what is going on in the shoulder. He opined that biceps tendon pathology of the shoulder is often times very difficult to diagnose radiographically and sometimes clinically.

Dr. Levin performed an impairment rating evaluation of petitioner and determined a 10% upper extremity impairment, or 6% whole person impairment, with respect to the injury petitioner sustained to her right shoulder on 12/3/11.

Dr. Levin opined that he had no problem with the surgery petitioner underwent. However, he did not see any findings on the MRI of the shoulder that correlate with the findings on the operative report being related to an alleged work injury in December 2011. Dr. Levin agreed that the reason for the surgery was continued subjective discomfort with lack of improvement, and it is totally appropriate in that situation to do an arthroscopy and surgical procedures to see what may be there. However, he opined the operative findings were not causally related to her accident. Dr. Levin agreed that sometimes there are operative findings that may not correlate with the MRI findings. Dr. Levin testified that he had no problem if a patient keeps complaining to do surgery. Dr. Levin was of the opinion that petitioner's subjective reports have varied all over the place, and after having had surgery performed, subjectively improved.

Based on the above, the arbitrator incorporates both the opinions and findings of Dr. Kolb and Dr. Levin as it relates to the petitioner's current condition of ill-being as it relates to her right shoulder and the accidents on 12/3/11 and 12/29/11. The arbitrator finds the petitioner clearly had subjective complaints inconsistent with her objective findings, but does not believe that all her subjective complaints were inconsistent. The arbitrator finds it significant that petitioner had no known history of any right shoulder complaints prior to these accidents and continued to have them, albeit to a degree that may not be supported by objective findings, and the video surveillance. Nonetheless, it is unrebutted that following the surgery by Dr. Kolb petitioner improved significantly and was ultimately released to full duty without restrictions. The arbitrator gives greater weight to Dr. Kolb's opinions that the mechanism of injury petitioner sustained would be consistent with his findings clinically, diagnostically and surgically; that the need for surgery was causally related to a 12/3/11 work injury; that the injury that occurred on 12/29/11 possibly exacerbated the injury of 12/3/11; that the pop petitioner heard when she sustained her injury on 12/3/11was consistent with the bicep tendon injury; that when lifting a patient up out of a bed, the biceps tendon would certainly be stressed at the shoulder and the elbow; that MRI's aren't always going to show what is going on in the shoulder; and that biceps tendon pathology of the shoulder is often times very difficult to diagnose radiographically and sometimes clinically.

The arbitrator finds it significant that Dr. Levin agreed that surgery can be performed for subjective complaints that do not improve, that he had no problem with the surgery performed, and that some operative findings may not correlate with the MRI findings. Dr. Levin also agreed that petitioner's subjective complaints improved following the surgery.

Based on the above, as well as the credible evidence, although the arbitrator finds the petitioner's subjective complaints were at times inconsistent with the objective findings, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that her current condition of ill-being as it relates to her right shoulder is causally related to the accident she sustained on 12/3/11. Since petitioner was on light duty at the time of the injury on 12/29/11, and her diagnosis did not change following this injury, the arbitrator finds the petitioner's condition of ill-being is related to the injury on 12/3/11.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner's current condition of ill-being as it relates to her right shoulder causally related to the injury she sustained on 12/3/11 the arbitrator finds all medical expenses related to petitioner's right shoulder from 12/3/11 through 10/8/12 were reasonable and necessary to cure or relieve petitioner from the effects of her injury.

Based on the above, as well as the credible evidence, the arbitrator finds the respondent shall pay reasonable and necessary medical services for petitioner's right shoulder/neck from 12/3/11 through 10/8/12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE IN DISPUTE?

Petitioner is claiming she is entitled to temporary total disability benefits from 5/22/12 through 10/8/12. Respondent denies any liability for temporary total disability benefits.

On 4/19/12 petitioner reported to Dr. Chen that the benefits of the injection she had on 4/10/12 lasted only 2 days. She rated her pain on that day as 8/10. As a result, Dr. Chen continued petitioner's current restrictions. However, that same day, respondent did about an hour and fifteen minutes of video surveillance of petitioner. After having viewed this surveillance video, the arbitrator finds the petitioner's behavior and actions on the video are totally inconsistent with a person who rated her pain that day as a 8/10. Petitioner appeared to be in no distress or discomfort and was clearly performing activities that she told Dr. Chen she could not do such as lifting, twisting, bending, pulling, and talking on her cell phone in excess of 5 minutes without any visible signs of discomfort. Petitioner was also seen driving with her right arm and carrying things with her right hand. Thereafter, petitioner continued to report that her symptoms were worsening.

Additionally, when petitioner presented to Dr. Levin on 5/3/12, she reported that she drives minimally, but does not use her right hand when she drives. She also reported that she cannot use her cell phone, or smoke with her right hand. She reported that she does not carry anything with her right hand. The arbitrator finds these claims all inconsistent with what was depicted on the video surveillance of petitioner on 4/19/12. Dr. Levin was of the opinion that petitioner's subjective complaints of pain were out of proportion to the objective findings. Dr. Levin believed petitioner was capable of working full duty and did not require any further treatment.

As a result, the arbitrator finds the petitioner was able to work within restrictions that Dr. Chen had placed on her prior to this date, that respondent was able to accommodate. The arbitrator finds the credible evidence supports a finding that petitioner exaggerated her subjective complaints to a level where Dr. Chen placed her on restrictions that respondent could not accommodate. Therefore, the arbitrator finds petitioner was capable of working light duty until the date of surgery, 6/14/12.

On 8/6/12 Dr. Kolb released petitioner to light duty work with restrictions on no overhead lifting or lifting in excess of 5 pounds. On 10/8/12 Dr. Kolb released petitioner to full duty work without restrictions. Since there exists no credible evidence to support a finding that respondent offered petitioner any light duty work on 8/6/12, the arbitrator finds petitioner was not capable of returning to work until 10/8/12.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner was temporarily totally disabled from 6/14/12 through 10/8/12, a period of 16-5/7 weeks.

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

As a result of the injury petitioner sustained on 12/3/11the arbitrator finds the petitioner sustained a 7.5% loss of her person as a whole pursuant to Section 8(d)2 of the Act. Pursuant to Section 8.1b of the Act the arbitrator, in determining the level of permanent partial disability, bases her decision on the following factors:

(i) The reported level of impairment pursuant to subsection (a);
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by the treating medical records.

With regard to subsection (i) of §8.1b(b), respondent offered into evidence an Impairment Rating offered by Dr. Levin. Dr. Levin provided a 10% upper extremity impairment, or 6% whole person impairment, with

respect to the injury petitioner sustained to her right shoulder on 12/3/11. Dr. Levin had the opportunity to examine the petitioner both before and after the surgery, and review the operative report and pictures of the surgery. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a CNA at the time of the accident and that she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes however that petitioner did not return to work as a CNA. It was petitioner's sole decision not to return to work as a CNA after she was released to full duty work by Dr. Kolb on 10/8/12. On 9/30/14 Dr. Levin noted that petitioner was able to do all activities, but noted that she had elected not to look for any new work. Because petitioner is capable of performing all duties associated with her prior job as a CNA, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 28 years old at the time of the accident. Despite petitioner's young age, because the petitioner has elected not to look for any work after being released to full duty, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that since petitioner has elected not to look for any work, the Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on 10/8/12 petitioner noted that she was improved 50% from her last visit. She also complained of neck pain with occasional radicular complaints to the posterior and superior aspects of the shoulder. Petitioner reported that she was not taking any pain medications. On 9/30/14 Dr. Levin noted that petitioner still gets intermittent pain and stiffness in her right shoulder and difficulty snapping her bra. He also noted that she has occasional popping of the shoulder, but denied any numbness or tingling. Dr. Levin noted that petitioner is able to do all activities and states that she has elected not to look for any new work. Petitioner noted that three years ago she was diagnosed with fibromyalgia and treats for this condition. Petitioner reported that she takes Aleve for her shoulder complaints, 3-4 times a week. An examination revealed tenderness across her bilateral trapezius, which she related to her fibromyalgia; no pain to palpation over the acromioclavicular or sternoclavicular joints bilaterally; some tenderness over the anterior aspect of the shoulder with no pain in the left shoulder; decrease with overhead reaching with her right arm by 10 degrees, abduction on the right decreased by 20 degrees, and extension on the right decreased by 10 degrees.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the man as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laren Killman,
Petitioner,
vs. NO: 10WC 005926

The American Coal Company,
Respondent,

15IWCC0721

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 17 2015
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DLG/ge
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KILLMAN, LAREN
Employee/Petitioner

Case# **10WC005926**

THE AMERICAN COAL COMPANY
Employer/Respondent

15IWCC0721

On 2/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
BRUCE WISSORE
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0693 FEIRICH MAGER GREEN & RYAN
CHERYL L INTRAVAIA
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

15IWCC0721

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Laren Killman
Employee/Petitioner

v.

The American Coal Company
Employer/Respondent

Case # **10** WC **05926**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **December 3, 2014**. 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 Petitioner incur an occupational disease that arose out of and in the course of employment with Respondent?
D. ☐ What was the last date of exposure?
E. ☒ Was timely notice of the occupational disease given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the exposure?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the last date of exposure?
I. ☐ What was Petitioner's marital status at the time of the last date of exposure?
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 from the occupational disease?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other - Disease/Exposure; causation; Sections 1(d) - (f), 19(d); Admissibility of RE 13.

FINDINGS

On **January 1, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner was last exposed to coal dust and fumes arising out of and in the course of employment.

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

On the last date of exposure, Petitioner was **60** years of age, ***single*** with **0** dependent children.

In the year preceding the last date of exposure, Petitioner earned $**80,000**; the average weekly wage was $**1,538.46**.

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

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

Respondent shall be given a credit of $N/A for TTD, $N/A for TPD, $N/A for maintenance, and $N/A for other benefits, for a total credit of $N/A.

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

ORDER

Petitioner failed to prove that he developed an occupational lung disease as a result of exposures arising out of and in the course of his employment with Respondent. Petitioner's claim for compensation is denied. No benefits are awarded.

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

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

Signature of Arbitrator

January 29, 2015
Date

FEB 4 - 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner's medical records from Dr. Ewell (PE5) and Harrisburg Medical Center (PE6; RE8) were placed into the record. Dr. Ewell's records revealed no shortness of breath in 2003 (PE5 at 7), no shortness of breath and clear lungs in 2006 (PE 5) and treatment for carpal tunnel syndrome (CTS) in 2009 at which time Petitioner denied any difficulty breathing. Follow up visits for CTS revealed normal breath sounds in July and October 2011. (PE 5 at 13, 16) Dr. Ewell's records contained no pulmonary complaints. (PE 5) The Harrisburg Medical Center records contain a chest film from May 20, 1995 that found no active lung disease and had a final impression of "normal" (PE6 at 71) and a chest x-ray dated August 14, 2006 that found clear lungs and had a final impression of negative chest, 0/0 classification. (PE6 at 11) The Harrisburg Medical Center records contained no pulmonary complaints. (PE6).

Petitioner's NIOSH records contain three chest x-ray films from December 1988 to August 2006 read by six different readers. (RE7). All six film readings were negative for pneumoconiosis. (RE7 at 6, 7, 9, 10, 13-14, 15-16).

On August 10, 2007 Petitioner was seen at Harrisburg Medical Center regarding a hand injury. His chest exam and breathing were normal. (PE 6; RE 8)

Petitioner underwent a chest x-ray on January 12, 2010 that was interpreted by the radiologist, Dr. Youssef, as being negative for pneumoconiosis. There was evidence of emphysema and mild thoracic spondylosis. (RE 3)

On January 20, 2010, Dr. Henry Smith, a B-reader and board certified radiologist, read Petitioner's January 12, 2010 chest x-ray as positive for CWP at 1/1. (PE 3)

On January 21, 2010 Petitioner executed a Voluntary Resignation Form with Respondent stating he had voluntarily resigned his position with the company as of January 9, 2010, effective on the 21st. (RE 10)

Petitioner signed his Application for Adjustment of Claim in this matter on February 8, 2010. (AX 2)

On April 8, 2010, and at Respondent's request, Dr. Jerome Wiot, a B-reader and board certified radiologist, read Petitioner's January 12, 2010 x-ray as negative for evidence of coal workers' pneumoconiosis. (RE 1)

Dr. Glennon Paul examined Petitioner on September 27, 2012 at the request of his attorney. (PE1 at 9) In his report of the same date Dr. Paul noted that Petitioner reported shortness of breath when walking a quarter of a mile and going up a flight of stairs. Petitioner's age was noted to be 63. Petitioner also reported wheezing and coughing especially with upper respiratory tract infections. According to the report Petitioner's symptoms had been present for ten years but worsening. He smoked a pack of cigarettes per day for thirty years. Petitioner's pulmonary function testing, based on a height of 67 inches, revealed an FEV1 of 2.40 (77% of predicted) and an FVC of 3.31 (80% of predicted). (PE1, Dep Exh. 2 at 4). Following administration of bronchodilator, the

FEV1 remained the same and the FVC reduced to 3.24 (78% of predicted). *Id.* Following review of the testing, examination, and a chest film taken January 12, 2010, Dr. Paul diagnosed coal workers' pneumoconiosis and emphysema. (PE1, Dep. Exh 2 at 2).

Dr. Paul's report was forwarded to Respondent's counsel on October 1, 2012. (RE11)

At Respondent's request, Dr. Byron Westerfield examined Petitioner on December 5, 2012 and reviewed Petitioner's medical records and reports. A written report followed. (RE5 at 1) According to the History and Physical Examination (RE 5, p. 7) Petitioner reported respiratory symptoms for a couple of years consisting mostly of shortness of breath with exertional activities. Petitioner reported an occasional cough but no regular mucus. He denied ever being hospitalized for respiratory problems or the need for breathing medications.

In conjunction with the examination Dr. Westerfield also read Petitioner's chest x-ray of that same date, finding it negative for evidence of CWP. Petitioner was noted to be 64.75" tall. His lung fields were clear to auscultation and percussion. Spirometry was normal. Diffusing Capacity was normal. Lung volume was normal and arterial blood gas was normal on room air at rest. Petitioner's carboxyhemoglobin was greatly elevated representing heavy cigarette smoking. Dr. Westerfield noted Petitioner had an adequate history of exposure to coal dust to develop pneumoconiosis if he were a susceptible individual. However, he found no evidence that that had occurred. He found no evidence of any pulmonary impairment in Petitioner as he had normal lung function. He felt Petitioner had few respiratory symptoms at that time and noted he was under no medical treatment for any respiratory disease at that time. Petitioner's extensive smoking history was noted in addition to the fact he was still smoking. He felt it unusual that Petitioner did not have any respiratory injury due to cigarette smoking. However, there was no physiological evidence of such impairment at this time. Dr. Westerfield did not feel Petitioner was disabled at the present time and that he could return to work in coal mining or anywhere else with equal energy requirements. (RE 5)

On December 19, 2012, and at Petitioner's request, Dr. Alexander, a duly qualified B-reader and board certified radiologist, read Petitioner's January 12, 2010 x-ray as positive for CWP at 1/1. He noted mild hyperinflation in Petitioner's lungs. (PE 4)

On January 18, 2013, and at Petitioner's request, Dr. Smith, a duly qualified B-reader and board certified radiologist, read Petitioner's December 5, 2012 x-ray as positive for CWP at 1/1. (PE 3)

On February 15, 2013, at Respondent's request, Dr. Christopher Meyer, a board certified radiologist and B reader, read Petitioner's January 12, 2010 chest x-ray as negative for coal workers' pneumoconiosis. He also noted Petitioner's lungs were hyperinflated. (RE 2)

On that same date, and again at Respondent's request, Dr. Meyer, a board certified radiologist and B reader, read Petitioner's December 5, 2012 chest x-ray as negative for coal worker's pneumoconiosis. He did note evidence of hyperinflation in Petitioner's lungs. (RE 2)

On October 23, 2013, Petitioner's attorney faxed a second report from Dr. Paul stating, "These are the recalculated PFTs we were discussing which were corrected for a 2" mistake made in the height of Petitioner." (RE12). The attached documentation was based on a height of 65 inches and revealed re-calculated pre-bronchodilator values finding the FEV1 at 86% of predicted and the FVC at 86% of predicted. The post-bronchodilator values revealed an FEV1 of 84% of predicted and an FVC of 83% of predicted. (PE1, Dep Exh. 3 at 2).

On December 24, 2013, and at Petitioner's request, Dr. Alexander read Petitioner's December 12, 2012 chest x-ray as positive for CWP at 1/1. He noted mild hyperinflation in Petitioner's lungs. (PE 4)

On February 14, 2014, and at the request of Respondent, Dr. Robert Tarver, a board certified radiologist and B reader, reviewed Petitioner's chest x-ray from December 5, 2012 as being negative for coal workers' pneumoconiosis. (RE 4)

Dr. Paul was deposed on March 24, 2014. (PE1). Dr. Paul is board certified in internal medicine, allergy, asthma and immunology. (PE1 at 5) He is not a pulmonologist or a B-reader. (PE1 at 8, 49) During the exam, Petitioner reported shortness of breath walking approximately one-half mile or going up one flight of stairs, and symptoms of coughing and wheezing that had been present for at least ten years and were worsening. (PE1 at 14-15) Dr. Paul attributed the coughing and wheezing to the emphysema and the inspiratory rales to CWP. (PE1 at 15, 17) The minimal obstructive airway disease was attributed to emphysema. (PE1 at 17) Dr. Paul explained that typically, CWP had no impairment but would eventually result in a restrictive condition if the disease progressed. (PE1 at 18) Dr. Paul attributed the decreased carbon monoxide diffusing capacity to emphysema and CWP. *Id.* Dr. Paul found that Petitioner had CWP caused by coal dust. (PE1 at 20-21). He also had emphysema and COPD caused by cigarette smoke and coal dust. (PE1 at 21-22). Based on the diagnoses, Dr. Paul felt Petitioner could not have any further exposure to coal mine dust without endangering his health. (PE1 at 22-23)

Dr. Paul testified that CWP was permanent and progressive and a person who had a coal dust-induced lung disease would not have an improvement in their pulmonary capability over time. (PE1 at 46) He did not think he would have a stronger basis for his opinion if he had been able to review Petitioner's medical records. (PE1 at 46-47). Petitioner reported the coughing and wheezing. (PE1 at 47) Dr. Paul suspected Petitioner's records included those symptoms. *Id.* He did not know if Petitioner expressed complaints of shortness of breath or difficulty climbing stairs to his physician. (PE1 at 48) Dr. Paul did not perform any exercise testing that confirmed Petitioner's alleged shortness of breath. *Id.* Petitioner did not appear short of breath during the examination. (PE1 at 49)

Dr. Paul stated the range of normal for pulmonary function testing was 80 to 120 percent of predicted. (PE1 at 50) Dr. Paul testified that Petitioner was 67 inches tall. (PE1 at 50) He stated the secretary, or pulmonary function testing girl, or the respiratory therapist had him at 65 inches. *Id.* Dr. Paul stated he re-calibrated the testing from 65 to 67 inches and made Petitioner taller at Petitioner's attorney's request. (PE1 at 9, 50-51). By making him taller, Petitioner's percent predicted values were decreased. (PE1 at 51) Dr. Paul stated the rales were not due solely to smoking but were associated with restrictive lung disease. *Id.* Dr. Paul conceded there was no evidence of restrictive disease in his pulmonary function testing. *Id.*

Dr. Paul testified that when he reviews an x-ray he does not compare it with NIOSH films. (PE1 at 52) He just looks to see if someone has it or not. *Id.* He disagreed that NIOSH requires a person to reach a certain level before they were classified as positive for pneumoconiosis. *Id.* According to Dr. Paul, 0/1 is a positive finding for CWP. *Id.* Petitioner had very significant interstitial fibrosis and was worse than many of the other patients Dr. Paul had seen with pneumoconiosis. (PE1 at 52-53). "Worse" was a 1/1 classification. (PE1 at 53) Dr. Paul also testified that Petitioner did not have the pulmonary capability to perform a heavy labor job. (PE1 at 54)

Dr. Westerfield was deposed on March 31, 2014. (RE6). He is a B-reader and board certified in pulmonary disease, internal medicine and sleep medicine. (RE6 at 4) He became a B-reader in 1991 and a board certified pulmonologist in 1980. (RE6 at 5) Dr. Westerfield examined Petitioner and found the physical findings

"unremarkable." (RE6 at 9) There was nothing to suggest any respiratory disease. *Id.* There were no rales when he examined Petitioner. *Id.* He testified that if a person had rales due to an occupational disease, they would continue over time. *Id.* Dr. Westerfield's testing consisted of pulmonary function testing that included spirometry, diffusing capacity, lung volume measurements, arterial blood gas and electrocardiogram. (RE6 at 9). He also took a chest x-ray and personally reviewed the film. *Id.* As a B-reader he was required to review the x-ray side by side with the standard ILO films and match them as closely as possible and make a decision on the presence or absence of pneumoconiosis based on the comparison. (RE6 at 10) He explained that the range of classification was from 0/0 through 3/3 on a profusion category for simple CWP and a reading of 0/1 was negative for pneumoconiosis. *Id.* That was the rule from the standardization of chest x-ray interpretations. *Id.* 0/1 is not almost positive, it was a negative x-ray. (RE6 at 10-11) Dr. Westerfield read the film as completely negative with no opacities of any size or shape. (RE6 at 11) This would be 0/0. *Id.* He did not find any abnormalities when he reviewed the film. *Id.*

Dr. Westerfield explained that spirometry measured the mechanics of the lung, i.e., how the lungs were able to take air in and blow it out. (RE6 at 11) The testing performed on December 5, 2012 was normal. (RE6 at 12) The FVC was 3.75 which was 96% of predicted. *Id.* The FEV1 was 2.78 which was 89% of predicted. *Id.* No bronchodilator was performed because Petitioner's values were normal. *Id.* The values obtained by Dr. Westerfield were higher than the testing performed by Dr. Paul. *Id.* Dr. Paul's testing was also based on an incorrect height. *Id.* This was relevant because the predicted values were based on the age, sex, height and race of the individual. (RE6 at 12) To say if a person is normal or not, it was important for all those things to be correct. (RE6 at 13) Miners were measured in bare feet - their shoes were not part of the height, and the height was recorded; Dr. Westerfield did not just ask them how tall they were. *Id.* It was a requirement to measure the patient with their shoes off. *Id.* Petitioner's height was 65 inches. *Id.* Petitioner's spirometry values did not indicate any pulmonary impairment. *Id.* Dr. Westerfield did not know what was going on when the testing was performed three months earlier at Dr. Paul's office but stated that if the reduced values seen on Dr. Paul's testing were due to coal dust exposure, they would not improve. (RE6 at 15-16). If Petitioner had airway obstruction from pneumoconiosis or inhaling coal dust, he would not get better. *Id.*

The diffusing capacity measured the ability of the lungs to take oxygen from the air and put it across the alveolar capillary membrane of the lungs into the blood stream, so it actually measured the ability to diffuse oxygen. (RE6 at 16) Petitioner's value during Dr. Westerfield's testing was substantially higher than Dr. Paul's testing. *Id.* Again, if Dr. Paul's value was caused by coal dust exposure, it would not have improved. (RE6 at 16-17). Lung volumes measured the compartments of the lung that couldn't be directly measured. (RE6 at 17) The residual volume was the amount of air left in the lungs after exhalation. *Id.* There had to be something in the lungs or they would collapse. *Id.* The total lung capacity measured that plus the total amount of air inhaled. *Id.* The lung volumes indirectly measured the values that you couldn't get on the spirometry. *Id.* Petitioner's values were normal. *Id.* The total lung capacity was 106% of predicted which was normal. The residual volume was up a little bit which was compatible with his cigarette smoking but it was basically normal. *Id.*

According to Dr. Westerfield, the arterial blood gas testing measured the exchange of gases, the oxygen level, and the carbon dioxide level. (RE6 at 17-18) Petitioner's testing was normal. (RE 6 at 18) He had excellent oxygenation with a pO2 of 84. *Id.* His CO2 was normal at 40 and the pH was normal at 7.42. *Id.* The elevated carboxyhemoglobin level was likely due to cigarette smoking. *Id.* Petitioner reported a smoking history of one-quarter of a pack per day but the carboxhemoglobin value was closer to two packs a day. *Id.* The electrocardiogram was normal. (RE6 at 18)

Dr. Westerfield testified that after reviewing all the data, he did not believe Petitioner had simple CWP. (RE8 at 19) While he had an adequate history of exposure, he had not developed pneumoconiosis. *Id.* Petitioner had

strong lungs to have worked in the coal mines and smoked as long as he did; the fact that he had no respiratory injury was really remarkable. *Id.* Petitioner had no pulmonary disease whatsoever. (RE6 at 20) In Petitioner's case there was no evidence of a restrictive or obstructive condition. (RE6 at 21) Petitioner had no respiratory impairment at all. (RE6 at 22) He could return to his previous position in the coal mine and had the pulmonary capability to perform jobs with equal energy requirements. *Id.* It was Dr. Westerfield's understanding that Petitioner did not retire because of his breathing. (RE6 at 24) Petitioner did not report that his breathing problems made it difficult for him to do his coal miner work. (RE6 at 24-25)

Petitioner met with June Blaine, a vocational rehabilitation counselor, on April 24, 2014 at which time she completed an initial interview and conducted vocational testing. (PE2) A vocational assessment issued on April 29, 2014 in which Ms. Blaine addressed Petitioner's background, education, training, work history, vocational testing, and subjective information. Ms. Blaine noted Petitioner was 5'7" tall. Petitioner told Ms. Blaine that he left mining in January of 2010 because he was having issues breathing. He didn't look for work anywhere because he didn't think he was able to do anything. Petitioner reported that his biggest difficulty was running out of air and that he was able to complete most activities, albeit at a slower pace. He used no inhaler or medicine. Petitioner was on social security. She believed Petitioner was employable but his age, lack of formal training since the 1970's, and lack of computer training were factors. However, she did not think he could probably find a salary in Southern Illinois where he would earn what he was earning in the mine ($120,000.00). (PE 2)

On October 30, 2014 she provided a second report that included a job market survey. (PE2, Pet. Dep. Exh. 2, Resp. Dep. Exh. 5).

Ms. Blaine's deposition testimony was taken on November 14, 2014. (PE2). Ms. Blaine worked as a vocational rehabilitation counselor for 32 ½ years. (PE2 at 4) She had a bachelor's degree in psychology and a Master's degree in rehabilitation counseling. (PE2 at 5) She was asked to see Petitioner at the request of Culley & Wissore. (PE2 at 6) Petitioner's attorneys asked her to make two assumptions. The first was that Petitioner could no longer work as a coal miner and the second was to construe any limitations most strongly in favor of the coal company and assume he had no physical limitations beyond those a person his age. (PE2 at 6-7).

Ms. Blaine testified that she asked Petitioner questions and conducted vocational testing to get an idea of his academic skill and/or training. (PE2 at 9) After reviewing all the data, Petitioner's strongest transferable skill would be working in a management level position. (PE2 at 13) From her assessment and knowledge of Southern Illinois, Petitioner would be able to find work making between $12 to $15 an hour in Southern Illinois. (PE12 at 16)

Ms. Blaine performed a labor market survey which involved surveying employers. (PE2 at 14) The labor market survey basically affirmed the information about available jobs. (PE2 at 16-17) Petitioner was employable; he had worked and demonstrated his ability to work in the market. (PE2 at 17) The problem was that he did not have any computer skills. *Id.* Given the labor market for Southern Illinois, she thought the most he would to be able to earn was $12-$15 an hour which was not what he was making before. *Id.* It was unreasonable to believe he would be able to earn a salary similar to the $120,000 he was making at the mine. (PE2 at 17-18)

Ms. Blaine did not review any employment documents as part of her assessment or review any medical reports or records. (PE2 at 23) Petitioner reported he was running out of air. *Id.* When asked if it would have been helpful to see if Petitioners' medical records confirmed the fact, Ms. Blaine responded that she "wasn't asked to review medical records in this case. I was asked to make some assumptions, which I did." *Id.* Ms. Blaine

admitted that typically, when she performed vocational assessments for attorneys other than Petitioner's attorneys, she looked at medical records. (PE2 at 23-24)

Ms. Blaine did not test Petitioner for any learning disability so she did not know if he had one. (PE2 at 25) She found nothing that would be a barrier if Petitioner wanted to obtain further skills. *Id.* The fact that he had no formal computer training was a factor in her ultimate conclusion regarding Petitioner's employability. *Id.* When asked if she recommended to Petitioner that he obtain computer training, Ms. Blaine responded, "I wasn't asked to make recommendations for training for him." (PE2 at 25-26)

When Petitioner came to her she was not assisting him to find any job. (PE2 at 27) She was not asked to do that. *Id.* She did not discuss with Petitioner if he was looking for another job. *Id.* The assumption that he had a 'work-related lung disease' played into her assessment that he was not going to go back to work in the mine. (PE2 at 27-28). If he did not have a lung disease he could go back to work as a miner, if that was what she was asked to assume. (PE2 at 28) She did not know what Petitioner's lung disease was or the specifics of the disease. (PE2 at 29) She did not know the specifics of Petitioner's job duties or skills as shot firer. *Id.* She knew what the actual duties were for a roof bolter because she had run one once. (PE2 at 30) The skills and job duties for a mine examiner were to oversee what was going on. *Id.* It was a management position; they were overseeing, examining different parts of the mine, making sure it met guidelines or requirements from the state. *Id.* Her knowledge about the mine examiner job came from her working with prior miners. *Id.* She thought that what Petitioner did would depend on what was going on in the mine that particular day. (PE2 at 31) She had a mine manager in the past but could not speak to what Petitioner did everyday because she did not ask Petitioner what he did on a daily basis. (PE2 at 31-32) She believed she knew what he did on a daily basis but that was based on her experience, not Petitioner's. (PE2 at 32-33)

Ms. Blaine agreed that Petitioner might be able to teach other people the skills he obtained as a mine examiner. (PE2 at 33) She did not consider that in her labor market survey. *Id.* She agreed Petitioner might be able to work as a consultant for a mine or explain the positions of a mine examiner or mine manager as long as it did not involve going underground. *Id.* She did not consider larger cities in Southern Illinois although she agreed larger cities might provide better employment opportunities. (PE2 at 35) She did not consider a supervisor position at UPS; she admitted there was a UPS in Marion, Illinois. (PE2 at 36) She agreed that Glassdoor was accurate in its reported salaries and admitted Glassdoor reported a UPS supervisor salary between $67,000 and $74,000. (PE2 at 37) She also admitted that she did not consider any government jobs for Petitioner, even though his veteran status would give him additional points on the civil service exam. (PE2 at 38) She did not consider civil service because she believed Petitioner's age would prohibit him from being hired in a federal job even though she conceded there were laws against that. *Id.* Ms. Blaine did not consider any civil service jobs at SIU. (PE2 at 38-39) When she was provided a copy of the SIU opening for a custodial operation supervisor that paid $64,674, she agreed Petitioner would able to work in that position if there was a job available. (PE2 at 39) She further agreed that the civil service jobs at SIU also provided additional points for veterans and were given priority in hiring. (PE2 at 40) Ms. Blaine did not consider any security guard supervisory positions at any of the local hospitals either. (PE2 at 40-41)

Petitioner did not ask Ms. Blaine to help him find a job. (PE2 at 44) When asked if she would have helped him find a job she responded, "I don't know. I guess I would have to – I don't know for sure. I could have provided him with some information, sure." *Id.* Petitioner did not give her any indication that he was hoping to find a job. *Id.* Ms. Blaine never spoke with Petitioner about his desire to work any of the jobs listed in her October 2014 report. *Id.*

At the arbitration hearing Petitioner testified that he was born on May 11, 1949, was 65 years old and a widower. He began mining while he was still in high school in 1968. After he graduated from high school, he joined the Army and served in Vietnam for two years. After his discharge from the Army, he returned to mining and worked as an underground coal miner for 40 years. Petitioner was regularly exposed to coal dust, silica dust, roof bolting glue fumes, and smoke from cable fires at the mine.

Petitioner testified that his last exposure was on January 1, 2010 at The American Coal Company - Galatia mine - where he worked as a mine manager. He stated that he left because he decided it was time for him to get out while he still had what health he had. When asked if he had any breathing problems when he left the mine Petitioner testified that he just did not have the air he used to have and did not feel like he could keep up the pace. He decided a couple of months before he quit that he would leave the mine. It was his decision to leave and he filled out a resignation form. He did not indicate anywhere on the form that he was leaving for a pulmonary problem.

Petitioner testified that he did not look for work after he left the mine. He stated he looked to see if there were jobs that had compensable pay but there was nothing he felt he could do to average it out or it would be less hard on him. He never had a desk job and never worked anything other than manual labor. Petitioner did not apply for any jobs after he retired from the mine.

Petitioner stated he first noticed breathing problems about ten years earlier. His main complaint was that he just didn't have the air and couldn't go on like he used to. He thought maybe he could walk a couple hundred yards on level ground at a normal pace before becoming short of breath. He had to rest after two or three flights of stairs. He stated his breathing got worse from the time he first noticed it until he left the mine and his breathing stayed the same or got a little worse after leaving the mine. If he were offered a job in the mine today, he did not believe he could do it because of his breathing difficulties.

Petitioner testified that he started smoking when he was 16 and continued to smoke at the time of the hearing. Currently, he smokes a pack every two to three days. At one time he probably smoked a pack a day. Petitioner stated his breathing difficulties affected his daily living. He could no longer do what he used to. He used to cut wood and put up hay. Now it took him a whole lot longer because he could not rush. He had a couple of acres with some horses and noticed problems when he built fences. He mowed his own yard but it took a lot longer than it used to.

Petitioner testified that several years ago he he talked to Dr. Ewell, his primary care physician, about his breathing problems and spoke to him about working in the coal mine and how that affected him. Petitioner was not taking any breathing medications. He stated he did not have any other health problems beyond "wear and tear." Petitioner denied taking any medication for any health problem.

The Arbitrator concludes:

1. Evidentiary Objection.

Petitioner objected to the admission of Employer's Exhibit 13 on the basis of foundation and relevance. (TR at 10). Exhibit 13 was The Occupational Safety and Health Series, No. 22, *Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconiosis*, International Labour Office (ILO), Geneva (Rev. Ed. 2000). (RE13). The foundation objection has no merit because the document is self-authenticating. (Ill. R. Evid. 902). The document was issued by the International Labour Office, can be found online at the ILO website and was most recently revised in 2011. See, http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---

protrav/---safework/documents/publication/wcms_168260.pdf. The document is relevant because it directly addresses Dr. Paul's testimony regarding what constitutes a "positive" reading for CWP under the ILO classification system. Employer's Exhibit 13 is admitted.

2. Issues (C) and (F) Accident/Occupational Disease and Causation.

a. COPD

Dr. Paula and Dr. Westerfield both provided expert opinions on Petitioner. In light of their qualifications the Arbitrator finds Dr. Westerfield's expertise in this area greater and, therefore, more persuasive. The Arbitrator also notes some inconsistencies in Petitioner's testimony and medical records which raises doubts as to whether Petitioner chose to retire, in whole or in part, due to alleged breathing problems. In particular she notes the histories provided to Dr. Westerfield and Dr. Paul. Petitioner told Dr. Paul his coughing and wheezing had been present for at least ten years prior to his 2012 exam. According to Dr. Westerfield's report of 2012 Petitioner gave a history of respiratory symptoms for a couple of years. First, this is a big inconsistency. Second, if what he told Dr. Westerfield is accurate, Petitioner's symptoms may not have come to light prior to his retirement from Respondent. Third, Petitioner provided no testimony to explain this contradiction in histories or suggest one was accurate and the other not.

With respect to the opinions of Drs. Paul and Westerfield, Dr. Paul diagnosed COPD and emphysema due to smoking and coal dust exposure; however, the pulmonary function data underlying Dr. Paul's opinion was flawed. The opinion was also undermined by Petitioner's medical records as well as Dr. Westerfield's testing that revealed no evidence of any pulmonary condition or impairment. Dr. Westerfield's testing was substantially more thorough than Dr. Paul's and further revealed normal total lung capacity, normal diffusing capacity and normal arterial blood gas testing. Dr. Westerfield explained that if the cause of the abnormal findings seen during Dr. Paul's testing were due to a coal dust-induced process, the condition would not improve. Both conceded that coal-dust induced diseases were permanent and progressive. The objective medical evidence revealed an improvement in the later testing, even when corrected for the correct height. Petitioner was 65" tall. Dr. Paul testified, however, that Petitioner was 57" tall and that he recalibrated the test to make Petitioner taller. Petitioner's medical records failed to support any finding of pulmonary impairment and undermined Petitioner's testimony regarding symptoms of shortness of breath and/or difficulty breathing. The preponderance of the evidence fails to support a finding of an obstructive pulmonary impairment that stemmed from Petitioner's employment.

b. Coal Workers' Pneumoconiosis.

Petitioner's medical records don't corroborate or show any evidence of respiratory problems and Petitioner has had very little medical care or treatment from any doctors since leaving his employment with Respondent. Also, the Arbitrator notes her comments above regarding the inconsistency in Petitioner's histories as to the onset of his complaints.

At Petitioner's request Dr. Smith and Dr. Alexander reviewed the January 12, 2010. Both were duly-qualified B-readers and board certified radiologists and read the film as positive for CWP at 1/1 ILO classification level. (PE3 at 1, PE4 at 3) The same film was read by Dr. Wiot and Dr. Meyer, who were also duly-qualified B-readers and board certified radiologists. (RE1; RE2) Both Dr. Wiot and Dr. Meyer read the film as negative for CWP. (RE1 at 1-2; RE2 at 1-2) Dr. Youssef also read the film as negative for CWP. (RE3 at 1)

B-reader, Dr. Westerfield, obtained a second chest film as part of his December 5, 2012 exam. (RE5 at 10) He read the film as negative for CWP. *Id.* Petitioner's experts Dr. Smith and Dr. Alexander read the film as positive at a 1/1 ILO classification level. (PE3 at 4; PE4 at 1) Respondent's experts, Dr. Meyer and Dr. Tarver, (Dr. Tarver is also a duly-qualified B-reader and board certified radiologist) read the film as negative for pneumoconiosis. (RE2 at 2-4; RE4 at 1-2)

In sum, Petitioner's two B-readers (Smith and Alexander) interpreted Petitioner's chest x-rays as positive for CWP while Respondent's two B-readers (Wiot and Meyer for the 2010 x-ray and Tarver and Meyer for the 2012 x-ray) interpreted them as negative for CWP. That leaves the radiologist interpreting the January 12, 2010 chest x-ray on the day it was taken (Dr. Youssef), Dr. Paul, and Dr. Westerfield.

The radiologist read the January 12, 2010 x-ray as negative for CWP.

Dr. Paul is not a B-reader or a board certified pulmonologist. Dr. Paul's finding of coal workers' pneumoconiosis was also flawed. His erroneous testimony regarding the required findings for pneumoconiosis based on the ILO classification system undermined the opinion, especially in light of the lack of B-reader training and/or radiological qualifications. Dr. Westerfield is a B-reader and board certified pulmonologist. As such his opinions carry greater weight. Neither the medical records, nor the NIOSH records revealed CWP. The Arbitrator adopts the well-qualified opinions and reports of Dr. Westefield, Dr. Wiot, Dr. Meyer, Dr. Tarver, Dr. Youssef, as well as the medical records and NIOSH reports in support of her decision that Petitioner failed to sustain his burden to prove pneumoconiosis.

Petitioner failed to prove by a preponderance of the evidence that he developed an occupational lung disease that arose out of or in the course of his coal dust exposure with Respondent. He has no occupational lung disease. Petitioner's claim for compensation is denied. No benefits are awarded and all other issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randall Bertetto,

Petitioner,

vs. NO. 11WC038785

Dynegy Midwest Generation,

Respondent.

15IWCC0726

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 6, 2014 is hereby affirmed and adopted.

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 23 2015
SJM/sj
o-8/6/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERTETTO, RANDY
Employee/Petitioner

Case# **11WC038785**

DYNEGY MIDWEST GENERATION
Employer/Respondent

15IWCC0726

On 11/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0368 WIMMER & STIEHL
WILLIAM L WIMMER
2 PARK PL
SWANSEA, IL 62226

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR SUITE 208
FAIRVIEW HEIGHT, IL 62208

15IWCC0726

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RANDALL BERTETTO
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION
Employer/Respondent

Case # 11 WC 38785

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **9/4/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/16/2011**, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$80,225.60**; the average weekly wage was **$1542.80**.

On the date of accident, Petitioner was **60** years of age, single with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$6171.20** for other benefits, for a total credit of **$6171.20**.Parties have stipulated that these benefits constitute payment in full of all TTD awarded.

Respondent is entitled to a credit of **$11,799.92** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on May 16, 2011 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his hands was causally related to his injury. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator — November 1, 2014 (Date)

NOV 6 - 2014

RANDALL BERTETTO v. DYNEGY MIDWEST GENERATION, INC.
11 WC 38785

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges bilateral carpal tunnel injuries to his hands as a result of repetitive trauma to both hands over thirty-six years of employment with Respondent. The disputed issues are: accident; notice; causal connection; medical expenses; and nature and extent. Respondent's representative at the hearing was Kevin Ziegler. Two witnesses testified: Petitioner and Mr. Ziegler.

The Arbitrator finds:

On April 27, 2011, Petitioner presented to his family doctor, Dr. Chung, who ordered electrodiagnostic testing. (PX8). Petitioner stated at trial that he complained to Dr. Chung of having pain and numbness in both hands.

Petitioner underwent bilateral upper extremity nerve conduction studies on May 3, 2011, which showed right advanced carpal tunnel syndrome and moderate left carpal tunnel syndrome. No history was recorded at the time the study was performed.(PX 8)

Petitioner had a follow-up visit with Dr. Chung, and after reviewing the findings of the nerve conduction studies with him, concluded that the medical condition was causally related to his work activities. Dr. Chung referred Petitioner to Dr. Harvey Mirly for a surgical consultation and left moderate carpal tunnel syndrome.

Petitioner signed his Application for Adjustment of Claim on October 3, 2011. (AX 2)

On October 7, 2011 Petitioner presented to Dr. Harvey L. Mirly, a hand surgeon, per the referral of Dr. Chung, his family doctor. Dr. Mirly noted Petitioner's nerve conduction study showed delayed motor and sensory latency of the median nerves bilaterally; however, the EMG was within normal limits. In discussion with Petitioner Dr. Mirly was advised that Petitioner had worked for Respondent for 37 years. His current job was as a shift technician and control room operator; however, over the years Petitioner had done activities including jack hammer operating, turning multiple valves, shoveling, and using an impact drill. Dr. Mirly did not have a job description and Petitioner advised the doctor that Respondent had denied his workers' compensation claim. Petitioner was not a smoker and had never had diabetes or hypothyroidism. His hobbies included fishing, shooting, and working on cars. Petitioner wished to proceed with surgery through his personal insurance and had retained an attorney. Petitioner advised Dr. Mirly that he had already tried a splint. Dr. Mirly also suspected petitioner might have some underlying CMC arthritis given his thenar pain and tenderness at the CMC joint. These were separate problems and surgery for the carpal tunnel syndrome

was to be scheduled at Petitioner's convenience. Petitioner was allowed to continue working with no restrictions. (PX 1)

Petitioner underwent a left carpal tunnel release on November 14, 2011, at Belleville Surgical Center. (PX 1, 2, 3) Petitioner was taken off work on the date of surgery. As of November 22, 2011 he was healing nicely and the sutures were removed. Petitioner was referred to physical therapy for a home exercise program and given a release to return to work on December 5, 2011 with no restrictions. Plans were made for surgery on the right hand/wrist. (PX 1)

Petitioner underwent his right carpal tunnel release on December 21, 2011 and returned to see the doctor on December 30, 2011. (PX1, 2,3) He had been taken off work as of the day of surgery. When examined on December 30, 2011 he had "just a little" distal forearm bruising but good range of motion of his fingers and reported improvement in his pre-operative symptoms. Petitioner wished to return to work on January 11, 2012 and was given a return to work slip with that date. He was given a wrist splint for palmar protection. He was released to return as needed. (PX 3)

The deposition of Dr. Mirly was taken on May 10, 2013. (PX 4) Dr. Mirly is an orthpedic surgeon. He testified that at the time of their first visit Petitioner completed a "patient encounter form" which provided information on Petitioner, his address, work, symptoms, and medical history[1]. Dr. Mirly reviewed Dr. Ravi's nerve conduction studies and agreed they showed bilateral carpal tunnel syndrome; however, he didn't rely upon the study to assess the severity of Petitioner's condition. While Dr. Mirly also felt Petitioner had some CMC arthritis, he did not feel the arthritis was responsible for any of Petitioner's numbness. He noted the arthritis was at the base of Petitioner's thumb. Dr. Mirly discussed Petitioner's treatment, including surgery and recovery. Dr. Mirly's testimony on this was consistent with his office notes discussed above.

Dr. Mirly was asked a hypothetical regarding Petitioner's job duties with Respondent. The hypothetical asked Dr. Mirly to assume that Petitioner began working for Respondent in 1974 and that from 1994 to the present Petitioner was a "shift technician" and, as such, monitors, adjusts, and repairs machinery and equipment at the power plant such as boilers, turbines, coal feeders, ash crushers, and water treatment equipment. The job requires the repeated use of manual, pneumatic, and hydraulic hand tools including pneumatic grinders, pneumatic jackhammers weighing 20 to 40 pounds, electric and pneumatic impact wrenches with ½ to 2-inch drives, chain hoists, manual valve wrenches ranging from 1 foot to 5 feet in length, torque multipliers to generate additional torque for opening and closing valves, and 5 to 10-foot long steel poke rods and jackhammers to manually break up slag from the bottom of boilers... The manual valve wrenches were used regularly to open and close valves ranging from 2" to 4' in diameter which were often under substantial pressure, corroded or bent and difficult to open and close. The job requires substantial and repeated use of the hands and exposure to vibration from the hand tools. Dr. Mirly was also asked to assume that Petitioner performed these job duties from September of 1994 to the present." (PX 4 at 14-16)

[1] This form was not included in PX 1.

In response to the hypothetical, Dr. Mirly testified that the work over 37 years of "the forceful, repetitive exposure to vibration, heavy use are a contributing factor." (PX4 at 16-17) He further noted that Petitioner lacked any risk factors. While Petitioner's outdoor and home activities also contributed to his condition the doctor also felt Petitioner's work activities were the primary contributing factor.

Dr. Mirly also testified that he did not know if the labels of shift tech and control room operator were two different titles and admitted that if the job description was flawed or in accurate it could change his opinions on causation. (PX4 at 20-22) He further admitted that if Petitioner moved to a less strenuous job during his career this would impact his opinion because his impression was that he was doing the tasks outlined in the hypothetical for 37 years straight, but further had no specific understanding of the employment activities frequency, duration, or hand positioning, nor any technical job descriptions or job videos. (PX4 at 21-25) Dr. Mirly went on to say that Petitioner's age (61) would also be a factor in the development of carpal tunnel syndrome. (PX4 at 22-23)

At the request of Respondent Dr. Strecker performed a medical records review regarding Petitioner's case and issued a report on August 14, 2013. (RX 1, pp. 5-6) He also reviewed a video of Petitioner's job duties and various job descriptions, a physical demands analysis and an ergonomic analysis. The records he reviewed included those of Dr. Chung, Dr. Mirly, and Dr. Ravi as well as Sparta Community Hospital and the deposition of Dr. Mirly. Dr. Mirly agreed that Petitioner had bilateral carpal tunnel syndrome and had undergone appropriate care and treatment. He felt Petitioner was at maximum medical improvement and was capable of full duty. Based upon the video, job descriptions, ergonomic analysis and physical demands analysis he reviewed he did not feel Petitioner's bilateral carpal tunnel syndrome was caused by, contributed to, or aggravated or accelerated by his job duties with Respondent. He reasoned that none of Petitioner's job duties required him to maintain his wrist in an abnormal position for prolonged periods of time nor did he have significant exposure to any vibratory tools. He did not issue any comments or opinions regarding Dr. Mirly's diagnosis of CMC arthritis. (RX 1, pp. 5-6)

Thereafter, on January 6, 2014 Petitioner was examined by Dr. Strecker at the request of Respondent. After the examination, the doctor issued a report. (RX 1) Petitioner gave a history of being a right-hand dominant utility employee for Respondent over the preceding 39 years. Beginning in approximately 2009 Petitioner began developing paresthesias of both hands associated with pain which would wake him up at night. Petitioner went to his family doctor, Dr. Chung, who issued splints which provided no relief. Thereafter, he underwent nerve conduction studies which were read as showing bilateral carpal tunnel syndrome. Petitioner then presented to Dr. Mirly who subsequently performed bilateral carpal tunnel releases followed by a release to full duty. Petitioner's only complaint at the time of the exam was some paresthesia he noticed when driving prolonged distances. He denied any other problems and was working full duty for Respondent. (RX 1)

Dr. Strecker noted his discussions with Petitioner regarding Petitioner's job duties for Respondent. Petitioner reported that for the preceding five years he was working in the control room which involved working with computers 75% of his time and physical work occasionally turning valves the remaining 25% of his time. Prior to working in the control room, Petitioner was a maintenance technician which required him to repair and overhaul turbine engines using both manual tools and pneumatic tools and wrenches. He also had to clean sledge. According to Petitioner he began using power tools rather than manual tools on a consistent basis in the late 1980's. (RX 1)

Petitioner's medical history included a diagnosis of hypertension. He had also undergone a right triceps and biceps repair. Petitioner's physical exam of his hands and wrists appeared normal. Grip strength in the left hand was less than in the right hand. (RX 1)

As part of the exam Dr. Strecker was provided with medical records and a "job requirement check list" for the jobs of a shift technician, control room operator, and unit attendant. He also had an ergonomic job analysis as well as a job video. Dr. Strecker had reviewed Dr. Mirly's deposition. Dr. Mirly was of the opinion that Petitioner had bilateral carpal tunnel syndrome as well as CMC joint arthropathy. His medical care had been reasonable and necessary. Dr. Strecker felt Petitioner was at maximum medical improvement, needed no further medical or surgical attention and could perform his regular job duties. (RX 1) Dr. Strecker further opined that "based upon the records he had reviewed, the job descriptions, and the work history, he could find no evidence that Petitioner's job duties were caused by, contributed to, aggravated by or accelerated by his job duties." Dr. Strecker did not feel that any of Petitioner's job duties required him to maintain his wrist in abnormal positions for prolonged periods of time nor did he have to perform any repetitive activities with force nor did he have any significant exposure to vibratory tools although he did have some exposure to these factors early in his career. Dr. Strecker felt Petitioner had had very limited exposure for fifteen years prior to his onset of symptoms and, therefore, there was no temporal relationship between Petitioner's exposure and his symptoms. (RX 1)

In a letter dated February 25, 2014 Dr. Strecker corrected his causation opinion as set forth on page 3 of his earlier report so that it referenced there was no causal connection, contribution, aggravation or acceleration between Petitioner's job duties and his carpal tunnel syndrome. (RX 1, p. 4)

Dr. Strecker's deposition was taken on June 12, 2014. (RX 2) The job descriptions and video were attached to that transcript. (RX2 at RX B and C) Dr. Strecker recorded a history that for the five preceding years, Petitioner worked in the control room, 75% of the time with computers and 25% of the time outside the control room turning valves. Dr. Strecker noted the prior work history of Petitioner as well. Dr. Strecker opined that because none of Petitioner's job duties in the relevant past involved significant exposure to vibratory tools there was no temporal relationship between that exposure and his bilateral carpal tunnel even though he took the prior work history into account. (RX1, RX2 at 12-13, 20, 33-35) Dr. Strecker was also of the opinion that none

of his job duties required him to maintain his wrists in abnormal positions for prolonged periods of time and that the turning of valves did not constitute sufficient enough activity to cause or aggravate the carpal tunnel. (Rx1, Rx2 at 12-14)

At the arbitration hearing Petitioner testified that he began working for Respondent in 1974 and his job duties were discussed at length at trial. Over the course of his employment with Respondent, Petitioner worked as a "shift technician." As such he was responsible for the operation and maintenance of all equipment in the plant. He used hand tools, grinders, sledge hammers, high torque pressure tools and other tools as he repaired and maintained boilers, pumps, and other equipment. Petitioner testified to a variety of sizes of equipment and tools. He acknowledged that some tools were vibratory.

Petitioner testified that his specific job title changed to that of a "unit attendant" in 1996. At that time he began working less on maintenance and more in operations. Petitioner worked as a unit attendant until 2004. According to Petitioner, this job ("valving") involved opening and closing various sized valves (ranging in size from a normal household faucet to four feet across) on an irregular basis. Petitioner testified he had to occasionally "beat" the valve off while, at other times, he would turn the valves by hand. Due to lots of steam the valves were under a great deal of pressure. The larger valves required substantial force and numerous turns with both hands. Often wrenches were needed for leverage since the valves were rusted, corroded and under a lot of pressure. The "racking and valving" operation would vary each day from 5% of the day up to the vast majority of the shift.

The unit attendant job also required Petitioner to perform "racking" which he described as turning equipment off and on using switches that were similar to a lever door handle or a rod system that was turned with both hands (like cranking an old car). Petitioner testified that while doing the unit attendant job, 75% of the day was spent checking equipment and 25% of the day was spent "racking." He admitted that the use of hand tools was very rare while working as a unit attendant. Petitioner testified that he occsionally helped the mechanics.

In 2004, Petitioner began a transition to the specific job assignment of "control room operator." The control room involved monitoring systems with a computer screen the use of pistol grip switches that control the coal feeders, conditions and conveyors. During this period, half of his time was spent as a unit attendant and the other half was spent working in the control room. The control room operator job required the use of a computer with a mouse and the less frequent use of lever type switches called "pistol grips" (there were sixty such switches) that were used in various amounts to control different mechanical operations throughout the power plant. The pistol grips were also described as similar to lever door handle type switches that would be turned 90 degrees to turn operations off and on. Petitioner testified that the pistol grips did not require any significant pressure to turn and he admitted there was no hand tool use as a control room operator.

In 2006, Petitioner started working 60-75% of his day in the control room and the remainder was spent "outside" as a unit attendant. Petitioner testified that between 2006 and 2008 he worked a lot of overtime. As Petitioner explained it, his regular shift was a twelve hour day and he worked 13 1/2 days per month. Petitioner recalled that in one year (2010) he worked as many overtime hours as straight time hours and most of it was spent outside "racking" and "valving." Petitioner also recalled that while working assisting with a system called a "refractory" (1994 - 2011) he complained that his hands bothered him as they were packing clay into studs with impact hammers, but confessed that his hands returned to normal when he finished with that job. He also recalled occasionally needing to soak his hands while on that task. He also admitted that in 2011 he spent less and less time outside the control room on his regular shift.

From 2007-May 16, 2011, Petitioner worked 80% of his day in the control room and 20% as a unit attendant.

Petitioner testified that he went to Dr. Chung for his annual check-up and asked him about the bilateral numbness he was experiencing. Dr. Chung referred him for a nerve conduction study and when he returned to see the doctor thereafter, he was told he had bilateral carpal tunnel syndrome. On that date Petitioner believed there was a correlation between some of his job and his hands. Petitioner testified that he then told John Reynolds he had undergone the nerve conduction study and had a follow-up appointment thereafter. He told Mr. Reynolds that he would be following up again. Petitioner believed the conversation took place on May 16, 2011.

Petitioner testified that since returning to work for Respondent, he has experienced a loss of grip strength and range of motion in both hands and his hands became numb after driving for a while. Petitioner also testified that his range of motion might be slightly reduced in his wrist and that he felt a dull sensation in his palm when pressure was applied. Further he indicated that his pinch grip might be reduced, but he thought it might be due to age. Lastly he testified that his group health insurance paid $11,799.92 for his medical treatment and he received the equivalent of salary continuation while off work recovering from his surgeries.

Petitioner agreed he took a leave of absence for ninety days in 1996 or 1997 and 2000 and another one in April of 2001. Petitioner agreed that the term "shift technician" was a broad category of jobs including "unit attendants", control room operator, and other jobs. Petitioner has always considered himself a shift technician for Respondent but agreed that his job duties have varied greatly over time.

Petitioner is currently working in the control room, earning the same rate of pay as before his injury, and has no restrictions.

Petitioner identified the tools shown in PX 6 as illustrative of the type of hand tools he used as a shift technician.

Petitioner testified he was honest with Dr. Strecker during his examination.

Mr. Kevin Ziegler, an employee of Respondent, testified that he was very familiar with the job history and job duties of Petitioner. He has worked for Respondent a little over ten years. He specifically testified that the control room operator and unit attendant do not do the job activities as posed to Dr. Mirly in his deposition (maintenance, break up slag, open/close valves, etc.). He acknowledged that Petitioner also worked outside the control room on valves, etc.

The Arbitrator concludes:

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

Issue (D): What is the date of accident?

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

Petitioner failed to prove he sustained an accident on May 16, 2011 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his hands was causally related to his employment with Respondent. The causation/ "arising out of" dispute in this case centers around the opinions of each party's expert.

Dr. Mirly's opinion appears primarily based upon Petitioner's longevity of employment with Respondent. However, liability for a repetitive trauma injury cannot be based solely on the length of one's employment. One must also consider the specific job tasks and the manner in which they were performed. Dr. Mirly acknowledged that he never saw a job description(s), job video or physical demands analysis for Petitioner's jobs. While he testified such information could be helpful he didn't feel it was dispositive because one really needs to talk to the patient and see what they do. (PX 4, p. 24) However, in Petitioner's case, Dr. Mirly didn't know the duration or frequency of the specific activities Petitioner performed or the positioning of his hands and arms while so engaged. Dr. Mirly acknowledged that such information has an impact on causation opinions. (PX 4, pp. 24-25) Dr. Mirly also acknowledged that he didn't know Petitioner's job schedules or whether he worked one job three days or another job two. (PX 4, p. 25) He wasn't aware of Petitioner's regular work schedule (12 hour days, 13.5 days/month). There was no mention or discussion of Petitioner working overtime in the deposition or factoring in of Petitioner's leaves from work. Dr. Mirly acknowledged that all of the foregoing was to be considered. However, none of it was in the hypothetical and while Dr. Mirly testified he had information from Petitioner himself, he also testified that that information was no different that what was contained in the hypothetical.

Petitioner worked for Respondent for an extended period of time, but over the span of his career moved to less and less strenuous jobs. Dr. Mirly testified as to his understanding of Petitioner's employment and his work history. This understanding as

expressed by Dr. Mirly is contradictory to the testimony of Petitioner. Mr. Ziegler testified credibly that the job activities as referenced in the hypothetical posed by Petitioner in the deposition of Dr. Mirly are not the activities that Petitioner has done since, at least, 2007. Dr. Mirly testified that he relied on a history from the claimant, and a hypothetical from Petitioner's counsel, to come up with his opinion on causation, but admitted that if this information was incorrect or flawed, his opinions might change. (PX 4, p. 22) In particular Dr. Mirly stated that if Petitioner went to less physically strenuous jobs it could impact his opinion. The information relied upon by Dr. Mirly was incorrect. Dr. Mirly did not have an outside source of accurate information to rely upon. Due to these inconsistencies, the causation opinions of Dr. Mirly are not persuasive.

It is also disconcerting that Dr. Chung's records are not in evidence as they might have shed light on what, if any, history Petitioner provided to him. The most that the Arbitrator knows is that Dr. Chung examined him on April 27, 2011 and gave him a provisional diagnosis of carpal tunnel syndrome. (RX 1)

Relying on the history obtained from Petitioner, the records of Drs. Mirly, Chung, and Ravi, written job descriptions, a job video, and the deposition of Dr. Mirly, Dr. Strecker credibly testified that Petitioner's bilateral carpal tunnel was not work-related. Dr. Strecker's opinions are credible, and while he took into account Petitioner's distant work history using vibratory tools, he stated that this remote activity did not have a temporal impact on Petitioner's more recent bilateral hand complaints and development of carpal tunnel.

Both Drs. Strecker and Mirly also agreed that age is a causative factor in the development of carpal tunnel syndrome and this can act independent of occupational hazards. (PX4 at 22-23, RX2 at 14-15)

In a repetitive trauma case, as here, Petitioner bears the burden of proving by a preponderance of the credible and persuasive evidence that he sustained an accidental injury arising out of and in the course of his employment and that his condition of ill-being was causally related to his employment. For the reasons set forth above, the Arbitrator has concluded that Petitioner has not met his burden of proof on accident and causal connection. Petitioner's claim is denied and no benefits are awarded.

All other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSHUA HARDING,

Petitioner,

15IWCC0716

vs.

NO: 11 WC 28334

CASEY'S GENERAL STORE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, TTD, wage rate, and evidentiary issues and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator only to the extent that it finds Petitioner was entitled to temporary total disability benefits only from April 5, 2011, through June 19, 2011, and from June 27, 2011, through September 20, 2011. September 20, 2011, represents the date Dr. Robert Beatty, Respondent's Section 12 examining physician, authored an addendum to his July 26, 2011, IME report. In said addendum, Dr. Beatty referenced his review of medical records not previously available to him, namely a negative neurological examination conducted by Dr. George DePhillips and radiographic films of the MRI Petitioner underwent on August 18, 2011, MRI. He interpreted the films as revealing no herniation or annular tears and consistent with his opinion that Petitioner, on April 4, 2011, sustained a lumbar strain/sprain that should have resolved within three months of the accident. The Commission finds Dr. Beatty's interpretation of Petitioner's medical record insightful.

The Commission does take notice of Dr. DePhillips regularly providing Petitioner with work slips after September 20, 2011, that declared Petitioner to be totally incapacitated but finds Dr. DePhillips' actions to be unsupported by any objective examination findings. Dr. DePhillips' examinations records denote only a single physical examination was performed of Petitioner, on July 18, 2011, and his subsequent records only document Petitioner's subjective complaints and the history of Petitioner's treatment elsewhere. Since Dr. DePhillips did not ascertain Petitioner's physical condition through regular

15IWCC0716

physical examinations, the Commission finds his repeatedly keeping Petitioner off work after September 20, 2011, was unreasonable.

As noted above, the Commission modifies Decision of the Arbitrator only to amend the awarded TTD benefits. All other aspects of the Decision of the Arbitrator are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $244.26 per week for a period of 23-6/7 weeks, commencing April 5, 2011, through June 19, 2011, and from June 27, 2011, through September 20, 2011, those being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $244.26 per week for a period of 37½ weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7½% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $50,027.43 for medical expenses under §8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit of $16,420.95 for medical benefits that have been paid, and Respondent shall how Petitioner harmless for any claims by any provider of services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $48,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 17 2015
KWL/mav
O: 07/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CORRECTED

15IWCC0716

HARDING, JOSHUA
Employee/Petitioner

Case# **11WC028334**

CASEY'S GENERAL STORE
Employer/Respondent

On 1/12/2015, 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:

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

3150 JAMES M KELLY LAW FIRM
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

15IWCC0716

Joshua Harding
Employee/Petitioner

v.

Casey's General Store
Employer/Respondent

Case # **11** WC **28334**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on **October 24, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0716

FINDINGS

On **April 4, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**12,701.52**; the average weekly wage was $**244.26**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**3,230.46** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,066.66** for PPD advance, for a total credit of $**4,297.12**.

Respondent is entitled to a credit of $**16,420.95** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary disability benefits of $244.26/week (minimum) for 96 weeks, commencing April 5, 2011 through June 19, 2011 and from June 27, 2011 through February 12, 2013, minus any TTD credit of Respondent, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule totaling $50,027.43 (Dr. DePhillips - $2,110.00; OSF Medical Group - $3,821.00; Pain & Spine Institute - $22,560.50; Millennium Pain Center - $1,955.00; OSF St. Joseph Medical Center - $8,095.93; Bloomington Radiology - $305.00; Heartland Emergency - $1,412.00; St. Mary's Hospital - $2,901.00; St. James Radiology - $276.00; EqMD - $6,591.00). All amounts hereunder to be paid pursuant to the medical fee schedule, and Respondent to receive credit for any sums previously paid.

Respondent shall be given a credit of $16,420.95, as provided above, for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $244.26/week (minimum) for 37.5 weeks, because the injuries sustained caused 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act. From the award, the Respondent is entitled to credit of $1066.66, as referenced above.

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. 5, 2015
Date

JAN 12 2015

15IWCC0716

FINDING OF FACTS

On April 4, 2011, the Petitioner, Joshua Harding was working as a cook for the Respondent, Casey's General Store. Duties and responsibilities included preparing and cooking lunch products such as pizza and pulled pork sandwiches. Additional tasks performed included changing garbage bags and stocking the cooler. On this date, Petitioner slipped and fell while working in the kitchen on what he believed to be grease. He testified that immediately after the fall he noticed pain in his back and elbow. He reported the fall immediately to his supervisor, Linda. After briefly attempting to work through the pain, Linda allowed Petitioner to go home as the pain was too great.

Petitioner sought treatment later that day at St. Joseph Medical Center emergency department. His chief complaint was severe lower back pain with some radiation and tingling into the right leg following a fall at Casey's. (Px.2) The pain has been gradually worsening. (Id.) The symptoms are worsened by bending and twisting. (Id.) Upon physical exam he appeared to be distressed. (Id.) He had normal range of motion, no edema, no deformity, negative straight leg raising, deep tendon reflexes were symmetrical, sensation was intact, and his lower lumbar area was tender. (Id.) A lumbar x-ray performed was within normal limits. (Id.) He was taken off work and instructed to follow up with Occupational Health. (Id.)

On April 8, 2011, Petitioner was seen again at St. Joseph Medical Center. (Id.) He reported still having pains from the fall at Casey's kitchen. (Id.) He indicated that the medication previously prescribed did not relieve his pain. (Id.) He complained of back pain, right leg numbness and constant radiating pain into both thighs. (Id.) Symptoms are worsened by twisting or bending. (Id.) Upon exam, he was positive for back pain, positive for tingling and numbness, and had a positive straight leg test. (Id.) He exhibited tenderness and bony tenderness in the

lumbar area. (Id.) A lumbar CT scan was interpreted by the radiologist as showing straightening of lumbar lordosis, small central disc protrusion at L4-5 and diffuse disc bulge at L5-S1 without central canal stenosis or neuroforaminal narrowing. (Id.) Dr. Sabbun, the emergency room physician, interpreted the CT scan as showing a 3mm disc herniation at L4-5. (Id.) He was diagnosed with low back pain radiating to both legs and a herniated disc. (Id.) He continued him on a muscle relaxant and non-steroidal anti-inflammatory medication, but also prescribed Vicodin and Medrol dose pack. (Id.) He was kept off work and instructed to follow up with Occupational Health. (Id.)

On April 13, 2011, Petitioner went to the Occupational Health clinic. He complained of pain in the mid low back around the right side of the abdomen with pain going down the back of his bilateral legs to his knees, especially when standing. (Px.7) Pain worsens with standing, changing positions and walking. (Id.) The musculoskeletal exam indicated limited range of motion of the back with complaints of pain and pain to palpation across the lumbosacral area. (Id.) The assessment was back pain, radiculopathy, and bulging disc. (Id.) He was continued on Flexeril and Vicodin. (Id.) Prednisone was prescribed. (Id.) He was kept off work and scheduled for a recheck in one week. (Id.)

Upon recheck on April 20, 2011, he continued to have the same symptoms but was also starting to have intermittent pain from his knees to his feet at night when sleeping and when waking up in the mornings. (Id.) He indicated that he has had to alternate sitting, standing, and lying down due to pain. (Id.) He has limited range of motion in his back, pain to palpation across the lumbosacral area and bilateral SI joint areas, and positive straight leg raising on the right. (Id.) He continued him on the same medication and was additionally prescribed Meloxicam. (Id.) He was kept off work and was referred to Dr. Jhee. (Id.)

On May 2, 2011, Petitioner reported to Dr. Jhee that his average low back pain is about 6/10 with medications. (Px.2) The pain frequently radiates to both knees and occasionally to the feet, more to the right side. (Id.) He feels the legs are weak. (Id.) Any activities of prolonged duration aggravate the pain. (Id.) Dr. Jhee's physical exam found mild tenderness on bilateral sacroiliac joint slightly worse on right side; positive straight leg raising on both sides; positive Faber test; positive Gaenslen's tests bilaterally; deep tendon reflexes are diminished but almost symmetrical; and antalgic gait. (Id.) He was diagnosed with low back pain, lumbosacral strain, lumbosacral radiculopathy, and SI joint arthritis. (Id.) An EMG study was ordered and he was referred to physical therapy. (Id.) He was kept off work. (Id.)

EMG/NCV testing performed on May 6, 2011 found no definitive evidence of lumbosacral radiculopathy bilaterally and no peripheral neuropathy in the lower extremities. (Px.7)

On May 13, 2011, Petitioner followed up with Dr. Jhee who documented similar complaints and similar exam findings as on the previous visit. (Px.2) He continued him on physical therapy and referred him to the Millennium Pain Center for bilateral sacroiliac joint steroid injections. (Id.)

Petitioner received an L5-S1 epidural steroid injection on June 15, 2011. (Id.) The next day Dr. Jhee put physical therapy on hold due to the low back pain preventing him from progressing, but indicated that as of June 20, 2011 he was allowing him to return to work with restrictions consisting of no lifting over 5 lbs.; no frequent bending or twisting at the waist line; allow him to rest 5 minutes after every hour of work; and restricted to 5 hours per day and 5 day per week. (Px.7)

Petitioner testified that he attempted to return to work with restrictions, but only lasted one or two hours as he was not able to rest consistent with the restrictions given as the store was

too busy. He testified that his supervisor told him to go home. He further testified that upon reporting to work the next day his supervisor told him that they had nothing for him.

On June 27, 2011, Petitioner followed up with Dr. Jhee who documented occasional radiating pain to the groin, leg weakness, sleep problems, and aggravation of pain with most physical activities. (Px.2) Upon physical exam, he had moderate tenderness on midline structure of low back and sacroiliac joint area; sacroiliac joint movements are limited on both sides; positive straight leg raising and Faber tests on both sides; and slow gait. (Id.) It was recommended that he resume physical therapy and he was taken off work again. (Id.) In a follow up visit on July 7, 2011, Dr. Jhee documented similar complaints and exam findings as on the previous visit, but indicated that there was severe tenderness noted at the bilateral sacroiliac joint. (Id.)

On July 18, 2011, Petitioner saw Dr. DePhillips for a neurosurgical consultation. (Px.3) Dr. DePhillips documented a work injury slip and fall on April 4, 2011 causing him to twist his lower back. (Id.) Neurologic examination indicated good strength in dorsiflexion and plantar flexion. (Id.) He was able to walk on his heels and toes. (Id.) Deep tendon reflexes were 2+ at the knees and ankles. (Id.) Straight leg raising was negative bilaterally. (Id.) Patrick's sign was positive on the right. (Id.) Dr. DePhillips' differential diagnosis included myofascial pain, discogenic pain, and right sacroiliac joint dysfunction. (Id.) He prescribed Flexeril and Norco, kept him off work, and recommended a lumbar MRI. (Id.)

At the request of the Respondent, Petitioner attended a medical evaluation with Dr. Beatty on July 26, 2011. (Rx.1) Dr. Beatty reviewed medical records from St. Joseph's Medical Center, Occupational Health, and Dr. Jhee as well as the CT scan and EMG. (Id.) Petitioner complained of constant lumbar ache into the buttocks, back of the right knee, and sometimes to the foot. (Id.) He has inconstant numbness of the right leg lasting about 10 minutes and a hot

tingling feeling in the leg. (Id.) Upon physical examination, forward bending was 30 degrees and bilateral bending was 15 degrees. (Id.) There was lumbar tenderness and questionable spasm. (Id.) Straight leg raising sitting was 80 degrees bilaterally, supine was 30 degrees equally, producing back, buttock and posterior thigh pain. (Id.) He diagnosed work related lumbar sprain and contusion in the lumbar area. (Id) He indicated that the diagnosis does have the possibility of disc tearing. (Id.) He agreed that a lumbar MRI should be performed. (Id.) Based on the examination and pending the MRI scan, Dr. Beatty indicated that the Petitioner is capable of working without any bending or lifting more than 10 lbs. (Id.)

On August 18, 2011, Petitioner underwent a lumbar MRI. (Px.3) The radiologist report impression was negative lumbar spine MRI. No focal disc herniation is seen. (Id.)

In a follow up appointment on August 22, 2011, Dr. DePhillips interpreted the MRI as showing mild disc dehydration and degeneration at the L4-5 level. (Id.) He documented continued lower back pain radiating into the buttocks bilaterally. (Id.) He recommended a lumbar epidural steroid injection at the L4-5 level and kept Petitioner off work. (Id.)

Petitioner also followed up with Occupational Health on September 1, 2011 (Px.7) His musculoskeletal exam revealed decreased back flexion with complaints of pain; pain with palpation to the lumbosacral and paraspinals; and pain down the bilateral thighs with straight leg raising at 45 degrees. (Id.) He was diagnosed with back pain and radiculopathy and instructed to continue to follow up with Dr. DePhillips. (Id.)

Dr. Beatty, Respondent's Section 12 physician, completed an addendum report on September 20, 2011 after reviewing the lumbar MRI. (Rx.2) He indicated that the L4-5 disc was slightly darker, but that the disc height was normal and there were no annular tears. (Id.) He indicated that Petitioner sustained a strain/sprain in the lumbar area as a result of the work accident. (Id.) He further indicated that the slightly darker disc at L4-5 is not a legitimate pain

generator by itself, but merely reflects the normal aging process. (Id.) He opined that the Petitioner reached maximum medical improvement and can return to full duty with no restrictions. (Id.)

Petitioner followed up with Dr. DePhillips on October 24, 2011. (Px.3) Dr. DePhillips indicated that the pain location is at the L4-5 level and that there is disc dehydration making it more susceptible to annular tearing. (Id.) Dr. DePhillips felt it necessary to rule out discogenic pain since the Petitioner had neurologic symptoms of right lower extremity numbness that was not consistent with a lumbosacral strain. (Id.) As such, he kept Petitioner off work and referred him to the Pain & Spine Institute for a lumbar discogram. (Id.)

Petitioner was seen by Dr. Patel at the Pain & Spine Institute on November 10, 2011. (Px.4) The chief complaint noted was low back pain radiating into both legs and muscle tightness. (Id.) The pain started after a work accident fall on April 4, 2011 after he slipped on grease. (Id.) The pain is primarily in the lower lumbar spine and radiates to the bilateral buttock and posterior thigh. (Id.) It is characterized as constant, moderate in intensity, severe, aching, dull, and sharp. (Id.) Aggravating factors may be bending over, twisting, prolonged positions, sitting, standing and walking. (Id.) Associated symptoms include numbness in the right buttock and right thigh. (Id.) He notes some relief with medications. (Id.) The musculoskeletal exam was positive for back pain, joint stiffness and limb pain. (Id.) Pain was elicited over the bilateral lumbar paraspinal muscles. (Id.) Sensation and muscle strength was intact. (Id.) There was limited active range of motion. (Id.) Facet loading was positive. (Id.) The assessment was lower back pain and muscle tightness. (Id.) He was prescribed Keflex and recommended to undergo a lumbar discogram post-discogram CT scan. (Id.)

Petitioner followed up with Dr. DePhillips on December 19, 2011 and February 6, 2012. (Px.3) These visits documented persistent low back pain with radiation into both lower

extremities. (Id.) He was kept off work while waiting for workers' compensation to approve the recommended lumbar discography. (Id.)

On February 16, 2012, Dr. DePhillips' evidence deposition was taken. (Px.9) He is a Board Certified Neurosurgeon. (Px.9, p.4) Dr. DePhillips testified that the August 18, 2011 lumbar MRI showed that the L4-5 disc was darker than the other discs, which signified dehydration at that level. (Px.9, pp.22-23) He explained that due to the dehydration, he suspected that there was an annular tear at that level. (Px.9, p.23) He testified that MRIs are not very sensitive to identifying annular tears. (Id.) He stated that the post-discogram CT scan is the gold standard image test for identifying annular tears. (Px.9, pp.28-29) The purpose of the discogram was to determine if there was an annular tear and, if so, is it the source of the pain. (Px.9, p.46) He explained that the positive Patrick's maneuver may be indicative of hip disease or sacroiliac joint dysfunction. (Px.9, pp.11-12) Positive facet loading would indicate a component of facet pain. (Px.9, p.30) He kept Petitioner off work to avoid risk of exacerbation of symptoms and neurologic injury. (Px.9, p.34) Additionally, Petitioner had previously attempted to return to work light duty and failed. (Px.9, pp.13-14) Dr. DePhillips opined that the April 2011 work injury is the cause of Petitioner's condition of ill-being. (Px.9, pp.24-25)

Petitioner continued to follow up with Dr. DePhillips and Dr. Patel. On August 30, 2012, Dr. Patel performed a L3-4, L4-5 discogram and post-discogram CT scan. (Px.4) The results indicated a grade 2 annular tear at L3-4 and a grade 3 annular tear at L4-5. (Id.) The testing was negative for discogenic pain. (Id.) An L5-S1 discogram was performed on December 13, 2012 that was negative for discogenic pain. (Id.)

The Petitioner saw Dr. DePhillips on February 12, 2013. The doctors notes indicate that he was aware of the fact that the discograms were negative for disc pain at the various levels tested. He explained his findings to the Petitioner; "I explained to Mr. Harding that although his

symptoms are neurologic and not consistent with muscle or ligamentous injury, I could not pursue surgery or even a biacuplasty procedure without a positive discogram." He declared the Petitioner to be at a point of maximum medical improvement. (PX 3) He performed several injections in order to diagnose the source of the Petitioner's ongoing pain. He found them all to be negative. His office note of April 5, 2013 states that, based upon the injections, the Petitioner did not have pain from the discs, the facet joints or the ligaments. (PX 4) The Petitioner returned to Dr. Patel on several occasions following that visit, as Dr. DePhillips had apparently moved out of the area. Dr. Patel's office records do not show any active treatment performed during or as a result of those visits. (Id)

Petitioner testified that on November 17, 2013 he began working as a machine operator after looking for other jobs. He did not provide any information concerning that job search. He testified that he has performed his present job on a full time basis. The job involves standing on a concrete floor operating a machine. He says he does some lifting and uses his hands frequently. At the present time, he continues to experience pain and pressure in his low back and numbness in his right leg. His symptoms increase with activity. He takes Ibuprofen and Tylenol at least once a day. He is unable to play with his 5 year old daughter due to back pain.

Linda Bradford testified on behalf of Respondent. She has worked for Respondent for 15 years and was manager of the Casey's store where Petitioner's accident occurred in April 2011. She testified that when Petitioner returned to work with restrictions on June 20, 2011, she provided him with assistance in working the cash register and he was provided a stool for which he would be able to sit. She testified that she worked with him that day, and that he did sit on his stool at times. She said that he was busy during the lunch hour. After working one to one and a half hours, she said he told her he was in pain and needed to stop work. She told him that was fine but that he would need a doctor's excuse to remain off work.

Misty Kitchens also testified on behalf of the Respondent. She has worked for Respondent as a cashier for 5 years. She testified that after the fall Petitioner would come into the store from time to time and that he did not appear to be injured to the extent he claimed. She testified that toward the end of May 2011 she observed the Petitioner and his brother pick a couch up and load it into the back of Petitioner's pickup truck. She took a photograph, which purportedly shows the Petitioner and his brother loading the couch into the pickup truck. (Rx.21)

On rebuttal, Petitioner conceded that the photograph appeared to show his pickup truck, but indicated he only provided minor assistance to his brother in loading the couch so as to prevent his brother from injuring himself.

During the course of care, Petitioner incurred medical expenses totaling $50,027.43 (Dr. DePhillips - $2,110.00; OSF Medical Group - $3,821.00; Pain & Spine Institute - $22,560.50; Millennium Pain Center - $1,955.00; OSF St. Joseph Medical Center - $8,095.93; Bloomington Radiology - $305.00; Heartland Emergency - $1,412.00; St. Mary's Hospital - $2,901.00; St. James Radiology - $276.00; EqMD - $6,591.00). (Px.1) Of this amount, Respondent has paid $11,650.50. (Id.) Discounts were given in the amount of $4,417.57. (Id.) There remains $33,959.50 in unpaid bills (Dr. DePhillips - $1,710.00; Pain & Spine Institute - $22,560.50; OSF St. Joseph Medical Center - $1,686.00; Heartland Emergency - $1,412.00; EqMD - $6,591.00). (Id.)

With respect to Issue (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner has no significant prior history of back problems. Following the fall in question, he sought treatment that day at St. Joseph's Medical Center Emergency Department. His chief complaint was severe lower back pain with some radiation and tingling into the right leg. (Px.2) On April 8, 2011, a lumbar CT scan indicated a small central disc protrusion at L4-5 and diffuse disc bulge at L5-S1 without central canal stenosis or neuroforaminal narrowing. (Id.)

Dr. Sabbun, the emergency room physician, interpreted the CT scan as showing a 3mm disc herniation at L4-5. (Id.)

From the initial treatment received on April 4, 2011 through the last treatment he received with Dr. Patel on September 24, 2013, Petitioner consistently complained of persistent low back pain that radiated into the legs. Such consistent complaints were documented in the records of St. Joseph Medical Center, Occupation Health Clinic, Millennium Pain Center, Dr. DePhillips, Dr. Beatty, and Dr. Patel.

At the hearing, he testified that he continues to experience pain and pressure in his low back as well as numbness in his right leg. His symptoms increase with activity. He takes Ibuprofen and Tylenol at least once a day.

At the request of the Respondent, Petitioner attended a medical evaluation with Dr. Beatty on July 26, 2011. (Rx.1) Dr. Beatty reviewed medical records from St. Joseph's Medical Center, Occupational Health, and Dr. Jhee as well as the CT scan and EMG. (Id.) Petitioner complained of constant lumbar ache into the buttocks, back of the right knee, and sometimes to the foot. (Id.) He has inconstant numbness of the right leg lasting about 10 minutes and a hot tingling feeling in the leg. (Id.) Upon physical examination, forward bending was 30 degrees and bilateral bending was 15 degrees. (Id.) There was lumbar tenderness and questionable spasm. (Id.) Straight leg raising sitting was 80 degrees bilaterally, supine was 30 degrees equally, producing back, buttock and posterior thigh pain. (Id.) He diagnosed work related lumbar sprain and contusion in the lumbar area. (Id) He indicated that the diagnosis does have the possibility of disc tearing. (Id.) He agreed that a lumbar MRI should be performed. (Id.)

Dr. Beatty completed an addendum report on September 20, 2011 following review of the lumbar MRI. (Rx.2) He indicated that the L4-5 disc was slightly darker, but that the disc height was normal and there were no annular tears. (Id.) He indicated that Petitioner sustained a

strain/sprain in the lumbar area as a result of the work accident. (Id.) He further indicated that the slightly darker disc at L4-5 is not a legitimate pain generator by itself, but merely reflects the normal aging process. (Id.)

On February 16, 2012, Dr. DePhillips' evidence deposition was taken. (Px.9) Dr. DePhillips testified that the August 18, 2011 lumbar MRI showed that the L4-5 disc was darker than the other discs, which signified dehydration at that level. (Px.9, pp.22-23) He explained that due to the dehydration, he suspected that there was an annular tear at that level. (Px.9, p.23) He testified that MRIs are not very sensitive to identifying annular tears. (Id.) He stated that the post-discogram CT scan is the gold standard image test for identifying annular tears. (Px.9, pp.28-29) The purpose of the discogram was to determine if there was an annular tear and, if so, is it the source of the pain. (Px.9, p.46) He explained that the positive Patrick's maneuver may be indicative of hip disease or sacroiliac joint dysfunction. (Px.9, pp.11-12) Positive facet loading would indicate a component of facet pain. (Px.9, p.30) He kept Petitioner off work to avoid risk of exacerbation of symptoms and neurologic injury. (Px.9, p.34) Additionally, Petitioner had previously attempted to return to work light duty and failed. (Px.9, pp.13-14) Dr. DePhillips opined that the April 2011 work injury is the cause of Petitioner's condition of ill-being. (Px.9, pp.24-25)

The Petitioner continued to treat with Dr. DePhillips and Dr. Patel on a regular basis through the end of 2013. He continued to complain of the same symptoms for which he'd been treated since his accident.

Based upon the lack of any prior significant back problems and the consistent documented complaints of persistent low back pain with radiating leg pain from the initial treatment through the Petitioner's trial testimony, the Arbitrator finds Petitioner's current condition of ill-being to be causally related to the April 4, 2011 work accident.

With respect to issue (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

During the course of care, Petitioner incurred medical expenses totaling $50,027.43 (Dr. DePhillips - $2,110.00; OSF Medical Group - $3,821.00; Pain & Spine Institute - $22,560.50; Millennium Pain Center - $1,955.00; OSF St. Joseph Medical Center - $8,095.93; Bloomington Radiology - $305.00; Heartland Emergency - $1,412.00; St. Mary's Hospital - $2,901.00; St. James Radiology - $276.00; EqMD - $6,591.00). (Px.1) Of this amount, Respondent has paid $11,650.50. (Id.) Discounts were given in the amount of $4,417.57. (Id.) There remains $33,959.50 in unpaid bills (Dr. DePhillips - $1,710.00; Pain & Spine Institute - $22,560.50; OSF St. Joseph Medical Center - $1,686.00; Heartland Emergency - $1,412.00; EqMD - $6,591.00). (Id.)

Having found the requisite causal relationship, the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary. As such, Respondent is responsible for all the bills related to the treatment received by Petitioner totaling $50,027.43 subject to the fee schedule.

With respect to issue (K.) What temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner was initially taken off work on April 4, 2011 by St. Joseph's Medical Center Emergency Department. (Px.2) He was kept off work by the Occupational Health Clinic until being released to attempt to return to work with restrictions on June 20, 2011. (Px.7) Upon attempting to return to work with restrictions, Petitioner was again taken completely off work by Dr. Jhee on June 27, 2011. (Px.2) Petitioner saw Dr. DePhillips for a neurosurgical consultation on July 18, 2011. (Px.3) Dr. DePhillips kept Petitioner completely off work. (Id.)

Dr. Beatty, Respondent's Section 12 physician, provided an addendum report on September 20, 2011 in which he opined that Petitioner reached maximum medical improvement and can return to full duty with no restrictions. (Rx.2)

On February 16, 2012, Dr. DePhillips testified via evidence deposition that he kept Petitioner off work to avoid risk of exacerbation of symptoms and neurologic injury. (Px.9, p.34) Additionally, Petitioner had previously attempted to return to work light duty and failed. (Px.9, pp.13-14)

Once Dr. DePhillips was able to review the discograms which he had been requesting for quite some time, and determine that the Petitioner's pain complaints were not discogenic, he declared him to be at MMI. All of the doctor's visits after that date, February 12, 2013, were aimed at diagnostics and not treatment.

Petitioner testified that on November 17, 2013 he began working as a machine operator as that was the only position he could obtain given his lack of education and prior work experience being limited to manual labor.

Having found the requisite causal relationship, the Arbitrator finds that the Petitioner was temporarily totally disabled from April 5, 2011 to June 19, 2011 and from June 27, 2011 to February 13, 2013, a period of 96 weeks.

With respect to issue (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

On April 8, 2011, a lumbar CT scan indicated a small central disc protrusion at L4-5 and diffuse disc bulge at L5-S1 without central canal stenosis or neuroforaminal narrowing. (Px.2) Dr. Sabbun, the emergency room physician, interpreted the CT scan as showing a 3mm disc herniation at L4-5. (Id.)

On August 30, 2012, Dr. Patel performed a L3-4, L4-5 discogram and post-discogram CT scan. (Px.4) The results indicated a grade 2 annular tear at L3-4 and a grade 3 annular tear at L4-

5. (Id.) The testing was negative for discogenic pain. (Id.) An L5-S1 discogram was performed on December 13, 2012 that was negative for discogenic pain. (Id.)

Subsequent testing by Dr. Patel ruled out the discs, the facet joints and the ligaments as a source of the Petitioner's pain complaints. He considered the pain source to be myofascial. Dr. DePhillips opined in his note of May 7, 2013 that the Petitioner's pain was multifactorial, but also chronic and permanent.

Petitioner testified that on November 17, 2013 he began working as a machine operator' and that he is able to perform that job. At the present time, he continues to experience pain and pressure in his low back and numbness in his right leg. His symptoms increase with activity. He takes Ibuprofen and Tylenol at least once a day. He is unable to play with his 5 year old daughter due to back pain.

Following consideration of the testimony and evidence presented, the Arbitrator finds the Petitioner experienced a loss of 7.5% loss of the person as a whole pursuant to Section 8(d)2.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antoinette Scarborough,
Petitioner,

vs.
Madden Mental Health Center,
Respondent,

NO: 08 WC 09440

15IWCC0725

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 January 9, 2015 is hereby affirmed and adopted.

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

No bond or summons for State of Illinois.

DATED: SEP 22 2015

MB/mam
o:7/30/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCARBOROUGH, ANTOINETTE
Employee/Petitioner

Case# **08WC009440**

15IWCC0725

MADDEN MENTAL HEALTH CENTER
Employer/Respondent

On 1/9/2015, 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:

1293 VITELL & SPITZ LTD
EDWARD SPITZ
155 N MICHIGAN AVE SUITE 600
CHICAGO, IL 60601

5031 ASSISTANT ATTORNEY GENERAL
JILL OTTE
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JAN 9 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

15IWCC0725

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Antoinette Scarborough
Employee/Petitioner

v.

Madden Mental Health Center
Employer/Respondent

Case # **08** WC **9440**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **October 2, 2014 & December 4, 2014 and January 2, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0725

FINDINGS

On **December 12, 2007**, 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 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 **$106,376.53**; the average weekly wage was **$2,045.70**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **2** dependent children.

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

Respondent ***has not*** paid all charges for all medical services received by Petitioner.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$5,318.64** for medical benefits, and her **full salary for extended benefits received from December 2007 through August 14, 2008, plus another week on December 30, 2008.**

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

ORDER

Based on the evidence presented at trial, including the witnesses' testimony, as well as both parties' exhibits, the undersigned Arbitrator hereby denies Petitioner's Application for Benefits and makes no award in her favor.

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

01-08-15
Date

JAN 9 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ANTOINETTE SCARBOROUGH,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	08 WC 9440
	)	Chicago – Arbitrator Carlson
MADDEN MENTAL HEALTH CENTER,	)	
	)	
Employer/Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Findings of Fact

This action was pursued by the Petitioner under the Workers' Compensation Act seeking relief from her employer the Madden Mental Health Center (hereinafter "Madden"). On October 2, 2014, a hearing was held by Arbitrator Kurt Carlson at the Illinois Workers' Compensation Commission in Chicago, Illinois. On December 4, 2014, proofs were closed with the presentation of exhibits by both parties. Petitioner was represented by counsel. The Illinois Attorney General appeared on behalf of Madden. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on all of the disputed issues. These findings are included in this document.

Petitioner's Testimony

According to Petitioner's testimony, she began working for Madden in August 2000 as a registered nurse. Her duties included giving medications and injections to clients.

On December 12, 2007 she was giving medication to a patient, when she dropped the pills. As she leaned down to retrieve them, the patient punched her on the top of the head. She

fell to the floor. She told the charge nurse, Gracie Ittera, who Petitioner claimed was her immediate supervisor, what happened. Petitioner was sent to Health Services. Petitioner noticed that she felt dizzy, dazed, a "little confused," nauseated and she had blurred vision. She did sign forms that were "shoved" in front of her.

Petitioner testified that prior to the day of her accident, she had "mediocre" headaches that were occasional. She claimed to not have dizziness prior to the day of her accident. However, on cross examination, it was pointed out to Petitioner that she had presented several times prior to the date of accident to MacNeal Health Center complaining of dizziness as well as headaches. The headaches after the day of her accident were constant and were accompanied by dizziness and blurred vision.

Petitioner testified that as of the day of the hearing, her headaches had resolved. She still has neck and right shoulder pain, though she admits she never sought treatment for her shoulder. She also has weakness and cannot pick up heavy things or she "gets more neck tension." She also cannot sleep on her stomach or do yard work anymore. Finally, Petitioner was unaware she had Chiari 1 prior to treatment after the date of her accident.

Finally, Petitioner was discharged for cause from her employment at Madden for Conduct Unbecoming a State Employee and Falsification of Records. RX 3 and 4. Prior to her termination, Petitioner signed an Extended Benefits Request which stated that she was to receive her regular salary and benefits and that she is "not employed by any other employer in which I receive monetary or non-monetary payment for my services." RX 1. Further, the signatory of the form also states "I also understand that if I have requested extended benefits and I am currently employed...that the extended benefits will be terminated and disciplinary action up to and including discharge will occur." Id. Also prior to her termination, Petitioner signed a

Report of Secondary Employment attesting that she was "not currently employed anywhere except with the Department of Human Services, and will, as a DHS employee, report accepting any secondary employment, within five (5) working days of commending such employment." RX 2. Both forms were signed the day of Petitioner's accident.

Aishamma Lawrence's Testimony

Respondent called one witness to testify at the hearing. Aishamma Lawrence has been employed at Madden for 20 years. In her career, she was promoted from Registered Nurse I, to Registered Nurse II, Clinical Nurse Manager, Associate Director of Nursing and Acting Director of Nursing.

Ms. Lawrence was Petitioner's supervisor in December 2007. She did not witness Petitioner's injury, nor is she aware of any witnesses to Petitioner's injury. Ms. Lawrence testified that Petitioner's duties as a Registered Nurse I included administering medications to patients, admitting and discharging patients, developing care plans, attending treatment team meetings, supervising mental health technicians and licensed practical nurses, and attending therapeutic groups for patients.

Ms. Lawrence testified that Petitioner's job duties did not include general lifting requirements. She explained that Madden is a psychiatric facility and that all of the patients are ambulatory. Petitioner would never be required to lift a patient or physically exert herself.

Medical Treatment

Petitioner's pre-accident records from MacNeal Health Center reveal Petitioner had a history of complaining of headaches and dizziness. RX 7. On May 21, 2007, Petitioner presented after a motor vehicle accident with a "severe" headache and an MRI of Petitioner's neck revealed "linear needle like opacity projecting over the right upper neck." RX 7. On

February 23, 2007, Petitioner presented with voice loss, dizziness, nasal congestion, left ear pain and cough. Id. On February 14, 2007, Petitioner complained of vomiting and nausea; at that visit her Effexor for depression was decreased. Id. On December 4, 2006, Petitioner is diagnosed with dizziness and headache, secondary to infection; her issues with depression are noted. Id. On October 10, 2005, Petitioner presented complaining of headaches, dizziness and pain in her neck for three weeks. Id. On September 18, 2003, Petitioner presented complaining of headaches for one week. Id. On January 29, 2003, Petitioner presented with a headache, and pain in both ears, on the back of her neck and down her spine. Id.

On the day of Petitioner's accident, she went to MacNeal Hospital's emergency room for initial evaluation of a head injury. She complained of severe headache, pain in the right side of head, dizziness, nausea, difficulty with ambulation and blurred vision. There was no open wound or lesion. A CT scan of the head was normal. She was diagnosed with a closed head trauma and told to remain off of work until a follow-up appointment.

The following day, December 13, 2007, Petitioner was seen for a follow-up of her head and neck trauma. Dr. Davidson diagnosed Petitioner with a cervical thoracic strain and kept her off of work.

On January 8, 2008, Dr. Bernard of Neurologic Care Associates evaluated Petitioner and diagnosed her with post-traumatic cervical strain, tension headaches, migraine headaches, and posttraumatic benign positional vertigo most likely. Dr. Bernard ordered an MRI.

The MRI of January 25, 2008 found a Chiari malformation with proximal cervical cord syrinx, specifically downward projecting cerebral tonsils consistent with Chiari I malformation. Associated with this finding is a syrinx within the upper cervical cord.

On September 23, 2008, Petitioner saw Dr. Cerullo at Chicago Institute of Neurosurgery

and Neuroresearch who referred her to Dr. Rosseau. In the medical records with this date, Dr. Cerullo noted that, as an adolescent, Petitioner had a headache that was particularly worsened with Valsalva, but that this is no longer the case.

On December 16, 2008, Dr. Rosseau performed a suboccipital craniectomy, C1 laminectomy and partial C2 laminectomy, and bovine pericardial duraplasty for decompression and Chiari malformation.

An MRI on December 17, 2008 showed post Chiari decompression, improvement of pneumocephalus, no intracranial hemorrhage and no findings suggestive of infraction.

Independent Medical Examination by Dr. Karen Levin

At the request of Respondent, Dr. Karen Levin conducted an independent medical examination of Petitioner. Dr. Levin is a board certified neurologist. RX 5 at 5.

Dr. Levin testified that prior to the physical examination of Petitioner, she did not review any of Petitioner's medical records because she did not want to be influenced by them; she wanted to draw her own conclusions independently. Id. at 11.

Dr. Levin reached the following opinions within a reasonable degree of medical certainty: that Petitioner's injury of December 12, 2007 was not related to her Chiari malformation; that it was not related to her current symptomology; that from the type of injury she had on December 12, 2007, at best, Petitioner would have had a very brief period of symptoms; that she should have been better with no residual symptoms; that she did not require any additional neurologic treatment; the she was at maximum medical improvement from a neurologic standpoint; and that she can work full duty with no restrictions. RX 5 at 16.

Dr. Levin elaborated on her opinions by stating that Chiari 1 is a congenital malformation and that it is something a person is born with. RX 5 at 17. It is possible that certain types of

trauma can aggravate Chiari formations, but in Petitioner's case, it was not a possibility because Petitioner had the same symptomatology prior to the injury as after the injury. Id. at 17 and 18. Also, Petitioner's injury was very mild and not the type that can cause an exacerbation of symptoms. Id. at 18. Dr. Levin based this opinion her exam, and then later review of Petitioner's medical records that pre-date the injury of December 2007, including those of Dr. Wiener, Dr. Villegis, Dr. Davison, Dr. Ahmad and Dr. Duong. Id. at 18 and 19. Further, Petitioner denied to Dr. Levin similar symptomology or headaches prior to the accident, yet Petitioner's medical records indicate a history of headaches dating back to 2003. Id. at 19, 23, 60 and 98. Dr. Levin also opined that Petitioner's symptoms are out of proportion to those of a person who has had surgery for her Chiari and her syrinx. Id. at 28. Additionally, Dr. Levin opined, "I strongly suspect that there's a significant psychological component and significant embellishment of her symptomatology." Id. at 32. Finally, Dr. Levin opined that Petitioner could return to any type of work, including nursing at a mental health facility, which does not require lifting of patients. Id. at 102 and 106.

During cross-examination of Dr. Levin, opposing counsel took issue with the fact that Dr. Levin's office did not comply with his subpoena. Dr. Levin explained that her office's policy regarding subpoenas is to produce copies of her records, but not secondary records. RX 5 at 40. Her office does not forward records that have come to them from other sources, including treating doctors, because they are not her records. Id. at 40 and 41.

Finally, at the presentation of exhibits on December 4, 2014, Petitioner's counsel withdrew his objection as stated within Dr. Levin's deposition transcript. For that reason, Respondent did not address the objection and neither will this Arbitrator.

Independent Medical Examination by Dr. Hurley

Dr. Hurley, Petitioner's Section 12 examiner, (not a treater) opined that the traumatic injury aggravated the underlying condition. He acknowledged that, in the absence of the injury, she may still have developed her chronic headaches and eventually would have been diagnosed with Chiari I malformation. He found that her neck pain is not of any consequence and not the cause of her headaches. He did not see the need for any further treatment. He opined she could return to work light duty and should avoid excessing lifting or exertion which would likely exacerbate her headaches.

II. Conclusions of Law

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

This Arbitrator finds that Petitioner established by a preponderance of the evidence that an accident occurred that arose out of and in the course of Petitioner's employment with Madden. Petitioner's testimony that she was struck in the head by a resident is undisputed by Respondent.

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

This Arbitrator finds that Petitioner failed to establish by a preponderance of the evidence that her current condition of ill being is causally related to her injury. The medical records, as well as Petitioner's testimony, establish that she suffered from the same symptoms prior to the work accident.

Petitioner's medical records dated prior to her accident establish that Petitioner has a history of headaches and dizziness dating back to at least 2003. RX 7. In the records from MacNeal Health Center, it is apparent that, before the work accident, Petitioner treated seven

different times for headaches, sometimes accompanied with dizziness. Id.

Petitioner's medical history as corroborated by her medical records directly contradicts the story she presented at hearing. At hearing, she testified that she had "mediocre" headaches that were occasional and she never had dizziness. Yet in review of the old records, it would seem that Petitioner is minimizing her pre-existing condition of headaches and dizziness. When this minimization is considered along with Petitioner's denials of similar symptomology to Respondent's IME Dr. Karen Levin, Petitioner further damages her credibility. Dr. Levin also opined that Petitioner was embellishing her symptoms.

Additionally, Petitioner's credibility is also put into question based on her termination from State employment. Petitioner was discharged for cause after she was charged with Conduct Unbecoming a State Employee and Falsification of Records. RX 4. The charges against Petitioner were based on workers' compensation fraud. RX 3. She received extended benefits (her full salary) while off of work for her work accident while also working for another agency and she signed paperwork indicating that she had no secondary employment. Id., RX 1, RX 2 and RX 6. These charges directly affect Petitioner's credibility in that they revolve around her inability to be truthful and indicate the Petitioner was able to work as an Registered Nurse.

Dr. Karen Levin's IME of Petitioner further supports that Petitioner did not successfully prove that her current condition of ill-being is causally related to her incident. Dr. Levin found that Petitioner's December 12, 2007 incident was not related to her Chiari I malformation, that it was not related to current symptomology, that her symptoms from the accident on December 12, 2007 would have been very brief, that she would have no residual symptoms, that she did not require any additional neurologic treatment, that she was at MMI from a neurologic standpoint and that she could return to work with no restrictions. RX 5 at 16.

Petitioner's IME Dr. Thomas Hurley's opinions are not persuasive. In his deposition, he indicates that his opinion is largely based upon the faulty assumption that the Petitioner had no pre-existing symptoms of headaches and dizziness. PX 14 at 33. However, the Petitioner had those symptoms prior to her work accident, and as a result, Dr. Hurley's opinions are not compelling as they could have been. The Arbitrator also finds that Dr. Hurley's opinion that the symptoms occurred because of "subtle change in how much decent there was of the cerebellar tonsils and now all of a sudden there seems to be a little more pressure in the spinal cord,..." to be purely speculative. (PX #14 T. p. 41) Finally, in response to the posit that Petitioner's headaches and dizziness were intermittent before the accident, then constant afterwards, the Arbitrator notes medical records dated December 31, 2007 state that the Petitioner had no dizziness nor change of vision 11 days after the occurrence. (RX #7) This evidence suggests that the Petitioner's condition did not alter after the occurrence.

The Arbitrator notes that no treating physician offered an opinion in this matter.

Based on all of the exhibits and testimony, one cannot state that the difficulties Petitioner experiences now can be attributed to the conditions she suffered prior to her accident. Both Respondent's and Petitioner's IME doctors testified that Chiari I malformation were congenital and can cause headaches. PX 14 at 9 and RX 5 at 17 and 20. Therefore, it is clear Petitioner had the Chiari I malformation prior to her work accident; she was, however, unaware that she had the condition and that it was likely the cause of her headaches.

Additionally, there was some evidence in the record indicating that the Petitioner collected a disability benefit (not TTD) while off work for this occurrence, yet still working at another job. The factual details of this were not well developed at trial, but the Petitioner was terminated from her employment with The State of Illinois, despite being represented by the

Union at her termination hearing. Such facts again damage the Petitioner's credibility and further suggest that she was able to work as her condition had not altered in any way.

If Petitioner suffered the same or similar symptoms before the accident and was not truthful to her doctors about her condition and also failed to be candid about her working for another employer during her disability, this Arbitrator is unwilling to believe that her unquantifiable symptoms had increased as a result of the work occurrence. Petitioner has not proved that the work accident caused her current condition of ill-being. Therefore, this Arbitrator makes no award in favor of the Petitioner.

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

The Arbitrator finds that the medical services provided to Petitioner immediately after her work-related accident were reasonable and necessary, including the emergency room treatment and the follow up office visit the next day. The Arbitrator finds that the medical evidence and the IME Report of Dr. Levin indicating that Petitioner's current condition is not causally related to a work-related injury are persuasive. Therefore, this Arbitrator finds that none of the medical treatment following December 13, 2007 was related to the work accident. The undersigned Arbitrator denies all of the medical treatment received after December 13, 2007, including the subsequent surgery. Respondent is not required to pay for any medical treatment after this date.

K. Is an award of TTD appropriate?

The Arbitrator finds that the Petitioner's current condition is not causally related to a work-related injury and, consequently, the Petitioner is not entitled to any further TTD benefits.

L. What is the nature and extent of Petitioner's injury?

The Arbitrator finds that the Petitioner's current condition is not causally related to a

work accident and, consequently, the Petitioner is not entitled to a permanency award.

III. CONCLUSION

It is clear from Petitioner's medical records that she suffered from headaches and dizziness prior to her work accident and she continued to suffer these same symptoms after the accident. Petitioner failed to establish by a preponderance of the evidence that her current condition of ill being is causally related to her accident. For these reasons this Arbitrator makes no award in Petitioner's favor.

01-08-15

ARBITRATOR KURT CARLSON DATE

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Dixon,

Petitioner,

vs.

NO: 13 WC 24886

15IWCC0710

ADM,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Dollison finding that as a result of accidental injuries arising out of and in the course of his employment on May 21, 2013, Petitioner was temporarily totally disabled from June 6, 2013 through August 22, 2013, a period of 11-1/7 weeks, that he was entitled to reasonable and necessary medical expenses of $23,763.80 and that Petitioner is permanently partially disabled to the extent of 100% loss of use of his right great toe, a period of 38 weeks. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of his employment on May 21, 2013, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability, the amount of medical expenses and the nature and extent of permanent disability. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on May 21, 2013 and denies Petitioner's claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 42 year old laborer, testified he became employed with Respondent on May 13, 2013. Prior to that, he was required to undergo two pre-employment physical examinations. One was an endurance physical examination where he had to climb ladders, get on a treadmill, etc. The other physical examination was where his body was examined and his hearing checked (Tr 10-11). At that time Petitioner disclosed that he was diabetic (Tr 11). He has been diabetic since 1993 at age 23 (Tr 11). He took pills at that time for his diabetes and he now takes insulin injections and has been doing so for the last 3 years. He administers the injections himself (Tr 11-12).

Respondent had a dress code consisting of hard hats, safety glasses, gloves, long-sleeved shirts, long pants and steel-toed boots (Tr 13). Petitioner's duties were to truckload out, to climb up to a little tower to fill diesel trucks with feed, to clean the feed house and do a lot of sweeping. If the coolers spilled over, he had to put the spillage into totes and roll them and dump them out. He had to go upstairs and check all pumps and fill them if needed, then go downstairs. He had to drive a Bobcat. If the feed got out of range to where he could not use the totes, he used the Bobcat. He had to check the Bobcats' hydraulic fluids, oil, tires and lights. He did whatever he was asked to do because he was a general laborer (Tr 14). Petitioner had to wear steel-toed boots the entire time he worked (Tr 15). He walked on cement floors (Tr 15). Petitioner performed these job duties on a regular basis while he was working for Respondent (Tr 15).

While he was performing these jobs at Respondent, Petitioner noticed on May 21, 2013 that both his great toes had gotten blisters (Tr 16). If Petitioner had blisters on his toes, the protocol was he could try to take care of them himself, but if they progressed, he needed to call the doctor right away (Tr 16). Petitioner tried to take care of the blisters on both his great toes on his own. He used peroxide and then triple antibiotic on them and put band-aids on them (Tr 17). After May 21, 2013, the blisters got worse (Tr 17). Petitioner never had serious blisters on his toes prior to wearing the steel-toed boots (Tr 17). He never had any problems like serious blisters prior to wearing the steel-toed boots (Tr 17-18). He had never worn steel-toed shoes prior to May 13, 2013 (Tr 18). Every day at work Petitioner had to wear steel-toed boots (Tr 18). The steel-toed boots aggravated his feet and blisters (Tr 18).

The first time Petitioner sought treatment for the blisters was on May 30, 2013 (Tr 18). The doctor looked at his blisters and asked Petitioner if he did anything different and Petitioner told him he started a new job and that he had to wear steel-toed boots (Tr 19). After that visit, it was Petitioner's understanding that if his blisters worsened he was to go to the emergency room (Tr 21-22). He had gone to Heartland on May 30, 2013 (Tr 22). His medical condition worsened (Tr 22). Petitioner worked from May 30, 2013 to June 5, 2013, his next medical visit (Tr 22). During that time, Petitioner continued to wear his steel-toed boots (Tr 22). His condition worsened (Tr 22). Petitioner then went to the emergency room at Methodist Hospital on June 5, 2013 in the evening and he was admitted as an inpatient (Tr 23). At Methodist Hospital, Petitioner was given IV and a lot of antibiotics and was visited by a podiatrist named Dr. Brattain (Tr 23). Petitioner was hospitalized until he was discharged on June 8, 2013

(Tr 24). When he was in the emergency room, the blister on his left great toe had started healing, but the blister on the right great toe had gotten infected and he could see the bone (Tr 24). Dr. Brattain has a wound clinic and he also worked at the hospital. Dr. Brattain would not let Petitioner return to work. When he was discharged from the hospital, Petitioner started treating with Dr. Brattain every week (Tr 25). Eventually, Petitioner had to have his right great toe removed. On July 13, 2013, Dr. Brattain removed Petitioner's right great toe. On August 19, 2013, Dr. Brattain released Petitioner from his care (Tr 25).

In order to return to work, Petitioner had to go through Respondent's company doctor at IWIRC. On August 22, 2013, Petitioner was released to return to work without restrictions by the doctor at IWIRC (Tr 26). Petitioner had no problems with his feet on August 22, 2013, other than missing his right big toe (Tr 26). Petitioner bought a new pair of steel-toed boots, a better and more expensive pair (Tr 27-28). Petitioner went back to work on August 26, 2013 wearing the new pair of steel-toed boots (Tr 28). After he went back to work, Petitioner started having problems with the right toe next to his great toe that had been amputated (Tr 28-29). He followed-up with Dr. Brattain for that blister (Tr 29). Respondent then terminated his employment (Tr 29). Petitioner is no longer wearing the steel-toed boots he bought (Tr 30). He now wears only tennis shoes (Tr 30). Since he stopped wearing the steel-toed boots, Petitioner has not developed any blisters or sores (Tr 30). Since he stopped wearing the steel-toed boots, the blisters he had on his feet healed (Tr 30-31). Petitioner never had any problems with his feet, including sores or infections, prior to starting his employment with Respondent (Tr 31). He has not had any problems since his employment at Respondent ended (Tr 31).

On cross-examination, Petitioner testified that during his employment at Respondent, he did not have any sort of a great or heavy object fall on his foot (Tr 32). It is Petitioner's contention that the sole basis for the injury that he sustained was because he was wearing steel-toed boots (Tr 32).

2. According to the records from Heartland Clinics, Px3, Rx3, Petitioner was seen on April 29, 2013 by Edward Etherton APN. Petitioner presented with: 1) history of diabetes since 1993; 2) neuropathy onset 1 day ago and acute, mild severity, location of numbness was the left foot and the context included diabetes. On May 30, 2013, Petitioner saw Mr. Etherton for acute maxillary sinusitis, foot abscess, lipoma and diabetes. On examination, Mr. Etherton found an open wound measuring 3cm with white skin surrounding the wound on outside of right big toe. The wound was vascular and had a healing appearance. There was also a close white-colored vesical on outside of the left big toe measuring 2cm in diameter. There was no erythema. Mr. Etherton also found a 3cm lipoma at the left upper groin, which was oval shaped and subdermal. Mr. Etherton referred Petitioner to a podiatrist for his foot abscess and he was to keep his feet clean and dry.

3. The records from UnityPoint Health-Methodist Medical Center, Px2, Rx5, indicate Petitioner was seen in the emergency room on June 5, 2013 for a chief complaint of cellulitis to his right big toe. The following history was noted: "Pt states began wearing steel toe boots on

May 13 and ever since then had blisters starting. Pt does have blister starting to left big toe that is popped. There is inflammation and redness noted to right big toe with delayed capillary refill. Pt also states his right big toe has been numb for approx. 1 year. Onset of symptoms was about approx. 14 days ago." The Nursing Assessment noted Petitioner complained of constant pain affecting his right shin, superficial and radiating to the middle of the leg. On examination, the emergency room physician found local skin erythema and inflammation suggestive of cellulitis, increased warmth was noted and local soft tissue swelling was present. The area was described as red and inflamed and the affected area was painful and was slowly spreading. The inflamed area was at the site of the wound. It was noted that Petitioner had been taking amoxicillin for a few days for a sinus infection. Petitioner was seen for diabetic peripheral neuropathy on April 28, 2013 and he had diabetes mellitus type 1. There was a tender indurated area that was inflamed involving the right first toe. The area surrounding the right first toe was red and inflamed and was consistent with a cellulitis. There were red streaks extending proximally from the right first toe. There was a decubitus ulcer approximately 4cm in diameter over the right first toe. Petitioner was diagnosed with 1) cellulitis of the right foot; 2) decubitus ulcer; 3) diabetes mellitus type 1; 4) septic shock. Petitioner was admitted for IV antibiotics.

The June 5, 2013 X-ray Report indicated x-rays of right foot were taken. The radiologist found a soft tissue ulcer in the medial distal first digit with additional first digit soft tissue swelling. No bone destruction was seen suspicious for osteomyelitis. There was advanced arthritis of the first metatarsophalangeal joint and additional arthritis of the first metatarsal head sesamoid articulation as well as mild arthritis of the second and third digit DIP joints. There was also midfoot-forefoot, midfoot and mild midfoot-hindfoot arthritis. There was atherosclerotic disease. The radiologist's impression was: 1) soft tissue ulcer first digit with soft tissue swelling presumably from cellulitis; 2) degenerative changes as described. There were no findings of osteomyelitis.

Petitioner saw Dr. Jaffer June 6, 2013 and presented with a right great toe ulcerated wound and right leg pain radiating to the mid leg. Dr. Jaffer noted that Petitioner went to OSF Clinic the previous Friday for sinusitis and a right toe wound. Dr. Jaffer noted Petitioner was given amoxicillin and had taken same for the past 5 days. Dr. Jaffer noted Petitioner is an insulin-dependent diabetic. Dr. Jaffer noted the following history: "The patient started a new job where he has to wear steel toed boots. His boots are small and he is on his feet for 12 hours for his shift. He noticed about a week ago that he started getting a blister at the base of the right great toe. The wound has not improved after outpatient antibiotic treatment and he says it appears to be getting worse although he has no feeling in that toe. The patient also noted a closed blister on the left great toe. The patient admits to both great toes being numb. The patient says that the pain in his right leg is approximately halfway up where he ties his boots tightly and stops above his boots. The pain is described as just a soreness that also started one week ago when he started wearing steel toed boots." Dr. Jaffer noted Petitioner's past medical history of insulin-dependent diabetes mellitus, hypertension and hyperlipidemia. Dr. Jaffer noted that in the emergency room Petitioner was given Zosyn, Motrin, Fentanyl and IV saline. On examination, Dr. Jaffer found a grade-1 diabetic ulcer on the right great toe base with minimal

weeping, a grade-0 diabetic ulcer on the right great toe, closed blister noted; the right leg was warm to the touch compared to the left leg, and no edema bilaterally. Dr. Jaffer's assessment was: 1) right great toe ulcer, diabetic grade-1 ulcer. For this Petitioner was to be given Vancomycin and Zosyn. Petitioner met sepsis criteria with a 15.6 white blood cell count, pulse of 119 and temperature of 100.7. A wound care consultation was recommended; 2) insulin-dependent diabetes mellitus. Petitioner was to continue medications and IV fluids at home. Dr. Jaffer noted x-rays showed soft tissue changes and there was an area of gas formation in association with an overlying infection, suggesting a gas-formation organism.

On June 7, 2013, Dr. Jaffer noted Discharge Diagnoses of: 1) right great toe ulcer, improving; 2) diabetes, stable; 3) hypertension, stable; 4) hyperlipidemia, stable. Dr. Jaffer noted that consultation Dr. Perez from Wound Care performed a debridement. The following history was noted: "The patient stated that he had started a new job where he has to wear steel toed boots. His boots are small, and he feels as if his toes are hurting all the time. He did see blisters, and they eventually turned into an open wound. There was a blister noted on the right toe as well as on the left toe." Dr. Jaffer noted Petitioner's treatment. Dr. Jaffer noted that by the next day (June 6, 2013), Petitioner's toe ulcers were looking better. Wound care Dr. Perez saw Petitioner and one of the toe ulcers was debrided. Petitioner was instructed to follow-up with Wound Clinic as an outpatient. Petitioner was to follow-up with his primary care physician within 3 days of discharge for his chronic medical conditions. Medications were prescribed and Petitioner was discharged from the hospital.

4. According to IWIRC records, Px6, Petitioner saw Jeff Buckinham PA-C on June 11, 2013 for a fitness for duty evaluation for his foot infection following discharge from the hospital. This evaluation was requested by Respondent. Mr. Buckinham noted the following history: "He states he got new steel toed boots a month ago that he has been wearing to work and noted blisters had developed along the great toes bilaterally. He notes that on 6/5/13 he had worked a shift and noted his right sock was full of blood when he removed his boots." Mr. Buckinham noted the emergency room treatment. Petitioner reported he continued to have pain and swelling to the right foot and was unable to stand for long. Petitioner rated his pain at 5/10 and was throbbing in nature. Mr. Buckinham reviewed the emergency room and admission records. On examination of the right foot, Mr. Buckinham found a 3-4cm full thickness ulcer to the plantar surface of the great toe with purulent drainage on the dressing. The left foot had a small dry, dusky area of the skin on the lateral, plantar aspect of the great toe and no ulceration or drainage was noted. Mr. Buckinham's assessment was: 1) full-thickness ulcer to right great toe; 2) diabetes, poorly controlled. Mr. Buckinham opined Petitioner was unfit for work at that time. He opined that Petitioner should not be bearing weight on the foot until it healed. Petitioner was to have his foot rechecked after his foot had healed and he was released to return to work regular duty by his wound specialist.

5. Petitioner saw Edward Etherton APN at Heartland Clinic on June 12, 2013. Mr. Etherton noted that the foot wound was healing and there were no signs of cellulitis. He noted Petitioner would be seeing a podiatrist for follow-up that coming Friday, June 14, 2013. Mr. Etherton noted that Petitioner's sinusitis had resolved. Mr. Etherton noted that Petitioner's anemia was most likely due to blood loss from his toe wound. Mr. Etherton opined that the injury was aggravated by standing and walking.

6. In his May 16, 2014 deposition, Px7, Dr. Brattain testified he is a podiatrist who is board certified in lower extremity surgery and wound care (Dp 3). He is in general podiatric practice and operates both wound clinics at Proctor and Methodist (Dp 4). The wound care is related to diabetes and peripheral vascular disease (Dp 4). He is familiar with Petitioner as a patient (Dp 4). Dr. Brattain first saw Petitioner in the hospital on June 6, 2013 (Dp 5). At that time, Petitioner had wounds on both feet. Dr. Brattain testified, "He told me that he had been a short time, I forget the length of time, at a new job and was wearing steel-toed shoes for the first time and noticed that one day after work he had had blisters with some bleeding in both shoes. It concerned him because they didn't heal. He showed up in the emergency room because of I think some redness and drainage and that's how he was admitted." (Dp 7). On examination, Dr. Brattain found Petitioner had two large blisters, great toe bilaterally, apparently a Grade 2 wound, which was minimal, but showed good blood flow, and no signs of active cellulitis. At that point, Dr. Brattain did conservative wound care and they should have healed (Dp 7). Wound care was done on both great toes (Dp 8). Dr. Brattain thought he did a minor bedside debridement just to determine viability of tissue (Dp 8). Dr. Brattain diagnosed diabetic wound ulceration great toes (Dp 8). At that point Petitioner could not work (Dp 9).

Dr. Brattain next saw Petitioner on June 14, 2013 at his office, Illinois Valley Podiatry (Dp 9). At that time, the ulcers were getting smaller. Petitioner reported that they were caused by wearing incorrect shoes (Dp 10). Dr. Brattain stated he probably debrided lightly and did more off-loading, a Plasticor accommodation, the material used to accommodate pressure points (Dp 11). Dr. Brattain prescribed medication and Petitioner was to remain off work and follow-up the next week (Dp 12). On June 21, 2013, the right toe condition had worsened and had gone to a subcutaneous extent and was not going to heal with conservative treatment. Dr. Brattain discussed with Petitioner the possibility of performing some type of surgery (Dp 13). The wound had deepened, became more fibrous, but not necrotic, and it looked like there was some active infection at least peripherally in the wound (Dp 13). Dr. Brattain explained that it is very typical in diabetics that if tissue damage is such that it is beyond the ability of their body to repair it, tissue begins to die, it loses blood flow and once it becomes avascular, a lack of blood flow, it cannot regenerate and the tissue progressively dies and it can progress on to bone infection and gangrene (Dp 14). Osteomyelitis is a bone infection and if osteomyelitis is contracted, at that point the bone needs to be debrided (Dp 14-15). The infected bone needed to be removed. In a situation like Petitioner's, amputation was the easiest, most efficient way to remove the infected bone (Dp 15). Petitioner had been in a post-operative shoe since being discharged from the hospital to take the pressure off (Dp 15). On June 27, 2013, Dr. Brattain found that there was some tunneling at that time, a deeper penetration of the wound, which was

not healing (Dp 16). Sixty percent of the wound at that point showed some granular tissue, which was not a lot. There was some swelling and a high concern for underlying infection (Dp 16). The right great toe's condition had worsened (Dp 16). Dr. Brattain debrided the tissue that was not viable and ordered a right foot MRI to look for osteomyelitis and any other underlying abscess. Dr. Brattain discussed with Petitioner the possible need for surgery and possible amputation (Dp 16-17). Other than a bone biopsy, MRI is the definitive gold standard for determining bone infection (Dp 17). Tunneling is when infection is progressing along a tendon or along a tissue plane and he is able to see a track and can probe into it (Dp 17). Petitioner was to remain off work. On July 2, 2013, a right foot MRI was performed and the findings were cellulitis and osteomyelitis of both bones in the great toe (Dp 18). On July 5, 2013, Dr. Brattain noted that the ulcer had worsened. He reviewed the MRI results with Petitioner and told him the toe was not going to heal with debridement and conservative wound care. Dr. Brattain suggested Petitioner consider doing surgery as the tissue death had been too extensive (Dp 18-19). Dr. Brattain recommended an amputation of the right big toe at that point (Dp 19). On July 11, 2013, Dr. Brattain performed the amputation (Dp 19).

Petitioner's first post-operative visit was on July 16, 2013. He had no pain, no drainage, the incision was intact, there was no active bleeding and no post-operative complications (Dp 20). Dr. Brattain opined that the amputation was successful (Dp 20). Petitioner remained off work (Dp 20). On July 19, 2013, Petitioner had some minor bloody drainage just due to normal post-operative swelling. There was no infection and no cellulitis was evident (Dp 20). Petitioner remained off work. On July 24, 2013, Petitioner reported a small amount of bleeding. The incision was dry, there was no drainage visible and he was at a normal post-operative status. Petitioner remained off work (Dp 21). Petitioner continued with Dr. Brattain and had a good recovery (Dp 21-22). Dr. Brattain last saw Petitioner on October 11, 2013 for a new wound (Dp 22). Petitioner was discharged for his great toe care on August 13, 2013 and remained off work (Dp 22). Dr. Brattain did not have in his notes that he released Petitioner to return to work, but typically he discharges patients to their chosen activity at that point. Dr. Brattain recommended Petitioner adjust the shoewear. Petitioner was released to return to work because he had requested it (Dp 23). Petitioner was told that if there was a way to change his work status to where he was not on his feet as much, he should do it (Dp 23-24). Dr. Brattain opined that there is no effect of loss of a toe; a person does not lose balance due to a loss of a toe (Dp 24).

Dr. Brattain was informed of Petitioner's job duties by Petitioner's attorney (Dp 24). Dr. Brattain opined that Petitioner's job duties absolutely aggravated his right toe condition (Dp 24). Dr. Brattain explained that Petitioner had insensitivity and opined that anybody that has insensitivity with diabetes is going to have inability to tell when they have developed a small problem. So anytime they are on their feet a lot doing aggressive activities that causes them to push, pull or climb is going to possibly cause increased friction and irritation (Dp 24-25). The wounds caused the need for medical treatment (Dp 25). Dr. Brattain believed that the work Petitioner did with his boots most likely at least aggravated those wounds (Dp 25). The development of the sore on his right big toe because it did not heal eventually led to the reason

which he had to amputate (Dp 25). It was the sore that he treated in the hospital led to the need for the amputation (Dp 25).

On cross-examination, Dr. Brattain recalled a letter he wrote dated August 6, 2013 and identified same (Dp 26). When Dr. Brattain first examined Petitioner, he had a Grade 3 wound on his right toe and a Grade 2 would on his left toe (Dp 26-27). The right great toe wound was worse than the left great toe wound (Dp 27). Petitioner had a wound on both toes. The wound on the left toe did heal eventually (Dp 27). Dr. Brattain never saw Petitioner's steel-toed boots (Dp 27). Dr. Brattain was shown the history from the admission date to the hospital on June 6, 2013 (Dp 28). Dr. Brattain opined that history was consistent with the history that he knew and understood from Petitioner (Dp 28). Dr. Brattain opined that Petitioner's wound would best be described as a pressure wound caused by the boot with the pressure caused by the boot (Dp 28). It was not his opinion that no one with diabetes should ever wear a steel-toed boot (Dp 29). Dr. Brattain testified: "Q. So you would agree with me that the pressure wound that Mr. Dixon sustained was actually due to the fact that Mr. Dixon, even by his own admission and history from the hospital records, was sustained because he was wearing a boot that was too small, correct? A. Likely, yes." (Dp 29). The pressure wound on his right and left big toes were in virtually identical places (Dp 29). Because of the size of the boots and his structure, the location was the same (Dp 29-30). Dr. Brattain never saw the boots and did not know if they were new or old (Dp 30). Dr. Brattain felt it would be an assumption if Petitioner had been wearing boots that were the correct size that he would not have sustained these pressure wounds (Dp 30). Dr. Brattain has seen diabetics of all sizes wear steel-toed boots who do not develop ulcerations (Dp 30). It is a mix of their anatomy, their degree of loss of sensitivity and the size and shape of the shoe (Dp 30). He could make an assumption that if Petitioner had worn a larger shoe, he may not have sustained pressure wounds (Dp 30-31). Dr. Brattain has seen wounds develop in diabetics that had a normal size shoe (Dp 31). Dr. Brattain only examined Petitioner's personal medical records that pertained to the wounds from the hospital records (Dp 31). Dr. Brattain did not examine Petitioner's whole medical history (Dp 31).

Dr. Brattain saw Petitioner in his office on June 14, 2013 (Dp 31). On that date, Dr. Brattain noted that aggravating factors were that Petitioner was wearing incorrect shoes. Dr. Brattain explained that he was referring to the size of the shoe or fit of the shoe, not the type of shoe (Dp 32). Dr. Brattain opined that the admission history of June 6, 2013 was consistent with his understanding that the wound Petitioner presented to him had been evolving for a period of time (Dp 33). Dr. Brattain was not aware of Petitioner's degree of diabetes (Dp 33). Dr. Brattain found Petitioner to be a reasonably intelligent man (Dp 34). At the time of Petitioner's admission on June 6, 2013, Dr. Brattain was not aware that Petitioner had been treated for many years at the Heartland Clinic (Dp 34). Dr. Brattain last worked at Heartland Clinic 15 years ago (Dp 35). Dr. Brattain was shown Rx2, date of August 11, 2005 that Goal Number 7 is an educational directive to Petitioner to check his feet daily and to seek medical attention if he notices a sore or irritation; he would agree with this (Dp 35-36). Dr. Brattain opined that the need for a diabetic to examine their feet on a daily basis would be critical for their own personal health and well-being (Dp 37). The same is noted in Rx2 for the dates July 18, 2006, January 4,

2007, April 29, 2008 and December 9, 2008; all are educational warnings for Petitioner to examine his feet daily and upon noticing a sore or irritation to seek medical attention (Dp 38-39). The same was true for Rx4 document dated April 2, 2013 (Dp 40). At the time he first saw Petitioner on June 6, 2013, the wounds were certainly days, if not weeks old (Dp 42). Dr. Brattain would agree that seeking medical attention as soon as possible for a wound or irritation on a foot is critical for a person with diabetes (Dp 42). It is true that the sooner that the person seeks the medical treatment, the more likely they are going to have success with conservative care, which is what Dr. Brattain attempted to do in the beginning (Dp 42). Respondent's attorney informed Dr. Brattain that Petitioner had been seen at Heartland Clinic on May 30, 2013 and it was suggested he see a podiatrist (Dp 42-43). Dr. Brattain opined that if Petitioner had seen a podiatrist 6 to 7 days earlier than he saw him, rather than working and aggravating the foot/toe, Petitioner's chances for a full recovery would have been greatly increased (Dp 43-44). If Heartland Clinic made that recommendation, they should have picked up the phone and called (Dp 44). Other than the problem Petitioner was experiencing with his right great toe, otherwise he was healthy (Dp 44). Petitioner was overweight, but Dr. Brattain would not call him obese (Dp 44). Dr. Brattain was aware Petitioner had hypertension. Dr. Brattain was not aware Petitioner suffered from chronic pancreatitis (Dp 44-45).

On re-direct examination, Dr. Brattain Dr. Brattain read from the history that was given to the hospital on June 6, 2013 (Dp 45). Dr. Brattain testified, "It says he noticed a week ago that he started to get a blister on the base of his great right toe. The wound has not improved after outpatient antibiotic treatment and he says it appears to be getting worse, although he has no feeling in that toe." (Dp 45). Dr. Brattain noted that once Petitioner noticed the wound, he did go to the doctor on May 30, 2013 (Dp 45-46). Dr. Brattain stated that if he had seen Petitioner earlier than June 6, 2013, he could not say that he could have saved Petitioner's right great toe from amputation, but he thought he would have had a good shot at it (Dp 49). Dr. Brattain opined that for a diabetic with loss of sensation, it was not unusual for Petitioner to seek treatment when he did (Dp 49). It appears Petitioner was trying to follow as best he could what he was told to do as a diabetic (Dp 50). Dr. Brattain opined that the size of the boots was the cause of the sores (Dp 50). Dr. Brattain would agree that while Petitioner's boots did not fit, his job duties was an aggravating factor in the development of those sores. Dr. Brattain opined, "In those shoes, an aggravating situation, they could make it worse the more activity you do, yes." (Dp 50). Working by standing on his feet for long periods of time, climbing ladders and such, would cause an aggravation to that big toe sore (Dp 51). Dr. Brattain noted that Petitioner did have neuropathy in both his feet and because of that, he had numbness and could not feel his feet (Dp 51). Dr. Brattain was asked, "Would it be consistent with somebody with neuropathy that they would think they were okay in the morning, put their sock on, go to work, work all day and then come home, take a boot off and the toe be – or the sock be drenched in blood and the sore had been worsened on his big toe?" Dr. Brattain answered: "Yes, that's the typical diabetic." (Dp 51-52).

On re-cross examination, Dr. Brattain testified that if a person is working and taking the boots off after work and wringing their socks out with blood on a daily basis, that is a pretty good indication there is a problem with that wound on that foot and immediate medical attention should be sought (Dp 52). If a person is experiencing some sort of wound on their foot and that person continues to work and does not advise a supervisor or co-worker and does not seek immediate medical treatment, Dr. Brattain would agree that the work is not the aggravating factor, but the fact that the employee has failed to properly care for himself; if that had been going on, Dr. Brattain would say yes (Dp 52-53).

On re-direct examination, Dr. Brattain noted that in the above hypothetical, the cause of the bloody foot is the job duties and lack of sensation; there would be multiple factors and no single cause (Dp 53). What day that person went to the doctor or did not go to the doctor would be fact specific (Dp 53). On re-cross examination, Dr. Brattain testified that Petitioner's wound was caused by the boot that he was wearing was too small (Dp 53). Dr. Brattain opined that if that boot was too small, any activity would have caused those injuries and that Petitioner would have sustained those injuries if he was walking down the street (Dp 54). On re-direct examination, Dr. Brattain opined that the more activity, the more aggravation there is (Dp 55). Dr. Brattain opined that the kind of activity Petitioner did at work, such as climbing ladders, loading/unloading grain, sweeping and on his feet all day, for a diabetic with loss of sensation in a steel-toed boot puts him at higher risk for damage than walking a dog down the block (Dp 56).

7. In a letter To Whom It May Concern dated August 6, 2013, Px7, Rx1, Dr. Brattain noted that he initially saw Petitioner at Methodist Hospital as a consultation for open wounds to both great toes. Dr. Brattain noted, "At that time he informed me that he had started a new job which required steel toes shoes and after a short period of time suffered injury or wounds to the toes which resulted in the hospitalization. Examination did not reveal any serious biomechanical deformity or restriction of motion or muscle weakness. He did have a grade 3 wound on the right great toe and a grade 2 wound to the left great toe in an area which certainly would be under greater friction or pressure in certain shoewear. Because he had never had a problem previously at these locations and never having a previous wound as a diabetic patient I would certainly concur that the shoewear were likely to blame for the ulcerations."

8. Proctor Hospital records, Px4, and Heartland Clinics records, Px3, Rx3, show Petitioner underwent a right foot MRI on July 2, 2013 ordered by Dr. Brattain. The radiologist found marked soft tissue swelling of the left first toe. There was increased signal intensity of the soft tissues of the right first toe consistent with cellulitis. No soft tissue abscess or fistula was visualized. There was irregular low signal intensity proximal aspect distal phalanx of the right first toe and distal aspect proximal phalanx of the right first toe. There was also irregular low signal intensity proximal aspect proximal phalanx of the right first toe. In addition there was cortical irregularity and these areas were high T2 signal intensity on the inversion recovery images and enhance on the post-infusion images consistent with osteomyelitis. On the inversion recovery images, there was mild increased signal intensity of the muscles of the forefoot,

consistent with myositis. The radiologist's impression was cellulitis and osteomyelitis of the proximal and distal phalanges of the right first toe.

Petitioner saw Dr. Springer on July 5, 2013 at Heartland Clinic for left lower quadrant abdominal pain. For his right foot, Petitioner was to continue antibiotics and follow-up with his podiatrist. On July 10, 2013, Petitioner saw Dr. Oloriegbe at Heartland Clinic for a pre-operative examination. Dr. Oloriegbe assessed right toe osteomyelitis. Dr. Oloriegbe noted Petitioner had failed several conservative debridements and was now after MRI on the antibiotic Levoquin for three weeks. Petitioner was scheduled on July 11, 2013 for right toe amputation by podiatrist Dr. Brattain. (Px3, Rx3). Dr. Oloriegbe's Heartland Clinic records, Rx2, show Petitioner had a past medical history of diabetes.

The records from the Illinois Valley Podiatry Group, Px10, Rx1, indicate Dr. Brattain performed surgery on July 11, 2013. In his Operative Report of that date, Dr. Brattain noted a pre-operative diagnosis of ulceration, right great toe, Grade 4, osteomyelitis, diabetes mellitus. The procedure was noted as a right great toe amputation.

9. IWIRC records, Px6, indicate Petitioner saw Dr. Hauter on August 22, 2013 for a fitness for duty evaluation for his foot infection following right great toe amputation. Petitioner reported he was 6 weeks post-op and had been released to return to work without restrictions. Petitioner denied pain and stated he had new inserts for his boots from his podiatrist. Dr. Hauter found Petitioner demonstrated safe performance of his job requirements and may return to work.

On September 6, 2013, Petitioner underwent a Non-Invasive Vascular Lower Extremity Arterial Physiologic Procedure at Methodist Medical Center. It was noted that a right great toe amputation was done in July 2013. The conclusion was that waveforms and toe pressures were consistent with normal arterial flow. (Px2, Rx5).

10. At Respondent's request, Petitioner saw Dr. Vaughn for a §12 evaluation on September 19, 2013. In his report, Rx6, DepRx4, Dr. Vaughn noted that Petitioner had his right great toe amputated. Dr. Vaughn noted the following history: "Patient states he has some blisters on both great toes from his steel toe boots, that eventually led to the amputation of his right great toe. Patient states that he started his job on May 13th, and got blisters on his great toes bilaterally around the 21st of May. The blister on the left foot healed without any problems, however the wound on the right great toe continued to be a problem. Patient continued to work in steel toe boots until June 5th when he was taken off of work. Patient was put into a boot at that time and was receiving wound care from his regular Podiatrist. Patient has an amputation due to osteomyelitis of the right hallux on July 13th. Patient does now have a sore on the tip of the 2nd digit and is putting medi honey on the area with a bandaid. Patient is in regular tennis shoes this date. He puts a pad under his 2nd digit to off load the tip of the 2nd toe. Patient has a boot at home. Patient has an appointment with his regular Podiatrist when he is done here. Patient states that he is now wearing a size 13 steel toe boot. Patient went back to work the last week of August after he healed from his amputation. He states that he worked two weeks and was

terminated from his job." On examination, Dr. Vaughn found positive open lesions present on the right 2nd toe, no edema in the right foot, the amputation site healed unremarkably, ulceration present to the tip of the right 2nd digit and measured 2 X 2 cm and was full thickness in nature, Grade II ulceration and had a good clean granular base with minimal yellow slough in the base; the tip of the 2nd digit was very edematous and bulbous. Dr. Vaughn's assessment was ulceration present to the tip of the 2nd right and history of amputation to the right hallux. Petitioner was to follow-up with his podiatrist for continued treatment to the right 2nd digit and be measured for proper shoe gear. Dr. Vaughn reviewed Petitioner's medical records. Dr. Vaughn opined that the ulceration to the great toe was a result of Petitioner purchasing ill-fitting boots. Dr. Vaughn opined, "The amputation resulted in increased and continual pressure to the wound. Patient continued to work with the boots until eventually taken off work. Fifteen days after the initial sore developed, patient was ordered off work by the Employer only after the Employer was made aware of the patient's problem from another employee." Dr. Vaughn noted that Petitioner had been undergoing diabetic counseling for years. Dr. Vaughn noted, "In his records there are notes that clearly advise him that if he experiences any wound on his foot that he must immediately seek medical attention. His failure to seek medical attention immediately is the reason he lost the distal and proximal phalanx of the right hallux."

11. In his August 29, 2014 deposition, Rx6, Dr. Vaughn testified he is board certified by the American Board of Podiatric Foot and Ankle Surgery. Dr. Vaughn recited from his report. Dr. Vaughn noted that the histories in the medical records indicate Petitioner was wearing an ill-fitting boot (Dp 9). Petitioner was measured for his shoe size and he had a length of 12½ inches bilaterally and an arch length of 14.5 on the right. Dr. Vaughn stated that if he were ordering diabetic shoes for Petitioner, he would definitely recommend that he was a size 13 (Dp 10). Petitioner did tell him he was now wearing a size 13 boot (Dp 11). Dr. Vaughn opined that the open wound he observed on Petitioner's foot, the 2nd digit, was not in any way related to Petitioner's employment at Respondent (Dp 11). Dr. Vaughn opined that the ulceration to the right great toe was the result of Petitioner purchasing or wearing ill-fitting boots, which resulted in increased and continual pressure to the wound and a repetitive trauma to the wound, resulting in the loss of his great toe (Dp 11). Petitioner also did not seek the immediate medical attention he needed to address his wound. Dr. Vaughn identified DepRx2 as Heartland Community Clinic diabetes patient self-management goals with Petitioner's name at the top (Dp 12). Dr. Vaughn opined that the injury Petitioner sustained was due to the fact he was wearing ill-fitting boots and then failed to have the blisters treated in a timely manner (Dp 14). Dr. Vaughn has diabetic patients who wear steel-toed boots (Dp 14). Dr. Vaughn opined that with properly fitting boots, it is perfectly appropriate for a diabetic person to wear steel-toed boots (Dp 14).

On cross-examination, Dr. Vaughn testified that he sees patients for anything in the foot and ankle, any trauma. He does surgery, reconstructions and amputations (Dp 15). Dr. Vaughn gives diabetic counseling to his patients with diabetes (Dp 15). Petitioner did not bring his steel-toed boots with him to the evaluation, so Dr. Vaughn did not inspect them (Dp 16). When Dr. Vaughn stated the boots were ill-fitting, he based this on Petitioner stating that he was wearing a 12½ shoe and the medical records that stated he had a smaller boot size (Dp 16). Dr. Vaughn

had no firsthand knowledge of the boot and how it fit Petitioner's foot (Dp 16). When Dr. Vaughn saw Petitioner, he was now wearing the appropriate sized boot at size 13, based on what Petitioner told him (Dp 17). Dr. Vaughn acknowledged that shoes do fit differently (Dp 17). Dr. Vaughn believed Petitioner sought treatment on June 5, 2013 and he saw Dr. Brattain on June 6, 2013 (Dp 17). Dr. Vaughn would agree that the boots were an aggravating factor (Dp 19). Dr. Vaughn noted that as Petitioner continued wearing the boots, it made that sore worse (Dp 19-20). If Petitioner had a normal blood sugar range at that time or if he knew he had a normal sugar range, the timing of the need for immediate medical attention might have been longer (Dp 20). Dr. Vaughn did not know what Petitioner's A1C or his blood sugars were at that time (Dp 20). Dr. Vaughn opined Petitioner's medical treatment with Dr. Brattain was reasonable (Dp 21). By the time Petitioner got to Dr. Brattain on June 6, 2013, Dr. Vaughn was not sure there was going to be much saving the toe anyway as Grade 3 is already to the bone and Dr. Brattain had diagnosed a Grade 3 on the right (Dp 21). Dr. Vaughn opined Petitioner would not need any restrictions without his right big toe (Dp 22). Petitioner could balance fine without his big toe (Dp 22). Dr. Vaughn knew Petitioner worked an 8-hour day (Dp 22).

On re-direct examination, Dr. Vaughn testified that the medical records from Methodist Medical Center looked familiar and the history noted there would be relatively consistent with the history he obtained from Petitioner (Dp 23-24). That history provided that Petitioner's boots were too small and that he did see blisters and they eventually turned into an open wound (Dp 24). Dr. Vaughn opined that there was no difference between walking in ill-fitting boots and engaging in regular labor activities as far as causation of this blister that caused Petitioner's amputation; the pressure is the same (Dp 26-27). Dr. Vaughn opined that the ill-fitting boots and the repetitive trauma to the area is what caused the amputation of his toe (Dp 27). Diabetes can play a role in that (Dp 27). Dr. Vaughn opined that the constant pressure that Petitioner had in that area is what continually broke down that capillary bed (Dp 28). That is why diabetics lose toes (Dp 28). Dr. Vaughn opined that merely walking in those ill-fitting boots caused constant pressure (Dp 28).

On re-cross examination, Dr. Vaughn testified that he did not know how often Petitioner climbed stairs at work, how often he carried bags of grain or how much he walked at work. All Dr. Vaughn knows is Petitioner just worked an 8-hour shift (Dp 29). Dr. Vaughn did not know the medical status of Petitioner's diabetes at the time of the injury or the surgery and that can determine how quickly or how severe his injury could develop (Dp 29).

12. Both parties admitted into evidence Heartland Community Health Clinic Diabetes Patient Self-Management Goals for Petitioner for various dates, Px7, Rx2 through Rx4. On all, Goal #7 stated, "I will check my feet daily. If I notice a sore or irritation, I will seek medical attention."

13. Petitioner submitted various medical bills and these were admitted into evidence as Px8. Petitioner also submitted Off Work Slips and these were admitted into evidence as Px9.

15IWCC0710

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on May 21, 2013 and denies Petitioner's claim.

The Commission notes that Petitioner has a preexisting condition of diabetes. Petitioner was required to wear steel-toed boots as part of Respondent's dress code. Apparently, Petitioner purchased steel-toed boots that were too small. As a result of wearing steel-toed boots that were too small, Petitioner developed blisters on both great toes. The right great toe blister became infected and eventually his right great toe was amputated. Petitioner bought the boots that were too small and he then wore them, which caused his blisters. It is not the fact that the boots were steel-toed; it is that the boots were too small. Both Dr. Brattain and Dr. Vaughn agreed that a diabetic person may wear steel-toed boots as long as they are properly fitted. The Commission finds that buying the right-sized boots was certainly within Petitioner's control. The Commission finds there was no accident here as Petitioner was simply wearing ill-fitting steel-toed boots which he had purchased.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment on May 21, 2013, his claim for compensation and medical expenses is hereby denied.

There is no bond as there is no award. 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: SEP 11 2015
MB/maw
o07/16/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ed Mazzei,

Petitioner,

vs. NO. 10WC013187

City of Des Plaines Fire Department,

15IWCC0727

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 23 2015
SJM/sj
o-9/3/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MAZZEI, ED
Employee/Petitioner

Case# **10WC013187**

CITY OF DES PLAINES FIRE DEPARTMENT
Employer/Respondent

15IWCC0727

On 11/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0863 ANCEL GLINK
BRITT ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Ed Mazzei
Employee/Petitioner

v.

City of Des Plaines Fire Department
Employer/Respondent

Case # **10** WC **13187**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 8, 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **May 26, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**80,009.28**; the average weekly wage was $**1,538.64**.

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

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

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

Respondent is entitled to a credit of $**18,370.04** under Section 8(j) of the Act.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$619.97/week** for **41.75** weeks, because the injuries sustained caused the **25%** loss of use of the left foot pursuant to Section 8 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$1,025.76 / week** for **14 3/7 weeks** commencing November 9, 2010 through February 16, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received for his ankle, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act. The parties agreed that the amount of medicals which is outstanding is $65,188.98, and that the Respondent is entitled to a credit pursuant to Section 8(j) of the Act, in the amount of $18, 370.04, which has been paid through group medical insurance. Petitioner agrees to hold Petitioner harmless and indemnify Petitioner if group medical insurance seeks reimbursement.

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.

Richard L. Simpson
Signature of Arbitrator

Nov. 7, 2014
Date

NOV 10 2014

15IWCC0727

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ed Mazzei,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 13187**
	)	
City of Des Plaines Fire Dept.,	)	
	)	
Respondent.	)	
	)	

CORRECTED FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on May 26, 2007, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner sustained accidental injuries that arose out of and in the course of employment and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) What were the Petitioner's earnings the year preceding the injury and what was his average weekly wage, calculated pursuant to Section 10 of the Act; (3) Were the medical services provided to the Petitioner reasonable and necessary medical services and has the Respondent paid for all reasonable and necessary medical services; (4) Is the Petitioner entitled to TTD from November 9, 2010 through February 16, 2011; and (5) What is the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner is currently employed at the City of Des Plaines Fire Department as a firefighter. He does all of the relevant duties of a firefighter including responding to and putting out fires and ambulance calls. He was first employed by the City of Des Plaines ("Respondent") on September 12, 1994. He testified that he is also employed by Lowe's in Carol Stream and that the Respondent is and was aware of his second job.

The Petitioner testified that prior to May 26, 2007, he had never had treatment for his left ankle or foot. The Petitioner also testified that he had never lost time as a result of injuries to his left foot before May 26, 2007.

On May 26, 2007, while working for the Respondent, the Petitioner stepped off his fire engine and while stepping down to the cement floor of the firehouse, he rolled his left ankle. The Petitioner testified that he had stepped approximately 22 ½ inches down from the fire engine to the cement floor. Immediately, the Petitioner felt sharp pain in his left ankle, feeling that it was the worse pain he had felt in his life, a ten on a scale of one to ten, with ten being the worst pain, the pain was located in his left ankle near the outside ball of the ankle.

The Petitioner informed his supervisor, Captain Burger, of his accident.

The Petitioner testified that he sought medical treatment first at Alexian Brothers in Mt. Prospect. He later followed up with Dr. Mark Levin at Barrington Orthopedics. He treated with Dr. Levin from May 29, 2007 through January 8, 2008. He testified that there was a two year gap in his treatment until April 12, 2010, when he started treatment again, this time with Dr. Howard Freedberg.

At the time that the Petitioner was released from treatment by Dr. Levin, the Petitioner stated that although his ankle was improved he still had pain in the ankle. The Petitioner testified that he continued having pain and discomfort in the left ankle between the last date he saw Dr. Levin on January 8, 2008 through the day he first started seeing Dr. Freedberg on April 12, 2010. He testified that the between January 8, 2008 and April 12, 2010, he always had pain, it was never a zero. He stated that even driving he would get left ankle pain. He stated that approximately ten times per day he would get excruciating pain that would last for eight to ten seconds each time and would start in his ankle and go up into his calf. The Petitioner testified on cross examination that when he was released from care by Dr. Levin he was told by Dr. Levin that he would still have pain but it would get better over time. He waited for it to get better for more than two years but it did not.

Dr. Freedberg's initial treatment consisted of injections. They provided temportary relief but the effects did not last long. On November 9, 2010, Petitioner underwent left ankle surgery with the following four procedures performed: (1) Left ankle arthroscopy and debridement of the cicatrix of the lateral gutter with an anterior tibial osteoplasty; (2) Left peroneal brevis tendon repair; (3) Left hind foot endoscopy with removal of the loose body; and (4) osteoplasty of the talus with removal of the stieda process with synovectomy. (PX. Group 4, Transcript of Dr. Freedberg, Dep. Ex. #3) The post-operative diagnoses following the November 9, 2010 surgery were listed as (1) left ankle anterior and lateral gutter impingement; (2) left pernoneus brevis tendon tear and (3) fracture of stieda process with a posterior impingement. The surgery was performed by Dr. Freedberg at the St. Alexis Medical Center.

The Petitioner testified that after surgery, he underwent physical therapy at Suburban Orthopedic from November 23, 2010 through January 14, 2011. (See also PX. 4) According to the Petitioner after the surgery and physical therapy he never had the sharp pain again even after he went back to work.

The Petitioner testified that the Respondent put him on light duty work until his surgery in November of 2010. The Petitioner was off work from the date of the surgery, November 9,

2010 through February 16, 2011, a total of 14 3/7 weeks. The Petitioner testified that he received no TTD benefits during this period. The Petitioner returned to work on February 17, 2011, and has since worked to the current date full duty with no permanent restrictions, as well as returning to his employment at Lowe's.

As he goes about his work and his daily activities, the Petitioner testified that he has never experienced the sharp pain in his left foot again that shot up his leg prior to the November 9, 2010 left ankle surgery. However, the Petitioner continues to have an achy feeling if he is on his feet more than 1 ½ – 2 hours at a time. He testified that he has been given no permanent restrictions on his activities from his physicians as a result of this accident. He testified that he currently performs all firefighting duties in a full duty manner. And the Petitioner also testified that he takes no prescriptions or over-the-counter medications for his pain or any current problems.

The Petitioner testified that he was seen by Dr. George Holmes on July 26, 2010, for the purpose of an independent medical evaluation. The Petitioner testified that he received no medical care from Dr. Holmes. Dr. Holmes touched his ankle, drew on it and said he would "be right back he was going to fire up the camera, and I never saw him again." A nurse came in and took pictures of where the doctor had drawn on Petitioner's ankle.

On January 25, 2011, the evidence deposition of Dr. Howard Freedberg, the treating surgeon, was taken by the parties. (PX. Group 4, Dr. Freedberg Deposition Transcript) Dr. Freedberg testified that he is a Board Certified orthopedic physician. He stated that after he examined Petitioner he diagnosed a left ankle posterior impingement with a left peroneal tendonitis, stress reaction of the fifth metatarsal. He then ordered an MRI which was completed on May 11, 2010. (Freedberg Dep. p.9). The MRI confirmed the diagnosis. He then performed an injection into the posterior hind foot area of the ankle. (Freedberg p.9).

On May 27, 2010, when Petitioner returned to see Dr. Freedberg, he reported that the injection helped significantly for the first few days. However, the pain continued with intense severity. Freedberg thought the "culprit" was the Stedia Process. (Freedberg p.10). Freedberg was confident he could resolve the problem with surgery. (Freedberg p. 10).

On September 8, 2010, Dr. Freedberg reviewed the report of Respondent's Section 12 examining physician, Dr. George Holmes. He disagreed with Dr. Holmes conclusions. Dr. Freedberg believed surgery was warranted and that the condition was work related. (Freedberg Dep. p. 11).

On November 8, 2010, Freedberg performed surgery. During his deposition Dr. Freedberg described the surgery that he performed in detail. Part of that explanation included photographs that he had taken during the procedure and which were included as part of the deposition exhibits. Dr. Freedberg pointed out the cicatrix on operative photographs. He also illustrated scar tissue that was the sequela of the injury. During the surgery, the scar tissue was removed. Once the scar tissue was removed it opened up the joint. (Freedberg, Dep. pp.13-14). The tibia osteophyte was removed. There was a loose fragment of bone. It was at the Stedia Process and was a free fragment in the os trigonum, just lateral to the flexor hallucis longus tendon. Freedberg opined:

> At the time of his injury he had actually not only sprained his ankle with this inversion injury, but his foot was plantar flexed, which means his toes were pointed down and that produced an abutment of a posterior impingement in the posterior ankle; he fractured this fragment.
>
> Now, why did not this produce lock or anything? Because it's just actually outside of the joint and it's large enough, it's never going to go into the joint, so it's not going to lock his ankle, but it's always going to produce pain especially when he was very active on it, which is what his symptoms really were. (Freedberg Dep. p.16)

Based upon operative findings Dr. Freedberg noted that Petitioner had a fractured Stedia Process. Dr. Freedberg found the pathology, he testified that "the proof is in the pudding." (Freedberg Dep. p.19). Dr. Freedberg opined that the incident of May 26, 2007 caused the pathology for which Petitioner was treated. The fact Petitioner inverted his ankle caused a tear in the anterior talofib ligament and produced this fracture. (Freedberg Dep. pp.20-21). Dr. Freedberg stated that while in the joint arthrosopically, he did not find degenerative changes that Dr. Holmes said existed. The findings, in his opinion, were traumatic. (Freedberg Dep. p.23).

And on October 25, 2011, the evidence deposition of Dr. George B. Holmes, Jr., M.D. was taken by the parties and has been admitted in to evidence. (RX. 1).

Respondent's Section 12 examining physician was Dr. George Holmes. Dr. Holmes first opined that the petitioner was at maximum medical improvement and the surgery Dr. Freedberg was going to perform was unnecessary. (RX 1, Dep Ex. 2). After the surgery was performed, Dr. Holmes posited that there was no concrete evidence that the injury caused any condition that Dr. Freedberg treated petitioner for. (RX 2). He opined that although the surgery relieved the offending pain in the foot that it was merely because of a placebo effect. He stated:

> Therefore, not to get the minutia of this discussion, it is my opinion that the surgery as it relates to the injury of 05/26/2007 was not indicated. Further, it should be stated that it is not surprising nor is it shocking that the patient improved after the surgery. Not to offend anyone in the field of medicine, we are all aware of the so-called placebo effect. The placebo effect can be negative and it can be positive. (RX 2)

Dr. Holmes, indicated he based his findings on the review of the medical records from Dr. Levine as well as Dr. Freedberg, noting that Dr. Levine released the Petitioner to return to work full duty, having reached MMI in Dr. Levine's opinion in January of 2008. He also indicated that the Petitioner had a history of prior left ankle sprains and that what Dr. Levine noted in his medical records was not in Dr. Holmes opinion consistent with the symptoms Dr. Freedberg was describing and the opinions or conclusions of Dr. Freedberg. (RX 2) Interestingly enough Dr. Holmes does note in his letter that different doctors can look at the same data and reach different opinions. "The initial doctor should not be offended by a different opinion from a different physician because if you put 5 physicians in a room you will get 7 different opinions." (RX 2)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

For treatment of an employee's workplace injury to be compensable under workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

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

Petitioner had an inversion injury to his left foot and ankle that caused immediate and unrelenting pain. He treated for the foot and ankle problem for the next eight months on a consistent basis with Dr. Levin, an orthopedic physician. Physical therapy was instituted and orthotics tried. One type of orthotic insert did not work a second type was ordered and tried. At the time of Petitioner's release by Dr. Levin from treatment and his return to work, Petitioner testified that although his ankle pain was improved he still had pain that never relented. Petitioner was told by Dr. Levin that he would still have pain but that it would get better over time. The Petitioner waited for more than two years for the pain to improve, but it did not.

When Petitioner sought treatment form Dr. Freedman it was for pain to the same area of the foot and ankle that had been bothering the Petitioner since the accident. Petitioner reportedly sprained his ankle in his youth but never had any other incident or accident since that time until this accident that occurred on May 26, 2007, while working for Respondent. He was credible in his testimony that after the accident his left ankle was problematic and that the pain continued from 2008 until 2010 when he consulted with Dr. Freedberg, who diagnosed the problem and treated it.

Before the treatment of Dr. Freedberg, the left ankle and foot were painful. After the surgery the pain relented. The surgery worked and cured the problem. After performing the surgery, documenting his findings with photographs and finding that the Petitioner had nearly 100% relief after the surgery and physical therapy Dr. Freedman felt that the Petitioner's actual injury was consistent with his mechanism of injury, and the fact that it never healed is consistent with his long-term course of chronic pain and problems until we performed the operative procedure.

The Arbitrator finds that Dr. Holmes's testimony on causation and necessity of the treatment is unpersuasive. Originally, Dr. Holmes opined that the surgery wasn't necessary but once it was successful Holmes said the reason was because of the placebo effect.

The Respondent's denial of causation is based upon Dr. George Holmes's opinions. The Arbitrator is not persuaded by those opinions in light of all the evidence.

For these reasons, the Arbitrator finds Petitioner and Dr. Freedberg more credible than Dr. Holmes with respect to the condition of Petitioner's left ankle and the necessity for treatment. The Arbitrator further finds that Petitioner current state of ill-being is causally related to his work injury.

What were the Petitioner's earnings the year preceding the injury and what was his average weekly wage, calculated pursuant to Section 10 of the Act?

The Petitioner claims that his earnings the year prior to the injury were $79,966.64 and his average weekly wage, calculated pursuant to Section 10 of the Act, was $1,537.82. The Respondent disagrees and claims the total wages were $73,466.64 and the average weekly wage was $1,412.86.

The unrebutted testimony on the concurrent wage issue was that Petitioner worked at Lowes part time with the knowledge of Respondent. He testified that he earned $125.82 per week at Lowes. That would be an additional $6542.64 per year. Adding that figure to the $73,466.64 that Respondent claims Petitioner made the year prior to his injury working for the Respondent Petitioner's earnings in the year prior to the accident would total $80,009.28. His average weekly wage is calculated as $1,538.64 per week. His TTD rate would be $1,030.89.

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

Based upon the foregoing discussion, the Arbitrator finds that the treatment received by Petitioner was reasonable and necessary, and related to his work injury and that the Respondent is responsible for the cost of the medical care that was provided .

Respondent has stipulated that it had no objection to the reasonableness of the bills but only to liability for them. Respondent is to hold harmless or reimburse Blue Cross Blue Shield

pursuant to the stipulation entered into between the parties. In addition Respondent is to pay the medical bills of $65,188.98 pursuant to the applicable Fee Schedule in effect as the bills for these amounts were causally related to the injury sustained on May 26, 2007.

Is the Petitioner entitled to payment for temporary total disability?

Respondent's contest with TTD is liability and not the period at issue. Based upon the Arbitrator's decision with regard to causation, Respondent is responsible for the period of TTD claimed, which was unrebutted as far as the time period was concerned, from November 9, 2010 through February 16, 2011, a total of fourteen and three sevenths weeks (14 3/7 weeks).

In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

After conservative care in 2007 and early 2008, including two different kinds of orthotics, which was unsuccessful, Petitioner sought treatment from another doctor, Dr. Freedberg. He underwent injections into the ankle which gave temporary relief and then on November 9, 2010, had a left ankle arthroscopy and debridement of the Cicatrix of the lateral gutter with an anterior tibial osteoplasty, left peroneal brevis tendon repair, left hind foot endoscopy with removal of the loose body and osteoplasty of the talus with removal of the Stedia Process with synovectomy. While the surgery was a success, the pathology was significant and the repair complicated. Petitioner is a firefighter which requires him to be engaged in very rigorous physical activity. Based upon the injury sustained and the operation performed Petitioner is entitled to 25 % loss of the left foot.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$619.97/week** for **41.75** weeks, because the injuries sustained caused the **25%** loss of use of the left foot pursuant to Section 8 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,025.76 / week for 14 3/7 weeks commencing November 9, 2010 through February 16, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received for his ankle, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act. The parties agreed that the amount of medicals which is outstanding is $65,188.98, and that the Respondent is entitled to a credit pursuant to Section 8(j) of the Act, in the amount of $18, 370.04, which has been paid through

group medical insurance. Petitioner agrees to hold Petitioner harmless and indemnify Petitioner if group medical insurance seeks reimbursement.

Robert L. Simpson
Signature of Arbitrator

Nov. 7, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☒ 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

Conception Hernandez,
Petitioner,
vs.

NO: 13 WC 17857

Modern Abrasive Corp.,
Respondent,

15IWCC0723

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2014 is hereby affirmed and adopted.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 22 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB /mam
o:7/30/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNANDEZ, CONCEPTION
Employee/Petitioner

Case# **13WC017857**

15IWCC0723

MODERN ABRASIVE CORP
Employer/Respondent

On 12/5/2014, 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:

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

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0723

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CONCEPTION HERNANDEZ,
Employee/Petitioner

v.

MODERN ABRASIVE CORP.,
Employer/Respondent

Case # 13 WC 17857

Consolidated cases: NONE.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Woodstock**, on **September 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 26, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged 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 alleged injury, Petitioner earned $22.809.28; the average weekly wage was $438.64.

On the date of the alleged accident, Petitioner was **50** years of age, *married* with **three** 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 $ **0.00** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **0.00**.

Respondent is entitled to a credit of $ **7,249.44** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained accidental injuries that arose out of and in the course of her employment with Respondent on January 26, 2013.

Petitioner further failed to prove that she gave Respondent timely notice of this alleged accident as defined by the Act.

Petitioner further failed to prove that the conditions of ill-being claimed were causally relate to any work activities performed on behalf of Respondent.

All claims made by Petitioner for benefits in this matter are hereby denied.

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

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

JOANN M. FRATIANNI
Signature of Arbitrator

December 1, 2014
Date

DEC 5 - 2014

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

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

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

Petitioner testified she worked for Respondent as an assembler. As an assembler, she takes small metal rods of 1-3" in length, dips them in glue, and places them into predrilled holes in small pieces of quartz that are also 1-3" in length. The rod is held in one hand and the quartz rock in the other, using the thumb, forefinger and middle finger of each hand, to set the rod into the quartz. Petitioner testified that a great deal of force was required for assembly, including twisting with both thumbs. Petitioner testified she rotated positions at work and the sizes of the pieces worked on would also vary. Petitioner worked 5 days a week for 40 hours. She would start each shift at 6:00 a.m. and end at 2:30 p.m. During the shift she was entitled to a 10 minute break at 8:00 a.m., a 15 minute break at 10:00 a.m., and a 30 minute lunch at 12:30 p.m.

Petitioner identified samples of the parts at trial. (Px5) She has performed such work for Respondent for a period of 20 years. She performed the same work during her entire length of employment with Respondent with no changes in her duties. Petitioner denied experiencing pain or difficulty with either thumb prior to January 26, 2013. She was diagnosed with diabetes by Dr. Maniquis with high sugar levels since 2009. (Rx1)

Petitioner testified that she began feeling pain in both thumbs in mid-2012, and began experiencing difficulty in grasping. By November, 2012, her thumbs would lock.

Petitioner testified she thought she told her supervisor, Ismael, about her thumb symptoms some time in 2012, but was not sure when. On cross-examination, she admitted not mentioning her thumb symptoms to Respondent until returning from her annual vacation from Mexico in January, 2013. At that time she mentioned experiencing pain.

On January 26, 2013, Petitioner sought treatment with Dr. Maniquis, her family physician. Petitioner complained of bilateral thumb pain and locking. Dr. Maniquis recorded a history of factory work and suspected tenosynovitis and trigger thumbs. The doctor then referred her to see Dr. DeLeon, an orthopedic surgeon. (Px1)

Petitioner saw Dr. DeLeon on February 1, 2013. Dr. DeLeon recorded complaints of bilateral thumb pain and finger locking, and that she performed factory work with repetitive movements required. Dr. DeLeon diagnosed bilateral thumb stenosing tenosynovitis. He injected both thumbs and instructed her to return as needed. (Px2)

Petitioner returned to see Dr. DeLeon on April 1, 2013. She reported the pain and triggering to her right thumb had resolved, but that she still experienced symptoms to her left thumb. Dr. DeLeon prescribed surgery to the left thumb. On April 4, 2013, Petitioner underwent a surgical release to the left thumb. By April 12, 2013, Petitioner was cleared to work light duty with no lifting, and full duty work four weeks later. (Px2)

Petitioner then applied for short term disability through a Guardian Life policy provided by Respondent. She filled out an application on April 2, 2013, and in response to a question if her condition is related to her employment, she answered "no." (Rx2)

Following her full duty return to work for Respondent, Petitioner testified that she continued to experience symptoms to her right thumb. She saw Dr. DeLeon on December 9, 2013 for this problem. Dr. DeLeon later prescribed surgery to the right thumb. On March 6, 2014, a surgical release to the right thumb was performed. By March 28, 2014, Petitioner was released to lighter duty work with full duty work two weeks later.

On March 14, 2014, Petitioner again applied for short term disability and again answered a question that the condition was not work related. (Rx2)

On July 7, 2014, Petitioner was examined by Dr. Michael Vender at the request of Respondent. Dr. Vender noted development of symptoms to both thumbs in June, 2012, without any specific injury. He agreed with the diagnosis and treatment by Dr. DeLeon, but concluded that her job duties did not cause or contribute to this condition. He also felt the diabetes was a significant factor in this condition. (Rx4)

Based upon the above, the Arbitrator finds that Petitioner failed to prove that an accidental injury occurred that arose out of and in the course of her employment with Respondent on January 26, 2013 through repetitive trauma. The Arbitrator had the opportunity to observe the pieces that Petitioner worked with, and also notes that Dr. Vender had the same opportunity. Dr. Vender concluded the work involved little force and only routine manipulation. In addition, the two applications for short term disability by Petitioner both denied a work condition.

The Arbitrator notes that while Drs. Maniquis and DeLeon recorded a history of factory work, neither rendered a specific medical opinion causally relating her work duties to her bilateral thumb conditions.

Based further upon the above, the Arbitrator finds that Petitioner failed to give Respondent timely notice of an alleged work injury as defined by the Act.

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?

See findings of this Arbitrator in "C," "E" and "F" above.

Based upon said findings, all claims made by Petitioner for medical charges in this matter are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C," "E" and "F" above.

Based upon said findings, all claims made by Petitioner for temporary total disability benefits in this matter are hereby denied.

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

See findings of this Arbitrator in "C," "E" and "F" above.

Based upon said findings, all claims made by Petitioner for permanent partial disability benefits in this matter are hereby denied.

M. Should penalties or fees be imposed upon Respondent?

See findings of this Arbitrator in "C," "E" and "F" above.

Based upon said findings, all claims made by Petitioner for penalties and fees in this matter are hereby denied.

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

David M. Foss,

Petitioner,

vs. No. 12 WC 17796

Alexian Brothers Health System,

15IWCC0730

Respondent.

DECISION AND OPINION ON REVIEW

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

Having carefully reviewed the entire record, the Commission agrees with the Arbitrator's determination that Petitioner's left knee condition and need for knee replacement surgery are causally connected to the work accident. However, the Commission finds the issue of causal connection warrants a more detailed analysis.

Petitioner's treating surgeon, Dr. Kuesis, and Respondent's section 12 examiner, Dr. Levin, testified via evidence depositions in this matter. On October 6, 2011, Dr. Kuesis performed: an arthroscopy, partial medial meniscectomy, chondroplasty of the medial femoral condyle, chondroplasty of chondromalacia patella, and synovectomy of the medial and lateral

gutters, suprapatellar pouch and femoral fat pad. Postoperatively, he diagnosed: a medial meniscus tear (moderate size), chondral damage (grade II to III) of the medial femoral condyle, patellofemoral chondromalacia/chondral damage (grade II to III), and synovitis of multiple compartments. After the surgery, Petitioner continued to complain of significant, persistent symptoms. With respect to the radiologist's reading of the postoperative MRI performed February 1, 2012, Dr. Kuesis stated: "They're discussing subchondral cyst formation in the tibial plateau. They have a joint effusion that's increased in size. Those are findings consistent with chondral damage or meniscal damage within the knee," adding: "[s]ubchondral cyst formation is a known finding of arthritis." On August 13, 2012, Dr. Kuesis recommended a total knee arthroplasty. On September 9, 2013, Petitioner followed up, complaining of increased pain, as well as popping, swelling and stiffness in the knee. X-rays showed moderate arthritis. Dr. Kuesis continued to recommend a knee replacement surgery. Dr. Kuesis felt that Petitioner had exhausted conservative treatment. Regarding causal connection, Dr. Kuesis opined: "If the patient didn't have any preexisting knee problems, it appears that his injury is from his work-related incident." On cross-examination, Dr. Kuesis explained: "His injury has led to progressive chondral damage and advancing osteoarthritis in the knee."

Dr. Levin, an orthopedic surgeon, testified that he first examined Petitioner on March 21, 2011. At that time, X-rays showed no significant evidence of medial or lateral compartment arthritis. Dr. Levin reviewed the MRI images from February 8, 2011, which he interpreted as showing a possible medial meniscus tear. Dr. Levin diagnosed a medial collateral ligament sprain and possible occult medial meniscus tear. Based on Petitioner's history and the chain of events, Dr. Levin opined the conditions he diagnosed were causally connected to the work accident, and recommended medication and physical therapy. In the event conservative treatment failed, Dr. Levin recommended surgery. On March 12, 2012, Dr. Levin reexamined Petitioner, who complained he was no better after the surgery and possibly worse. On physical examination, Petitioner complained of pain, tenderness and soreness in the knee. Dr. Levin opined the surgery performed by Dr. Kuesis was "the appropriate procedure for the intraoperative findings that he described in his postoperative diagnosis," and physical examination was "consistent with a fairly good result from a postoperative knee. His motion is greater than 90 degrees. There was no evidence of infection. He had some localized findings along both the medial and lateral joint line but certainly no evidence of any kind of post-operative infectious process." Dr. Levin reviewed the MRI images from February 1, 2012, noting "minimal postoperative changes along the medial meniscus" and no evidence of any significant degenerative or osteoarthritic changes or loose bodies within the knee. Dr. Levin recommended against a knee replacement surgery, explaining: "An indication for a total knee replacement is a diagnosis of arthritis, whatever form it is, inflammatory, degenerative, post-traumatic; with documentation of that diagnosis, imaging studies that show destruction or narrowing of a joint space, failure of conservative measures, and not being able to live with the condition with nonoperative treatment."

Dr. Levin further testified that on April 10, 2012, he issued an addendum report after reviewing intraoperative pictures. Dr. Levin noted "some changes which appear on the central

and lateral aspect of the medial femoral condyle and posterior aspect which were probably debrided." Dr. Levin felt Petitioner's continuous subjective complaints were out of proportion to what one would expect, noting the postoperative MRI showed no suggestion of large segmental collapse or avascular necrosis in the area of the medial femoral condyle. Petitioner's clinical presentation did not suggest RSD, either. Dr. Levin did not recommend a knee replacement surgery or any additional treatment. On cross-examination, Dr. Levin testified that although longstanding inflammation from a torn medial meniscus might contribute to arthritis, he did not think that happened in this case.

The Commission finds credible both Dr. Kuesis and Dr. Levin. Like the Arbitrator, the Commission is persuaded by the opinion of the treating surgeon, Dr. Kuesis. The Commission notes that X-rays performed June 27, 2012, and September 9, 2013, did show degenerative joint disease and arthritis, whereas X-rays performed January 7, 2011, and March 21, 2011, showed no such findings. The Commission is therefore persuaded by the opinion of Dr. Kuesis that the work injury led to progressive chondral damage and advancing osteoarthritis in the knee.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2014, is hereby expanded, affirmed and adopted.

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

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

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

15IWCC0730

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

DATED: SEP 23 2015
o-09/03/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

FOSS, DAVID M
Employee/Petitioner

Case# **12WC017796**

12WC017797

ALEXIAN BROTHERS MEDICAL CENTER
Employer/Respondent

15IWCC0730

On 11/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2095 LAW OFFICE PHILIP BLOMBERG
11516 W 183RD ST
SUITE NE
ORLAND PARK, IL 60467-9473

0075 POWER & CRONIN LTD
WILLIAM P DEWYER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

15IWCC0730

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)

David M. Foss
Employee/Petitioner

v.

Alexian Brothers Medical Center
Employer/Respondent

Case # **12 WC 17796**

Consolidated cases: **12 WC 17797**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 19, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 6, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$71,752.72**; the average weekly wage was **$1,379.86**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **no** dependent children.

Respondent shall be given a credit of **$5,125.21** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,125.21**.

Respondent's possible entitlement to a credit under Section 8(j) of the Act **is deferred**.

ORDER

Respondent shall authorize and pay for left total knee arthroplasty, as recommended by Dr. Daniel Kuesis.

Case number 12 WC 17796 and case number 12 WC 17797 are severed.

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

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

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

Signature of Arbitrator

November 8, 2014
Date

ICArbDec19(b)

NOV 10 2014

FACTS

Petitioner has been employed with Respondent over 37 years. He is a Receiving Dock Lead, whose job duties include unloading supplies from trucks and delivering them within the hospital. He operates equipment

and physically handles up to 150 pounds. Petitioner injured his left knee on January 06, 2011 when he stepped down from a forklift. Petitioner was initially treated at Alexian Brothers Occupational Health Clinic for a left knee strain. Petitioner received anti-inflammatories, pain medication, physical therapy, work restrictions, an MRI and referral to orthopedics (PX1). Petitioner began orthopedic treatment with Dr. Daniel Kuesis on March 14, 2011, who diagnosed a medial collateral ligament sprain and prescribed Tramadol, Mobic, as well as physical therapy (PX3, p57).

Dr. Kuesis injected the left knee with Kenalog and Lidocaine on April 06, 2011 for inflammation and chondral damage (PX3, p56). Dr. Kuesis recommended Supartz injections for osteoarthritis on May 09, 2011 (PX3, p 55). Dr. Kuesis performed five Supartz injections to the left knee from July 20, 2011 through August 17, 2011, noting mechanical symptoms, no significant progression of arthritis, and minimal degenerative changes (PX3, pp49-53). Petitioner continued to have severe pain on September 09, 2011, and arthroscopy was recommended (PX3, p48).

Left knee surgery, performed by Dr. Kuesis on October 06, 2011, included a partial medial menisectomy, patellar chondroplasty, femoral chondroplasty and synovectomy of the medial and lateral gutters, suprapatellar pouch and femoral fat pad (PX3, pp46-47).

Dr. Kuesis noted significant chondral damage and prescribed physical therapy on October 13, 2011 (PX3, p45). Dr. Kuesis recommended six more weeks of therapy and restricted Petitioner to desk duties on October 31, 2011 (PX3, p44). Dr. Kuesis administered another Kenalog and Lidocaine injection on December 12, 2011 (PX3, p43).

Dr. Kuesis noted severe pain, grinding and catching on January 09, 2012. Dr. Kuesis recommended holding off on knee replacement as long as possible, and he recommended Ibuprofen, physical therapy and desk duty (PX3, p42). Dr. Kuesis fitted and supplied a custom knee brace on February 16, 2012 (PX3, p41). Dr. Kuesis recommended Orthovisc injections on April 02, 2012, and four were administered from May 07 through June 04, 2012 (PX3, pp24-34).

Petitioner attended physical therapy for his left knee at Core Physical Therapy, from March 26, 2011 through March 31, 2011, May 14, 2011 through June 17, 2011 and October 12, 2011 through October 21, 2011 (PX4). Petitioner had further therapy at Athletico, from October 06, 2011 through July 19, 2012 (PX5).

Dr. Cirrincione examined Petitioner on January 23, 2012 and noted ongoing symptoms (PX6, p4).

Dr. Kuesis ordered an FCE on June 27, 2012 and noted that advancing arthritis will require knee replacement surgery (PX3, p23). Dr. Kuesis recommended knee replacement surgery on August 13, 2012 and work restrictions per an FCE including medium demand level with occasional standing and walking, no kneeling or crouching, and avoiding ladders and heights (PX3, p21). Petitioner last saw Dr. Kuesis on September 09, 2013, who repeats his work restrictions and recommends left total knee arthroplasty (PX7, DX5).

Dr. Kuesis testified at an evidence deposition regarding the medical treatment and recommendations, and he opined that the current condition of ill-being is causally related to the injury (PX7, p21).

Petitioner was temporarily totally disabled from March 14, 2011 through March 23, 2011 and from October 06, 2011 through November 06, 2011 (AX1). Petitioner testified that he has been working at full duty. Petitioner testified that he has pain in his left knee every night.

Dr. Jay Levin performed two examinations for Respondent. Following the first examination on March 21, 2011, Dr. Levin concurred with the treatment (RX1, DX2 and DX3). Following the second examination on March 12, 2012, Dr. Levin reported Petitioner at MMI and did not recommend left knee replacement surgery (RX1, DX4 and DX5). Dr. Levin testified at an evidence deposition regarding the examinations and his opinions (RX1, p35).

CAUSATION

Petitioner had no history of left knee injury or complaints over a long standing career with Respondent, until the stipulated accident on January 06, 2011. Petitioner's credible testimony and his medical records

document continuing and worsening complaints thereafter. Dr. Kuesis opined in persuasive deposition testimony that there is a causal relationship.

To the extent that Dr. Levin has contrary opinions, they are not persuasive. The Arbitrator notes that so far nothing

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury.

PROSPECTIVE MEDICAL TREATMENT

Respondent's dispute on this issue is premised essentially on causation, which has been resolved in favor of Petitioner. The Arbitrator notes that despite all of the prior medical treatment, the symptoms persist.

Therefore, the Arbitrator finds that Petitioner's is entitled to the requested total knee replacement surgery.

SEVERANCE

Case number 12 WC 17796 for a left knee injury is consolidated with case number 12 WC 17797 for a subsequent left wrist fracture. Consolidation for docketing is not consolidation for trial. The findings herein are limited to case number 12 WC 17796.

Case number 12 WC 17796 and case number 12 WC 17797 are hereby severed.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENT BROOKMAN,

Petitioner,

vs. NO: 09 WC 42991

STATE OF ILLINOIS / MENARD CORRECTIONAL CENTER,

15IWCC0707

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, medical expenses and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on September 30, 2009, for the reasons stated below.

The Petitioner worked as a correctional officer for Respondent since 1992. While he was promoted several times into more supervisory positions, he testified that he continued to perform many of the same duties, though not as often. This included keying doors, cranking a crank box to open cell doors, rap bars, gripping and pulling heavy cell doors, keying and cuff/uncuffing handcuffs. He testified he began to develop symptoms of night waking with hand numbness.

Petitioner initially sought treatment with Dr. Brown on September 30, 2009. He reported a five year history of pain, numbness and tingling in both hands radiating up the arms, as well as night waking with symptoms. He told Dr. Brown he worked for Respondent since 1992, as a sergeant until about 1.5 years prior, and that as a sergeant he would open/close, lock/unlock cell doors up to 1,000 times per day. In his last 10 months as a lieutenant he reported doing about 4 hours per day of computer use. Physical examination was essentially normal except for some

15IWCC0707

bilateral discomfort with direct compression testing over the median and ulnar nerves. Dr. Brown opined that Petitioner had some symptoms consistent with bilateral carpal tunnel syndrome. Petitioner was prescribed wrist splints and prescribed EMG testing with Dr. Phillips that same day. Dr. Brown noted the September 30, 2009 EMG testing was negative for both cubital and carpal tunnel syndrome. He recommended observation, with a reevaluation in 4 to 6 months if the Petitioner didn't improve or worsened. (Px3).

Petitioner testified that September 30, 2009 was the first time he was made aware, by Dr. Brown, that he had a work related condition. He subsequently completed workers compensation paperwork with Respondent on October 23, 2009. (Rx3). Dr. Fuentes, who appears to be the Respondent's facility physician, on October 23, 2009 noted a 10 year history of bilateral carpal tunnel symptoms. (CMS "Initial Workers' Compensation Medical Report", Rx3).

Petitioner next sought treatment with Dr. Mirly on February 28, 2013. The Petitioner complained of the bilateral hands, primarily numbness into the ring and small finger, noting this occurred at night and often when he fell asleep or rested his elbows on objects. He denied significant symptoms in a median nerve distribution. Reporting complaints of the entire arm occasionally going numb, particularly when sleeping on his stomach with his arm overhead, Dr. Mirly advised this was more suggestive of dead arm syndrome or an embarrassment of the blood supply. He noted Petitioner was well-developed, an obvious weight lifter and that he could have muscular compression. (Px5).

Dr. Mirly referred Petitioner to Dr. Goldring for repeat EMG on September 25, 2014, and the test reflected evidence of mild to early right-sided median neuropathy. Dr. Mirly's report of October 2, 2014 indicated that Petitioner is ambidextrous. He noted that the EMG was essentially normal with a small degree of slowing of the orthodromic sensory latency of the median nerve, but that the symptoms were primarily of ulnar neuropathy. Given the EMG findings and a lack of weakness in the arms, Dr. Mirly did not believe surgery was indicated. (Px5). Barring a worsening of the symptoms, surgery was "not strongly recommended". Petitioner last treated with Dr. Mirly in October, 2014. At that time his opinion was that Petitioner's bilateral symptoms were indicative of cubital tunnel syndrome more than carpal tunnel, and that he could have an element of "dead arm syndrome". Following the September 25, 2014 EMG test, he continued to opine Petitioner's symptoms were primarily of an ulnar neuropathy as opposed to a median neuropathy. (Px5).

Petitioner submitted a job analysis for a correctional officer (Px5) and a job video (Px8) into evidence. The Petitioner also submitted a report (Px9) and deposition transcript (Px10) of Dr. Anthony Sudekum. The Sudekum report was prepared on behalf of the Respondent with regard to the general job duties performed by correctional officers at the Menard Correctional Center, and he was asked to comment on the possible causative effect of their job duties on the development of repetitive trauma injuries.

Dr. Sudekum reviewed a job analysis report for a correctional officer at Respondent's facility, and indicated he toured the facility himself and both watched officers performing the duties as well as performing many of the duties himself. (Px9). He opined that the job duties could contribute to upper extremity repetitive trauma injuries. He testified that bar rapping and regular operation of abnormal and/or difficult locks were the primary possible causative factors. (Px10). Petitioner testified that the job analysis reviewed by Dr. Sudekum was accurate. (Tr. 32-33).

The Respondent did not obtain any independent medical examinations of Petitioner pursuant to Section 12 of the Act, and did not submit any evidence rebutting or refuting the opinions of the Petitioner's treating physicians.

Based on the totality of the evidence and our factual findings above, we find that the Petitioner sustained accidental bilateral upper extremity injuries arising out of and in the course of his employment with Respondent. While it appears that the activities that could have contributed to his upper extremity conditions have been reduced as Petitioner has been promoted through the ranks of correctional officer, it also appears that the Petitioner has continued to work for a significant number of years with symptoms. As stated in the seminal case of *Peoria Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026, 106 Ill.Dec. 235 (1987): "We believe the purpose behind the Workers' Compensation Act is best served by allowing compensation in a case like the instant one 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". The Court also noted in *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918, 930, 308 Ill.Dec. 715 (2006): "We decline to penalize an employee who diligently worked through progressive pain until it affected (his) ability to work and required medical treatment."

Here, it appears that the Petitioner simply continued to work despite ongoing symptoms. We find the manifestation date in this case to be September 30, 2009, as we believe this to be the date upon which both the fact of the injury and the causal connection to claimant's work would have become plainly apparent to the reasonable person. (See *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 510 N.E.2d 502, 508, 109 Ill.Dec. 634 (1987)). This is based on the fact that this was the first medical visit for Petitioner, the first time he was given a specific diagnosis, and the first time, per his testimony, that he understood his job duties could be causative of the medical condition diagnosed.

The Petitioner reported his injuries to Respondent on October 23, 2009, which is well within the 45 day requirement for notice to Respondent pursuant to Section 6(c) of the Act.

The Petitioner has also sustained his burden of proof with regard to the issue of causation. In making this finding, we rely on the opinions of Dr. Brown (Px3) and Dr. Sudekum (Px9; Px10) in finding that Petitioner's work duties were a causative factor in the development of

Petitioner's upper extremity conditions. There may have been other contributing causes, possibly weightlifting, but we believe and find that the work duties contributed to the conditions.

Based on our findings regarding accident and causation, the Petitioner is entitled to payment of the causally related medical expenses contained in Petitioner's Exhibit 1, subject to the Medical Fee Schedule. Respondent is entitled to credit for any bills paid prior to hearing.

The Petitioner continued working from 2009 through the December 19, 2014 hearing date, and testified that he had recently been promoted to Adjustment Committee Lieutenant. He testified that the job involves typing up forms, and one to two days per week he is required to work in a jail gallery or wing. He also sometimes has to work "front street", which involves using keys to open locks and doors. He continues to note paresthesias in the arms and hands, and occasional shooting pain, and that he takes ibuprofen at times. (Tr. 29-33).

Given the evidence in the record, it is difficult to determine exactly what conditions Petitioner has been formally diagnosed with. He was initially found by Dr. Brown to have a likely diagnosis of carpal tunnel syndrome. Dr. Mirly, on the other hand, believed that Petitioner more likely suffered from cubital tunnel syndrome, along with possible "deal arm syndrome". No surgeries have been recommended, and there is no indication of any specific future treatment recommendations. As noted, the Petitioner has not alleged any lost time from work as a result of the injuries. He also has moved into a position that, while sometimes requiring him to perform the duties which Dr. Sudekum indicated could contribute to upper extremity repetitive trauma injuries, no longer requires him to perform said duties as often. We believe the evidence indicates evidence of both carpal and cubital tunnel bilaterally, but in mild form. As such, we find that Petitioner sustained the loss of use of 2.5% of the left arm and 2.5% of the right arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed, as indicated above, and the Commission finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on September 30, 2009.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses listed and contained in Petitioner's Exhibit 1 pursuant to §§8(a) and 8.2 of the Act, and Respondent is entitled to credit for any awarded bills that were paid prior to the December 19, 2014 hearing date.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week, the maximum allowable permanency rate, for a period of 12.65 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 2.5% of the left arm and 2.5% of the right arm.

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

15IWCC0707

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including any and all awarded medical expenses that were previously paid; any medical credit is limited as noted above.

DATED: SEP 10 2015
TJT: pvc
O 07/20/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Barbara Keske,

Petitioner,

vs.

NO. 13WC021313

15IWCC0728

Adecco USA,

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, prospective medical, 8(j)credit, permanent disability, temporary disability, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2015 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.

15IWCC0728

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 23 2015
SJM/sj
o-8/6/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KESKE, BARBARA
Employee/Petitioner

Case# **13WC021313**

15IWCC0728

ADECCO USA
Employer/Respondent

On 2/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2904 HENNESSY & ROACH PC
PAUL BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Barbara Keske
Employee/Petitioner

Case # **13** WC **21313**

v.

Adecco, USA
Employer/Respondent

15IWCC0728

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **December 3, 3014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0728

FINDINGS

On **May 31, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**29,162.12**; the average weekly wage was $**560.81**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **5** dependent children.

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

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

Respondent shall be given a credit of $**6,743.09** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,743.09**.

Respondent is entitled to a credit of $**38,122.92** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**373.87**/week for **16 6/7** weeks, commencing **July 3, 2013** through **October 28, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**6,743.09** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**336.49/week** for **9.58** weeks, because the injuries sustained caused **1%** loss of her right hand, **1%** loss of her right arm, and **1%** loss of her person-as-a-whole as provided in Sections 8(e) and 8(d)2 of the Act.

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

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

Arbitrator Anthony C. Erbacci

January 30, 2015
Date

FEB 4 - 2015

15IWCC0728

FACTS:

On May 31, 2013 the Petitioner sustained undisputed accidental injuries which arose out of and in the course of her employment with the Respondent. The Petitioner testified that she was employed by the Respondent as a janitor and that, as part of her job duties, she was required to operate a side by side floor buffer. The Petitioner testified that on May 31, 2013 she plugged in the floor buffer and it "took off". The Petitioner explained that, unbeknownst to her, the on/off switch of the machine had been duct taped in the on position and when she plugged the machine in it began moving around. She testified that as she attempted to unplug the machine, she was struck by the machine multiple times and pushed into a locker before the machine was ultimately brought to a stop. The Petitioner testified that she was struck by the machine on her right arm, hand and thumb, her right shoulder, and her left knee and ankle. The Petitioner testified that an accident report was completed but that she could not remember the details of that report. An Employer's First Report of Injury was completed on June 7, 2013.

The Petitioner testified that on the day following the incident she noticed bruising on her right shoulder and that, thereafter, she began to experience pain and popping in her right shoulder. The Petitioner testified that she returned to work on the Monday following her injury and that she ultimately sought medical treatment at OSF Occupational Health, where she was directed by her employer.

The records of OSF Occupational Health Network demonstrate that the Petitioner was seen there on June 7, 2013 and gave a consistent history of being struck by a floor buffer. The Petitioner was noted to have complaints of pain in both legs and her right upper extremity. She was noted to have bruising below her knees to her ankles, a small abrasion on the left leg, bruising on the right hand and elbow and difficulty with range of motion of the right shoulder. It was also noted that the Petitioner "has been working and walking since the incident." X-rays of the right hand, wrist and shoulder were performed and the Petitioner was prescribed medication and given work restrictions of waist level work only with the right upper extremity and no gripping, pushing or pulling with the right upper extremity.

The Petitioner returned to OSF Occupational Health on June 14, 2013 and was noted to complain of pain in her right hand, elbow and shoulder as well as her left ankle. The Petitioner was continued on the same medication and work restrictions and she was referred for physical therapy at Advanced Rehab. The Petitioner attended one physical therapy session on June 17, 2013 and she did not return to Advanced Rehab thereafter.

On June 19, 2013 the Petitioner returned to OSF Occupational Health complaining of increased pain in her right shoulder and hand, as well as her right ankle and right knee, since going to physical therapy. The Petitioner was prescribed additional medications, a hinged knee brace, and continued physical therapy. The records of Advanced Rehab demonstrate that the Petitioner was discharged from physical therapy on July 17, 2013 because she did not return after her initial session.

On June 26, 2013 the Petitioner saw Dr. Gregory Schierer at Galesburg Orthopedics. It appears from the record of that visit that the Petitioner was following up for complaints of bilateral knee pain. The Petitioner's complaints were noted to include pain, swelling, stiffness, and instability in her right knee and it was noted that the onset of the symptoms was "Following and injury." It was also noted that the Petitioner reported that she was working full time without restrictions as a fork lift driver and that she could not take time off work to have surgery because of economic reasons. Dr. Schierer diagnosed the Petitioner as having internal derangement of the posterior horn of the medial meniscus and patellar chondromalacia in her right knee and he noted that she needed a right knee arthroscopy. Dr. Schierer also noted that the Petitioner was fit for unrestricted work.

On July 3, 2013 the Petitioner sought treatment with Dr. Blaire Rhode on referral from her attorney. The Petitioner gave a history of injury consistent with her testimony and complained of right knee pain, right hand pain, right elbow pain, and right shoulder pain and weakness. It was noted that the Petitioner had previously been diagnosed with a right knee medial meniscus tear and had undergone a ligament reconstruction in her left ankle when she was in college. Dr. Rhode indicated that the Petitioner had sustained multiple contusions as a result of her work injury and that she demonstrated evidence of a right shoulder rotator cuff tendinopathy lateral meniscus symptoms in her right knee, and left ankle and right hand contusions. Dr. Rhode ordered an MRI of the Petitioner's right shoulder and knee and he prescribed her off work. The Petitioner followed up with Dr. Rhode on September 25, 2013 and October 9, 2013, and Dr. Rhode continued to prescribe her off work pending the results of the MRIs.

On October 7, 2013 the Petitioner was examined by Dr. Lawrence Li at the request of the Respondent. Dr. Li noted the Petitioner's history of injury and treatment and her complaints of pain in her right shoulder, elbow, wrist, and hand. Dr. Li opined that the Petitioner sustained a right hand contusion, a right wrist contusion, a right elbow contusion and likely a right shoulder contusion as the result of her work accident and he opined that the Petitioner was at maximum medical improvement with regard to her right hand contusion, right wrist contusion, and her right elbow contusion. With regard to her left shoulder, Dr. Li agreed that the Petitioner required an MRI to evaluate for a rotator cuff injury and he opined that if the MRI was negative, the Petitioner had reached maximum medical improvement with regard to her right shoulder. Dr. Li further opined that the medical treatment the Petitioner had received to that point was reasonable and necessary. Dr. Li also reported that he performed an impairment rating for the Petitioner's right wrist, right hand and right elbow and found that the Petitioner sustained 0% upper extremity impairment.

On October 16, 2013, the Petitioner underwent a right shoulder MRI which was reported to demonstrate marked tendinosis with a probable small longitudinally orientated split type tear in the region of the musculotendinous junction supraspinatus tendon; several small foci of fluid intensity with the largest insinuated along the fascial plane between the supraspinatus and infraspinatus muscles; a small amount of fluid in the subacromial/subdeltoid bursa possibly related to bursitis; and extensive subcutaneous soft tissue edema about the upper anterior, posterior and superior subcutaneous soft tissues of

the right shoulder. On October 17, 2013, the Petitioner also underwent a right knee MRI which was reported to demonstrate evidence of only degenerative changes.

On October 23, 2013, the Petitioner followed up with Dr. Rhode for her complaints of knee pain, shoulder pain, elbow pain, ankle pain, low back pain, and hand pain. Dr. Rhode indicated that the Petitioner's shoulder MRI showed a high grade partial thickness tear of the supraspinatus tendon and a paralabral cyst which was "suspicious for superior labral tear". Dr. Rhode's impression of the Petitioner's right knee MRI was central edema medial femoral condyle. Dr. Rhode injected the Petitioner's shoulder with Kenolog and Lidocaine and he continued the Petitioner off work and provided her with Norco.

On October 28, 2013, Dr. Li authored an addendum report after reviewing the Petitioner's October 16, 2013, right shoulder MRI. Dr. Li opined that the Petitioner's MRI showed a ganglion cyst and significant tendinosis in the rotator cuff tendon, but no evidence of a full-thickness tear or tendon retraction. Dr. Li opined that the longitudinal orientated linear tear would be extremely unlikely to have been caused by the Petitioner's work injury. Dr. Li did not believe the ganglion cyst was related to the Petitioner's May 31, 2013, work accident. Dr. Li opined that the Petitioner did not need any further treatment related to her right shoulder.

On November 6, 2013, the Petitioner followed up with Dr. Rhode and Dr. Rhode recommended a shoulder arthroscopy, subacromial decompression and probable rotator cuff repair. On December 10, 2013 Dr. Rhode performed a subacromial decompression and synovectomy on the Petitioner's right shoulder. In his operative report, Dr. Rhode noted that he removed a subacromial spur, performed a subacromial decompression and inspected the rotator cuff which showed evidence of mild to moderate tendinopathy. No rotator cuff repair was performed.

On January 30, 2014, Dr. Li authored a second addendum report after reviewing Dr. Rhode's December 10, 2013, surgical note. Dr. Li opined that the Petitioner's rotator cuff tendinopathy found at the time of surgery was not related to her May 31, 2013, work accident. Dr. Li noted that tendinopathy is a degenerative condition. Dr. Li noted that he had reviewed Dr. Rhode's surgical note and he opined that the Petitioner's right shoulder surgery was related to her underlying tendinopathy and not her May 31, 2013, work accident.

On February 12, 2014, the Petitioner followed up with Dr. Rhode. Dr. Rhode recommended formal physical therapy and continued to keep the Petitioner off of work. The Petitioner did not undergo any physical therapy by her three month follow up with Dr. Rhode on March 26, 2014. The Petitioner testified that she never underwent physical therapy because of difficulties with transportation.

On June 4, 2014, the Petitioner presented to Dr. Rhode 6 months post surgery. Dr. Rhode opined that the Petitioner had permanent work restrictions of medium duty work and no overhead lifting over 10/20 pounds.

On June 9, 2014, Dr. Rhode performed an impairment rating. Dr. Rhode opined that the Petitioner was at Maximum Medical Improvement and sustained 1% whole person impairment as a result of her work injuries. Dr. Rhode affirmed his prior opinion that the Petitioner had permanent work restrictions of medium duty work and no overhead lifting over 10/20 pounds.

On August 4, 2014, Dr. Li examined the Petitioner for a second time for the purpose of providing an impairment rating. Dr. Li noted that he reviewed all of the Petitioner's records as part of his examination and report and he reported that the Petitioner sustained 0% whole person impairment as a result of her December 10, 2013, right shoulder surgery. Dr. Li reiterated his opinion that the Petitioner's surgery was not related to her work accident.

Dr. Rhode's June 18, 2014 deposition testimony was admitted into the record as Petitioner's Exhibit 13. Dr. Rhode testified as to the history that the Petitioner provided to him and the course of treatment he rendered to the Petitioner. Dr. Rhode testified he performed a right shoulder arthroscopy on December 10, 2013. Dr. Rhode testified that he performed a subacromial decompression of a 7 millimeter spur; that the Petitioner did not have a labral tear and; that her rotator cuff did not require any formal repair. Dr. Rhode opined that the Petitioner's work accident "was causative to" the Petitioner's shoulder symptomatology and that the Petitioner sustained a contusion to her right knee as a result of her work accident. Dr. Rhode testified that the last time he saw the Petitioner was in March 2014 and, at the time of his testimony, he was not sure what the Petitioner's current work status was.

Dr. Li's September 29, 2014 deposition testimony was admitted into the record as Respondent's Exhibit 2. Dr. Li testified as to the history of injury the Petitioner provided to him, the medical records he reviewed and the findings of his two examinations of the Petitioner. Dr. Li testified that, as a result of her work accident, the Petitioner sustained a right hand contusion, a right wrist contusion, a right elbow contusion and a right shoulder contusion. Dr. Li opined that the Petitioner was at Maximum Medical Improvement for her right hand, right wrist and right elbow contusions on July 31, 2013 and he reported that the Petitioner sustained 0% upper extremity impairment from her right wrist, right hand and right elbow contusions.

Dr. Li testified that he reviewed the Petitioner's October 16, 2013, right shoulder MRI and he opined that it did not demonstrate that the Petitioner had a rotator cuff tear. Dr. Li testified that there was possibly a longitudinal split-type tear, but that the tear pattern would be very unlikely to have been caused by being hit on the shoulder as described by the Petitioner, and would heal itself. Dr. Li opined that the Petitioner was at Maximum Medical Improvement for her right shoulder contusion by the time of his letter on October 28, 2013. Dr. Li opined that the Petitioner's rotator cuff tendinopathy, for which Dr. Rhode performed surgery, was not in any way related to the Petitioner's May 31, 2013, work injury. Dr. Li testified that tendinopathy is a degenerative condition and that getting hit by a floor scrubber would not cause tendinopathy. Dr. Li testified that the need for the surgery that Dr. Rhode performed for the Petitioner's impingement syndrome would not be caused by her work injury. Dr. Li also testified that when he examined the Petitioner, she was showing evidence of cogwheeling and

pain with palpation everywhere which was indicative of the Petitioner magnifying her symptoms. Dr. Li testified that he prepared an impairment rating for the Petitioner's right shoulder following the surgery performed by Dr. Rhode and that the Petitioner had 0% whole person impairment.

The Petitioner testified that she currently continues to experience weakness, numbness, and a burning sensation in her right thumb as well as weakness in her right knee. The Petitioner further testified that she currently continues to experience weakness and a burning sensation in her right shoulder. The Petitioner acknowledged that she had a prior injury to her right knee in December of 2012 when a car backed into her and struck her knee.

CONCLUSIONS:

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

Dr. Rhode and Dr. Li agree that the Petitioner sustained contusions to her right hand, right wrist, right elbow and right shoulder as a result of her work accident. Dr. Rhode also opined that the Petitioner sustained a right knee contusion as a result of her work accident. Dr. Li rendered no opinion with regard to the Petitioner's right knee. Neither doctor opined that the Petitioner sustained any injury to her left knee, or any other part of her body, nor is there any evidence that she obtained any medical treatment for her left knee or any other part of her body.

With regard to the Petitioner's right knee, the Petitioner acknowledged that she had a prior injury to her right knee when she was struck by a car in December of 2012. She described that injury as a "contusion". The records of OSF Occupational Health reflect that the Petitioner did report bilateral leg pain when she was first seen on June 7, 2013, and that she again had right knee complaints and was prescribed a hinged knee brace when she was seen at OSF Occupational Health on June 19, 2013. The records of Dr. Schierer, whom the Petitioner saw on June 26, 2013, indicate, however, that the Petitioner had been seen previously for her right knee complaints, that she was diagnosed as having internal derangement in the knee, and that a right knee arthroscopy had been recommended for her. The "injury" that led to the onset of the Petitioner's right knee complaints is not described in Dr. Schierer's records and there is no indication that it was a work injury. No opinion as to the cause of the Petitioner's right knee condition is contained in Dr. Schierer's records. Dr. Schierer also noted that the Petitioner reported that she was working full time without restrictions and that she was fit for unrestricted work.

When the Petitioner first saw Dr. Rhode on July 3, 2013, Dr. Rhode noted that the Petitioner was previously diagnosed with a medial meniscus tear, but developed lateral joint line symptoms after her work accident. Dr. Rhode testified that the Petitioner's right knee MRI revealed pre-existing degenerative changes and he ultimately opined that the Petitioner sustained a right knee contusion as a result of her work accident.

15IWCC0728

The Arbitrator notes that the Petitioner's testimony as to her right knee condition and Dr. Rhode's opinions as to the Petitioner's right knee condition are not consistent with the information contained in Dr. Schierer's records. The Arbitrator also notes that the records of the treatment the Petitioner received for her prior right knee injury were not offered into the record. Thus, the Arbitrator questions the reliability of the Petitioner's testimony regarding her right knee condition and the opinions of Dr. Rhode regarding the Petitioner's right knee condition. Thus, the Arbitrator concludes that the Petitioner failed to prove any right knee condition of ill-being which is causally related to the Petitioner's work injury.

With regard to the Petitioner's left shoulder, Dr. Rhode opined that the Petitioner's work accident "was causative to" the Petitioner's shoulder symptomatology and that the surgery he performed was necessitated by her symptomatology. Dr. Li opined, however, that the Petitioner's rotator cuff tendinopathy, for which Dr. Rhode performed surgery, was a degenerative condition and was not in any way related to the Petitioner's May 31, 2013, work injury. Dr. Li also opined that the Petitioner was magnifying her symptoms.

The Arbitrator finds the opinions of Dr. Li to be more reliable, credible and persuasive in the instant matter than those of Dr. Rhode. In so finding, the Arbitrator notes that Dr. Li reviewed all of the Petitioner's MRI films and records and had a sufficiently reliable basis for his opinions. Dr. Li examined the Petitioner on two separate occasions, as well as authoring two addendum reports during the course of the Petitioner's treatment. Dr. Li testified that he reviewed the Petitioner's October 16, 2013, right shoulder MRI and that he did not believe the Petitioner had a labral tear or rotator cuff tear. This was confirmed by Dr. Rhode when he testified that the Petitioner did not have a labral tear and that her rotator cuff did not require any formal repair. Dr. Li opined that the Petitioner's rotator cuff tendinopathy, for which Dr. Rhode performed surgery, was not in any way related to the Petitioner's May 31, 2013, work injury. Dr. Li opined that tendinopathy is a degenerative condition and getting hit by a floor scrubber would not cause or aggravate tendinopathy. Dr. Rhode testified he performed a subacromial decompression of a 7 millimeter spur for the Petitioner's impingement syndrome. Dr. Li testified that the need for surgery for the Petitioner's impingement syndrome would not be caused by her work injury. Dr. Li explained the impingement syndrome is typically caused by a person doing repetitive overhead work and that being hit by a scrubber would not cause impingement syndrome. Dr. Rhode opined merely that the Petitioner's work accident was causative to her symptoms.

Based upon the foregoing, and having considered the totality of the reliable credible evidence adduced at hearing, the Arbitrator adopts the opinions of Dr. Li and finds that the Petitioner sustained a right hand, right wrist, right elbow and right shoulder contusions as a result of her work accident of May 31, 2013. The Arbitrator finds that the Petitioner reached maximum medical improvement for her right hand, right wrist and right elbow contusions as of July 31, 2013 and that the Petitioner reached maximum medical improvement for her right shoulder contusion as of October 28, 2013. The Arbitrator further finds that the Petitioner failed to prove she sustained an injury to any other part of her body as a result of her work accident of May 31, 2013.

15IWCC0728

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

The findings and conclusions of the Arbitrator with regard to causal connection are adopted and incorporated herein. The Arbitrator finds that the Petitioner failed to prove that the medical treatment she received after October 28, 2013 was necessary and causally related to her work accident of May 31, 2013. The Arbitrator finds that, pursuant to the parties' stipulation and Respondent's Exhibit 1, the Respondent has paid all reasonable and necessary medical expenses related to the Petitioner's right hand, right wrist, right elbow and right shoulder contusions.

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

The findings and conclusions of the Arbitrator with regard to causal connection are adopted and incorporated herein.

The Petitioner claims to be entitled to Temporary Total Disability benefits from May 31, 2013, the date of her work injury, through June 4, 2014, the date Dr. Rhode indicated she had permanent work restrictions. The Arbitrator notes, however, that the Petitioner's testimony as to when she stopped working for the Respondent was vague and her claimed inability to work after May 31, 2013 is contradicted by her personnel records and the medical records.

The Petitioner's testimony, the records of OSF Occupational Health and the notes in the Petitioner's Personnel records demonstrate that the Petitioner continued to work until at least June 5, 2013. The Petitioner testified that she returned to work on the Monday following her accident and that she continued to work for some period of time. The Petitioner's personnel records indicate that she stopped working for the Respondent on June 7, 2013 when she reported her injury and was advised that that no assignment to a different job could be offered until she was cleared to work by her doctor. When the Petitioner was seen at OSF Occupational Health Network on June 7, 2013 she was placed on work restrictions of waist level work only with the right upper extremity and no gripping, pushing or pulling with the right upper extremity. There is no evidence that the Petitioner requested or was offered any work within those restrictions at that time. When the Petitioner was seen by Dr. Schierer on June 26, 2013, it was noted that the Petitioner reported that she was working full time without restrictions as a fork lift driver. On July 3, 2013 the Petitioner began treating with Dr. Rhode and he prescribed her off work at that time. Dr. Rhode continued to prescribe the Petitioner off work until June 4, 2014, when he opined that the Petitioner had permanent work restrictions of medium duty work and no overhead lifting over 10/20 pounds.

Dr. Li opined that with regard to her right hand contusion, right wrist contusion, and

15IWCC0728

right elbow contusion the Petitioner the Petitioner was at maximum medical improvement when he saw her on October 7, 2013. With regard to the Petitioner's right shoulder, Dr. Li opined that the Petitioner had reached maximum medical improvement as of October 28, 2013 and was capable of returning to work.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner was entitled to Temporary Total Disability benefits from July 3, 2013, when she was taken off work completely by Dr. Rhode, through October 28, 2013, the date she was determined by Dr. Li to have reached maximum medical improvement from her injuries.

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

The Petitioner's work accident occurred after September 1, 2011. Therefore, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The level of impairment reported by a physician licensed to practice medicine in all of its branches which includes an evaluation of medically defined and professionally appropriate measurements of impairment that establish the nature and extent of the impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

* the occupation of the injured employee:

* the age of the employee at the time of the injury;

* the employee's future earning capacity; and

* evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability and the relevance and the weight of any factors used in addition to the level of impairment as reported by the physician must be explained.

In the instant case, the Petitioner suffered right hand, right wrist, right elbow and right shoulder contusions as a result of her work accident of May 31, 2013.

With regard to the reported level of impairment pursuant to Section 8.1(b), the level of impairment reported by Dr. Li pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment is 0% whole person impairment for the Petitioner's shoulder condition and 0% upper extremity impairment for the Petitioner's right hand, right

wrist and right elbow conditions. The Arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act and is only one factor to be considered in making such a disability evaluation. The Arbitrator notes that in the instant matter, the Petitioner had subjective complaints without definitive objective findings. Dr. Li opined that the Petitioner was showing evidence of symptom magnification and the Arbitrator has questioned the reliability of the Petitioner's testimony. The Arbitrator believes that, in the instant matter, an impairment rating is an important factor determining disability due to the Petitioner's subjective complaints. The Arbitrator therefore gives great weight to this factor.

With regard to the occupation of the injured employee, the Petitioner's occupation at the time of the accident was that of a maintenance worker. The Petitioner is able to return to work in her prior capacity and her injuries have not impaired her ability to perform her occupation. Thus, the Arbitrator concludes that the Petitioner's occupation is not a significant factor in determining the Petitioner's disability in the instant matter.

With regard to the age of the employee at the time of injury, the Petitioner was 40 years old at the time of the accident. Because of the Petitioner's age, her contusions would be expected to resolve quickly and will not have any long-term effect on the Petitioner's health. Thus, the Arbitrator concludes that the Petitioner's occupation is not a significant factor in determining the Petitioner's disability in the instant matter.

With regard to the employee's future earning capacity, the Arbitrator notes that there was no evidence introduced into the record which indicates that the Petitioner's future earning capacity would be affected by her work accident and subsequent injuries. Thus, the Arbitrator concludes that the Petitioner's future earning capacity is not a significant factor in determining the Petitioner's disability in the instant matter.

With regard to the evidence of disability corroborated by the treating medical records, the Petitioner testified that he currently experiences weakness, numbness, and a burning sensation in her right thumb as well as weakness in her right knee. The Petitioner further testified that she currently continues to experience weakness and a burning sensation in her right shoulder. These subjective complaints are not corroborated in the records of the Petitioner's medical treatment. The Petitioner's complaints as supported by the medical records, evidences that her work injury resulted in minimal, if any, permanent disability as indicated by Commission decisions regarded as precedent pursuant to Section 19(e).

The determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, having considered the factors enumerated in Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), the Arbitrator finds that as a result of her accidental injuries the Petitioner has sustained permanent partial disability to the extent of 1% loss of her right hand, 1% loss of her right arm, and 1% loss of her person-as-a-whole as provided in Sections 8(e) and 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larissa Bryant,
Petitioner,
vs.
Hyatt Regency McCormick Place,
Respondent,

NO: 09 WC 28770

15IWCC0733

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 6, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,000.00. 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: SEP 2 4 2015

MB/mam
o:7/30/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRYANT, LARISSA
Employee/Petitioner

Case# **09WC028770**

15IWCC0733

HYATT REGENCY McCORMICK PLACE
Employer/Respondent

On 11/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0704 SANDMAN LEVY & PETRICH
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
JAMES MORAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0733

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

Larissa Bryant
Employee/Petitioner

v.

Hyatt Regency McCormick Place
Employer/Respondent

Case # **09** WC **28770**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 25, 2014**. 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

15IWCC0733

On **July 3, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,924.84**; the average weekly wage was $**383.17**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay $**26,192.44** for medical services, as provided in Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall pay Petitioner permanent partial disability benefits of $**229.90**/week for **25** weeks, because the injuries sustained caused the **5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be entitled to a credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

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

Milton Black

Signature of Arbitrator

November 6, 2014
Date

NOV 6 - 2014

FACTS

Petitioner testified that on July 3, 2009 she was employed by Respondent as a full time cafe attendant and had been in that job for about two years. Her job duties included working the cash register, stocking material, and customer service. Accident is not in dispute.

Petitioner testified that on July 3, 2009 she slipped on hand sanitizer or water and fell directly on to her low back in the employee-only restroom. An ambulance was called, and she was taken to Mercy Hospital. Petitioner complained of low back pain from a fall at work. An X-ray of her lumbar spine was done and showed mild levoscoliosis (PX2).

Petitioner presented to Dr. Zaki Anwar for an examination on July 10, 2009. Her initial complaints were of left leg numbness and low back pain from her work-injury. Her initial diagnosis was sacroilitis, coccygodynia, lumbar radiculitis and a lumbar strain. She was advised to undergo an MRI of her lumbar spine, attend physical therapy and take medications which included nonsteroidal anti-inflammatory medication, a muscle relaxant and a muscle stimulator. An MRI was performed the same day at Advantage MRI in South Holland and revealed a bulging disc at L5-S1. Dr. Anwar saw Petitioner for a follow up on July 14, 2009 and diagnosed her with lumbar disc displacement at L5-S1, and he recommended she undergo bilateral transforaminal lumbar injections at L5-S1. He further recommended she take Mobic, a non-steroidal anti-inflammatory, as well as a muscle relaxant. Petitioner underwent her first bilateral L5-S1 transforaminal injections at L5-S1 on July 17, 2009 (PX3). She testified that this injection provided relief.

She began physical therapy at Premier Physical Therapy on July 23, 2009 (PX5).

On July 29, 2009, at the request of Respondent, Petitioner presented to Dr. Jesse Butler for an in independent medical examination. Dr. Butler opined that Petitioner suffered a lumbar contusion and that the

epidural steroid injections Petitioner underwent on July 17, 2009 were not necessary. He further opined that she did not require any additional treatment. He further opined that she might benefit from a two week course of physical therapy along with some anti-inflammatory medication (RX2).

Petitioner underwent a second bilateral L5-S1 transforaminal injection at L5-S1 on July 31, 2009. She testified that this injection provided better relief than the first one. She followed up with Dr. Anwar on August 4, 2009 and he noted that the injections provided her with significant relief. He recommended that she undergo her final injections, continue her medications and physical therapy and opined she may be at maximum medical improvement in 2 weeks (PX3).

Petitioner underwent her final bilateral L5-S1 transforaminal injections at L5-S1 on August 14, 2009. The operative report states that she was given her first epidural injection with almost 50-60% relief and that she was given a second treatment with more than 60-70% relief (PX3). Petitioner testified this final injection made her feel a lot better

Dr. Anwar saw Petitioner for a follow up on August 20, 2009. He released Petitioner to return to work with a restriction of no lifting over 40 pounds. He advised her to end physical therapy and continue anti-inflammatory medication and muscle relaxants (PX3).

Petitioner was discharged from Premier Physical Therapy that same day (PX5).

Petitioner saw Dr. Anwar on September 9, 2009. She was advised to continue with anti-inflammatory medication and muscle relaxants. Petitioner saw Dr. Anwar for a final time on December 7, 2009. He noted that he believed "the patient's injuries are causally connected to the incident outlined above". He noted that all the care he recommended for Petitioner was medically necessary and in line with standard treatment guidelines with published standards of care (PX3).

Petitioner testified that she never suffered any low back pain prior to her work-injury on July 3, 2009. Petitioner testified that she still experiences low back. Petitioner testified that she gets back massages for the

pain. Petitioner testified that she no longer works for Respondent and that her subsequent employment has been sedentary in nature.

Respondent offered the testimony of Dr. Jesse Butler (RX2), Dr. Steven Blum (RX3), and Dr. Richard Adkins (RX4) to dispute the reasonableness and necessity of Petitioner's medical care. Dr. Butler had performed a medical examination. Dr. Blum and Dr. Adkins had authored utilization reviews.

CAUSATION

Petitioner's testimony regarding her back pain is corroborated by the medical records, is consistent with the sequence of events, and is corroborated by Dr. Anwar's opinions.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being causally related to the injury

MEDICAL

The Arbitrator finds that Petitioner's medical treatment has been reasonable and necessary. The medical treatment records are corroborative and well documented.

Dr. Butler's opinions are inconsistent asserting that Petitioner did not require any additional treatment and then asserting that she might benefit from a two week course of physical therapy along with some anti-inflammatory medication.

Dr. Blum testified that he based his opinions, in part, on the Official Disability Guidelines, which he admitted he does not always follow. Dr. Blum admitted that he did not review all the medical records.

Dr. Adkins testified that he based his opinions, in part, on the Official Disability Guidelines, which he admitted he does not always follow. Dr. Adkins admitted that he did not review all the medical records. Dr. Adkins, when presented with the fact that the injections did in fact help Petitioner, testified, "Well, since they helped her, of course they should have taken place, but that doesn't mean they should be paid for" (RX4, p18).

The totality of the evidence demonstrates that all of the medical care that Petitioner received was reasonable and necessary in order to relieve her from pain from the work injury. Therefore the claimed medical expenses are awarded.

NATURE AND EXTENT

Petitioner testified to the ongoing low back symptoms that she has been living with since her work injury of July 3, 2009. The actual injury and treatment are well documented.

Based upon the evidence in this case, the Arbitrator finds Petitioner has sustained a 5% loss of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shirley McCauley,
Petitioner,
vs.

NO: 11WC 34431
12 WC 9765

Illinois State University,
Respondent,

15IWCC0732

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, 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 January 5, 2015, 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.

DATED: SEP 24 2015
MJB/bm
o-09/21/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCAULEY, SHIRLEY
Employee/Petitioner

Case# **11WC034431**

12WC009765

ILLINOIS STATE UNIVERSITY
Employer/Respondent

15IWCC0732

On 1/5/2015, 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
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BLOOMINGTON, IL 61701

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 52794-9209

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

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

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

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

JAN 5 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shirley McCauley
Employee/Petitioner

Case # **11** WC **34431**

v.

Consolidated cases: **12 WC 9765**

Illinois State University
Employer/Respondent

15IWCC0732

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 8, 2011 and January4, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned $**26,325.00**; the average weekly wage was $**506.25**.

On the date of alleged accidents, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**31,343.02** under Section 8(j) of the Act.

ORDER

Petitioner's claims for compensation are denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

December 24, 2014
Date

JAN 5 - 2015

15IWCC0732

FACTS:

The Petitioner has filed two repetitive trauma claims which were consolidated for hearing. In claim number 11 WC 34431 the Petitioner alleges a left hand carpal tunnel injury on June 8, 2011, and in claim number 12 WC 9765 the Petitioner alleges a cervical injury on January 4, 2011.

The Petitioner testified that she has been employed by the Respondent as an office manager since July 1, 2002. She testified that her job duties included supervising 12-15 students at an information center, answering phone calls and opening mail, retrieving and handling personnel files, performing computer work, and storing office supplies. The Petitioner testified that she used her computer and keyboard 6 hours a day and that she used a phone approximately 10-20 times a day. She described that she would be on the phone from only a few minutes to 20 minutes or more at a time and that, while she was on the phone, she cradled the phone between her left shoulder and head so that she could use her hands to type into the computer or take messages. The Petitioner also described the filing that she did and testified that she put away office supplies once each week.

The Petitioner testified that prior to 2008 she used an office chair that she had selected for herself based upon her physical attributes. The Petitioner explained that her legs are short and that she had selected a chair which had a smaller seat, a waterfall front, and a lower height. She testified that in 2008, she was assigned to work at a new desk with a new chair that was selected by the Respondent and which was the same as the chairs used by all of the Respondent's office staff. The Petitioner described that the chair did not accommodate her short legs and that she had bad posture when she sat in the chair because of the poor fit to her body. The Petitioner described that she either had to sit all the way back in the chair or slouch in order to perform her typing. The Petitioner testified that said that after 2008, when she typed on her keyboard, she held her hands at an angle with her hands higher than her wrists.

The Petitioner testified that prior to January of 2011 she began to notice "tiredness" and "achiness" in her left shoulder and occasional numbness in her left hand. The Petitioner testified that she spoke to her supervisor, Jim Carlson, about her discomfort and asked if she could get a new chair that would accommodate her short legs and help her posture. The Petitioner testified that her request for a different chair was refused. The Petitioner testified that her left shoulder and left hand symptoms gradually worsened and that she sought medical treatment for her complaints at OSF PromptCare on January 5, 2011.

The January 5, 2011 record of OSF PromptCare reflects that the Petitioner was seen there for complaints of back pain that "started Monday". It was noted that the Petitioner had subjective complaints of neck pain and that "This is a recurrent problem. The current episode started 3 to 5 days ago." The Petitioner was diagnosed with a cervical strain, given an injection of Toradol, and prescribed medication and no work for 48 hours. The Petitioner testified that she took the off work slip to her supervisor, Jim Carlson, and that she also informed Mr. Carlson that her neck and shoulder hurt.

On January 10, 2011, the Petitioner saw her primary care physician, Dr. Dennis Caffery, with complaints of back pain. Dr. Caffery noted that the Petitioner had severe pain in the upper back the previous week and had gone to PromptCare where she was given an injection of Toradol and prescribed ketorolac as well as Skelaxin. The Petitioner reported that she was somewhat better but had difficulty sitting at a desk, and still had pain in the upper back and difficulty sleeping. The Petitioner denied any numbness or tingling in the arms or legs. Dr. Caffery noted that the Petitioner had diffuse tenderness over the upper back, the thoracic spine, and the low back, and he prescribed prednisone.

On January 14, 2011 the Petitioner underwent x-rays of her cervical spine, which were reported to reveal multi-level degenerative disc disease and significant cervical spondylosis, and x-rays of her thoracic spine, which were also reported to reveal multi-level degenerative changes. On February 8, 2011 the Petitioner underwent an MRI of her cervical spine which was reported to demonstrate degenerative spondylo-arthritic changes from C3-C4 through C5-C6.

The Petitioner next saw Dr. Craig Charmichael on referral from Dr. Caffery. Prior to being seen by Dr. Carmichael, the Petitioner filled out an information sheet which indicated that her main symptom was pain in both shoulders and her right side which started on the evening of Jan. 4 while she was "sitting and watching TV" and increased during the night. The Petitioner also reported periodic numbness/tingling in her left arm and hand as well as weakness in her shoulders, elbows, wrists and hands. The Petitioner indicated that it was not a work injury or the result of an accident. The Petitioner reported that she was currently on sick leave and that she felt her work as an office manager contributed to her pain.

On March 1, 2011, Dr. Carmichael noted that the Petitioner had a whiplash injury years ago and had some intermittent neck pain. Dr. Carmichael also noted that the Petitioner had low back pain since the 1990s. Dr. Carmichael noted that the Petitioner reported that she was just watching TV in January when she had increased onset of neck and arm pain with associated left arm pain numbness and tingling. Dr. Carmichael administered cervical epidural steroid injections to the Petitioner on March 25, 2011 and April 15, 2011, which the Petitioner indicated did not improve her neck pain. Dr. Carmichael then referred the Petitioner to Dr. Atwater, an orthopedic surgeon at the same office, on May 4, 2011.

Dr. Atwater noted that the Petitioner had a chief complaint of some neck pain that has been going on since January 4, 2011 without a specific injury or accident. Dr. Atwater performed an examination and reviewed radiological findings, and he diagnosed the Petitioner with degenerative disc disease at the C4-5 and C5-6 level with mild disc bulges and acute cervical pain as well as degenerative disc disease in the low back.

On June 11, 2011, Dr. Carmichael performed an EMG at Dr. Atwater's request. The EMG was reported to reveal a moderate to severe median neuropathy at the left wrist as well as a left C6 greater than C7 radiculopathy.

The Petitioner testified that after the EMG was performed, she learned of her left carpal tunnel diagnosis. The Petitioner testified that she completed an accident report for the Respondent on June 30, 2011 and a copy of that report was admitted into the record as Respondent's Exhibit 5. In the accident report, the Petitioner indicated that the date of the injury was "Fall 2010" and that her problem was confirmed on June 8, 2011 during medical testing. The Petitioner indicated that the injury occurred while she was performing "Repetitive office duties – keyboarding, filing, etc." and that she initially experienced pain in various areas of her hand and wrist which "after January" frequently felt like it was asleep with pain in her wrist and thumb with movement.

On July 18, 2011, the Petitioner underwent a decompressive lumbar laminectomy at the L3-4 level performed by Dr. Atwater. The Petitioner testified that she did not think that her low back condition or the need for the low back surgery was causally related to her work for the Respondent and that she did not file a claim for a low back injury.

On August 25, 2011, Dr. Atwater noted that the Petitioner had cervical radiculopathy at C6 and 7 and that she was interested in having an operative fixation at the C5-6 level which he thought was reasonable. Dr. Atwater also noted that the Petitioner had left carpal tunnel syndrome and wanted to have a left carpal tunnel release at the same time. Dr. Atwater noted that the Petitioner had ongoing cervical radiculopathy secondary to cervical spondylosis and herniation in addition to her left carpal tunnel syndrome and that both of those conditions were "either pre-existing conditions that were aggravated or were caused by the ongoing work that she does."

On September 12, 2011, the Petitioner underwent an anterior cervical decompression and arthrodesis, with instrumentation, performed by Dr. Atwater. Dr. Atwater's post-operative diagnosis was C5-6 cervical spondylosis, degenerative disc disease and herniation with C7 radiculopathy. The Petitioner did not undergo surgery for her left carpal tunnel.

Post surgically, the Petitioner underwent a course of physical therapy and on December 7, 2011 Dr. Atwater noted that the Petitioner's fusion looked great. Dr. Atwater indicated that the Petitioner could return to work after the Christmas holiday 3 days a week full time, and then without restrictions after that. The Petitioner testified that the Respondent would not provide her with part-time work and that after the Respondent provided her with a new chair with a foot stool and a hands-free phone/headset, she returned to her regular full-time work on January 22, 1012.

At the request of the Respondent, the Petitioner was examined by Dr. Joseph Williams, a board certified orthopedic surgeon, on December 26, 2012. Dr. Williams' deposition testimony of June 3, 2014 was admitted into the record as Respondent's Exhibit 1. Dr. Williams noted that the Petitioner had cervical spondylosis, cervical facet arthropathy and questionable cervical radiculopathy, as well as EMG findings which were consistent with carpal tunnel syndrome. Dr. Williams opined that the Petitioner's cervical condition was not related to her job duties but, rather was related to her age and genetic makeup. Dr. Williams testified that he did not render an opinion on Petitioner's carpal tunnel when he wrote his report, but that he

did not find anything on his examination of the Petitioner which suggested that she had carpal tunnel syndrome.

Dr. Atwater's March 26, 2014 deposition testimony was admitted into the record as Respondent's Exhibit 1. Dr. Atwater opined that the Petitioner had symptomatic degenerative disc disease with some spinal stenosis that was causing C6-C7 radiculopathy and left carpal tunnel syndrome. Dr. Atwater opined that the Petitioner's "work environment could have contributed or caused some of her demise. The carpal tunnel more likely than the cervical syndrome." With regard to her job activities, Dr. Atwater further opined that "the paperwork that's involved, the typing, repetitive motions with the hand in particular could probably contribute to the carpal tunnel."

The Arbitrator notes that, with regard to the Petitioner's work duties, Dr. Atwater testified that his records indicate that he likely spoke to the Petitioner about her work duties. During his deposition, Dr. Atwater reviewed the Respondent's written description of the Petitioner's job duties for the first time. Dr. Atwater testified that these descriptions were consistent with his understanding of the Petitioner's work activity for Respondent and he opined that the Petitioner's repetitive motions with her hands typing and performing paperwork likely contributed to the development of her carpal tunnel syndrome.

With regard to her prior whiplash injury in 1991, the Petitioner testified that following a motor vehicle accident, she treated for a short time and was released. The Petitioner testified that, thereafter, she did not experience any ongoing cervical pain until after her work site was changed in 2008. The Petitioner testified that after her work station was changed, she began to experience periodic recurrent cervical, left shoulder, and left arm pain which gradually worsened over time.

The Petitioner testified that the cervical surgery she underwent improved her neck pain but that she still has pain in her cervical area with quick motions. The Petitioner testified that she notices this most when she is traveling in a car and it suddenly stops or swerves. The Petitioner further testified that she did not have any pain in her left wrist or hand and that she did not have left carpal tunnel symptoms prior to working for the Respondent in 2002. The Petitioner testified that currently, her left hand goes numb, that her grip strength is not good, and that she has a pinprick sensation in her left hand. The Petitioner testified that her left hand sometimes wakes her up at night.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of her

claim by a preponderance of the credible evidence and that an award of benefits cannot be based upon mere speculation or conjecture. In the case of an alleged repetitive trauma injury, the injury and its relationship to the Petitioner's work activities must be supported by a competent, credible, and reliable medical opinion. The Arbitrator finds that the Petitioner has failed to meet her burden of proof in the instant matter. In so finding, the Arbitrator notes that the opinions of Dr. Atwater are vague, indefinite, and based upon his unspecified understanding of the type of work the Petitioner performed as opposed to actual knowledge or understanding of the Petitioner's actual job activities. In short, the Arbitrator finds the opinions of Dr. Atwater to be unpersuasive and unreliable in the instant matter.

The Arbitrator notes that Dr. Atwater opined that the Petitioner's "work environment could have contributed to or caused" some of her complaints, "the carpal tunnel more likely than the cervical syndrome" and that the "typing, and repetitive motions" involved in the type of work the Petitioner "could probably contribute" to her carpal tunnel syndrome. There is, however, no evidence that Dr. Atwater had an actual understanding of the Petitioner's actual job duties. Dr. Atwater testified that he assumed that he likely discussed the Petitioner's job duties with her when he first saw her, but he did not appear to have a specific recollection of having done so and he did not articulate the specifics of what the Petitioner may have told him. Dr. Atwater did not testify as to his specific knowledge of the Petitioner's actual job activities and there is nothing in his records which demonstrates that he had an accurate understanding of the Petitioner's actual job activities. Reduced to its essence, Dr. Atwater's opinion is that the Petitioner had a job that involved typing and filing and that those work activities could have possibly contributed to or caused her conditions.

Dr. Williams, the Respondent's examining physician, opined that the Petitioner's cervical condition was not related to her job duties but, rather was related to her age and genetic makeup. The Petitioner is over 60 years old and clearly had degenerative disc disease throughout her spine which pre-existed her alleged work injuries. Under the circumstances, the Arbitrator finds Dr. Williams opinions to be at least as persuasive and reliable as those of Dr. Atwater.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment with the Respondent and failed to prove that her current condition of ill-being is causally related to her work activities for the Respondent.

Based upon the Arbitrator's finding and conclusions relating to the issues of accident and causal connection, determination of the remaining disputed issues is 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

Diane Jenkins,
Petitioner,
vs.

NO: 10WC 10665
11 WC 4197
11 WC 4499

State of Illinois, Dept. of Human Services,
Respondent,

15IWCC0737

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2015, 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: SEP 2 4 2015
MJB/bm
o-09/21/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JENKINS, DIANE
Employee/Petitioner

Case# **10WC010665**

11WC004197
11WC004499

ST OF IL-DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

15IWCC0737

On 2/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
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SPRINGFIELD, IL 62703

0502 STATE EMPLOYEES RETIREMENT
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PO BOX 19255
SPRINGFIELD, IL 62794-9255

4993 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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CHICAGO, IL 60601-3227

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 5 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DIANE JENKINS,
Employee/Petitioner

v.

Case # **10** WC **10665**

Consolidated cases:
11 WC 4197 and 11 WC 4499

STATE OF ILLINOIS-DEPARTMENT OF HUMAN SERVICES,
Employer/Respondent

151 IWCC0737

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/20/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/26/10, 2/15/10 and 3/3/10**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

Petitioner's current condition of ill-being ***is not*** causally related to these alleged accidents.

In the year preceding these alleged injuries, Petitioner earned **$54,080.00**; the average weekly wage was **$1,040.00**.

On the alleged dates of accident, Petitioner was **46** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$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

Petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her right upper extremity due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 1/26/10, 2/15/10 or 3/3/10, and her current condition of ill-being as it relates to her right upper extremity is causally related to the alleged accidents. 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

2/3/15
Date

FEB 5 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 46 year old Senior Rehabilitation Counselor, alleges she sustained an injury to her right upper extremity due to repetitive work activities, that arose out of and in the course of her employment by respondent on 1/26/10 (10 WC 10665), 2/15/10 (11 WC 4499) and 3/3/10 (11 WC 4197).

Petitioner began working for respondent in 1983. From 1983 until 1998 she worked as a clerk typist II/ correspondence I/ correspondence II in the Department of Professional Regulation, Department of Transportation, and the Department of Transportation Aeronautics. As a clerk typist II/correspondence I in the Department of Professional Regulation petitioner used her hands 80 to 85% of the time. She typed on the computer and typewriter, but primarily on the CRT/workstation. When petitioner worked on the workstation she would check fields on various screens, and also used microfiche. She stated that she typed 80% of the time. While working as a clerk typist II/and correspondence I in the Department of Transportation petitioner would type letters all day every day, 100% of the day, on a word processor. Petitioner was in this position for about a year and a few months. As a correspondence II/Office Coordinator in the Department of Transportation Aeronautics petitioner worked as a receptionist and office support staff. She testified that she performed a lot of typing, answering phones, faxing, and filing. Petitioner worked in this capacity for 12 years from 1986 to 1998, and had no problems performing this job.

Petitioner left her employment with the state of Illinois between 1998 and 2000. During this period petitioner got her Master's degree. Petitioner resumed her employment with respondent in September 2001 as a Rehabilitation Counselor Trainee. She worked in this capacity for about six months. Petitioner then became a Rehabilitation Counselor and then a Senior Rehabilitation Counselor. In these capacities petitioner worked with persons with disabilities. She reviewed medical documents for eligibility for the program. She would also work with vendors and providers for rehabilitation services. She testified that her duties varied a lot. She testified that she worked 37.5 hours, and was right-hand dominant. She stated that she worked primarily out of one location and had a workstation provided for her.

Petitioner testified that she was allowed 2-15 minute breaks each day and a one-hour lunch. However she testified that she rarely ever took any breaks.

Petitioner testified that her work station consisted of an L-shaped metal desk that was very wide and deep. She worked with her notes, medical records, documents from vendors, and community reports from the rehabilitation providers. Petitioner worked at her workstation and later on a laptop. She testified that she would type approximately 55% of the day, and draft handwritten documents 45% of the day. She testified that she handled a lot of paperwork. She took handwritten notes when she interviewed people, would make notes from

her medical records, and then would enter these handwritten notes into the computer. What interviewing a client she would type into the computer, and do handwritten notes.

Petitioner worked in Lincoln one day a week all day. When she went to this office she would handwrite things all day before she was given a laptop. Petitioner could not recall when she was given a laptop. When she did not have the laptop and had to handwrite all her notes, when she got back to her office she would enter all her notes into the computer. Petitioner testified that since the desk in her office was high and she would need to keep her arms essentially outstretched to type on her computer, she brought a TV tray from home to put her computer on so that her arms were at a 90° angle when she would type. She testified that she brought the TV tray from home in 2008. Petitioner's activities also involved using the phone. Petitioner would hold the phone between her shoulder and the left side of her head, and would handwrite notes or type them in the computer while she was on the phone. Petitioner testified that there were goals set statewide, regionally, for the office, and for each counselor. She testified that no allowances were given for injuries or illness.

Petitioner testified that in addition to working in the office she also worked at home about 10 hours a week. This work involved reading medical reports and typing initial interview notes. At times she would type until midnight. Petitioner testified that she would use her mouse primarily when she was filling in forms on the computer screens. She also typed in reports that were 3/4 of a page to 1-1/2 pages in length.

In January 2010 petitioner testified that she noticed that the more she wrote and typed, the more her right hand and right forearm would go numb, she would get pain in her right wrist, and the fingertips of her right hand would get numb.

On 1/26/10 petitioner presented to Dr. Russell, on the referral of her primary care physician, Dr. Wenthe. Petitioner reported pain over the dorsum of the thumb that was present most of the time, and bothers her when she wears long sleeve shirts. She also reported that her little finger on the right hand floats out away from the hand, and she cannot adduct it. Dr. Russell performed a physical examination that showed pain over the first dorsal compartment, negative Tinel over the superficial branch of the radial nerve, the ability to extend all fingers, the inability to bring the little finger in line with the other fingers in adduction, and no irritation of the ulnar nerve at the elbow or the canal of the Guyon by palpitation over Tinel. Dr. Russell was of the opinion that the fact that petitioner could not bring her little finger in line with the other fingers in adduction meant that she may have some ulnar nerve weakness. Dr. Russell performed a steroid injection in the first dorsal compartment to treat her de Quervain. He also recommended that she come to a Hand Conference to see if anyone would do a cross intrinsic transfer to correct for little finger abduction.

On 2/15/10 petitioner presented to Dr. Joel Wietfeldt at SIU Healthcare Division of Plastic Surgery at the Hand Conference on the referral of Dr. Russell. She complained of pain on the dorsum of her right thumb which bothers her when she wears a long sleeve shirt and it rubs this area. She also complained of abduction of her small finger with an inability to adduct that digit. She stated that it gets in her way when she is writing or having difficulties with typing. She reported that she works on a computer throughout the day at her job. She stated that she did have an injury to her little right finger when she was in high school. She stated that a volleyball caught it and caused her finger to abduct. She stated that since then it has progressively gotten worse, and she is unable to adduct her right little finger since then. She stated that she had some splinting initially, but it did not work. With regards to her thumb she does wear a resting splint at night, which she states does help. She stated that if she uses her thumb she has some soreness in that area after some time. An examination revealed pain over the distribution of the dorsal right thumb, wrist, and proximal forearm. She had a negative Finkelstein test. She had a tender spot in the junction of the distal and middle third on the dorsal radial aspect. She had full flexion and extension of the thumb. She noted abduction of her small finger, and the inability to adduct her small finger. Petitioner demonstrated full flexion and extension. Petitioner demonstrated no Tinel's or compression sign at the ulnar nerve or over the Guyon's canal. Dr. Wietfeldt was of the opinion that petitioner may have impingement of the superficial radial nerve in the distal forearm, and a subclinical deQuervain's. He was of the opinion that this would hopefully be resolved with an exploration release of the first compartment, as well as decompression of the nerve. With regard to her little right finger, he was of the opinion that petitioner may benefit from either having a splint made that helps to adduct the fingers so that it does not get in the way. Another option was to have the radial lateral band of the right little finger transposed and intertwined with the other lateral band of the right ring finger to adduct the finger so that it would not get in the way. Petitioner was referred back to Dr. Russell for evaluation of these problems and potentially scheduling the procedure.

On 3/5/10 petitioner completed a Worker's Compensation Employees Notice of Injury. She identified the date of injury or illness as 2/15/10. She indicated that the last day she worked was 3/5/10. She noted that she reported the injury to her supervisor Martin Pereira. She identified the duties she was performing as typing, writing, carrying laptop and case work. The place where her injury occurred was identified at her job at 1124 N. Walnut and at Logan County. She identified the "detail how injury occurred" as "I have right wrist and right hand pain from typing, writing, and carrying my laptop and work cases."

On 3/16/10 petitioner returned to Dr. Russell. He noted that petitioner's pain over the dorsum of her thumb had been present for a long time, and bothers her when she wears long sleeve shirts. He also noted her

little finger ulnar deviation. Petitioner gave a history of working at home, regularly using a computer. She stated that the injection she received provided her with really no relief of symptoms. Petitioner reported some discomfort over the distal radius about 2 cm proximal to the radial styloid with tenderness. She also described an unusual sensation over the entire radial nerve distribution. Dr. Russell recommended a lateral band transfer of the right ring finger to the radial side of the small finger in an attempt to place the little finger back into a better position. Petitioner stated that as long as she could remember she has had this problem with the little finger, and wanted to undergo the recommended procedure. Dr. Russell told her that that the surgery may not completely correct this problem, and she may still have difficulty with slight abduction of that digit. He further stated that while performing the surgery he would explore the first extensor compartment and release this, as well as the superficial radial nerve, to help relieve some of the discomfort. Dr. Russell noted that petitioner wanted to file this under worker's compensation. However he was of the opinion that petitioner's problems were not work related.

On 3/18/10 petitioner filed her Application for Adjustment of Claim with respect to case 10 WC 10665, with an alleged date of accident of 1/26/10, with injuries to her right upper extremity, the nature of which was DeQuervain's syndrome/overuse syndrome.

On 6/16/10 petitioner presented to Dr. Greatting. Petitioner had previously treated with Dr. Greatting for an unrelated condition, a repair of a ligament in her left thumb. Petitioner presented for evaluation of bilateral hand complaints. Dr. Greatting noted that petitioner was right-hand dominant. He further noted that she was employed doing vocational rehabilitation for the Illinois Department of Human Services. Petitioner complained of some right wrist pain, a dull throbbing sensation in her right wrist, some sharp stabbing pains, the inability to bring her right little finger towards her right ring finger, and numbness and tingling of her thumb, index fingers, and right small fingers at night. Petitioner reported that she uses a mouse frequently at work with her right hand. She sometimes switches to the left and this helps her symptoms some. She stated that her work involves a lot of driving, as well as use of a laptop with a keyboard, a mouse, and writing. She reported increased symptoms while doing her work activities. She had no neck or shoulder pain complaints. She denied any specific injury or trauma. She reported that she has hypertension and asthma. Dr. Greatting performed an examination. Petitioner had good motion of her elbows, forearms, wrists and hands bilaterally, except for decreased flexion of her right wrist compared to her left. She had a negative Tinel's and negative elbow flexion test over her right cubital tunnel. She had difficulty adducting her right small finger towards her right ring finger, and held it in a somewhat abducted position. Dr. Greatting noted some mild atrophy of her right first dorsal interosseous as compared to the left, and possible weakness. He noted some mildly positive Tinel's over

her right radial sensory nerve, and a positive Tinel's over her right carpal tunnel, as well as a positive compression test. She had a negative Phelan's test, and a good radial pulse. Petitioner had intact motor function without weakness or atrophy in the radial, median, and ulnar nerve distributions of her right arm. Dr. Greatting assessed right carpal tunnel syndrome. He was of the opinion that she may also have some problems with her ulnar nerve at the elbow, although she did not have any exam findings suggesting sensory symptoms in the ulnar nerve distribution of her right elbow. He noted that petitioner had some decreased motion of her right wrist. He recommended an EMG nerve conduction study to evaluate for cubital and/or carpal tunnel syndrome. He also asked that she get an arthritis panel to rule out any type of inflammatory arthropathy with a decrease flexion of her wrist. Based on petitioner's history of getting increased symptoms while doing her work activities, Dr. Greatting felt that petitioner's work activities had caused, contributed, or aggravated the problems she was having with her right arm. An x-ray was taken of the right wrist. The impression was right wrist radiographs with diffuse osteopenia of the visualized bony structures. Petitioner's arthritis panel was normal.

On 7/27/10 petitioner underwent an EMG nerve conduction study performed by Dr. Trudeau. The results indicated mild carpal tunnel and mild cubital tunnel.

On 8/12/10 petitioner returned to Dr. Greatting. Her main complaint was related to pain over the radial side of her right wrist or distal forearm. She had some mild complaints of numbness and tingling. An examination revealed good motion of the right elbow, forearm, wrist and hand. Petitioner had a negative Tinel's over her right cubital tunnel, her right carpal tunnel, as well as her radial sensory nerve. She complained of pain and burning over the distal radial forearm area. She had slight decrease flexion and extension of her wrists. She was very tender directly over the insertion of the brachial radialis into the radius. Dr. Greatting was of the opinion that the mild cubital tunnel and carpal tunnel syndrome that were noted on the EMG nerve conduction study were not accounting for a significant part of her symptoms. Since petitioner had pain or inflammation to the area of insertion of the brachial radialis tendon, he injected that area with a corticosteroid injection. Petitioner had a follow-up examination scheduled for 9/29/10 with Dr. Greatting but did not appear.

Petitioner took an unrelated medical leave from work from 8/23/10 through 1/12/11. Petitioner testified that her symptoms during this period improved and did not worsen until she resumed her duties in January of 2011.

Petitioner next followed-up with Dr. Greatting on 10/28/10. She reported that she was still having pain, numbness and tingling into her right arm. She was of the opinion that the corticosteroid injection that he performed on 8/12/10 did help some. Petitioner was nontender over the first dorsal compartment, had a negative Finkelstein's test, reported constant numbness in the right ring and little fingers of her hand, some

intermittent numbness and tingling in her other fingers of the right hand, had a negative Tinel's over her cubital tunnel despite increasing symptoms with elbow flexion test, constant feeling of decreased sensation in the right ring and little fingers to light touch, and a positive Tinel's over her right carpal tunnel. Dr. Greatting recommended a right ulnar nerve release at the right elbow, and right carpal tunnel release.

On 2/7/11 petitioner filed her Application for Adjustment of Claim with respect to case 11 WC 4197, with an alleged date of accident of 3/3/10, with injuries to her right upper extremity, the nature of which was DeQuervain's syndrome/overuse syndrome.

On 2/8/11 petitioner filed her Application for Adjustment of Claim with respect to case 11 WC 4499, with an alleged date of accident of 2/15/10, with injuries to her right upper extremity, the nature of which was DeQuervain's syndrome/overuse syndrome.

On 10/12/11 petitioner returned to Dr. Greatting's office for reevaluation of her right hand. She was examined by Dr. Greatting's Physician Assistant Erica Lukac. She stated that her right hand had been causing her problems for quite some time. Petitioner noted that she was going to be scheduled for surgery but had to take a stress leave from work, and while she was off the numbness and tingling got better. She stated that since she has been back to work and doing her normal work activities the numbness, tingling, and pain has intensified. Petitioner felt like it was a constant numbness and tingling that comes with typing, writing, and answering the phone, which is what she does most of the day. She stated that she has been performing the same job for 10 years. She stated that she takes a lot of notes, typing, and writing. She also does a lot of driving to and from her site visits. She reported a lot of increased discomfort with her job. Petitioner reported pain at night even though she wears splints at night, which help. She reported some pain radiating from the right elbow down the forearm into the hand. She also reported some decreased sensation in the right hand, especially on the ulnar side. She complained of constant numbness, tingling on the ulnar side of her right hand, and intermittent numbness and tingling in the first through third fingers of the right hand. She also complained of right hand weakness. Dr. Greatting examined petitioner and assessed right hand carpal tunnel syndrome and right arm cubital tunnel syndrome. Dr. Greatting noted that he would be going ahead and trying to obtain Worker's Compensation approval for carpal and cubital tunnel release on the right upper extremity.

On 5/9/12 the petitioner underwent a Section 12 examination performed by Dr. James Williams, at the request of the respondent. Petitioner identified herself as a senior rehabilitation counselor for respondent. She reported that she was hired on 9/16/01. Her current complaints included pain from the elbow to the fingertips on the right. She said her small finger felt like it was anesthetized. She reported that the pain shoots up through the center of her hand on the top. She stated that she drops things, aches, has burning on the top of her right

thumb, and pain on the dorsum of the right forearm that feels like a blood pressure cuff is being placed on her right arm. She noted that her right little finger will not pull back in, and if she sits with her arm with any pressure on the elbow it goes numb. She has problems sleeping. She rated her pain on the right at rest at a 6/10, and with activity and 8/10. She denied any problems on the left side. Petitioner testified that she works one week Monday through Thursday 8:30 AM to 6 PM, and Friday 8:30 AM to 4:30 PM. The next week she will work Monday through Thursday 8:30 AM to 6 PM, and has Friday off. She stated that she drives to Lincoln, IL a couple times per week. There she types forms and emails about five hours a day. She stated that she writes case notes and forms which vary depending on the number of hours. She lifts files. She has wheeled luggage with a pulley arm that is filled with files and forms. She works on a laptop computer. She also attends job fairs and makes phone calls, interviews people, photocopies and faxes, goes to community rehab, and deals with Spark and UCP. She reported that her office is set up with a mouse on the right side, a keyboard and a TV tray, an old metal desk, an adjustable chair, and a monitor that she can move. Dr. Williams was of the opinion that it sounded like petitioner's workstation was reasonable. Petitioner reported that she had high blood pressure, asthma, reflux, and anxiety. She reported that her hobbies include gardening and reading. Dr. Williams reviewed with her the description of a Senior Rehabilitation Counselor in the Department of Human Services, Division of Rehabilitation Services, and she did not note any significant discrepancies. He also went over the demands of the job of a Senior Rehabilitation Counselor which includes use of hands for fine manipulation, typing, and good finger dexterity 4 to 6 hours per day. It also noted that use of hands for gross manipulation was 0 to 2 hours per day, and lifting was said to be 0 to 2 hours per day.

Following a record review and examination, Dr. Williams was of the opinion that petitioner had right carpal tunnel syndrome as well as right cubital tunnel syndrome. However, he did not feel, based on description of what petitioner reported with respect to her job description and the job description provided by CMS, that petitioner's job duties were either aggravating and/or causative to her condition of right carpal tunnel syndrome or right cubital tunnel syndrome. He noted that even the nerve study put her condition as mild and neuropraxic, meaning that this was just an inflamed nerve. He noted that no real change had happened in the nerve since that exam. As a result he did not feel the surgery was reasonable. He also did not believe any further treatment was needed under worker's compensation. He believed petitioner had reached maximum medical improvement. Based on recent literature, Dr. Williams did not believe that typing is an aggravating or causative factor of the condition of carpal tunnel syndrome. He opined that she does not do any work which involves any repetitive, forceful gripping, or any vibration, and that's why this condition is not related to her job duties.

On 7/30/12 petitioner returned to Dr. Greatting. She reported that she had been experiencing numbness and tingling which had now become constant. She stated that in October 2011 it was intermittent. She stated that she had been experiencing numbness and tingling as well as pain in her right upper extremity since 1/26/12. She stated that the numbness/tingling gets worse with time, but now it is constant. She stated that her pain has also gotten worse. She reported that the numbness and tingling in her fourth and fifth right fingers was constant. She stated that the decreased sensation and numbness in her first through third fingers on her right hand were also not constant. She reported a pain and some shooting, shocking sensations from her right upper forearm to her right elbow. She noted that her right little finger was not adducting as normal. She reported pain in the tip of her right middle finger that she felt was due to holding her pen tighter because she has weakness in her right hand. Dr. Greatting examined petitioner and his impression remained unchanged from 10/12/11. Dr. Greatting was of the opinion that petitioner definitely has right carpal and cubital tunnel syndromes. He was of the opinion that her numbness and tingling were getting worse, and she definitely needed to have a surgical release before she ends up getting permanent damage.

On 8/17/12 petitioner underwent a release of the ulnar nerve at the right elbow, and a release of the right carpal tunnel. The surgery was put through her group health insurance. Her postoperative diagnosis was right cubital tunnel syndrome, and right carpal tunnel syndrome. These procedures were performed by Dr. Greatting. Petitioner was authorized off work. Petitioner followed up postoperatively with Dr. Greatting on 8/30/12 and 9/27/12. On 9/27/12 petitioner felt that the numbness was improving but had not completely resolved. Dr. Greatting noted that petitioner was able to adduct her right small finger better. She stated that she still felt some weakness. Dr. Greatting authorized petitioner off work for two more weeks. As of 10/15/12 he released petitioner to work with no restrictions. Petitioner asked if she would benefit from having her work area evaluated and ergonomic modifications. Dr. Greatting was of the opinion that certainly this could be done to reduce or minimize the chance of her having further problems in the future. He stated that he would write a letter concerning this.

On 9/27/12 Dr. Greatting drafted a letter to whoever it may concern. He stated that petitioner had recently undergone surgical treatment of cubital and carpal tunnel syndrome involving her right arm. He felt that petitioner would benefit from evaluation of her work area and making appropriate ergonomic modifications to her area as needed. He felt that this would reduce or minimize the risk of her developing recurrent problems in the future.

On 11/28/12 petitioner followed up with Dr. Greatting. She stated that she was 90% better. She felt that her numbness was almost resolved. She reported that her strength was better, and that she had better control of

her right little finger. Dr. Greatting examined petitioner and noted that she had full motion, good strength in the median and ulnar nerve distribution, and was able to almost fully abduct/adduct her right little finger to her right ring finger. Dr. Greatting was of the opinion that petitioner was doing well, and would continue to improve with time. He was of the opinion that she could work without restrictions or limitations. He released her from his care. He was of the opinion that she was at maximum medical improvement. He instructed her to return as needed.

On 12/11/12 Dr. Williams drafted an addendum report after reviewing additional medical records that included Dr. Russell's reports of 1/26/10 and 3/26/10, reports of Dr. Greatting dated 6/16/10, 8/12/10, and 10/28/10, as well as report of Dr. Trudeau dated 7/27/10. Based on these records Dr. Williams opinions on causation remained unchanged. He stated that he still did not feel that petitioner's carpal or cubital tunnel were related to her work activities. He was of the opinion that petitioner's carpal and cubital tunnel were probably of an idiopathic origin. He based this opinion on the fact that recent literature clearly shows that typing is in no way a causative factor of carpal tunnel syndrome.

On 12/13/12 the evidence deposition of Dr. Williams, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Williams opined that having high blood pressure is a risk factor in the possible development of carpal tunnel. He noted that petitioner suffers from high blood pressure and is on multiple medications for this condition. These medications included Carvedilol. Dr. Williams was of the opinion that the swelling petitioner felt in her arms could have been a side effect from her high blood pressure medication. Dr. Williams testified that the medical literature he relied on in determining that typing does not cause carpal tunnel was medical literature put out by the American Society for Surgery of the Hand and published by David Ring. He stated that some of the papers he looked at relied on biological factors, some looked at occupational factors, and others looked at both biological and occupational factors. Dr. Williams stated that 50% of the Section 12 examinations he performs are not for respondent.

On cross-examination Dr. Williams testified that he does approximately 3 to 4 Section 12 examinations a week for respondent, at a rate of $2500 each. He further testified that his testimony at a deposition is $1000 an hour. Dr. Williams testified that he performs 2-3 depositions a week. Dr. Williams admitted that not every person who has hypertension will develop carpal tunnel. He testified that carpal tunnel syndrome is more prevalent among females, postmenopausal women, diabetics, and obese individuals, but that doesn't mean that all these individuals will develop carpal tunnel syndrome. Dr. Williams testified that if petitioner's ergonomic situation was not as he assumed, and her hands were not held in a neutral position, that that would affect his opinion on causation. Dr. Williams agreed that cumulative occupational risks factors can increase the

likelihood of someone developing carpal tunnel syndrome. Dr. Williams also agreed that there is no correlation between the level the impingement identified on an EMG and the level of symptoms personal experience. Dr. Williams agreed that some medical doctors, orthopedic surgeons, and hand surgeons continue to believe that there is an association between typing and carpal tunnel syndrome.

On 10/8/13 the evidence deposition of Dr. Greatting, an orthopedic surgeon, was taken on behalf of petitioner. Assuming that petitioner worked for the Department of Rehabilitation for nine years; that her job involved using a laptop computer approximately 50 to 60% of her day; that she typed 4 to 6 hours a day; used her mouse to navigate through screens; and worked on a desk that was not something that she could adjust to be ergonomically comfortable; that the rest of the day she would be answering phone calls with her left hand and typing or writing with her right hand, and that her job involves some driving to various sites. Dr. Greatting opined that these type of activities could have caused or contributed to her right carpal and cubital tunnel syndrome. Dr. Greatting testified that even if there was an idiopathic element petitioner's carpal tunnel and cubital tunnel syndrome, that her work duties significantly aggravated or made the symptoms worse. Dr. Greatting was of the opinion that given the fact that when petitioner removed herself from work her symptoms improved, and when she returned to work they worsened, that her work activities were contributing or an aggravating factor to her carpal tunnel and cubital tunnel syndrome. Dr. Greatting opined that petitioner's work activities, as she described, were sufficiently repetitive to aggravate and contribute to her carpal and cubital tunnel syndrome.

On cross-examination Dr. Greatting opined that if petitioner had a right little finger that she could not adduct, a finger stuck in that position for over 20 years, that would not aggravate a carpal tunnel syndrome. Dr. Greatting testified that he was not aware of any specific injury to petitioner's right little finger and since she improved with the ulnar nerve decompression, he opined that the condition was from weakness of the muscles related to her ulnar nerve. With respect to petitioner's job duties, Dr. Greatting stated that he was aware that petitioner uses the mouse with the right-hand, with occasional switches to her left hand, and that her job involves driving, as well as the use of a laptop with a keyboard and mouse, and writing. Dr. Greatting testified that he did not see a picture or video of petitioner's work area. He also testified that petitioner did not describe her work area to him. Dr. Greatting opined that hypertension is not a risk factor for the development or aggravation of carpal and cubital tunnel syndrome. Dr. Greatting testified that he had no history that petitioner suffered pain in her thumb while wearing long sleeved shirts.

On redirect examination Dr. Greatting opined that petitioner gave him a history of her work activities with enough detail upon which to formulate an opinion as to the cause of her carpal and cubital tunnel syndrome. Dr.

Greatting opined that carpal and cubital tunnel syndrome are progressive conditions which can continue to worsen, and in fact did worsen in petitioner. Dr. Greatting opined that typing in an awkward or non-ergonomic position can be associated with the development of carpal and cubital tunnel syndrome if it is done repetitively.

After she was released from care by Dr. Greatting on 11/30/12 petitioner did not follow up with Dr. Greatting for anymore treatment. She testified that she thought her condition was permanent. She stated that the surgery reduced the pain in her right hand and she was able to get her right little finger closer to her ring finger. She testified that it still bothers her to write, and she still has numbness in her right hand in the ring and little finger. She testified that she still experiences a burning sensation on the top of her right forearm from her thumb to midway up her forearm. She testified that this burning/tingling pain has not gone away. She testified that when she lifts or carries things the pain in her forearm worsens, and will continue aching for a while after she has completed her lifting activities. She testified that when she rotates her right wrist it aches.

Petitioner testified that after she returned to work after being released by Dr. Greatting she still had difficulties when she would write long handed. She testified that it was better than what it was before her surgery. She believed the strength of her arm was weaker by 35%.

Petitioner testified that she had a prior injury to her right little finger. She testified that while playing volleyball in high school the ball hit her right little finger and extended it backwards.

Petitioner testified that she has not worked since the middle of December 2013. She testified that she is currently off work because of the stress of her job and short-term memory problems. Petitioner testified that her right little finger did not float out from her right hand following the injury in high school until a couple months before she saw Dr. Russell.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
E. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner alleges that she sustained accidental injuries to her right upper extremity due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 1/26/10 (10 WC 10665), 2/15/10 (11 WC 4499), and 3/3/10 (11 WC 4197).

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.

Since petitioner is claiming an injury to her right upper extremity due to repetitive work activities, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity.

The manifestation date in a repetitive trauma claim is the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. In the case at bar petitioner is claiming three separate and distinct manifestation dates, 1/26/10, 2/15/10 and 3/3/10.

On 1/26/10 petitioner presented for treatment with Dr. Russell. There is no credible medical evidence in Dr. Russell's records to support a finding that on this day petitioner related any of her symptoms to her work duties. On 2/15/10 petitioner presented to Dr. Wietfeldt and reported that she works on a computer throughout the day at her job. She also reported complaints, as they relate to her right thumb and right little finger, and stated that her right little finger gets in the way when she is writing or typing. The arbitrator finds nothing in the records to support a finding that anything occurred on 3/3/10 that would support a finding that 3/3/10 is the manifestation date of her alleged injury.

Given these alleged accident dates, the arbitrator finds 2/15/10 is the only one of these dates on which both the fact of the injury and the causal relationship of the injury to the claimant's employment could have become plainly apparent to a reasonable person. The arbitrator bases this on the fact that this was the day on which petitioner reported to Dr. Wietfeldt what her symptoms were, what her job duties include, and how her symptoms relate to her job duties.

Petitioner testified that in January of 2010 she noticed that the more she wrote and typed, the more her right hand and right forearm would go numb, she would get pain in her right wrist, and the fingertips of her right hand would go numb.

Petitioner began working for respondent in 1983. From 1983 to 1998 she worked as a clerk typist II, and correspondence I/correspondence II. She testified that during this period she would type from 80-100% of the time and had no problems performing this job.

From 1998 through 2000, petitioner left her employment with respondent, and went back to school to get her Master's Degree. Upon completion of her Master's Degree petitioner returned to work for respondent in September 2001 as a Rehabilitation Counselor Trainee.

From September of 2001 through the alleged dates of injury petitioner testified that she was employed as a Rehabilitation Counselor Trainee, Rehabilitation Counselor, and then a Senior Rehabilitation Counselor. Petitioner's duties included working with disabled people and reviewing their medical documents for eligibility in the program. She also worked with vendors and providers for rehabilitation services. She testified that her duties as a Senior Rehabilitation Counselor varied a lot.

When working in her office she worked with notes, medical records, documents from vendors, and community reports from the rehabilitation providers. She testified that she would also interview clients, and take notes by hand. She also took hand notes while reviewing medical records, and then would enter them in the computer. Petitioner claims that she typed 55% of the day, and drafted handwritten notes the remaining 45% of the day. She also testified that she handled a lot of paperwork and would pull many files during the day. She testified that her work activities included the use of the phone. Petitioner would hold the phone between her left shoulder and left side of her head, and while on the phone took handwritten notes or typed the notes in the computer.

In addition to working at her home office petitioner would go to Lincoln, IL a couple times a week where she would interview clients. She testified that this required a lot of driving, carrying her laptop and work cases. When petitioner first went to Lincoln, IL she would take notes by hand and then enter them in the computer when she returned. At some point, which petitioner could not remember, she got a laptop. She would take that laptop with her to Lincoln and enter the notes from the interviews in the laptop.

Petitioner testified that since her desk was too high for her she brought a TV tray from home in 2008. She placed the computer on her TV tray where her arms were at a 90 degree angle when she typed. Petitioner also had an adjustable chair.

In addition to her 37.5 hours of work per week, petitioner testified that she would work an additional 10 hours at home each week. The work involved reading medical reports and typing initial interview notes. She

testified that this work also involved use of the mouse to fill in the forms on the computer screens. Petitioner also typed reports that were 3/4 of a page to 1-1/2 pages in length.

Petitioner told Dr. Russell that she injured her right little finger when she was in high school. She reported that a volley ball caught it and caused her finger to abduct. She reported that since then her right little finger has gotten progressively worse and she has been unable to adduct her right little finger. She reported that the right little finger was initially splinted, but it did not help. Dr. Russell attributed this problem to some ulnar nerve weakness. Petitioner also reported pain over the dorsum of her thumb. For this condition he performed a steroid injection in the first dorsal compartment.

When petitioner returned to Dr. Russell on 3/16/10 she reported that the pain over her right thumb had been present for a long time, but did not indicate how long. She also stated that it bothered her when she wears long sleeve shirts. Dr. Russell was of the opinion that petitioner's right thumb, hand and right little finger problems were not causally related to her work. Petitioner did not return to Dr. Russell for any further treatment.

Petitioner next sought treatment with Dr. Greatting, who she had previously treated for an unrelated repair of a ligament in her left thumb. Petitioner reported that she uses a mouse frequently at work with her right hand, and sometimes switches the mouse to her left hand when her right hand bothers her. She told Dr. Greatting that she does a lot of driving, a lot of work on a laptop with a keyboard and mouse, and writing. Based on this history Dr. Greatting felt that petitioner's work activities had caused, contributed, or aggravated the problems she was having with her right arm.

Petitioner underwent an EMG/NCS on 7/27/10 that showed mild right cubital tunnel and carpal tunnel, as well as her sensory nerve. However, when petitioner presented to Dr. Greatting on 8/12/10 he was of the opinion that the mild cubital tunnel and carpal tunnel syndrome that were noted on the EMG nerve conduction study were not accounting for a significant part of her symptoms.

After petitioner presented to Dr. Greatting on 8/12/10 she went on an unrelated medical leave on 8/23/10 and remained off work through 1/12/11. Petitioner testified that during this time her symptoms improved. However, the arbitrator finds this testimony less than credible based on the fact that when petitioner presented to Dr. Greatting on 10/28/10, while she was off work for over two months, she was still having pain, constant numbness in the right ring and little fingers, and some intermittent numbness and tingling in her other fingers, increased symptoms with elbow flexion test, constant feeling of decreased sensation in the right ring and little fingers to light touch, and a positive Tinel's over the right carpal tunnel. Based on these symptoms Dr. Greatting

recommended a right ulnar nerve release and right carpal tunnel release. The arbitrator finds these complaints and Dr. Greatting's findings and recommendations consistent with someone whose symptoms had not improved while she was off work.

In October of 2011 petitioner told Dr. Greatting's physician assistant Lukac that while she was off work for a stress related condition her numbness and tingling got better. She also told Lukac that since she returned to her normal work activities the numbness, tingling and pain had intensified. The arbitrator finds this history inconsistent with Dr. Greatting's medical record of 10/28/10, which show increased symptoms while petitioner was off work. At that time petitioner's symptoms had worsened to the point that Dr. Greatting recommended that she undergo a right ulnar nerve release and right carpal tunnel release.

When petitioner was examined by Dr. Williams at the request of the respondent on 5/9/12 she told him that she has to drive to Lincoln, IL a couple of times a week. She reported that while there she types forms and emails about 5 hours a day. She also reported that she writes case notes and forms, but the amount of time she performs this activity varies. She reported that she lifts files, wheels luggage that holds her files and forms, works on a laptop, attends job fairs, makes phone calls, interviews people, photocopies and faxes, goes to community rehab, and deals with Spark and UPC. Petitioner described her workstation setup to Dr. Williams and he believed it was reasonable. Petitioner gave Dr. Williams a history of high blood pressure. Dr. Williams also had a copy of her job duties as Senior Rehabilitation Counselor that he reviewed with petitioner, and she noted no significant discrepancies. He also went over the demands of the position with her. The demands of her job included use of hands for fine manipulation, typing, and good finger dexterity 4-6 hours per day. Use of hands for gross manipulation, and lifting were identified as 0-2 hours a day.

Based on his examination, her description of what she did, and review of her job description and demands, Dr. Williams was of the opinion that petitioner's job duties were neither aggravating and/or causative to her condition of right carpal tunnel or right cubital tunnel syndrome. Dr. Williams was also of the opinion that typing is not an aggravating or causative factor of carpal tunnel syndrome. He opined that petitioner does not do any work which involves any repetitive, forceful gripping, or any vibration. Dr. Williams was of the opinion that petitioner's carpal and cubital tunnel were probably of an idiopathic origin. He also opined that high blood pressure is a risk factor in the possible development of carpal tunnel, and noted that petitioner has high blood pressure and was on multiple medications for this condition. Dr. Williams believed that the swelling petitioner felt in her arms could have been a side effect of the high blood pressure medication.

Dr. Williams was of the opinion that if petitioner's ergonomic situation was not as he assumed, and her hands were not held in a neutral position, that would affect his opinion on causation. However, petitioner testified that once she brought the TV tray in her hands were at a 90 degree angle when she typed.

Dr. Greatting opined that even if there was an idiopathic element to petitioner's carpal and cubital tunnel syndromes, the fact remains that her work duties significantly aggravated or made the symptoms worse based on her testimony that when she was off for an unrelated condition the symptoms improved and when she returned to full duty work, the symptoms worsened. The arbitrator finds this opinion not supported by the credible record which shows that petitioner was off work from 8/23/10 through 1/12/11, and on 10/28/10 Dr. Greatting was of the opinion that petitioner's condition had worsened to the point where she needed to undergo a right ulnar nerve release and right carpal tunnel syndrome release. The arbitrator finds it significant that Dr. Greatting did not recommend surgery until the petitioner had been off work for 2months. In addition to not having an accurate history of when petitioner was off work and her condition during that period, Dr. Greatting admitted that he did not see a picture or video of petitioner's workstation and she did not describe it to him. Dr. Greatting did not believe high blood pressure is a risk factor for carpal or cubital tunnel syndrome.

At trial petitioner testified that she was currently off work due to an unrelated condition. Despite her being off work, petitioner testified that it still bothers her to write, and she still has numbness in her right hand in the ring and little finger. She also testified that she still experiences a burning sensation on the top of her right forearm from her thumb to midway up her forearm, that has not gone away. She testified that when she lifts or carries things the pain in her forearm worsens and will continue aching for a while after she has completed the lifting activities. She also testified that when she rotates her right wrist it aches. Petitioner believes her strength in her right arm is weaker by 35%.

Based on the above, as well as the credible evidence, the arbitrator finds 2/15/10 is the only date of the three filed that petitioner could claim was the manifestation date of her alleged injuries. Therefore, before beginning an analysis of this claimed injury, the arbitrator denies petitioner's claim for compensation with respect to case 10 WC 10665, with an alleged accident date of 1/26/10, and 11 WC 4197, with an alleged accident date of 3/3/10.

In order to prove a repetitive trauma injury, the petitioner must place into evidence specific and detailed information concerning her 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. In the case at bar petitioner provided an extensive list of work duties that she performs. These included taking handwritten notes; reviewing medical records; interviewing clients; entering her handwritten

notes in the computer; handling a lot of paperwork; pulling many files during the day; taking handwritten notes or entering data in the computer while on the phone; driving a lot; carrying her laptop and work cases in a luggage cart with a pulley; traveling a couple days a week to Lincoln, IL; attending job fairs; making photocopies and sending faxes; going to community rehab and, dealing with Spark and UPC. Petitioner herself testified that her duties were varied. Overall, she testified that she types 55% of the time, and takes notes the other 45% of the time. However, based on all these activities that petitioner claims she performed, the arbitrator finds it unlikely that the time she spent typing and the time she takes handwritten notes could accounts for 100% of her work duties. The arbitrator finds it significant that petitioner did not provide the frequency and duration of the multiple tasks that did not involve typing or handwriting. Even though her job description indicates that she uses her hands for fine manipulation, typing, and good finger dexterity 4-6 hours per day, and uses her hands for gross manipulation, and lifting 0-2 hours a day, how much time was spent on each specific task was not identified. However, the petitioner herself testified that her tasks were varied.

With respect to the requirement that the medical experts have a detailed and accurate understanding of the petitioner's work activities, the arbitrator finds the only medical expert that had this was Dr. Williams. Dr. Williams not only took a detailed history from petitioner, but also had the opportunity to review her CMS job description for a Rehabilitation Counselor and go over it with her. Petitioner's history to Dr. Greatting was that she does a lot of driving, a lot of work on a laptop with a keyboard and mouse, and a lot of writing. Based on this history Dr. Greatting opined a causal connection between her current condition of ill-being and her work duties. The arbitrator finds it significant that Dr. Greatting did not review petitioner's CMS job description or have a detailed and accurate understanding of her work activities. The arbitrator finds petitioner's own testimony and the histories she provided other medical experts, were far more extensive than what she provided Dr. Greatting. The arbitrator also finds it significant that Dr. Greatting did not know that the problem with her right little finger not being able to adduct has been present since she injured it in high school while playing volleyball, based on the history she provided Dr. Russell.

Given the fact that Dr. Williams was able to review petitioner's CMS job description, as well as get a detailed list of her work duties during his examination of her, the arbitrator finds he had a more detailed and accurate understanding of her work activities, and therefore finds his opinions regarding her work activities more persuasive than those of Dr. Greatting, who did not have as detailed and accurate understanding of petitioner's work activities. The arbitrator also finds Dr. Greatting had no knowledge that the problems with petitioner's right little finger not being able to adduct were not something that arose while she was working for

respondent, but rather had been present since she was in High School, based on the history she provided Dr. Russell.

Based on the petitioner's own testimony that her work activities varied a lot; Dr. Williams review of her job description and petitioner's history to him that it was accurate;, the fact that petitioner's complaints were so severe on 10/28/10, while she was off work, that Dr. Greatting recommended a right ulnar nerve release and right carpal tunnel release; and that petitioner still has significant complaints with respect to her right hand and forearm despite the fact that she has not worked for over 1-1/2 years, the arbitrator adopts the opinions of Dr. Williams and finds petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her right upper extremity due to repetitive work activities that arose out of and in the course of her employment by respondent on 2/15/10.

Notwithstanding the arbitrator's finding that petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her right upper extremity due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 1/26/10, 2/15/10 or 3/3/10, the arbitrator further adopts the opinions of Dr. Russell and Dr. Williams that petitioner's current condition of ill-being as it relates to her right upper extremity are not causally related to her alleged work injury.

The arbitrator finds it significant that petitioner's claim that her symptoms improved while she was off work is not supported by the credible evidence. Although the petitioner testified that her symptoms improved while she was off work from 8/23/10 through 1/12/11, the credible record rebuts this testimony. After petitioner had been off for two months, on 10/28/10 Dr. Greatting was of the opinion that petitioner's symptoms were so severe he recommended a right ulnar nerve release and right carpal tunnel release. Additionally, the arbitrator points to petitioner's testimony at trial that despite being off work since the middle of 2013 it still bothers her to write, she still has numbness in her right hand in the ring and little finger, she still experiences a burning sensation on the top of her right forearm from her thumb to midway up her forearm and the burning/tingling pain has not gone away. She also testified that when she lifts and carries things the pain in her forearm worsens, and her right wrist aches when she rotates it. For these reasons the arbitrator finds petitioner's current condition of ill-being as it relates to her right upper extremity is not casually related to the alleged injuries.

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 petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her right upper extremity to repetitive work activities that arose out of and in the course of her

employment by respondent and manifested itself on 1/26/10, 2/15/10 or 3/3/10, and her current condition of ill-being as it relates to her right upper extremity is causally related to the alleged accidents, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hyun Sook Lee,

Petitioner,

vs.

NO. 10WC043837

15IWCC0731

University of Illinois,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 18, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 3 2015
SM/sj
o-7/30/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEE, HYUN SOOK
Employee/Petitioner

Case# **10WC043837**

UNIVERSITY OF ILLINOIS
Employer/Respondent

15IWCC0731

On 9/18/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MEGAN WAGNER
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

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

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY A WELCH
120 W STATE ST
ROCKFORD, IL 61101

0902 UNIVERSITY OF IL/CLAIMS MGMT
CHUCK HUTCHISON
1737 W POLK ST M/C 940 STE B
CHICAGO, IL 60612

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

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

SEP 18 2014

RONALD A. HASKA, Acting Secretary
Illinois Workers' Compensation Commission

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

15IWCC0731

- [ ] 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

Hyun Sook Lee
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **10** WC **043837**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago, IL**, On **July 24, 2014 and August 18, 2014**. 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. [ ] 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 _____

15IWCC0731

FINDINGS

On **5/30/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**98,524.50**; the average weekly wage was $**1,970.49**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

Petitioner ***has in part*** received 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 $**16,336.62** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**16,336.62**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,243.00/week from June 1, 2010 through August 31, 2010 and from September 15, 2010 through July 31, 2011, a total of 58 6/7 weeks, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $16,336.62 in benefits it paid prior to the hearing.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $280.00 to Petitioner for unpaid medical bills at Green Wellness Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Molly C Mason
Signature of Arbitrator

9/18/14
Date

SEP 18 2014

Hyun Sook Lee v. University of Illinois
10 WC 43837

15IWCC0731

Procedural History

Petitioner's original Application for Adjustment of Claim, filed on November 12, 2010, alleged a work accident of May 3, 2010.

English is not Petitioner's native language. At the first hearing, held on July 24, 2014, Petitioner began testifying without an interpreter. Although some of her answers were responsive to the questions posed, others were not. In the midst of direct examination, the Arbitrator recommended that the trial be continued so that Petitioner could return with an interpreter. The parties followed this recommendation.

After the July 24, 2014 hearing, Petitioner filed an Amended Application for Adjustment of Claim, changing the date of accident to May 30, 2010. PX 9.

The Arbitrator conducted a second hearing on August 18, 2014. A Korean-speaking interpreter was present at that time but, for the most part, Petitioner testified in English. Petitioner indicated she has some difficulty understanding Korean because she has lived in the United States for many years. Petitioner also explained that many of the technical terms she needed to use in order to describe her duties and the accident are not readily translatable.

Respondent did not object to the accident date amendment. The trial was concluded on August 18, 2014.

Arbitrator's Findings of Fact

Petitioner testified she is five feet tall. As of her claimed May 30, 2010 work accident, she weighed about 112 or 114 pounds. As of the accident, she had worked for Respondent for about 13 years. She worked as a "STEM" nurse, preparing patients for surgery. Some of her duties were physical in nature. She had to lift trays, move equipment and transfer patients from gurneys to tables. Some of the patients weighed as much as 350 pounds. She typically obtained assistance from another nurse and/or a resident when transferring a patient.

Petitioner testified that, on the date of her claimed accident, she worked the night shift, which began at 11 PM. Near the end of that shift, she had to prepare a patient for a 7 AM surgery. In order to do this, she had to maneuver a Neptune machine, which is used to suction patients. She testified that this machine is about 4 ½ feet tall. At the first hearing, she indicated the machine weighs 120 pounds. At the second hearing, she indicated that it weighs 106 pounds. Initially, she moved the machine by pulling it. She had no difficulty doing so. The machine moved smoothly. Then she had to push the machine into place. She started pushing but the machine would not budge. After checking the brake, she pushed the machine again, more forcefully. At the first hearing, she testified she did not experience symptoms during the

rest of that day but began experiencing left-sided neck pain that night. At the second hearing, she described a slightly different time frame.

Petitioner testified that, on May 30, 2010, she left work at about 8 AM, went home and went to sleep. The following day, she experienced some discomfort in her left shoulder and the left side of her neck. She took Tylenol but was not able to sleep that night. By June 1, 2010, she was experiencing terrible pain in her left shoulder, the left side of her neck and her left upper back. She went to the health department at work and reported the injury to a supervisor. At the first hearing, she identified this supervisor as "Jerry." At the second hearing, she was not able to recall the supervisor's name. [Notice is not in dispute]. The supervisor completed a form and allowed her to go to health services.

Petitioner acknowledged previously injuring her neck and left shoulder in a motor vehicle accident that occurred on September 21, 2005. As a result of that accident, she underwent a cervical spine discectomy and disc replacement in 2008. Records in PX 1 reflect that, following an extensive but unsuccessful course of conservative care, Dr. Yapor performed an anterior cervical discectomy and artificial disc replacement at C5-C6 at Swedish Covenant Hospital on March 3, 2008. Dr. Yapor described Petitioner as doing very well postoperatively. He released Petitioner from care on a PRN basis on July 22, 2008. He cleared Petitioner to resume her regular activities on the same date. PX 1.

Petitioner testified that, following her cervical spine surgery, she returned to her regular job at Respondent in August of 2008. She testified she felt fine at that time. She also testified she did not undergo any acupuncture or other treatment for her neck or shoulder between the time she returned to work in August of 2008 and the accident of May 30, 2010.

The University Health Service records of June 1, 2010 reflect that Petitioner complained of "left-sided neck & shoulder pain after moving a heavy piece of surgical equipment, w/a reportedly defective wheel" on May 30, 2010. The records also reflect that Petitioner reported feeling only minor soreness and stiffness shortly after the accident but began experiencing 7-8/10 pain and difficulty moving her neck and left shoulder the following day.

On cervical spine examination, Dr. Marder noted limited forward flexion and rotation, tenderness on palpation and a positive Spurling's test, in addition to the scar from the previous surgery. On left shoulder examination, Dr. Marder noted anterior tenderness on palpation, some weakness, a positive Neer's test and somewhat equivocal Hawkins and "empty can" tests. He diagnosed cervical and posterior shoulder strains "with apparent RTC (supraspinatus) injury/strain." He prescribed Naprosyn and Flexeril and imposed various restrictions, including no lifting overhead. He indicated that Petitioner's supervisor could not accommodate these restrictions. PX 2. He instructed Petitioner to return to him on June 4, 2010.

Petitioner returned to University Health Services on June 4, 2010, as instructed, and again saw Dr. Marder. Petitioner complained of left-sided neck and posterior shoulder pain,

radiating down her left arm. Dr. Marder noted that Petitioner had remained off work since the initial visit because her supervisor was unable to accommodate her restrictions.

Dr. Marder's cervical spine examination findings remained unchanged. On left shoulder examination, he noted no tenderness or weakness and negative Neer's, Hawkins and "empty can" tests. He also noted a slightly diminished left hand grip strength as compared to the right. He obtained cervical spine X-rays which showed "C6-C7 spondylosis with disc space narrowing and anterior osteophyte." He continued the previous restrictions, recommended CPM and instructed Petitioner to return on June 8, 2010. PX 2.

Petitioner testified that, on June 4, 2010, Dr. Marder imposed restrictions of no lifting over 5 pounds and no overhead work. Petitioner further testified that Respondent did not provide her with work within these restrictions.

Petitioner returned to Dr. Marder on June 8, 2010 and reported no change in her symptoms. Dr. Marder continued the work restrictions and directed Petitioner to return to the surgeon who had performed her 2008 surgery as soon as possible. On June 23, 2010, Dr. Marder noted that Petitioner was scheduled to see her surgeon on July 7, 2010. He continued the restrictions and referred Petitioner to Respondent's transitional work program. PX 2.

Petitioner saw Dr. Yapor on July 7, 2010. In his note of that date, the doctor indicated that Petitioner reported feeling "extremely well until she had an injury at work with a large suction machine." He noted that Petitioner "injured her neck during a maneuver" and complained of pain and numbness in her left shoulder and the left side of her neck. He also noted that Petitioner had undergone cervical spine X-rays and was obtaining some relief from the medication prescribed by Dr. Marder.

Dr. Yapor interpreted the X-rays as showing "that the cervical disc prosthesis at the C5-C6 level seems to produce flexion-extension in a normal pattern" but that they also showed "spondylitic changes at the C6-C7 level with disc space narrowing."

On examination, Dr. Yapor noted no focal motor weakness, some decreased sensation over the C5 dermatome on the left side, good deltoid strength and physiologic reflexes.

Dr. Yapor prescribed Celebrex, Lyrica and a cervical spine CT scan. He noted than an MRI "would have too much artifact from the metal." He instructed Petitioner to stay off work. PX 1.

On July 9, 2010, Petitioner began a course of care at Green Wellness Center. The records from this facility document three visits between July 9 and 15, 2010 and dozens of visits between December 6, 2010 and January 22, 2013. The records are handwritten, very brief and difficult to interpret. Some of the notes are in a language other than English. All of the notes reflect complaints of neck and shoulder or scapular pain but they also contain mention of

backaches, fatigue, headaches, eye ailments and dizziness. They contain references to electro-stimulation and cupping. PX 3.

The cervical spine CT scan, performed without contrast on July 12, 2010, showed "excellent alignment" of the C5-C6 disc prosthesis, "good placement of cortical screws at both C5 and C6" and "minimal osteophytic change at C5-C6 and C6-C7 without significant spinal canal or neural foraminal stenosis." PX 4, p. 4.

Petitioner returned to Dr. Yapor on July 21, 2010. The doctor reviewed the CT scan, noting no complications in the cervical hardware and no herniated discs or stenosis at any level. He further noted that Petitioner was still experiencing discomfort in her left shoulder and the left scapular area. He indicated it was possible Petitioner had pulled a muscle in her left shoulder or left scapular region, "completely independent of cervical issues." He recommended a month-long course of physical therapy and instructed Petitioner to continue taking the Celebrex and Lyrica. He continued to keep Petitioner off work. PX 1.

On July 26, 2010, Petitioner underwent an initial therapy evaluation at AthletiCo. The evaluating therapist, Ioulia Fudukos, P.T., recorded a lengthy, detailed account of the 2008 cervical spine surgery and the May 30, 2010 work accident. The account of the accident is fully consistent with Petitioner's testimony, with Fudukos indicating Petitioner was initially able to pull a Neptune suction machine without difficulty but had great difficulty pushing the machine. Fudukos indicated that Petitioner attempted to push the machine with "all her might" and eventually had to resort to rotating and pulling the machine. PX 5, pp. 22-23. She also indicated that Petitioner complained of difficulty flexing and abducting her left arm, rotating her neck when driving, looking down to read a patient's chart, using her left arm to push/pull an object and reaching behind her back or across her chest. Fudukos described Petitioner as right-handed. PX 5, p. 22. A subsequent note, dated August 13, 2010 and authored by a different therapist, Zachary Gregory, P.T., describes Petitioner as presenting "with a wide variety of symptoms that seem to change at each visit with different movement." Gregory commented that some of Petitioner's findings "seem inconsistent as far as her pain production goes." PX 5, pp. 37-38. On August 16, 2010, Gregory indicated that Petitioner's complaints were not consistent with "objective observation of [Petitioner] while getting into her car upon leaving treatment." He described Petitioner as "turning head to both right and left without hesitation" and displaying "active left shoulder flexion to 90 degrees without hesitation using her left arm while in her car." PX 5, pp. 39-40. On August 18, 2010, Gregory noted that Petitioner reported some improvement but was still complaining of shoulder and neck pain, aggravated by driving. PX 5, p. 41. In a progress note dated August 20, 2010, Gregory noted overall improvement since the start of therapy but indicated Petitioner remained symptomatic. He recommended continued therapy. PX 5, p. 46. There is no evidence indicating that Petitioner continued attending therapy thereafter. Gregory issued a discharge note on September 20, 2010. PX 5, p. 48.

Petitioner returned to Dr. Yapor on August 24, 2010. The doctor noted that Petitioner reported improvement but was still complaining of pain, primarily in her left shoulder. The

doctor prescribed a left shoulder MRI. He continued to keep Petitioner off work. PX 1, pp. 34-35.

Petitioner returned to University Health Services on August 25, 2010 and again saw Dr. Marder. The doctor noted that Petitioner reported improvement but was still experiencing neck and shoulder pain as well as intermittent paresthesias down her left arm. On examination, he noted limited movement in both the neck and left shoulder "but no impingement signs." He indicated that therapy notes revealed "some suspicion of thoracic outlet syndrome as a potential" cause of Petitioner's complaints. He indicated that a brachial plexus MRI or ultrasound would be beneficial in assessing Petitioner for this syndrome. He also indicated that Petitioner was being assigned to a "transitional work assignment that is within her current functional abilities." PX 2, pp. 35-36.

The left shoulder MRI, performed without contrast on August 31, 2010, showed a trace amount of fluid in the subacromial/subdeltoid bursa and a trace effusion. The radiologist noted "no evidence of internal derangement of the left shoulder." PX 1, p. 36. PX 4, p. 5.

Petitioner testified she attempted to perform light duty computer work for Respondent on September 1, 2010 but began experiencing terrible pain after using the computer for 30 to 60 minutes. She testified she could not return to work the following day.

Petitioner returned to Dr. Marder on September 8, 2010. The doctor noted that Petitioner "started in the transitional work program but started calling in after one day of work, stating her left neck & shoulder pain [was] too severe." The doctor noted that Petitioner described her current pain as "just as bad as when it first happened." On re-examination, he noted a limited range of cervical spine motion, persistent tenderness on palpation of the left-sided cervical and trapezius muscles and some limitation in left shoulder range of motion. He noted that Petitioner planned to see her chiropractor the next day. He released Petitioner to sedentary duty on September 10, 2010 with the additional restriction of a 5 to 10 minute break every 1 to 2 hours for icing and stretching. PX 2, p. 38. PX 6, p. 35. There is no evidence indicating Petitioner returned to work at any point after September 8, 2010.

Petitioner saw Dr. Lee, a chiropractor, on September 9, 2010. The doctor recorded a consistent history of the 2008 surgery and work accident of May 30, 2010. He described Petitioner as making a full recovery from the surgery and having no neck or shoulder problems before the May 30, 2010 accident. He indicated Petitioner rated her current pain level at 7-9/10. PX 6, p. 7.

On September 14, 2010, Dr. Lee issued a note recommending that Petitioner avoid performing any lifting, carrying, pushing, stooping, bending, sitting or standing beyond 30 minutes at a time until September 21, 2010. PX 6, p. 21. Dr. Lee also prescribed a neurological consultation and EMG/NCV testing. PX 6, p. 28.

Petitioner also saw Dr. Yapor on September 14, 2010. The doctor noted that Petitioner denied forearm or hand pain but was still experiencing left shoulder pain and some discomfort in the left paracervical area. After reviewing the left shoulder MRI, he ordered an EMG/NCV of the left upper extremity. He refilled Petitioner's Lyrica prescription and directed Petitioner to remain off work. PX 1, pp. 38-39.

Petitioner returned to Dr. Marder on September 15, 2010. The doctor noted that Petitioner had seen her chiropractor and neurosurgeon since her last visit and that she did not feel able to return to her transitional job. He informed Petitioner that "failure to report to her transitional job may result in a stoppage of TTD payments from work comp." PX 2, p. 42.

A letter in Dr. Lee's chart reflects that a claims specialist provided written authorization for a neurological consultation and EMG/NCV on September 15, 2010. PX 6, p. 17.

Dr. Osman, a neurologist, examined Petitioner and performed EMG/NCV testing of the left upper extremity and cervical paraspinal muscles on September 21, 2010. On examination, he noted cervical and trapezius spasm, tenderness and limited range of motion, worse on the left. He found the test results to be "compatible with left C5-C6 radiculopathy." He prescribed Naprosyn and recommended Petitioner continue chiropractic therapy for five to six weeks. PX 1, p. 40. PX 7, p. 3.

Petitioner continued seeing Dr. Lee thereafter. On September 28, 2010, Dr. Lee issued a note taking Petitioner off work for two weeks.

On September 30, 2010, Dr. Marder noted that Petitioner remained symptomatic, was off work at the direction of her treating physicians and planned to apply for SURS disability. He directed Petitioner to return on October 15, 2010. PX 2, p. 45.

Petitioner returned to Dr. Yapor on October 13, 2010. The doctor noted that Petitioner was undergoing chiropractic care with Dr. Lee and deriving benefit from this care. He also noted the EMG/NCV results, indicating that the report was silent as to whether the C5-C6 radiculopathy was chronic, old, healing or active. He indicated that the EMG/NCV revealed "absolutely no neurological deficit." He indicated this was "identical" to his own examination. He prescribed Naprosyn, as well as continued chiropractic care (PX 6, p. 19) and completed some paperwork for Petitioner. PX 1, p. 41.

On October 21 and November 9, 2010, Dr. Lee issued notes indicating that Petitioner should refrain from working (through November 23, 2010) to avoid aggravating her condition. PX 6, pp. 23-24. A note in Dr. Lee's chart reflects that a claims specialist provided written authorization for eight chiropractic treatments on October 27, 2010. PX 6, p. 25.

Petitioner next saw Dr. Yapor on November 16, 2010. The doctor noted she complained of left-sided neck pain that went into the scapular area but did not radiate into the arm. He described Petitioner's "old radicular pain" as "completely resolved." He indicated it was "very

possible that her pain may be due to facet arthropathy at the level of C5-C6." He described Petitioner as neurologically intact but "quite disturbed about the continued pain." He increased Petitioner's Lyrica dosage, prescribed Ibuprofen and recommended Petitioner see Dr. Xie or Dr. Chang for a left C5-C6 facet block. He directed Petitioner to stay off work. PX 1, p. 42.

Petitioner testified that insurance would not cover the facet block and that she was not given authorization to undergo pain management.

On November 19 and December 2, 2010, Dr. Lee sent letters to the claims specialist requesting authorization of additional chiropractic care. PX 6, pp. 26-27.

On December 14, 2010, Dr. Yapor noted that Petitioner had been denied authorization to visit a pain clinic. He further noted that Petitioner had not started a previously prescribed Medrol Dose-Pak because she "wanted to wait until she was seen by the pain clinic." He described his neurological examination as stable. He prescribed Norco and encouraged Petitioner to take the Medrol Dose-Pak in the interim. He took Petitioner off work pending a pain clinic evaluation. PX 1, pp. 44-45.

At Respondent's request, Petitioner saw Dr. Gunnar Andersson for purposes of a Section 12 examination on January 20, 2011. In his report of that date, Dr. Andersson indicated he reviewed records from University Health Services, Athletico, Dr. Yapor, Dr. Lee and Resurrection Medical Center as well as a job description and the Application for Adjustment of Claim.

Dr. Andersson's report sets forth a consistent account of the 2008 surgery, the May 30, 2010 work accident and the post-accident care. Dr. Andersson noted that Petitioner had not yet undergone the injection recommended by Dr. Yapor and that Petitioner reported treating via medication and acupuncture. He indicated that Petitioner complained of pain, primarily in the left shoulder but also in the left side of the neck. He also indicated that Petitioner complained of some numbness around her left shoulder.

On cervical spine examination, Dr. Andersson noted some tenderness over the left part of the neck and a decreased range of motion, with flexion to 30 degrees, extension to 10 degrees, right and left lateral bending of 0 degrees and right and left rotation of 0 degrees. On shoulder examination, he noted generalized weakness of all shoulder muscles. He indicated that "two of six non-organic physical signs are positive."

Dr. Andersson indicated it would be helpful to review the radiographic studies. After noting that Petitioner presented "with evidence of illness behavior," he recommended a functional capacity evaluation. At the current time, he found Petitioner capable of light duty with occasional lifting of 20 pounds. Based on the CT and EMG/NCV reports, which he described as benign, he did not feel that Petitioner injured her cervical spine in such a way as to cause permanent problems. RX 1.

On February 8, 2011, Petitioner returned to Dr. Yapor. The doctor described Petitioner as "unchanged." He noted she had not received authorization for pain management. He also noted she still had not taken the previously prescribed Medrol Dose-Pak.

Dr. Yapor noted that, while the EMG/NCV was compatible with a left C5-C6 radiculopathy, Petitioner had "no radicular symptoms in her forearm" and primarily complained of pain in her trapezius muscle and lateral cervical region. He again prescribed a Medrol Dose-Pak. He also recommended 20 pounds of cervical traction. He refilled Petitioner's prescriptions for Norco and Lyrica and directed Petitioner to remain off work. PX 1, p. 46.

Petitioner saw Dr. Yapor again on March 17, 2011. In his note of that date, Dr. Yapor indicated that Petitioner reported improvement secondary to the Medrol Dose-Pak and acupuncture but stated she was more symptomatic than usual that day due to the weather.

Dr. Yapor commented as follows concerning Dr. Andersson's findings:

> "Dr. Gunnar Andersson performed an IME on the patient and he feels that the patient is suffering from symptom magnification. He is recommending a functional capacity evaluation with validity testing, which I feel would be an excellent idea. I recommend that the patient have the evaluation performed and return to me once it has been completed."

PX 1, p. 48. PX 8, p. 21.

Petitioner underwent the functional capacity evaluation at ATI on June 9, 2011. It is not clear why the functional capacity evaluation did not take place earlier. Jonathan A. Beaty, ATC, CSCS, a KEY certified assessment specialist, performed the evaluation. Beaty rated the evaluation as valid. He noted that Petitioner was employed as a RN/surgical nurse. He categorized this job as a light physical demand occupation, with occasional lifting up to 25 pounds, based on the Dictionary of Occupational Titles but noted that no detailed job description had been made available to him. He indicated that Petitioner reported being required to lift 10 pounds. He found that Petitioner's capabilities technically met this level but that Petitioner exhibited "significant deficits when comparing unilateral lifting with left arm vs. right arm." He noted that left arm lifting "caused increased pain and weights lifted were significantly lower than right arm." He indicated that Petitioner might benefit from a course of work conditioning with the goal of increasing her left upper extremity strength and tolerance to activity. PX 8, p. 4. RX 5.

On July 19, 2011, Dr. Yapor reviewed the functional capacity evaluation and released Petitioner to work, with the caveat that Petitioner was "to follow FCE recommendations." He directed Petitioner to return to him on August 1, 2011.

Petitioner testified that July 31, 2011 was her last date of employment by Respondent. She testified she felt physically unable to resume her former operating room duties. She applied for disability benefits and retired due to her disability and pain.

Dr. Andersson issued an addendum on March 8, 2013, after reviewing the radiographic studies, including the CT scan and cervical spine MRI scan, the records from Green Wellness (which he characterized as "in longhand, very short and not very helpful") and the functional capacity evaluation.

Dr. Andersson addressed causation as follows:

> "It is possible that the [work accident] resulted in a temporary aggravation of [Petitioner's] pre-existing condition, which had been treated with a fusion C5-C6. There is no evidence that there was a permanent aggravation of her underlying condition."

Dr. Andersson characterized Petitioner's work injury as "primarily a strain to the back" but he "could not exclude that she temporarily aggravated her underlying condition."

Dr. Andersson opined that Petitioner reached maximum medical improvement on August 1, 2011. He indicated her prognosis was excellent.

Dr. Andersson opined that all of the treatment Petitioner underwent prior to his examination was reasonable "except for the excessive acupuncture treatments that she has received." RX 2.

Petitioner testified that, due to her work injury, she is no longer able to work, lift heavy objects or comfortably use a computer or read a book. When she tries to use a computer or read, she experiences neck pain. Cold weather causes her muscles to tighten. She was not sensitive to weather changes before the injury. She is still undergoing chiropractic and acupuncture treatment.

Under cross-examination, Petitioner testified she was honest with her medical providers, including those at University Health Services. She recalled the EMG/NCV as showing radiculopathy at C6-C7, not C5-C6. If in fact the radiculopathy was at C5-C6, it would be at the same level as her previous surgery. She acknowledged telling the functional capacity evaluator she was required to lift ten pounds. She is not familiar with the Dictionary of Occupational Titles. In 2007, she signed a written description of her job. RX 7. Her job title was "clinical nurse 1." Following the functional capacity evaluation, Dr. Yapor released her to regular duty. She is able to perform activities of daily living so long as she avoids heavy lifting. No provider is currently recommending treatment but she continues to feel pain. She regularly takes Tylenol for pain. She does not take prescription pain medication.

On redirect, Petitioner testified that, as of her 2010 work accident, her job requirements included moving heavy equipment and performing heavy lifting on a daily basis.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's fairly lengthy employment by Respondent weighs in her favor, credibility-wise.

Petitioner provided detailed, unrebutted testimony concerning her work accident. Petitioner acknowledged undergoing cervical spine surgery about two years prior to this accident but indicated she recovered fully from the surgery and was able to resume her regular nursing duties thereafter. Dr. Yapor's records support Petitioner's testimony on these points.

Dr. Marder, a physician of Respondent's selection, did not raise any questions concerning Petitioner's presentation. In fact, he imposed additional restrictions after Petitioner's failed attempt to resume light duty and recommended a work-up to exclude thoracic outlet syndrome. There is no evidence indicating Petitioner ever underwent this work-up. A physical therapist noted inconsistencies in Petitioner's presentation in August 2010 but nevertheless recommended continued therapy. Respondent's examiner, Dr. Andersson, noted "illness behavior" in his report of January 20, 2011 but nevertheless recommended a 20-pound lifting restriction pending a functional capacity evaluation. Dr. Yapor did not note symptom magnification but agreed with Dr. Andersson's suggestion of a functional capacity evaluation with validity profiling. The functional capacity evaluation proved to be valid.

The Arbitrator finds credible Petitioner's testimony that she was required to push/pull heavy equipment and assist with transfers of potentially heavy patients as of May 30, 2010. RX 7, a job description dated November 2007, is not in conflict with Petitioner's testimony on these points. RX 7 reflects that one of Petitioner's duties was to assure patient safety. RX 7 also reflects that Petitioner was expected to "adapt rapidly" and adjust her activities as necessary due to "the degree of unpredictability that can occur from day to day." Lifting is one of the listed physical requirements of the job. The extent of the required lifting is not stated.

Overall, the Arbitrator found Petitioner credible.

Did Petitioner sustain an accident arising out of and in the course of her employment? What is the date of the accident?

The Arbitrator finds in Petitioner's favor on the issue of accident. As noted above, no witness contradicted Petitioner's detailed testimony concerning the Neptune machine and the circumstances leading to the accident. Petitioner credibly testified her symptoms progressively worsened after the accident. She reported the accident within a couple of days and provided consistent accounts of the accident to various treating physicians.

Petitioner established that her accident occurred on May 30, 2010 and that it arose out of and in the course of her employment.

Did Petitioner establish a causal connection between her work accident and her current condition of ill-being?

The Arbitrator finds that the work accident of May 30, 2010 resulted in a permanent aggravation of Petitioner's pre-existing but then asymptomatic C5-C6 cervical spine condition of ill-being, bringing about the need for treatment and impairing Petitioner's ability to resume her former occupation. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony that she recovered fully from her 2008 cervical spine surgery and was able to resume her regular nursing duties thereafter; 2) Petitioner's credible testimony that she did not undergo cervical spine treatment between the time Dr. Yapor released her from treatment in 2008 and the work accident; 3) Dr. Yapor's treatment records, which reflect Petitioner did very well following the 2008 surgery and targeted the work accident as the cause of her symptoms when she returned to him in 2010; 4) Petitioner's credible account of the size and weight of the Neptune machine and the mechanism of injury; 5) the records from University Health Services and Dr. Marder.

Is Petitioner entitled to acupuncture-related expenses totaling $8,890?

Petitioner claims a bill from Green Wellness Center in the amount of $8,890. She testified she underwent acupuncture treatment at this facility for about eight months, beginning on July 9, 2010. She further testified the treatment alleviated her neck and shoulder pain and improved her function.

Respondent offered into evidence a retrospective utilization review notice of determination that modified a previous determination by certifying four acupuncture visits. The author of the notice of determination based the modification on ODG Guidelines recommending an initial trial of four acupuncture visits. The author noted that the records did not show clear functional improvements after the fourth such visit. RX 3.

The Arbitrator relies on RX 3 in awarding Petitioner the costs associated with her first four acupuncture sessions at Green Wellness Center. These costs total $280.00. There is no evidence Respondent paid these costs prior to the hearing. See payment print-out. RX 4.

The Arbitrator declines to award Petitioner the expenses associated with the subsequent acupuncture sessions. While Section 8(a) of the Act clearly contemplates palliative as well as curative care, and while Petitioner testified she derived benefit from the acupuncture, the records from Green Wellness Center are brief, difficult to decipher and generally unhelpful, as noted by Dr. Andersson. They do mention neck and shoulder pain but they also mention various other maladies. They also show gradually increasing pain ratings

over time, with the provider noting a rating of 2/10 on July 9, 2010 and 8/10 on January 22, 2013. PX 3, pp. 26-22.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from June 1, 2010 through July 31, 2011. The parties agree Respondent paid $16.336.62 in temporary total disability benefits prior to the hearing. Arb Exh 1.

The Arbitrator, having reviewed the treatment records, finds that Petitioner was temporarily totally disabled from June 1, 2010 (the day Dr. Marder imposed restrictions) through August 31, 2010 (the day before Petitioner attempted to resume light duty) and from September 15, 2010 (the day after Dr. Yapor took Petitioner off work) through July 31, 2011, a period of 45 5/7 weeks. The Arbitrator awards benefits from June 1, 2010 through August 31, 2010 based on the following: 1) Dr. Marder's restrictions and Petitioner's credible testimony that Respondent did not accommodate same; and 2) Dr. Yapor's "off work" notes and treatment recommendations. The Arbitrator declines to award benefits from September 1, 2010 through September 14, 2010 because it appears, based on Dr. Marder's notes, that Petitioner did not make a second attempt at resuming light work after the doctor imposed additional rest break restrictions on September 2, 2010. In awarding benefits from September 15, 2010 through July 31, 2011, the Arbitrator relies on the following: 1) Dr. Yapor's "off work" note and treatment recommendations of September 14, 2010; 2) Dr. Lee's subsequent "off work" notes and treatment recommendations; 3) Dr. Andersson's recommendation that Petitioner avoid lifting more than 20 pounds, pending a functional capacity evaluation; 4) the valid results of the functional capacity evaluation, with the evaluator noting significant difficulty with left-handed lifting; 5) the fact that Dr. Yapor instructed Petitioner to adhere to the recommendations of the functional capacity evaluation; 6) the absence of evidence indicating that Respondent offered work within the recommendations of the functional capacity evaluation; 7) Petitioner's credible testimony concerning the large size of some patients and her lifting/pushing/pulling duties; and 8) the fact that Petitioner had a broad, ill-defined responsibility to "assure patient safety" per Respondent's job description (RX 7).

What is the nature and extent of the injury?

This is a pre-amendatory case, since Petitioner's accident occurred prior to September 1, 2011. Based on the valid functional capacity evaluation, which demonstrated significantly limited left-handed lifting ability, along with Petitioner's credible testimony concerning her ongoing complaints, typical duties and the broad work responsibilities outlined in RX 7, the Arbitrator finds that the work accident affected Petitioner's ability to resume her former nursing job. Dr. Yapor released Petitioner to work but on the condition that Petitioner would adhere to the recommendations of the functional capacity evaluator.

The Arbitrator awards permanency equivalent to 12.5% loss of use of the person as a whole, or 62.5 weeks of compensation, under Section 8(d)2 of the Act.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dan Olson,

Petitioner,

15IWCC0718

vs.

NO: 13 WC 31020

John Deere,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2014, 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.

15IWCC0718

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: SEP 17 2015
O8/4/15
RWW/rm
046

Ruth W. White

Joshua D. Luskin

DISSENTING OPINION

I must respectfully dissent. Petitioner credibly testified regarding his work activities as a painter for Respondent for six years. These job duties included sanding and painting pieces of metal. He would sand the pieces with an air-driven palm sander, which required pressure to get the baked-on paint off, and also by hand. He would then spray on primer and then paint using his hands.

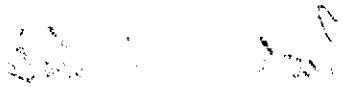
Due to a non-work-related injury to his left thumb, Petitioner sought the care of Dr. Thomas VonGillern of ORA Orthopedics on April 16, 2013. On May 3, 2013, Dr. VonGillern performed surgery on the left thumb. During his May 16, 2013, post-operative evaluation, Dr. VonGillern noted that Petition was suffering from numbness and tingling in his left thumb.

On July 15, 2013, Petitioner returned to Dr. VonGillern who noted that Petitioner was still experiencing numbness and tingling. An EMG of the left upper extremity on July 18, 2013 revealed compressive neuropathy of the left median nerve at the wrist. On July 25, 2013, Dr. VonGillern diagnosed left carpal tunnel syndrome and noted that Petitioner might be suffering from right carpal tunnel syndrome as well since he reported that his right hand was also falling asleep with some activities. An EMG of the right upper extremity on August 13, 2013 revealed neuropathy of the right median nerve at the wrist as well.

On September 9, 2013, Dr. VonGillern noted that Petitioner's left thumb had improved but he was still having bilateral numbness and tingling in his hands. Dr. VonGillern noted that Petitioner works as a painter and does a lot of tight repetitive gripping. Dr. VonGillern recommended bilateral carpal tunnel releases which were performed on the left hand on November 1, 2013, and on the right hand on January 24, 2014.

Neither Petitioner nor his doctor knew that he had carpal tunnel syndrome until the July 25, 2013 appointment that followed the EMG of Petitioner's left hand. On that date, the relationship between the repetitive duties that Petitioner performs at his job and the development of carpal tunnel syndrome would have become plainly apparent to a reasonable person. I would reverse the Arbitrator and find that Petitioner sustained a work-related injury that manifested on July 25, 2013 with Dr. VonGillern's formal diagnosis of carpal tunnel syndrome.

Respondent had Petitioner examined by Dr. Christine Deignan who opined that Petitioner's conditions were not causally related to his work for Respondent. She wrote that based on recent literature there is no strong evidence to indicate that repetitive work, as typically performed by a painter, can cause carpal tunnel syndrome. In adopting the opinion of Dr. Deignan, the Arbitrator wrote that the only medical opinion of causation is contained in the



15IWCC0718

February 28, 2014 report of Dr. VonGillern and found it unpersuasive. The Arbitrator found that Dr. Deignan's opinions were "at least as reliable and persuasive" as those of Dr. VonGillern.

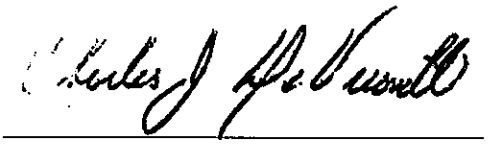
The Arbitrator adopted the opinion of an in-house physician who is employed by Respondent and whose opinions are not independent in the spirit of Section 12. Furthermore, it is not at all clear whether Dr. Deignan is even an orthopedic surgeon, as she works in the Occupational Health Services department for Respondent. Dr. Deignan's report is essentially just a summary of other doctors' medical opinions regarding the causes of carpal tunnel syndrome. In contrast, Dr. VonGillern, who clearly is an orthopedic surgeon, authored a report in which he reasonably noted that constant tight repetitive gripping could cause carpal tunnel syndrome. Dr. VonGillern opined that it is within a reasonable degree of medical certainty that Petitioner's bilateral carpal tunnel syndrome was caused and/or aggravated by his work activities of tight repetitive gripping.

It is unfathomable to imagine that sanding down pieces of metal all day and then painting them could not be a causative factor in the development of carpal tunnel syndrome. The opinion that this work could not have even been a causative factor in Petitioner's development of carpal tunnel syndrome is not one that this Commission should consider adopting.

The law is clear that Petitioner does not need to prove that his work activities were the sole causative factor but, rather, that they were *a* contributing factor to his development of carpal tunnel syndrome. Even if the Commission were to find Dr. Deignan's opinion persuasive that age and increased body mass index are factors, it should not disregard the fact that constant tight gripping, consistent with Petitioner's job description, is also a causative factor in the development of carpal tunnel syndrome.

The true dispute in this matter stems from a determination of which medical opinion the Arbitrator should have adopted with regard to the issue of causal connection. A review of those opinions in conjunction with the testimony of Petitioner should lead to a reversal of the Arbitrator's decision as it was clearly based on an inherently biased opinion authored by an employee of Respondent and disregarded the reasonable opinion of Dr. VonGillern that constant tight repetitive gripping is a causative factor in the development of carpal tunnel syndrome.

Based on the above, I would reverse the Arbitrator regarding accident and causation and would award benefits including medical expenses, temporary total disability, and permanent partial disability.



Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0718

OLSON, DAN
Employee/Petitioner

Case# **13WC031020**

JOHN DEERE
Employer/Respondent

On 11/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
JASON RUBENS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

2119 CALIFF & HARPER PC
STEVEN L NELSON
506 15TH AVE SUITE 600
MOLINE, IL 61285

15IWCC0718

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dan Olson
Employee/Petitioner

Case # **13** WC **31020**

v.

John Deere
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **September 9, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 25, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**57,057.00**; the average weekly wage was $**1,097.25**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,496.00** for other benefits, for a total credit of $**2,496.00**.

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

~~Arbitrator~~ Anthony C. Erbacci

November 5, 2014
Date

NOV 10 2014

15IWCC0718

FACTS:

On July 25, 2013 the Petitioner was employed by the Respondent doing "paint repair" and he had been so employed for approximately six years. The Petitioner explained that his job duties required him to repair flaws in the paint on various parts and pieces of machinery produced by the Respondent. The Petitioner testified that in performing his job duties he was required to sand the painted surfaces down to bare metal and then clean the area, apply a coat of primer and, finally, apply a coat of new paint. The Petitioner testified that he primarily used an air powered palm sander to sand off the paint but that he was, at times, also required to use a hand sander to remove the paint. The Petitioner testified that he used an air powered sprayer to spray on the primer and the finish paint. The Petitioner testified that in early 2013 he began to notice numbness and tingling in both of his hands.

On March 29, 2013 the Petitioner sought treatment from his primary care physician, Dr. Bindu Alla, for an injury he sustained to his left thumb while he was on vacation. Dr. Alla noted complaints of left thumb pain and swelling and he noted findings of swelling of the hands, swelling of the first carpometacarpal joint and tenderness on palpation of the hands. The Petitioner then came under the care of Dr. Thomas VonGillern of ORA Orthopedics for his thumb injury and on May 3, 2013 Dr. VonGillern performed surgery on the Petitioner's left thumb.

On July 15, 2003 the Petitioner followed up at ORA Orthopedics and was seen by Physician Assistant Jennifer Scardino. Ms. Scardino noted that the Petitioner was doing well with regard to his left thumb symptoms but she noted that the Petitioner "does continue to have numbness on the volar aspect of the thumb, distal to the IP joint, on both the radial and the ulnar aspect." Ms. Scardino's assessment included possible left carpal tunnel syndrome and she ordered left upper extremity EMG studies. On July 18, 2013, EMG/NCV studies were performed which were reported to reveal compressive neuropathy of the left median nerve at the wrist.

On July 25, 2013 the Petitioner returned to ORA Orthopedics and was again seen by Physician Assistant Jennifer Scardino. Ms. Scardino noted the Petitioner's positive EMG/NCV results and she noted that "At today's appointment, he also relates that he has noticed that his right hand does fall asleep at night and also when he is using a pole with fishing." Ms. Scardino recommended surgery for the Petitioner's left carpal tunnel syndrome and she ordered right EMG studies to confirm her impression of right carpal tunnel syndrome. On August 13, 2013, EMG/NCV studies were performed which were reported to reveal compressive neuropathy of the right median nerve at the wrist.

On August 14, 2013 the Petitioner reported to the Respondent's medical department and reported that he was recently diagnosed with bilateral carpal tunnel syndrome. On August 18, 2013 he was seen by Dr. William Candler at the Respondent's medical department. At that time, the Petitioner reported that he had bilateral hand numbness for six to seven months. He also reported that he was told he had bilateral carpal tunnel syndrome when he had surgery on his left thumb which was in May of 2013. He complained of hand numbness at night that

wakes him up and he denied numbness at work.

On November 1, 2013, the Petitioner underwent surgery for left carpal tunnel syndrome and on January 24, 2014, the Petitioner underwent surgery for right carpal tunnel syndrome. On February 5, 2014 the Petitioner was released to return to his regular work on February 17, 2014. The Petitioner did return to his regular work for the Respondent without restrictions, and he continues to perform that job with no restrictions to the present time.

In a letter report dated February 28, 2014 and directed to the Petitioner's attorney, Dr. VonGillern noted that the Petitioner worked at the Respondent "doing painting with a constant tight repetitive gripping". Dr. VonGillern noted that "Constant tight repetitive gripping can cause carpal tunnel syndrome" and he opined that the Petitioner's bilateral carpal tunnel syndrome "were caused and/or aggravated by his work activities of tight repetitive gripping."

At the request of the Respondent, the Petitioner was examined and evaluated by Dr. Christine Deignan, the Medical Director of the Respondent's Occupational Health Services, on May 19, 2014. Dr. Deignan noted that the Petitioner was right hand dominant and that his job as a painter required him to use an air sander and sometimes a hand sander as well as an air sprayer to apply paint. Dr. Deignan noted that the Petitioner used both hands for his painting job and that his hands were required to be positioned with different orientations for each surface he had to sand or paint. Dr. Deignan concluded that the Petitioner's required work activity fell below the defined criteria for repetitive work, and she opined that the Petitioner's bilateral carpal tunnel syndrome was not caused by his work activity for the Respondent.

Dr. Deignan also noted that the Petitioner was satisfied with the results of his surgeries and reported that he had no numbness or tingling and had regained full strength and no longer dropped things as he had in the past. Dr. Deignan also reported that the Petitioner's level of impairment pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment, 6th Edition, was 0%.

The Petitioner testified that he currently experiences occasional numbness, tingling and weakness in both of his hands and that he occasionally drops things. He testified that, other than his thumb injury, he has had no prior injuries to his hands and that he has had no subsequent injuries to his hands.

CONCLUSIONS:

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

It is axiomatic that the Petitioner bears the burden of proving all the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner

failed to meet that burden here. In so finding, the Arbitrator notes that the only medical opinion of causation is contained in the February 28, 2014 letter report of Dr. VonGillern. The Arbitrator questions the reliability of that report and finds it to be unpersuasive.

The Arbitrator notes that there is nothing in Dr. VonGillern's report or his treatment records which indicates that he had an understanding of the Petitioner's actual job activities. Dr. VonGillern merely indicated that the Petitioner worked at the Respondent "doing painting with a constant tight repetitive gripping". Further, it appears from Dr. VonGillern's report that the doctor was not clear as to the course of the Petitioner's medical treatment. In his report, Dr. VonGillern notes that the Petitioner "had bilateral upper EMG/NCV done on 8/13/13 showing bilateral Carpal tunnel syndrome". The Petitioner was actually diagnosed with left carpal tunnel syndrome after a July 18, 2013, EMG/NCV study and with right carpal tunnel syndrome after an August 13, 2013 EMG/NCV study. Dr. VonGillern also notes "I have recommended proceeding with bilateral median nerve lysis with possible limited flexor tenosynovectomy." This would seem to indicate that Dr. VonGillern forgot about the surgeries he performed on November 1, 2013 and January 24, 2014. Again, the Arbitrator questions the reliability of Dr. VonGillern's report and the opinions expressed therein.

The Arbitrator also notes the report of Dr. Deignan, the Respondent's examining physician who opined that the Petitioner's bilateral carpal tunnel syndrome was not caused by his work activities for the Respondent. Dr. Deignan noted that the Petitioner's job as a painter required him to use an air sander, a hand sander, and an air sprayer and she concluded that the Petitioner's required work activity fell below the defined criteria for repetitive work. The Arbitrator finds that Dr. Deignan's opinions are at least as reliable and persuasive as those of Dr. VonGillern.

Based upon the forgoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner failed to prove that his condition off ill-being is causally related to his employment activities for the Respondent.

As the Arbitrator has found that the Petitioner failed to meet his burden of proof with regard to the issues of accident and causal relation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied and no benefits are awarded herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF La SALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Stella,
Petitioner,

vs. No. 08 WC 38073

United Express System,
Respondent.

15IWCC0736

DECISION AND OPINION ON REVIEW

A Petition for Review having been timely filed by Respondent and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability benefits, and the nature and extent of permanent disability, and being advised of the facts and law, modifies the October 6, 2014 decision of Arbitrator Flores, as stated below. In particular, the Commission finds that Petitioner failed to show that the condition of his back was causally connected to the work accident, and thus vacates the Arbitrator's award of medical expenses, temporary total disability and permanent partial disability associated with Petitioner's back. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner's Accident and Medical Treatment

Petitioner, a 58-year-old truck driver, claimed an injury to his back and left leg incurred on June 6, 2008. That day, he was standing on the back ledge of his truck when both of his feet slipped out from underneath him. At the time, he was holding with his right hand onto a strap that was connected to the top of the truck's rear door, which prevented him from hitting the ground. At trial, he testified repeatedly that his body was "jolted" -- that he "came down and jolted," he "jolted [him]self real bad," "it was the jolting that got [him]." After he regained his footing, while walking back to the truck, he felt a sharp pain in the calf of his left leg.

Petitioner timely reported the accident and continued working full duty until a week later, when he informed Respondent that he desired medical treatment. Petitioner presented at Provena Occupational Health, where he was diagnosed with a left calf strain. He was placed on light duty. On July 22, 2008, he was evaluated by Dr. Suresh Velagapuddi of Castle Orthopedics. The doctor noted that Petitioner's slipping-off-the-truck-while-holding-onto-a-strap account did not seem to explain the etiology of Petitioner's complaints or correlate to his symptoms. The doctor noted possible lumbar radiculitis and kept him on restricted duty.

Thereafter, for ongoing leg pain, Petitioner presented to chiropractor Dr. Thomas Solecki, who treated Petitioner from October 28, 2008 through December 2, 2008. On November 17, 2008, Petitioner saw orthopedic surgeon Dr. Thomas McNally of Suburban Orthopedics, to whom he had been referred. Petitioner related the account of his accident and that he felt immediate left calf pain, but no back pain. A lumbar MRI indicated marked spinal stenosis most pronounced at L4-L5. Dr. McNally diagnosed him with lumbar disc displacement, spondylolisthesis, scoliosis, lumbar spondylosis, and lumbosacral disc degeneration.

As to specific complaints of back pain subsequent to the accident, Petitioner's first overt complaint thereof in the medical records occurs nearly two years after the accident. Petitioner first complained of back pain during a July 8, 2010 visit to Surburban Orthopedics. Notably, on August 27, 2010, during a visit to Advanced Pain Centers, he stated his back pain was chronic and he was unaware when it began. Significantly, he denied any initiating incident. He stated that his leg pain began when he fell in the summer of 2008 while unloading a truck at work.

Dr. McNally discussed the possibility of fusion surgery with the claimant on subsequent appointments. Petitioner saw Dr. McNally for the last time on March 19, 2013. Dr. McNally indicated that, absent surgical intervention, Petitioner was at maximum medical improvement and would require permanent restrictions pursuant to a functional capacity evaluation.

Deposition of Dr. Thomas McNally and Dr. Steven Mather

Dr. McNally testified through two depositions regarding his treatment of Petitioner and his opinion that, while Petitioner's accident did not cause the degenerative condition in his spine, it aggravated and caused the pre-existing condition to become symptomatic.

Regarding his pre-existing condition, Petitioner's medical history is notable for a 2006 laminectomy at L2-L4, performed by Dr. Andrew Zelby. At that time, it was clear that he had severe pre-existing lumbar degeneration and a dropped right foot. This surgery was necessitated by an injury that was itself the basis of a prior workers' compensation claim[1].

At Respondent's request, Dr. Steven Mather performed a review of Petitioner's treating medical records and transcript of Dr. McNally's first deposition in November 2009. Dr. Mather testified through deposition that MRI films from November 4, 2008 showed severe degenerative

[1] This workplace injury occurred on December 20, 2005. At trial, Petitioner testified that he slipped on ice while filling his truck at a fuel island and landed on his back. However, a December 21, 2005 record from Concentra Medical Centers submitted into evidence contains the following: "Patient states: 'I slipped on the back of the tractor[.] He gives a history that yesterday while he was at the back of his truck when he slipped backward ..."

spondylolisthesis at L4-L5 with a synovial cyst off the left L4-L5 facet joint and some moderate left L3-L4 stenosis. This was indicative of a severe, pre-existing condition whose progression to the point of Petitioner's current need for surgery was inexorable (Dr. Mather recommended an L4-L5 laminectomy, fusion, and decompression of spinal stenosis). Dr. Mather did not believe that Petitioner's accident of June 6, 2008 was a contributory cause of the spinal stenosis and spondylolisthesis, nor did it cause aggravation of this pre-existing condition. Most importantly, as he explained, the MRI did not show evidence of any acute trauma. There were no structural changes that could be referred to an actual injury, no disc herniation, and no evidence of acute slippage such as a fracture. All that was revealed by the MRI were chronic changes. Dr. Mather further opined a slip such as Petitioner described is not the type of mechanism that would tend to worsen spinal stenosis.

The Commission's Analysis

The Arbitrator found that Petitioner proved an accident that arose out of and in the course of his employment. Further, the Arbitrator adopted Dr. McNally's causation opinion, relating Petitioner's accident to "his lumbar spine condition" and awarding medical, temporary total and permanent partial disability benefits based upon this finding.

The Commission agrees with the Arbitrator that Petitioner sustained an accident at work, insofar as Petitioner testified that he slipped off the ledge of a truck and felt immediate pain. The critical issue here is causation. More specifically, causation as to two different injuries: to Petitioner's leg and to Petitioner's back. At the outset, the Commission notes that it is difficult from Petitioner's account to discern an intelligible mechanism of the injury to either his leg or back. There is no mention of a "jolt" to his body in the medical records. At any rate, as to whether Petitioner hurt his left leg that day, his accounts to his supervisors and medical providers are consistent – he slipped off the back of his truck, he was prevented from hitting the ground because he was hanging onto a strap, and there was immediate onset of pain in his calf. The Commission finds that Petitioner injured his left leg while on the job the day of June 8, 2008.

However, his later-arising lower back pain – the first complaint appearing two years after the accident, as reflected in the medical records – is a different issue. In the Arbitrator's view, the parties' dispute centers on "Petitioner's credibility and whether the reported mechanism of injury at trial is consistently reflected in the medical records." (Arbitrator's Decision at p. 10). The Arbitrator, having found Petitioner's testimony at trial to be credible and consistent with reports given to various medical providers, awarded benefits based on injury to "his lumbar spine," which included leg and back.

However, Petitioner testified that upon his accident, he felt immediate pain to his leg, but not his back. At trial, he claimed that he did not remember when his back first started hurting, but averred that he knows the accident caused his back pain "because that's what they told me." So, the question is whether "they" – that is, Petitioner's advocates – have proffered expert opinions sufficient to sustain Petitioner's burden. Whether Petitioner sincerely believes that his accident as described eventually caused his low back pain is immaterial.

Therefore -- at least as it regards the current ill-being of Petitioner's back -- this matter is about conflicting medical opinions. Dr. Mather testified with clarity and a high degree of confidence regarding the severity and chronic character of Petitioner's spinal condition. Petitioner's prior laminectomy and right foot drop is further evidence of his severe, pre-existing condition. Despite this, the Arbitrator found the opinion of Dr. McNally to be more persuasive than that of Dr. Mather. The Commission finds the opposite.

For the reasons set forth above, the Commission finds that Petitioner has proven causal connection as to his left leg strain only. The Commission modifies the Arbitrator's finding of causal connection between Petitioner's accident and his current condition of ill-being insofar as this condition includes Petitioner's spine or anything beyond his left leg strain. The Commission also vacates the awards of medical expenses and temporary total disability benefits insofar as the awards are associated with Petitioner's back or anything beyond his left leg strain. The Commission also vacates the Arbitrator's award of 50% loss of the person as a whole in favor of a permanency award consistent with a leg strain, as detailed below.

IT IS THEREFORE ORDERED BY THE COMMISSION that the October 6, 2014 Decision of the Arbitrator is modified, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to his left leg strain through December 2, 2008, pursuant §8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $621.80/week, commencing October 21, 2008 through December 2, 2008, a period of 6 & 1/7 weeks, that being the period of temporary total incapacity from work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $559.62/week for a period of 10.75 weeks, for the reason that the injuries sustained caused the 5% loss of use of the left leg, as provided in Section 8(e) of the Act.

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 injuries.

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

15IWCC0736

Bond for 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 the Circuit Court.

DATED: SEP 2 4 2015

Joshua D. Luskin

o-08/12/15
jdl/ac
68

Ruth W. White

DISSENT

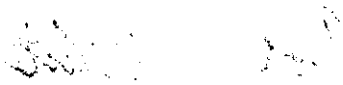
I must respectfully dissent from the majority's decision that the Petitioner failed to prove that his current condition of ill-being was causally connected to the accident on July 6, 2008. I would instead affirm and adopt the findings of Arbitrator Flores. She found that Petitioner did prove an accident arising out of the scope and course of his employment and that his current condition of ill-being was causally connected to that accident.

The Arbitrator correctly found that Petitioner's testimony was very credible. His accounts of the injury were consistent with the various medical providers throughout his medical treatment. Petitioner testified to a definite time and circumstance of his accident.

The Petitioner was symptom free prior to his accident on June 6, 2008. He did have a prior back surgery in 2006 but that clearly was to right side symptoms and a dropped right foot. In this accident Petitioner complained of left calf pain after he slipped from the truck and that pain became progressively worse.

Dr. Vilagapoddi suspected lumbar radiculopathy on July 22, 2008 and suggested a lumbar MRI which Respondent refused to authorize. Dr. McNally was of the opinion that the Petitioner's initial complaints after the injury at work were consistent with radicular complaints. (Petitioner Exhibit 6 Pgs. 16-17)

I find Dr. McNally's testimony much more credible than Dr. Mather's. Dr. Mather never examined the Petitioner, while Dr. McNally provided him treatment through 2013. Respondent refused to authorize the treatment recommended by Castle Orthopedics and Dr. McNally and therefore Petitioner could not get the treatment ordered performed timely.



Petitioner returned to light duty with the Respondent and worked light duty until he was laid off on October 20, 2008. He was still on light duty restrictions at the time he was laid off. He never reached maximum medical improvement until Dr. McNally last saw him on March 19, 2013. The doctor testified that the FCE performed on July 15, 2013 was valid and indicated that Petitioner could only perform light duty on a permanent basis. (Petitioner Exhibit 8) Respondent never offered the Petitioner a light duty job through March 19, 2013. Therefore he should be entitled to receive temporary total disability payments from October 21, 2008 through March 19, 2013 as ordered by the Arbitrator.

Since Petitioner successfully proved accident and causal connection, all the medical bills and services rendered should be paid by Respondent.

Dr. McNally prescribed Petitioner lumbar surgery. This was based on the CT Myelogram, MRI imaging and EMG which were consistent with Petitioner's complaints of pain. (Petitioner Exhibit 5) Petitioner has declined surgery at this time. The Arbitrator's award of 50% loss of use of the person as a whole should be affirmed and adopted.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STELLA, FRED
Employee/Petitioner

Case# **08WC038073**

UNITED EXPRESS SYSTEM
Employer/Respondent

15IWCC0736

On 10/6/2014, 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 0.04% 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:

0146 CRONIN PETERS & COOK
JOHN J CRONIN
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
JEFFREY N POWELL
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Fred Stella
Employee/Petitioner

v.

United Express System
Employer/Respondent

Case # **08** WC **38073**

Consolidated cases: **N/A**

15IWCC0736

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 28, 2014**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 6, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**48,500.00**; the average weekly wage was $**932.70**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of $**87,052.54** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,487.32** for other benefits (i.e., PPD advance), for a total credit of $**89,539.86**.

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

ORDER

As explained in the Arbitration Decision Addendum, Petitioner established that he sustained a compensable accident on June 6, 2008 and causal connection between his lumbar spine condition and injury at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $621.80/week for 230 & 1/7th weeks, commencing October 21, 2008 through March 19, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 6, 2008 through June 6, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $87,052.54 for temporary total disability benefits that have been paid.

Medical Benefits

Respondent shall pay the reasonable and necessary medical services reflected in bills submitted into evidence pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $559.62/week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of $2,487.32 for permanent partial disability benefits that have been paid.

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

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

Signature of Arbitrator

October 2, 2014
Date

OCT 6- 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Fred Stella
Employee/Petitioner

v.

United Express System
Employer/Respondent

Case # **08** WC **38073**

Consolidated cases: **N/A**

15IWCC0736

FINDINGS OF FACT

The issues in dispute at this hearing include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he had been employed by Respondent a year or so before June 2008. He was a "house" driver that always worked as a full time truck driver. He could deliver wine or tv's as directed by his boss. Petitioner testified that he performed over the road delivery and that his normal day started at 3, 4 or 5 a.m. He worked eight hours or more, up to 15 hours per day.

June 6, 2008

Petitioner testified that when he went into work on Friday, June 6, 2008 his boss told him to take a small box truck with three deliveries to Vitamin Shoppes in Indiana. He explained that it was raining hard on this date and the truck held approximately 12 pallets or more. He also explained that the truck was loaded to capacity, and incorrectly loaded.

To make the deliveries, Petitioner explained that there was a strap attached to the handle of the overhead door in the rear of the truck and the truck platform was approximately 4-5 feet above ground. There were also a couple of steps to get up to the truck platform and that he used the overhead door strap with his right arm. He testified that he had to remove the pallets in the front to the get to the ones in the back.

Petitioner testified that some Vitamin Shoppe staff yelled at him because the product was getting wet. On cross examination, Petitioner testified that there were pushy customers at his first stop which is when he slipped on the back lip of the truck.

Petitioner testified that he was holding the overhead door strap, which was wrapped around his right hand and arm several times since it was so long. The strap was touched the ground when the overhead door was closed. He testified that the back of the truck was very slippery and described being "jolted" all the way down to the ground when both feet slipped in front of him. He testified that the overhead door came down with him and that he hit his head and left leg on the ground. Petitioner described that he felt like a knife was in his leg.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Petitioner believed that there was oil residue from the exhaust and he would have cracked his head had he not been holding the overhead door strap. He explained that he weighed approximately 210-220 pounds at the time of the accident.

Petitioner testified that he called his boss, Mr. Tolomeo, after this incident using his Nextel phone. He was unsure whether he spoke to Mr. Tolomeo or someone at dispatch, but he told them that he was hurt. Petitioner then took the truck back to Respondent and then went home for the weekend.

On cross examination, Petitioner testified that he went home and noticed left calf pain that was really sharp over the weekend. Petitioner acknowledged that he used to go with his daughter to entertainment events as a DJ, but he was not paid. He denied doing anything with his daughter the weekend after the accident.

Regarding prior injuries, Petitioner testified that he injured his back previously in 2006. *See also* RX9-RX11. He was fueling his over the road tractor at work and slipped on ice and landed on his back. He had a lumbar laminectomy and discectomy surgery with Dr. Zelby. RX11. He testified that he had lower back with pain, pain in his right leg and a drop foot. Petitioner testified that he returned to work on October 25, 2006 and had no treatment thereafter.

Medical Treatment

Over the weekend after his injury, Petitioner testified that he had excruciating pain in his left calf and that bending made it worse. Petitioner testified that he went to work on June 9, 2008 and reported the injury again. Petitioner was referred by Respondent to Provena Occupational Health.

The medical records reflect that Petitioner went to Provena Occupational Health on June 16, 2008. PX2. He reported that it was raining on June 6, 2008 and, while unloading a truck, he lost his balance and felt a pull on his left calf. *Id.* He was diagnosed with a left calf strain and placed off work with restrictions of no stooping or bending. *Id.*

He returned to Provena on June 24, 2008 reporting the same left leg pain. *Id.* He was placed on light duty work restrictions including walking as tolerated and only driving an automatic transmission. *Id.* Dr. Woodward noted that Petitioner had a left calf strain with a probable plantaris muscle rupture. *Id.* He referred Petitioner to an orthopedist, Dr. Velagapuddi, at Castle Orthopedics. *Id.*

On July 22, 2008, Petitioner had an initial evaluation with Dr. Velagapuddi. PX3. Petitioner reported that he was on the back of a truck holding onto a strap when he slipped with his left foot still on the truck and he was hanging down. *Id.* Petitioner reported that it was a wet day. *Id.* He also reported that he developed pain in the lateral aspect of the left leg and described the dopplar testing and ace bandage prescribed at Provena. *Id.* Dr. Velagapuddi noted that none of this seemed to explain the etiology of Petitioner's pain or resolve his symptoms. *Id.* He also diagnosed Petitioner with possible lumbar radiculitis giving rise to his symptoms following the work injury and ordered a lumbar MRI. *Id.* Dr. Velagapuddi kept Petitioner restricted to only driving automatic transmission trucks. *Id.*

Petitioner testified that he continued working for Respondent through October 20, 2008. He testified that he was asked by Mr. Tolomeo to call him on Monday, Wednesday and Friday on which days he was told there was

no work for him. Petitioner filed for unemployment, which he received. Petitioner testified that he was not offered any other work by Respondent after his injury.

Thereafter, Petitioner testified that he continued to have pain. Petitioner testified that Dr. Thomas Solecki is at the National University of Health Science. One day he drove by a sign, which is how he found Dr. Solecki.

The medical records reflect that Petitioner underwent a lumbar MRI as ordered by Dr. Solecki on October 27, 2008. PX4. The interpreting radiologist noted the following: (1) moderate degenerative disc disease at L2-L3 through L5-S1; (2) mild degenerative disc disease at L1-L2; (3) mild facet arthrosis at L2-L3 through L5-S1; (4) Grade I spondylolisthesis of L4 on L5; and (5) various postural alterations. *Id.*

Petitioner began treatment with Dr. Thomas Solecki, a chiropractor, on October 28, 2008. PX4. Dr. Solecki's office notes reflect Petitioner's consistent report of injury when he fell from a truck followed by immediate left leg pain. PX4. Petitioner reported numbness on the top of his left foot, toes and in the ball of his foot. *Id.* He also reported that it was painful to reach up or bend. *Id.* Petitioner testified that Dr. Solecki did some manipulation, applied an electrical apparatus, and heat/cold treatments. *See also* PX4.

On November 3, 2008, Petitioner underwent bilateral lower extremity MRIs. PX4. With regard to the left leg, the interpreting radiologist noted mild medial and lateral femorotibial arthrosis, suspected old avulsion fracture of the medial malleolus to be clinically correlated, a soft tissue injury that could not be ruled out with conventional radiography, and no gross fracture or dislocation. *Id.*

He also underwent a recommended lumbar spine MRI. *Id.* The interpreting radiologist noted the following: (1) Grade I degenerative spondylolisthesis of L4 on L5; (2) degenerative disc disease with circumferential disc bulging from L1-L2 to L4-L5, degenerative modic endplate disease type II at L2-L3 and mildly accentuated disc bulging from L1-L2 to L5-S1; (3) facet arthrosis from L1-L2 to L5-S1; (4) degenerative stenosis of the spinal canal and both neural foramina from L1-L2 to L5-S1; (5) evidence of laminectomies at L2-L4; and (6) no evidence of abnormal enhancement. *Id.*

Petitioner testified that he saw Dr. Solecki from October 28, 2008 through December 2, 2008, but the treatment he received did not really provide him with any relief. Dr. Solecki reviewed his MRIs and referred Petitioner to Dr. McNally. PX4. Petitioner testified that he stopped treating with Dr. Solecki on December 2, 2008.

Petitioner then saw Dr. Thomas McNally on November 17, 2008. PX5. He reported an injury at work on June 6, 2008 when he fell off the back of a truck and, did not hit the ground, but was hanging from the truck. *Id.* He reported immediate left calf pain, no low back pain, and his treatment at Provena, Castle Orthopedics, and with Dr. Solecki. *Id.* Dr. McNally reviewed Petitioner's November 4, 2008 lumbar MRI noting that it showed marked spinal stenosis most pronounced at L4-L5, the level of spondylolisthesis. *Id.*

Dr. McNally diagnosed Petitioner with lumbar disc displacement, spondylolisthesis, scoliosis, lumbar spondylosis, and lumbosacral disc degeneration. *Id.* He ordered an EMG and CT myelogram of the lumbar spine, but indicated that Petitioner was to check with his cardiologist to see if he could hold off on his Coumadin for these tests. *Id.* He also ordered an EMG of the bilateral lower extremities. *Id.* Dr. McNally further noted that Petitioner had significant multi-factorial stenosis in the lumbar spine that was consistent with his complaints of left calf pain since his accident at work. *Id.* He indicated that while Petitioner's injury did not cause the degenerative condition in the spine, it caused his pre-existing condition to become symptomatic. *Id.*

Dr. McNally – Deposition Testimony of June 19, 2009

On June 19, 2009, Petitioner called Dr. McNally as a witness at which time he gave testimony at an evidence deposition. PX6. He is a board-certified spine surgeon. PX6 at 5-6.

Dr. McNally testified about his initial examination of Petitioner, review of prior medical treatment records, and diagnoses. PX6 at 6-13. He diagnosed Petitioner with lumbar disc displacement, spondylolisthesis, scoliosis, lumbar spondylosis, and lumbosacral disc degeneration. PX6 at 13. Dr. McNally testified that these conditions pre-existed Petitioner's injury at work, but that the injury at work aggravated his conditions. PX6 at 13-14. As a result, he recommended that Petitioner undergo further medical treatment in the form of a CT myelogram and bilateral lower extremity EMGs, but only after receiving clearance from his cardiologist to do so. *Id.* He also indicated that, depending on the results of those tests, he would likely recommend a revision decompression and fusion. PX6 at 15.

On cross examination, Dr. McNally testified that Petitioner had neural impingement that became symptomatic after his accident at work. PX6 at 16-17. He based this causal connection opinion on Petitioner's reported history of an immediate onset of left lower extremity pain after his accident and his significant stenosis. *Id.* Dr. McNally testified that Petitioner would not have necessarily felt immediate back pain after sustaining the mechanism of injury that he described. PX6 at 17.

He acknowledged that walking could have caused Petitioner's problem and that an altered gait, given the right foot drop, could have exacerbated his condition also. PX6 at 17-18. Dr. McNally also testified with regard to different histories given by Petitioner to different providers. PX6 at 18-19. He testified that, given Petitioner's severe underlying degenerative changes, even minor trauma could have brought about Petitioner's symptoms. PX6 at 18-19.

Dr. McNally also testified that it was not unusual, especially given Petitioner's reported mechanism of injury, that Petitioner did not have low back complaints in the two weeks following the accident. PX6 at 20-21. He explained that radicular symptoms are often confused especially on the first exam, which is why the Castle Orthopaedics doctor ordered a lumbar MRI; he did not think Petitioner sustained a distal lower extremity injury. *Id.* Dr. McNally also explained that the pain generators in the spine are not fully understood and that his pain was isolated to the left leg initially. *Id.*

Dr. Mather – Records Review Report & Addendum

Dr. Steven Mather performed a review of Petitioner's treating medical records at Respondent's request. RX12. He issued a report dated November 5, 2009. *Id.* He noted that Petitioner's November 4, 2008 MRI at Advantage does not mention spinal stenosis or nerve root compression. *Id.* He also noted that Petitioner's November 10, 2008 MRI at National Chiropractic does not mention spinal stenosis. *Id.* Dr. Mather further indicated that Dr. McNally's November 17, 2008 note agreeing with the radiologist's reading of the latest MRI showing "severe stenosis" was questionable given that the official report did not mention stenosis. *Id.*

Dr. Mather also reviewed Dr. McNally's deposition transcript and rendered opinions based on his review of the records and transcript. *Id.* Specifically, Dr. Mather opined that Petitioner's left leg pain and foot pain were of unknown etiology. *Id.* He noted that the radiologists' readings of Petitioner's lumbar MRIs revealed no nerve root compression in spite of which Dr. McNally maintained his opinion that severe spinal stenosis was causing Petitioner's subjectively reported lumbar radiculopathy. *Id.*

Finally, Dr. Mather opined that if the November 4, 2008 MRI did not show nerve root compression, Petitioner's complaints were subjective without objective evidence of lumbar radiculopathy. *Id.* He indicated that if the images from this MRI were marginal or there appeared to be some nerve root compression, then he would recommend a CT myelogram. *Id.*

On December 16, 2009, Dr. Mather issued an addendum report indicating that he was provided with the MRI films dated November 4, 2008 from Advantage MRI. RX13. He interpreted the films to show severe degenerative spondylolisthesis at L4-L5 with a synovial cyst off the left L4-L5 facet joint and some moderate left L3-L4 stenosis. *Id.* He also indicated that Petitioner's "left leg symptoms do correlate with his MRI findings,[but opined that he did not believe] that this is work-related given his severe spinal stenosis." *Id.*

He recommended an L4-L5 laminectomy and fusion as well as a left L3-L4 hemilaminectomy and decompression of spinal stenosis. *Id.* He opined that the stenosis was degenerative and "so severe he would have required surgery in the next two years irrespective of any work injury." *Id.*

Dr. Mather – Deposition Testimony

Respondent called Dr. Mather as a witness at which time he gave testimony at an evidence deposition. RX1. He is a board-certified orthopedic surgeon focused primarily in adult spine. RX1 at 4-5.

Dr. Mather testified about his records review and rendered opinions. RX1 at 6-10. He testified that Petitioner's accident at work did not aggravate Petitioner's pre-existing low back condition because the MRI does not show any evidence of acute trauma, such as a disc herniation or acute slippage or fracture. RX1 at 10-11. He also indicated that the slipping mechanism of injury described by Petitioner is not the type that would worsen spinal stenosis. *Id.* He testified that he would expect that a severe extension injury to the lumbar spine (e.g., arching one's back like when one is putting in a light bulb in a ceiling fixture) would worsen stenosis. RX1 at 11.

Dr. Mather agreed that Petitioner's treatment was reasonable and necessary, and that Petitioner required surgery to address his chronic lumbar spine condition, but testified that neither the treatment or recommended surgery were necessary to address a work-related injury or aggravation of pre-existing condition. RX1 at 13-15, 20.

On cross examination, Dr. Mather testified that Petitioner's chronic condition necessitated surgery, but acknowledged that Petitioner did not need surgery before June 2008. RX1 at 15-16. He also acknowledged that he did not physically examine Petitioner or know his height or weight. RX1 at 17-18. Dr. Mather further agreed with Dr. McNally's diagnosis that Petitioner had probably neural impingement of the L4-L5 nerve roots. RX1 at 19-20. However, Dr. Mather did not believe that there would be any significant extension of the spine if, for example, a large person over six feet tall weighing about 250 pounds slipped off the back of a truck and grabbed onto a strap to prevent him from falling off the truck. RX1 at 21-22.

Dr. Mather also acknowledged that Petitioner had no reported symptoms prior to his injury at work in June 2008 and that his symptoms reportedly began after his accident. RX1 at 22, 24. He testified that Petitioner would have required surgery at some point anyway, but acknowledged that he would not perform surgery unless Petitioner was symptomatic. RX1 at 24-25.

Continued Medical Treatment

Petitioner eventually underwent the recommended CT myelogram and bilateral lower extremity EMGs on May 24, 2010 and June 21, 2010. PX5. He testified at the hearing that he also began receiving workers' compensation benefits as of April 16, 2010.

Petitioner then returned to Dr. McNally on July 8, 2010 reporting that his symptoms had not changed. PX5. Specifically, Petitioner reported that his low back and left leg pain with numbness in both feet, more pronounced on the left. *Id.*

Dr. McNally reviewed Petitioner's CT myelogram which showed degenerative disc changes at the facet joints, most marked at L4-L5 where there was some degree of spinal stenosis. *Id.* It also showed stenosis secondary to a combination of factors including bulging disc material, facet hypertrophy and degeneration, and bilateral anterior listhesis of L4 on L5. *Id.* The bilateral lower extremity EMGs were abnormal. *Id.* They showed acute-to-subacute bilateral L5-S1 and left-sided L4-L5 lumbosacral radiculopathy and underlying sensory motor peripheral neuropathy of at least moderate degree and mixed axonal demyelinating type. *Id.* Dr. McNally also reviewed Petitioner's lumbar MRI as ordered by Dr. Zelby, which he indicated showed marked spinal stenosis, most pronounced at L4-L5 level of spondylolisthesis as noted by the interpreting radiologist also. *Id.*

Dr. McNally diagnosed Petitioner with lumbar disc displacement, lumbar spinal stenosis, lumbar spondylosis, lumbosacral disc degeneration, spondylolisthesis, and scoliosis. *Id.* He recommended a posterior spinal fusion from L2-L5 and discussed the risks including those stemming from his cardiac comorbid conditions. *Id.* Petitioner indicated that he would consider the option. *Id.*

At the hearing, Petitioner also testified that he was told that there could be complications with surgery due to his cardiomyopathy condition. He testified that he is worried about that issue. Petitioner also testified that Dr. McNally referred him to Dr. Lipov.

The medical records reflect that Petitioner went to see Dr. Eugene Lipov at Advanced Pain Centers as referred by Dr. McNally on August 27, 2010. PX9. He reported chronic low back pain and left lower leg pain. *Id.* Specifically, he reported that his back pain had been chronic and he was unaware when it began; he denied an initiating event. *Id.* Petitioner also reported that his left leg pain began in the summer of 2008 when he fell while unloading a truck. *Id.* Dr. Lipov recommended a caudal epidural steroid injection. *Id.* Petitioner underwent the recommended injection under conscious sedation on October 1, 2010. *Id.* Petitioner testified that he felt good for three days thereafter.

Petitioner returned to Dr. McNally on December 2, 2010. PX5. He kept Petitioner off work and continued to recommend treatment with Dr. Lipov. *Id.* However, Petitioner testified that he did not see Dr. Lipov because the nurse for the insurance company would not approve the treatment and she told them not to give him any more appointments.

Petitioner eventually returned to Dr. McNally on January 24, 2012. PX5. Dr. McNally noted that Petitioner was unable to get medically cleared for surgery. *Id.* He also noted that Petitioner would likely need chronic pain medication, pain injections, and possible surgery in the future. *Id.* Dr. McNally kept Petitioner off work. *Id.*

Petitioner testified that he returned to see Dr. McNally one last time on March 19, 2013. *See also* PX5. He reported that he underwent an epidural steroid injection with sedation, which gave him good low back pain relief for 2-3 weeks, but no relief in the legs or with paresthesias. *Id.* Dr. McNally ordered an updated lumbar MRI and EMG/NCVs of the lower extremities. *Id.* Petitioner underwent the recommended MRI on March 26, 2013. *Id.* Dr. McNally kept Petitioner off work and indicated that he should consider whether he wanted to pursue surgery. *Id.* Absent surgical intervention, Dr. McNally indicated that Petitioner was at maximum medical improvement and would have permanent restrictions per a functional capacity evaluation. *Id.*

On July 19, 2013, Petitioner underwent the recommended functional capacity evaluation at ATI. PX8. The evaluating physical therapist noted that the results were valid. *Id.* Petitioner was placed at the light physical demand level capable of occasionally lifting 19.2 pounds chair-to-floor, 28 pounds desk-to-chair, and 32.4 pounds above shoulder bilaterally. *Id.*

Petitioner testified that Dr. McNally then referred him back to the pain clinic. Petitioner also testified that he looked for work and was sent to various places through the unemployment office, but he did not find any work. He also testified that Dr. McNally had him off work since he first started treatment.

Dr. McNally – Deposition Testimony of November 15, 2013

Dr. McNally provided additional testimony at an evidence deposition on November 15, 2013. PX7. Dr. McNally testified about his subsequent treatment of Petitioner, review of additional diagnostic films and reports, and his diagnoses. PX7 at 5-19. He diagnosed Petitioner with lumbar spinal stenosis, lumbar spondylosis, lumbosacral disc degeneration, spondylolisthesis, and scoliosis. PX7 at 19. He also opined consistent with his first deposition testimony that these conditions pre-existed Petitioner's injury at work, but that the injury at work caused these pre-existing, asymptomatic conditions to become symptomatic and require treatment. PX7 at 19-20. Regarding further medical treatment, Dr. McNally recommended to continue treatment with him or continue with interventional pain management noting that he would likely require lifelong pain management. PX7 at 20. Regarding his work restrictions, Dr. McNally testified that Petitioner could work light duty within the restrictions of his functional capacity evaluation. PX7 at 20-21.

On cross examination, Dr. McNally testified that to the best of his recollection he had conversations with Petitioner where he indicated that he did not initially have the CT myelogram and bilateral lower extremity EMGS because "as far as I understood it is everything was being denied and so he was being uncared for, not cared for by me because he didn't follow up. He didn't want to be racking up debt that he couldn't pay, so he didn't get any of these studies done. I believe he had a primary care doctor or his cardiologist was acting as a primary care doctor and kind of just doing it with good will." PX7 at 26-28.

He further testified about Petitioner's reports of low back pain, or lack thereof, prior to July 8, 2010. PX7 at 28-31. Dr. McNally testified that it was not significant if the medical records showed no reports by Petitioner of low back pain prior to July 8, 2010, two years after his accident at work, because he was complaining of radicular left leg pain the entire time. *Id.* When asked again about Petitioner's reported symptomatology on July 8, 2010, Dr. McNally reiterated that Petitioner reported left calf pain, which he noted was in an L5 distribution as correlated by a series of diagnostic tests including a CT myelogram and MRI showing significant impingement on L5. PX7 at 33-35.

With regard to the medications prescribed to Petitioner, Dr. McNally testified that Dr. Brusil ordered Lyrica, Neurontin and Cymbalta. PX7 at 39-40. He indicated that there is some overlap between Petitioner's

symptoms of peripheral neuropathy and radiculopathy such that those medications are also used to treat his work-related condition of radiculopathy. *Id.* Dr. McNally testified that he did not order those medications for Petitioner's radiculopathy, but rather referred him to an interventional pain management doctor. *Id.* He did order Ultram for pain while Petitioner was treating at Advanced Pain where he received a lumbar epidural steroid injection. PX7 at 40-41. Dr. McNally also testified that he was not aware whether Petitioner reported on August 27, 2010 to the staff at Advanced Pain that he did not know when his back pain started. PX7 at 50.

During the same period of time, Dr. McNally testified that Petitioner did not have physical therapy between July 8, 2010 and December 2, 2010 because, as he understood it, the workers' compensation insurance carrier denied it. PX7 at 44-46. He testified that he did not recommend physical therapy again when Petitioner returned to him on December 2, 2010. *Id.*

Approximately one year and three months later, on January 24, 2012, Dr. McNally testified that he saw Petitioner again at which time he reported that he was not medically cleared for surgery. PX7 at 47-48. Dr. McNally took x-rays on that date and noted that the slippage at L4-L5 worsened a little bit. PX7 at 49.

Michael W. Tolomeo

Mr. Tolomeo currently employed by Respondent as the Director of Operations for the past six years, and has been employed by Respondent for the last 11 years. Mr. Tolomeo testified that he is responsible for about 180 truck drivers including employees and independent contractors, 15 dispatchers, and over 2000 orders per day. With regard to employee drivers, Mr. Tolomeo testified that he is responsible to ensure that they get to work on time, complete their logs, perform their work efficiently, and log out at the end of the day. On June 6, 2008, Mr. Tolomeo testified that he was either the Director of Operations or Operations Manager. He testified that there is no difference in the responsibilities in these positions.

Mr. Tolomeo testified that there are guidelines to be followed when an employee is injured. The employee has to report it to dispatch, who then reports it to either Mr. Tolomeo, Jan Chane, Gene Rennells, Director of Compliance and Legal, or Brad Westron, President. When a worker reports an injury, one of these four individuals must fill out an incident report. When an injury is reported to Mr. Tolomeo, he always completes an injury report.

Mr. Tolomeo testified regarding a June 9, 2008 incident report that he completed when Petitioner reported the injury. RX4. In the narrative section, Mr. Tolomeo noted Petitioner's report as follows: "Driver 210, Fred Stella mentioned to me that on Friday, 6-6-08 he tweaked his calf making a delivery but thought it was getting better. He did not request any time off and continued with his work for that day." *Id.*

On cross examination, Mr. Tolomeo testified that he spoke with Petitioner in person. He does not recall the conversation word-for-word nor did he take down the conversation verbatim, but he testified that the phrase "tweaked his calf" is not his own. Mr. Tolomeo also testified that an incident report can be completed either while speaking to the employee or afterward and that it goes into the driver's file. On further cross examination, Mr. Tolomeo testified that he did not indicate which leg Petitioner reportedly injured.

Mr. Tolomeo also testified regarding an accident report prepared by Mr. Rennells. RX3. The form was completed on June 19, 2008. *Id.* Mr. Tolomeo testified that the difference between this form and the incident report that he completed is that this form was completed when Petitioner requested medical treatment. *Id.* In

the accident report, Mr. Rennells noted the following in pertinent part: "Moving skids on truck to facilitate delivery. Slipped on wet surface – twisted [left] leg while trying to keep from falling." *Id.*

Mr. Tolomeo also testified about Petitioner's timesheets from June 7, 2008 through October 25, 2008. RX6. These timesheets are kept for all employees. He testified that the spreadsheet information comes from a clipboard in the dispatch office with time in and time out for every employee driver. They sign in their name, the assigned truck, and then they go off to work.

Mr. Tolomeo testified that Petitioner no longer works for Respondent due to lack of work. Mr. Tolomeo testified that they either lost work or determined that someone had to be laid off because there were too many drivers.

On cross examination, Mr. Tolomeo testified that Petitioner worked for Respondent for some time before his injury. He testified that he does not recall disciplining or writing Petitioner up before the injury. Prior to that date, Mr. Tolomeo testified that he could not recall whether Petitioner had been laid off due to lack of work.

Mr. Tolomeo testified that he did not follow up with Petitioner after he began getting medical treatment. He also testified that he did not get any information or medical report restricting Petitioner to driving only an automatic truck. He added that this information would have come to him.

Additional Information

Petitioner testified that he is no longer working and is now retired. On cross examination, he testified that the unemployment office was still trying to help him get a job. He received unemployment benefits through the day Respondent started paying Petitioner temporary total disability benefits through about April 2010. He did receive social security disability benefits for a time, but then he started receiving workers' compensation benefits.

With regard to his medications, Petitioner testified that he gets medication through the veterans' administration. Petitioner testified that he receives Hydrocodone and goes to the VA once per month for Coumadin. He also testified that he takes 2-4 pills per day, but that the pain medication does not work.

Regarding his current condition, Petitioner testified that he notices that his toes are curling and he had to get a much bigger size shoe to comfortably put on his shoes. Petitioner also testified that his left leg pain is really bad. He explained that if he tried to bend over now he would scream as a result of the pain in his left leg. Petitioner testified that he has had no new injuries.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits (AX1, PX1-PX9, RX1-RX10) are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Petitioner testified at trial that he slipped off the back of a truck on a rainy day while holding onto a strap connected to the truck's rear overhead door, which essentially prevented him from crashing to the street approximately 4-5 below the lip of the back of the truck. Petitioner reported an injury at work occurring on June 6, 2008, which is noted in Respondent's accident report and Mr. Tolomeo's report as well as reflected in the medical records. Thus, the Arbitrator finds that Petitioner's alleged accident at work was sustained in the course of his employment.

The parties' dispute with regard to accident centers on the "arising out of component." Specifically, Petitioner's credibility and whether the reported mechanism of injury at trial is consistently reflected in the medical records. In consideration of all of the evidence, the Arbitrator finds that Petitioner's testimony at trial is credible and consistent with the reports he gave to various medical providers shortly after his accident and throughout his medical treatment.

The histories provided by Petitioner as noted by various medical providers are not as detailed as his description about the mechanism of injury given at the hearing. Notwithstanding, the documented histories are generally consistent with his description of the mechanism of injury at the hearing. Petitioner consistently reported that he slipped on the back of a truck on a wet or rainy day falling, but not hitting the ground, with immediate left leg pain after somehow, in his view, he hurt his left leg.

The evidence at trial also contains the medical opinions of Petitioner's treating physician, Dr. McNally, and the physician engaged by Respondent to perform a records review, Dr. Mather. Both physicians are board-certified spine surgeons and they agree on various points.

Petitioner had severe pre-existing lumbar degeneration that previously required surgery and that required further surgery after his accident at work regardless of causation. Petitioner had no need for medical treatment to the low back for a period of years after his release by Dr. Zelby in 2006 through the date of accident on June 6,

2008. He reported no low back pain or left leg symptoms between that release by Dr. Zelby and his June 6, 2008 accident. Dr. McNally and Dr. Mather also agree that Petitioner's first MRI after the accident at work performed on November 4, 2008 showed stenosis or nerve compression on the left. Dr. Mather acknowledged that these films are objectively consistent with symptoms of radiculopathy in the left leg.

Regardless of the foregoing, Dr. Mather opined that Petitioner's spinal stenosis was so severe that even walking would have aggravated his condition and he would have required surgery within two years whether or not he sustained the reported injury at work. He also maintained that the mechanism of injury reported by Petitioner, as he understood it, would be insufficient to cause the severe extension of the spine necessary to causally relate the injury at work with Petitioner's worsening stenosis. Dr. Mather's ultimate opinion and his admissions on cross examination, however, are incongruent.

Dr. Mather never physically examined Petitioner and he never took a detailed history from him. He only reviewed the treating medical records which contained abridged versions of Petitioner's reported mechanism of injury and those records are nonetheless generally consistent with Petitioner's testimony at trial that he fell off the back of a truck feeling immediate left leg pain. Dr. Mather also generally described that the type of mechanism required to aggravate a pre-existing stenosis condition would be a severe extension injury akin to arching one's back as when one is putting in a light bulb in a ceiling fixture.

Petitioner was over 200 pounds and six feet tall at the time of his injury. He explained that he had a long overhead truck door strap that dragged on the ground when the door was closed and the strap was not in use. He wrapped it several times around his right hand/arm when he slipped off the back lip of the truck due to the rain. He explained that, because of the strap wrapped around his hand, he did not come down to hit the ground located approximately 4-5 feet below the lip of the truck.

Moreover, before seeing Dr. McNally Petitioner was seen at Castle Orthopedics where Dr. Velagapuddi ordered a lumbar MRI because he suspected that Petitioner's left calf symptoms might be radiculopathy stemming from the lumbar spine. At his deposition, Dr. McNally testified that radicular symptoms are often confused on an initial exam. This testimony is consistent with Dr. Velagapuddi's order for a lumbar MRI to rule out a distal lower extremity injury that he believed was lumbar radiculitis.

After careful observation of Petitioner at trial and consideration of his description of this mechanism of injury compared to other record evidence, the Arbitrator finds that it is generally consistent with the abbreviated slip-off-the-back-of-the-truck-but-didn't-hit-the-ground histories noted by doctors shortly after his accident. The description is also consistent with the type of severe extension injury described by Dr. Mather to be necessary to aggravate a stenosis condition and the suspected lumbar radiculopathy diagnosed by Dr. Velagapuddi at his initial visit on July 22, 2008. Thus, the Arbitrator finds Dr. Mather's opinion to be unpersuasive and finds the opinions of Dr. McNally to be more persuasive given the totality of the evidence in this case.

Based on all of the foregoing, the Arbitrator finds that Petitioner did sustain a compensable accident that arose out of and in the course of his employment with Respondent on June 6, 2008 as claimed.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Even where an employee has a pre-existing condition that renders him more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative

factor." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 205 (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)). As explained above, the Arbitrator finds that Petitioner sustained a compensable accident at work as a result of an aggravation of his underlying degenerative low back condition when he slipped on the back of a truck at work on June 6, 2008.

Prior to June 6, 2008, Petitioner was symptom free despite his severely degenerative, pre-existing low back condition for almost two years. Even though Petitioner had prior low back surgery with Dr. Zelby in 2006, it was related to right-sided symptoms unlike the current left-sided stenosis and nerve compression that both Dr. McNally and Dr. Mather agree necessitate further surgery regardless of causality. Dr. Velagapuddi also suspected lumbar radiculopathy as early as July 22, 2008, less than two months after Petitioner's accident, despite the fact that Petitioner had not reported low back pain to that point. Furthermore, no evidence was presented that Petitioner sustained any intervening injuries after June 6, 2008.

Based on all of the foregoing, the Arbitrator further finds that his claimed current condition of ill being in the low back is causally related to his injury at work on June 6, 2008.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner sustained a compensable accident and that he has established a causal connection between his current low back condition and his accident on June 6, 2008. In addition, the record reflects that Petitioner underwent medical treatment for left leg complaints that were eventually determined to be radicular complaints stemming from the lumbar spine.

Thus, the Arbitrator awards the medical bills incurred by Petitioner that remain unpaid and that were submitted into evidence to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any such bills already paid and Petitioner shall be held harmless for any group payments made against the foregoing bills.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County*

v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 887 (2nd Dist. 1990) (*emphasis* added).

As of August 26, 2008, Dr. Velagapuddi placed Petitioner on work restrictions limiting him to driving only automatic vehicles. On October 20, 2008, Petitioner was released from employment with Respondent due to a lack of available work as indicated by Mr. Tolomeo. Prior to Petitioner's injury at work and during his years of employment for Respondent he had not been laid off for any similar reason. Notwithstanding, Petitioner remained under the care of Dr. Velagapuddi, Dr. Solecki, or Dr. McNally with light duty or no-work restrictions through March 19, 2013.

Based on the facts and conclusions explained in detail above, the Arbitrator finds that Petitioner has established his entitlement to temporary total disability benefits for the period beginning on October 21, 2008 through March 19, 2013.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole—which reflects that Petitioner aggravated his lumbar spine condition causing left leg radiculopathy resulting in a recommended 3-level fusion from L2-L5 which Petitioner cannot undergo due to unrelated health risks, permanent work restrictions placing Petitioner at the light physical demand level with lifting restrictions and an inability to find work thereafter, as well as continued pain in the low back and left leg necessitating ongoing daily use of narcotic pain medications—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 50% loss of use of the person as a whole pursuant to Section 8(d)(2).

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marc Quillman,
Petitioner,
vs.

NO: 11WC 33413

SOI/ Menard Correctional Center,
Respondent

15IWCC0738

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §(19b), having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses,and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2015 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: SEP 24 2015
MJB/bm
o-9/21/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

QUILLMAN, MARC
Employee/Petitioner

Case# **11WC033413**

15IWCC0738

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 2/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

FEB 11 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marc Quillman
Employee/Petitioner

v.

SOI/ Menard Correctional Center
Employer/Respondent

Case # 11 WC 33413

Consolidated cases: N/A

15IWCC0738

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 18th, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0738

FINDINGS

On the date of accident, **August 17th, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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 $**58,500.00**; the average weekly wage was $**1125.00**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

Petitioner shall be barred from recovery. Petitioner's failed to meet his burden of proof. Petitioner failed to prove that he sustained an injury that arose out of and in the course or his employment with Respondent. The medical evidence does not demonstrate a compensable accident. Furthermore, the Respondent's section 12 examiner credibly testified the Petitioner did not suffer a compensable work related injury. Claim 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.

Edward Lee — Signature of Arbitrator

2/9/15 — Date

ICArbDec19(b)

FEB 11 2015

Findings of Fact

This matter was heard on a 19b hearing in Collinsville. The issues were accident, causation, notice, medical expenses, medical and prospective medical care.

Petitioner is a Correctional Officer employed at Menard Correctional Center. He has been employed with the Department of Corrections since February of 1998. Mr. Quillman testified he began his career at Tamm's Maximum security Prison and then transferred to Menard Correctional Center in early 2002. Petitioner's testimony was that he was given the position of Personal property officer from 2008 through 2012. He was operating as a property box officer during his allegations of injury.

He further testified under direct examination that as a property box officer he would pack up property boxes for inmates that were transferring out of the facility. Additionally, he also did engraving with a Dremel tool as well as computer input but only typed up to ten hours a week. Petitioner admitted that Menard only has chuckholes in Segregation and "Receiving and Classification" as opposed to Tamms where every cell has a chuck hole. He further testified that in the years before he was assigned as a property officer he rarely worked in Segregation.

His testimony was he noticed his hands starting to go to sleep more often in May of 2010. He stated there was not a specific event which elicited his symptoms. He further testified he turned one Folger Adams key to get into his office as Personal property officer. He stated he could turn it up to 20-30 times a day. There is NO bar rapping involved in this position. His testimony was that he typed approximately one to two hours per day. Additionally when working in this capacity he does not open the sliding doors on the galleries. His testimony was that he was pulled to work on the galleries 10-15 percent of the time.

Petitioner filed an application of claim alleging repetitive trauma to his right and left hands as well as his right and left arms. The application of claim was filed stamped by the Commission August 25th, 2011 with a date of accident of August 17th, 2011. Mr. Quillman turned in an Employee's notice of injury dated September 7th, 2011.

Petitioner initially presented not to a family physician but to Dr. Paletta after being sent there by his Workers' Compensation Attorney. He initially presented with complaints of a year and a half history of bilateral elbow, forearm, wrist and hand pain as well as some numbness and tingling. It was noted these started in approximately May 2010. It is noteworthy Dr. Paletta put in his history, "[h]e does all of the usual activities that are required at the Menard Correctional Facility...In addition, he has to do the keying to open and close the cells, open and close the doors, and do the other repetitive daily activities of prison guard." Upon physical examination his Ulnar nerve exam was unremarkable, he had a negative tinel sign, negative ulnar nerve compression test and a negative elbow flexion test. Additionally, he had negative Tinel signs at both wrists but a positive phalen's test. Dr. Paletta's impression was, "possible bilateral carpal tunnel syndrome, upper extremities" as well. His recommendation was for an EMG and nerve conduction studies to be conducted.

Mr. Quillman had electrical diagnostic studies conducted by Dr. Phillips on August 17th, 2011. He reported gradually progressive dull/throbbing/aching bilateral lateral elbow pain since May/2010 as well as intermittent global hand numbness that was occurring three to four times a week and lasting only a

minute. Dr. Phillips also reported negative Tinel signs at the Cubital tunnels or condylar grooves. Additionally he found negative Tinel and Phalen signs at the Carpal tunnels as well. He reported the motor testing was unremarkable. Dr. Phillips diagnosis was "mild medial sensory neuropathy across the right tunnel. There is evidence for very mild demyelinative median sensory neuropathy across the left carpal tunnel...." There was no evidence of cubital tunnel syndrome. Dr. Paletta indicated Mr. Quillman had a mild right carpal tunnel syndrome and a medial sensory neuropathy at the right carpal tunnel. He failed to mention the left carpal tunnel test indicated the left was a "very mild" neuropathy.

The Petitioner returned to Dr. Paletta on October 19th, 2011 for a follow-up after giving him a diagnosis of lateral epicondylitis of both elbows. Mr. Quillman's chief complaint was his elbows and Dr. Paletta ordered an MRI of the elbows. Dr. Paletta's review of the MRI indicated there was no evidence of a partial tear of the common extensor tendon with the medial side of the elbow appearing normal. Dr. Paletta gave a diagnosis of Mild common extensor tendinitis consistent with clinical diagnosis of lateral epicondylitis.

Mr. Quillman also had a series of injections to his elbows conducted by Dr. Luke Choi. When he presented to Dr. Choi on December 2nd, 2011 he reported, "[p]er the patient, his job requires repetitive chores at the prison that include performing bar taps...the application and removal of handcuffs, cranking of heavy wheel to open a row of cells as well as the use of finger-long Folger Adams keys." At this visit Dr.Choi recommended a series of cortisone injections and a left side injections was administered. On January 20th, 2012 Petitioner returned with his symptomology to his left elbow having improved. Dr. Choi noted that, "[a] focal exam of his bilateral elbows shows that tenderness along the lateral epicondyle along the left elbow has resolved." A right sided cortisone injection was ordered and administered. The Petitioner returned on March 2nd and indicated the right side was not as successful.

On March 16th, 2012 Mr. Quillman was once again seen by Dr. Phillips at Dr. Paletta's behest. At this time there was NO evidence of the "previously noted mild/very mild median sensory neuropathies across the carpal tunnel..." Additionally there was no electrodiagnostic significance of cubital tunnel syndrome.

On October 24th, 2012 Dr. Paletta gave a recommendation to the Petitioner that he seek a second opinion. His rationale being, "I am making a recommendation for second opinion because the patient's EMG and nerve conduction study are normal. He does have symptoms suggestive of carpal tunnel syndrome, but I would not recommend surgery at this time." There is no evidence in the record that Mr. Quillman, the Pet

Respondent had the Petitioner examined for an IME by Dr. Anthony Sudekum, a board certified Surgeon of no small renown, with a specialty in upper extremities as well as plastic and reconstructive surgery. Dr. Sudekum has personally toured the Menard Correctional Center. Dr. Sudekum physically examined Mr. Quillman on June 24th, 2013 and prepared a report as well as a supplemental report on May 29th, 2014. Additionally, Dr. Sudekum also testified by Deposition on September 18th, 2014. Dr. Sudekum's initial report was based upon the job duties of a Correctional officer, which is a misnomer as Mr. Quillman was operating as a Personal Property officer during his allegations of complaint. Dr. Sudekum's supplemental IME report and deposition were based upon a proper understanding of Mr. Quillman's job duties as a property officer.

Dr. Sudekum conducted a physical examination and reported Mr. Quillman complained of pain in his bilateral lateral elbow regions that occurred throughout the day and also at night. He also had complaints of decreased grip strength with numbness and tingling on his dorsal and palmar aspects of

both hands; again throughout the day and also at night. Mr. Quillman reported that he had started smoking again; a half of a pack per day. When examined he had normal full range of motion for his elbows, forearms, wrists, thumbs, and fingers with normal sensation. Additionally, both wrist and elbow Tinel's and Phalen's signs were negative bilaterally. X-rays taken at his office revealed evidence of an old left wrist ulnar styloid fracture nonunion. There were Neurometrix nerve conduction studies taken as well, which revealed normal latencies for the bilateral median and ulnar nerves at the wrist and the elbow. In his initial report Dr. Sudekum gave a diagnosis of mild bilateral lateral epicondylitis and recommended conservative treatment. Dr. Sudekum opined there was not objective evidence of carpal tunnel syndrome, cubital tunnel syndrome, median neuropathy and or an ulnar neuropathy.

Dr. Sudekum issued his supplemental report on May 29th, 2014 which was based upon additional medical records he received as well as a job description for the post of "Personal Property Officer." Based upon the new information he received Dr. Sudekum opined that based upon the information he had received of this posting, "...the job duties performed by a Correctional officer assigned to the Personal Property Post would not serve to cause or aggravate lateral epicondylitis, carpal tunnel syndrome, or cubital tunnel syndrome....[i] is my opinion, with a reasonable degree of medical certainly, that Mr. Quillman's job actitivities as a Correctional Officer at Menard Correctional Center did not cause or aggravate carpal tunnel syndrome, cubital tunnel syndrome, or lateral epicondylitis. Dr. Sudekum pointed out in his supplemental report:

> There is no indication in the job description which I received for Personal Property Officer that this post requires bar wrapping or the same degree of opening and closing of cell doors as would be required of a Correctional Officer working on one of the Galleries or Housing Units within the institution. In my opinion, the job of Personal Property Officer would not cause or aggravate peripheral neuropathies or lateral epicondylitis.

Dr. Sudekum also testified by Deposition and testified in line with his reports. He very carefully put forth his reasons for why the job of Personal Property Officer would contribute to these conditions. Dr. Sudekum opined this post was considerably less strenuous than that of a Correctional Officer on a Gallery or housing unit. In his words, there are less upper extremity stressors.

Mr. Quillman's claim is denied. The objective diagnostic testing for Mr. Quillman for bilateral carpal and cubital tunnel syndromes was negative. Additionally, Dr. Sudekum, the Section 12 examiner for the Respondent, credibly testified the job duties of a Personal Property Officer would not cause or aggravate lateral epicondylitis.

Conclusions of Law:

Petitioner shall be barred from recovery. Petitioner's failed to meet his burden of proof. Petitioner failed to prove that he sustained an injury that arose out of and in the course or his employment with Respondent. The medical evidence does not demonstrate a compensable accident. Furthermore, the Respondent's section 12 examiner credibly testified the Petitioner did not suffer a compensable work related injury. Claim denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DEWITT)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judith Gilbert,
Petitioner,

vs.

NO: 06 WC 39558
07 WC 54463

Abraham Lincoln Memorial Hospital,
Respondent.

15IWCC0715

DECISION AND OPINION ON §19(H) AND §8(A) PETITION

Petitioner filed a Petition under §19(h) and §8(a) of the Illinois Workers' Compensation Act alleging a material increase in her disability and requesting additional medical expenses since the decision of Arbitrator Holland dated September 10, 2009 in which he found that as a result of accidental injuries arising out of and in the course of her employment on March 26, 2006 and November 19, 2007 Petitioner was temporarily totally disabled for a period of 15-3/7 weeks, is entitled to 4,218.00 in medical expenses and permanently lost 35% of the use of his left arm under Section 8(e) of the Act. Neither party appealed this Decision and it became final. The issues now before the Commission are whether Petitioner's permanent disability has materially increased since the September 10, 2009 Arbitrator's decision, the amount of additional reasonable and necessary medical expenses and whether Petitioner is entitled to mileage under §8(a) of the Act. The Commission, after reviewing the entire record, finds that Petitioner failed to prove she sustained a material increase in her disability under §19(h) and failed to prove she is entitled to additional reasonable and necessary medical expenses and mileage under §8(a) of the Act, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On March 26, 2006 Petitioner was hit in the left shoulder by a falling can while at work. Petitioner saw Dr. Hardiek, her family doctor who referred her to Dr. Wottowa. Shen then saw Dr. Nicholson at her employer's request for an evaluation. She chose to treat with Dr. Nicholson.

2. Petitioner's June 9, 2006 left shoulder MRI showed no evidence of a full thickness rotator cuff tear but evidence of at least partial tear without tendon retraction in the distal supraspinatus tendon along with fluid in the subacromial/subdeltoid bursa and moderate to severe osteoarthritis at the glenohumeral joint.

3. On December 11, 2006, Dr. Nicholson performed surgery on Petitioner's left arm. The post-operative diagnosis was left subacromial impingement syndrome and left long head of biceps tendinitis.

4. On August 28, 2007 Petitioner followed up with Dr. Nicolson who noted she is now eight months post-surgery. At the last visit, she was complaining of pain of the anterior shoulder. Today, it is more pain over the lateral deltoid. The pain is primarily experienced with overhead activities. She really does not have much night pain. She is still doing her home exercises and she is still able to perform her full time job. On physical examination, she demonstrated some mild tenderness to palpation over the AC joint. Her bilateral active forward elevation is 170 degrees. External rotation with the arm at the side is 70 degrees and internal rotation is to L4 bilaterally. She has 5/5 rotator cuff strength testing in external and internal rotation. She has a negative belly press sign. She has minimal pain with cross body adduction. Dr. Nicolson remarked that her condition does not appear to be too debilitation at this time and he characterized it as more of a nagging type issue. Lastly, he noted that she is still able to perform all of her activities of daily living as well as her job activities without much difficulty and he recommended that she continue with her home exercises and return to the clinic as needed.

5. On October 9, 2007, Dr. Nicolson noted that Petitioner has done remarkably well but she continues to have pain over the lateral aspect of the deltoid with abduction and elevation above the horizontal with internal rotation. He opined that this is really more of a persistent probable rotator cuff fibrosis. She reported that she is doing full duty work without any restrictions. Based on his examination, he opined that Petitioner has reached maximum medical improvement and he released her from care without any restrictions.

6. On August 26, 2008 Petitioner again returned to Dr. Nicolson. He noted that he had not seen Petitioner since October 9, 2007. Currently, she states that on November 19, 2007 while she was carrying a pan at work when someone jammed into her left arm and injured her left shoulder. She reports that since then she had had significant pain in the shoulder which is localized into the upper trapezius and posterior area of the shoulder along with being in the spine of her scapula. Dr. Nicolson noted that on examination she is neurologically and vascularly intact. She has extreme spasm and tightness in the left upper trapezius. She is painful to palpation along the posterior aspect of the shoulder along the spine of the scapula specifically about two centimeters medial to the

posterolateral border of the acromion. There does not seem to be crepitus in this area. The AC joint is non-tender. She has 5/5 external rotation strength, 5/5 belly press strength, and 4/5 supraspinatus abduction strength with pain and most of the pain is in the trapezius. The long head of biceps is intact; Her Speed test and Yergason sign are negative. There is no crepitus within the glenohumeral joint itself. He noted that she has not had any new imaging studies and he ordered a MRI.

7. The October 10, 2008 left shoulder MRI demonstrated an anterolateral down sloping of the acromion, mild acromioclavicular osteoarthritis, tendinosis of the supraspinatus and infraspinatus tendons, but no full thickness tendon tear or muscle atrophy.

8. On her December 10, 2008 follow up appointment with Dr. Nicholson, he noted that he has reviewed Petitioner's MRI and did not see any evidence of a rotator cuff tear in the subscapularis, supraspinatus or infraspinatus. However, there is mild encroaching acromial morphology, but at this point this is a good study and she has an intact rotator cuff.

9. At the September 4, 2009 Arbitration hearing, Petitioner testified she no longer works for the Respondent as a head cook. She was fired on May 3, 2009. Currently she has constant pain with her left shoulder and excruciating pain when the weather changes. If she drives to Iowa City, which is a 400 mile round trip, she has to use her TENS unit for 3-4 days after that because of the pain. She does not take medication because she is allergic to a lot of medication. She just relies on the TENS unit, which provides her some relief from her pain. She cannot lift her shoulder up to chest level. When she lifts it up, it is very weak. The pain shoots down her elbow. It takes longer to perform household duties and she cannot do them as thorough as she used to because she cannot use both arms. She has a hard time combing her hair. She cannot reach her back. She experiences problems on cold and rainy days. She does not have the strength she used to have. On September 4, 2009, Arbitrator Holland found, among other things, that she had lost 35% of the use of her left arm.

10. On April 13, 2011, Petitioner filed a Petition under §19(h)/8(a) claiming she had sustained a material increase in her condition and claiming that she incurred additional medical expenses related thereto. Petitioner testified that shoulder was giving her some problems. The pain was constant and her shoulder had gotten worse. She was experiencing trouble lifting her arm above her head and she could not move it behind her back. If she lifts up, she has to push it up and hold it. She wanted to go to a doctor she could drive to so she looked in the phone book and chose Dr. Johnson with Midwest Orthopedics in Peoria. She did not want to drive to Chicago. She noticed that if she drives a long distance, lifts items or moves in any way whatsoever, her shoulder hurts so bad she can hardly stand it.

11. On October 28, 2011, Petitioner saw Dr. Johnson. Petitioner reported she previously underwent surgery and experienced some relief following her surgery but she has had continued pain in the anterior aspect of her shoulder since then. Currently, she complained of intermittent pain in the superior and lateral aspect of her shoulder which she rated as being 10 out of 10. She reports she has pain and difficulty sleeping. She has

associated weakness to the shoulder, particularly with lifting and overhead activities. She reported she has been taking Aleve for her pain and her symptoms have been relieved with Aleve and rest, but lately her symptoms have worsened. Dr. Johnson noted that while Petitioner said she was in pain when he saw her she seemed to be sitting fairly comfortably. On examination, she has tenderness over the area of the coracoid, supraspinatus and trapezius. She has 4+/5 strength with forward elevation, which is limited secondarily to pain. She has external rotation strength of 5/5 and internal rotation of 5/5 on the left. She has a positive impingement sign and a mildly positive painful arc. The AC compression, subscapularis signs, lift off and abdominal press, biceps signs, labral signs, dynamic compression test and O'Brien's test are all negative. She has no crepitus and her sensation to touch is intact. Her active forward elevation shows a range of motion of 170 degrees on the right and 165 degrees on the left. Her external rotation is 70 degrees on the right and left; her internal rotation is to T10 on right and T11 on left. Dr. Johnson diagnosed Petitioner as having left shoulder pain and he prescribed a corticosteroid injection and instructed her to continue with her home exercise program. The Petitioner declined the injection.

12. Petitioner testified that Dr. Johnson recommended a corticosteroid injection but she did not get it done because she is allergic to steroids. He also recommended continuing a home exercise program which she tries to do daily and does at least twice a week.

13. On October 9, 2012 Petitioner returned to Dr. Nicholson who noted that he had not seen her since 2008. Currently, she is complaining of left shoulder pain; On examination, he found that her active forward elevation is 160 degrees. She has an arc of pain from about 70-120 degrees that goes up and down that narrowed subacromial space. Her AC joint is non-tender. She has 5/5 external rotation strength, 5/5 belly press strength and 5/5 supraspinatus abduction strength but this causes pain. She has some subjective pain down her biceps. Her Speed test and Yergason signs are negative and the long head of her biceps is intact. There is no evidence of adhesive capsulitis. Her passive motion is symmetric to her active motion. Dr. Nicholson opined he does not believe her status has changed in any significant clinical way over the last four years except for the fact that she is four years older. She is almost 73 and she has intermittent shoulder pain. He instructed her to follow up as necessary and noted that she is not in need of any further shoulder intervention at this time.

14. Petitioner testified that she saw Dr. Nicholson on October 19, 2012 and he stated there was nothing more he could do for her shoulder. It was just deteriorating and if she had pain she should take aspirin or Naproxen. She initially testified that she has not received any pain medication since the arbitration hearing, but then she testified that she said she got pain medication after the arbitration hearing from Dr. Evans in Clinton. She testified that she currently takes Naproxen but only so often because it makes her stomach hurt. She takes it once or twice a month at most.

15. Petitioner submitted into evidence PX5, a medical bill for Dr. Johnson with a $73.51 balance due after an insurance payment. The type of insurance was not identified. She also submitted a medical bill for Dr. Nicholson showing a zero balance after a MON AMCC payment was made. Again, no indication was as to who specifically paid this bill.

Lastly she submitted PX6, a mileage record of her trip to and from to Dr. Nicholson's office. Petitioner testified that while there have been payments of some of the medical bills, workers' compensation has not made these payments. Petitioner said she thinks they were paid by Social Security through Medicare. She paid Dr. Johnson's bill for $73.51 but she did not pay Dr. Nicholson's bill. She identified PX6 as mileage from her house to Dr. Nicholson's office in Oak Park. She initially said she drove 30 miles to the hearing site. Then she said she drove the first 20 miles to the hearing and her son drove the rest of the way. She testified she plans on driving back home, but she brought her son in case she cannot drive. She still has the TENS unit from before arbitration and she still uses it. If she is doing something active with her shoulder such as a lot of driving or lifting she uses the TENS unit a couple of times a week. She uses the TENS unit now more frequently than she did before the Arbitration hearing.

In reviewing the objective findings contained in the October 9, 2012 visit with Dr. Nicholson and comparing them to the August 28, 2007 and August 26, 2008 visits with Dr. Nicholson it appears that Petitioner's active forward motion was 10 degrees less than before the Arbitration hearing and 5 degrees less than before per Dr. Johnson's October 28, 2011 exam while her supraspinatus abduction strength was better than last time. Petitioner's strength with forward elevation was slightly less on Dr. Johnson's October 28, 2011 exam but was back to the pre Arbitration point by the time of Dr. Nicholson's October 9, 2012 exam. Furthermore, while Petitioner claims her pain was constant at the July 25, 2012 Review Hearing, she told both Dr. Nicholson on October 9, 2012 and Dr. Johnson on October 28, 2011 that her pain is intermittent. The majority of the other objective tests remain the same from pre/post Arbitration. Additionally Dr. Nicholson states Petitioner's status has not changed in any significant clinical way over the last four years except for the fact that it is four years later and he recommends no further treatment. Given the above, the Commission finds that it appears that if there was a material increase it was slight in nature and would be primarily based on Petitioner's subjective pain complaints as opposed to the objective findings. Furthermore, given Dr. Nicholson's statement that there has not been any significant clinical change in the last four years, Dr. Nicholson stated that range of motion measurements can vary slightly from time to time and Petitioner is currently reported intermittent pain as opposed to the constant pain she testified to during the Review hearing, the Commission finds that there has not been a material change in Petitioner's condition that warrants an increase in her permanency award.

Respondent claims that Petitioner surpassed the chain of referrals allowed under §8(a) of the Act. The Commission finds that Dr. Hardiek and his referral to Dr. Wottowa count as Petitioner's first choice of medical treatment. Dr. Nicholson counts as Petitioner's second choice of medical care and Dr. Johnson counts as Petitioner's third choice of medical care. As such, the Commission finds the medical treatment provided by Dr. Johnson is outside reasonable and necessary chain of referrals allowed under §8(a) of the Act and is not compensable.

The Commission notes that Dr. Nicholson's bill shows a zero balance after a MON AMCC (entity not defined) payment. While Petitioner testified she thinks this bill

was paid by Medicare, she is not sure. Currently, it appears that there is nothing due and owing on this bill and as such the Commission denies payment of this bill.

In terms of the mileage Petitioner is seeking for her trip to Dr. Nicholson, the Commission finds that Petitioner was able to obtain the same service on a local basis as is evident by her treatment with Dr. Johnson and as such Petitioner is not entitled to mileage.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove her disability has materially increased, her claim for compensation under §19(h) is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to any additional medical expenses or mileage cost under §8(a) of the Act.

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

DATED: SEP 15 2015

MB/jm

O: 8/6/15

43

Mario Basurto

David L. Gore

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nels Madsen,

Petitioner,

vs.

NO: 10 WC 26158
11 WC 35998

Builders Transportation Co.,

Respondent.

15IWCC0729

DECISION AND OPINION ON REVIEW

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

The Commission expands upon the decision of the Arbitrator with respect to the denial of wage differential benefits under section 8(d)(1) of the Act in case No. 11 WC 35998. Although the Commission agrees with the denial of wage differential benefits, the Commission notes that the Arbitrator did not explain the reasons for his ruling. In considering the evidence de novo, the Commission notes that petitioner is under permanent restrictions with regard to use of his left upper extremity and lifting above the shoulder. The testimony is undisputed that the petitioner may return to employment as a semi- trailer or no touch box truck driver. The petitioner himself testified that over the road truck drivers can earn up to .51 cents per mile. He has no restrictions on the hours per day or days per week he is able to work. At the time of the accident petitioner was earning .31 cents per hour from respondent.

Petitioner seeks a wage differential award under Section 8(d)(1), instead the Arbitrator awarded PPD benefits under Section 8 (d)(2) of the Act. It is undisputed that petitioner is unable to return to his usual and customary employment as a flatbed truck driver.

Section 8(d) of the Act details two types of compensation for employees who are permanently and partially disabled; subparagraph (1) provides for a wage differential award and paragraph (2) provides for a percentage of the person as a whole award. In order to qualify for a wage differential award under section 8(d) (1) of the Act the petitioner must satisfy a two prong test; (1) a partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) an impairment in earnings.

The purpose of a wage differential award is to compensate an injured claimant for his reduced earning capacity, and if the injury does not reduce his earning capacity, his is not entitled to such compensation. *Dawson v. Illinois Workers' Compensation Comm'n*, 382 Ill.App.3rd 581, 585, 888 N.E. 2d 135 (2008). In the present case petitioner did not prove reduced earnings. The arbitrator appropriately awarded PPD benefits representing the loss of 21% of the person as a whole. In his opinion however the arbitrator did not explicitly deny the wage differential or explain the basis for that denial. This failure is error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 9, 2014 is hereby expanded, affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $69,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 23 2015
SM/msb
o: 7/30/15
44

Stephen Mathis

David Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MADSEN, NELS
Employee/Petitioner

Case# **10WC026158**

10WC035998

BUILDERS TRANSPORTATION CO
Employer/Respondent

15IWCC0729

On 10/9/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOIXVILLE AVE
PEORIA, IL 61603

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

15IWCC0729

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NELS MADSEN
Employee/Petitioner

v.

BUILDERS TRANSPORTATION CO.
Employer/Respondent

Case # **10** WC **26158**

Consolidated cases: **11 WC 35998**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **July 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Wage Differential under Section 8(d)(1)**

15IWCC0729

FINDINGS

On **10/12/09**, 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 part.

In the year preceding the injury, Petitioner earned $**44,822.96**; the average weekly wage was $**861.98**.

On the date of accident, Petitioner was **47** 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 $**39,901.55** for TTD, $**8,889.83** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**48,791.38**. Respondent shall be given a credit in the amount of $**97,530.82** for medical bills paid pursuant to section 8(a) to be applied to medical bills already paid.

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

ORDER

Respondent shall pay petitioner TTD from 10/12/09 through 4/9/10 representing 25-4/7 weeks at the rate of $574.64 pursuant to section 8(b) of the Act.

Petitioner's request for payment of outstanding medical bills is denied.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **12/4/12** at the rate of $517.76 per week for a period of 105 weeks because the injuries sustained by petitioner caused a loss equal to 21% loss to the person as a whole pursuant to section 8(d)(2) of the Act.

Respondent shall receive a credit for all medical, TTD and TPD benefits paid.

Petitioner's claim for benefits alleging a repetitive trauma theory in connection with 10 WC 26158 is denied.

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

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

Robert E Dibo
Signature of Arbitrator

September 23, 2014
Date

OCT 9 - 2014

CSC:ms 99 417 001

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
WAUKEGAN VENUE

NELS MADSEN,

Petitioner,

vs.

BUILDERS TRANSPORTATION COMPANY,

Respondent.

15IWCC0729

No. 10 WC 26158 consolidated with 11 WC 35998

DATE OF ARBITRATION: 07-29-2014

Arbitrator Robert Falcioni

MEMORANDUM OF DECISION OF ARBITRATOR

I. Disputed Issues

C. Did an accident occur that arose out of and in the course of employment ? [10 WC 26158- repetitive trauma/work conditioning only]
F. Is Petitioner's current condition of ill being casually related to the injury ?
J. Were the medical services that were provided to Petitioner reasonable and necessary ? Has Respondent paid all appropriate charges for all reasonable and necessary medical services ?
K. What temporary benefits are in dispute ?
L. What is the nature and extent of the injury ?
O. Wage differential

II. FACTS

The parties stipulated and Petitioner testified as follows. Petitioner is 51 years old. He is single with no children. (PX1 and PX2). Petitioner testified that he had been in the military. He also worked as a route sales driver and had some truck driving experience. He has a high school education.

Petitioner began working for BUILDERS TRANSPORTATION COMPANY in October of 2007. He was hired as a flatbed truck driver.

Flatbed truck involved the hauling of oddly shaped loads. The loads themselves were exposed to the air. As a result, his duties differed from that of a traditional truck driver. He was required to climb on top of the loads. He would have to move tarps weighing up 125 pounds. He had to move chains that weighed 60 to 80 pounds. He would have to secure loads so as to

make sure they did not fall off the truck when he was going down the road. He drove all over the United States. While driving, he would be required to make various stops along his route. These stops were required by Federal guidelines. He had to make sure that his load was fastened securely. This required him to get out of the truck and repeat similar movements to the ones he had done when he initially would tie down a load. He also had to climb about his tractor to do post-trip and pre-trip inspections.

Petitioner was injured on October 12, 2009. He was at Nichols Aluminum. He was fastening aluminum coils onto his flatbed. He was pulling one of the chains over the coils. A plastic insert on the chain gave way. The chain slacked and he was "launched" off the flatbed into a guardrail. He suffered injuries to his neck and left shoulder. He testified that he only suffered injuries to his neck and left shoulder.

Following the accident, Petitioner was first seen at Concentra Urgent Care in Memphis, Tennessee on October 12, 2009. He had pain in the front part of his shoulder. He was given a 10 pound lifting restriction. Cervical range of motion was normal. The patient complained about pain in his neck and both shoulders. The shoulders showed no deformity. His diagnosis was he suffered from a shoulder contusion and cervical strain. He was given a restriction of no lifting over 10 pounds. (PX7). He was referred for therapy on October 20, 2009. He participated in therapy from October 20, 2009 through October 30, 2009. (PX7).

Petitioner first saw Dr. John Lochemes on October 27, 2009. Dr. Lochemes diagnosed a Grade I AC sprain. He was prescribed Lortab. He was to be seen back in two weeks. Dr. Lochemes gave him a 10 pound lifting restriction. (PX9). Petitioner was seen again on

November 13, 2009. The diagnosis of AC joint sprain continued along with a diagnosis of bursitis. An MRI was recommended. He was restricted to 10 pounds lifting. (PX9).

Petitioner returned on November 20, 2009. The MRI showed AC joint fluid. Fluid signal and edema was noted on the MRI. There was no tear. Dr. Lochemes did not recommend surgery. He recommended observation. A 10 pound lifting restriction was continued. (PX9). Petitioner followed up on December 11, 2009. He had limited motion overhead. His left arm gave way. A distal clavicle resection and diagnostic arthroscopy was recommended. The 10 pound restriction was continued. The surgery was scheduled for December 18, 2009. (PX9).

The surgical report dated December 18, 2009 shows that Dr. Lochemes observed the inside of the left shoulder. It was stated that the rotator cuff was "pristine". (PX20).

Petitioner was seen post-operatively and it was recommended that he start physical therapy as of January 6, 2010. During this time, Petitioner worked light duty. Physical therapy was continued from January 6, 2010 until February 15, 2010. It was noted in a follow-up visit with Dr. Lochemes on January 20, 2010. that the patient had finally turned a corner. He cancelled physical therapy appointments on February 1 and February 8, 2010. (PX9).

Occupational rehabilitation was started on February 16, 2010. A note signed by Dr. Lochemes dated March 18, 2010 shows the Petitioner was not ready to go back to work because he said he could not lift 150 pounds overhead. Petitioner had testified on direct that the tarps weighed up to 100 pounds. The note indicates that Mr. Madsen did not concur with the statement that the tarps only weighed up to 105 pounds. That is inconsistent with his testimony at arbitration. (PX9). Work conditioning was continued again on March 19, 2010.

As of March 30, 2010 the Petitioner reported no pain. Upon discharge on April 8, 2010, Petitioner indicated "he has no pain now." (PX9). He was released from care on April 9, 2010. He was released to regular duty. (PX9).

Petitioner returned to Dr. Lochemes on June 25, 2010. He claimed that his shoulder hurt in the lateral aspect of the acromion. Dr. Lochemes noted that post surgery the operation was shown to be successful.

A new MRI dated July 9, 2010 showed Petitioner with a full thickness left rotator cuff tear. The prior MRI had shown the rotator cuff as pristine as had the operative report. (PX9). Petitioner was scheduled for surgery again on September 18, 2010. The biceps tendon anchor was frayed. Biceps tendotomy was performed. He had some impingement despite the previous acromioplasty. The acromioplasty was revised. During the surgery, the supraspinatus became detached, but Dr. Lochemes indicated it would have to have been repaired anyway. Intraoperative diagnosis was partial thickness tear of the rotator cuff. (PX21). It was recommended he participate in physical therapy. He was taken off work.

Petitioner eventually followed up with Dr. Lochemes on January 13, 2011. He noted that an FCE taken by Champion Fitness in Bloomington showed that the Petitioner did not engage in full effort. He failed 6 out of 13 performance criteria. Dr. Lochemes indicated Petitioner could actually function higher than what he was willing to do. He acknowledged Petitioner could not return to his old job and recommended continued therapy. Nevertheless, he stated the FCE would not project Petitioner's treatment abilities given the inconsistency of the FCE. (PX9, RX4).

Dr. Lochemes explained on April 8, 2011 that there was no structural cause for Petitioner's complaints of pain. He stated in his records that the cause and cure of petitioner's symptoms seemed to be unavailable.

A repeat MRI showed pinning of the biceps tendon within the bicipital grove. There was no evidence of any recurrent rotator cuff tear. (PX9).

There are no other doctor notes from Dr. Lochemes after April of 2011. There is a note from Ryan Meikamp contained within the records. Mr. Meikamp is with the law offices of Petitioner's counsel. The letter states that Petitioner is not going to be going to Memphis anymore. The letter indicates that Petitioner was going to stop showing up for light duty work. Records reflect the Petitioner was paid TPD through September of 2011. (RX6). Petitioner had testified that he quit showing up for work. (RX7, pp 161-164).

Petitioner started seeing Dr. Edward Kolb on May 23, 2011. Dr. Kolb took a history on that day. Petitioner reported he was feeling worse now after the surgery. He also had some chest pain that had never been worked up.

He followed up on May 27, 2011. The MRI showed some bulging to the right side at T6-7. This did not match up with his complaints of left-sided neck pain. Dr. Kolb referred him to Dr. Jay Li for further workup. (PX18).

Petitioner returned to see Dr. Kolb on June 24, 2011. Dr. Li had been attempting to get approval for some injections. Petitioner could elevate his arm to 180°. He had a mildly positive impingement sign. An EMG was recommended. Dr. Kolb felt the pain was related to the neck. Petitioner stated he had been off work. He claimed that his work was not talking to him. He was not traveling for work. (PX18).

Petitioner next saw Dr. Kolb on September 16, 2011. He had two steroid injections. He was given restrictions of no long driving as of September 16, 2011.

Petitioner next saw Dr. Kolb on October 26, 2011. The EMG was negative for any cervical radiculopathy. He did had bilateral carpal tunnel syndrome. Dr. Kolb did not have a good explanation for his persistent symptoms. He thought the patient should be able to work light duty.

Dr. Kolb saw the Petitioner again on November 28, 2011. Restrictions were not addressed. Dr. Kolb offered a third surgery. However, he explained that the results would be unpredictable. He noted the Petitioner's pain had been the same since the first surgery.

Petitioner was next seen by Dr. Kolb on January 16, 2012. Petitioner has continued to see Dr. Kolb who had stated there was no surgery that would take care of the issue experienced by the Petitioner. He indicated he was frustrated that he had to live on Vicodin. Dr. Kolb recommended a referral to Dr. Singh in Chicago. (PX18).

Petitioner was seen by Dr. Richard Kube upon a referral from Dr. Kolb on February 13, 2012. Dr. Kube examined the petitioner to determine if there was any pathology in the neck and if that was causing his ongoing problems. (Px 12). He had negative cervical provocative maneuvers on examination. Dr. Kube concluded that that petitioner's subjective report of paresthesias did not correlate with any dysfunction of the cervical spine. (Px 12).

Petitioner was seen by Dr. Joseph Newcomer on May 4, 2012. Petitioner gave a history of injuring himself in September of 2009. He gave history of injury consistent with his testimony at arbitration. Dr. Newcomer observed that a MRI that was taken revealing edema in the distal clavicle. Petitioner underwent surgery on 12/08/09. After several months of therapy the

petitioner was returned to work full duty having achieved MMI. The petitioner eventually returned for more left shoulder treatment. This time a rotator cuff repair was performed. Dr. Newcomer observed that the original MRI and operative report showed the rotator cuff to be intact. A subsequent MRI (Px8) showed a full thickness rotator cuff tear. Surgery was performed in September consisting of a rotator cuff repair and biceps tenodesis. (Px 21). Dr. Newcomer concluded that the second surgery was not related to the accident because he could not conceive of how the rotator cuff went from pristine to showing a complete tear. He also stated petitioner was not in further need of treatment. (Rx 1, Exhibit 2).

Petitioner also told Dr. Newcomer that he did well for the first five months after the surgery. He then re-injured his shoulder in therapy. There is no record of this in any of the physical therapy records introduced into evidence following the first or second surgery. (Px 9, Px 11 and Px 18).

Petitioner returned to see Dr. Kube on June 26, 2012. Dr. Kube recommended a referral to Dr. Rhode. Dr. Kube saw the petitioner again July 31, 2012 noting that a MRI of the cervical spine did not show any neurocompressive lesion. He had a relatively homogenous appearance down his spine. (Px 12). Dr. Kube recommended that he follow up with Dr. Rhode and observed that Dr. Rhode did not feel there was really anything else they could do for the petitioner. Dr. Kube did request to review a nerve study that had been mentioned by the petitioner. (Px 12).

Petitioner was seen by Dr. Blair Rhode on June 27, 2012. Dr. Rhode documented petitioner's two surgeries and observed that a MRI taken on April 11, 2011, seven months after the second surgery did not show a recurrent tear. Petitioner has impingement and was given an

injection. He was taken off work as of June 27, 2012. Dr. Rhode recommended a repeat MRI at his next visit on July 11, 2012. (Px 13).

Petitioner was seen again on July 25, 2012. The MRI did not show any frank tear. Petitioner had tendinopathy. Dr. Rhode diagnosed acromioclavicular pain and took the patient off work. (Px 13).

Dr. Kube saw the petitioner again on September 13, 2012. He observed that the nerve study did not show any cervical radiculopathy. He recommended against surgery for the neck. (Px 12).

The next office visit on October 17, 2012 indicates petitioner was one month out from a acromioclavicular injection reporting mild relief. Petitioner elected against surgery. A FCE was recommended. (Px 13). Dr. Rhode released the petitioner to drive a semi-truck. (Px 13).

A FCE was performed on November 19, 2012. Range of motion of the left shoulder was within functional limitations. The FCE results placed the petitioner in the medium capacity of work and showed he had some limitations for elevated work. The FCE results contemplated an eight hour five day work week. (Px 14). Dr. Rhode placed the petitioner at medium work carrying up to fifty pounds with frequent carrying of twenty five pounds. He determined the petitioner could lift up to 20 pounds overhead and 10 pounds overhead on a frequent basis. These restriction levels appear to be below what had been reported on the FCE. (Px 13 and 14). Dr. Rhode placed petitioner at MMI as of December 4, 2012.

Petitioner testified that he returned to work as a semi-truck driver for Celadon. Wage record show that he earned .215 per mile and received .11 per mile per diem. Petitioner did not

distinguish between the two per mile methods of payment. He also stated he did not present his receipts to justify reimbursement of his per diem.

He claimed that he work complete weeks for Celedon. However, wage records from Celedon do not support that testimony. The wage records show that he worked for Celedon from December 5, 2012 through January 17, 2013. Records show the petitioner was dispatched on December 4, 5 , 11 and 13. He did not take another job until December 27. He was dispatched again on December 29. He was not dispatched again until January 7, 2013. The dispatches in December took him to Michigan, Ohio, Virginia and Indiana. The dispatch in January involved a trip to Indiana. A reasonable inference can be made that petitioner did not work full work weeks for Celadon as his distance from home in Illinois would never justify the gaps in time between each dispatch. Petitioner offered no explanation on his wage records from Celadon. The records appear to be contrary to his claim that he worked full weeks for Celedon. (Px 25). There was never any testimony that 40 hours of work a week was not available.

Dr. Rhode saw the petitioner again on January 28, 2013. Petitioner acknowledged that he had returned to driving a truck. He stated the bouncing was killing him. Work restrictions were unchanged despite these complaints. (Px 13).

Dr. Rhode testified at arbitration stating petitioner could not return to work as a flatbed truck driver. (Px 15, p. 28). As long as he was not required to perform the duties of a flat-bed truck driver, he could drive a semi. (Px 15, p. 28). He confirmed on cross examination that the petitioner could drive a semi-truck so long as he avoided the duties of a flat-bed truck driver. Petitioner had no restrictions on hours driven in a semi on account of his injuries. (Px 41). Dr. Rhode further acknowledged that the rotator cuff is aggravated when it is repetitively called

upon. A forward reach type activity can reproduce above the shoulder activity. (Px 15, p. 45). He acknowledged that as a truck driver in a semi petitioner's arms would be positioned well below his shoulder level. This kind of positioning would not stress the rotator cuff. (Px 15, pp. 45-46).

Records show petitioner worked for BP transportation from January 23, 2013 to June 19, 2013 despite complaining to Dr. Rhode that he could not drive a semi. (Rx. 25). Records from BP Transportation also show petitioner was earning .38 per mile. (Px 24).

Petitioner met with Bob Hammond on June 23, 2013 shortly after he stopped working for BP Transportation. Hammond observed that petitioner could not go back to flat-bed truck driving. Petitioner reported to him that he had trouble lifting more than ten pounds. This is contrary to what is depicted on the FCE. It is also inconsistent with the restrictions authored by Dr. Rhode. (Px 16). Mr. Hammond went on to state that petitioner had unresolved back issues, but petitioner testified that his claimed injuries were confined to his left arm and neck. Mr. Hammond also concluded the petitioner will have limited access to no touch freight as most available job are local. Mr. Hammond reached these conclusions without conducting a labor market surgery. (Px 16). He never contacted Celedon or other trucking companies to check on the availability of semi-truck driving jobs. (Px 17, p. 36).

Petitioner testified contrary to many of the findings in Mr. Hammond's report. He acknowledged that the need for over the road truck drivers is high. He acknowledged that the jobs that fall into the no touch, over the road category are plentiful. He acknowledged that over the road truck drivers can earn up to .51 cents per mile. He could not recall what he earned at Builders transportation. No touch freight jobs were plentiful.

Petitioner testified that he failed his CDL/DOT physical. However, there was no documentation or testimony to support why he failed his CDL/DOT physical.

Deanna Bailye, a vocational expert testified on behalf of respondent. She said that Mr. Madsen earned $600 a week for Celadon, but worked reduced hours. There was nothing in the medical records which showed the petitioner was prevented from working forty hours a week. She researched jobs for Mr. Madsen stating that Frontier Trucking was offering 2300-2700 miles per week guaranteed at .36 cents per mile. She stated under this scenario Mr. Madsen could earn $828 to $972 per week. She testified that no touch semi-trucking jobs are readily available in the economy. (Rx 2, pp. 10-13, Ex. 2). She found three such jobs as part of her labor market survey. (Rx 2, p. 31). Petitioner suffered no wage loss as a result of not being able to drive a flat-bed truck. (Rx 2, pp. 10-13, Ex. 2). She stated the vocational rehabilitation would not help petitioner because he already found a job using his transferrable skills. Ms. Bailye testified that she received no evidence that the job with Celadon was an on call job. There was no evidence that petitioner was prevented from accepting any of the trucking assignments offered him by Celadon. (Rx 2, p. 38).

AJ Sellers testified on behalf of the respondent. He has been involved in the trucking industry since 1992. (Rx 5, p. 7). He worked as an over the truck driver and now is manager of safety at Builders Transportation. He was a truck driver from 1992-1997 driving both semi and falt-bed trucks. He indicated he was familiar with the job duties of both and still drives today. (Rx 5, p. 11). He stated he was familiar with the pay in the industry. (Rx, p. 12). He testified that petitioner was earning .32 a mile at the time of his injury. (Rx 5, p. 11). He also explained that some drivers have an option to be paid a per diem. If a driver accepts a per diem up front

then they are unable to deduct the per diem at the end of the year. (Rx 5, p. 15). When petitioner worked for respondent, he elected against taking a per diem and was instead paid .32/mile. (Rx, p. 15).

He further testified that petitioner's hours per week varied. (Rx 5, p. 16). Petitioner worked as an over the road truck driver. (Rx 5, pp. 16-17).

Mr. Sellers testified that box truck drivers encounter a lot of drop and hook scenarios where they drop freight and quickly pick up another load. Flat-bed truck drivers typically find themselves in yards, delayed and waiting around while their loads are processed. (Rx 5, pp.19-21). Given the differences in these jobs, flat bed drivers typically average 2000-2500 miles per week whereas box truck drivers can achieve in excess of 3,200 miles per week. This results in box drivers potentially earning more than flat-bed truck drivers. (Rx 5, p. 22). Mr. Sellers explained that 2500 miles a week for a flat bed truck driver represents approximately the same amount of driving time for a box truck driver at 3200 miles per week. (Rx 5, pp. 25-26). Mr. Sellers also confirmed that petitioner was reimbursed his lumper pay and would have been paid detention pay while working as a box truck driver for Celedon upon viewing the wage records from Celedon. (Rx 5, pp. 27-28). Mr. Sellers also confirmed that there is a truck driver shortage in the industry. (Px 5, p. 29). He testified that box truck operators pay over forty cents a mile today. (Px 5, p. 30).

Mr. Sellers also testified about the movements a box truck driver is required to make when operating his vehicle and trailer. First, brakes are set by pulling out the plungers evacuating the air from the braking system. The driver then gets out of the cab and goes to the back of the truck. He cranks his dolly down while standing on the ground. (Rx 5, pp. 32-33).

The dolly raises the trailer from the cab as the trailer legs push off from the ground. The driver then reaches under the truck and pulls a level releasing the jaws of the truck from the trailer. Service air and emergency airline are disconnected from the trailer. Power, brake lights and emergency flashers are also disconnected. Each of these moves are done with the driver standing on the ground. None of the movement require overhead reaching or lifting. (Rx 5, pp. 33-34). Even for a shorter person at 5'6'', all movements in attaching and detaching the trailer will be done at or below chest level. (Rx 5, p 35). There are no overhead movements with the exception of maintaining three points of contact while entering or exiting the cab. Petitioner testified that this DOT requirement is a safety measure. There is no medical evidence indicating petitioner was prevented from exiting or entering the cab of a truck.

Mr. Sellers also testified that Mr. Madsen quit showing up for work when he was being provided light duty. (Rx 5, p. 39). Mr. Sellers indicated that petitioner was performing light clerical work. He was working in Memphis. He stayed overnight in a hotel and respondent paid the cost of the hotel. (Rx 5, p. 39). Mr. Sellers did confirm that once it is determined a petitioner on light duty has permanent restrictions, light duty accommodations end. (Rx 5, p. 41).

III ARBITRATOR'S FINDINGS

C. Did an accident occur that arose out of and in the Course of Petitioner's Employment with Respondent ? [Case no. 10 WC 26158 only]

Petitioner alleges injuries as a result of work events consisting of repetitive trauma/work conditioning with a manifestation date of October 12, 2009. (Px 1(a), Arb. Ex 3). The foregoing evidence does not support a finding of accident in this case. The Arbitrator finds that the claims

associated with 10 WC 26158 are hereby denied. The parties stipulated that an accident had occurred in 11 WC 35998.

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

The Arbitrator finds that petitioner suffered injuries to his left shoulder and neck as a result of the injury that occurred on October 12, 2009. Following the injury, petitioner underwent a course of physical therapy. A surgery was performed on December 18,2009 consisting of a diagnostic arthroscopy, acromioclavicular joint decompression with distal clavicle excision and subacromial decompression. Dr. Lochmes testified that the rotator cuff appeared to pristine from inside the joint. Bursitis was noted. There was some rotator cuff irritation on the top side of the supraspinatus tendon. (Px 22, p. 13). Following surgery petitioner participated in physical therapy and work hardening through January 21st to April 8th, 2010. (Px 22, pp. 15-21). Nothing in the PT records that Petitioner in any way injured his rotator cuff during the course of said therapy. Petitioner saw Dr. Lochmes on April 9, 2010. As indicated by the discussion above petitioner reported that he had no pain as of that date. Dr. Lochmes returned the petitioner to full duty work. (Px 22, p. 21). Petitioner would later return to Dr. Lochmes on June 25, 2010 complaining of left shoulder symptoms. A second MRI taken on July 11, 2010 showed a full thickness rotator cuff tear. Petitioner eventually underwent a second surgery on September 17, 2010. (Px 21).

The Arbitrator finds that he agrees with the testimony of Dr. Newcomer in this case. He did not believe the second surgery was caused by the event. He explained that petitioner had already achieved MMI. He indicated that the pathology caused by the fall was already addressed. (Rx 1, p10). Dr. Newcomer explained that the findings from the July 11, 2010 MRI were

different from what was found intraoperatively during the first surgery of December 18, 2009. Dr. Newcomer observed there was a complete change from an intact cuff to a fully torn cuff in between petitioner's release date of April 9, 2010 and the second MRI of July 11, 2010. (Rx 1, p. 12). There was no indication petitioner suffered an injury during physical therapy. (Rx 1, pp. 13-15). There was no indication the surgery further damaged the rotator cuff. (Rx 1, p. 23). Dr. Newcomer testified that in order to do a subacromial decompression a physician must address a partial rotator cuff tear. If there was a tear, Lochemes should have addressed it. Dr. Newcomer explained that the second surgical report contradicted the July 11, 2010 MRI which found a full thickness tear. Dr. Newcomer explained that the petitioner likely had impingement as a result of the injury. It likely resulted in edema in the AC joint which led to the distal clavicle resection. (Rx 1, p. 37). The second surgery was not related because he had a pristine footprint of the rotator cuff at the time of the first surgery. (Rx 1, p. 37). That changed at the time of the second surgery.

Dr. Newcomer did state the petitioner should not use his left arm at or above chest level. (Rx 1, p 16). The restrictions were based upon petitioner's subjective complaints. Further they were not related to the work injury. (Rx 1, pp. 16-17).

Dr. Lochemes testified that petitioner may have had a diseased rotator cuff. (Px 22, p. 38). He only connected the second surgery to the incident by way of petitioner's history. (Px 22, p. 39). He stated that at the time of the first MRI the rotator cuff appeared to be without any significant pathology. The whole purpose of the first surgery was to give additional space around the rotator cuff structures to prevent further injury. The rotator cuff remained intact from the surgery until Mr. Madsen's release date on April 9, 2010. He acknowledged that he was hoping

to prevent any progressive deterioration of the left rotator cuff structures because he might have a progressively degenerative condition. Indeed, Dr. Lochemes indicated that rotator cuff tears can occur without any inciting event. (Px 22, pp. 39-41). His operative report from December 18, 2009 shows the rotator cuff to be pristine intrarticularly. (Px 20). His operative report from September 17, 2010 show intraticularly the supraspinatus was frayed. (Px 21). The biceps tendon was pristine in December, but frayed in September. (Px 20 and 21).

These intra-operative findings observed by Dr. Lochemes between the first surgery and second are different. Dr. Lochemes acknowledged that petitioner might have a degenerative left shoulder. These new findings also support Dr. Newcomer's conclusion that the second surgery is not related to the incident. Petitioner recovered following the first surgery and was given a full duty release. Petitioner had reported pain following the first surgery for a significant period of time, but even Dr. Lochemes suggested the petitioner's pain did not correlate with his improvement in physical function. His reported range of motion did not correlate with what was observed by the physical therapist. (Px 22, p. 49). A FCE had been ordered in April of 2010, but the request was withdrawn because petitioner had gained sufficient strength to return to his regular job. (Px 22, p. 49).

In light of the above the Arbitrator finds the first surgery and subsequent treatment until petitioner's release date of April 9, 2010 is related to the October 12, 2009 incident and that all treatment thereafter is not, as is Petitioner's condition related to the second surgery.

J. What medical services provided to petitioner reasonable and necessary ? Has respondent paid all appropriate charges for all reasonable and necessary medical services ?

Respondent has paid all related medical bills. Respondent is ordered to pay all related medical bill per the fee schedule with service dates from October 12, 2009 through April 9, 2010. Respondent is due a credit in the amount of $97,530.82 for medical bills paid to be applied towards bills already paid.. (Rx 6).

K. What temporary benefits are in dispute ?

The Arbitrator finds that petitioner was temporarily totally disabled from October 12, 2009 through April 8, 2010 or a total of 25 4/7 weeks. Respondent shall pay petitioner TTD in the amount of 574.64 per week for a total of $14,612.27. The Arbitrator further finds that petitioner paid a total of $10,145.22 as a combination of TTD and TPD during from October 12, 2009 to April 9, 2010 for which it receives a credit. (Rx 6).

L. What is the nature and extent of the injury

In light of the above, the Arbitrator finds that the petitioner has suffered a permanent partial disability equivalent to 21.5% loss of the person as a whole pursuant to section 8(d)(2). Respondent shall pay weekly benefits at the rate of $517.18.

N. Is Respondent due any credit ?

. Respondent is due a credit in the amount of $38,461.60 which represents the TTD/TPD overpayment after deduction of the TTD/TPD credit outlined in paragraph K. (Rx 6).

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nick Pappas,
Petitioner,

vs.

NO: 11 WC 15636

Illinois Tollway,
Respondent.

15IWCC0735

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, additional compensation and attorneys' fees and evidentiary rulings and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the exception noted below.

The Commission strikes the citation of Sevilla v. Illinois Workers' Compensation, 6 IWCC 918 (2006) as one of the bases for the denial of penalties. The Commission otherwise, affirms the Arbitrator's finding that additional compensation and attorneys' fees are not warranted in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 28, 2015 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.

15IWCC0735

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: SEP 2 4 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 9/3/15

43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PAPPAS, NICK P
Employee/Petitioner

Case# **11WC015636**

15IWCC0735

ILLINOIS TOLLWAY
Employer/Respondent

On 1/28/2015, 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:

0491 SOSTRIN AND SOSTRIN PC
ELLIS M SOSTRIN
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

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

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

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

1024 IL STATE TOLL HIGHWAY AUTHY
WORKERS' COMPENSATION
2700 OGDEN AVE
DOWNERS GROVE, IL 60515

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

JAN 28 2015

ROMEO ARASCIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0735

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nick P. Pappas
Employee/Petitioner

v.

Illinois Tollway
Employer/Respondent

Case # 11 WC 15636

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **June 3, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0735

FINDINGS

On **January 24, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**60,590.40**; the average weekly wage was $**1,165.20**.

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

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

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

Respondent shall be given a credit of $**42,058.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**42,058.16**.

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 $**776.80**/week for **54-1/7** weeks, commencing **1/27/2011** through **2/9/2012**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**42,058.16** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $**20,517.05**, as provided in Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **194.425** weeks, because the injuries sustained caused a **38.885%** loss of use, man as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

January 28, 2015
Date

JAN 28 2015

Nick P. Pappas v. Illinois Tollway
11WC 15636
Date of Accident: January 24, 2011

15IWCC0735

RIDER TO THE ARBITRATION DECISION

Introduction

Evidence in the above-captioned matter was presented at arbitration on June 3, 2014. On that date the Arbitrator heard testimony of the Petitioner, Nick P. Pappas, and received into evidence numerous exhibits including medical records, medical bills, two reports authored by Respondent's Section 12 examining physicians, Dr. Pietro Tonino and Dr. Jesse P. Butler, an evidence deposition of the treating doctor, Dr. Mark A. Lorenz, a telephone evidence deposition of a Utilization Review doctor, Dr. Graham Neil Gitlin, a Corvel Peer Review Reminders and Respondent's Comp MC medical fee schedule analysis.

The Arbitrator carefully considers the following issues in connection with this case:

1. Medical bills
2. Nature and extent of the injuries
3. Penalties

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

FINDINGS OF FACT

Petitioner testified on June 3, 2014. Petitioner testified that on January 24, 2011, he was employed as an equipment operator/laborer for Respondent, Illinois Tollway, and that he had been working for Respondent for 22 ½ years. Petitioner testified that his job duties included maintaining the roadway, responding to accidents, plowing snow in the winter, cutting grass, and aiding motorists if stranded (e.g., changing a tire, adding water to a battery and calling a tow). He also would perform maintenance work on the tollway or highway such as replacing delineator posts, trimming trees and replacing guardrails. Petitioner classified his work as medium duty.

Petitioner testified that on January 24, 2011, he was called in due to a snowstorm after midnight. He filled his truck with 20,000 pounds of salt and got out on the road. As he was plowing and spreading salt, he pulled out onto Butterfield Road and as he passed the Roosevelt Road overpass, his plow struck an abutment of the bridge joint. Petitioner testified that the plow was totaled, both latches snapped and the headlight popped.

The Petitioner experienced a jolt and suffered immediate pain in his neck. Petitioner further testified that since the plow was totaled, he went to the yard, got in

another truck and continued to work. He worked about 5 hours in total that night. He began to notice tingling down both arms and a stiffening of his neck.

Petitioner sought treatment at the company clinic, Advocate Occupational Health. (Pet Ex 10) X-rays were taken of his neck and an MRI was prescribed. On January 27, 2011, Petitioner underwent a cervical MRI. After the MRI, the Petitioner was referred by the company clinic to Hinsdale Orthopaedics. (Pet Ex 2)

Petitioner first saw Dr. Lorenz of Hinsdale Orthopaedics on February 3, 2011 and at that time, Dr. Lorenz noted Petitioner's cervical pain and right arm pain. Dr. Lorenz prescribed a Medrol dosepak, Norco, physical therapy, traction, and an MR arthrogram of Petitioner's right shoulder. Dr. Lorenz's assessment on that date was C5-6 spondylosis with an acute disc herniation and right arm radiculopathy and right shoulder pain. (Pet Ex 2)

Petitioner underwent the MR arthrogram at Community Imaging, which revealed a full-thickness tear of the rotator cuff; a full-thickness tear of the supraspinatus with extension into the infraspinatus, a SLAP lesion, and subscapularis tendinosis. (Pet Ex 2)

Petitioner testified that he sought a second opinion from Dr. Matthew J. Ross (Pet Ex 9) on February 23, 2011. Dr. Ross prescribed a second Medrol dosepak. Such medication provided no relief.

Petitioner testified that he attempted to work, but experienced piercing, excruciating pain in the base of his neck when he drove the truck.

Petitioner returned to Hinsdale Orthopaedics on March 7, 2011 where physical therapy was put on hold. Petitioner was taken off work. An injection to his cervical spine was prescribed. Dr. Giridhar Burra prescribed an injection to Petitioner's right shoulder as well as shoulder surgery.

On April 18, 2011, after receiving the injection to his right shoulder, Petitioner returned to Dr. Burra. Petitioner noticed little relief from such injection.

At that time, CCMSI (Respondent's TPA) sent Petitioner to Dr. Tonino for a Section 12 examination (Pet Ex 7) regarding the need for shoulder surgery and to Dr. Butler (Pet Ex 8) regarding Petitioner's cervical spine condition.

On June 8, 2011, Dr. Burra performed surgery on Petitioner at Silver Cross Hospital. (Pet Ex 3) Such surgery consisted of an arthroscopy of the right shoulder with a rotator cuff (subscapularis) repair and debridement of the supraspinatus articular surface tear, biceps tendon tenodesis, a subacromial debridement of the frayed superior labrum, and a subacromial decompression acromioplasty. (Pet Ex 2)

Following the shoulder surgery, Petitioner returned to Hinsdale Orthopaedics on June 20, 2011 and Dr. Burra prescribed an abduction pillow, Norco, removal of the sutures, a sling for use during the day, and physical therapy (Pet Ex 2, 5)

On July 18, 2011, Petitioner returned to Hinsdale Orthopaedics where the co-existing neck pain and symptoms continued. His doctor prescribed continued physical therapy and Norco.

On August 17, 2011, Petitioner saw Dr. Lorenz and had significant pain at the base of the neck. The doctor prescribed a repeat MRI, additional physical therapy and a possible injection. The cervical MRI was performed August 20, 2011 and demonstrated:

> [a]t the C3-4 level, disc space narrowing is present with bilateral spondylotic protrusions and a shallow right disc protrusion...[a]t the C4-5 level, disc space narrowing is present with bilateral spondylotic protrusions...[a]t the C5-6 level, disc space narrowing is present with bilateral spondylotic protrusions and a rightward disc protrusion. This protrusion is effacing the anterior subarachnoid space, predominantly on the right side...[a]t the C6-7 level, disc space narrowing is present with a shallow central disc protrusion... [a]t the T3-4 level, global disc bulge is present with disc space narrowing.... (Pet Ex 2)

On August 29, 2011, Petitioner returned to Hinsdale Orthopaedics. At that time, Petitioner's shoulder was slowly getting better but he was still having neck pain.

On September 21, 2011, Dr. Lorenz reviewed the MRI. Petitioner testified that at that time his neck pain was "pretty constant." On September 21, 2011, Dr. Lorenz prescribed an anterior cervical fusion at C5-C6, and also prescribed a discography "just to be sure that the C5-C6 disk is the culprit." (Pet Ex 2)

On October 10, 2011, Petitioner returned to Dr. Burra for a right shoulder visit. Petitioner testified to lack of full range of motion and pain although the pain had decreased. Dr. Burra prescribed continued physical therapy for 4-6 weeks to increase strength. He restricted Petitioner from overhead work, repetitive pushing or pulling and lifting of greater than 5 pounds, but only if cleared by Dr. Lorenz. (Pet Ex 2)

On October 18, 2011, as prescribed by Dr. Lorenz, the Petitioner underwent the discogram. Dr. Neeraj Jain carried out this procedure. Petitioner described the procedure as extremely painful even though he was sedated.

On November 7, 2011, Petitioner returned to Dr. Lorenz. Dr. Lorenz noted that Petitioner does not feel he can live with the pain and disability, so Dr. Lorenz prescribed the C5-6 discectomy and fusion.

Petitioner returned for a visit with Dr. Burra on November 21, 2011 where the doctor noted increased endurance and strength. However, the Petitioner was unable to

reach across his chest. Petitioner was to continue physical therapy exercises for his shoulder while awaiting surgical authorization for his cervical spine.

Petitioner returned on December 14, 2011 for an office visit and physical.

Petitioner was to be admitted to Good Samaritan Hospital on December 20, 2011. (Pet Ex 2) On December 20, 2011, Dr. Lorenz and Dr. Fronczak performed the surgery that consisted of a C5-C6 fusion with cage insertion 8 mm. Blackstone; C5-C6 anterior cervical plating with 28 mm. Blackstone Plate; stem cell allograft transplant with a posterior decompression and foraminotomies. (Pet Ex 2,4)

Petitioner remained in the hospital for two days. (Pet Ex 4)

On January 30, 2012, Petitioner saw Dr. Burra who discharged Petitioner for his shoulder with home exercises and to follow up with Dr. Lorenz.

Petitioner saw Dr. Lorenz on February 9, 2012 and was eager to return to work. Dr. Lorenz released Petitioner to return to full-duty work with a prescription of no hydrocone during the day – only evening and weekends, a home exercise program and a return in 4-6 weeks for a re-evaluation. (Pet Ex 2)

Petitioner testified he returned to work at that time.

Petitioner saw Dr. Lorenz on March 4, 2012. At that time, Petitioner continued to have with neck pain while working full duty and was to return in 1 year for x-rays. Petitioner returned for a visit with Dr. Lorenz on May 9, 2012 and continued to complain of aching in the back of his neck particularly at the end of the day. Petitioner testified that when he laughed or sneezed, he saw stars. The doctor prescribed a CT scan to check the fusion. This was performed on May15, 2012. Petitioner returned to Dr. Lorenz on May 24, 2012 and described the pain intensity as 6 out of 10 with driving increasing the pain. Dr. Lorenz's assessment on that date was C5-C6 anterior cervical fusion, facet joint syndrome, and CT spinous process bursitis. (Pet Ex 2) Dr. Lorenz recommended that Petitioner continue to work as tolerated. He prescribed 6 mg. of Norco and referred him to Dr. Jain for a cervical trigger point injection.

Petitioner underwent this trigger point injection on June 26, 2012. He testified that it provided little relief.

Petitioner testified that his final visit with Dr. Lorenz was on July 18, 2012. Petitioner identified and testified to the discogram bill (Pet Ex 1), which remains unpaid.

When asked what he notices about himself presently, Petitioner testified that his neck always hurts. If he sits in a car or a chair, he feels moderate pain. He testified that he has experienced a severe loss of muscle in his neck. He feels like he has now has a "pencil neck" and that his neck is fragile. When he tries to sleep, he cannot put his right arm under the pillow in the same way that he previously did. He is right-handed and

right-arm dominant. He does not sleep well because of his shoulder and neck pain. If his arm bends a certain way, it hurts and he wakes up yelling.

Petitioner testified that he returned to his regular job. He performs the same duties that he performed before the accident. He does most of these duties the same way, but finds them harder to perform. He has made modifications in the manner in which he performs some of his job duties. He changes tires differently. If he needs help on a job, he calls on his co-workers to help him. He has a fear of re-injury. Petitioner testified that he takes Advil all the time: 3 tablets, 3-6 hours apart. He told his doctor that he did not want to be dependent on narcotics. Petitioner testified that he puts in 8-12 hours a day at work. By the end of the day, his neck is killing him. It is mainly his neck that hurts, but sometimes his shoulder hurts. Petitioner testified that since the accident, he "has lost a tremendous amount of muscle."

On July 18, 2012, which was approximately five months after Petitioner returned to full-duty work, Petitioner saw Dr. Lorenz. Upon examination of Petitioner's neck, Dr. Lorenz found the following: "He has limited extension. Normal flexion and rotation. Strength is 5 over 5. Light touch is intact."

Petitioner offered the evidence deposition of Dr. Mark A. Lorenz, whose testimony related to the need for prescribing a discogram prior to performing the cervical fusion. (Pet Ex 6)

Respondent offered the telephone evidence deposition of Dr. Graham Neil Gitlin, whose testimony related to the Utilization Review he performed in determining that the discogram was not medically necessary. (Resp Ex 1)

CONCLUSIONS OF LAW

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator concludes as follows:

The only medical bill incurred by Petitioner and unpaid by Respondent was the bill for the discogram from Accredited Ambulatory that was performed by Dr. Jain (Pet. Ex. 1) prior to the cervical fusion that Dr. Lorenz carried out. The Utilization Review was conducted 3 days after the discogram was performed.

Dr. Graham Neil Gitlin, the Utilization Review physician, is board-certified in orthopedic surgery. He is a general orthopedist who has not performed spine surgery in approximately 10 years. Dr. Gitlin cited several studies in support of his statement that, according to the Official Disability Guidelines, cervical discography is not recommended.

On direct examination, Dr. Gitlin testified to the following:

Q: And when you looked at the Official Disability Guidelines, did it indicate whether the discogram was medically necessary or not?

A: Well the official terminology is - - in the Official Disability Guidelines cervical discography is not recommended.

Q: And why is it not recommended?

A: Well, there's - - I can read it to you from - - directly from the guidelines. It's "Conflicting evidence exists in this area, though some recent studies condemn its use as a preoperative indication for ... fusion, and indicate that discography may produce symptoms in control groups more than a year later, especially in those emotional and chronic pain problems."

There are studies by Carragee in 2000; Bigos in 1999; Grubb in 2000; Zeidman in 1995; Manchikanti, 2009.

"Cervical discography has been used to assist in determining the specific level or levels causing the neck pain and, potentially, which levels to fuse; however, controversy regarding the specificity of cervical discograms has also been debated and more research is needed. (Wieser, 2007) Assessment tools such as discography lack validity and utility. (Haldeman, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005)."

In summary, "Discography is not recommended in the Official Disability Guide-Lines."

Q: Now, when you apply that to the medical documentation you reviewed in Mr. Pappas's case, what was your conclusion as to whether to certify or noncertify the discogram?

A: In light of the MRI study of, I think I already mentioned, 8-20-2011, and I believe there was actually a prior MRI scan that was mentioned in one of Dr. Lorenz's report, so there were essentially two MRI scans of the cervical spine, In my opinion, these provided more than enough data regarding the issues involving Mr. Pappas's cervical spine, and a discogram at this point after these MRI scans would have served no further purpose.

Q: Okay. Now, you also indicated that you used the ACOEM guidelines as well; correct?

A: That's correct.

On cross-examination, Dr. Gitlin testified to the following:

Q: Doctor, would you agree that a discogram is a medically-accepted diagnostic tool?

A: Well, I mean, once again you're not being specific. I think discography is certainly more medically accepted in the lumbar spine than the cervical spine.

Q: Okay. Is a discogram a medically-accepted diagnostic tool in the treatment of a cervical disc injury?

A: I will give you that it has been in the past. I think it is less so in current treatment regimens.

Dr. Gitlin testified that he had two different reports and he could not explain why he had two reports. (Resp Ex 1) Dr. Gitlin also testified that after non-certification of the discogram, he did not contact Dr. Lorenz or any other doctor for a peer-to-peer review of his Utilization Review and stated that he had specific instructions not to conduct a peer-to-peer review. (Pet Ex 11)

Dr. Mark A. Lorenz, a board-certified orthopedic surgeon who specializes in spine surgery, testified that the discographic study was "to identify with a higher degree of certainty the pain generator and avoid fusion on segments that don't need it." (Pet Ex 6) He testified he disagreed with the report of the Utilization Review because "the discographic study in this particular case was necessary in order to delineate the pain generator and avoid fusion on excessive levels." (Pet Ex 6) Dr. Lorenz further testified that the discogram demonstrated that the C5-C6 was the culprit and was the pain generator in this patient.

The significance of this finding was that it further supports the evidence provided by the MRI and the clinical examination and increased the doctor's comfort level in proceeding with a fusion surgery at C5-C6. Of critical importance is that Dr. Lorenz testified that had the discogram been negative, he would not have recommended surgical intervention. (Pet Ex 6)

On cross-examination, Dr. Lorenz testified to the following:

Q: All the - - which the prior two MRI studies had showed was the source of the problem?

A: No, because two tests show different things. The MRI showed a complete herniation of a disc. It doesn't say anything about the pain or symptoms.

Q: But you recommended a fusion in April of 2011 without a discogram, correct?

A: Yes.

Q: And the only reason you didn't proceed with the fusion at that point in time is because he was going to be seen by Dr. Burra and have shoulder surgery, correct?

A: Right.

Q: So Mr. Pappas was a surgical candidate in April 2011?

A: Correct.

*****

Q: But before you even did the discogram, you had already determined Mr. Pappas was a surgical candidate, right?

A: Being a surgical candidate and actually performing the surgery are two different issues. Yes, I did.

*****

Q: If you look at Dr. Gitlin's report, he actually refers to two different ACOEM and ODG guidelines?

A: Yes.

Q: And under ACOEM guidelines it calls for certification?

A: We don't accept ACOEM guidelines in orthopaedics. We use North American Spine Association and the American Academy of Orthopaedic Surgery guidelines and the guidelines that were published in Spine in the National Review.

Q: But ACOEM is an acceptable national standard for utilization review?

A: Not for this particular instance. Not for orthopaedics. That's not correct.

On re-direct examination, Dr. Lorenz testified to the following:

Q: Even if he was a surgical candidate had the discogram been ordered and was negative, surgery wouldn't have been performed because it would not have done him any good, correct?

A: That's generally true, but I think that the problem we are having here is what the understanding of a surgical candidate means in our language, in treaters'

language, in physician language. It means that you have exhausted all other options and to consider the patient for a possibility of surgery pending on data points is an option.

*****

Q: And again, Doctor, why in this case was a discogram both reasonable and necessary?

A: The reason for that was that the patient had pure axial pain. He had no hard findings of any radicular component. He had soft findings. Those are not sufficient for me to proceed and operate regardless of what an IME says.

I need to assure myself that the patient has the additional data point of coinciding identical pain in a particular area for me to identify the pain generator. If he didn't have it, I would not recommend it. It's not likely to help him.

Q: And in effect, the performance of the discogram gave you the assurance that surgery was the right treatment plan for Mr. Pappas in this case, correct?

A: It was the last data point that was missing in order to feel very comfortable with proceeding with surgical intervention.

After considering all of the opinions of Dr. Gitlin with regard to his Utilization Review in which he non-certified the discogram, the Arbitrator finds that the opinions of the treating physician, Dr. Lorenz, persuasively rebut such non-certifying opinions. Dr. Gitlin, in his report, relied on an element of the ODG that holds that surgical intervention is not warranted if there are no documented clinical findings consistent with radiculopathy or any red flag/observation.

Even Dr. Jesse P. Butler, Respondent's Section 12 examining physician, apparently spotted such red flag(s) and opined in his April 6, 2011 report that Petitioner "would require an anterior cervical discectomy and fusion at C5-6." Dr. Gitlin was not provided with Dr. Butler's report.

Dr. Gitlin testified that the discogram was not necessary based on the ODG and the fact that Dr. Lorenz had previously prescribed the fusion surgery and had "more than enough data," including the two MRIs of Petitioner's cervical spine, before performing such surgery.

Dr. Lorenz testified that in order to feel comfortable performing the surgery, he needed the additional data point of coinciding, identical pain in that particular area. He needed to identify the pain generator

Pursuant to Section 8.7(i)(4), "[w]hen a payment for a medical service has been denied or not authorized by an employer or when authorization for medical services is

denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury." 820 ILCS 305/8.7(i)(4) (2011).

The Arbitrator finds that Petitioner has met his burden of proof.

Consequently, the Arbitrator finds that the discogram was reasonable and necessary. Therefore, Respondent shall pay the charges for this reasonable and necessary medical service in the amount of $20,517.05, as provided in Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator concludes as follows:

Based on the medical records, the testimony of the Petitioner and the deposition testimony of Dr. Lorenz, the Arbitrator finds that Petitioner has sustained permanent partial disability to his right shoulder and his cervical spine.

Right Shoulder: On June 8, 2011, Dr. Burra performed arthroscopic surgery that consisted of a rotator cuff (subscapularis) repair and debridement of the supraspinatus articular surface tear, biceps tendon tenodesis, and a subacromial debridement of the frayed superior labrum, and a subacromial decompression acromioplasty. (Pet Ex 3)

Following the shoulder surgery and post-operative rehabilitation, Petitioner returned to Dr. Lorenz for treatment of his cervical spine injury.

Petitioner was released to return to full-duty work, effective February 10, 2012.

Petitioner testified that he modifies the way he performs some of his duties.

The Arbitrator finds that Petitioner's complaints (pages 4-5 of Decision) regarding his dominant arm to be credible. Petitioner testified that he has difficulty sleeping due to shoulder pain, but that mainly his neck hurts at the end of the day.

Based on the course of medical treatment he underwent for his right shoulder injury (as evidenced by the medical records), his ability to return to full-duty work and his current complaints (pages 4-5 of Decision), the Arbitrator finds that as a result of the January 24, 2011 accident, Petitioner has sustained a loss of use, man as a whole, of 11.385%, pursuant to Section 8(d)2 and the Court's holding in Will County Forest Preserve District v. Illinois Workers' Compensation Commission, 970 N.E.2d 16, 361 Ill. Dec. 16 (3d Dist. 2012) that "a shoulder does not qualify as a scheduled loss to the arm."

Cervical Spine: On December 20, 2011, Petitioner underwent a C5-C6 discectomy with microscope assist; C5-C6 fusion with cage insertion and anterior

cervical plating with stem cell allograft transplant with posterior decompression and foraminotomies.

Following a course of rehabilitation, Petitioner was released to return to full-duty work, effective February 10, 2012.

Petitioner testified that he has had to modify the way he performs some duties.

Petitioner last saw Dr. Lorenz on July 18, 2012. Following such examination, Dr. Lorenz wrote, *inter alia*, the following:

> **History of Present Illness:** Patient returns today for a final visit. He did have a local injection over the spinous process at C7 which helped for about a day and a half or so. He gets increasing achiness in his neck when he drives for prolonged periods of time, but does seem to improve. Taking Norco 10 mg tablets. He's been working full duty." *****
>
> X-rays: Show mature C5-6 fusion.
>
> Exam: He has limited extension. Normal flexion and rotation. Strength is 5 over 5. Light touch is intact.
>
> Assessment: C5-6 fusion
>
> Recommendation: We'll start him on a weaning protocol for the Norco. He'll continue a (sic) full duty. He is at maximum medical improvement. We'll see him back on an as-needed basis. The patient is in agreement with this plan. (Pet Ex 2)

Based on the course of medical treatment he underwent for his cervical spine injury (as evidenced by the medical records), his ability to return to full-duty work and his current complaints (pages 4-5 of Decision), the Arbitrator finds that as a result of the January 24, 2011 accident, Petitioner has sustained a loss of use, man as a whole, to the extent of 27.5%, pursuant to Section 8(d)2 of the Act.

In awarding permanency for both Petitioner's right shoulder (11.385% loss of use, man as a whole) and cervical injuries (27.5% loss of use man as a whole), the Arbitrator awards a total of 38.885% loss of use, man as a whole, for the totality of Petitioner's injuries.

In support of his decision with regard to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator concludes as follows:

On June 2, 2012, the day before the trial, Petitioner filed with the Commission a Petition for Penalties and Attorneys' Fees. The Petition was then served on Respondent's counsel when the parties appeared before the Arbitrator for trial on June 3, 2012.

Section 19(e) of the Act states, in pertinent part, the following:

> "Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act."

In Sevilla v. Construx of Illinois, 06 IWCC 0918 (October 25, 2006), the claimant made a verbal motion for penalties at the time of trial, and acknowledged that the first notice of penalties to the employer was on the day of trial. The arbitrator denied the petition for penalties. On review, the Commission affirmed the denial of penalties.

The facts of the present case are only slightly different from those in Sevilla. In this case, Petitioner filed a Petition for Penalties with the Commission one day before the trial. However, Petitioner did not give notice of the Petition and did not place penalties in dispute and at issue until the time of trial, which is what occurred in Sevilla.

Regardless of when the Petitioner filed the Petition, he seeks penalties and attorneys' fees for Respondent's denial of liability for the charges related to the October 18, 2011 discogram.

The Arbitrator finds that Respondent's conduct in denying liability for the charges was not unreasonable or vexatious. Respondent relied on the "retro" Utilization Review determination of October 21, 2011 in which Dr. Gitlin non-certified the diagnostic test. Dr. Gitlin cited studies and stated that discography is not recommended in the Official Disability Guidelines. Dr. Gitlin opined that Dr. Lorenz already had two MRIs of Petitioner's cervical spine that would have provided more than enough data and that a subsequent discogram would have served no purpose.

Respondent also relied on the fact that both Dr. Lorenz and Dr. Butler recommended C5-C6 fusion surgery back in April of 2011.

The Arbitrator notes that Respondent did not dispute or otherwise delay Petitioner's access to all reasonable and necessary medical treatment. Such treatment was provided to Petitioner is a timely fashion, as evidenced by his attainment of MMI and discharge from care in July of 2012.

Based on the foregoing, the Arbitrator finds that penalties and attorneys' fees are not warranted in this case.

Brian Cronin
Arbitrator

January 28, 2015
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Katherine De La Pasqua,
Petitioner,

vs.

NO: 12 WC 30925

15IWCC0734

Park Ridge/Niles CCSD #64,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Hegarty finding Petitioner sustained an accidental injury arising out of and in the course of her employment on May 4, 2011. As a result Petitioner is entitled to $7,649.86 in medical expenses under Section 8(a) of the Illinois Workers' Compensation Act and permanently lost 10% of the use of her right hand and 2.5% use of her left hand under Section 8 (e) of the Act. The Issues on Review are whether Petitioner sustained an accidental injury arising out of and in the course of her employment on May 4, 2011, whether a causal relationship exists between the alleged May 4, 2011 work accident and Petitioner's present condition of ill-being, and if so, whether proper notice was provided to the Respondent, the extent of Petitioner's temporary total disability, the nature and extent of Petitioner's permanent disability and the amount of reasonable and necessary medical expenses. The Commission, after reviewing the entire record and file, reverses the Arbitrator and finds Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on May 4, 2011, that a causal relationship exists between the alleged May 4, 2011 work accident and Petitioner's present condition of ill-being, and that proper notice was provided to the Respondent, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 40 year old right-handed school teacher, testified that she is a middle school language arts teacher who has been teaching for 22 years. She teaches four core language arts classes, back to back which are 50 minutes each, and one elevated language arts class. She starts her work day at 7:35 a.m. When the students come in she has a writing prompt on the board to start a discussion. Next, she types on the computer different things that appear on the SMART board. She may pause from time to time from typing to have a discussion with the students. She then corrects the students' work for 25 minutes. During the last part of the class she types their homework assignments on the SMART board. She repeats the process again for her next class. Her 30 minute lunch break occurred after her four core classes. There is also a recess. So in total she had a break from 35-40 minutes. After that she had team meetings, a 40 minute elective class and then a prep period. She performs these tasks four days a week. On the fifth day, they spend the day working on reading. During her class room time, she stands approximately 90% of the time. She does not have a desk in her classroom. Instead, she has a work station. There are ten periods in all. In addition to her classroom time, she has two planning periods. One of her periods is a team planning period during which they use keyboards to input data into the students' records and they send e-mails to the parents. She spends four periods at her desk typing and entering data including attendance and communications with staff. She leaves school at 3:40-3:45 every day. On average, she also performed about two hours of work at home during the evening. Of that period, 85% of the work is done on a computer. Her work has become more computerized over the twelve years she has worked at the school through the use of Google applications and spreadsheets. Otherwise, she uses a computer very little at home.

2. She has a desk in an office she shares with some fellow teachers. While she has been asking for a new desk chair since 2009 because her chair will not stay in a raised position, her desk chair has not been ergonomically evaluated. She shares the office with James Romey and Mark Stefanik. They were aware of her problem because they talked every day and from time to time she would wear wrist braces while at school. Ralph Heatherington, was one of the interim principals the school had and from time to time he would stop by the office and talk to the gentlemen that she worked with. He would be present when she discussed the pain in her wrists and he observed her wearing the wrist braces.

3. In March of 2011, Petitioner reported that her hands were aching throughout the day and they were waking her up. It got to the point where her fingers were numb and she could not hold things so she went to the doctor. Her hands bothered her the most at the end of a school day or after grading homework. During Christmas break and the summer, her hands were less achy and numb. Petitioner delivered her last child in 2008. While Dr. Lindeman, her primary care physician, has a note that says she had carpal tunnel syndrome while she was pregnant, he never mentioned that fact to her. Petitioner said she is not sure what exact dates she filled out the incident reports but when she talked to Dr. Lindeman and specialist in 2012, they said she had carpal tunnel syndrome and they suggested she report it. She could not give Kelley Evola from human resources an exact date because it was something that happened over time. On the Commission's Request for Hearing form Petitioner listed her date of accident as March 1, 2011. On the Commission's Application for Adjustment of Claim Petitioner listed the date of accident as May 4, 2011. On the January 17, 2012 Form 45 report it was listed that Petitioner's bilateral carpal tunnel condition occurred while grading and performing computer work and the date of accident was listed as March 1, 2011. It further indicated that she saw the doctor in May of 2010 and her condition became worse over time. A series of e-mails were exchanged between Petitioner and Kelley Evola, who is with the human resource department for Respondent. Kelley Evola indicated you stated on the Form 45 that the accident happened in March of 2011. Can you

adjust the accident report to May 2, 2011, initial it and have Joel Martin initial as well. Petitioner responded it did start in March but May 2nd was when the doctor gave her a shot of cortisone. It's not like there is an exact date because this had developed over time. I understand you need a number so if you must have a date just list March 1st. Kelley Evola then indicated okay I'll list March 1, 2011. Petitioner responded sorry I don't have an exact date. I never thought to write down the date that my wrists were sore until I saw the specialist. On the February 7, 2012 Supervisor's Report of Incident Investigation from Joel Martin the date of accident is listed as March 1, 2011 and the date reported is listed as January 23, 2012. The condition and mechanism of injury are listed as developed bilateral carpal tunnel syndrome from continued grading and typing for her job.

4. Petitioner testified that she put her medical expenses for her wrists under her husband's group insurance plan. She underwent surgery for her right wrist on July 31, 2012. She had no surgery for her left wrist because the recovery was difficult for the right wrist. Currently, she does not have any numbness. Her hand still aches a bit when she does a lot of work on the computer, but it is improving. During the summer her right wrist does not hurt as much. When she is performing computer work at school they ache. When this occurs, she uses ice packs, hot compresses and rubs her wrists. If she has a lot of grading to do, she puts her brace back on. The left side feels the same way. The right side is still the worse. She has not sought any additional medical treatment and she has no restrictions from her doctors.

5. Ralph Heatherington testified he is currently retired and works part-time at a golf course. He did work on a part-time basis as an interim co-principal for Respondent in 2009-2010. He does not remember Petitioner ever reporting a work accident to him. He does not recall her ever wearing wrist braces during the time he worked there. He does not recall ever witnessing a conversation between Petitioner and James Romey regarding her wrist injuries. Occasionally he would go into their offices and have a conversation but it was small talk normally.

6. On February 21, 2011, Petitioner treated with Dr. Lindeman. The doctor noted that Petitioner reported she has had a recent onset of numbness in both hands with her right hand being more affected. Specifically, the numbness is in the palmer surface of her thumb and her first two fingers. It is worse in the morning. The patient is a teacher and she does use her hands at work a lot. She did have some carpal tunnel syndrome during her last pregnancy. On examination, there is some questionable minor atrophy of the left thenar eminence. The right side is normal. Dr. Lindeman diagnosed Petitioner as having bilateral carpal tunnel syndrome and he recommended that she use over the counter wrist splint for the next two months and stated that he would refer her to orthopedic doctor if she did not experience significant improvement within next month. On March 23, 2011, Petitioner returned to Dr. Lindeman and he indicated the patient's carpal tunnel syndrome has been much improved on the right since she started to wear splints at night. However, her left hand is still having problems with pain shooting from her wrist into her thumb. On March 29, 2011, Dr. Lindeman indicated the patient has been wearing night braces for the past month without any improvement and he is referring her to an orthopedic doctor. He also stated that the patient had an episode last year which improved with steroid injections.

7. Petitioner next treated at Chicago Orthopedics on May 2, 2011. On the patient history form and in the response to the question is this injury related to work she said no. Petitioner was assigned to Dr. Guelich on that day and the doctor noted that petitioner is complaining of bilateral wrist pain, insidious in nature, which began as night pain and improved with wrist splints. However, even with conservative treatment she has had persistent problems with pain,

numbness, tingling and aching. The doctor noted that Petitioner has had no history associated with her wrists prior to these recent events. On examination she has a positive Tinel's and median nerve compression tests of both wrists. The doctor diagnosed Petitioner as having bilateral wrist pain and carpal tunnel syndrome.

8. Petitioner did not treat again until December 27, 2011 when she returned to Dr. Lindeman who indicated that she reports has been wearing night braces for the past month without any improvement. She had an episode last year that improved with steroid injections. He again referred her to an orthopedic doctor.

9. On December 30, 2011, Petitioner returned to Dr. Guelich who indicated that he last saw her in May for bilateral carpal tunnel complaints. He indicated she had injections at that time which provided significant relief. Unfortunately, the symptoms have returned and she is here to discuss further management. On examination she has a very positive Tinel sign on left and modestly positive Tinel on the right. Dr. Guelich again gave her some injections and he refereed for an EMG/NCV. An EMG/NCV was conducted on February 9, 2012 and it was noted to be a normal study of both upper limbs. On February 13, 2012, Dr. Guelich noted that Petitioner's exam showed a positive median nerve compression with slightly atypical findings on the left and less pain on the right. She also demonstrated mildly positive Tinel on the left and minimal findings on the right. Her EMG does not note any evidence of median nerve compression or evidence of carpal tunnel syndrome. Dr. Guelich diagnosed her with bilateral wrist pain with carpal tunnel findings, left greater than right and without any diagnostic evidence of nerve compression. He ordered an MRI and instructed her to see Dr. Vitello for a second opinion if the MRI is equivocal.

10. *NOTE: Several of Dr. Vitello's medical entries are cut off on the right hand side. This is the case for the original in file as well as the copy in the transcript. His complete April 23, 2012 and July 2, 2012 entries are found in PX3, Dr. Lindeman's records.

On March 26, 2012 Petitioner saw Dr. Vitello for findings on the right. She (cut off) of median nerve pathology to suggest carpal tunnel. There (cut off) degenerative changes and a small ganglion cyst within the l (cut off) and triquetrum, mild tendinopathy at the left extensor carp (cut off) ulnar styloid, and probable ganglion cysts along the radial (cut off) ECU proximal to the ulnar styloid. She states that her pai (cut off) on the palm, both hands and volar forearm. She (cut off) she has got volar wrist pain with use on the left and state (cut off) the fingers are tight and stiff and the plamar pain is worse (cut off) morning. She has no significant past medi(cut off) On physical examination she has – (cut off) and – median nerve compression test of the right wri (cut off) point discrimination of the left hand. Dr. Vitello diagnosed Petitioner with trigger digit and tenosynovitis, right and left ring f(cut off), FCR tendinitis, left wrist. He recommended corticosteroid injection in both finger AI (cut off) as the distal extent of the FCR.

11. Petitioner saw Dr. Vitello in a follow up visit on April 23, 2012. He noted that Petitioner states that the right and left ring fingers as well as the left wrist FCE injection did not significantly improve her complaints of pain from her last visit. Her complaints today are volar wrist pain, aching into the hand and numbness and tingling with forceful grasping and holding objects such as reading a book causes numbness in the fingers and any prolonged activities such as playing with her children and writing, coloring books and typing causes increased pain in the volar wrist and some mild numbness and a dull ache. Her symptoms are worse on the right than the left, but remain consistent. Her MRI and EMG were both essentially negative. The MRI showed some diffuse fluid along the ECU, more so on the right. This does not correlate with her

pain and her complaints today. On examination, she has a positive median nerve compression test bilaterally, which is more pronounced on the right. The ring finger A1 pulleys bilaterally remains tender. She does not have tenderness over the dorsal wrist bilaterally. She has negative Tinel's bilaterally. She has an equivocal Phalen's test bilaterally and minimal tenderness over the FCR today. Her subjective complaints and selective physical exam are consistent with carpal tunnel syndrome, more so on the right than the left as well as flexor tenosynovitis of the ring fingers. I made it clear to her that she had a negative EMG and that her complaints or diagnostic test are not supportive of carpal tunnel syndrome. There is a possibility of a false negative. Her complaints and some of her physical exam findings do lead me to believe that surgery could be a potential benefit for her for resolution of some of her symptoms in addition to an A1 release of her ring finger. I would like her to seek a second opinion for this. She thinks this is a reasonable option as well. She is going to call with the name of the person she is going to get the second opinion from. I will have a short discussion with this doctor prior to her appointment and I will see her back at the conclusion of that appointment.

12. On July 2, 2012, Petitioner followed up with Dr. Vitello. He noted that Petitioner is being seen for left wrist pain. She states her pain is still persistent. She has pain and numbness with writing. She is waking up in the middle of the night with numbness of the ulnar two digits. On examination, she does have some mild tenderness over the distal FCU. She has tenderness over the Guyon's canal. She has a positive Guyon's canal compression test with numbness in the small and ring fingers. There is mild tenderness at the FCU insertion through the pisiform. I think she is a candidate for release of Guyon's canal.

13. On July 3, 2012, Petitioner saw Dr. Lindeman who indicated the patient is to have carpal tunnel release surgery for chronic carpal tunnel syndrome. On July 31, 2012, Petitioner underwent surgery. The post-operative diagnosis was right ulnar nerve compression at wrist with median nerve compression. She underwent a procedure consisting of a right Guyon's canal release and a right carpal tunnel release. It was noted that Petitioner has had has long-standing persistent numbness and tingling in the ulnar nerve distribution with periodic numbness and tingling in the median nerve distribution with pain in the hyperthenar eminence as well as cramping of the digits. She had an EMG. She had conservative management and sought a second opinion which was consistent with compression in Guyon's canal.

14. On September 12, 2012, Petitioner followed up with Dr. Vitello. At that time Petitioner reported she is doing much better. She has no complaints of hand numbness or tingling. On examination, the scar looks quite good and it is healing well. There is a little bit of thickening across the wrist crease. Otherwise, it looks quite benign and she has no numbness or tingling. He noted he would see her back on an as-needed basis.

15. In a March 7, 2013 letter from Dr. Vitello to Petitioner's attorney the doctor erred in noting that he first saw Petitioner on July 23, 2013 based on the medical record which shows the first visit with Petitioner was on March 26, 2012. He noted that Petitioner has a negative EMG for carpal tunnel syndrome and a recommendation for a second opinion was made. She sought a second opinion but I do not have the medical records for review. Dr. Vitello opined that it is possible that her activities may have aggravated a pre-existing condition leading to compression of the ulnar and medial nerve in the right wrist. He further noted that there was no a work-related injury and she was not restricted.

16. On September 12, 2013, Dr. Vender issued an evaluation report. In the report he indicated that Petitioner reported she developed symptoms in both upper extremities in approximately 2009. The Petitioner currently continues to complain of achiness and soreness in both hands. She has difficulty grasping and is feeling weak. She indicated that she has limited range of motion. There is no numbness or tingling noted. He further noted that Petitioner works as an English teacher. He noted that her work activities are non-repetitive type activities that would not cause or contribute to the development of various upper extremity conditions. Her EMG was normal. It is not clear what specific condition, if any, Petitioner may have suffered from. He stated he does not believe there is a causal relationship between Petitioner's current complaints, her prior diagnoses and her work activities.

The Commission notes that the manifestation date is not always easy to determine and it can often be attached to any number of dates. The Commission further notes even though it is difficult at times to determine the proper manifestation date, it is still the Petitioner's burden to indicate a specific date in which she, as a reasonable person, knew of the condition and she connected the same to her work. In this instance, Petitioner placed the date of accident on May 4, 2011in her Application for Adjustment of Claim. This date is problematic in that there are numerous instances in the treating records and Petitioner's own testimony which demonstrate that her alleged condition manifested itself prior to this date. As such, it does not appear that the proper manifestation date is May 4, 2011. The Commission further notes that Petitioner did not obtain any medical treatment on that date. Her treatment with Dr. Guelich was two days earlier which appears to match up with her exchange with Kelley Evola in the January 12th e-mails. A second possible date that was given was March 1, 2011, which is the date of accident contained on the Request for Hearing form and the date Petitioner instructs Kelley Evola to use. Again, this date is problematic in that Dr. Lindeman's medical entry from February 21, 2011 indicates he diagnosed Petitioner with bilateral carpal tunnel syndrome on February 21, 2011 which is prior to the March 1, 2011 date. Furthermore, he noted that she had carpal tunnel syndrome during her last pregnancy, which based on her testimony would be in June of 2008. Additionally, Dr. Lindeman's medical entries from March 29, 2011 and December 27, 2012 make mention of having an episode last year which improved with steroids. The latter would place it in 2011 but the former would place it in 2010. On the Form 45, Petitioner indicated she saw a doctor in May of 2010 and it (presumably the carpal tunnel syndrome) got worse over time. The 2010 date would supposedly line up with the time period Interim Principal Heatherington was working at the school and would be when she allegedly gave notice to him. Lastly, she reported to Dr. Vender that her symptoms developed in 2009 and he, himself, notes that the records indicate a date of accident on March 1, 2011. As such, just like the May 4, 2011 date, it appears that there are numerous instances in the treating records and Petitioner's own testimony that her alleged condition manifested itself prior to March 1, 2011. Also like the alleged May 4, 2011 date of accident, Petitioner did not obtain any medical treatment on that date. The most logical date appears to be February 21, 2011 when Dr. Lindeman diagnosed Petitioner with carpal tunnel syndrome and he prescribed conservative treatment in the form of over-the-counter wrist splints. However, this still doesn't explain the numerous references to earlier complains dating back to 2008.

In terms of the diagnostic test and Petitioner's treating records showing whether or not Petitioner has bilateral carpal tunnel syndrome and whether the same is causally related to work, the evidence indicates that while on February 21, 2011 Dr. Lindeman diagnosed bilateral carpal tunnel syndrome Petitioner's examination did not demonstrate the same. This is also the case in the follow up visits that took place in March of 2011. Furthermore it is interesting to note that on

the May 2, 2011 patient form, Petitioner marked that her carpal tunnel syndrome is not related to a work injury and she told Dr. Guelich that she has no history associated with her wrist prior to recent events. The May 2, 2011 records indicate that this is the first time clinically Petitioner demonstrated signs of carpal tunnel syndrome with positive Tinel and medical nerve compression tests. During this time Petitioner is treated conservatively followed by a seven month gap in treatment from May of 2011 through December of 2011 and it is not until the following year on February 7, 2012 that an EMG takes place and it was deemed to be "normal" according to the EMG itself along with the notations made by Drs. Guelich and Vitello. An MRI was ordered and the results were not included in the record. Based on Petitioner's lack of objective testing, Dr. Vitello notes that he made it clear to her that her objective testing and subjective complaint were not supportive of a carpal tunnel finding and he urged her to get a second opinion. Additionally, he found her to be a candidate for a release of the Guyon's canal but not the carpal tunnel. Moreover, while Dr. Vitello indicated Petitioner is in need of a second opinion in regard to her carpal tunnel diagnosis and he indicates there was no objective basis for the same, he proceeds to perform a Guyon canal release with a right carpal tunnel release. Post-surgery, Dr. Vitello noted that while Petitioner obtained the second opinion (no records regarding such are contained in the file) he did not have the medical records to review. When he is asked for a causal relationship opinion from Petitioner's attorney on March 7, 2013 he responded it is possible that her activities may have aggravated a pre-existing condition and then he further states that there was no work-related injury. This was additionally supported by Dr. Vender's opinion that Petitioner's non-repetitive/non-forceful activities were not the type to cause or contribute to the development of upper extremity conditions and as such he found no causal relationship to her work. Lastly, it appears that even Petitioner did not believe it was work related as evident by the fact that she put her medical expenses under her husband's group insurance; she stated it was not related to work in the Chicago Orthopedics history form and she claims that it was not until the specialist suggested that she report it that she filed a claim.

Having reviewed all of the evidence, the Commission finds that contrary to the Arbitrator's holding, that Petitioner failed to prove the threshold issues of accident and causal connection. Specifically, the Commission finds that Petitioner's manifestation date is all over the place and at times it pre-dates both the alleged dates of accident contended by Petitioner on her Application for Adjustment of Claim and the Request for Hearing form. Additionally, the Commission finds that neither Dr. Vitello nor Dr. Vender opined that Petitioner's condition is causally related within a degree of medical certainty. Thus, the Commission finds that Petitioner failed to provide any treating or evaluators opinions that her condition is causally related to her work activities.

In terms of the issue of notice, the Commission further reverses the Arbitrator and finds that Petitioner failed to provide notice within the 45 day period set forth under Sec. 6 (c) of the Act. The Commission finds that it was impossible for Petitioner to have given notice to Mr. Heatherington, the interim principal, in 2011 as Mr. Heatherington was only employed by Respondent from 2009-2010. Additionally, Mr. Heatherington was called as a witness and he denied any knowledge that Petitioner reported any physical problems to him, that he saw Petitioner wearing wrist braces or that he witnessed a conversation between Petitioner and her co-worker regarding her alleged wrist problems. Based on the evidence in the record and using any of the alleged manifestation dates supplied by Petitioner, it appears that the first notice that Respondent received from Petitioner was on/around January of 2012, which is well beyond the 45 days period set forth on Section 6 (c) of the Act.

15IWCC0734

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on May 4, 2011, that a causal relationship exists between the alleged May 4, 2011 work accident and Petitioner's present condition of ill-being, and that proper notice was provided to the Respondent, her claim for compensation is hereby denied.

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

DATED: SEP 2 4 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 9/3/15

43

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Liss,

Petitioner,

vs. NO. 13WC042001

15IWCC0742

Darien Police Department,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 27, 2015 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.

15IWCC0742

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 24 2015
SJM/sj
o-9/10/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LISS, STEVEN
Employee/Petitioner

Case# **13WC042001**

13WC042002

DARIEN POLICE DEPARTMENT
Employer/Respondent

15IWCC0742

On 2/27/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2542 BRYCE DOWNEY & LENKOV
RICH LENKOV,
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

15IWCC0742

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Liss
Employee/Petitioner

v.

Darien Police Department
Employer/Respondent

Case # 13 WC **042001**

Consolidated cases: **13 WC 42002**

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 **Wheaton**, on **1-23-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4-10-12**, 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 **$80,690.48**; the average weekly wage was **$1,551.74**.

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

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

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

Respondent shall be given a credit of **$5,035.34** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,035.34.**

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

ORDER

Respondent shall pay Petitioner the sum of **$695.78**/week for a further period of **50** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **10% loss of use of the person as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **4/10/12** through **1/23/15**, 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.

Carolyn Doherty
Signature of Arbitrator

2/26/15
Date

FEB 27 2015

FINDINGS OF FACT

Two consolidated matters were presented at trial. The current matter, 13 WC 42001, with a 4/10/12 date of accident involves injury to Petitioner's low back. Petitioner's accident of 6/5/12 with an injury to his right foot is addressed in a separate Decision in consolidated case 13 WC 42002.

At trial in this matter 13 WC 42001, the parties placed causal connection and nature and extent at issue. ARB EX 1. On 4/10/12, Petitioner worked as a patrol officer, swat operator and canine handler for the Respondent Darien Police Department. He was hired in 1998.

At trial, the parties stipulated to the issue of accident. Petitioner testified that on 4/10/12 he participated in a swat training scenario day working on a team. Petitioner was wearing a duty belt and swat tack vest with equipment attached weighing approximately 50 pounds. Petitioner was also carrying a ram used to smash open doors which weighed 50 pounds. Upon hearing the order to move during the exercise, Petitioner ran through a field, stepped in a dip in the ground and felt a shock in his back with pain down his right leg. He fell to the ground. When he stood up, pain shot down the back of his leg.

Petitioner testified that he was taken to the ER at Good Samaritan Hospital and given a Medrol dosepak under a diagnosis of acute sciatica and possible herniated disc. Petitioner was told to follow up with his physician. He was taken off work. PX 1.

On 4/11/12, Petitioner saw Dr. Papaeliou at Meridian Medical Associates. The records contain a consistent history of accident and complaints of SI joint pain. Dr. Papaeliou diagnosed SI joint pain in exam and ordered Petitioner to remain on Medrol. He also prescribed ice and heat as well as an elastic pelvic belt and kept Petitioner off work. PX 2.

Petitioner next saw Dr. Papaeliou on April 16, 2012. Petitioner reported significant improvement with no radicular symptoms. He reported some discomfort with pivot of the right foot. No tenderness of the SI joint was noted on exam and Petitioner was able to flex forward reaching to the middle and distal thirds of his legs with his fingers without apparent discomfort. Rotation of the trunk did not exacerbate any discomfort. PX 2. The diagnosis was resolving SI joint sprain and Dr. Papaeliou recommended three PT sessions with a follow up on 4/24/12. Petitioner stated he wanted to try returning to work so Dr. Papaeliou returned him without restrictions at the visit of 4/16/12. PX 2.

Dr. Papaeliou's record of 4/18/12 indicates that Petitioner called to office to report that he returned to work and while wearing the duty belt felt some numbness in his right foot and left great toe. The numbness had since ceased. He reported that his back was "feeling pretty good." PX 2. Dr. Papaeliou recommended an MRI under a diagnosis of possible lumbar radiculopathy. He took Petitioner off work.

An MRI of 4/23/12 at Naperville Imaging indicated degenerative changes at L4-5 greater than L5-S1 including bilateral neural foraminal stenosis greatest at L4-5 where there is moderate-severe right neural foraminal stenosis and no significant lumbar spinal canal stenosis. PX 2.

On 4/24/12, Dr. Papaeliou noted that Petitioner reported some numbness in both feet which resolved and that he was no longer having any "back symptoms." Under a diagnosis of resolved sciatica Petitioner was sent for 3 more sessions of PT. On May 2, 2012, Dr. Papaeliou continued PT and sent Petitioner to Dr.

See for pain management based on Petitioners' continued complaints of SI joint discomfort and a recurrence of numbness in the left foot exacerbated by sitting or driving.

On 5/4/12 Petitioner saw Dr. See who noted Petitioner's complaints of left foot numbness. Petitioner had no radiating pain and no weakness. He reported that wearing a gun belt and sitting for long periods caused left foot numbness. Petitioner further reported that his low back pain improved somewhat "although he still had some numbness and tingling doing to the legs to the bottom of the feet." Dr. See read the MRI to indicate a bulging lumbar disc at L4-5. He diagnosed bulging lumbar disc and lumbar radiculopathy. He recommended injections. Petitioner received a right L4-5 transforaminal epidural and a right L5-S1 right transforaminal epidural on 5/9/12. The plan that day was to "tentatively" return Petitioner to full duty work as of May 15. Petitioner was to attempt the full duty and follow up if he was unable to perform the full duty work. PX 2.

Petitioner continued to work full duty as of 5/15/12. However, he also received additional injections on 6/11/12, 12/3/12, and 12/19/12 due to continued complaints of back spasm, right leg radicular pain and right foot pain. On 10/28/13, Dr. See placed Petitioner at MMI for his low back. Petitioner was told to report back with any flare ups. On 12/6/13, Petitioner returned to report a flare up of symptoms including tightness and spasms on right side lower back and some shooting pain down the right side as well as left side symptoms. On 12/17/13, Petitioner received more epidural injections. On 5/19/14, Dr. See gain placed Petitioner at MMI following months of sustained improvement. Finally, on 7/18/14 Petitioner returned to Dr. See after a return of back discomfort following back exercise. He received a final injection. He has not returned to see Dr. See for his low back condition. PX 2.

Subsequent to his return to full duty work on 5/15/12, Petitioner continued to work for Respondent. In November 2012 he was promoted to sergeant with lesser physical demands. Petitioner testified that he is no longer required to drive or work on patrol for long periods. His duties are now more administrative and he is at a desk for 50% of his day. Petitioner testified that after sitting for a half hour he notices fatigue in his back and that he has to remove some equipment to take the weight off his back. He currently takes over the counter medication for his symptoms.

On cross exam, Petitioner testified that he exercises 5 days per week using a treadmill and weights. He walks on the treadmill for 20 minutes on a flat surface but is unable to run. He stands and lies down on his back while doing sets of weight lifting on a weight machine and with dumbbells wearing a weight belt and taking 5 minute breaks between lifting sets. He testified that he is unable to do squat exercises but can occasionally do calf raises. Specifically with regard to his current exercise ability, Petitioner testified that he exercises for ½ hour per day and his exercise regimen includes walking on a treadmill, stretching and lifting weights with both a multi-purpose machine and dumbbells. He exercises at home and at a gym. The heaviest dumbbell that he uses is 60 to 65 pounds. In response to specific questioning, Petitioner indicated that he performs the following exercises: Chest press – Three sets of eight repetitions using 60 to 65 pounds; Lat pull down bar - Three sets of eight repetitions using 60 to 65 pounds; Triceps press - Three sets of eight repetitions using 40 pounds; Biceps curls - Three sets of eight repetitions using 25 to 30 pounds; Treadmill – 15 to 20 minutes at 3 to 3.4 miles per hour. Petitioner testified that he exercises to stay in shape for his work duties. T. 33-44.

Respondent submitted an impairment rating performed by Dr. Shapiro dated 12/9/14. Dr. Shapiro reviewed Petitioner's medical records including his records from Meridian. He also reviewed the films

from Petitioner's MRI of 4/23/12 and noted evidence of degeneration at L4-L5 and L5-S1 and right-sided herniated discs at L4-L5 and L5-S1. Dr. Shapiro noted a provided history of "He continues to have complaints of pain in the low back and right leg. His subjective leg pain is consistent with an L5 radiculopathy. He is engaged in a home exercise program. His level of pain is 2/10 on most days, 1/10 on his best day and 9/10 on his worst day. His back pain is worse than his right leg pain. He is working full duty without restrictions. Dr. Shapiro's AMA evaluation indicated that Petitioner would fall under the category of "Motion Segment Lesions Class 3 (hnp at multiple levels with residual radiculopathy at a single level). The grade modifier for Functional History is 1 (PDQ 39). The grade modifier for Physical Exam is 0. The grade modifier for Clinical Studies is 2. The sum of the grade modifiers is -2 + -3 + 1a Grade A. The Impairment Rating is 15%" RX 1. Dr. Shapiro's deposition was not taken.

CONCLUSIONS OF LAW

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

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

Petitioner testified that he injured his low back while working on 4-10-12. Treatment was provided at Good Samaritan Hospital the same day. Follow-up treatment was provided beginning on 4-11-12. Petitioner denied a prior or subsequent low back injury. Based upon the foregoing, the Arbitrator finds that Petitioner's low back treatment and disability are causally related to the accident on 4-10-12.

L. What is the nature and extent of Petitioner's injury?

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

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

(b) Also, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

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

No single enumerated factor shall be the sole determinant of disability.

With regards to the above enumerator factors in Section 8.1b (b) the Arbitrator notes that the now 44 year old Petitioner suffered a low back injury when he stepped into a dip or hole during a SWAT training exercise on 4-10-12. Petitioner testified that he experienced low back pain and an electric shock sensation down his right leg. Petitioner was diagnosed by his treating physicians with an aggravation of his

degenerative disc disease, bulging lumbar disc and lumbar radiculopathy. He underwent physical therapy and several epidural injections between April 2012 and July 2014.

Petitioner returned to work on 5-15-12. Petitioner was promoted to sergeant in November 2012 and is working full duty. Approximately 50% of his time is spent at a desk working on reports, paperwork and administrative tasks and the remainder in a squad car in a supervisory capacity. He only occasionally answers calls when a patrol officer is not available and makes only a "handful" of arrests per year. Accordingly, the Arbitrator finds that Petitioner has not sustained any loss of future earning capacity and little weight is given to the factors of Petitioner's occupation or age at the time of the injury given his promotion to sergeant and the lesser physical duties associated with that position.

With regard to the reported level of impairment and the evidence of disability corroborated by the medical records and Petitioner's trial testimony, the Arbitrator notes Petitioner testified that while working his desk duties he notices that after sitting for a half hour he experiences fatigue in his back and that he has to remove some equipment to take the weight off his back. He currently takes over the counter medication for his symptoms. Petitioner testified at trial regarding his current exercise ability on which the Arbitrator places significant weight in the determination of permanent partial disability and Petitioner's level of impairment. Specifically, the Arbitrator notes that Petitioner, at age forty-four, is capable of significant physical activity with minimal impairment as demonstrated by his ability to perform a consistent and fairly rigorous exercise regimen. The Arbitrator finds that Dr. Shapiro does not adequately explain his rating and given Petitioner's physical abilities there is little evidence in the record to support Dr. Shapiro's impairment rating of 15% of the person. When Dr. Shapiro's rating is weighed with the remaining factors, less disability is indicated.

Based upon the foregoing, the Arbitrator finds that Petitioner suffered 10% permanent partial loss of a man as a whole.

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

Renee Rogers,

Petitioner,

vs. NO: 10 WC 38552

Cintas Corporation,

15IWCC0743

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, average weekly wage/benefit rates, temporary total disability overpayment, medical expenses, and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 47 year old employee of Respondent, who described her job as healthcare major account manager/sales. Petitioner was working for Respondent on the date of accident and Petitioner had been with Respondent since December 1999. Petitioner sells to hospitals under Respondent's product lines. Petitioner stated Respondent provides many services, from document shredding, uniform direct sale, rental uniforms, facility services like microfiber products, chemicals, storage; kind of an environmental services realm. Currently Petitioner works only with uniforms; direct sales uniforms only. In February 2010, Petitioner was working all of the business lines. Petitioner had seen RX 1. She agreed it showed her regular paychecks and some bigger paychecks. Petitioner testified that she has a base pay and then she has performance money that comes in depending on what she is selling. Petitioner identified July 2009 check for $36,656.00

was a performance pay. Petitioner testified that there is a formula that is used of what she sells and the growth from what she sells for the company. She agreed there are several other checks that are noted different than the standard number and those checks would have been the same. She indicated it was not discretionary pay (like a Christmas turkey).

- Petitioner testified that prior to February 2010 she had never injured her left shoulder. Petitioner is right hand dominant. Petitioner testified that prior to February 2010 she had never injured her neck. Petitioner had been in prior motor vehicle accidents; about 2006; then she was on her way to a meeting with her boss at a hospital. Then she had a follow up appointment with her primary doctor and she may have had some chiropractic treatment. As far back as 2006 Petitioner did have an MRI ordered or done. Petitioner testified that other than that incident she had no other problems with her neck. Petitioner indicated that from that accident her neck in 2006 bothered her for a very short time and it was fine and she was back to work the next day and she did not have any problems from that.

- On the date of accident, February 10, 2010, Petitioner testified that she was in South Bend and she had met the sales manager from one of the rental locations. Petitioner stated they got into the sales manager's vehicle and started driving together to an appointment. Petitioner stated they pulled up to a light and they were sitting at the light for a minute or so and Petitioner stated she turned her head to talk to the manager about something as they were waiting for the light to change and then they were struck from behind pretty hard. Petitioner testified at that time, as she had her head turned, she immediately felt an impact and sharp pain that went through her neck and her left shoulder. Petitioner agreed she was then treated at the emergency room at Memorial Hospital in South Bend and they recommended Petitioner to follow up with her own doctor. Petitioner came under the care of Dr. Jolanta Milet, D.C. on February 13, 2010 and continued under her care into April 2010. There Petitioner had manipulations and a cervical MRI was ordered. Petitioner then saw Dr. McNally-(on referral from Dr. Milet), Suburban Orthopedics, initially March 26, 2010 and that doctor examined Petitioner. Petitioner testified at that time she had extreme neck pain and shoulder pain and it was not going away with any type of therapy. Petitioner testified that Dr. McNally referred Petitioner to some pain doctors who provided Petitioner with some cervical injections. Petitioner was also getting physical therapy at Suburban Physical Therapy. Petitioner indicated the therapy was directed to her neck and her shoulder. Petitioner was also seen by Dr. An at Midwest Orthopedics at Rush; as Petitioner had wanted a 2nd opinion. Petitioner testified she had discussed getting a 2nd opinion with Regina, the case manager for Respondent's WC TPA. Petitioner saw Dr. An on July 30 and August 17, 2010 and that doctor recommended surgery. Petitioner ended up seeing Dr. Douglas Johnson, a neurosurgeon (now deceased) on August 26, 2010. Petitioner testified as to seeing Dr. Johnson that she had also discussed that with Regina, and Regina had indicated approval for Petitioner to see that doctor. Petitioner indicated Dr. Johnson initially tried some therapy. Petitioner ultimately had the cervical surgery November 17, 2010 at Central Du Page Hospital. Petitioner had follow-up with Dr. Johnson, and therapy was resumed. Petitioner was off work post-surgery for 6-1/7 weeks and during her time off, Petitioner had received checks from Respondent's TPA.

- Regarding her neck and/or shoulder, after surgery she started the therapy and she was still having a little bit of trouble and pain with her neck and shoulder and they told Petitioner that it would last for a while. Petitioner testified that she did feel better after the surgery; she then did not have the tingling she had down her arm from her neck, and the strong pain she had prior had gone away, but Petitioner stated that she still had some trouble with her neck and her shoulder at that point. Petitioner testified specifically that her shoulder was actually also in pain, but it was hard for her to distinguish neck, shoulder, how it all worked together because it was kind of one pain she was feeling. Petitioner stated that it was definitely trouble with like lifting her arm and things like that, at that point. Petitioner testified at that time she was also having some headache problems and she was referred by Dr. Johnson to Neuromed where they did various testing. Petitioner had some of that testing previously as there was some family history of aneurysm and she wanted that to get checked out. Petitioner testified that in December 2011, Dr. Johnson referred Petitioner to Dr. Erickson regarding her shoulder; first seen December 27, 2011. Petitioner testified that at that time she was feeling pain around her neck and in her shoulder area, but she thought it was more her neck, so she had gone back to Dr. Johnson to see what the problem was. Petitioner testified that Dr. Erickson recommended an MRI. Petitioner had the MRI and returned to Dr. Erickson February 14, 2012 and the doctor recommended Petitioner have surgery (shoulder) and Petitioner testified at that time she opted not to have that surgery. At Respondent's request, Petitioner was seen for an IME with Dr. Tonino November 19, 2012. Petitioner testified that since the MVA in South Bend, she has not had any new injuries to her neck or to her left shoulder.

- As to Petitioner's work traveling, Petitioner stated that she covers Michigan, parts of Illinois, Indiana, and some of Wisconsin. Petitioner stated it is her job to go out and work with large hospitals on identification uniform programs, which means one for every size to a hospital and perform a fitting where people are trying clothes on, catalog samples. Petitioner stated that she brings catalogs to the hospitals also, to the different departments. Petitioner testified her travel is mostly driving, but she also does fly as needed. Petitioner testified that there is lifting involved with her job; lifting out of her car. She does have a rolling rack she uses, but there is still the lifting from the car. She stated she does get help when she needs it but basically she does some lifting.

- Petitioner agreed the past summer-(2013) she had suffered a mini stroke and she had treated at Rush; she had been making a presentation there when it had occurred. Petitioner stated from that she had numbness in her legs and she had trouble walking and her left arm just went dead and she could not lift it. Petitioner had gone through treatment for the stroke and she had resumed working and her normal activities. Petitioner indicated since the February 10, 2010 accident it just seems that any kind of activity she feels a strain in her neck and shoulder and arm when she is working; she indicated she did not have that prior. Petitioner indicated she knew she was going to be working and she understood she had to live with that, but it is a struggle. She stated there are days she will have trouble, at the end of the day feeling the way that she does. Petitioner testified that currently it was basically her shoulder and she has some stiffness in her neck at times, but it was mostly in her shoulder she has the trouble. Petitioner testified that her left arm is definitely weaker than before. She indicated with lifting or washing or brushing her hair

she will feel the pain and that is sometimes a struggle. She indicated difficulty lifting her arm over her head is one of those things. Petitioner testified the sensations she had from the neck and shoulder was not the same as the sensation from her stroke; with the stroke she felt like her arm was dead, she could not lift it, and also with her stroke her legs fell asleep so it was totally different type of pain in her arm. Petitioner agreed when she saw Dr. Tonino, he had recommended Petitioner get an x-ray and she had that at Gottlieb Hospital and she had received the bill for that and she had paid that bill.

- **Arbitrator questioned Petitioner regarding performance pay—
--Petitioner indicated in the major account manager role, it is kind of broke up quarterly depending on what she is selling. Petitioner indicated it is an equation divided by 52 weeks. She indicated every contract that she sold was a 3 year contract so there was some formula she must sell "X $" amount and then there was a growth aspect, as she was growing accounts there was all a few buckets in one type of pay. Petitioner indicated she did know what the formula was; each quarter she could figure it out. She indicated there was a formula to double check the numbers and it was talking to her boss and there was a chart of what target to hit to get what money. Petitioner testified that the formula was not static depending what she was selling and how long it was being sold to them. Petitioner stated it was actually a formula on "X" amount of dollars; it did not matter who she was selling to, it was on account growth, percentage of growth. Petitioner indicated at that time there was also, she believed a uniform direct sale piece, how much business she sold for the uniforms. Petitioner agreed that was quarterly bonus with the last quarter being the biggest amount, so they would withhold some to make sure she was on pace. Petitioner stated she called it a quarterly bonus as based on what she did, so if she did not sell anything she would not get it. Respondent counsel indicated the bonuses could be identified inspecting the wage audit. Petitioner had viewed that Respondent exhibit and she indicated it was pretty accurate. Petitioner indicated travel expenses went via an expense report via computer and approved by the boss and audited; an entirely different thing.

- Respondent's exhibit regarding Petitioners wages and bonus checks during prior year noted--
--42 weeks at $1,191.16
-- 5 weeks at $1,193.00
-- 2 weeks at $1,202.91 and
-- 4 'bonus' checks $4,630.25, $36,656.45, $9,216.16, $17,243.00

- Respondent's exhibit-RX 2: List of TTD paid totaled $7,635.57

The Commission finds, as to causal connection, that there is no issue that Petitioner was in a work related motor vehicle accident-(MVA) and suffered injury. The records indicate Petitioner suffered a cervical injury and had left cervical radiculopathy for which she had cervical surgery with a pretty good result. There is clearly a causal connection established as to the cervical injury. Petitioner did make left arm complaints early on and those complaints related to the

radicular symptoms. Petitioner had the cervical surgery and it was noted her cervical and radicular left arm symptoms were better after the surgery. There were no clear documented left shoulder symptoms to indicate impingement or rotator cuff type symptomatology until much later after recovering from the cervical surgery; there were the clear cervical radicular symptoms documented as result of the accident, but no such objective findings or subjective complaints indicating the impingement/rotator cuff symptoms. Of note, post-surgery Petitioner noted the new complaints regarding her left arm/shoulder that she did not have after the accident. One may accept some masking of a shoulder injury given the cervical radicular injury sustained, but again, Petitioner was recovering well with little to no cervical and left arm complaints until early 2012-(almost 2 years after the accident and good recovery from the cervical disc replacement surgery) when the left shoulder complaints really appeared and an MRI was done then indicating shoulder pathology that required surgical intervention. Petitioner's testimony is not supported in the medical records as to a causal connection regarding the left shoulder impingement type pathology. The evidence and testimony finds Petitioner met the burden of proving a causal relationship as to the cervical injury with left radiculopathy requiring surgical intervention, but Petitioner failed to meet the burden of proving a causal connection as to the left shoulder pathology. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection cervical/cervical radiculopathy only.

The Commission finds, as to average weekly wage-(AWW)/benefit rates, that the 'quarterly bonuses' indicated here, do appear to be as a discretional bonus, like a Christmas bonus or safety bonus, rather than a bonus based on productivity/sales/performance-(part of her regular earnings) Respondent had discretion as to what quarter payment would be made to be sure Petitioner stayed at a proper quota level. While Petitioner indicated there is an equation used to determine the 'bonus', there is nothing in evidence supporting that. The evidence of the 'bonus' payments indicates a more discretionary bonus method given the variety of 'bonus' payment amounts with no clear explanation of a formula, or evidence of productivity/sales to substantiate Petitioner's contention. There is evidence of the 'bonuses' paid on a quarterly basis in the year before, as well as, the years after the accident, but again nothing to support that being based on incentive or production/sales quotas exceeded, and no way of determining if there was any formula incentive basis to be included in average weekly wage. A Petitioner bears the burden of proving every element of her case and here, Petitioner's testimony alone is not sufficient to support the inclusion of the 'bonus' in the average weekly wage. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to average weekly wage/benefit rates.

The Commission finds, as to Petitioner's claimed temporary total disability credit/overpayment that with the above finding affirming the Arbitrator's AWW/benefit rate findings affirms the TTD award with Respondent receiving the credit for amounts paid-(overpayment). The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to TTD overpayment.

The Commission finds, as to medical expenses, that with the finding above of causal relationship only to cervical/left radiculopathy-(Not shoulder pathology) that Petitioner is not entitled to any further medical expenses. The evidence indicates the Gottlieb bill had been paid which had been ordered by Respondent's §12 IME examiner. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses.

The Commission finds, as to permanent partial disability-(PPD), that with the finding above of causal connection only regarding the cervical/cervical radiculopathy condition, the evidence and testimony of Petitioner's accident and injury, and her cervical surgery and residual condition of ill-being regarding the cervical issue. The Commission finds the evidence and testimony supports a slightly higher PPD award to 25% loss of Petitioner's person as a whole, as more consistent with prior Commission decisions of similar nature and extent. The evidence and testimony finds Petitioner met the burden of proving entitlement to the PPD award as noted above. The Commission finds the decision of the Arbitrator as insufficient given the weight of the evidence, and, herein, modifies the PPD award to find a loss of 25% loss of use of Petitioner's person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $794.74 per week for a period of 6-1/7 weeks-($4,882.97 total TTD), that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive credit for benefits paid of $7,635.57.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 25% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for any reasonable and necessary unpaid medical expenses under §8(a) of the Act. Respondent shall receive credit of $388.00 for medical benefits paid and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving credit.

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

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

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

DATED: SEP 25 2015
o-7/30/15
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROGERS, RENEE
Employee/Petitioner

Case# **10WC038552**

CINTAS CORP
Employer/Respondent

15IWCC0743

On 12/20/2013, 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 0.09% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
CHARLES G HASKINS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0210 GANAN & SHAPIRO PC
JOE BROUCHY
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0743

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Renee Rogers
Employee/Petitioner

v.

Cintas Corp.
Employer/Respondent

Case # **10WC 38552**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **11-19-13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **02-10-10**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $ **61,989.72**; the average weekly wage was $ **1,192.11**.

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

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

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

Respondent shall be given a credit of $**7,635.57** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,635.57**.

Respondent is entitled to a credit of $**388.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 100 weeks, as injuries sustained caused 20% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of $**7,635.57** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,635.57**.

Respondent shall be given a credit of $388.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $794.74/week for 6 1/7 weeks, commencing 11/17/10 through 12/29/10, as provided in Section 8(b) of the Act.

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

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

Signature of Arbitrator

Date 12·19·13

DEC 20 2013

STATEMENT OF FACTS

Renee Rogers ("Petitioner") began working for Cintas Corporation ("Respondent") in 1999 as a healthcare account manager. She testified Respondent performs various services for employers, most notably selling uniforms. Petitioner testified she has worked for Respondent in sales since that time.

On February 10, 2010, Petitioner was in South Bend, Indiana for a sales call for Respondent when a vehicle in which she was a passenger was struck from behind by another vehicle. Following the accident, Petitioner was seen in the emergency department of Memorial Hospital of South Bend. (PX6 at 2). Petitioner complained of pain in her neck radiating to both shoulders. (PX6 at 2). Petitioner underwent x-rays of her neck that were negative and was diagnosed with a paracervical muscle strain. (PX6 at 2).

Petitioner testified she sought treatment on her own with chiropractor Dr. Jolanta Milet on February 13, 2010. Petitioner reported to Dr. Milet bilateral neck pain that radiated to both shoulders. (PX7 at 4). Petitioner underwent a course of chiropractic treatment with Dr. Milet that lasted several months. (PX7). An MRI was performed on March 22, 2010 at Dr. Milet's request that revealed a central disc herniation to the left at C5-6, and a bulging disc at C6-7. (PX7 at 63).

The Arbitrator notes that throughout the course of her care with Dr. Milet, the Petitioner's left arm treatment (massage) was referenced in conjunction to radiating pain from her neck. While it is true left shoulder massages were given, it is also true that left shoulder complaints were rarely documented in the records. (PX 7)

Dr. Milet (DC) referred the Petitioner to treat with Dr. McNally at Suburban Orthopaedics on March 26, 2010. (PX8 at 3). Petitioner reported experiencing left arm and shoulder complaints after the accident, and reported continued neck and back pain. (PX8 at 3). Dr. McNally diagnosed cervical disc displacement and recommended pain management with Dr. Jain, and continued treatment with Dr. Milet. (PX8 at 7). As of April 14, 2010, Petitioner discontinued her treatment with Dr. Milet. (PX7).

On April 16, 2010, Petitioner first saw pain management physician Dr. Jain, who diagnosed cervical radiculopathy, cervical discogenic pain, cervical facet syndrome, and cervical degenerative disc disease, and performed an interlaminar cervical epidural steroid injection. (PX8).

During an April 23, 2010 follow visit with a physician's assistant at Suburban Orthopaedics, Petitioner reported no more upper extremity pain. (PX8 at 8). Dr. Jain performed a second injection on May 7, 2010, and a third on May 21, 2010. (PX8 at 10-14). Petitioner returned to Suburban Orthopaedics on May 28, 2010 and reported left sided neck and periscapular pain with only minimal improvement from the injection. (PX8 at 16). On May 22, 2010, the Petitioner stated that her pain "radiates to her low back and left arm." (PX #7 at 60) The pain diagram created by the Petitioner noted posterior pain. (Id.)

Petitioner testified that at this time she requested Cintas provider her with a second opinion evaluation with Dr. Howard An at Rush Hospital. Petitioner testified she chose Dr. An because of her prior work

experiences with Rush through working for Respondent. The evaluation took place on July 30, 2010. Petitioner reported continued neck pain radiating to her left arm with numbness to the left leg. (PX12). Dr. An reviewed the MRI and diagnosed cervical spondylosis and left sided radiculopathy associated with a herniated disc. Id. Dr. An recommended an anterior discectomy and fusion at C5-6, and noted Petitioner inquired about a disc replacement. Id.

Petitioner returned to Dr. An on August 17, 2010 and reported improved left arm pain, but significant neck and lower back pain. Id. Dr. An diagnosed a small herniated disc at left C5-6 with some impingement of the C6 nerve root, and again recommended a fusion. Id.

Petitioner testified that at this point she assisted Cintas in finding and setting up treatment with neurosurgeon Dr. Johnson at DuPage Neurosurgery. Petitioner first saw Dr. Johnson on August 26, 2010. (PX9 at 3, 4). She reported constant neck pain with intermittent numbness on the anterior aspect of her left arm from the shoulders to the elbow area. Id. at 4. Dr. Johnson diagnosed cervical spondylosis without myelopathy, displacement of cervical intervertebral disc, cervicalgia, and a neck sprain. Id. at 4. Dr. Johnson recommended some physical therapy, a discogram, and possibly a visit with a shoulder specialist if her shoulder symptoms persisted. Id. at 4.

Petitioner began a course of physical therapy at Central DuPage Hospital on September 2, 2010. Her physical therapy records state that later that week, she stated that her main compliant was "located at the left side of her neck." No other complaints were listed. (PX 8 at 29) Dr. Johnson examined Petitioner again on September 30, 2010 and reported continued left sided neck pain. Dr. Johnson recommended either a fusion or a disc replacement surgery. (PX9).

On October 6, 2010, the Petitioner filed her application for adjustment of claim at The Illinois Industrial Commission. No specific body part was listed on the form, nor was it signed by Petitioner or her attorney. On October 23, 2010, Petitioner underwent a physical examination by Dr. Thomas McNally who noted, "full and painless range of motion" of the left shoulder. Additionally, "full strength and intact sensation." Finally, negative Hoffman's, Spurlings, and L'Hermittee's exams." (PX 8 at 5)

Petitioner saw Dr. Bizios for a pre-operative evaluation on November 1, 2010 and reported a weak left arm from her neck injury. (RX9 at 40).

On November 17, 2010, Dr. Johnson performed a total disc arthropathy with an anterior approach, including a discectomy with end plate preparation at C5-6. (PX9 at 29). Petitioner testified she was paid TTD benefits for the time she spent off work following this procedure.

Petitioner returned to Dr. Johnson on December 1, 2010 and reported that she no longer had any arm pain. (PX9 at 14). An x-ray taken that day revealed normal disc heights and no adverse features. Petitioner began a course of post-operative physical therapy at Central DuPage Hospital on December 2, 2010. By December 23, 2010, Petitioner was discharged from physical therapy after showing significant improvement.

Petitioner reported only very minimal neck pain to Dr. Johnson on December 28, 2010. (PX9 at 21). He advised she could return to light duty work on December 29, 2010, and could progress to full time work as of January 17, 2011. Id. at 21. Petitioner testified she returned to work December 29, 2010. Petitioner testified this was the only time she spent off work related to her accident.

Respondent's Exhibit Two is a TTD document that indicates Respondent paid Petitioner a total of $7,635.57 in TTD benefits from November 17, 2010 through December 30, 2010, at a rate of $1,243.00 per week. (RX2).

On March 1, 2011, Petitioner returned to see Dr. Johnson and reported an incident a few days prior with garbled speech, imbalance, and weakness on the left side. Petitioner had full range of motion and no pain with motion. Dr. Johnson referred her to a neurologist. (PX10 at 24).

Petitioner was seen the next day by neurologist Dr. Bajwa at NeuroMed Clinic. (PX10 at 10). She reported she awoke the previous Friday with left arm pain that became worse on Saturday. Id. Petitioner reported this was different from the weakness she experienced prior to the surgery. Id. She also reported occasional pain shooting to the left leg. Id. Petitioner was diagnosed with cervical disc disorder with radiculopathy and cerebral arterial thrombosis. Id. Petitioner was advised to obtain MRI scans of her head and brain, and an MRA. Id. These were performed that day and were determined to be essentially normal, with a small pineal gland abnormality that was most likely a cyst. The next day, Petitioner was advised to obtain a CT angiogram of the brain. This was performed on March 9, 2011 and revealed a patency of the intracranial vasculature. (PX10 at 20-3).

Petitioner testified that at the end of 2011, and beginning of 2012, her complaints were different than before.

On November 10, 2011, Petitioner returned to Central DuPage Hospital after feeling as if her left arm and leg had fallen asleep. (RX7 at 53). She stated she felt as if her legs would give out beneath her. Id. at 53.

She stated the symptoms started the prior morning. Id. at 53. Petitioner was educated as to the signs and symptoms of a stroke and was advised to go to the ER if she experienced any of those symptoms. Id. at 56. Petitioner's sister and both her parents have a history of strokes. Id. at 58.

On December 7, 2011, Petitioner returned to Dr. Johnson with complaints of cervical and left arm pain. (PX9 at 26). She was seen by Dr. Johnson on December 22, 2011 and reported "new symptoms" of constant left arm pain, heaviness, left-sided neck pain, and bilateral lower extremity numbness and tingling. (PX9 at 27). At that time, Dr. Johnson diagnosed a left shoulder sprain. (PX9 at 28). This was the first time Petitioner had been diagnosed with a left shoulder condition.

On January 17, 2012, Petitioner was seen by Dr. Erickson at Wheaton Orthopedics and reported a left shoulder problem that developed over the past 3-4 months. (PX11 at 5). Petitioner stated that it was not caused by work, not was it caused by an auto accident. There was no reported date of injury. (Id.) Dr. Erickson examined Petitioner and found a mildly positive impingement sign on the left shoulder. Id. at 10. Dr. Erickson felt the shoulder problem could have come from the accident, but was just obscured by

the neck issue. Id. at 10. He also alternatively opined the petitioner could have developed weakness of her shoulder girdle and had subsequent impingement development. Id. at 10. Petitioner put the billing through her husband's group insurance.

A January 31, 2012 MRI found a small full thickness tear of the distal tendon of the supraspinatus. Id. at 11. Petitioner returned to Dr. Erickson on February 14, 2012. Id. at 9. He reviewed the MRI and prescribed surgery. Id. at 9.

Petitioner returned to Dr. Echiverri on April 17, 2012 and complained of weakness in her legs and left shoulder that made both walking and using a computer difficult. (PX10 at 5). Dr. Echiverri noted a brain MRI was normal. Id. at 5.

Petitioner testified she saw Dr. Tonino on November 19, 2012. She testified Dr. Tonino performed a physical exam. She testified she was honest with him. Dr. Tonino noted Petitioner had complaints of left shoulder pain as early as the spring of 2010, though he incorrectly indicates some of these occurred in the spring of 2012. (RX4 at 1). It is clear he meant 2010, as he notes a cervical MRI from March 22, 2012 that actually occurred in 2010. Id. at 1. Dr. Tonino noted Petitioner first reported pain referable to the left shoulder in January 2012, which she stated she had for the three to four prior months with no specific cause. Id. at 1. Dr. Tonino opined the pain Petitioner felt in her left shoulder prior to that time was cervical pain that was radiating to her left arm area. Id. at 1. Based on the delay in left shoulder-specific complaints until late 2011 – early 2012, Dr. Tonino opined Petitioner's left shoulder condition was not related to the work accident. Id. at 2. He felt Petitioner suffered an atraumatic onset of leg shoulder rotator cuff tear and may benefit from left shoulder arthroscopy. Id. at 2.

Petitioner next sought treatment at Central DuPage on April 17, 2013 for chronic headaches, fatigue, and dizziness. (RX7 at 77). There is no mention of left shoulder pain or treatment. A shoulder shrug and neck strength test were both normal. Id. at 89. Petitioner was advised to obtain a brain MRI and head MRA. Id. at 84. Petitioner underwent these tests on May 1, 2013 and they were negative. Id.

Petitioner returned to Central DuPage on July 9, 2013. (RX7). Again, Petitioner's family history of aneurysms and her history of persistent headaches and a pineal cyst are mentioned. There is no mention of left shoulder pain. Id.

Petitioner testified she had a stroke in August 2013 that caused left side complaints. She testified she was on a sales call at Rush Hospital when she had the stroke.

Petitioner returned to Central DuPage on August 22, 2013 and reported she was wearing a heart monitor due to a recent stroke. (RX7 at 110). Petitioner returned to Central Dupage on August 31, 2013 and reported having two ischemic strokes on August 9, 2012 at Rush. Id. at 99.

Petitioner testified to seeing Dr. Erickson in 2013 and treating for her shoulder. No records were submitted at trial of this treatment. Petitioner is not currently seeking any shoulder treatment and does not have any treatment recommendations.

Petitioner testified in her current position at Cintas she performs uniform sales all over the Midwest. Petitioner testified she flies and drives to clients in Michigan, Indiana, Illinois, and Wisconsin. Petitioner testified she brings catalogues and samples with her to these clients. Petitioner testified she rarely takes any time off work. Respondent's Exhibit Five is listing of all sick time requested by Petitioner since 2010. (RX5). It indicates Petitioner has taken off only day since returning to work in December 2010. Id.

Petitioner testified she has received pay increases since the accident. Respondent's Exhibit One shows Petitioner's earnings have increased steadily since 2009. (RX1-6). Petitioner has not had any lost wages since being off work following the November 2010 surgery. Id. at 3-6.

Petitioner testified her salary has a performance based element. She testified she receives a "bonus", and that Respondent makes the last quarter "bonus" larger.

Petitioner testified she currently feels some strain and stiffness in her neck. She testified she has left shoulder pain. She testified she has difficulty lifting overhead or brushing her hair with her left hand. Petitioner is right handed.

Respondent's Exhibit Two is a list of TTD payments made by Respondent. (RX2). Respondent's Exhibit Three is a list of Medical payments made by Respondent. (RX3).

Respondent's Exhibit Eight is a Gottlieb Memorial Hospital bill. (RX8). It indicates a $275.50 charge for an x-ray exam performed as part of his November 20, 2012 exam. (RX8). On November 23, 2012, the balance was reduced from $341.50 to $136.60 as part of an "Uninsured Discount." (RX8). Respondent paid the balance, which was $136.60, on March 15, 2013. (RX8).

Respondent's Exhibit Nine is a SportsMed Wheaton Orthopaedics balance. (RX9).

CONCLUSIONS OF LAW

The Arbitrator makes the following findings on the issue of **(F) is the Petitioner's present condition of ill-being causally related to the injury?**

The Arbitrator finds Petitioner suffered a herniated disc at C5-6 with left sided radiculopathy as a result of the work accident.

Following Petitioner's accident, she was seen at Memorial Hospital in South Bend and made no mention of any trauma or injury to her left shoulder. (PX6). She complained of neck pain radiating to both shoulders and was diagnosed with a paracervical muscle strain. Id. at 2. No diagnosis was made related to the left shoulder and there was no mention of any left shoulder-specific complaints.

Petitioner next treated with chiropractor Dr. Milet for several months and reported bilateral neck pain radiating to both shoulders. (PX7 at 4). Dr. Milet never diagnosed any left shoulder condition. (PX7). To determine the nature of Petitioner's injury, Dr. Milet recommended a cervical MRI, and not a shoulder MRI. (PX7 at 63). Petitioner's left shoulder was neither x-rayed in the ER, nor at Dr. Milet's office.

Petitioner next sought treatment with Dr. McNally at Suburban Orthopaedics, beginning in March 2010. (PX8 at 3). Petitioner reported left arm and shoulder complaints after the accident, but that she had continued neck and back pain. Id. at 3. To determine the nature of the injury, Dr. McNally took a cervical x-ray and reviewed the cervical MRI. Id. at 7. Dr. McNally diagnosed cervical disc displacement and recommended pain management with Dr. Jain. Id. at 7. Throughout his treatment of Petitioner, Dr. McNally never made a left shoulder diagnosis, and recommended no treatment or testing for a left shoulder condition. Id.

Dr. Jain first saw Petitioner on April 16, 2010 and diagnosed cervical radiculopathy, cervical discogencic pain, cervical facet syndrome, and cervical degenerative disc disease. (PX8). During follow up exams, Petitioner complained at times of periscapular and upper extremity pain. Id. At no time did Dr. Jain make a left shoulder diagnosis or propose treatment to the left shoulder. Id.

Petitioner sought a second opinion with Dr. Howard An at Rush on July 30, 2010. (PX12). Petitioner related to Dr. An continued neck pain that radiated to her left arm, along with numbness to her left leg. Dr. An diagnosed cervical spondylosis and left-sided radiculopathy associated with a herniated disc at C5-6, and recommended an anterior discectomy and fusion at that level. Id. Dr. An made no left shoulder diagnosis, and recommended no care for the left shoulder. Id.

Petitioner chose to pursue treatment with Dr. Johnson at DuPage Neurosurgery on August 26, 2010 and related constant neck pain with intermittent numbness on the anterior aspect of the left arm from the shoulders to the elbow area. (PX9 at 3, 4). Petitioner's complaints to her left shoulder were to the anterior aspect only. Id. at 4. Dr. Johnson diagnosed cervical spondylosis without myelopathy, displacement of intervertebral disc, cervicalgia, and a neck sprain. Id. at 4. Dr. Johnson recommended physical therapy, and advised Petitioner could see a shoulder specialist if her left arm symptoms persisted. Id. at 4. After a month of physical therapy, Petitioner returned to Dr. Johnson on September 30, 2010 and reported continued left sided neck pain. Id. at 8. Dr. Johnson recommended a disc replacement surgery. Id. at 9. Dr. Johnson made no left shoulder diagnosis, recommended no left shoulder treatment, and made no referral for left shoulder treatment. Id. at 9.

Petitioner was seen by her primary care physician, Dr. Bizios on November 1, 2010 for a pre-operative evaluation. (RX9 at 40). Petitioner related her left arm felt weak from her neck injury, and Dr. Bizios diagnosed a C5 herniation causing left upper extremity radiculopathy. Id. Dr. Bizios made no left shoulder diagnosis, and recommended no care for her left shoulder. Id.

Petitioner chose to undergo a total disc arthropathy with anterior approach, including discectomy and with end plate preparation at C5-6 with Dr. Johnson on November 17, 2010. Following this surgery, Petitioner returned to Dr. Johnson on December 1, 2010 and reported she no longer had any left arm pain. (PX9 at 14). A January 27, 2011 physical therapy discharge note contains no mention of left shoulder symptoms. Id. at 61-2. The note indicates Petitioner still had some slight residual weakness and limited range of motion in her left wrist and elbow, but makes no mention of any limitations regarding her left shoulder. Id. at 62. Petitioner returned to Dr. Johnson on December 28, 2010 and was released to full duty work. Id. at 21.

Prior to December 2011, it is unequivocal Petitioner had left arm complaints. As she had a herniated disc to the left at C5-6, this was to be expected. Petitioner had complaints of left arm pain that were associated with pain radiating from her neck down to her left arm, sometimes her right arm, and sometimes her low back. These complaints were consistent with a C5-6 dermatome (anterior left shoulder, left wrist). Her left upper extremity complaints were noted by many physicians along the way, qualified physicians chosen by Petitioner, and they consistently felt she had a herniated disc at C5-6 with radiculopathy to the left. The Arbitrator finds Petitioner's complaints of left shoulder pain before her surgery were the result of radiculopathy related to a herniated disc at C5-6, as was the diagnosis of Petitioner's own physicians.

On December 7, 2011, Petitioner returned to Dr. Johnson with complaints of cervical and left arm pain. (PX9 at 26). She was seen by Dr. Johnson on December 22, 2011 and reported "new symptoms" of constant left arm pain, heaviness, left-sided neck pain, and bilateral lower extremity numbness and tingling. (PX9 at 27). At that time, Dr. Johnson diagnosed a left shoulder sprain. (PX9 at 28). This was the first time Petitioner had been diagnosed with a left shoulder condition. Petitioner was seen by Dr. Erickson on January 17, 2012 and reported left shoulder pain for the past three to four months that she felt was not related to work. (PX11 at 5). Dr. Erickson opined Petitioner had a rotator cuff tear that was related to the work accident because the pain was obscured by her neck injury, or that she could have developed impingement due to weakness of the shoulder girdle muscles. (PX5).

Dr. Erickson's argument is not persuasive for three reasons. First, Petitioner's neck pain was not obscuring her left upper extremity pain. As mentioned above, there are plenty of examples of left upper extremity pain complaints prior to the November 2010 surgery, a time when Petitioner had her most severe neck pain. Second, if the neck pain obscured her shoulder pain, then the neck surgery would have "unmasked" Petitioner's shoulder complaints. Instead, the opposite occurred. Post-surgery, Petitioner no longer had any left arm complaints. (PX9 at 54). Third, there is no indication Petitioner had a weakened shoulder girdle as a result of her neck pain. As of a March 1, 2011 follow up visit with Dr. Johnson, Petitioner was noted to have intact and symmetrical upper body strength. (PX9 at 23). By that time, Petitioner was no longer complaining of neck pain, so it would seem unlikely that Petitioner would suffer neck pain severe enough to cause a lapse in shoulder girdle strength between March 1, 2011 and January 17, 2012 that would cause her left rotator cuff tear. In conclusion, Dr. Erikson's causal connection was not made with a reasonable degree of medical certainty.

Dr. Tonino examined Petitioner on November 19, 2012. Dr. Tonino noted Petitioner experienced cervical pain radiating to her left arm following the accident, beginning in the spring of 2010. (RX4 at 1). Dr. Tonino felt Petitioner's reports of shoulder pain developing in late 2011 and early 2012 represented the first reported pain referable to the left shoulder only. (RX4 at 1). Dr. Tonino felt that the twenty-two month gap between the February 2010 accident and the December 2011 left shoulder pain reports indicated Petitioner's left shoulder condition was not related to the work accident. (RX4 at 2). Instead, he felt it was more likely Petitioner suffered an atraumatic onset of leg shoulder rotator cuff tear and may benefit from left shoulder arthroscopy. (RX4 at 2). This is supported by the histories Petitioner reported to Drs. Johnson and Erickson of "new" left shoulder pain at this time. In addition, Petitioner testified that her left upper extremity complaints at this time were "different" than before.

Dr. Tonino's opinion matches the Petitioner's own history on January 17, 2012 when she stated that her left shoulder problems were not caused by an auto accident, were not caused by work, there was no injury date. (PX 11 p.5)

Since the accident, it appears Petitioner's left sided symptoms and complaints have been related to a pre-existing and non-work related condition. This condition is not a shoulder specific injury, as is indicated by the fact Petitioner's left arm pain is almost always accompanied by leg pain. Were Petitioner's left arm pain caused by a left shoulder rotator cuff tear, it would be most unique for that tear to cause symptoms in other parts of her body.

On March 1, 2011, Petitioner reported to Dr. Johnson a recent incident of garbled speech, imbalance, and weakness on the left side. Petitioner began treating with Dr. Bajwa at NeuroMed Clinic the next day, and reported left arm pain that was accompanied by shooting left leg pain. (PX10 at 10). Dr. Bajwa ordered MRI scans of Petitioner's head and brain that revealed a pineal gland cyst. (PX10). Petitioner returned to Central DuPage on November 10, 2011 and reported feeling as if her left arm and leg had fallen asleep. (RX7 at 53). Petitioner was educated as to the signs and symptoms of a stroke and was advised to go to the ER if she experienced any of those symptoms. (RX7 at 56). Petitioner also underwent a lumbar MRI on March 7, 2012 to attempt to explain the leg symptoms. It was negative. On April 17, 2012 Petitioner complained to Dr. Echiverri of weakness in her legs and left shoulder. (PX10 at 5). Petitioner testified she suffered a stroke a Rush Hospital in August 2013 that caused left sided symptoms.

Based on the above, the Arbitrator finds Petitioner's pre-December 2011 complaints of pain to the left upper extremity were the result of radicular pain from the undisputed cervical herniation at C5-6. The Arbitrator finds Petitioner suffered an atraumatic onset of a small rotator cuff tear in late 2011 to early 2012, which is reflected in Petitioner's reports of shoulder pain onset at the time. The Arbitrator notes Petitioner suffers left sided symptoms throughout her body that are not related to cervical or shoulder problems. Along with the radicular complaints, the Arbitrator finds these complaints make up nearly all of Petitioner's left shoulder complaints, with the exception of those complaints in late 2011 to early 2012 that were the result of an atraumatic onset of a left shoulder rotator cuff tear. Therefore, the Arbitrator finds Petitioner suffered a herniated disc at C5-6 with left sided radiculopathy as a result of the work accident, and did not suffer a left shoulder injury.

The Arbitrator makes the following findings on the issue of: **(G) what were Petitioner's earnings?**

The Arbitrator finds Petitioner earned an AWW of $1192.11.

Section 10 of the Illinois Workers' Compensation Act indicates calculations of average weekly wage shall not include bonus or overtime. 820 ILCS 305/10. Petitioner has the burden of proving every element of her claim. To have her bonuses included in her calculation of her AWW, Petitioner must show that the bonuses were not discretionary.

Petitioner testified in her current position at Cintas she earns a salary with periodic bonuses. Petitioner asserted at trial the bonuses were partly related to whether sales were made to new clients, or to some clients over some others, which indicates the bonuses were not related to actual sales totals. She testified Respondent always made the last quarterly bonus larger than the previous three. Petitioner did not indicate how Respondent weighed any particular factors in determining the amount of the bonus, except for the increased bonus towards the end of the year.

Based on this, the Arbitrator finds Petitioner's bonuses were at the discretion of Respondent. Petitioner was unable to provide any rhyme or reason regarding the amount of bonus money she was paid quarterly. Instead, the only evidence as to how the bonuses were calculated is her testimony that Respondent chose to increase the bonuses towards the end of the year and the holiday season. As the bonuses, are discretionary, they should be excluded from any calculations of AWW.

Respondent's Exhibit One is a list of Petitioner's earnings beginning with the pay period ending February 7, 2009. (RX1). It is apparent Petitioner earned $1191.16 in almost every week from that time through December 26, 2009. (RX1). At that time, Petitioner's pay increased to $1193.00, and it would stay at that rate through the date of accident. (RX1). For pay periods ending April 4, 2009, July 24, 2009, October 10, 2009, and January 9, 2010, Petitioner was paid $4,630.25, $36,656.45, $9,216.16, and $17,243.00, respectively. (RX1 at 1-2). When the weeks of these bonuses are omitted from the AWW calculation, we are left with a total of $56,028.97 in earnings over a 47 week period, yielding an AWW of $1192.11.

Based on the above, the Arbitrator finds Petitioner earned an AWW of $1192.11.

The Arbitrator makes the following findings on the issue of **(J) has Respondent paid all appropriate charges for all reasonable and necessary medical services?**

The Arbitrator finds Respondent has paid all reasonable and necessary medical expenses.

First, Petitioner failed to prove she is entitled to $660.00 in charges related to left shoulder treatment provided by Dr. Erickson in 2012 and 2013. (PX5). As an initial matter, Respondent's Exhibit 10 is a balance from SportsMed Wheaton Orthopaedics for Dr. Erickson's services. (RX10). It indicates that of the initial $660.00 in charges, $272.00 was reduced as exceeding either the fee schedule or an agreed upon rate, leaving a $388.00 balance that was then paid by Respondent's group insurance. Id. The current balance is $0. Id. The parties stipulated Respondent is due a credit of $388.00 for payments made by its group insurance. Therefore, there is no current outstanding balance from SportsMed Wheaton Orthopaedics for which Petitioner can request payment.

In the event the Arbitrator finds there is a balance remaining from SportsMed Wheaton Orthopaedics, Petitioner has failed to prove the balance is related to a work accident. As argued above, Petitioner failed to prove her left shoulder condition is related to the work accident. As a result, Respondent is not liable for the bills related to Dr. Erickson's services.

In addition, Dr. Erickson's treatment is the result of a third chain of referral, and Respondent is not liable. Petitioner testified she began treating with Dr. Milet, and that Dr. Milet referred her to Dr. McNally at

Suburban Orthopaedics. This is her first chain of referral. Petitioner testified she was not improving with her current course of treatment and that at her request she was allowed to begin treatment with Dr. An. This is her second chain of referral. Petitioner testified she was comfortable with Dr. An and Rush from her work encounters with the provider. Dr. An recommended a fusion on July 30, 2010, but noted Petitioner wanted a disc replacement surgery. (PX12). Dr. An again recommended a fusion on August 17, 2010. Id. He provided no referral for surgery, and as he is an orthopedic spine surgeon it is likely he intended to perform the procedure himself. This was the last time Petitioner saw Dr. An. At this time, she testified she chose to treat with Dr. Johnson at DuPage Neurosurgery. Dr. Johnson's notes do not contain any referral from any other physician. (PX9). This is her third chain of referral. Under the Act, Petitioner is limited to only two choices of physician. As Dr. Erickson saw Petitioner as a referral from Dr. Johnson, his care arises from the third chain of referral. Respondent is therefore not liable for any of Dr. Erickson's alleged charges.

Second, Petitioner is seeking reimbursement for a March 26, 2013 balance of $189.06 that she paid to Gottlieb Memorial. (PX3).

Respondent's Exhibit Eight is a Gottlieb Memorial Hospital bill. (RX8). It indicates a $275.50 charge for an x-ray exam performed as part of his November 20, 2012 exam. Id. On November 23, 2012, the balance was reduced from $341.50 to $136.60 as part of an "Uninsured Discount." Id. Respondent paid the balance, which was $136.60, on March 15, 2013. (RX8; RX3 at 1). At that time, Gottlieb revoked its "Uninsured Discount" and reinstated a balance of $189.06. (RX8). This was paid by Petitioner in an April 3, 2013 check. (RX8). Since that time, the balance has been $0.00. Id. Respondent agrees it liable for the cost of Dr. Tonino's exam and the associated x-ray exam. If Gottlieb Memorial Hospital does not reimburse Petitioner for the April 3, 2013 check, Respondent will resolve the charge directly with Petitioner.

Based on the above, the Arbitrator finds Respondent has paid all reasonable and necessary medical expenses and is not responsible for any additional charges.

The Arbitrator makes the following findings on the issue of **(L) what is the nature and extent of the injury?**

Based on the above, Petitioner failed to prove her left shoulder condition is causally related to the work accident. Instead, Petitioner suffered, as a result of the work accident, cervical spondylosis and left-sided radiculopathy associated with a herniated disc at C5-6, as diagnosed by Dr. An. (PX12). Petitioner was recommended a cervical fusion by Dr. An. Id. However, she declined, and chose to seek treatment with Dr. Johnson. Dr. Johnson recommended either an anterior cervical discetomy and placement of artificial disc or a fusion. (PX9 at 43). Petitioner chose the disc replacement surgery. The operative report indicates Petitioner had a cervical disc replaced, and did not have a fusion. (PX9 at 29-31). As Dr. Johnson explained, "[t]he advantages of disc replacement are as follows: [p]reserved cervical range of motion, less change of adjacent level degeneration, easier and faster recovery." (PX9 at 9).

Following the November 17, 2010 surgery, Petitioner reported she no longer had any radiating arm pain by December 1, 2010. (PX9 at 14). After a course of physical therapy, Dr. Johnson released Petitioner to

work as of December 29, 2010, with a return to full duty a few weeks later. Id. at 21. Petitioner returned to Dr. Johnson in December 2011 for some left arm pain and bilateral leg tingling. Id. at 27. This was the last time she sought any treatment for her neck. Petitioner's records indicate her recent treatment has been for headaches and strokes. (RX7 at 99, 77). There are no recent complaints of neck issues.

Petitioner testified in her current position at Cintas she performs uniform sales all over the Midwest. Petitioner testified she flies and drives to clients in Michigan, Indiana, Illinois, and Wisconsin. Petitioner testified she brings catalogues and samples with her to these clients. Petitioner testified she rarely takes any time off work. Respondent's Exhibit Five is listing of all sick time requested by Petitioner since 2010. (RX5). It indicates Petitioner has taken off only one day since returning to work in December 2010. Id.

Petitioner testified she has received pay increases since the accident. Respondent's Exhibit One shows Petitioner's earnings have increased steadily since 2009. (RX1-6). It also shows Petitioner has not had any lost wages since being off work immediately following the November 2010 surgery. Id. at 3-6.

Petitioner testified she currently feels some strain and stiffness in her neck. She testified she has left shoulder pain. She testified she has difficulty lifting overhead or brushing her hair with her left hand. Petitioner is right handed.

The evidence indicates Petitioner's cervical disc replacement surgery was a success. The surgery itself is intended to provide greater range of motion. Petitioner was off work for only five weeks as a result. She has no restrictions, has had no complications, and has required no treatment. Petitioner's current complaints are minimal, and appear to be related to her un-related left shoulder condition. Petitioner's current condition, as well as the case law, indicates she sustained permanent partial disability in the amount of 20% loss of use of the person as a whole.

The Arbitrator makes the following findings on the issue of (N) **is the Respondent due any credit?**

As noted *supra*, Petitioner failed to prove her bonuses should be included in a calculation of her AWW. Therefore, her AWW is $1192.11, with a resulting TTD rate of $794.74. As stipulated by the parties, Respondent paid Petitioner TTD benefits from November 17, 2010 through December 29, 2010, or 6 1/7 weeks. (Arb. Ex. 1). Using the correct TTD rate, Petitioner should have been paid $4,881.97. However, Respondent actually paid $7,635.57 in TTD. (Arb. Ex. 1). Therefore, the Arbitrator finds Respondent is entitled to a TTD overpayment credit of $2,753.60.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Daugherty,

Petitioner,

vs. NO. 13 WC041372

Pinckneyville Correctional Center,

15IWCC0749

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015 is hereby affirmed and adopted.

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

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

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

Pursuant to §19(f) (l) of the Act, there is no right to judicial review.

DATED: SEP 2 8 2015
SJM/sj
o-9/10/2015
44

Stephen J. Mathis

David L. Moore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

DAUGHERTY, WILLIAM
Employee/Petitioner

Case# **13WC041372**

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

15IWCC0749

On 1/5/2015, 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:

1580 BECKER SCHROADER & CHAPMAN PC
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0498 STATE OF ILLINOIS
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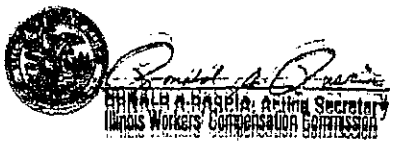
1350 CENTRAL MANAGEMENT SYSTEMS
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-0208

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

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

JAN 5 - 2015



STATE OF ILLINOIS)
)SS 15IWCC0749
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

WILLIAM DAUGHERTY
Employee/Petitioner

v.

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

Case # **13** WC **041372**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 23, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being in his lumbar spine *is not* causally related to the accident. Petitioner's current condition of ill-being in his right hand/wrist is causally related to the accident.

In the year preceding the injury, Petitioner earned $**58,680.00**; the average weekly wage was $**1,128.46**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**44,813.19** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**44,813.19**.

Respondent is entitled to a credit of $**if any** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner's right arm/wrist condition is causally related to the accident that occurred on May 23, 2013; however, Petitioner failed to prove he sustained a lumbar spine injury as a result of the May 23, 2013 accident. Petitioner's claim for prospective medical treatment for the lumbar spine is denied.

Respondent shall pay Petitioner temporary total disability benefits of $752.23/week for 7 weeks, commencing August 13, 2014 through September 30, 2014. Respondent shall receive a credit for TTD payments previously made.

Respondent shall pay reasonable and necessary medical services pertaining to Petitioner's right wrist as set forth in PX 15 per the stipulation of the parties and per the Medical Fee Schedule. Petitioner's claim for payment of medical bills found in PX 15 which relate to Petitioner's low back injury are denied. Respondent is to receive credit for any bills pertaining to Petitioner's right wrist that have been paid by its group medical plan pursuant to Section 8(j) of the Act.

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

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

15IWCC0749

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

December 19, 2014
Date

JAN 5 - 2015

WILLIAM DAUGHERTY v. PINCKNEYVILLE CORRECTIONAL CENTER,
Case No. 13 WC 041372 (19(b))

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner sustained an accident on May 23, 2013. There is no dispute that Petitioner injured his right wrist at the time of the accident. There is a dispute as to whether Petitioner injured his lumbar spine and that is the focus of the 19(b) hearing herein. The issues in dispute are causal connection, prospective medical, medical bills, temporary total disability benefits, and credit for overpayment of temporary total disability payments. Witnesses testifying at the hearing included Petitioner and James Goldsborough. Respondent had a representative, Michael Edwards, present throughout the proceeding.

The Arbitrator notes that proofs were closed on October 23, 2014. Thereafter, Respondent filed a Motion to Re-open Proofs and Supplement the Record. That Motion was heard on December 1, 2014 and allowed without objection. Proofs were re-opened that day to allow for the substitution of an exhibit. Proofs were closed that same day. A copy of the Notice of Motion and Order are included with the exhibits.

The Arbitrator finds:

Respondent entered into evidence records from Dr. Robert Eaton, a chiropractor at DuQuoin Health Center. (RX12) The records indicate that Petitioner began treating with Dr. Eaton in 2012. On the initial intake information sheet Petitioner indicated that he had current complaints of neck, left knee and back pain. Petitioner reported that he had experienced neck and back pain for 10 years. Petitioner acknowledged a motor vehicle accident in 1992. (RX 12)

On June 28, 2012, Petitioner presented for treatment with Dr. Eaton with the chief complaint of low back pain for 10 years "on and off." Petitioner reported that three years before he was on a riding lawn mower when it bounced over tree roots, and he was unable to get off the mower for two hours. Petitioner reported undergoing physical therapy which did not help. Petitioner reported that his pain began to get severe the day before and that he could not remember anything specific to injure it. Petitioner reported that he had experienced left-sided neck pain on and off for 10 years as well. Petitioner was treated with electric stimulation and hot packs. Petitioner's lumbar and cervical spine were also adjusted. (RX 12)

On June 30, 2012, Petitioner again presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that his pain was still there, but he had felt better since treatment. Petitioner received another adjustment. (RX 12)

On July 5, 2012, Petitioner presented to Dr. Eaton again with the chief complaint of low back pain. Petitioner reported that he was still very sore but overall he was 30-40% better since treatment began. Petitioner received an adjustment of the lumbar spine. (RX 12)

On July 9, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that he was still sore with dull aches off and on but had no sharp pain. Petitioner reported that he was around 50% better since he had begun treatment. (RX 12)

On July 12, 2012, Petitioner again presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that he did not have any substantial changes since his last treatment. Petitioner reported that he still had a dull ache most of the day. Dr. Eaton noted that Petitioner's adjustments had been similar the last few treatments. (RX 12)

On July 19, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that he was about 50% better, and that he experienced sharp pain very infrequently but had almost a constant dull ache. Dr. Eaton noted that Petitioner was still adjusting well, but there were 2-3 segments on both sides of the lumbar spine which had not mobilized yet. (RX 12)

On July 26, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported no change since his last treatment, but stated he felt better for about three days before the dull aches returned. (RX 12)

On August 2, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported he had frequent dull aches, but no sharp pain. Petitioner reported feeling very good for three to four days after his last treatment. (RX 12)

Petitioner presented to the Center for Medical Arts for an "Urgent Care Visit" on August 6, 2012. Petitioner reported mid to lower back pain on his left side that had begun on August 1, 2012. He denied any history of an injury. Petitioner described a sharp "knife-like" pain in his low back, without radiation. He noted he did lots of bending and squatting at work and that his symptoms were aggravated by bending, flexion and lying/rest. Petitioner also reported that he had a history of periodic back pain over the last three years which had started after he hurt himself. He had previously been told he possibly had a bulging disc but no x-ray was done at that time. Some physical therapy had helped but he still noted occasional flare-ups. This most recent episode had begun about 1 1/2 months earlier. The doctor noted Petitioner had been doing a lot of stooping and bending delivering meals to inmates during lockdown. Petitioner also noted that he had been seeing Dr. Eaton without much relief and had gone to Dr. Fasnacht three weeks earlier and been given soma. It helped initially but he had been hurting so badly since August 1st, that he had missed work since then and didn't think he could go in for the next few days. Petitioner was

given medication and a lumbar spine revealed severe degenerative disc space narrowing at L4-5 and mild osteophytes. Petitioner was taken off work pending his appointment with Dr. Fasnacht on August 9th. (RX 10)

Petitioner was seen by Dr. Fasnacht on August 9, 2012 regarding his back. Petitioner was requesting work restrictions Dr. Fasnacht described Petitioner's condition as acute on chronic lower back pain exacerbated by morbid obesity with findings of severe osteoarthrits of the lumbar spine. He was released to return to work with restrictions and his condition was to be monitored closely. (RX 10)

As of August 17, 2012 Dr. Fasnacht, re-examining Petitioner's low back, noted Petitioner had injured his low back two years earlier and that he was experiencing pain, stiffness, and decreased range of motion. He denied any lower extremity symptoms. Chiropractic care with Dr. Eaton was to be formalized that day. (RX 10)

On August 30, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that overall he had done well since his last visit. Petitioner reported that he was still having dull aches most of the time, but almost no sharp pains. Petitioner reported that he was 50-60% better but had plateaued there. (RX 12)

On September 5, 2012, Petitioner presented to Dr. Eaton with a chief complaint of low back pain. Petitioner reported that he still had dull aches most of the day and no sharp pain. Petitioner reported that he was staying in the 50-60% improvement range. (RX 12)

Dr. Fasnacht continued to see Petitioner for a variety of health issues, periodically checking on Petitioner's "chronic" back pain. He eventually released Petitioner to return to full duty for his back as of November 8, 2012. (RX 10)

On May 23, 2013, Petitioner completed an Adult and Juvenile Divisions Incident Report pertaining to an accident on May 23, 2013 at 4:05 a.m. (RX2) Petitioner stated that "[o]n the above date and approx. time this R/O was counting R5 Cwing when I/M Jones...started to have a seizure. This R/O called a code 3. HCU staff treated I/M Jones...and took him to HCU." (RX2) Petitioner also marked "NO" to the question regarding if there were any injuries or hospitalizations. (RX2)

According to Petitioner's timesheets, Petitioner worked until June 4, 2013 when he began a leave of absence. (RX5)

Petitioner presented to Dr. Elbert Fasnacht on June 7, 2013 with "chronic low back pain." (PX1) Dr. Fasnacht noted that Petitioner's condition occurred when "lifting a prisoner onto a

backboard" at work one week prior. Petitioner's symptoms included pain, stiffness and decreased range of motion. The onset was "gradual immediately after the injury." Petitioner denied any leg weakness or numbness. Dr. Fasnacht further noted Petitioner was currently unable to work since "the date of injury last [T]uesday 5/28/2013." On examination Dr. Fasnacht noted moderate tenderness. Petitioner's pain "accumulates" with activity and on movement and refers to buttocks on affected side. Dr. Fasnacht's impression was chronic recurrent, persistent back pain associated with obesity. His plan was to monitor closely with appropriate repeat evaluation and adjust management over time. Needs aggressive weight loss. Dr. Fasnacht also noted sciatic pain. According to the "story," 6/7/2013 recurrent pain with lifting event in the workplace o tue nite 5/28/2013 with pain requiring him to leave work with persistent pain for the last 4 days, he was helping a guy pack a couple weeks ago and it started bothering him, Tuesday he said the pain became worse than what it was." Medication was prescribed and restricted work activities were discussed. A return to work excuse was given to Petitioner with a specific date given for release. (RX 10)

On June 11, 2013 Petitioner completed an Employee's Notice of Injury form. (RX1) Petitioner reported that he injured his lower back, left knee, and right forearm on May 23, 2013 when he was "carrying an inmate out of the cell house on a backboard." Petitioner added "inmate on a backboard, strapped him down and carried him out of the cellhouse where I placed him on a small ambulance vehicle for transport to the HCU." Petitioner listed Major Edwards and Lt. Jordan as witnesses. Petitioner's last day of work was June 1, 2013. Petitioner also indicated that he had not reported any injury on the date of the incident because he didn't realize the extent of his injuries for a few days.

On June 11, 2013 Petitioner completed another Incident Report. (RX3) Petitioner stated that he had carried inmate Jones out on a backboard following a code 3. Petitioner stated that he did not report any injury at the time of the incident but in the following days he had severe back pain, his left knee was swollen, and he had pain in his right forearm.

Petitioner followed up with Dr. Fasnacht on June 18, 2013 in a visit primarily focused on Petitioner's hypertension. However, Dr. Fasnacht also reviewed Petitioner's low back, right wrist, and left knee pain. Petitioner's left knee was examined. The doctor did not mention any swelling. He did indicate Petitioner had complaints of pain. With regard to Petitioner's low back he noted chronic persistent pain with little benefit from conservative management. Petitioner remained off work with no plan to return to work. Dr. Fasnacht's impression was chronic recurrent back pain associated with obesity and disability. X-rays were ordered. No other changes were made to Petitioner's treatment plan for his low back. (PX1; RX 10)

Dr. Fasnacht saw Petitioner again on June 24, 2013 but only for his right wrist and forearm. Petitioner was scheduled for a CT scan of his wrist as Petitioner felt like something was torn i his

wrist. Dr. Fasnacht noted, "pain right wrist and forearm S/P Work incident on 5/23/2013 involving low back pain lifting inmate on a back board." (RX 10)

On June 26, 2013 Major M. Edwards completed an Incident Report. (RX4) Major Edwards wrote that Petitioner did not report any injury to him on May 23, 2013 or any other day prior to June 26, 2013. Major Edwards also commented on Lt. Cynthia Jordan's knowledge of any accident/injury as she had been named as a witness. Major Edwards noted that Lt. Jordan reported having no knowledge of Petitioner's alleged injury, Major Edwards stated that Petitioner had reported to work as scheduled from May 23, 2013 until June 4, 2013 at which time he began calling in sick. Major Edwards stated his belief that if petitioner had injured himself on May 23, 2013 he had ample time to report it earlier but failed to do so. (RX 4)

On June 28, 2013 Dr. Fasnacht scheduled a CT lumbar scan at Petitioner's request. Petitioner also wanted one for his knee. (RX 10)

Petitioner returned to see Dr. Fasnacht on July 10, 2013. Dr. Fasnacht noted persistent pain and disability in Petitioner's right forearm, left knee and low back. The plan was to evaluate Petitioner every month for two months. (RX 10)

On July 16, 2013 Petitioner underwent an MRI on his lumbar spine and his right arm. (RX11) The MRI of Petitioner's lumbar spine showed central canal stenosis at L4-L5, bilateral foraminal stenosis, L4-L5 and L5-S1, right greater than left. The MRI of Petitioner's right arm showed a small joint effusion in the radiocarpal joint, and there were no other remarkable abnormalities identified.

On July 19, 2013 Petitioner again returned to Dr. Fasnacht. Dr. Fasnacht telephoned Dr. Jones' office and left a message about an appointment for Petitioner.

On July 31, 2013 Petitioner presented to Dr. Fasnacht with wrist tendonitis. (PX1) Petitioner reported pain, swelling, and stiffness located in the right dorsal wrist with pain radiating in to the right forearm. Dr. Fasnacht noted that Dr. Jeff Jones' office was called on July 19, 2013 to schedule Petitioner to be seen for his low back pain. With regard to his right wrist, Dr. Fasnacht noted that Petitioner was being sent for a physical therapy evaluation and referred to Dr. Brett Miller, an orthopedic surgeon. Petitioner was kept off work. Dr. Fasnacht described Petitioner's back condition as a back strain occurring on May 23, 2013. (RX 10)

Petitioner began therapy for his right wrist on August 5, 2013. (PX 12)

On August 27, 2013 Petitioner was seen for a re-evaluation of his "work-related" health problems which he described as a back strain. lumbar spine and right wrist. Petitioner's condition

was noted as a work-related back strain. Petitioner was to remain off work until his evaluation on September 9, 2013. (RX 10)

On August 30, 2013 Petitioner completed a patient intake questionnaire for Dr. Steven Young. (PX2) Petitioner reported that he injured his right wrist and forearm when lifting an inmate on a backboard.

On September 9, 2013 Petitioner was seen by Dr. Young. Petitioner gave a history of experiencing pain in the radial aspect of the right wrist when lifting a prisoner onto a gurney. Petitioner reported that he had a pain level of 8/10. Petitioner was diagnosed with right de Quervain's tenosynovitis. Petitioner was given a thumb spica splint, Flector patches, and an injection at the first dorsal compartment of the right wrist. Petitioner was ordered to continue therapy three times a week for the next four weeks. Petitioner was given restrictions of left upper extremity work only. (PX 2)

On September 27, 2013 Petitioner completed a patient intake questionnaire for Dr. Jeffrey Jones. (PX3) Petitioner reported that he injured himself at work on May 23, 2013 when lifting an inmate on a backboard. Petitioner was seen by Dr. Jones' physician's assistant on that same date. (PX3, PX14) The history contained in the record reported that Petitioner had a four month history of low back pain and left lower extremity pain and parasthesias which radiated to his knee. Petitioner's symptoms began with tripping over an object while carrying an inmate that had had a seizure on a backboard. Petitioner was assessed with a "backache." It was recommended that Petitioner exhaust all conservative treatment options prior to considering surgical intervention. It was further noted that Petitioner would begin 4-6 weeks of physical therapy and that he would follow up in 6 weeks.

Petitioner returned to see Dr. Fasnacht on October 2, 2013 for his "work-related" back strain of May 23, 2013. Petitioner reported difficulty arising from a kneeled position or a chair, donning shoes and socks, dressing himself, climbing up and down stairs, walking, using his right wrist and forearm, grasping, pinching, and lifting with his hand. Petitioner was referred for both orthpedic and neurological consultations. (RX 10)

Petitioner began therapy for his back on October 3, 2013. It ended on October 31, 2013 as Petitioner had stopped attending. (PX 12)

On October 7, 2013 Petitioner followed up with Dr. Young. Petitioner reported no change in his symptoms. On physical exam he had a slight swelling over the radial aspect of the wrist, primarily over the first dorsal compartment. Dr. Young noted most of his pain was with palpation over the first dorsal compartment. Dr. Young recommended a right de Quervain's

release. Dr. Young reiterated Petitioner's restrictions of left upper extremity work only pending authorization for surgery.

Dr. Jones' office kept Petitioner off work as of October 31, 2013; however, no office note pertaining to an examination is in the record. (PX 3)

On December 10, 2013 Petitioner signed his Application for Adjustment of Claim. (AX 2)

Petitioner was seen by Dr. David Robson on May 27, 2014 for a Section 12 exam at Respondent's request for his lumbar spine condition. (RX7) Dr. Robson's narrative report noted that Petitioner had injured himself while walking backwards carrying an inmate on a backboard, and that he tripped over a medical bag and fell hurting his right wrist, left knee, and lower back. Dr. Robson noted that Petitioner reported only an "occasional history of lower back pain problems," and that the last time he went to the chiropractor was three to four years prior to the injury. Petitioner's physical exam revealed negative straight leg testing bilaterally, active flexion of the spine at 70 degrees and no tenderness on palpation. An antalgic gait was noted. Dr. Robson opined that Petitioner had sustained a lumbar strain superimposed on his pre-existing lumbar spondylosis and noted objective findings of reduced flexion and trace weakness in Petitioner's left quadricep. Dr. Robson stated that Petitioner's lumbar strain had since resolved and he was capable of working full duty and required no further treatment. (RX 7)

On June 12, 2014 Petitioner was seen by Dr. James Williams for a Section 12 exam at Respondent's request regarding his right upper extremity condition. (RX9) Dr. Williams noted that Dr. Young has put him on restrictions of no use of the right hand with a brace and full use of the left hand. (RX 9 at 1). Petitioner continued working until June 1, 2013 when the right wrist was swollen and painful. (RX 9 at 2). Dr. Williams noted Petitioner's job duties as a correctional officer included cuffing and uncuffing inmates, using large and small keys as well as Folger Adam keys in order to open up doors. (Id.) Dr. Williams also stated Petitioner did wing checks, which includes passing ice in segregation, passing food trays, doing shakedowns of cells, and lifting property boxes. (Id.) Dr. Williams noted that he visited Pinckneyville Correctional Center, himself, on July 12, 2011 for 2 ½ to 3 hours and on that day he, himself, performed many of the activities as a correctional officer. (RX 9 at 2). Dr. Williams noted that Petitioner was right hand dominant. (RX 9 at 3). Dr. Williams noted that Petitioner's right wrist pain was rated at a 10 when aggravated. (RX 9 at 3). Dr. Williams stated that he believes that Petitioner had right wrist de Quervains tenosynovitis and Dr. Williams attributed that to the injury which occurred to him on May 23, 2013 when lifting the gurney with the inmate on the back of a golf cart. (RX 9 at 6, 7).

Dr. Williams felt the treatment that had been rendered was reasonable and necessary and he felt non-operative measures had been exhausted. (RX 9 at 7). Dr. Williams noted that currently he would keep Petitioner at full use of his left hand and no use of his right hand with a forearm based thumb spica splint in place. (RX 9 at 7). Dr. Williams would also restrict him from activities of daily living or use of the right hand for any lifting or any significant use of the right hand other than to bathe and/or cloth himself. (Id.) Dr. Williams noted that he believed Mr. Daugherty had exhibited good effort and that he did not believe there was any evidence of symptom magnification or malingering. (RX 9 at 7). Dr. Williams felt the treatment that had been rendered was reasonable and necessary and Dr. Williams felt the surgery, which had been proposed by Dr. Young, was indeed directly related to the injury which occurred to Mr. Daugherty on May 23, 2013. (Id.)

On July 29, 2014 Petitioner followed up with Dr. Young. (PX2) Dr. Young advised Petitioner was going to be scheduled for a right de Quervain's release.

Dr. Jones, a neurosurgeon, testified via evidence deposition on July 29, 2014. (PX14) Dr. Jones testified that he has never personally seen or examined Petitioner. (PX14, pg. 17) Dr. Jones stated Petitioner was seen by his PA Angie Arnold. (PX14, pg. 6) Dr. Jones admitted that he had not reviewed any of Petitioner's prior treatment records from Dr. Fasnacht or Dr. Eaton. Dr. Jones testified that Petitioner had a pre-existing bad back, but that he believed Petitioner had an acute disc herniation at L4-5 on top of what was old spondylosis and disc bulging. Dr. Jones testified that the only area of Petitioner's back that he related to the May 23, 2013 incident was the disc herniation at L4-5. (PX14, pg. 24) Dr. Jones testified that it was possible that either lifting the inmate or falling and trying to catch himself could have caused petitioner's acute disc herniation. (PX 14, p. 11) Dr. Jones further testified that on Petitioner's MRI at L4-5 there was an area in the annulus that looked more acute because it had a higher signal on T2. (PX14, pg. 20) Dr. Jones testified that due to the fact that Petitioner already had advanced degeneration of his lumbar spine this would have likely happened to him over time anyway. Dr. Jones admitted that if the accident that Petitioner described did not happen as he related it to Dr. Jones' PA then that could change Dr. Jones' opinion. (PX14, pg. 44)

Dr. Jones also testified that he would largely defer to Dr. Robson's opinions on Petitioner since he had seen Petitioner more recently. (PX 14, p. 31) On redirect examination Dr. Jones was given the opportunity to skim Dr. Robson's report. He also believed it was possible that the accident could have exacerbated what was clearly a pre-existing condition, given that this was a "significant event." (PX 14, p. 12)

Dr. Jones noted that as far as treatment, Petitioner would probably need a new MRI and epidurals might also be good for getting rid of the acute inflammatory process. He also discussed the possibility of therapy and a small surgical procedure depending upon the existence of any ongoing leg complaints. (PX 14, pp. 13 - 15)

On August 13, 2014, Dr. Steven Young performed an operation to repair Petitioner's right wrist performing a de Quervain's release with a post-operative diagnosis of right de Quervain's tenosynovitis. (PX 11 at 1). On August 27, 2014 Petitioner was returned to work with no use of the right upper extremity; however, he was given permission to write with a pen. (PX 2 at 35). Petitioner returned on September 29, 2014 to Dr. Young with Petitioner complaining of having more pain than what he was having prior to surgery, which, in Dr. Young's opinion, was a very rare instance. He noted that Petitioner worked at the prison and was not yet back to work. (PX 2 at 39). Dr. Young noted Petitioner had a positive Finkelstein's test and had pain over the first dorsal compartment with palpation. (Id.) Dr. Young felt that Petitioner needed physical therapy to work aggressively with modalities, strengthening and range of motion. (PX 2 at 39). Dr. Young also placed Petitioner on a Medrol Dosepak. (Id.) Petitioner was to remain on light duty. (Id.)

Dr. Robson testified via evidence deposition on August 21, 2014. (RX8) Dr. Robson testified that he had reviewed records from Dr. Fasnacht, Dr. Young, and Dr. Jones. Dr. Robson testified he had also reviewed the imaging studies from Petitioner's lumbar spine x-ray of 9/19/13, CT of his lumbar spine on 7/3/13, and the MRI of his lumbar spine on 7/16/13. (RX8, pg. 7) Dr. Robson opined that he believed Petitioner had suffered a lumbar strain on May 23, 2013 which had since resolved, and the basis for that opinion was his prior history of low back pain and sciatica. Dr. Robson testified that he believed Petitioner's current complaints were as a result of his congenital and degenerative spine conditions. Dr. Robson did not believe that the films showed a disc herniation at L4-5 or L5-S1. (PX8, pg. 12) Dr. Robson disagreed that Petitioner's MRI showed a higher signal on T2 or a higher STIR signal, and he testified that the radiologist did not report it either. Dr. Robson believed that Petitioner would have recovered from his strain by the fall of 2013. (RX 8, pp. 10 - 13)

On cross-examination Dr. Robson acknowledged that it was possible the accident aggravated Petitioner's underlying condition. (RX 8, p. 18) He also agreed that the MRI findings at L4-5 could be acute and that Petitioner's injury was more than just a lumbar strain. (RX 8, p. 19) Dr. Robson had no quarrel with Dr. Young's treatment. (RX 8, p. 19) Dr. Robson agreed with the medical treatment plan as laid out by Dr. Jones. When answering the question about recommendation for work status, Dr. Robson replied:

> The condition, which I'm not attributing completely to this injury, I would say that this condition in -- would cause for a light duty restriction, which would be 20 to 30 pound lifting limits, no repetitive bending, stooping, twisting, or awkward positions. (RX 7 at 21).

Dr. Robson also stated that a lifting incident could have strained Petitioner's back and also done damage to the disc as well. (RX 7 at 25). Dr. Robson admitted that he could not absolutely say there wasn't an acute component. (RX 7 at 29).

On August 27, 2014 Petitioner followed up with Dr. Young post-surgery. (PX2) Petitioner reported that his pain was minimal. Petitioner was offered therapy, but he stated he would do exercises on his own. Dr. Young advised Petitioner could return to work with no use of his right upper extremity.

On September 29, 2014 Petitioner was again seen by Dr. Young. (PX2) Petitioner reported having more pain than he did prior to surgery. Dr. Young ordered aggressive physical therapy.

Dr. Jones completed an Authorization for Disability Leave and Return to Work on October 31, 2013. It noted Petitioner was last seen on September 27, 2013 and no follow-up was scheduled pending authorization for LESI. Petitioner was limited from standing, climbing, bending, use of hands, stooping, and lifting.

Petitioner testified at arbitration on October 23, 2014. Petitioner testified on direct examination that on May 23, 2014 an inmate had a seizure and Petitioner had to get the inmate out of his cell and put him on a backboard to carry him out of the cell house. Petitioner testified that he and Officer Goldsborough picked up the inmate on the backboard. Petitioner testified that he was walking backwards carrying the inmate out of the cell house, and one of the nurses was holding the front door of the cell house open. Petitioner testified that the nurse had a large medical bag and that he did not see it and he stumbled over it on his way out of the door. Petitioner testified that then he had to pick the inmate up with the backboard to put him on the golf cart they used for an ambulance, and at that time he felt a pop in his right wrist. Petitioner testified that he felt something in his back when he stumbled over the bag in the doorway.

On cross-examination Petitioner was asked to review his incident report and notice of injury and the fact that he did not report stumbling or falling over a medical bag. Petitioner testified that he thought he did report it, but upon examination admitted that he did not. Petitioner testified that he did not fall to the ground, but that he had a slight trip. Petitioner denied telling Dr. Robson that he fell to the ground. Petitioner also denied telling Dr. Jones that he fell to the ground.

Petitioner testified that he did not say anything about his back at the time because he thought it would get better. Petitioner testified that he worked for another week but that the pain kept getting worse. Petitioner testified that after a week his back was hurting "so bad I couldn't hardly walk," and that his wrist had swelled up and looked like there was a golf ball under his skin.

Petitioner testified that he underwent surgery for his right wrist on August 13, 2014 and was still getting treatment for his wrist. Petitioner testified that at his last appointment the doctor had ordered another four weeks of physical therapy.

Petitioner testified that he is still awaiting approval to have an injection in his low back. Petitioner testified that he still experiences constant pain in his back, and that, at times, it will get to the point where he walks with a limp.

Petitioner was asked on cross-examination if he could have gone through his group health insurance to obtain the injections, and Petitioner testified "Not that I know of". However, petitioner later admitted that he became aware that he could obtain treatment through his group health insurance 6 months later. Petitioner then testified that he has not gone through his group health insurance to get the injection because he had to have a denial letter from work comp, but he had never received a denial letter. Petitioner eventually admitted that he had no idea whether or not he ever received a denial letter.

Petitioner testified that before May 23, 2013 he had had prior back problems, and had seen a chiropractor about 6 months before his accident. Petitioner testified that during the six months since his last chiropractor visit and his accident he had experienced a little pain but it was not horrible.

Petitioner was asked on cross-examination if he had told Dr. Robson that he had not treated with a chiropractor for three to four years, and he admitted that he didn't know. Petitioner was then asked if he had any reason to dispute Dr. Robson's records and testimony which stated Petitioner had denied treating with a chiropractor for three to four years. Petitioner testified, "I know I've seen a chiropractor a couple of times. I don't remember exactly when I did."

Petitioner testified that after the accident on May 23, 2014 his back hurt worse than it ever had before. Petitioner testified that if his back hurt before, it would usually get better after taking it easy for a week. Petitioner testified that since May 23, 2013 his back has never gotten better.

On cross-examination Petitioner was asked how severe his back pain was prior to his accident. Petitioner testified that it was probably about a two to three on a scale of ten. However, after review of his chiropractor's note on June 28, 2012 Petitioner admitted that he would describe that pain as more than a two to three.

On cross-examination Petitioner admitted he has a business called Daugherty's Armory selling guns part-time. Petitioner testified that he did not have an active shop and had closed it three years prior. Petitioner testified that he no longer maintains a supply of guns at his shop.

However, Petitioner admitted that he had sold guns since May 23, 2013. Petitioner estimated that he had sold approximately 20 guns since that date.

Respondent called James Goldsborough as a witness. Mr. Goldsborough is a correctional officer at Pinckneyville Correctional Center. Mr. Goldsborough testified that he did recall the May 23, 2013 incident where he and the Petitioner carried an inmate out of segregation on a backboard. Mr. Goldsborough testified that he did not see the Petitioner stumble or trip over a medical bag. Mr. Goldsborough testified that when going through the doorway he was in the lead facing forwards with the stretcher behind him. Mr. Goldsborough testified that Petitioner was behind him facing the same direction. While Mr. Goldsborough did not see Petitioner the entire time and figured there was a medical bag on the floor somewhere he probably would have felt it if Petitioner had stumbled or tripped. In addition, he did not recall having to step over a medical bag.

The Arbitrator concludes:

1. Issue (F) Is Petitioner's current condition of ill-being causally related to the accident?

The parties stipulated that Petitioner's right arm/wrist condition is causally related to the accident that occurred on May 23, 2013. The Arbitrator concludes that Petitioner failed to prove that his current condition of ill-being in his lumbar spine is causally related to his May 23, 2013 accident.

While accident is not in dispute, the details of the accident are critical to the causation determination between Petitioner's low back and the accident. Petitioner's testimony that he stumbled over a medical bag is not consistent with the early medical records and other documents in evidence. Petitioner completed an Incident Report on the day of the occurrence. He denied any injury and made no mention of stumbling/tripping over anything. Petitioner continued working full duty until approximately June 1, 2013 or June 4, 2013 when he began a leave of absence. (RX 4)

When Petitioner presented to Dr. Fasnacht on June 7th he gave a history of "lifting a prisoner onto a backboard." He made no mention of a trip or stumble. Petitioner completed a Notice of Injury form and a second Incident Report on June 11, 2013. In addition, Petitioner told Dr. Fasnacht that he had been helping a guy pack a couple of weeks before his visit of the 7th and his back started bothering him. He also noted that Petitioner's pain became worse on Tuesday, May 28, 2013 than it had been. (RX 10)

Petitioner made no mention of a trip or stumble in either report. Lt. Jordan, who was present at the time of the accident, was questioned regarding her knowledge of an accident/injury and she denied same. (RX 4)

When Petitioner initially presented to Dr. Young he reported injuring his right wrist and forearm when lifting an inmate on a backboard. He made no mention of a trip or stumble.

The first mention of a trip is found in Dr. Jones' records of September 27, 2013. When Petitioner was then examined by Dr. Robson on May 27, 2014 he not only mentioned tripping but he also said he fell. Petitioner never provided any testimony to explain why he never mentioned tripping prior to September 27, 2013. He simply testified that he thought he had mentioned it in his incident report but when it was shown to him, he acknowledged he had said nothing.

At the hearing Petitioner testified on cross-examination that it was just a "slight trip." Petitioner denied telling Dr. Jones or Dr. Robson that he fell. When asked if he told Dr. Robson he had not treated with a chiropractor for three to four years before his accident, he replied that he didn't know. Petitioner went on to testify that he knew he'd seen a chiropractor a couple of times but didn't recall exactly when that was. Petitioner further testified that after the accident he didn't think "it" was all that bad; however, he continued to work hunched over and opening the chuck holes and the pain got worse and he was finally prompted to go to the doctor when he ended up with a knot about the size of a golf ball on his wrist and he couldn't use it anymore. Interestingly, Petitioner did not mention his wrist to Dr. Fasnacht when he presented on June 7, 2013. That came up at the next visit on June 18, 2013.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). Preponderance of the evidence is "evidence which is of greater weight or more convincing than the evidence offered in opposition of it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Gonzales v. United Airlines, Inc.*, 03 IL.W.C. 30483, 09 I.W.C.C. 0458 (2009), citing *Jones v. J. Rubin Co,* 98 IL.W.C. 7779, 02 I.I.C. 0142 (2002). "Among the factors to be considered in determining whether a claimant has sufficiently carried his burden is his credibility." *Id.* At trial, a "witness' credibility is always in question." *Bish v.Guiseppe's Pizza*, 07 IL.W.C. 27341, 09 I.W.C.C. 0382 (2009). Credibility is the quality of a witness which renders his evidence worthy of belief. *Gonzales*. It is the Arbitrator's duty to evaluate a witness' credibility, as well as, "the witness's demeanor and internal and external inconsistencies in his testimony." *Id.*

A claimant's testimony, "standing alone, may support an award where all of the facts and circumstances do not preponderate in favor of the opposite conclusion." *Sieber v. Indus. Comm'n*, 82 Ill.2d 87, 97, 411 N.E.2d 249 (1980). However, "when the claimant's testimony is virtually the only evidence favoring an award, and that testimony is repeatedly contradicted by the record, then it is this court's duty to disallow the claim."

Caterpillar Tractor Co. v. Indus. Comm'n, 73 Ill.2d 311, 315, 383 N.E.2d 220, 222 (1978).

As discussed above, Petitioner's medical records are inconsistent with regard to the details of the accident itself.

Petitioner also told Dr. Robson that he had not treated with a chiropractor for his back in three to four years; however the medical records reflect that Petitioner had treated with a chiropractor less than nine months prior to his accident. The Arbitrator finds that in light of the many inconsistencies at issue in this case the Petitioner's testimony is less than credible.

The Arbitrator is not persuaded by the opinions of Dr. Jones. Dr. Jones has never met nor examined Petitioner, and he admitted he had not reviewed any prior treatment records. Dr. Jones also admitted on cross-examination that if the history provided to his office was incorrect, his opinions could change. That history was incorrect.

While Dr. Fasnacht and Dr. Robson both felt Petitioner might have sustained a back strain as a result of the accident, those opinions were based upon inaccurate histories. Petitioner told Dr. Robson he was walking backwards, tripped and fell hurting his right wrist, back, and left knee. Petitioner didn't fall and he didn't injure his right wrist in any alleged fall. Petitioner injured his right wrist when he felt a pop in it while lifting up the gurney. Similarly, Dr. Fasnacht had an incorrect history. Therefore, their opinions are given no weight.

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

Petitioner is awarded temporary total disability benefits from August 13, 2014 through September 30, 2014, a period of 7 weeks, because the parties stipulated on the record that Petitioner was off work during that period of time for his work-related right wrist injury. The parties disputed the time period from June 9, 2013 through June 11, 2014 when Petitioner was off work for his low back. The Arbitrator declines to award Petitioner temporary total disability benefits for that period of time based upon her causation determination above.

3. Issue (K): Prospective Medical Care.

The Arbitrator declines to award Petitioner any prospective medical care consistent with her causation determination pertaining to Petitioner's low back.

4. Issue (K): Other - Overpayment of Temporary Total Disability Benefits.

Petitioner has been awarded seven weeks of temporary total disability benefits. The parties stipulated that Respondent has paid $44,813.19 in TTD benefits for which it should receive credit.

5. Issue (J): Medical Bills.

Petitioner's medical bills are set forth in PX 15. The parties stipulated that Respondent would be responsible for those bills pertaining to Petitioner's right wrist/hand injury. Therefore, they are awarded pursuant to the Stipulation of the parties. Consistent with her causation analysis above, Petitioner is not awarded any bills pertaining to treatment for his low back.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY BUCIO,

Petitioner,

vs. NO: 12 WC 13065

DIVERSIFIED RECYCLING,

Respondent.

15IWCC0750

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner worked for Respondent, assisting in the processing and sorting of recyclable materials. Prior to November 6, 2011 he had never been prescribed glasses or contact lenses.

2. On November 6, 2011, Petitioner was tasked with fixing a conveyor belt, which required him to drill holes into metal. He was working with his supervisor indoors, but there was inadequate lighting. Due to this inadequacy, he removed the safety goggles he was wearing in order to obtain better vision.

3. While drilling, a bracket broke and Petitioner felt something in his left eye. He then

went to the restroom and noticed a black spot in his eye.

4. Petitioner informed his supervisor, and was provided with some eye drops, which did not solve the problem. Subsequently the supervisor recommended that Petitioner rub Vick's Vapor Rub on his face.

5. Three days later Petitioner began losing his eye sight in his left eye.

6. On February 7, 2012 Petitioner was diagnosed with ocular penetration and was referred to the Illinois Eye Infirmary.

7. On February 18, 2012 he complained of left eye pain, redness and photo phobia. He underwent emergency surgery to remove metal out of his eye, and did not return to work until March 5, 2012. However, at that time he still had no vision in his left eye. The following day Petitioner brought a letter in authored by his doctor, which indicated that he was legally blind in his left eye. He was subsequently terminated.

8. On May 22, 2012 Petitioner received a contact lens from the Illinois College of Optometry. He must return for a new lens every 6 months for the remainder of his life. With the lens, he testified that he can see "a little bit," but cannot distinguish small things, such as facial features, at a distance of 7 feet. At a distance of 20 feet he is unable to distinguish a man from a woman.

9. Petitioner underwent an Independent Medical Examination (IME) with Dr. Golden-Brenner on December 16, 2013. Using the American Medical Association's "Guides to the Evaluation of Permanent Impairment," Dr. Golden-Brenner found a 0.4% of an eye impairment rating. Dr. Golden-Brenner also noted that Petitioner was a 45 year old Laborer at the time of accident, noted his current earnings of $14.25/hr. at his place of new employment (which is more than what he earned working for Respondent), and noted that Petitioner must visit an optometrist every 6 months for the remainder of his life to receive new contact lenses. However, Petitioner can only wear the lenses 8-10 hours daily, which means he must navigate the rest of each day without vision in his left eye. He also must use lubricating drops in his eye.

Regarding permanent partial disability, the Commission views the evidence in a slightly different manner than does the Arbitrator, and thus modifies the award up to a 45% loss of use of Petitioner's left eye.

Using the American Medical Association's "Guides to the Evaluation of Permanent Impairment" evaluation, the Commission finds that the appropriate permanent partial disability award is a 45% loss of use of Petitioner's left eye. The impairment finding of Dr. Golden-Brenner is credible and unrebutted. Furthermore, Petitioner was only 45 years old at the time of accident, which is not a significant detriment to his employability, as is evidenced by the fact that he now earns more than he did pre-accident.

15IWCC0750

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 72.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 45% loss of use of Petitioner's left eye.

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 $42,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 8 2015
DLG/wde
O: 7/30/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCIO, ANTHONY
Employee/Petitioner

Case# **12WC013065**

DIVERSIFIED RECYCLING
Employer/Respondent

15IWCC0750

On 9/23/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0233 DePAOLO ZADEIKIS & GORE
DONNA ZADEIKIS
309 W WASHINGTON ST SUITE 550
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

15IWCC0750

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ANTHONY BUCIO
Employee/Petitioner

v.

DIVERSIFIED RECYCLING
Employer/Respondent

Case # **12** WC **13065**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 6, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**350.00**; the average weekly wage was $**18,200.00**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

- Petitioner has incurred medical bills in the amount of $30,458.44 as stipulated by the parties. The Arbitrator orders that pursuant to Section 7080.2 of the Administrative Code, "Payments of Proceeds on Litigation", Respondent will pay the fee schedule amount of Petitioner's bills directly to Petitioner's attorneys for the benefit of Petitioner. Respondent is ordered not to pay the providers directly.

- Respondent will pay to Petitioner TTD for 1 and 3/7 weeks at a rate of $286.00 per week.

- The Arbitrator finds that Petitioner has lost 25% of the vision in his left eye and is entitled to 40.5 weeks of compensation at a permanency rate of $286.00.

- The Arbitrator orders the Respondent to pay for future in medical in the form of the costs of necessary contact lenses and follow-up examinations for life *or* the intraocular lens implant procedure as recommended as a possible option by Dr. Carrie Golden-Brenner at Petitioner's discretion.

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

9/22/14
Date

SEP 23 2014

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

15IWCC0750

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY BUCIO,
Petitioner,

vs.

DIVERSIFIED RECYCLING,
Respondent.

Case No.: 12 WC 13065

ADDENDUM TO ARBITRATION DECISION

FINDINGS OF FACT

The Petitioner was employed by Respondent for three years prior to November 6, 2011. His job title was laborer. Petitioner testified that prior to November 6, 2011 he never wore glasses or contact lenses. Petitioner received an OSHA license to drive a lift.

At approximately 9:00 a.m. on November 6, 2011, the Petitioner was working at Respondent's plant in Homewood, Illinois. He was assigned the task of fixing a conveyor by drilling holes into metal in order to install a plastic guard so that the recycling materials would not fall off the conveyor. Petitioner testified that although he was working indoors, it was cold and his safety glasses kept getting foggy so he removed them. Petitioner was working side by side with his supervisor, Ernesto Valencia.

Petitioner testified immediately after the metal shard struck his eye he noticed a dark spot in his field of vision. Petitioner attempted to wash his eye and apply eye drops. Petitioner's supervisor also suggested that he apply Vicks vapor rub on his face to cause the eye to tear up. Petitioner testified that he followed his supervisor's advice to no avail.

Petitioner testified that by the third day after the accident, his left eye was red and he was beginning to lose his vision.

Medical Treatment

Petitioner sought assistance at a family medical clinic called "Aunt Martha's" as his eye condition was getting worse. Petitioner testified that the Aunt Martha clinic was unable to assist him and referred him to the Midwest Eye Center.

Petitioner testified that after three days, he had lost vision in his left eye and the eye was red and irritated.

On February 7, 2012, Petitioner presented to the Midwest Eye Center where a history of "drilling without safety glasses and getting metal in his left eye" was noted. Petitioner was diagnosed as suffering from "ocular penetration" and referred the Petitioner to the UIC Eye Infirmary. (PX. 2).

On February 18, 2012, Petitioner presented to the UIC Eye Infirmary, whose records reflect Petitioner's complaints of pain, redness and lack of vision in the left eye. (PX. 3). Petitioner was scheduled for same day surgery noted to be a pars plana vitrectomy lensectomy, intra ocular foreign body removal and orbital exploration.

The surgery resulted in the removal of the foreign body metal measuring .3 cm.

On February 28, 2012, Dr. Chow at UIC noted that Petitioner is "waiting to get a contact lens to improve vision in his left eye. He is legally blind without the contact lens. However, he has perfect 20/20 vision [in the] right eye. He can return to work but needs safety goggles at all times. No high heights." (PX 3).

On March 26, 2012, records from UIC documents vision without correction for finger counting at 1 foot. Vision with a +16 lens was 20/60 + 2. Petitioner's status post surgery was noted as "doing well; inflammation improved."

Petitioner testified that after surgery, he was blind in the left eye.

Petitioner testified that he was provided with a disability slip and off work instructions from February 18, 2012, through February 28, 2012.

Petitioner continued to follow-up at the University of Illinois through March 26, 2012.

Petitioner was referred to the Illinois Eye Institute for fitting of a contact lens.

Petitioner testified that he is still treating at the Illinois Eye Institute and will be required to follow up every six months for life for the purpose of obtaining a new supply of contact lenses. (PX. 1).

Petitioner testified that he is blind in the left eye. Petitioner testified that he cannot see two fingers in front of his left eye from one foot away. Petitioner testified that with the contact lens, he can barely distinguish that a human being is standing seven feet in front of him.

Dr. Golden-Brenner Exam on behalf of Respondent

On December 16, 2013, Petitioner was examined at Respondent's request by Dr. Carrie Golden-Brenner. Dr. Golden-Brenner performed several tests on Petitioner. Based on the testing, it was the doctor's opinion that Petitioner has 20/20 vision in his right eye and corrected 20/20-2 vision for distance and 20/20 for nearby vision in his left eye. Petitioner was found to have decreased depth perception. Dr. Golden-Brenner explained in her report that Petitioner's decreased depth perception may improve over time with the contact lens. Examination with flourescin demonstrated no scarring which shows a well healed scar in the left eye. Dr. Golden-Brenner agreed Petitioner would require use of a contact lens to correct his vision due to the type of surgery performed secondary to the incident on November 6, 2011.

Dr. Golden-Brenner also prepared an impairment rating detailing the level of impairment experienced by Petitioner according to the AMA 6th edition guidelines. Dr. Golden-Brenner reported

an impairment rating of 0.4% based upon the AMA guidelines and reported Petitioner essentially has no functional disability when using his contact lens as a result of his November 6, 2011 incident.

CONCLUSIONS OF LAW

Medical Bills:

Respondent stipulated that they would hold Petitioner harmless from any bills incurred for reasonable and related treatment to the alleged injury pursuant to the Illinois Worker's Compensation Medical Fee Schedule or previously negotiated rate. (AX. 1).

The medical bills incurred by Petitioner are as follows:

Provider	Start Treatment	Stop Treatment	Charges
Midwest Eye Center	2/07/12	02/07/12	185.00
University of Illinois Hospital& Health Sciences System	02/18/12	02/22/12	22,496.44
University of Illinois at Chicago Physician Group	02/18/12	02/18/12	7,526.00
Illinois College of Optometry- previously Illinois Eye Institute	05/22/12	06/08/12	251.00
		TOTAL	**30,458.44**

TTD:

Petitioner was instructed to be off work from the surgery date of February 18, 2012, through February 28, 2012. (PX. 3). Respondent is ordered to pay to Petitioner TTD for 1 3/7 weeks at a rate of $286.00.

Nature and Extent:

The Arbitrator notes Dr. Golden-Brenner's impairment rating of 0.4% of an eye is only one of the five considerations taken into account when determining disability. Consistent with the Illinois Workers' Compensation Act, the Arbitrator is to base the permanency determination on the following factors:

(i) The reported level of impairment pursuant to subsection (a) (e.g.; the AMA rating)
(ii) The occupation of the injured employee
(iii) The age of the employee at the time of the injury
(iv) The employee's future earning capacity
(v) Evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

Petitioner was 45 years old at the time of his injury. The Arbitrator assigns this factor relatively little weight.

Petitioner is currently employed by Sterling Lumber as a laborer. The Arbitrator does give this factor some weight in her determination as Petitioner's occupation is physical in nature.

Petitioner testified he was making more money at the time of trial than he was when employed by Respondent. His current earning capacity has not diminished as a result of his injury which is a likely indication that his injury will have no bearing on his future earning capacity.

According to Dr. Golden-Brenner, Petitioner's impairment rating is 0.4% of an eye. The Arbitrator does accord Dr. Golden-Brenner's rating a great deal of weight in her deliberation.

The Arbitrator notes the following evidence of disability that is corroborated by the treating records:

1. Petitioner must visit an optometrist every year for life for the purpose of an eye exam and contact re-orders;
2. Petitioner was instructed by his doctor to wear the contact lens for no longer than 8-10 hours a day which means he must go for part of the day without the visual correction that the lens affords;
3. Petitioner must use lubricating drops in his left eye.

The Arbitrator accords a great deal of weight to the disability as evidenced by Petitioner's treating records and finds that Petitioner has suffered a significant, permanent disability.

After careful consideration of the five factors, the Arbitrator awards Petitioner 25% of a left eye or 40.5 weeks of PPD at a rate of $286.00.

Future Medical Care:

Petitioner testified that he is still treating at the Illinois Eye Institute and will be required to follow up every six months for life for the purpose of obtaining a new supply of contact lenses. (PX. 1).

Dr. Carrie Golden-Brenner opined that Petitioner may continue the use of the contact lenses. Dr. Golden-Brenner also noted that Petitioner may be a candidate for further surgery in the form of a secondary intraocular lens implant.

The Arbitrator orders the Respondent to pay for future in medical in the form of the costs of necessary contact lenses and follow-up examinations *or* the intraocular lens implant procedure as recommended as a possible option by Dr. Carrie Golden-Brenner at Petitioner's discretion.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

vs.

NO: 13 INC 457

15IWCC0713

Golebiowski's Transport, Inc. and Tomasz Golebiowski, Individually and as President of, And Halina Golebiowski, Individually, and as Secretary of Golebiowski's Transport, Inc.,

Respondents.

ORDER

On August 7, 2015, the Commission found that Respondents willingly and knowingly violated Section 4 of the Illinois Workers' Compensation Act by failing to maintain workers' compensation insurance coverage for a minimum period of 1,683 days, from December 29, 2010 through August 7, 2015. The Commission ordered Respondents to pay $841,500.00 under Section 4(d) of the Act and issued a work-stop order requiring cessation of all business operations of Respondents at the place of employment until proof of insurance was provided under the Act.

On September 4, 2015, Respondents caused to be filed a Motion entitled Emergency Motion to Vacate or Temporarily Abate Work Stop Order. Said Motion was brought before the Commission on September 4, 2015 and set for hearing by agreement of the parties on September 8, 2015, with all parties appearing and represented by counsel. Testimony was taken on September 8, 2015. Thereafter, the matter was continued for further hearing on September 14, 2015, based upon a Motion for a Continuance that was made by the Petitioner, Illinois Workers' Compensation Commission (hereinafter "IWCC"), Insurance Compliance Division.

On September 14, 2015, at hearing before Commissioner Michael J. Brennan, Petitioner and Respondents entered into a Stipulation of certain facts, which would require the Commission to release the work-stop order. It was stipulated that: 1) Respondents provided proof of workers' compensation insurance coverage, policy number WC-12-87-032635-00. 2) The insurance policy was originally issued with the understanding that due to a past audit, the policy had a cancellation date effective November 5, 2015, or until the audit issue was cleared. 3) Respondents have provided proof of clearance of the audit issue. 4) And, further stipulated that workers' compensation insurance coverage has been obtained for all employees of Respondent, including truckers, under the policy. This was so stipulated by the Respondents, through their counsel and the IWCC, Insurance Compliance Division through the Illinois Attorney General.

Having provided proof of workers' compensation insurance as required under the Illinois Workers' Compensation Act, and based upon the Stipulation of the parties, as aforesaid, the Commission finds that Respondents are no longer in violation of Section 4 of the Illinois Workers' Compensation Act and lifts the work-stop order, allowing Respondent to resume business. The remainder of the Commission's Decision under its case number 15 IWCC 0630 remains in full force and effect.

IT IS THEREFORE ORDERED BY THE COMMISSION that the work-stop order is lifted.

DATED: SEP 15 2015
MJB/ell
H-09/14/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Beneke,

Petitioner,

vs.

No. 12 WC 06181

15IWCC0748

Danville Dashers,

Respondent.

DECISION AND OPINION ON REVIEW

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

With respect to Petitioner's cervical spine condition, the Arbitrator noted that on April 18, 2014, Dr. Butler examined Petitioner and diagnosed a resolved cervical disc herniation and cervical strain. Dr. Butler opined that Petitioner had reached maximum medical improvement and required no restrictions with respect to any cervical spine issues connected to the work accident. In the Conclusions section of his Decision, the Arbitrator found that Petitioner's cervical spine condition was causally connected to the work accident. The Commission clarifies the Arbitrator's Decision to further provide, consistently with his Findings of Fact, that Petitioner had reached maximum medical improvement with respect to the cervical spine condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2015, is hereby clarified, affirmed and adopted.

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

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

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

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

DATED: SEP 2 8 2015
o-09/10/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

BENEKE, SCOTT
Employee/Petitioner

Case# **12WC006181**

DANVILLE DASHERS
Employer/Respondent

15IWCC0748

On 2/10/2015, 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:

1937 TUGGLE SCHIRO & LICHTENBERGER
TODD D LICHTENBERGER ESQ
510 N VERMILION
DANVILLE, IL 61832

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

15IWCC0748

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Scott Beneke
Employee/Petitioner

Case # 12 WC 06181

v.

Consolidated cases: n/a

Danville Dashers
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on December 22, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0748

FINDINGS

On the date of accident, November 3, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $31,200.00; the average weekly wage was $600.00.

On the date of accident, Petitioner was 52 years of age, single with 1 dependent child(ren).

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

Respondent shall be given a credit of $26,360.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $26,360.00.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right shoulder and left elbow surgeries recommended by Dr. Lawrence Li.

Respondent shall pay Petitioner temporary total disability benefits of $400.00 per week for 159 2/7 weeks commencing November 30, 2011, through December 22, 2014, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

January 30, 2015
Date

FEB 10 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent on November 3, 2011. The Application alleged that Petitioner sustained injuries to the "Whole Body" when he was knocked to the ice during hockey practice (Arbitrator's Exhibit 2). At trial, the parties stipulated as to accident. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits, medical bills, and prospective medical treatment. Respondent disputed liability on the basis of causal relationship.

Petitioner testified he started working for Respondent in March 2011. Respondent is a professional hockey team and was employed as General Manager/Coach. Petitioner testified he was on the ice and conducting a practice on November 3, 2011, when a player accidentally struck him from behind causing him to fall to the ice. Petitioner testified he was not wearing any protective gear and instinctively stuck his elbows out to break the fall. Petitioner testified he was also trying to keep from striking his head on the ice.

Petitioner testified he spoke about the accident with the team owner, who was there that day for team photos. Petitioner testified he was feeling bad that day. Petitioner testified the next day he called the "Team Doctor," a Physician's Assistant named Michael Wagner.

Petitioner testified he spoke with PA Wagner at a hockey match that Saturday after the accident and complained of pain in the left arm, right shoulder, and neck. Petitioner testified he made an appointment to see PA Wagner at his medical office.

Petitioner was seen by PA Wagner at his office on November 23, 2011, complaining of neck pain, right shoulder pain, and upper back pain to the right. Petitioner was seen again by PA Wagner on November 30, 2011, and was told he could return to work with activities as tolerated. Petitioner testified Respondent did not have light duty available. PA Wagner prescribed physical therapy (Petitioner's Exhibit 1).

Petitioner started a physical therapy regimen at Provena United Samaritans Medical Center on December 19, 2011. Petitioner attended twelve physical therapy appointments on various dates through January 12, 2012 (Petitioner's Exhibit 2).

Petitioner saw PA Wagner for the final time on January 17, 2012. The record of that dated indicated injuries to the neck, back, right shoulder, and left arm. An MRI of the cervical spine and right shoulder was ordered (Petitioner's Exhibit 1).

Petitioner initially saw Dr. David Fletcher, an occupational medicine specialist, on February 6, 2012. He examined Petitioner and his diagnosis was right C6 radiculopathy directly related to the fall and severe left recurrent ulnar neuropathy aggravated by the work-related injury. Dr. Fletcher found Petitioner to be temporarily totally disabled. Dr. Fletcher ordered a MRI of the cervical spine and nerve conduction studies of the upper extremities. Petitioner was referred to Dr. Edward Trudeau (Petitioner's Exhibit 3).

Petitioner saw Dr. Edward Trudeau, a physiatrist, on February 21, 2012, for nerve conduction studies of the upper extremities. Those tests revealed mild to moderately severe right C6 radiculopathy and severe left ulnar neuropathy (Petitioner's Exhibit 4).

Petitioner returned to Dr. Fletcher on May 8, 2012. It was noted he was in a great deal of pain and that his left elbow appeared swollen. Dr. Fletcher again recommended a MRI of the cervical spine and referred Petitioner to Dr. Lawrence Li, an orthopedic surgeon, for a surgical consult (Petitioners Exhibit 3).

Petitioner initially saw Dr. Lawrence Li on May 10, 2012. Dr. Li examined Petitioner and made a diagnosis of recurrent left cubital tunnel syndrome, recurrent right medical epicondylitis, and possible right rotator cuff injury. MRIs of the left elbow and right shoulder were recommended (Petitioner's Exhibit 6).

Petitioner continued to follow-up with Dr. Fletcher and saw him on June 14, 2012, July 5, 2012, and July 19, 2012. Dr. Fletcher continued to recommend MRIs of the cervical spine, left elbow, and right shoulder (Petitioner's Exhibit 3).

MRIs of the cervical spine and left elbow were performed on August 30, 2012, at Christie Clinic. The MRI of the cervical spine evidenced multilevel disc disease, disc bulges and right paracentral disc protrusion at C6-C7. The MRI of the left elbow showed mild arthritic change with small degenerative subchondral cysts in the medial aspect of the lateral humeral condyle. On September 7, 2012, Petitioner had an MRI of the right shoulder which revealed a significant tear of the glenoid labrum (Petitioner's Exhibit 7).

Petitioner returned to Dr. Li on September 20, 2012, at which time Dr. Li reviewed the MRIs and noted a large SLAP tear in the right shoulder. It was also noted that Petitioner was scheduled for an independent medical examination in 3 weeks (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Gary Kronen, an orthopedic surgeon, on October 11, 2012. In connection with his examination of Petitioner, Dr. Kronen reviewed medical records provided to him by Respondent. In his report, Dr. Kronen referenced the nerve conduction studies of February 8, 2011, which revealed no evidence of ulnar nerve compression of the left elbow. Dr. Kronen opined that Petitioner's current diagnosis is continued left ulnar nerve compression at the elbow (cubital tunnel syndrome). Dr. Kronen also opined that the persistent ulnar nerve compression at the left elbow is related to an original diagnosis of ulnar nerve compression established in 2008-2009. Further, Dr. Kronen opined that the work accident of November 2011 did not aggravate or cause Petitioner's continued symptoms of the left ulnar nerve compression at the elbow. Dr. Kronen did not provide any medical opinions regarding any other injuries claimed by Petitioner (Respondent's Exhibit 3).

Petitioner returned to Dr. Li on October 25, 2012, at which time another exam was performed resulting in a continued diagnosis of right shoulder labral tear and recurrent left cubital tunnel syndrome. Petitioner attended regular appointments with Dr. Li thereafter (Petitioner Exhibit 6).

Petitioner saw Dr. Fletcher on November 21, 2012, December 17, 2012, January 10, 2013, and February 11, 2013. Petitioner continued to complain of pain in the neck, right shoulder, and left upper extremity. Dr. Fletcher ordered nerve conduction studies to be performed by Dr. Trudeau (Petitioner's Exhibit 3).

Petitioner returned to Dr. Trudeau for nerve conduction studies on March 6, 2013. Those tests again revealed severe left ulnar neuropathy at the elbow, right C6 radiculopathy, and left C3 radiculopathy (Petitioner's Exhibit 4).

On March 28, 2013, Petitioner saw Dr. Li and discussed surgical options. On May 8, 2013, Dr. Li performed surgery which consisted of right shoulder arthroscopy with repair of SLAP tears in the right shoulder and extensive debridement of chondral fragments of the humeral head. Petitioner saw Dr. Li for post-surgical follow-ups on May 16, 2013, June 6, 2013, and July 3, 2013 (Petitioner's Exhibit 6).

Petitioner also continued to be seen by Dr. Fletcher who saw him on May 16, 2013, June 6, 2013, June 21, 2013, and July 12, 2013 (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Li on August 8, 2013, at which time he opined Petitioner was at maximum medical improvement in regard to the right shoulder; however, Dr. Li recommended revision left cubital tunnel release and anterior transposition of the ulnar nerve once approval was obtained (Petitioner's Exhibit 6).

Petitioner was again seen by Dr. Fletcher on October 1, 2013, complaining of increased pain in the right shoulder after doing push-ups as well as ongoing pain and numbness in the left upper extremity. Dr. Fletcher indicated Petitioner urgently needed a left ulnar nerve procedure and continued to express concern about C6 radiculopathy (Petitioner's Exhibit 3). Petitioner continued to treat with Dr. Fletcher seeing him on October 31, 2013, December 16, 2013, January 13, 2014, and February 24, 2014. On April 9, 2014, Dr. Fletcher referred Petitioner to Dr. Jesse Butler, a spine surgeon, for a consult regarding the on-going neck issues (Petitioner's Exhibit 3).

On April 10, 2014, Petitioner an MRI of the cervical spine was performed which revealed multilevel degenerative disc disease, minimally changed compared to the prior MRI. The MRI also showed spinal canal narrowing at various levels (Petitioner's Exhibit 7).

On April 18, 2014, Petitioner saw Dr. Jesse Butler regarding ongoing neck pain. Dr. Butler examined Petitioner and diagnosed him with a resolved cervical disc herniation and cervical strain. Dr. Butler was of the opinion there were no current issues with the cervical spine which required injection or surgical treatment. Dr. Butler opened Petitioner had no restrictions in regard to the neck and was at maximum medical improvement regarding any cervical spine issues connected to the fall on the ice. Dr. Butler recommended treatment for ongoing issues with the right shoulder, arm, and left elbow (Petitioner's Exhibit 9).

Petitioner continued to be treated by Dr. Fletcher, who saw him on April 14, 2014, and May 8, 2014. On May 16, 2014, Dr. Fletcher ordered an MRI arthrogram of the right shoulder and on

June 6, 2014, referred Petitioner to Dr. Trudeau for updated nerve conduction studies (Petitioner's Exhibit 3). On June 9, 2014, Petitioner had an MRI arthrogram of the right shoulder which revealed a recurrent multifocal labral tear (Petitioner's Exhibit 26). On June 10, 2014, Dr. Trudeau performed nerve conduction studies which again revealed ulnar neuropathy at the left elbow and right C6 radiculopathy (Petitioner's Exhibit 4).

Petitioner returned to Dr. Li on June 11, 2014. Dr. Li reviewed the right shoulder MRI, examined Petitioner, and diagnosed persistent labral tear in the right shoulder. On June 16, 2014, Dr. Li prepared a letter indicating that the persistent right labral tear was due to incomplete healing of the labral repair performed on May 8, 2013. He also recommended a right biceps tenodesis to relieve Petitioner's symptoms (Petitioner's Exhibit 6).

Petitioner continued to treat with Dr. Fletcher, seeing him on June 16, 2014, August 15, 2014, and September 23, 2014. Dr. Fletcher continued Petitioner's work restrictions and continued to recommend treatment for the left ulnar neuropathy and the ongoing problems with the right shoulder (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Nikhil Verma, an orthopedic surgeon, on August 14, 2014. In connection with his examination of Petitioner, Dr. Verma reviewed medical records provided to him by Respondent. In his report dated August 14, 2014, Dr. Verma diagnosed Petitioner with mild to moderate osteoarthritis in the right shoulder. Dr. Verma opined Petitioner's current condition was related to a pre-existing osteoarthritic condition. Dr. Verma opined that Petitioner had reached maximum medical improvement regarding the right shoulder. Dr. Verma did not offer any medical opinions regarding any other injuries claimed by Petitioner (Respondent's Exhibit 4, Deposition Exhibit 2).

On September 15, 2014, Dr. Verma issued an addendum to his original IME report dated August 14, 2014. Dr. Verma, in his report dated September 15, 2014, stated he reviewed a MR arthrogram of Petitioner's right shoulder dated June 9, 2014, and opined there was no evidence of recurrent labral tear. As such, Dr. Verma's opinion remained unchanged relative to his original report dated August 14, 2014 (Respondent's Exhibit 4, Deposition Exhibit 3).

Petitioner saw Dr. Li on October 16, 2014, at which time Dr. Li noted continuing pain in the right shoulder and continuing numbness and tingling in the left arm, with no improvement in either condition (Petitioner's Exhibit 6). Petitioner saw Dr. Fletcher again on November 24, 2014, at which time he continued to complain of left arm pain, right arm pain, and neck pain. Dr. Fletcher continued to restrict Petitioner's work duties (Petitioner's Exhibit 3).

Dr. Li was deposed on March 11, 2013, and again on November 10, 2014, and his deposition testimony was received into evidence at trial. When Dr. Li was deposed on March 11, 2013, he testified that with regard to the right shoulder, Petitioner's diagnosis was that of an extensive labral (SLAP) tear and acromioclavicular joint pain. Dr. Li testified an arthroscopic surgery was needed to address both problems. As it relates to the left arm, Dr. Li testified that Petitioner's diagnosis was that of recurrent cubital tunnel syndrome and recommended a revision of the left cubital tunnel release. In regard to causality, Dr. Li testified both the right shoulder condition

and the left arm condition were caused by the work-related accident in November 2011 (Petitioner's Exhibit 22, pp 15-21).

When Dr. Li was re-deposed on November 10, 2014, he testified he had performed surgery on Petitioner's right shoulder on May 8, 2013. Dr. Li testified he released Petitioner to a home exercise program, regarding the right shoulder issue, on August 8, 2013. Dr. Li testified that as of August 8, 2013, Petitioner continued to have an issue with the left ulnar nerve. Dr. Li testified Petitioner returned to him on June 11, 2014, with symptoms in the right shoulder. Dr. Li stated he reviewed updated films and diagnosed Petitioner with a recurrent labral tear in the right shoulder. Dr. Li recommended a second surgery on the right shoulder. In regard to causality, Dr. Li testified the repair done in May 2013 had not healed and that the current condition was still in the causal chain of the work accident in November 2011. Dr. Li also testified Petitioner was still experiencing a problematic left ulnar nerve which required surgery. Dr. Li testified the problematic left ulnar nerve was aggravated by the work-related accident in November 2011. Dr. Li noted that while Petitioner had a pre-existing left elbow problem, nerve conduction studies performed were normal prior to the work-related injury (Petitioner's Exhibit 24, pp. 10-16).

Dr. Fletcher was deposed on June 4, 2014, and his deposition testimony was received into evidence at trial. Dr. Fletcher's diagnosis in regard to the cervical spine injury was that of disc herniation at C6-7 and multiple level degenerative disc disease. Dr. Fletcher's diagnosed a right shoulder injury. Dr. Fletcher's diagnosis of the left arm was that of a recurrent ulnar neuropathy. Dr. Fletcher testified the work-related accident in November 2011 caused and aggravated Petitioner's cervical spine and right shoulder conditions. Dr. Fletcher testified the recurrent left ulnar nerve neuropathy was caused by the work-related accident in November 2011, in that the accident aggravated a pre-existing condition. He noted that while Petitioner had a prior left elbow injury, nerve conduction studies performed before the work-related injury were normal (Petitioners' Exhibit 23, pp. 11-15, 24).

Dr. Verma was deposed on November 19, 2014, and his deposition testimony was received into evidence at trial. Dr. Verma testified that from an arthroscopic standpoint there was no indication for a second surgery on the right shoulder. Dr. Verma testified that any ongoing symptoms Petitioner was experiencing were related to right shoulder conditions which pre-existed the work accident in November 2011. Dr. Verma did not provide any testimony regarding Petitioner's left upper extremity injury or the cervical spine condition (Respondent's Exhibit 4. Pp. 12-15).

Petitioner testified he had prior problems with his right shoulder and left elbow at times prior to the work-related accident of November 3, 2011. Petitioner testified he was involved in a motor vehicle accident in 2006 and had surgery on the left elbow in 2009. The records indicated that surgery was performed on March 31, 2009, by Dr. Daniel Fox (Respondent's Exhibit 2). Petitioner testified he was not having any significant problems with his neck, right shoulder, or left elbow when he started working for Respondent in March 2011. An EMG/nerve conduction studies of the left upper extremity was performed on February 8, 2011, by Dr. Fawzy Salama. The findings of that study were normal as it related to Petitioner's left ulnar nerve (Petitioner's Exhibit 25).

At trial, Petitioner testified that he still has right shoulder and left elbow symptoms, the more significant symptoms being in the left elbow which Petitioner stated were "killing me."

Conclusions of Law

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

The Arbitrator concludes Petitioner's current conditions of ill-being in regard to the cervical spine, right shoulder and left elbow are related to the accident of November 3, 2011.

In support of this conclusion the Arbitrator notes the following:

In regard to the cervical spine injury, Petitioner's treating physician, Dr. Fletcher, testified the injury to the cervical spine was caused by the work-related accident. That testimony was unrebutted as Respondent did not offer any evidence regarding causal connection of that injury.

In regard to the first right shoulder surgery, Petitioner' treating physicians, Dr. Fletcher and Dr. Li, both testified the right shoulder injury, and the need for surgery, was caused by the work-related accident. That testimony was unrebutted as Respondent did not offer any evidence regarding causal connection of the first right shoulder surgery.

In regard to the current condition of the right shoulder and need for additional surgery, Dr. Li testified Petitioner has a recurrent labral tear and needs another surgery. Dr. Li testified the surgical repair work he had done on May 8, 2013, had not healed properly. Dr. Li opined the recurrent tear and need for additional surgery was still in the causal chain of the work-related accident.

Respondent's first Section 12 examiner, Dr. Kronen, did not provide any testimony or opinion regarding Petitioner's right shoulder condition.

Respondent's second Section 12 examiner, Dr. Verma, opined there was no indication for a second surgery on the right shoulder and that on-going symptoms in Petitioner's right shoulder were related to conditions which pre-existed the work-related accident.

In regard to causality and the current condition of Petitioner's right shoulder, the Arbitrator finds the opinion of Dr. Li to be more persuasive than that of Dr. Verma. The MRI arthrogram performed on June 9, 2014, revealed a recurrent multifocal labral tear. Although Petitioner did have a pre-existing condition in regard to the right shoulder, there was no evidence that it was symptomatic at the time of the work-related accident. Further, it has already been determined the right shoulder surgery in May 2013 was work-related.

In regard to the left ulnar nerve condition, treating physicians Dr. Fletcher and Dr. Li both testified the work-related accident aggravated Petitioner's left ulnar nerve condition. Dr. Li testified Petitioner is in need of a revision of the left cubital tunnel release.

Respondent's first Section 12 examiner, Dr. Kronen, in his report dated October 11, 2012, opined that the persistent ulnar nerve compression at the left elbow is related to the pre-existing ulnar nerve compression diagnosed in 2008-2009. Furthermore, Dr. Kronen opined that the work-related accident of November, 2011, did not aggravate or cause Petitioner's continued symptoms of the left ulnar nerve compression at the elbow.

In regard to causality as it relates to the left ulnar nerve condition, the Arbitrator finds the opinions of Dr. Fletcher and Dr. Li to be more persuasive than that of Dr. Kronen. Petitioner did have a pre-existing condition which required surgery in 2009. However, the EMG/nerve conduction studies performed on the left upper extremity in February 2011, were normal. There was no evidence the left ulnar nerve was symptomatic at the time of the work-related accident. Petitioner testified that when he fell he extended both elbows behind him to break the fall. The overall evidence is consistent with the opinions of Dr. Fletcher and Dr. Li that the work-related accident caused the recurrent and severe ulnar neuropathy at the left elbow.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary, and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibits 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the right shoulder and left elbow surgeries, as recommended by Dr. Lawrence Li.

In support of this conclusion the Arbitrator notes the following:

Dr. Li opined when he saw Petitioner on October 16, 2014, he was still in need of surgery to address the left ulnar nerve injury as well as another surgery to address recurrent labral tear in the right shoulder.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 159 2/7 weeks commencing November 30, 2011, through December 22, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physicians had Petitioner either off work completely or subject to restrictions that Respondent did not accommodate.

While Petitioner was found to be at maximum medical improvement only in regard to his right shoulder on August 8, 2013, Dr. Li subsequently saw Petitioner and opined that further right shoulder surgery was necessary because of incomplete healing following the first right shoulder surgery. Petitioner was never released from care regarding his left elbow injury.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Karen Cobine,

Petitioner,

vs. NO. 12WC038253

J. C. Penney,

15IWCC0747

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical care, causal connection, 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 March 31, 2015 is hereby affirmed and adopted.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 28 2015
SJM/sj
o-9/10/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

COBINE, KAREN
Employee/Petitioner

Case# **12WC038253**

J C PENNY
Employer/Respondent

15IWCC0747

On 3/31/2015, 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:

4463 GALANTI LAW OFFICES PC
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
180 N STETSON AVE SUITE E4525
CHICAGO, IL 60601

15IWCC0747

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Karen Cobine
Employee/Petitioner

v.

J.C. Penney
Employer/Respondent

Case # **12** WC **038253**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 2, 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.

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

In the year preceding the injury, Petitioner earned $**13,894.40**; the average weekly wage was $**267.20**.

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

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

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

Respondent is entitled to a credit of $**0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to provide timely notice of her alleged accident as required by the Act. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

March 25, 2015
Date

ICArbDec19(b)

MAR 3 1 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner previously filed two workers' compensation claims for repetitive hand injuries. Case number 10 WC 45839 was filed against the Village of Hartford and case number 10 WC 46045 was filed against Respondent.

Both cases were consolidated for hearing on a 19(b) Petitioner before Arbitrator Tobin held on August 11, 2011. (RX 4)

At the hearing held in August of 2011 Petitioner testified that she was employed by both the Village of Hartford and Respondent as of November 16, 2010. Petitioner worked for Respondent as a sales clerk initially but became a "replenisher" in October of 2009. Petitioner worked approximately twenty hours per week for Respondent. She performed janitorial services for the Village of Hartford, having begun about 18 to 20 years earlier. That job also involved about twenty hours per week of work. (RX 4)

Petitioner testified at the hearing that she presented to Dr. Michael Beatty on November 16, 2010 for her hands, having been referred to him by her family doctor, Dr. Kuebrich. Dr. Kuebrich had treated Petitioner in September and December of 2009 and referred her for EMG/NCS testing in January of 2010. Petitioner testified that Dr. Beatty was recommending hand surgery and she wished to proceed with it. (RX 4)

Petitioner testified that she began treating with her family doctor for hand complaints and that they have worsened since her initial visit. She further added that in September of 2009 she was experiencing a lot of pain in her elbows: however, that had gotten "a little better" but the numbness in her hands has worsened. (RX 4)

On cross-examination Petitioner provided further information regarding her job for the Village, explaining that in the last ten years it has increased in responsibilities. Initially, she was only responsible for one building but that has increased over time to three buildings. She does all of the cleaning. Petitioner further testified that her job for Respondent required her to move a lot of clothing from one rack to another. She lifts clothing from one rack to another. She also works at a table opening boxes and dumping the material or she takes the material out of the bags, stacks them, and puts them on carts. She will then either take a rack of clothing out that's hanging and put them on another rack or she will be the one to take the large three tier cart out to the floor (filled with clothing) and take the clothing off the cart and place them on tables or shelves. She will also take merchandise back to the storeroom and restock it onto shelving or re-hang them. Petitioner also described using a scanning gun to scan items. She is also the person who goes upstairs to handle shipments for "Home and Children's". Up there she takes boxes

piled on pallets, opens them, removes the items, puts them on carts, and takes them to the sales floor, finds their areas, scans them, and scans them onto the fixture. What isn't displayed is left on the cart or taken by cart back to the storeroom and restocked by Petitioner. (RX 4)

Petitioner felt there were more repetitive work and motion with her upper extremities as a replenisher than as a sales clerk. Petitioner also testified that she had elbow pain and hand numbness prior to going to replenishing but it then got worse. She further noted that during the winter months she did more cleaning for the Village due to the weather. (RX 4)

Petitioner's job for the Village required her to vacuum for two hours per day, sweep floors, mop floors and use her hands to scrub toilets and tile. She cleaned sinks, scrubbed refrigerators, stoves and ovens, and used a duster to dust. She also shampooed/steam cleaned the carpets. She would also clean/polish furniture and fixtures, perform outside maintenance/ground work, and assist with removing decorations from walls. (RX 4)

Petitioner testified that the scanning gun weighs about three pounds -- no more than a bag of sugar. (RX 4)

Petitioner testified that her hobbies include camping and motorcycle riding. She denied driving a motorcycle. (RX 4)

Jon Pannulo testified at the hearing also. Mr. Pannulo testified he was the store manager at the Alton store and had worked there from 2002 to 2005 and again from April of 2007 through the date of hearing (August 11, 2011). He acknowledged that Petitioner reported her wrist and hand condition to him on November 23, 2010. Notice was not in dispute regarding that claim. (RX 4, pp. 69 - 78)

According to Commission records, the Arbitrator issued a decision in 10 WC 45839 on September 23, 2011 denying Petitioner's claim against the Village of Hartford. A decision was entered in her favor in the other case (10 WC 46405). Reviews in both cases were sought before the Commission.

According to Commission records, the Commission affirmed the Arbitrator's Decision in 10 WC 45839 on May 15, 2012.

According to Dr. Beatty's records (offered into evidence as PX 1) Petitioner presented to Dr. Michael Beatty's office on July 2, 2012 with three issues: bilateral carpal tunnel and bilateral cubital tunnel syndrome; right ring finger stenosing tensoynovitis; and, third, a possible need for a repeat nerve conduction study. Dr. Beatty's office notes indicated Petitioner was a candidate for the first two and obtaining the nerve conduction study/EMG had been a "long standing problem." Dr. Beatty was going to get the information to Petitioner's attorney and start the process for scheduling surgery. According to Dr. Beatty's handwritten notes of the same date, he added a notation that using a scanner at work on the right increased Petitioner's complaints of triggering in the right ring finger. (PX 1, p. 16) In a letter to Petitioner's attorney of the same date Dr. Beatty reiterated the foregoing noting a six month history of right ring finger stenosing

tenosynovitis or trigger finger. He also added, "As to the triggering, that is a new complaint and I am not sure how you may want to handle that, let me know." (PX 1, p. 22)

In a letter to Petitioner's attorney dated October 1, 2012 Dr. Beatty opined that Petitioner's right trigger finger was related to her work duties for Respondent. (PX 1, p. 13)

Petitioner underwent left upper extremity surgery in October of 2012. (PX 1, p. 9/24)

Petitioner filed her Application for Adjustment of Claim herein on November 5, 2012. (AX 2)

Post-operatively Petitioner followed up with Dr. Beatty and she was sent for therapy. (PX 1, p. 9) As of December 12, 2012 Petitioner was back to work on a light duty basis. Petitioner was reporting right thumb CMC pain. She had been approved for her right carpal tunnel surgery. Her present issues included the right trigger finger, right carpal tunnel problem, and an ulnar nerve problem. Dr. Beatty noted, "The CMC area pain was mentioned again as before." Dr. Beatty had asked for bilateral thumb x-rays. He felt an MRI might be necessary. Dr. Beatty wrote that he felt her trigger finger was work-related. He added that work did not necessarily cause her type of arthritis -- CMC arthritis of the thumbs. However, work could be the basis for an increase in her symptoms. (PX 1, p. 8)

Dr. Brown performed an examination at the request of Respondent on February 12, 2013. At that time Petitioner complained of only right ring trigger finger. (RX 1 & 3) She didn't have any complaints of pain to the right thumb or left thumb. Dr. Brown testified that Petitioner never mentioned that she attributed her right ring finger condition to using the scan gun at work (RX 3) Dr. Brown examined Petitioner and noted Petitioner's history of triggering of the right ring finger. (RX 3) Dr. Brown was unable to detect any right ring finger triggering at the time of the exam. (RX 3) The doctor recommended surgical treatment of the right ring finger, however indicated this treatment or condition was due to her arthritis and not to her work activities with JC Penney. (RX 3) This was because Petitioner fit the common profile that she was a female in her 50's for this type of condition. (RX 3) Further, Petitioner only worked at JC Penney 20 hours a week and did various activities. (RX 3)

Petitioner underwent right elbow and hand surgery thereafter and was seen in follow-up on March 26, 2013 and April 3, 2013. It appears that she resumed a normal workload in June of 2013. (PX 1, p. 7/24)

Petitioner returned to see Dr. Beatty on September 11, 2013 reporting that she was having a problem with triggering which had been going on for some time. She noticed locking in her thumbs and increasing pain. Dr. Beatty noted that Petitioner seemed to be at a point where she might have to be taken off work and Petitioner agreed. Both thumbs were injected. (PX 1, p. 5/24) Petitioner called the doctor's office on September 23, 2013 reporting that she was 80% pain free and she could bend her knuckles and felt a lot better. (PX 1, p. 5/24)

According to Commission records, Petitioner settled her workers' compensation claim with Respondent in 10 WC 46045 on October 15, 2013.

Petitioner called Dr. Beatty's office on October 18, 2013 reporting that 80% of her pain was gone, that her knuckles were bending, and she felt better. Dr. Beatty recommended observation but if she experienced triggering or soreness they ought to proceed with surgery. (PX 1, p. 5/24)

Petitioner next returned to see Dr. Beatty on November 6, 2013 reporting that her right thumb had "started triggering again." She also mentioned that both thumbs were locking and she was experiencing increasing pain. She received injections to both thumbs resulting in about 80% improvement in her pain. (PX 1, p. 5) However, by November 6, 2013 Petitioner was calling in reporting her right thumb was triggering again and she was unable to bend it. A message was relayed to Dr. Beatty regarding Petitioner's desire to proceed with surgery. (PX 1, p. 5)

Dr. Brown performed a supplemental review of Petitioner's updated treatment to address Petitioner's right thumb issues on February 3, 2014. (RX 2) He was later deposed (RX 3). Dr. Brown's opinions were the same and further testified that any right thumb condition was due to her arthritis. (RX 3) He indicated that Petitioner's varied activities and only working part time were not the result of any triggering of the thumb or any other digit. (RX 2 and 3) Dr. Brown also compared Petitioner's job as a janitor with the Village of Hartford and that given that her duties as a janitor including forceful gripping would be more hand intensive than what she described as her job duties with Respondent. (RX 3)

Dr. Beatty was deposed on July 24, 2014. (PX 3) Dr. Beatty is a plastic reconstructive and hand surgeon. He testified to treating Petitioner for bilateral carpal tunnel syndrome. Dr. Beatty testified that during his treatment of Petitioner he also diagnosed Petitioner with right ring trigger finger in July of 2012. Dr. Beatty testified that he was familiar with Petitioner's job duties for Respondent as she had previously furnished him with information as to those duties in November of 2010. (PX 3, pp. 5 - 7, 18) He specifically recalled that when Petitioner came to see him in July of 2012 she related that she was using a scanner at work with her right hand and that was increasing her complaint of triggering. Petitioner told him she had been experiencing symptoms for six months. (PX 3, pp. 7, 18) Dr. Beatty testified that trigger finger can be caused by rheumatoid arthritis and Petitioner has some evidence of arthritis in her hands; however, he did not feel the arthritis was the cause of her trigger finger. (PX 3, p. 9)

Dr. Beatty further testified that subsequent to December of 2012 Petitioner was also experiencing triggering in her thumbs. X-rays were taken of her thumbs and they showed "polyarticular arthritis, worse at the right scaphoid joint into -- next to the thumb." (PX 3, p. 10) Dr. Beatty also felt Petitioner's job with Respondent was aggravating her thumb triggering. (PX 3, p. 11)

Dr. Beatty testified that Petitioner underwent hand and elbow surgery in December of 2012 and was released in June of 2013 only to return on September 11, 2013 due to increasing severity with the triggering. (PX 3, p. 13) At that time Petitioner underwent cortisone injections for the thumbs but not the ring finger. (PX 3, p. 13) Dr. Beatty testified that the injections helped

for awhile but Petitioner called him in November of 2013 reporting the thumbs were again problematic and they decided to proceed with surgery. (PX 3, p. 15)

Dr. Beatty has not seen Petitioner since November of 2013 and while he recommends a right thumb release for the trigger finger condition he would like to see her before doing so to make sure surgery was still appropriate. (PX 3, p. 15)

On cross-examination Dr. Beatty was asked about activities that cause trigger fingering and he explained that it's an inflammatory response of tissue that occurs around tendons and in joints and it causes swelling. It can be caused by gripping activities or direct force activities that cause inflammation and swelling. It can be singular or multiple depending upon the activity and circumstances surrounding the activity. He "supposed" it could also be caused by gripping a mop, broom, or vacuum." (PX 3, p. 22)

At her arbitration hearing Petitioner testified that she was employed with Respondent on July 2, 2012 as an associate in the replenishment department. She further testified that she was also employed with the Village of Hartford as a maintenance person on July 2, 2012. As a replenisher for Respondent, her duties involved opening pallets, boxes, taking out clothes, sorting out the clothes and putting them on carts to take to the floor for sale. She also testified to using a scan gun to scan in merchandise for tracking and identification. She testified that the scan gun is the size of a cell phone but much heavier than a cell phone. She testified that to scan the merchandise she holds the scan gun in her right dominant hand. Petitioner testified that she uses her right index finger and thumb to operate the scanner. She also testified that the ring finger cradles or holds the scan gun in place.

Petitioner testified to prior work injuries with Respondent that involved bilateral carpal tunnel and cubital tunnel. Petitioner filed workers' compensation cases against both Respondent and the Village of Hartford for these conditions with an onset date of November 16, 2010. (RX 4)

Petitioner testified at trial that her right trigger finger condition has been ongoing since January or February 2012.

Petitioner testified that Dr. Beatty performed cortisone injections in December 2012. Petitioner indicated they worked for about two months and then the snapping and locking returned.

Petitioner testified she continues to experience pain in the thumb and right ring finger. Petitioner hasn't seen Dr. Beatty in two years.

Petitioner testified that during her treatment with Dr. Beatty she explained to him not only her job duties but provided information about her hobbies. One of those hobbies includes riding motorcycle. She testified she was a passenger on the motorcycle and would not drive. Petitioner was questioned about what she did with her hands while riding. She testified that she did not hold or grip on to anything. She testified and also demonstrated at trial, she would tuck both her hands in her lap or sometimes tucked them under the thighs of her legs, so her thighs would be resting on her fingers and thumbs.

Petitioner testified that she knows the importance of reporting a work injury to her employer in a timely fashion.

Petitioner testified she saw Dr. Brown for an independent medical examination on February 12, 2013. She was truthful and honest when answering questions about her condition to Dr. Brown so that her pain would improve. She further testified that his records confirm that she had pain in the right ring finger since December of 2011.

Janet Welsh testified on behalf of Respondent. Ms. Welsh is currently Petitioner's supervisor in the replenishment department. Ms. Welsh was also Petitioner's supervisor in July of 2012. She manages a team of ten employees. Ms. Welsh testified that the duties of a replenisher are to open boxes of store merchandise and pull it onto the floor for customers to purchase. Ms. Welsh testified that replenishers use a box cutter and hand held scanner. Respondent has used a scanner for 13 years and they have used two scanners during that time. The current one was replaced and put into use in 2013 or early 2014. All scanners weighed less than a pound and were about 6 inches in length. The scanners were replaced because they were obsolete. Ms. Welsh testified that to operate, the employee pushes button on the top so the merchandise is scanned to know where it went onto the floor.

Ms. Welsh testified that Respondent's procedure when an employee is injured at work is to report it to their immediate supervisor. Ms. Welsh was Petitioner's immediate supervisor in July 2012 and was as of the date of trial. The paperwork that is completed includes: accident report, name, address and what happened, what was in the area and who was around. This procedure is the same for all of Respondent's employees. Ms. Welsh testified that all of her employees, including Petitioner, are aware of the procedure and they are aware to report injuries directly to her. Ms. Welsh further testified Petitioner never reported an injury to her on July 2, 2012. Further, Petitioner never complained to her of pain in the right ring finger in July of 2012. Petitioner never complained of either left thumb or right thumb pain in July of 2012. Ms. Welsh testified that Petitioner never complained of any pain prior to July of 2012 in the right finger, right thumb or left thumb. Ms. Welsh testified that Petitioner never complained of pain in the right ring finger, right thumb or left thumb after July 2, 2012. Ms. Welsh was not made aware of any injury until early January of 2015. Ms. Welsh further testified that none of her other employees complained of pain associated with use of the scan gun.

Petitioner testified in rebuttal. Petitioner testified that she notified Jon Pannulo, the store supervisor, of her thumb and ring finger conditions.

The Arbitrator concludes:

With regard to issue (E) was timely notice of the accident given to Respondent:

Petitioner failed to provide timely notice of her alleged accident to Respondent.

Notice of an alleged accident must be given to the respondent within forty-five days of one's alleged accident. Failure to provide timely notice as required by the Act bars one's claim.

Petitioner alleges an accident date of July 2, 2012. On both direct and cross-examinations Petitioner provided no testimony whatsoever regarding the disputed issue of notice. Respondent's witness, Janet Welsh, Petitioner's supervisor in July of 2012 and presently, testified Petitioner never reported an injury to her nor did Petitioner complain of right ring finger pain or right thumb pain in July of 2012 or prior thereto. Ms. Welsh was unaware of any such complaints in October of 2012. She first became aware of Petitioner's claim approximately three weeks before the hearing when Respondent's attorney called her. It was only after this testimony that Petitioner addressed notice -- testifying that she reported her thumb and ring finger complaints to Jon Pannulo, the store supervisor. She never said when she did so or that she related said complaints to her work.

Petitioner filed her Application for Adjustment of Claim in this case on November 5, 2012, alleging right hand and right trigger finger injuries. At the time of trial she amended her Application for Adjustment of Claim to strike any right hand injury and asserted a bilateral thumb injury. (AX 2) The filing of her Application for Adjustment of Claim was beyond the 45 day reporting requirement. Therefore, timely notice wasn't provided by the filing of the claim itself.

Having concluded that Petitioner failed to provide timely notice of her accident to Respondent, Petitioner's claim for compensation is denied and no benefits are awarded. All other issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ 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

Esteban Valdovinos,
Petitioner,
vs.

15IWCC0741
NO: 13 WC 14128

Hickory River Smokehouse,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, 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 March 4, 2015, is hereby affirmed and adopted.

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

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

The 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: SEP 2 4 2015
KWL/vf
O-9/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0741

VALDOVINOS, ESTEBAN
Employee/Petitioner

Case# **13WC014128**

HICKORY RIVER SMOKEHOUSE
Employer/Respondent

On 3/4/2015, 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:

0080 WINNE LAW OFFICE LLC
JOSEPH E WINNE
416 W MAIN ST SUITE 300
PEORIA, IL 61603

2674 BRADY CONNOLLY & MASUDA PC
JULIA B McCARTHY
705 E LINCOLN ST SUITE 313
NORMAL, IL 61761

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0741

Esteban Valdovinos
Employee/Petitioner

Case # **13** WC **14128**

v.

Consolidated cases: _____

Hickory River Smokehouse
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 **McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **January 21, 2015**. 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. Is Petitioner entitled to any prospective medical care?

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

M. Should penalties or fees be imposed upon Respondent?

N. Is Respondent due any credit?

O. X Other Medical, Prospective Medical, and Prospective TTD

FINDINGS

On the date of accident, **2-21-13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 N/A causally related to the accident.

In the year preceding the injury, Petitioner earned $**26,325.00**; the average weekly wage was $**506.25**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

PETITIONER HAS FAILED TO PROVE AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT, AS WELL AS FAILING TO PROVE NOTICE WITHIN 45 DAYS OF THE ALLEGED ACCIDENT.

ALL BENEFITS ARE DENIED.

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

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

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

D. Ryan McCarthy
Signature of Arbitrator

Feb. 23, 2015
Date

MAR 4 - 2015

ICArbDec19(b)

FINDINGS OF FACT

The petitioner testified he worked as a dishwasher for the Respondent, Hickory River Smokehouse, from approximately August 2012 through April 2013. Petitioner testified his job duties included not only washing dishes but cleaning walls and various other duties.

Petitioner testified that in February of 2013 he had two supervisors, Mike and Shane.

Petitioner testified on February 21, 2013, he turned a bucket upside down to stand on and get up onto a sink to clean. As he was coming down back onto the bucket, the bucket flipped and petitioner slipped and fell on top of the sink. Petitioner testified he hit the floor landing on his buttocks. He testified he was hanging onto the sink with his right hand. Petitioner testified he also injured his hips, back and chest.

Petitioner testified he was not too bad at first however his symptoms increased as the day went on. He did finish out the day.

Petitioner testified he then reported the incident that day to either Shane or Mike Houston, his supervisors. He was told to be more careful. There was no discussion regarding medical treatment per the petitioner's testimony. Further, in his testimony petitioner stated he did not remember which one he told.

The following day he indicated his hips were hurting and approximately two to three days later he told both of his supervisors.

Petitioner testified he continued to work at the restaurant. He had ongoing pain in his chest from lifting. He testified that he also told Mike Johnstone, the owner, within approximately two to three weeks. He did testify that the owner told him to get medical treatment if he needed. He also said that the owner manually helped him adjust his back in the restaurant. However he did not get any medical treatment, stating that the owner would not pay for treatment.

The petitioner testified his first medical treatment was the emergency room April 22, 2013. The petitioner testified he was terminated April 13, 2013, after an incident wherein some dishes were broken. He testified he was fired approximately two to three days after the incident.

Petitioner testified at the emergency room he was given some medication for pain. He then followed up with another doctor, Dr. Rhode. He was sent to the emergency room and to Dr. Rhode both by his first attorney.

The petitioner testified that he gave the information in the emergency room through a computer or call for translating. He testified that Dr. Rhode only spoke a few words of Spanish.

Petitioner testified he then underwent physical therapy throughout May of 2013. He subsequently requested a release so he could return to work. Petitioner testified he has worked in various capacities since October 1, 2013.

The petitioner currently complained that he cannot do the work he used to do. He wants to go to the doctor. He last saw the doctor December 17, 2014, regarding ongoing chest pain, cracking, with a cough. He advised this problem has continued since the date of accident.

On cross-examination the petitioner admitted that the incident wherein dishes were broken also involved him intentionally breaking one dish. He acknowledged he was terminated after that incident. Petitioner admitted he did not seek any medical treatment between February 21, 2013 and April 22, 2013.

Petitioner agreed that if the termination papers reflected he was terminated April 14, 2013, that would be accurate.

The petitioner testified he initially saw an attorney and signed a paper. His application which he said that he signed was dated April 22, 2013. Petitioner testified that after signing the Application he then went to the emergency room as the attorney directed him.

The emergency room records from OSF (Pet. Exh. #4) reflects a timeline of petitioner initially appearing in the emergency room at 1:33 p.m. He remained at the emergency room until discharge until 5:20 p.m. that day. Further, the emergency room records reflect petitioner was Spanish speaking and his history was taken through an interpreter. The emergency room records reflect a history as follows (Pet. Exh. #4, Page 9) ...

> Interpreter used to communicate with patient. Patient to ED with c/o chest pain with a product cough x one week. Patient also states he fell at work x two weeks ago and states he has left hip and back pain as well. Patient alert and oriented, denies shortness of breath, N/V/D, or fever. Petitioner relates he has tried some home remedies such as herbals and tea with no relief of pain.

The emergency room records reflect physical exam of the pulmonary/chest, effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He exhibits tenderness.

Chest x-ray showed no evidence of acute disease .

X-ray of the lumbar spine showed mild rotary scoliosis, otherwise normal.

On physical exam he had normal cervical range of motion.

Diagnosis was low back pain. Pain medication was prescribed.

Petitioner next followed up with Dr. Rhode. Again petitioner testified he was directed to Dr. Rhode by his attorney. The petitioner testified Dr. Rhode only speaks a few words of Spanish.

Dr. Rhode's records (Pet. Exh. #5) reflect petitioner was seen on April 24, 2013. He presented for consultation for low back pain and neck pain.

The history presented to Dr. Rhode was that of a work-related injury two months ago. He was cleaning a sink when he fell. He has been off work since the injury. He complained of significant sternal pain, cervical pain, denied pain radiating down his hands or his legs. Denies prior chest or cervical injury. Dr. Rhode prescribed physical therapy.

Pet. Exh. #6, review records of Prairie Spine & Pain Institute Physical Therapy. The records reflect petitioner was first seen on April 30, 2013. The history presented to the therapist is that of an injury two months ago on the job trying to clean the dishwasher from an elevated surface and slipped and fell on the left side. He landed on his buttock and twisted to the right. The pain progressively got worse in his low back, upper back and chest. **He did not formally notify work of the incident since he was afraid to lose his job.** He decided to report to OSF St. Francis ED. They performed some x-rays that were essentially negative. He was prescribed medication. He was referred to Dr. Rhode last week.

Petitioner underwent physical therapy from April 30, 2013 through May 22, 2013 (Pet. Exh. #6).

Petitioner testified he last sought treatment December of 2014. Pet. Exh. #5, the records of Dr. Rhode reflect petitioner was seen on April 24, 2013, May 22, 2013, and not again until December 17, 2014.

On behalf of the respondent testimony was presented by Mike Houston. Mr. Houston testified he is a manager with Hickory River Smokehouse. He was the manager in February of 2013. Mr. Houston testified petitioner never presented a history of a work-related injury to him. Mr. Houston testified he oversaw petitioner. He never saw petitioner have any problems carrying out his work between February 21, 2013 and April 14, 2013.

Mr. Houston testified his first knowledge that petitioner was claiming a work-related injury was when he was contacted by Mike Johnstone, the owner, after Mike Johnstone had received a letter from an attorney regarding representation of Mr. Valdovinos.

Also on behalf of the respondent Mike Johnstone testified. He is an owner of the respondent, Hickory River Smokehouse. He hired the petitioner in September of 2012. Mr.

Johnstone testified petitioner never reported a work-related injury to him between February 2013 and his termination April of 2013.

Mr. Johnstone testified petitioner was terminated following the dish-breaking incident as he intentionally broke company property and was insubordinate to his supervisor at that time, Heather. He testified he prepared the termination document (Resp. Exh. #3).

Mr. Johnstone testified he had no notice petitioner was claiming a work-related injury until receipt of correspondence from the attorney (Resp. Exh. #4).

Mr. Johnstone testified that following the termination of petitioner in April 14, 2013, petitioner did return to the restaurant and requested Mr. Johnstone prepare a letter of reference for him as he had another job opportunity. Mr. Johnstone told him he would have to think about it. Subsequent to that meeting Mr. Johnstone received the Notice of Representation from the attorney for petitioner. At that time Mr. Johnstone contacted petitioner to inquire as to the basis of the claim. He had a very brief conversation with the petitioner and then Mr. Johnstone followed up with his insurance company. At that time he was requested by the insurance company to complete a Form 45 (Pet. Exh. #2). He completed that document indicating no injury had ever been reported to him. Mr. Johnstone testified that document was completed subsequent to receipt of the correspondence from the attorney for Mr. Valdovinos which is dated April 25, 2013 (Resp. Exh. #4).

Mr. Johnstone testified between February 21, 2013 and April 14, 2013, he never saw petitioner have any problems with carrying out his work activities. He testified petitioner's work activities included not only dishwashing but also unloading meat weighing in excess of 50 pounds on a regular basis and working up to 50 hours a week. Petitioner carried out all of his work duties without problems.

Both Mr. Houston and Mr. Johnstone testified they communicated with petitioner without a problem.

ISSUES

C. In support of the Arbitrator's decision relating to item (C) that an accident occurred that arose out of and in the course of petitioner's employment by the respondent? The Arbitrator finds as follows:

The Arbitrator notes the Findings of Fact and incorporates herein. The petitioner admitted that following the alleged incident on February 21, 2013 until April 14, 2013, he continued to work. He did not seek any medical treatment. The petitioner testified that he did not seek medical treatment until after he sought representation from an attorney. The petitioner testified he sought attorney representation after he was terminated on April 14, 2013. The petitioner admitted in his testimony that he intentionally broke a dish leading to his termination.

The evidence reflects petitioner signed an Application on April 22, 2013 (Pet. Exh. #1). He then proceeded to the emergency room on that afternoon (Pet. Exh. #4). He then sought treatment with Dr. Rhode as directed by his attorney (Pet. Exh. #5) and petitioner's testimony. He then underwent physical therapy per the direction of Dr. Rhode.

While the records reflect a history of injury at work, the emergency room records also have various inconsistencies with respect to when the accident occurred. The emergency room records reflect they were taken through an interpreter.

The testimony of Mr. Johnstone and Mr. Houston support petitioner carried out all of his work activities without difficulty or complaint between February 21 until his termination on April 14, 2013. Both Mr. Johnstone and Mr. Houston denied any notice of any alleged work-related injury during that time. There is no indication of any treatment sought by the petitioner.

Further, the physical therapy records from Prairie Spine & Pain Institute where petitioner was referred by Dr. Rhode (Pet. Exh. #6) reflects petitioner stated he did not formally notify

work of the incident as he was afraid to lose his job. This statement by the petitioner to the therapist contradicts petitioner's own testimony that he reported the incident to Mike Johnstone, Mike Houston, and another manager, Shane.

The Arbitrator finds the evidence in total fails to support petitioner sustained a work-related injury on February 21, 2013. The Arbitrator finds the petitioner failed to meet his burden of proof in establishing an accident arising out of and in the course of petitioner's employment.

E. In support of the Arbitrator's decision relating to (E) was timely notice of the accident given to the respondent? The Arbitrator finds as follows:

Pursuant to Section 6(c) of the Illinois Workers' Compensation Act regarding Notice, the Act provides the following:

Notice of the accident shall be given to the employer as soon as practical but not later than 45 days after the incident.

The evidence reflects petitioner did not provide notice within 45 days. The testimony of Mike Johnstone was that his first notice was upon receipt of correspondence from an attorney representing petitioner. That correspondence is dated April 25, 2013. As that Notice was received at the Illinois Workers' Compensation Commission April 30, 2013, reflecting receipt of the Application and filing at the Commission and Mr. Johnstone's testimony of receipt of the information at the end of April 2013 this would be beyond the 45-day notice for the alleged injury of April 21, 2013.

Further Mike Houston testified petitioner never provided him notice of a work-related injury.

Further, the records of the Prairie Spine & Pain Institute for physical therapy dated April 30, 2013, state:

He did not informally notify work of the incident as he was afraid to lose his job.

Thus, the evidence supports no notice within 45 days.

The Arbitrator notes there was not defective notice but no notice within the 45-day provision. Petitioner has failed to meet his burden of proof on Notice.

As the petitioner has failed to prove either accident or notice, the claim is denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Laudicina,

Petitioner,

vs. NO: 13WC 34980

Cosmo's Hair Design,

Respondent,

15IWCC0751

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, causal connection, temporary partial 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. 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 January 12, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,100.00. 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: SEP 28 2015
o092415
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

LAUDICINA, DEBRA
Employee/Petitioner

Case# **13WC034980**

COSMO'S HAIR DESIGN
Employer/Respondent

15IWCC0751

On 1/12/2015, 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:

0320 LANNON LANNON & BARR LTD
PATRICIA LANNON KUS
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
THEODORE POWERS
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CHICAGO, IL 60606

15IWCC0751

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Debra Laudicina
Employee/Petitioner

v.

Cosmo's Hair Design
Employer/Respondent

Case # **13** WC **34980**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **12/4/14**. 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. xx Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **5/15/12**, 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 $**20,040.80**; the average weekly wage was $**385.40**.

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

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

Respondent shall be given a credit of $**14,131.15** for TTD, $**6,822.65** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**20,953.80**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**256.93**/week for **55-3/7** weeks, commencing **1/29/13** through **6/10/13 & 1/28/14** through **10/9/14**, as provided in Section 8(b) of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $**6,822.65** commencing **6/11/13** through **1/27/14**, as provided in Section 8(a) of the Act. Respondent shall receive credit for amounts paid. ARB EX 1. In addition, the Respondent shall pay TPD benefits of **$210.93** per week for the 4 weeks worked during the period between 10/10/14 and 11/24/14. SEE DECISION and PX 6.

Prospective Medical benefits

The Arbitrator orders the Respondent to pay for surgery and its attendant care as recommended by Dr. Domb, pursuant to Sections 8 and 8.2 of the Act.

Medical Benefits

Respondent shall pay Petitioner the reasonable and necessary medical benefits incurred in the care and treatment of her causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

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

1/5/15
Date

ICArbDec19(b)

JAN 12 2015

FINDINGS OF FACT

Petitioner, a 52 year old hairdresser, worked for Respondent on 5/15/12. Respondent, Cosmo's Hair Design, was owned by Petitioner's father. Petitioner testified that on 5/15/12, she was in the shop working alone. While in the washroom she heard the telephone ring. Petitioner testified that she left the washroom in a hurry to answer the phone. In order to reach the phone, Petitioner had to maneuver past some cabinetry that was on the floor of the shop outside of the bathroom door. Petitioner testified that she maneuvered past the cabinets on the floor and then fell into a half wall that acted as a space divider next to a hair cutting station. Specifically, Petitioner testified that the small wall was approximately 49 inches in height and that a black coat hook was mounted on the front face of the wall. PX 5. Petitioner testified that she fell into the wall striking her right arm and shoulder while simultaneously catching her smock on the hook causing her momentum to stop suddenly. Petitioner testified that she "went black" immediately upon striking the wall.

At trial, Petitioner introduced photos taken two weeks before trial depicting the work space in which she maneuvered and fell. PX 5. The parties agreed that the photos do not depict the area exactly as it appeared on the day of the fall. PX 5A shows a full wall with hanging hooks directly outside the bathroom door. Petitioner testified that on the date of the accident, there were cabinets located on the floor at the bottom of this wall which she maneuvered around. The cabinets stuck out about 2 feet from the wall and approximately one foot into the hallway space. PX 5B. PX 5A also shows the divider half wall which Petitioner fell against. The divider wall is directly across from where the cabinets were located on the floor of the shop on the date of accident. PX 5D and 5E depict the black hook on the divider wall on which Petitioner's smock became entangled after she struck the wall. Petitioner is right hand dominant. She testified that she did not have any prior right arm or shoulder problems.

Petitioner testified that she did not continue to work on 5/15/12 after she fell. Petitioner testified that she originally thought she broke her arm. Petitioner testified that she continued to work the next few weeks after the accident but was unable to raise her right arm. She testified that she had pain in her arm which did not go away, along with numbness and tingling down the arm into her hand which became worse over the next several weeks.

Petitioner testified that she eventually contacted her family doctor when her arm was not improving and saw Dr. Sonya Tolani at DuPage Medical Group. She testified that she saw the doctor around the end of May 2012 and the doctor referred her to Dr. Barbara Heller at DuPage Medical Group. She was unable to obtain an immediate appointment and did not see Dr. Heller until July 9, 2012. The records of DuPage Medical Group were submitted into evidence regarding the initial treatment the Petitioner received. The dates on the DuPage Medical Group records are confusing and difficult to decipher. Many visit dates and records are repeated and pasted into subsequent record dates. PX 1. Pages 52-55 of PX 1 contain the first reference to a visit with Dr. Tolani that records shoulder complaints. This record is dated February 22, 2012. The history on 2/22/12 indicates that Petitioner was seen for upper respiratory symptoms for 3 weeks. The respiratory symptoms are documented in one paragraph. The next paragraph of the 2/22/12 records indicate "Pt comes in with pain in rt arm since:2 weeks .. radiation: into forearm and into thumb caused by: bumped against a wall—into the corner." PX 1, p. 53 of 55. The exam of 2/22/12 indicates some tenderness over the deltoid of the right upper arm. Petitioner's "assessment and plan" on 2/22/12 references prescribed medication for the upper respiratory complaints and a Celebrex prescription for the

"arm pain." Petitioner was diagnosed with "arm pain" and with "upper respiratory infection" on 2/22/12. Petitioner was to return or call if her symptoms persisted. PX 1, p. 54 of 55.

The next relevant record is one prepared by Dr. Heller on 7/9/12. In one record section it references a referral at the request of a physician without referencing the name of the referring physician. However, under the "reason for visit" section, it reads "consult right arm pain, PCP Tolani, Self Pay." PX 1, p. 48 of 55. Dr. Heller is also at Dupage Medical Group. This 7/9/12 record reflects a history of "Debra A. Laudicina is a 52 year old female, who complains of 2 month duration, dull ache right shoulder. Pain began when she inadvertently walked into a half corner of a wall at work, forcefully striking her right deltoid area. Since that time, she has had pain with overhead activity, lying on right side, reaching behind back. She works as a barber which requires her to use her arms outstretched in front of her. She keeps working but really is hurting at the end of the day. No neck pain, no numbness in arms. No weakness in arms noted." PX 1, p. 48 of 55. Shoulder impingement signs were present on exam along with atrophy. Dr. Heller diagnosed a right rotator cuff strain and injected the right shoulder. PX 1, p. 50 of 55. The records further indicate that the visit records of 7/9/12 were sent back to Dr. Tolani on 7/9/12 based on the "routing history" and that Dr. Tolani reviewed the 7/9/12 records on 7/16/12. PX 1, p. 52 of 55. Lending to the confusion of the records is the fact that right after the 7/16/12 review note signed by Dr. Tolani is the entry documenting the visit of 2/22/12 indicating that Petitioner had bumped her arm 2 weeks earlier and that she continued to complain of upper respiratory problems from a cold "several weeks" earlier. PX 1, p. 52 of 55.

The parties agree that the DuPage Medical Group records at PX 1 do not contain any record of a May 2012 visit to Dr. Tolani by Petitioner complaining of her accident and subsequent right arm pain. However, at trial, Petitioner adamantly testified on direct and cross exam that she saw Dr. Tolani in May and not February for the initial right arm treatment. She further testified that she recalls seeing a record from Dr. Tolani dated May 2012 documenting her complaints but agreed that record is not in PX 1.

On July 25, 2012, Dr. Heller wrote to Dr. Tolani regarding Petitioner's follow up visit of 7/25/12. Dr. Heller referenced her treatment of Petitioner on July 9, 2012 for a dull ache in her right shoulder of 2 month duration after striking her right shoulder on a wall. PX 1, p. 45 of 55. When the Petitioner saw Dr. Heller on July 25, 2012, she charted that the Petitioner's condition was unchanged since the initial evaluation and Petitioner was prescribed physical therapy and Advil.

The Petitioner returned to Dr. Heller on September 5, 2012. Dr. Heller noted that despite physical therapy and one injection and oral medication which helped temporarily, Petitioner was not improved and referred Petitioner to Dr. Asselmeier at DuPage Medical Group. PX 1, p. 43 of 55.

Petitioner initially saw Dr. Asselmeier on September 10, 2012. Dr. Asselmeier diagnosed rotator cuff syndrome and capsulitis of the right shoulder. He recommended an MRI to better evaluate the rotator cuff. He also noted that the reason for the visit was that she walked into the corner of a wall "6/2012" and had pain ever since. She had undergone therapy and an injection which did not help. He charted that she had loss of range of motion and numbness in her hand (Px.#1, p.39 of 55). Petitioner underwent the MRI at DuPage Medical. The MRI showed rotator cuff tendinopathy with minimal undersurface fraying. The radiologist suspected a tear of the posterior superior glenoid labrum. When the Petitioner returned to Dr. Asselmeier on September 17, 2012, he felt that the MRI showed significant tendinopathy without obvious

cuff tear, moderate AC disease and recommended an arthroscopy with distal clavicle resection (Px.#1, p.37 of 55).

Petitioner subsequently underwent surgery at Edward Hospital by Dr. Asselmeier on January 29, 2013. He performed an arthroscopic acromioplasty with distal clavicle resection. The post-op diagnosis was impingement of the right shoulder with adhesive capsulitis. Dr. Asselmeier stated in the operative report that the Petitioner had struggled with the disability in her right shoulder and her symptoms were consistent with ongoing impingement and acromioclavicular processes. He stated she had failed conservative management and needed the surgery (Px.#1). Following surgery, the Petitioner began physical therapy. She continued therapy until June 2013. The Petitioner testified that she continued having ongoing pain and stiffness in her shoulder after the surgery.

Petitioner saw Dr. Asselmeier on May 13, 2013. He noted that the Petitioner continued to struggle with functional intolerance, pain, ache and stiffness. He recommended a subacromial injection and ongoing therapy. He also noted that she might need an MRI of her neck and shoulder (Px.#1, p.14 of 55). Petitioner saw the physical therapist on June 7, 2013. The therapist stated that the Petitioner was having more pain in the shoulder and no improvement with therapy. She concluded that the patient had plateaued in therapy and would benefit from physician consultation before returning to therapy. She stated that she was going to discharge the Petitioner due to lack of progress (Px.#1).

Petitioner returned to Dr. Asselmeier on June 10, 2013. He charted that she had been doing therapy without significant improvement. He stated that the last cortisone injection did little to change her symptoms and she continued to have pain in the mid arm distally with some radiation and neck stiffness. He recommended an MRI of the neck to evaluate the cervical elements and gave her a four hour work restriction (Px.#1, p.4 of 55). The Petitioner then returned to work on June 11, 2013, with restrictions. Petitioner's last visit to Dr. Asselmeier was on June 26, 2013. She had undergone the cervical MRI at DuPage Medical on June 24, 2013. The doctor felt that she might have right cervical radiculitis. He stated that the Petitioner continued to have cramping and burning in the right shoulder, and some stiffness in the neck with a poor response from the injection. He did not have a good explanation for her ongoing problem and recommended pain management with selective injections (Px.#1, p.2 of 55).

Petitioner then sought a second opinion from Dr. Domb at Hinsdale Orthopedics on July 18, 2013. The doctor noted that the Petitioner's problems began in May 2012, after a fall into a corner of a table. He stated that she had undergone therapy, followed by surgery, but still had pain, numbness and tingling in her arm. Dr. Domb felt that the Petitioner's problems could be due to the direct blow injury to the radial nerve in the arm or it could be due to a pinched nerve in the cervical spine. He ordered EMG testing, a new MRI/arthrogram of the shoulder and wanted to review the original cervical MRI. He continued the Petitioner on light duty work of four hours per day (Px.#2).

Petitioner underwent EMG testing on August 13, 2013, which was normal. She also underwent an MRI/arthrogram at Hinsdale Orthopedics on August 21, 2013. The arthrogram showed a small partial thickness articular surface tear of the supraspinatus and infraspinatus as well as post surgical changes of the distal clavicle and a SLAP tear into the biceps anchor extending to the labrum (Px.#2). When Petitioner returned to Dr. Domb on September 12, 2013, the doctor felt the MRI showed evidence of a SLAP tear and partial thickness tear and recommended additional surgery. Dr. Domb stated that he felt her problems were due to a combination of a SLAP tear, partial thickness tear, biceps tendonitis and

residual AC joint impingement. He recommended additional surgery since the Petitioner had failed to improve up to date. He also continued the Petitioner's work restrictions to a maximum of four hours per day (Px.#2).

Petitioner underwent surgery performed by Dr. Domb on January 28, 2014. The doctor performed a mini open biceps tenodesis with arthroscopic rotator cuff repair of the supraspinatus and sub-scapularis, with a subacromial decompression with revision AC joint resection and labral debridement (Px.#2).

Following the surgery, Petitioner underwent physical therapy at ATI. On March 25, 2014, the therapist at ATI wrote a progress note stating that after seventeen sessions the patient continued with range of motion limitations along with significant pain and guarding (Px.#2). Petitioner returned to Dr. Domb on March 28, 2014. The doctor noted that she was status post surgery but still had stiffness of her shoulder and hand with neurologic symptoms. The doctor's office recommended that she see a neurologist to rule out RSD (Px.#2).

Petitioner subsequently saw Dr. Christopher Morgan at Pain Care Specialists on April 17, 2014. Dr. Morgan charted that there was mild increased redness in the right upper arm and right shoulder as compared to the left along with limited range of motion of the right shoulder with forward flexion. The cervical range of motion was without pain. Dr. Morgan recommended treatment for complex regional pain syndrome consisting of a right stellate ganglion block. He felt that if she had some temporary improvement, then a series of injections would be recommended. He also stated that her symptoms were directly related to the injury (Px.#4). The Petitioner did not undergo the injections. Instead, the Petitioner continued with physical therapy and returned to Dr. Domb. Petitioner saw Dr. Domb on May 8, 2014. Dr. Domb noted pain and stiffness and felt she might need another injection if the stiffness continued (Px.#2).

Dr. Domb also referred the Petitioner to Dr. Kazan at West Suburban Neurosurgical Associates. Dr. Kazan ruled out that the Petitioner would need any further investigation regarding cervical spine surgery. PX 3. However, he recommended a new MRI of the cervical spine which was performed on July 21, 2014, at Hinsdale Orthopedics. The impression was degenerative changes of the cervical spine. Petitioner returned to Dr. Domb on August 14, 2014. At that time, the doctor charted that she had ongoing shoulder pain with radiculopathy and adhesive capsulitis. He prescribed an injection into the shoulder. He felt that if she continued to have pain despite the injection, a possible arthroscopy would be warranted (Px.#2).

Respondent had the Petitioner evaluated by Dr. Slobodan Vucicevic on August 14, 2014. The Section 12 doctor concluded that the Petitioner's condition had nothing to do with the injury of May 15, 2012. He stated that the Petitioner did not sustain any type of blow to the area and the blow was several inches below shoulder level. He felt that she merely scraped the area on a partition wall and there was no causal connection between the scraping type of injury and all of her issues. His exam of Petitioner's cervical and right shoulder was normal. RX 1. Dr. Vucicevic further opined that the Petitioner did not need any further treatment and could merely take some anti-inflammatory medication and was capable of returning to work performing her regular duties (Rx. #1). Petitioner's TTD benefits were terminated based on the Section 12 exam.

On August 22, 2014, the Petitioner was discharged from physical therapy at ATI. The therapist noted that the Petitioner had undergone 77 sessions of therapy and had minimally increased range of motion and strength. Further therapy was not prescribed until she underwent a manipulation under anesthesia. Dr. Domb ordered a right shoulder arthrogram which was performed on September 3, 2014, at Hinsdale Orthopedics. The radiologist stated that there was a mild increased signal within the tendon possibly due to post surgery or tendinosis and there was also fluid extending into the labrum (Px.#2).

Petitioner returned to Dr. Domb on September 4, 2014. The doctor charted that the Petitioner had continued pain and stiffness in the shoulder. He stated that the injection gave the Petitioner some relief but her pain returned and there was no improvement in her range of motion even though she had many months of physical therapy. He felt that the MRI showed an intact rotator cuff and the Petitioner would need further surgery for the adhesive capsulitis (Px.#2). Petitioner saw Dr. Domb on October 30, 2014. Dr. Domb noted ongoing shoulder stiffness and pain and no improvement with range of motion. He felt she still needed an arthroscopic capsular release with a manipulation.

Dr. Domb's record dated November 5, 2014, indicating that Petitioner had attended an IME who indicated that her shoulder injury was not work related. In response, Dr. Domb indicated that he saw the pictures of the wall which Petitioner told him she struck. The wall came to waist or chest level and in his opinion could cause an injury to the rotator cuff. He stated that the original injury at work was the cause of the Petitioner's ongoing disability. PX 2. Dr. Domb reiterated the need for further care.

Petitioner testified at the hearing that she has continued to work in a light duty capacity as recommended by Dr. Domb but that she is in need of surgery. Petitioner testified that she currently has pain in her right shoulder and is unable to move the shoulder in certain directions. Petitioner is unable to hold her right arm at shoulder level for any long period of time, experiences tightness in her right shoulder and her right hand "falls asleep." She further testified that she would like to undergo the recommended treatment by Dr. Domb.

CONCLUSIONS OF LAW

The above 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?

The Arbitrator initially notes that Petitioner's testimony at trial regarding her accident was highly credible and unrebutted. Petitioner testified that she had no problems with her right arm or shoulder prior to 5/15/12. Petitioner credibly testified that on 5/15/12, she was at work as a barber when she quickly exited the bathroom to answer a ringing phone and fell while maneuvering through the styling area to answer the phone. The photos at PX 5 support Petitioner's testimony regarding the area where she fell. Specifically, the photos depict a short divider wall with a coat hook. Based on Petitioner's testimony as buttressed by the photos, the Arbitrator finds that Petitioner fell against the divider wall, caught her smock on the hook, struck her right arm and shoulder against the wall and was jerked to a stop due to her smock catching on the hook.

The confusing nature of the initial treating records at PX 1 and the lack of a May 2012 corroborating treatment date for right shoulder complaints are not lost on the Arbitrator. However, the Arbitrator places greater weight on Petitioner's testimony that she reported the injury to Dr. Tolani in May 2012 when combined with a review of the DuPage Medical Group in their entirety in finding that Petitioner sustained accidental injury to her right arm and shoulder while at work on 5/15/12. Specifically, the July 2012 records of Dr. Heller clearly indicate arm pain of 2 months duration after striking her right shoulder on the wall at work. A reference to pain of "2 months duration" would indicate an accident in May 2012 as adamantly and credibly testified to by Petitioner at trial. Accordingly, the Arbitrator finds that Petitioner sustained a work related accident on 5/15/12.

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

The Arbitrator again notes that Petitioner had no prior problems with her right arm or shoulder prior to 5/15/12. Petitioner testified that subsequent to 5/15/12, Petitioner continued to work while experiencing significant pain and limited range of motion to her right arm. Petitioner began her treatment with Dr. Tolani who referred Petitioner to Dr. Heller. Dr. Heller then referred Petitioner to Dr. Asselmeier who performed the initial shoulder surgery on January 29, 2013. After failing to recover, Petitioner sought treatment with Dr. Domb and underwent a second surgery on January 28, 2014. Petitioner has continued to treat with Dr. Domb to the present with a current recommendation for additional surgery following the failure of her post surgical conservative care.

Dr. Domb opined that Petitioner's condition of ill-being in her right shoulder which currently continues is causally related to the accident of 5/15/12 when Petitioner struck her right arm and shoulder on the divider wall. Dr. Domb opined that the mechanism of injury as described to him by Petitioner and buttressed by the photos of the wall was sufficient to cause Petitioner's shoulder injury including the rotator cuff injury and the current adhesive capsulitis. The Arbitrator agrees with this opinion. The Arbitrator places greater weight on the opinion of Dr. Domb with regard to the mechanism of injury and causal connection than on the opinion of the Section 12 examining physician Dr. Vucicevic who opined that the Petitioner's condition of ill-being was not related to the injury. It appears Dr. Vucicevic's opinion is based in part on his note that Petitioner reported the divider wall to be 3 to 4 inches below shoulder level and that as such he concluded that Petitioner hit her brachial area and not her shoulder area. He concluded that Petitioner "scraped" her shoulder area at most. Dr. Vucicevic stated that he "doubted" there was any type of forceful blow that occurred at the time of the incident. Petitioner testified that she reported hitting her shoulder area to Dr. Vucicevic. Nevertheless, Dr. Vucicevic opined that he did not feel that Petitioner sustained a severe hit or fall. In contrast, the Arbitrator notes that the Dupage Medical Group records from July 2012 all indicate a reported history of a hard strike to the right shoulder or deltoid area of the right arm on the wall at work. These records certainly support a finding that Petitioner's mechanism of injury resulted in more than a "scrape" to her shoulder area.

In light of the record in its entirety, including the objective treatment records documenting Petitioner's right shoulder condition and need for treatment which developed immediately after the work accident of 5/15/12, the Arbitrator finds causal connection for Petitioner's condition of ill-being which currently continues. As such, the Arbitrator finds that Petitioner is entitled to receive the surgical treatment currently prescribed by Dr. Domb. The Arbitrator further finds that Respondent shall authorize and pay for the recommended surgery and its attendant care pursuant to Sections 8 and 8.2 of the Act.

L. What temporary benefits are in dispute? TTD/TPD

Based on the Arbitrator's findings on the issues of accident and causal connection, Petitioner's treating medical records and the Respondent's dispute based on liability, the Arbitrator further finds that Petitioner was temporarily and totally disabled for intermittent periods commencing 1/29/13 through 6/10/13 and again from 1/28/14 through 10/9/14 for a total TTD period of 55-3/7 weeks. Respondent is to pay TTD for the period of 55-3/7 weeks, including any underpayment of TTD, at the rate of $256.93 per week based on Petitioner's stipulated average weekly wage. ARB EX 1. Respondent shall receive credit for amounts paid. ARB EX 1.

The Arbitrator further finds that Petitioner was temporarily partially disabled and entitled to TPD benefits when she returned to work earning less while working under restrictions for the period of 6/11/13 through 1/27/14. ARB EX 1. The Arbitrator notes that Respondent paid Petitioner TPD for the period of 6/11/13 through 1/27/14. Respondent shall receive credit for amounts paid during that period.

Petitioner claims further TPD for a period of 6-4/7 weeks commencing 10/10/14 through 11/24/14. However, the Arbitrator notes that PX 6 does not reflect earnings through the entire claimed 6-4/7 week period. Rather, PX 6 is 4 individual pay stubs for 4 separate weeks worked within that period. In short, the evidence shows that Petitioner worked 4 weeks, not 6-4/7 weeks, based on PX 6. PX 6 reflects that Petitioner earned a total of $276.00 during those 4 weeks. Petitioner's average weekly wage was $385.40. ARB EX 1. If working full duty, Petitioner would have earned $1,541.60 for 4 weeks. Based on the evidence at trial, in order to reach and award a weekly TPD payment, the Arbitrator calculates the TPD rate as follows: $1,541.60 – 276.00 =$1,265.60 x 2/3 = $843.73 /4 = $210.93. Accordingly, Respondent shall pay Petitioner temporary partial disability of $210.93 per week for 4 weeks based on PX 6.

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

Based on the Arbitrator's findings on the issues of accident and causal connection and the Respondent's dispute based on liability, the Arbitrator further finds that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related shoulder condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph J. Thoron,
Petitioner,

vs. No: 08 WC 19579

Freeman United Coal Mining Company,
Respondent.

15IWCC0739

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, and nature and extent of the permanent disability, and being advised of the facts and law, affirms the August 15, 2014 Decision of Arbitrator Molly Dearing, which is attached hereto and made a part hereof, with the following modifications.

Arbitrator Dearing found Petitioner proved he suffered from coal workers' pneumoconiosis ("CWP") and chronic cough as a result of his exposure to irritants while working in Respondent's mines and plant. The Arbitrator awarded Petitioner 10% loss of the person as a whole.

Petitioner alleged that he was injured by exposure to irritants during his 17 years below ground working in Respondent's mine and 14 years above ground working in Respondent's plant. He identified his date of accident as August 29, 2007, the date the mine closed and all workers were laid off. Petitioner testified that during the 31 years he worked for Respondent, he was exposed to coal and silica dust, roof bolting glue, diesel fumes, and epoxy adhesive. He consulted with his family physician, Dr. Gauen, for breathing problems in the 1990's, and the symptoms waxed and waned over the years. When necessary, he used Advair and a rescue inhaler.

Petitioner introduced reports from B-readers, Dr. Cohen and Dr. Smith, as well as Dr. Cohen's deposition. These doctors found that Petitioner's lungs showed evidence of CWP. Respondent's expert B-readers, Dr. Meyer and Dr. Rosenberg, found no radiographic evidence of CWP. Arbitrator Dearing was persuaded by Petitioner's doctors' opinions.

Dr. Gauen, Petitioner's primary care physician, testified by deposition that Petitioner suffered from asthma and that his 31 years of coal mining for Respondent had aggravated that condition. However, Dr. Gauen admitted that the spirometry he ordered evidenced no obstruction or restriction in the airway and indicated that Petitioner was capable of working heavy manual labor.

15IWCC0739

Dr. Gauen further admitted on cross-examination that there was no objective evidence of a permanent aggravation to Petitioner's asthma from working at the mine. Dr. Cohen conceded that the Methacholine Challenge test may not have been valid, so the results were questionable. Thr Commission concludes that Petitioner's asthmatic condition was not caused or permanently aggravated by his work exposure.

Petitioner also alleged the development of a chronic cough as a result of his exposure to fumes and dust. Dr. Cohen diagnosed Petitioner with chronic cough based solely on Petitioner's representation, and Arbitrator Dearing found this condition to be causally related to Petitioner's mine exposure. However, no expert witness provided a clear causation opinion linking Petitioner's alleged cough to his work exposure, and the Commission notes Dr. Gauen's March 14, 2013 office note reflects that Petitioner reported that he seldom coughed. The Commission concludes that the petitioner has failed to prove either a chronic cough or a causal relationship between his coughing and his workplace activities.

The Commission agrees with the Arbitrator that Petitioner proved that he developed pneumoconiosis from exposure to the irritants in Respondent's mine and plant, but further finds that Petitioner failed to prove that he suffered from chronic coughing and that either the asthmatic condition or the coughing condition resulted from his work exposure. The Commission affirms the Arbitrator's award of 10% loss of a person as a whole, based upon his work-related CWP.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 2014, is hereby affirmed with changes.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $636.15 per week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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 injuries.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,100.00. 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 the Circuit Court.

DATED: SEP 2 4 2015

Joshua D. Luskin

Charles J. DeVriendt

o-08/05/15
jdl/dak
68

15IWCC0739

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain his burden of proving that he developed an occupational disease, reversed the Decision of the Arbitrator, and denied compensation.

The Arbitrator found that Petitioner sustained his burden of proving he developed coal miner's pneumoconiosis. The majority agreed and affirmed the Decision of the Arbitrator. In this case there was testimony from four B-readers. The two B-readers presented by Petitioner, Dr. Smith and Dr. Cohen, interpreted his x-rays to be positive for coal miner's pneumoconiosis. The two B-readers presented by Respondent, Dr. Meyer and Dr. Rosenberg, interpreted his x-rays to be negative for coal miner's pneumoconiosis. In my opinion, if there is such an even split of opinion and all the B-readers are equally persuasive the claimant has likely failed to sustain his burden of proving he developed coal miner's pneumoconiosis.

In addition, Petitioner's general practitioner, Dr. Gauen, testified that he did not know whether Petitioner had coal miner's pneumoconiosis. He noted that Petitioner did have asthma but never reported to him any asthmatic attack associated with his work in the coal mine. While other doctors testified that exposure to some elements found in a coal mine environment can exacerbate asthma, none of them opined that such exacerbation would be anything more than a temporary exacerbation. Dr. Gauen further testified that Petitioner did not complain of breathing problems until after he terminated his employment in a coal mine and began working as a carpenter. Saw dust can aggravate an asthmatic condition. Finally, all of the doctors posited that Petitioner's spirometry results indicated he was still capable of working at a heavy physical demand level.

In conclusion, in looking at the record as a whole, I conclude that Petitioner did not sustain his burden of proving he developed an occupational disease or current disablement. I would have reversed the Decision of the Arbitrator and denied compensation. For these reasons, I respectfully dissent

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THORON, JOSEPH J
Employee/Petitioner

Case# 08WC019579

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

15IWCC0739

On 8/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
BRUCE R WISSORE
300 SMALL ST SUITE 3
RALEIGH, IL 62977

1662 CRAIG & CRAIG
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOSEPH J. THORON
Employee/Petitioner

Case # **08** WC **19579**

v.

Consolidated cases: ____

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

15IWCC0739

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **June 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Disease/Exposure, Causation and Sections 1(d)-f of the Occupational Disease Act**

FINDINGS

On **August 29, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,439.08**; the average weekly wage was **$1,162.29**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Signature of Arbitrator

August 12, 2014
Date

AUG 15 2014

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOSEPH J. THORON
Employee/Petitioner

15IWCC0739

v.

Case #08 WC 19579

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was fifty eight years of age (Arb. X 1), and he had been employed by Respondent as a coal miner for thirty one years at its Crown II mine. Petitioner worked underground during the first seventeen years of his career, and the last fourteen were spent in the prep plant above ground. During his coal mining tenure, Petitioner was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes, coal dust, and Trowel-On, an epoxy adhesive that is used to repair coal chutes.

Petitioner worked his last shift in his position as a coal miner for Respondent on August 29, 2007. On that date, he was classified as prep plant maintenance, and he testified that he was exposed to and breathed coal dust, diesel fumes, roof bolting glue fumes, and Trowel-On fumes. He was given notice that he was being laid off on August 29, 2007 and the mine closed. Petitioner went on the panel for recall, but he limited his recall position to hoisting engineer. Petitioner testified that he listed a job for recall that he believed he would not be recalled to because he did not want to return to coal mining and begin anew. Petitioner testified that if he had been recalled to the Crown III mine, his company seniority would have disappeared. Petitioner testified that if he wanted to return immediately as an underground laborer, he could have been hired the next day. He stated that following the mine closure, he was offered coal mine jobs at other mines which he declined. Petitioner testified that he would have reported to work the next day had the mine not closed on August 29, 2007.

Petitioner first noticed breathing difficulties at work in the 1990s while he was working on the surface at the prep plant. The silica, mine dust, roof bolting glue, Trowel-On, and diesel fumes caused him to wheeze and cough, and other's smoking caused difficulty breathing. Petitioner would get a coughing spell and it would become difficulty to breath. Petitioner described his shortness of breath as an inability to get enough oxygen. When he would have an attack, he would utilize his inhaler and leave the area. He testified that his foreman knew what was happening at the time, and oftentimes co-workers would have to physically help him leave the area. Petitioner testified that he would get bronchitis every winter and he would have a difficult time recovering. Petitioner testified that when he began experiencing difficulty

breathing, he presented to his family physician, Dr. Gauen. Dr. Gauen ran a test on him and prescribed medication at that time. Petitioner took Advair and occasionally utilized his rescue inhaler for acute situations while employed in the mine. Petitioner testified that in his position at the prep plant, there are nine floors with no elevators, and he would be forced to climb those stairs each shift and several more times on some days. After years of working there, he would have to utilize his inhaler and rest after climbing a few floors.

In the year following the mine closure, Petitioner testified that he did not search for new employment because Respondent provided insurance for one year. Thereafter, he became employed by the State of Illinois on May 15, 2009 as a maintenance carpenter. In that position, he worked in State buildings replacing ceiling tile, doors and wall panels. He described it as maintenance work, rather than total construction. Petitioner retired at the end of 2013 when he reached age sixty five and began collecting Social Security and Medicare. He had been collecting his pension from the United Mine Workers since shortly after the mine closed.

Petitioner began his apprenticeship program with the carpenters union in 1969 and continued through 1976, eventually becoming a journeyman. The work was very seasonal. Petitioner was thereafter offered a job at the coal mine, though he kept his journeyman card current for a period of time during his coal mining career. He acknowledged that if he had wanted to leave the coal mine at any time and return to carpentry, he could have done so.

Petitioner testified that he continues to utilize Advair and his rescue inhaler. He can presently walk on flat ground at regular pace about a quarter of a mile before becoming short of breath. He can climb two flights of stairs before stopping to rest, though he used to be able to climb significantly more.

Petitioner testified that his current breathing problems affect his activities of daily living. He owns farm ground, but he testified that he does not have the breathing capabilities to perform farm work himself. The farm is a grain farm and the ground is farmed by other people, while some of the acreage is used for deer hunting and fishing. Petitioner used a shotgun to deer hunt from a stand in 2013. He also fishes from a boat. He likes to golf, but because of his diminished ability to walk long distances, he must ride in a cart. He plays golf a couple of times per month. Petitioner testified that he never smoked cigarettes. In the 1990s, he was diagnosed with type II diabetes, which he controls with medication.

Petitioner presented to Dr. Robert Cohen on April 24, 2009 at the request of his counsel. Dr. Cohen is an attending physician at Stroger Hospital of Cook County and is the medical director of the Pulmonary Physiology and Rehabilitation Section. He is also the Medical Director of the Black Lung Clinic at Stroger Hospital, and of the National Coalition of Black Lung and Respiratory Disease Clinics. He is board certified in internal medicine, pulmonary medicine and critical care. Dr. Cohen has been a B-reader since 1998. PX 1.

On April 24, 2009, Petitioner gave Dr. Cohen a history of shortness of breath on exertion for ten to twelve years. He also reported wheezing. These symptoms were worse with heavy exertion. Petitioner also reported a history of having been diagnosed with asthma and having a non-productive cough. Petitioner related to Dr. Cohen that he had never smoked cigarettes and that he had thirty one years of coal mine employment. PX 1.

Dr. Cohen's physical examination of Petitioner's chest was normal. Dr. Cohen interpreted the chest radiograph of February 6, 2008 as positive for the opacities of pneumoconiosis with P/Q opacities in the upper and mid lung zones bilaterally with a profusion of 1/0. The pulmonary function testing performed as part of Dr. Cohen's examination was normal. The exercise testing was submaximal, but he had a normal work capacity. Dr. Cohen testified that there were no significant limitations detected on Petitioner's cardiopulmonary exercise test. PX 1.

Dr. Cohen testified that within a reasonable degree of medical certainty, Petitioner had coal workers' pneumoconiosis based on his chest radiograph reading. He testified that the pneumoconiosis and the symptoms of wheezing and coughing were caused by Petitioner's thirty one years of exposure to coal mine dust. PX 1.

Based on his diagnosis of coal workers' pneumoconiosis, Dr. Cohen testified that Petitioner could not have any further exposure to coal mine dust without endangering his health. Dr. Cohen testified that if someone was concerned that Petitioner's lung function had deteriorated, it would be prudent to repeat the lung function testing. PX 1.

Dr. Cohen further testified that there are exposures in the coal mine environment that can cause and aggravate asthma, including glues used in the roof bolting process and in repairing coal chutes. Fumes from high sulfur coal can exacerbate asthma, and smoke and fumes from electrical cable fires, diesel fumes and exhausts, creosote and bioaerosols can be respiratory irritants which can exacerbate and cause asthma as well. Dr. Cohen testified that the symptoms or complaints of asthma could wax and wane over time. The pulmonary function testing that Dr. Cohen performed on one occasion would not rule out occupational asthma in Petitioner. Dr. Cohen did not believe that Petitioner met the criteria for chronic bronchitis. PX 1.

Dr. Cohen stated that Petitioner did not relate to him any specific exacerbations of his breathing problem at work. He described his breathing as worse with exertion and with climbing stairs. Dr. Cohen testified that shortness of breath with exertion is a non-specific complaint and can be due to many causes. The most common cause is deconditioning. At the time Dr. Cohen examined Petitioner, he had a body mass index of 35.30, which placed him in the obese category. Petitioner did not tell Dr. Cohen that he left coal mining at the time he did due to a respiratory problem or on the advice of a physician, nor did he tell Dr. Cohen that he was unable to perform the duties of his last job in the mine. Dr. Cohen testified that more likely than not, coal workers' pneumoconiosis will not progress once exposure ceases. PX 1.

Dr. Cohen testified that Petitioner had a history of exposure to grain dust on his farm after he left coal mining, and he likely would be exposed to pesticides as well. Dr. Cohen stated that both grain dust and pesticides can exacerbate asthma. Dr. Cohen felt his examination of Petitioner was complete and that the significant findings from same were accurately recorded in his report. Petitioner's O_2 saturation, which indicates whether the oxygen carrying capacity of the blood is appropriately saturated, was 98%. Petitioner's saturation level indicates that he was appropriately saturated. PX 1.

Dr. Cohen testified that the pulmonary function testing he performed on Petitioner revealed no evidence of an obstruction or restriction. His lung volumes and diffusing capacity were normal. Petitioner's arterial blood gases were measured both at rest and with exercise. Dr.

Cohen testified that exercise testing is considered to be a gold standard for determining an individual's cardiopulmonary ability, and no functional impairment was revealed by Dr. Cohen's testing. There was no pulmonary cause identified for Petitioner's complaint of shortness of breath. Dr. Cohen testified that functionally, Petitioner is capable of heavy manual labor. Dr. Cohen noted in his report that Petitioner was not disabled in his last coal mine job based on the results of the testing which revealed no pulmonary limit to exercise. Dr. Cohen testified that it is possible for a person to have coal workers' pneumoconiosis despite having normal pulmonary function, arterial blood gases, normal exercise testing and normal physical examination of the chest. In those areas of the lungs where the scar exists, the lung function would not be normal. PX 1.

Dr. Cohen also provided a medical opinion dated February 12, 2013, following his review of a report by Dr. Rosenberg, and medical records from Physicians Group Associates, Memorial Medical Center in Springfield and St. John's Hospital. Dr. Cohen testified that in the records he reviewed, he noted that Petitioner had frequent episodes of bronchitis, that he had a non-productive cough, except when he had the episodes of bronchitis, when he had symptoms of wheezing. Petitioner was diagnosed with asthma in 2004. He had physiology testing and a positive methacholine challenge test. Petitioner had reversible obstruction impairments. Dr. Cohen testified that the data set was consistent with asthma. He testified that Petitioner's asthma was aggravated by his exposures as a coal miner. He testified that in Petitioner's work as a coal miner, he was exposed to respiratory irritants which would clearly aggravate one's hyperactive airways disease. Dr. Cohen testified that because of Petitioner's asthma and potential for asthma attacks, he could not safely work in a coal mine, and he would not advise asthmatics to work in a coal mine because of the respiratory irritants in the mines. Dr. Cohen testified that the triggers for a person's asthma attacks are not continuously present, but they are intermittently present and one has symptoms when he is exposed at those times. PX 2.

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted the chest radiograph of February 6, 2008 as positive for pneumoconiosis with P/P opacities in the mid to lower lung zones bilaterally, category 1/0.

Petitioner testified that he also presented to Dr. Paul at the request of his counsel, at which time he underwent a breathing test similar to the one administered by Dr. Cohen. Petitioner testified that he had a copy of the report at home, but he did not bring it with him to Arbitration.

Dr. Cristopher A. Meyer, board certified radiologist and B-reader since 1999, reviewed a PA and lateral chest radiograph of Petitioner dated February 6, 2008 at the request of counsel for Respondent. He testified by way of evidence deposition on October 12, 2012. Dr. Meyer testified that there was no radiographic finding of coal workers' pneumoconiosis on Petitioner's film. He noted a region of plate atelectasis at the left lung base, which he described as an area of linear density in the lung where the lung literally sticks together. Dr. Meyer testified that this area is potentially a sequella of the failure to take a full and complete deep breath, but it is not a manifestation of dust exposure nor would there be any impairment associated with it. Dr. Meyer noted the film to be quality 2 due to underinflation, which he stated was significant as underinflation can accentuate the pulmonary vasculature and can mimic a round opacity. He stated that the lower zones are typically more accentuated by underinflation. RX 1.

Dr. Meyer testified that the B-reader looks at the lung to decide whether there are any small nodules or opacities or any linear opacities and based on the size and appearance of the small opacities, they are given a letter score. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the lung involvement for the small opacities is the extent of the lung involvement or the so-called profusion. Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. RX 1.

Petitioner underwent a chest radiograph on November 15, 2002. The film was interpreted by two NIOSH B-readers as negative. RX 5.

Dr. David Rosenberg has been board certified in internal medicine since 1977 and in pulmonary disease since 1980. He received his board certification in occupational medicine in 1995. After graduating from medical school, Dr. Rosenberg did a pulmonary fellowship at the National Institute of Health in Bethesda, Maryland. Dr. Rosenberg has been a B-reader since July 2000. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians and the American College of Occupational and Environmental Medicine. He has done black lung evaluations in Kentucky for various attorneys or insurance companies. Dr. Rosenberg presently treats patients with black lung disease. RX 2.

Dr. Rosenberg conducted a review of medical records at the request of Respondent's counsel, and he testified by way of evidence deposition on August 9, 2013. He reviewed the B-readings of Drs. Meyer and Smith, the evaluation by Dr. Cohen from April 24, 2009, medical records of Dr. Gauen, Dr. Villegas, Carlinville Area Hospital, Memorial Medical Center, and Physicians Group Associates, and a chest radiograph dated February 6, 2008. RX 2.

Dr. Rosenberg interpreted Petitioner's chest radiograph of February 6, 2008 as quality 2, being light. Dr. Rosenberg testified that there was some atelectasis in the left costophrenic angle without the presence of micronodularity. He found the chest radiograph to be 0/0 for pneumoconiosis. RX 2.

Dr. Rosenberg acknowledged that methacholine testing performed on Petitioner on April 30, 2004 established a diagnosis of asthma. Dr. Rosenberg testified that he did not have the flow volume loops so he could not confirm that complete efforts were made. He testified that the American Thoracic Society required a valid test before a diagnosis could be made. Dr. Rosenberg agreed with Dr. Cohen that Petitioner had a normal work capacity and that he was capable of heavy manual labor from a pulmonary or ventilatory standpoint. Dr. Rosenberg testified that there was not any objective evidence that Petitioner had suffered a permanent functional impairment from aggravation suffered to his pulmonary system over time. He stated that there is not any reason for an individual with asthma not to be employed as a coal miner. Dr. Rosenberg concurred with Dr. Cohen in the opinion that Petitioner did not have chronic bronchitis. He also agreed with Dr. Cohen's testimony that dust, including grain or wood dust, could aggravate asthma, in which irritants are intermittently present and can aggravate symptoms when so exposed. RX 2.

Dr. Rosenberg testified that based on his review of the chest radiograph, Petitioner's normal total lung capacity, normal diffusing capacity, and exercise testing, Petitioner did not have interstitial involvement related to past coal mine dust exposure. Dr. Rosenberg testified that Petitioner's baseline pulmonary function test did not demonstrate the presence of an airway obstruction. He had a mild degree of bronchoreactivity consistent with asthma as assessed by his positive methacholine challenge test in 2004. The asthma had intermittently been treated and over the last three years of recorded treatment notes up until 2008 and no associated respiratory symptoms were reported. Dr. Rosenberg testified that coal mine dust and other exposures in the coal mines would not have precipitated this disorder. Dr. Rosenberg concluded that Petitioner did not suffer from pulmonary disease or impairment as a result of coal mine related exposures. Dr. Rosenberg noted that the Accupril prescribed for Petitioner's hypertension can cause a chronic cough. Dr. Rosenberg testified that while coal dust, grain dust or wood dust as well as diesel fumes, roof bolting fumes and isocyanate-containing adhesives in the coal mine could cause and aggravate asthma, it would do so transiently. RX 2.

Dr. Rosenberg testified that a tissue reaction, either in the airway or in the lung parenchymal, to the trapped coal mine dust is required to have coal workers' pneumoconiosis. That tissue reaction can be called scarring or fibrosis. Most patients with simple coal workers' pneumoconiosis have preserved lung function. He testified that on a microscopic basis, if scar tissue is laid down in normal structures, the area would not be working correctly. Dr. Rosenberg testified that coal workers' pneumoconiosis is a chronic disorder that can be progressive. It can progress even after one leaves the coal mine although the chance is much less. He testified that individuals can have low levels of exposure without having increased risk for progressing. RX 2.

Dr. Ralph Gauen testified by way of evidence deposition on April 10, 2014. He is board certified in internal medicine, and he has practiced in the Springfield, Illinois area since 1977. Dr. Gauen treated Petitioner from 2002 until July 2013 at Physicians Group Associates. PX 3. Dr. Gauen responded to questions posed to him by Petitioner's counsel in a letter dated March 12, 2013. PX 6.

Dr. Gauen opined that Petitioner had asthma which was caused in part, aggravated and made worse by his thirty one years of coal mine employment. He also opined that if Petitioner was to return to work in the environment of a coal mine, it would present a risk to his health in the form of an increased potential for worsening of his asthma. Dr. Gauen indicated that despite the diagnosis of asthma and considering Petitioner's clinical presentation, he maintains the pulmonary capacity to perform heavy manual labor on a full-time basis. Dr. Gauen testified that Petitioner would be unable to do manual labor if he were having an asthma attack or just recovered from one. Dr. Gauen did not know whether Petitioner had coal workers' pneumoconiosis, but he testified that if he had pneumoconiosis and would return to the environmental coal mine, same would endanger his health in the form of increased risk of progression of his pneumoconiosis. PX 3.

Petitioner's treating medical records with Physicians Group Associates were admitted as Petitioner's Exhibits 9 and 10, and Respondent's Exhibit 3.

Petitioner presented to Dr. Gauen on April 26, 2004 with complaints of wheezing, shortness of breath, and a cough present since January. On April 30, 2004, Petitioner

underwent pulmonary function studies, which Dr. Gauen testified revealed a possible mild restriction. Dr. Gauen testified that the methacholine challenge dated April 30, 2004 was positive with a 22% drop in FEV1 consistent with reactive airways disease, such as asthma. On May 6, 2004, Petitioner was still wheezing, and he was assessed with asthma. Petitioner was prescribed Advair and Albuterol. PX 3.

On November 18, 2004, Petitioner returned to Dr. Gauen for a follow up visit regarding his blood pressure and diabetes, and a general examination. He did not have any pulmonary complaints on that date. Thereafter, Petitioner presented to Dr. Gauen on March 23, 2006 for a physical examination, which was unremarkable. PX 3.

Petitioner presented to Dr. Gauen on April 12, 2006, May 15, 2006 and June 14, 2006, in follow up regarding his diabetes. Petitioner was seen on June 22, 2006 following an emergency department visit for an eye injury and nose laceration incurred at work. PX 3.

On October 2006, Petitioner complained of shortness of breath and wheezing, and he was prescribed Advair and Albuterol. On January 10, 2007, Petitioner presented for treatment for his diabetes, a prostate examination, and a simple cold. He had some bronchial symptoms for three days. He followed up for his diabetes and monitoring of medications on May 27, 2007 and December 21, 2007. PX 3.

On March 24, 2008, Petitioner returned to check his diabetes. Dr. Gauen testified that during this time, Petitioner had been taking some Advair samples. On September 15, 2008, Petitioner was taking Advair, and he was still utilizing Advair on March 9, 2011. On July 13, 2011, Dr. Gauen's records indicate a diagnosis of asthma and reported that Petitioner had symptoms twice a week. Petitioner was using Advair at that time. PX 3.

On January 18, 2012, Petitioner presented to Dr. Gauen with complaints of shortness of breath, and Petitioner was taking Advair. Petitioner returned to Dr. Gauen on March 14, 2013 with complaints of wheezing in the evenings, shortness of breath while traversing hills and duck hunting, and climbing stairs. He denied frequent coughing. Petitioner indicated that he did not always report his symptoms. His occupation was listed as a carpenter. Dr. Gauen performed spirometry testing on March 14, 2013, which was normal with no evidence of obstruction or restriction. Petitioner underwent a chest radiograph on March 15, 2013. It was interpreted by Dr. Denise Hooper, a radiologist, as expanded lungs and bilaterally clear without evidence of active airspace disease or pleural effusion. PX 3.

According to Dr. Gauen, Petitioner had more asthma symptoms in recent years than previously. Dr. Gauen testified that it was reasonable to assume that as a carpenter, Petitioner would be exposed to saw dust, which he testified can aggravate asthma. Dr. Gauen stated that he did not diagnose Petitioner with coal workers' pneumoconiosis, nor did he restrict Petitioner from work due to a respiratory problem. Dr. Gauen testified that there was no objective evidence of a permanent aggravation suffered by Petitioner at the mine to his lungs. He stated that Petitioner had mild intermittent asthma that would flare-up from time to time with periods of being asymptomatic. Based upon the spirometry testing, Dr. Gauen opined that Petitioner was capable of heavy manual labor. PX 3.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner to be credible, as he testified in an open and forthcoming manner at Arbitration, and he appeared to endeavor to give the full truth, even on cross examination.

In regards to disputed issue (C), pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public."

The Arbitrator findings that Petitioner suffers from coal workers' pneumoconiosis and a chronic cough that were caused and aggravated by exposures during his thirty one years of coal mining employment. In so concluding, the Arbitrator finds the opinions of Drs. Cohen and Smith to be more credible than those of Drs. Rosenberg and Meyer. The Arbitrator finds it significant that Dr. Cohen physically examined Petitioner, reviewed his medical records, and took a history of Petitioner's work, symptomatology and medical treatment directly from him. The Arbitrator further notes Dr. Cohen's credentials and the lack of remuneration for his services. Dr. Cohen's finding of coal workers' pneumoconiosis is corroborated by B-reader and radiologist Dr. Smith. PX 4. While Dr. Cohen's and Dr. Smith's findings were not identical, both physicians found P opacities in the mid zones and both readings were 1/0 positive for coal workers' pneumoconiosis. PX 4, 5.

Respondent's experts, while well-qualified, appear to have a financial interest in performing examinations for coal companies (PX 11; RX 1, 2), something which goes to the weight of their opinions. Nonetheless, Dr. Rosenberg acknowledged that radiographically significant coal workers' pneumoconiosis can exist despite normal physical examinations, normal pulmonary testing, and absent any symptoms. RX 2. Both he and Dr. Meyer stated that a coal miner would not likely know he has simple coal workers' pneumoconiosis until he obtains a B-reading. RX 1, 2. Dr. Rosenberg further confirmed that an individual can lose up to one third of his lung capacity due to injury or disease, or an entire lobe of a lung with surgery, and still have values on a pulmonary function test within the normal range. RX 2. As such, he testified that testing within the range of normal does not mean the lungs are free from injury or disease. RX 2. Dr. Rosenberg acknowledged that those parts of the lung damaged by coal workers' pneumoconiosis cannot function as healthy lung tissue, though he downplayed the related functional loss as occurring on a microscopic, theoretical basis. RX 2.

Further, while the Arbitrator finds that Petitioner's asthma was aggravated by his exposure while mining coal for Respondent, in accordance with the opinions of Petitioner's treating physician, Dr. Gauen, and Dr. Cohen, the Arbitrator finds that said aggravation was intermittent and temporary in nature, and did not cause any permanent aggravation or disablement.

Based upon the foregoing, and in accordance with the opinions of Dr. Cohen and Dr. Smith, the Arbitrator finds that Petitioner suffers from coal workers' pneumoconiosis and chronic cough resultant from exposures while mining coal for Respondent. The

preponderance of the evidence supports the diagnosis of these conditions, and the credible medical testimony of Dr. Cohen indicates that exposures in the mine would contribute to the development of these conditions. PX 1.

In regard to disputed issue (F), Section 1(e) of the Workers' Occupational Diseases Act defines the term "disablement" as "the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease...." 820 ILCS 310/1(e). The Illinois Supreme Court has held that a claimant is considered disabled for purposes of the Act when he can no longer work without endangering his life or health. *Owens-Corning Fiberglass Corp. v. Industrial Comm'n*, 66 Ill. 2d 247, 252 (1977); *Freeman United Coal Mining Company v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120564WC (2013). The Commission has recognized that even in the absence of measurable impairment, a diagnosis of coal workers' pneumoconiosis equates to disability under the Act. *See Eubanks v. Consolidation Coal Co.*, 08 IWCC 1515 (2008); *Samuel v. FW Electric*, 08 IWCC 1296 (2008); *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (2008); *Brooks v. Consolidation Coal Co.*, 07 IWCC 1693 (2007); *Chrostoski v. Freeman United Coal Mining Co.*, 07 IWCC 226 (2007).

In this case, Dr. Cohen testified that to prevent Petitioner's radiographic findings from progressing, he would recommend Petitioner avoid any exposure to pulmonary toxins, including coal dust and tobacco smoke. PX 1. Drs. Rosenberg and Meyer agreed that to prevent the progression of pneumoconiosis, one should minimize his exposure to coal dust. RX 1, 2. Drs. Rosenberg and Meyer further acknowledged that the only treatment for coal workers' pneumoconiosis is to remove the individual from any further exposure. RX 1, 2. Dr. Meyer testified that there is no medicine or treatment to stop or reverse the progression of coal workers' pneumoconiosis, and that the macule of a coal workers' pneumoconiosis is a permanent abnormality. RX 1. Therefore, as Petitioner cannot return to mining without risking the progression of his coal workers' pneumoconiosis, he has proven disablement within the meaning of the Act.

In regard to disputed issue (L), the Arbitrator finds that Petitioner presently suffers from occupationally-related coal workers' pneumoconiosis and chronic cough. Petitioner testified that his breathing difficulties affect his activities of daily living, such as his ability to walk, climb stairs, farm and golf. He has never smoked. Petitioner is currently taking breathing medication and utilizing a rescue inhaler, and has been for a significant period of time. Based on the foregoing, the Arbitrator concludes that Petitioner is permanently and partially disabled to the extent of 10% of the person as a whole.

In regard to disputed issue (O), or timely disablement, Petitioner's last injurious exposure occurred on August 29, 2007. His radiographic abnormalities were present and diagnosed by Dr. Smith on March 1, 2008 (PX 4), and he filed his claim two months later on May 1, 2008 (Arb. X 2), well within two years of his last exposure. Therefore, the Arbitrator finds that Petitioner's disability was timely pursuant to Section 1(f) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Shabez,
Petitioner,
vs.

NO: 09 WC 27207

Pace Bus,
Respondent,

15IWCC0724

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, temporary total disability, causal connection, permanent partial disability, medical, prospective medical, 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 January 15, 2015 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 22 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:7/30/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHABEZ, JOSEPH
Employee/Petitioner

Case# **09WC027207**

15IWCC0724

PACE BUS
Employer/Respondent

On 1/15/2015, 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:

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

1505 SLAVIN & SALVIN
MARK F SALVIN
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

15IWCC0724

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph Shabez
Employee/Petitioner

v.

Pace Bus
Employer/Respondent

Case # 09 WC 27207

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 2, 2013 and January 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 8, 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 not*** sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned **$50,835.20**; the average weekly wage was **$977.60**.

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

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment or, more specifically, that he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act ("Act") on April 8, 2009, as claimed.

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore 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.

Deborah L. Simpson — Signature of Arbitrator

Jan 14, 2015 — Date

JAN 15 2015

15IWCC0724

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Shabez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 09 WC 27207**
	)	
Pace Bus,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on April 8, 2009, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $50,835.20, and that his average weekly wage was $977.60.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of employment; (2) Did the Petitioner give the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is the Respondent liable for the unpaid medical bills to Dr. Collins, Dr. Dybal, Loyola University Med. Center and Hines VA Hospital; (5) Is Petitioner entitled to TTD from May 26, 2009 through July 2, 2013; and (6) What is the nature and extent of the injury.

STATEMENT OF FACTS

Mr. Shabez has worked for the Northwest Division of Pace Bus in Des Plaines, Illinois, since November 1979. (T. 13-14). He was initially hired as a fueler, also known as service worker. (T. 14). He was a member of ATU Local 1028. (T. 156). He would start his shift at 4:00p.m. and work until 12:30a.m. *Id.* When Mr. Shabez initially started as a fueler he had Sunday and Monday off. As his seniority grew, he chose to have Friday and Saturday off. (T. 16).

As a fueler, Mr. Shabez would park buses as they came in to the facility off of their runs. The buses would start coming in off of their runs around 6:00p.m., and most of the buses were back from their runs by 9:00p.m. (T. 161-162; 183). He would fuel them and air them out. The

buses were left running while they were being fueled. (T. 157). The bus would be washed and then parked back in the garage so it would be ready for the next day. (T. 15). In addition to the job duties outlined above, Mr. Shabez would sometimes have to help clean up the maintenance garage or whatever else was needed. (T. 18; 163; 183). During this time from 4:00p.m. until 6:00-7:00p.m. when the buses started coming in, there were buses being worked on in the maintenance garage while he was doing odds and ends. (T. 183). Rarely would he have to make service calls, for example if a bus had to be switched out for a bad fare box. *Id.*

Mr. Shabez described the layout of the facility. The garage that the buses were parked in held 64 buses. (T. 15). There was another maintenance garage for servicing of these buses with 8 or 10 bays. (T. 16-17, 154). In between the parking garage and the maintenance garage there was a wash rack where the buses could be swept, aired out, and washed. (T. 17). After they were washed they were taken to be fueled. *Id.* There were no ventilation hoses in the maintenance garage at this time. (T. 23). The parking garage did not have any ventilation system or exhaust hoses either. All of the buses vented their exhaust on top of the bus, approximately nine feet off the ground. (T. 158, 164).

Mr. Shabez was promoted to a mechanic's helper in 1984. (T. 19, 163). At this time he started doing brake jobs, radius rods, shocks, tires, and other duties. (T. 19, 163-164). This required him to spend a lot more time in the maintenance garage. *Id.* His hours were changed to midnight to 8:30a.m. (T.19-20). He was also sent to a school for technical training and was required to hold a Commercial Driver's License. (T. 20).

Mr. Shabez's job duties as a mechanic's helper required him to spend time in the old parking garage that held 64 buses without any ventilation systems. On Sunday nights, he would have to check the antifreeze on the buses and get them ready to go in the morning, start them up, and let them run. Not all of the buses would start easily, and 15-20 buses could be dead and need to have the batteries charged. (T. 166). This was done year round. However, in the winter time, the buses would need to be run all night, from midnight until they started pulling out around 4:00a.m. (T. 23-24). When it wasn't winter time the buses would only have to be run for approximately 2 hours. (T. 25). This was done to charge up the batteries and make sure the buses would run properly. *Id.*

When Mr. Shabez was working the shift from midnight to 8:30a.m., he would have to spend 4-5 hours in the parking garage where the 64 buses were warming up without any ventilation or exhaust hoses attached to these running buses. (T. 26). There were 4 doors on each side of the building that could be opened, but most of the time, unless it was really cold out, only one or two doors would be open. (T. 26, 155). Approximately 6 months out of the year, the doors would be open. (T. 168). These doors were about 25-30 feet wide and 15-20 feet high. (T. 155). Even with the doors opened exhaust still accumulated in the parking garage when the 64 buses were running. (T. 27). Mr. Shabez would be in the parking garage checking the antifreeze and starting the buses up by going row by row. (T. 28).

After the buses started pulling out for their routes around 4:00a.m., Mr. Shabez would spend the remaining hours of his shift in the maintenance garage, working on buses such as

changing tires, changing out a head light, or fixing a fare box. (T. 30). He would perform general maintenance repairs until his shift ended at 8:30a.m. *Id.*

In the old maintenance garage there were doors on one side that could be left open for ventilation purposes, but they would not be opened in the winter time. These bay doors were approximately 12-13 feet wide and 15-20 feet high. (T. 154). When the doors were closed there was no other source of ventilation for the exhaust fumes. (T. 32, 34). There were no windows available to open. (T. 34). Mr. Shabez explained that during the hours in the winter that he spent in the maintenance garage, if there were one or two buses running, the smoke would be coming out of the exhaust because they were old buses and they were old engines so they would burn more. (T. 34-35). The one to two buses that would be running at any given time were backed in to the old maintenance garage. (T. 35). The engine was located on the back of the bus and the exhaust would be coming out directly where the work benches were located (T. 35-36).

Mr. Shabez also described the wash rack located between the maintenance and the parking garage buildings. These lanes were covered, but they had an open door at each end for the bus to go through. (T. 36-37, 169). In the winter time the doors would go up and down automatically as the buses needed to pull through. (T. 37). Even though the bus would be turned off during the cleaning time, the wash rack area would still be smokey from the bus before, as the bus needed to be started back up again to leave the wash area. (T. 37).

Mr. Shabez estimated that while working as a mechanic's helper in the old garage system, he spent approximately 6 hours a work day around diesel exhaust fumes. (T. 37-38). He was able to get a rest from these fumes when doing a brake job, changing a tire, or maybe a bus wouldn't be running at the time. (T. 38-39, 170).

Mr. Shabez estimated that he worked the aforementioned midnight shift until 8:30a.m. for approximately three years as a mechanic's helper before he gained seniority to change to the day shift. (T. 40). Initially, the day shift hours were from 8:00a.m. to 4:30p.m. This was subsequently switched to 6:30a.m. until 3:00p.m. *Id.* When Mr. Shabez worked as a mechanic's helper in the old garage system on the day shift he would perform brake jobs, change shocks, radius rods, windows, and perform inspections on the bus. (T. 41). He would also change air conditioning condensers. When Mr. Shabez worked the day shift, he did not perform any of the washing or fueling. (T. 41-42).

When Mr. Shabez was working in the old maintenance garage on the day shift there were certain tasks that required him to keep a bus running. (T. 184). If he had to check the heat or work on the air conditioning, the bus had to be running. (T.42). Mr. Shabez estimated that when he worked the day shift he was still exposed to approximately 6 hours of diesel exhaust fumes per day. (T. 43). It was common for the buses to remain running for certain repairs. *Id.* Buses would run for repairs on a daily basis. *Id.* Even if Mr. Shabez was performing a repair to brakes or shocks with the bus off, his other ten coworkers could have been performing one of the tasks that required a bus to remain running. (T. 184). There were not any ventilation fans or hoses present to remove the diesel exhaust fumes from the old maintenance garage building. (T. 44).

Approximately fifteen years ago the garage system was renovated. *Id.* The parking g building still held 64 buses; but exhaust fans were installed on the roof. (T. 44, 48). There were still no exhaust hoses installed in new parking building. (T. 48). While these ventilation fans removed some diesel exhaust from the parking building, it would not take all of the smoke out. *Id.* There remained exhaust exposure in the parking building even after the ventilation fans were installed. *Id.* Doors were now available to be opened on both sides of the building. (T. 175).

As part of this renovation, the wash rack was expanded to have two lanes. However, it remained the same as far as coverage and doors on both ends. (T. 49). There were no ventilation fans or hoses installed in the wash racks. *Id.*

In the new maintenance garage there were ten repair bays. *Id.* There was also room in the new maintenance garage for repairs to be done outside of a bay if there was an overflow situation. This overflow area could fit about six extra buses if needed. (T. 50). The new maintenance garage was equipped with exhaust hoses. *Id.* Mr. Shabez was able to confirm that eight of the ten repair bays were equipped with these exhaust hoses. (T. 51). However, there were no hoses present for when the overflow space was used for repairs. *Id.* Mr. Shabez testified that sometimes the exhaust hoses would work, but sometimes guys would forget the hoses were attached to the buses and would pull the bus out of the garage and rip the hose down. (T. 51-52). Mr. Shabez also explained that sometimes the buttons for the on and off switch wouldn't work. (T. 52).

The additional apron overflow space was used every day to repair additional buses. *Id.* Even with the addition of the exhaust hoses, Mr. Shabez estimated that he was still exposed to diesel exhaust approximately 4 hours per day. *Id.* This was due to the fact that when the buses would be taken to the overflow area, they would be left running because the crew would try to fix them right away and pull them out. *Id.* Mr. Shabez testified that air conditioning recharges did not have to be completed in a maintenance bay. (T. 66). They were often done in the apron overflow area of the new maintenance garage. (T. 67). For these air conditioning recharge procedures the bus had to remain running. *Id.* These procedures would be done a couple of times a week in the summer. *Id.* No exhaust hose would be attached to the bus during this procedure that would take approximately three hours to complete. (T. 68). During these three hours, Mr. Shabez would be exposed to the diesel exhaust fumes coming out of that bus. *Id.* This continued to be the procedure in a new maintenance garage until Mr. Shabez stopped his employment in May of 2009. *Id.* These air conditioning recharges would have been started in April or May to get the buses ready for the summer. *Id.* Therefore, he was doing his air conditioning recharge procedures immediately prior to his departure from Pace Bus. (T. 68-69).

Mr. Shabez testified that there were some days where there would be no buses running in the maintenance garage. (T. 53). On an average work week, this would be one to two days per week. (T. 54). Mr. Shabez generally worked six days per week with the sixth day being an overtime day that he chose to work. *Id.*

The new maintenance garage has two garage doors on each side that could be opened for ventilation purposes. (T. 55, 175). However, these doors did not always remain open in the winter and for security purposes. (T. 55, 177). It was Pace policy to have the doors of the new

maintenance garage closed in the winter for security purposes. (T. 69). However, when it was real warm outside, workers were allowed to have the door open as long as they put something in front to block the door, like parking a bus. (T. 70). Employees were instructed to put some sort of blockade in front of the door to prevent any theft. *Id.* If a bus was parked in front of the bay door, it blocked approximately half the width and half the height of the door's opening. (T. 193-194).

Approximately ten other mechanics would be working with Mr. Shabez in the new maintenance garage. He was promoted to mechanic in 1986 or 1987. (T. 56, 169). His job duties as a mechanic's helper and a mechanic were substantially similar. *Id.* When the new garage was built, Mr. Shabez was working as a mechanic. (T. 57). He was performing repairs in the new maintenance garage with a bus running and exhaust fumes being emitted every day. *Id.* He would use exhaust hoses when they were available. *Id.*

In the new garage, Mr. Shabez continued to work from 6:30a.m. to 3:00p.m. *Id.* During an 8-hour shift, Mr. Shabez would have a half hour for lunch break. He would take his lunch to the TV room, the lunch room, or a picnic table in the shop that you could eat at. *Id.* If he took his lunch break at the picnic table in the shop, he was exposed to exhaust fumes if somebody was working on a bus. (T. 71). But usually everyone ate lunch at the same time and no repairs would be going on during that hour period. (T. 71).

As a mechanic after the renovations, Mr. Shabez still had job duties that would take him to the new parking garage two to three times per week. This was if a bus driver was having a problem with his bus that he wanted a mechanic to check out to see what was going on with it before taking it to the maintenance garage. (T. 61). When Mr. Shabez would make these trips to the new parking garage, the buses would be running at that time. (T. 61). Mr. Shabez was exposed to diesel exhaust fumes during this time period. *Id.* This exposure continued until he ceased working for Respondent in May 2009. *Id.*

Mr. Shabez testified that Respondent never provided masks to be worn for exhaust fumes. (T. 64-65). They were given masks to assist with lubricant application to the chains on handicap ramps. *Id.*.. Buses started to be equipped with such handicap ramps approximately ten years ago. (T. 66).

Mr. Shabez worked in this capacity until May 2009. (T. 61). His last pay period was for May 17, 2009 thru May 30, 2009. (T. 62). At the time of his departure he explained that not all of the exhaust hoses were operational at the time. (T. 58). Two weeks prior to his departure, a company was called out to fix all of the switches and hoses. *Id.* Mr. Shabez testified that he and his co-workers often made complaints with regards to the function of these hoses. (T. 59). They would make these complaints to foreman, Joseph Luster, or the superintendent of maintenance, Rick McCormick. (T. 59).

Mr. Shabez testified that he was exposed to diesel exhaust up until the time of his departure from Pace in May 2009. (T. 111). He was exposed to diesel exhaust on a daily basis. He was exposed to this diesel exhaust approximately four hours per day. *Id.* This exposure

continued even with the addition of the exhaust hoses and ventilation systems in the new garage system. *Id.*

Mr. Shabez served in the military from October 21, 1968 to May 24, 1970. (T. 102). He is a veteran of the Vietnam War. *Id.* During his service, he was exposed to Agent Orange, an herbicide that was used by the U.S. military during the war. (T. 102, 140). On May 6, 2009, he filed for service connection benefits with the Department of Veteran Affairs for his bladder and prostate cancer. (T. 102). On September 26, 2009, the Department of Veterans Affairs issued a decision regarding his service connection application for bladder cancer and prostate cancer. (T. 103). Service connection for high grade urethral carcinoma claimed as bladder cancer was denied. *Id.* Therefore, the Department of Veterans Affairs denied that Mr. Shabez's exposure to Agent Orange was connected to his diagnosis of bladder cancer. *Id.* Mr. Shabez was denied service connection benefits for both the bladder cancer and prostate cancer. (T. 105). It was Mr. Shabez's understanding that the Department of Veterans Affairs denied that his bladder and prostate cancer conditions were related to any exposure he may have received to Agent Orange. (T. 108). He received no service benefits in relation to his conditions. (T. 109).

Mr. Shabez also applied for service-connection benefits for post-traumatic stress disorder. (T. 144). His primary doctor at the Hines VA is Dr. Whitelock. (T. 145). Records from Dr. Whitelock were entered into evidence, showing that he was followed at the VA for mostly medication management. (P.E. 9).

After being honorably discharged from the service, Mr. Shabez worked odd jobs. (T. 144, 149). He tried painting, but it didn't last. (T. 150-151). He worked in a print shop for General Telephone Directory Company in Des Plaines, putting phone books together. (T. 151-152). He did not work on the floor with the printing machines. (T. 152). They had good ventilation and all kinds of windows. (T. 153).

Mr. Shabez testified that he has never smoked cigarettes. (T. 140-141). It was noted on his June 21, 2005, visit with Dr. Collins that Petitioner had a history of Smoking. (PX 3) Mr. Shabez lived with his parents for 18 years, and his father smoked. (T. 141). He's never lived with anyone else that smoked. (T. 142). While he had coworkers who smoked, there was no smoking ever allowed in the shop, garage, or break room. (T. 142-143). Mr. Shabez's parents and four siblings are all alive and in fair health with no history of cancer. (T. 180-182).

Medical Treatment:

Petitioner's primary care physician is Dr. Mark Collins with Alexian Brothers Medical Group. (T.72). He has been seeing Dr. Collins for a long time for regular checkups for his health. *Id.* Dr. Collins was aware that Mr. Shabez worked as a mechanic for Pace Bus. (T. 132). Mr. Shabez had a routine checkup with Dr. Collins on January 28, 2009. (P.E. 3, 1/28/09). At this time, he had complaints of hematuria or blood in his urine. *Id.* Mr. Shabez denied having had blood in his urine, prior to January or February of 2009. (T. 89, 115-117). However the medical records show a history of hematuria dating back to 2006. (PX. 3) Dr. Collins recommended various lab work and testing regarding this complaint (T. 73). After the results of

this testing, Dr. Collins referred Mr. Shabez to Dr. Dybal at Northwest Suburban Urology Associates.

Mr. Shabez first saw Dr. Dybal on February 18, 2009. (T.73). At this initial visit Mr. Shabez did tell Dr. Dybal that he was a mechanic. (T.73). Mr. Shabez informed Dr. Dybal of his diesel exhaust exposure at work. (T. 111; P.E. 5, 2/18/09). They discussed his work for approximately a half hour. (T. 131-132).

Mr. Shabez explained that this bleeding was going on for a month to a month and a half prior to the appointment. The bleeding was intermittent and would stop for a day or two. After a while, he decided to get it looked at with Dr. Collins. *Id.* He denied ever having been treated for urinary tract infection in the past. (T. 90). Mr. Shabez denied having seen a urologist prior to Dr. Dybal. (T. 115-118).

On February 27, 2009, Dr. Dybal performed a cystourethroscopy. (T. 74). This procedure was done to perform a visual inspection and conduct a biopsy on Mr. Shabez's bladder. (PX 6, p. 15; T. 74). This inspection revealed a five-centimeter bladder tumor. (PX 6, p. 15). Following this procedure, Dr. Dybal performed a second procedure, cystoscopy/transurethral resection, to remove the bladder tumor at Alexian Brothers Medical Center on March 10, 2009. (PX 6, p. 15-16). The biopsy studies of the tumor that was resected revealed an invasive papillary urothelial transitional cell carcinoma, also known as a high grade pathologic T2 lesion. (PX 6, p. 16).

Mr. Shabez followed up with Dr. Dybal on April 8, 2009. (T.75). At this time he was provided with the diagnosis of cancer of the bladder. *Id.* Mr. Shabez was not sure what his actual condition was until he saw Dr. Dybal on April 8, 2009 and was actually given the results of the bladder biopsy. (T. 86). Mr. Shabez then informed his superiors at Pace Bus. *Id.* The next day he went to work and told the superintendent of maintenance, Rick McCormick, what the diagnosis was. *Id.* He informed Mr. McCormick that he didn't know exactly when they were going to do surgery yet. Mr. Shabez also had a DOT physical at the company clinic on April 9, 2009. (T.76). He informed the physician at the company clinic that he was diagnosed with bladder cancer the previous day. *Id.*

After Mr. Shabez's appointment with Dr. Dybal on April 8, 2009, Dr. Dybal wanted to test for additional cancers. Mr. Shabez received test results that showed an elevated PSA and enlarged prostate. *Id.* They then took 12 core samples from his prostate for a biopsy. (T. 77). Eleven of twelve cores were returned benign. One of the cores returned a high grade PIN, or prostatic intraepithelial neoplasia, which can be a precursor to prostate cancer. (PX 6, p. 18). Dr. Dybal explained that in about 40 percent of patients who undergo a radical cystoprostatectomy for their bladder cancer will also have prostate cancer. (PX 6, p. 17-18).

Mr. Shabez discussed these results with Dr. Dybal at his follow up on April 22, 2009. *Id.* Dr. Dybal recommended that Mr. Shabez seek a consultation with Dr. Flanigan at Loyola University Medical Center for surgery regarding his bladder cancer. *Id.* Dr. Dybal recommended a radical cystectomy with urinary diversion, which would remove the entire bladder and prostate and then create some kind of urinary diversion to collect his urine. (PX 6, p. 16-17).

Mr. Shabez saw Dr. Flanigan at Loyola on May 11, 2009. (T. 78). Dr. Flanigan noted that Mr. Shabez's urologic history began in February with intermittent invasive gross hematuria. (P.E. 7). Dr. Flanigan also noted that Mr. Shabez works as a diesel mechanic. *Id.* At this time he was scheduled for surgery on May 27, 2009. *Id.* He gave Mr. McCormick this surgery date. (T. 78). Mr. Shabez was not aware that he was going to need to be missing any time from work until he saw Dr. Flanigan on May 11, 2009 to receive his surgery date. (T. 86-87). He had to work with Pace to arrange some sort of leave to attend to this surgery. (T. 79). Mr. Shabez also had conversations regarding his diagnosis and needed to be off work for surgery with personnel in the safety department. He requested workers' compensation information, and was provided with this. (T. 79-80). He completed forms with his safety department prior to going off of work for surgery. (T. 80).

Mr. Shabez could not recall the exact date he spoke to Mr. McCormick and the safety department regarding this. However, he was advised of his surgery date on May 11, 2009 and surgery was scheduled for May 22, 2009, so it had to be during this time frame. (T. 82). Given that Mr. Shabez needed to make arrangements to be off of work for a serious procedure, it is likely that these conversations occurred shortly following the time he was given his surgery date on May 11, 2009. *Id.* Mr. Shabez believes he spoke with Mr. Mike Strauss in the safety department. (T. 83). Mr. Shabez told Rick McCormick that he thought his cancer was from the exhaust. (T. 83-84). This conversation occurred after Mr. Shabez received the schedule for surgery. (T. 84). Mr. Shabez was not given copies of the papers that he filled out in the safety department. (T. 84). Mr. Shabez filed an application for adjustment of claim on May 14, 2009. (T. 85). This was within days of receiving his surgery date from Dr. Flanigan on May 11, 2009. *Id.* At this time, Mr. Shabez believed that his condition was related to his work. *Id.*

On May 26, 2009, Mr. Shabez had surgery in the form of radical cystectomy, with orthotopic neobladder, bilateral pelvic node dissection, prostatectomy, and urinary diversion. (T. 87). Mr. Shabez explained that they took out part of his colon and made a bladder out of it. They took his old bladder out and diverted everything so he could still urinate. (T. 87). His prostate was removed at that time as well, along with some lymph nodes. (T. 88). Mr. Shabez was hospitalized for this procedure from May 26, 2009 through June 3, 2009. (PX 7). He was discharged with a Foley catheter and instructed not to lift more than ten pounds for six weeks. *Id.*

Mr. Shabez returned to the Emergency Department at Loyola University Medical Center on June 10, 2009, with post-operative fever, vomiting, and chills. (T. 88; P.E. 7). He was diagnosed with a febrile urinary tract infection (UTI), and the culture was positive for e. coli. (PX 7). He was admitted to the hospital for same through June 14, 2009. *Id.*

Petitioner followed up with Dr. Flanigan on June 22, 2009. (T. 90). Mr. Shabez's urethral catheter was removed and bladder training was conducted. (PX 7). He was continued on antibiotic medications for a Cipro resistant e. coli infection. *Id.* Dr. Flanigan noted that Mr. Shabez had already lost 13 pounds. *Id.* Dr. Flanigan explained that Mr. Shabez's surgery was such that he did not require any chemotherapy treatments at that time. (T. 91). There was no prostate cancer noted on the specimen removed during the surgery. (PX 7).

Mr. Shabez followed up with Dr. Flanigan on July 15, 2009. Post-operatively, he continued to have complaints as it related to post-operative infection complications, including intermittent bilateral back/flank pain. (PX 7). He also complained of persistent incontinence and was instructed to continue his exercises. *Id.* Dr. Flanigan did not authorize him to return to work. (T. 91). He was given medications to treat the post-operative infection. (T. 92). He was not enrolled in any formal rehabilitation program, but recovered on his own at home. *Id.*

On August 27, 2009, Dr. Flanigan noted that Mr. Shabez was getting up 7-8 times per night with incontinence. (PX 7). His urine culture on August 18, 2009 was again positive for e. coli. *Id.* He was prescribed Ampicillin. *Id.* On October 29, 2009, Dr. Flanigan noted that Mr. Shabez had been treated for five UTIs, four of which were e. Coli and one was resistant e. coli. Mr. Shabez usually complained of left flank pain, but these were not always accompanied by fever. His culture the previous day was again positive for e. coli. He was instructed to cease daily catheterization/irrigation. *Id.*

Mr. Shabez testified that he followed up with Dr. Flanigan on December 3, 2009, at which time Dr. Flanigan recommended additional testing. (T. 93). Dr. Flanigan continued to keep Mr. Shabez off work because he was still having problems and was getting sick a lot. *Id.* He had complaints of chills, dehydration, and other symptoms. In January of 2010 there was concern that Mr. Shabez's cancer had returned. (T. 94). This date and information were not contained in the medical records.

Ultrasounds were conducted on January 8 and 10, 2010, with concern for a lesion in the neobladder of uncertain etiology. (PX 7). A cystoscopy was conducted on February 23, 2010, but was negative for pathology. *Id.*

Mr. Shabez followed up with Dr. Flanigan on July 1, 2010. (T. 95). Mr. Shabez was not authorized to return to work at this time. (T. 95, 188). Mr. Shabez was placed on an anti-infection medication that he has to take for the rest of his life for recurrent UTIs. (T. 184). This infection was causing kidney problems. (T. 185). His last UTI prior to this appointment was April 2010. (PX 7). He also had complaints of frequent urination and had to catheterize himself. (T. 184-185). He has lost 40 pounds and lost strength from lack of sleep because he had to get up every two to three hours to empty his bladder. (T. 188, 191). To return to work as a mechanic at Pace Bus, Mr. Shabez would have had to be capable of lifting 120 pounds. (T. 189). Dr. Flanigan noted he had substantial leakage during the night with three to four times. (PX 7). There was no sign of cancer recurrence at this time. *Id.*

Mr. Shabez continued to attend routine follow-ups with Dr. Flanigan to manage his treatment and make sure that his cancer was not returning through July 2011. (T. 95-96). On October 4, 2010, a CT scan confirmed no recurrent disease. (PX 7). On October 7, 2010, Dr. Flanigan prescribed Tofranil to help with the nighttime incontinence. *Id.* A CT scan on January 6, 2011 again showed no evidence of metastatic disease. *Id.* When Mr. Shabez followed-up with Dr. Flanigan on January 13, 2011, it was noted that his last UTI was October 22, 2010 and the Tofranil was improving nighttime leaking to 2-3 times per night. *Id.* He complained of constant right mid-abdominal discomfort for the past three weeks. *Id.* He was getting his medications at the VA. *Id.* On July 14, 2011, Mr. Shabez reported to Dr. Flanigan fatigue from

lack of sleep from getting up to void. *Id.* He was still having leakage, worse at night than during the day. *Id.* Dr. Flanigan converted him to a new medication regimen for the chronic UTIs. *Id.*

Mr. Shabez returned to Dr. Flanigan in January of 2012, with concerns again that the cancer had returned. (T. 98). A CT scan on January 12, 2012 showed newly enlarged lymph nodes in the periaortic region and right pelvis, which are suspicious for metastatic disease. (PX 7). On January 26, 2012, Dr. Flanigan prescribed a PET scan and colonoscopy with Dr. Eberhardt. *Id.* The PET scan demonstrated uptake in those nodes, as well as uptake in the rectum/sigmoid concerning for a second focus of primary disease. *Id.* To determine if the disease had spread to the colon, Dr. Eberhardt performed a colonoscopy with polypectomy on February 13, 2012. *Id.* The polyp was positive for multifocal intramucosal adenocarcinoma arising in association with a mixed tubulovillous edema. *Id.*

On February 27, 2012, Dr. Eberhardt explained that the biggest risk to Mr. Shabez's life was the newly found LAD probably related to genitourinary cancer. (PX 7). The rectal pathology was benign but there was a chance some remains in the colon, so Dr. Eberhardt wanted to remove the polyp site in the colon. *Id.* Petitioner discussed this with Dr. Flanigan on March 1, 2012. Dr. Flanigan agreed that the nodal tissue more likely represents metastatic bladder cancer, but he wanted to biopsy the pelvic lymph nodes to determine their nature. *Id.* Also on March 1, 2012, Dr. Eberhardt indicated he planned to move forward with excision of the polypectomy site after the biopsy. *Id.* On March 30, 2012, Dr. Eberhardt performed transanal endoscopic microsurgical resection of rectal polypectomy site. *Id.* Mr. Shabez was admitted through April 1, 2012. *Id.* No evidence of adenomatous changes or malignancy was identified on the removed portion of the colon. *Id.* Dr. Eberhardt felt that no further treatment was needed for this particular lesion. *Id.*

Mr. Shabez followed-up with Dr. Flanigan on May 11, 2012, at which time it was noted that his lymph nodes were found to be decreased in size on follow-up imaging so he decided not to proceed with repeat biopsy. (PX 7). Mr. Shabez complained of significant pain at the right groin biopsy site. *Id.* He was slightly diaphoretic and uncomfortable appearing. *Id.* Dr. Flanigan recommended a CT of the pelvis and right thigh to assess for hematoma. *Id.* These were negative for hematoma, but did show larger previously biopsied right pelvic soft tissue. *Id.* On May 14, 2012, Dr. Flanigan prescribed a renal ultrasound and bone scan to evaluate the etiology of Mr. Shabez's pain. *Id.* The bone scan on May 17, 2012 showed no evidence of osseous metastatic disease. When Mr. Shabez returned to Dr. Flanigan on May 31, 2012 it was noted that he had lost 13 pounds over the last 10 weeks. *Id.* Dr. Flanigan felt they needed to repeat the biopsy to determine the etiology of the mass. *Id.*

Mr. Shabez followed up with Dr. Flanigan on June 18, 2012 to receive these results (T. 100). Per Dr. Flanigan, the biopsy result from June 12, 2012, was positive for metastatic urothelial cell carcinoma, Dr. Flanigan referred him to Dr. Gaynor for consideration of chemotherapy. (PX 7). On July 6, 2012, Dr. Gaynor noted that the disease was not curable, but sensitive to chemotherapy. *Id.* She referred Mr. Shabez to neurology for nerve entrapment syndrome. *Id.* On July 13, 2012, Dr. Merchut felt that the tumor may be compressing a nerve. *Id.*

Mr. Shabez started chemotherapy treatments on July 25, 2012 with Dr. Gaynor. (PX 7). This continued until September 26, 2012. *Id.* On September 20, 2012, Dr. Flanigan noted Mr. Shabez to have significant weight loss and continued nocturia 2-3 times per night. *Id.* On October 17, 2012, Dr. Gaynor explained that Mr. Shabez had a mixed response to chemotherapy according to his recent CT scan. *Id.* His most problematic area has not improved and appears to have worsened slightly, but it did show decreased size of the other lymph nodes. *Id.* Dr. Gaynor referred Mr. Shabez to Dr. Harkinrider for palliative radiation treatment to this area. *Id.* Mr. Shabez was continued on Norco and Dr. Gaynor added Neurontin for his nerve pain. *Id.*

Mr. Shabez started treatment with Dr. Harkinrider on October 19, 2012. (PX 7). He was offered palliative radiation treatment to the lymph nodes to reduce Mr. Shabez's pain. *Id.* Mr. Shabez was admitted to Loyola from October 21, 2012 through November 3, 2012 for dehydration. *Id.* He completed radiation on November 7, 2012. *Id.* On November 13, 2012, Dr. Gaynor explained that recent CT showed improvement in the periaortic and pelvic nodes, but the pelvic mass was slightly more prominent with erosion of the right iliac bone. *Id.* On December 17, 2012, Dr. Harkinrider explained that radiation was able to help the pain in the sacrum, but Mr. Shabez still had a painful sacral bony metastasis. *Id.*

On January 16, 2013, Mr. Shabez started a new chemotherapy treatment. (PX 7). On May 8, 2013, Dr. Gaynor explained that the CT scan was stable to improved. *Id.* Mr. Shabez had a chemotherapy treatment scheduled for the day following his testimony on July 3, 2013, with Dr. Gaynor. *Id.* Mr. Shabez planned to follow up with Dr. Flanigan in September 2013. *Id.*

Petitioner testified that Drs. Dybal, Flanigan and Collins all told him that there might be a connection between diesel exhaust and his condition of bladder and prostate cancer. (T. 121-122, 126-131). Dr. Collins authored a letter under date of January 29, 2011, wherein he stated, "The possible association of hydrocarbons (diesel exhaust) has been well known to me before seeing your meta-analysis. I feel that there is *probably a causal* {emphasis added}relationship between his bladder cancer and his exposure to diesel exhaust while working for Pace Bus." (PX 3, 1/19/11).

Mr. Shabez was granted Medicare benefits as of November 1, 2011. Mr. Shabez continued to submit his medical bills through the group health insurance he receives through Pace. (T. 96). Mr. Shabez was awarded Social Security Disability as of December 2009. (T. 97, 171). Mr. Shabez's employment with Pace ended as of January 1, 2012. However, he remains on a leave of absence. *Id.* He continues to receive health insurance through Blue Cross Blue Shield as a primary payer with Medicare as a secondary payer. (T. 98).

Testimony of Dr. Eric J. Dybal, M.D., Treating Urologic Surgeon

Dr. Eric J. Dybal, M.D. testified as the treating Urologic Surgeon of Mr. Shabez. Dr. Dybal received his Medical Doctorate from Loyola University in 1987 and thereafter completed a seven-year residency in General Surgery and Urology. (PX. 6, p. 5). Dr. Dybal has been practicing general adult urology in the Chicagoland area since 1989. *Id.* He is affiliated with Alexian Brothers Medical Center, St. Alexius Medical Center, and served as Chief of the Urology Department at Northwest Community Hospital. (PX 6, p. 5-6). As a urologist, Dr. Dybal specializes in diseases of the urinary tract system. (PX 6, p. 6).

Dr. Dybal first evaluated Mr. Shabez on February 18, 2009. (PX 6, p. 7). Mr. Shabez's complaint at that time was gross hematuria, blood in the urine. *Id.* Mr. Shabez gave a history that this has been going on for approximately two months. *Id.* Dr. Dybal testified that the risk factors for hematuria are kidney stones, blood disorders, tuberculosis, trauma, smoking, blood thinners, urine infections and occupational exposure. (PX 6, p. 7-8). Dr. Dybal explained that in addition to diesel exhaust exposure, occupational exposure can include dyes handled in the tire and rubber industry or by hair stylists, oil-based paints, and certain inks in the printing industry. (PX 6, p. 23). Any hydrocarbon-based solvent is also a known risk for developing bladder cancer. (PX 6, p. 15). Dr. Dybal discussed Mr. Shabez' employment with him at this initial visit and identified that Mr. Shabez had an exposure to diesel fuel and solvents at work. (PX 6, p. 8).

Dr. Dybal reviewed Mr. Shabez's medical history and indicated that the only risk factor for the development of bladder cancer was occupational exposure to diesel exhaust during the course of his employment for Pace Bus. (PX 6, p. 8, 19). Dr. Dybal authored a letter containing this opinion dated July 26, 2012. (PX 6, Dep. Ex. 1). Dr. Dybal reviewed the configuration of Mr. Shabez's work environment, but did not detail same in his letter. *Id.* Dr. Dybal understood that Mr. Shabez had daily exposure when he was at work. (PX 6, p. 14).

Dr. Dybal stated, "My professional opinion is his only risk factors for developing bladder cancer is his chronic exposure at work to diesel fumes, as well as the use of solvents. This is well documented in the literature, not only the review article that was provided to myself, but also in standard urologic textbooks, including Campbell's Urology." (PX 6, p. 9-10). Dr. Dybal explained that Campbell's Urology is considered among urologists to be the definitive textbook for urology, and this textbook teaches urologists of the association between diesel exhaust fumes and bladder cancer. (PX 6, p. 10).

The review article referenced by Dr. Dybal in his letter of September 11, 2013 is titled "A Meta-Analysis of Bladder Cancer and Diesel Exhaust Exposure" by Paolo Boffetta and Debra T. Silverman, published in Epidemiology, January 2001, Volume 1, No. 1, pages 125 to 130. (PX 6, Dep. Ex. 2). Dr. Dybal explained that this meta-analysis looked at previous studies on diesel exhaust exposure and found that a relative risk was increased for those patients who had been exposed to diesel exhaust. (PX 6, p. 11-12). According to the Meta-Analysis, 35 studies were identified that provided information on bladder cancer occurrence associated with exposure to diesel exhaust. (PX 6, P.D.E. 2). The Meta-Analysis resulted in summary relative risks of 1.23 for any exposure and 1.44 for high exposure. *Id.* According to this Meta-Analysis, there are several arguments in favor of a causal relationship between diesel exhaust exposure and occurrence of bladder cancer. *Id.* An increased relative risk was observed in all groups of studies in which the meta-analysis was performed. *Id.* This result is consistent with biological knowledge on the composition of this mixture, its metabolism and its interaction with the bladder urothelium. *Id.*

Dr. Dybal could not quantify how much exposure to diesel fumes is necessary in order to cause bladder cancer because such studies would require human volunteers to be exposed, which would be inhumane. (PX 6, p. 20). However, Dr. Dybal was able to state that the exposure needs to be chronic. *Id.*

If Mr. Shabez did have prior hematuria 10 years ago related to urinary tract infection, Dr. Dybal explained that bladder infection is more strongly associated with squamous cell cancer, and Mr. Shabez has transitional cell cancer. (PX 6, p. 12). Further, Dr. Dybal was of the opinion that routine bladder infections do not put patients at an increased risk for bladder cancer. (PX 6, p. 13). It is chronic infection, such as actinomycosis, that would put a patient at risk for bladder cancer. *Id.* There was no history that Mr. Shabez had any such infections. *Id.*.

Dr. Dybal reviewed the World Health Organization, International Agency for Research on Cancer, Press Release No. 213, dated June 12, 2012. (PX 6, RX Dep. 1). This states that there was sufficient evidence that diesel exhaust is a cause of lung cancer and also noted a positive association (limited evidence) with an increased risk of bladder cancer. *Id.* Dr. Dybal testified that for him limited evidence is enough. (PX 6, p. 22). This article supported Dr. Dybal's opinion. (PX 6, p. 28).

Dr. Dybal testified that while it seems to be coming out that Agent Orange can cause anything in a Vietnam vet, he did not know if it's really true or not. (PX 6, p. 27). Dr. Dybal testified that if the Department of Veterans Affairs disclaimed an association between Agent Orange and Bladder cancer, this would change his opinion about knowing of a correlation. (PX 6, p. 28).

Dr. Dybal explained that second-hand smoke probably has a loose correlation to bladder cancer, but this has not been fully studied. (PX 6, p. 23). Dr. Dybal reviewed an article titled Tobacco Smoke and Bladder Cancer—in the European Prospective Investigation into Cancer and Nutrition by Bjerregaard *et al*, published in the International Journal of Cancer, 119, 2412-2416 (2006). (PX 6, RX Dep. 2). While Dr. Dybal was familiar with the Journal, he was not a subscriber as it was not a journal that people in his field would find a standard authoritative type peer-reviewed journal. (PX 6, p. 24). This was an epidemiological study done to look to see if something might be causative. (PX 6, p. 26). Dr. Dybal was not surprised this study found that exposure to environmental tobacco smoke during childhood increases the risk of bladder cancer. (PX 6, p. 26-27). If a child was exposed to second-hand smoke every day for 18 years, it could possibly increase his chance for bladder cancer. (PX 6, p. 27). However, this would be exceedingly remote. (PX 6, p. 29). This article absolutely did not change Dr. Dybal's opinion with regards to the increased risk Mr. Shabez sustained from his exposure to diesel exhaust at work. (PX 6, p. 28-29).

Petitioner had testified that his father smoked a pack of cigarettes per day and he was exposed to it for 18 years. Additionally, Petitioners medical records document that he was a smoker at one time.

Testimony of Dr. Shirley A. Conibear, M.D., MPH, CIME, Section 12 Reviewer

Dr. Shirley A. Conibear, M.D., testified as the Section 12 records reviewer for Respondent. Dr. Conibear received a Doctor of Medicine and a Master's of Public Health from the University of Illinois. (RX 3, p. 5). Dr. Conibear practices occupational medicine, anything that's work-related or regulatory driven. (RX 3, p. 6). She sets up and runs medical surveillance

programs for companies for OSHA compliance, performs physical exams for EPA and OSHA requirements, acts as a Medical Review Officer to review drug screens pursuant to Department of Transportation regulations, conducts Independent Medical Examinations, and does some epidemiology. (RX 3, p. 6, 13).

As a physician, Dr. Conibear sees patients mainly for regulatory-driven exams or immigration exams. (RX 3, p. 17). Dr. Conibear is employed by a financial institution where she acts as the physician of record for 25 call center sites around the United States. *Id.* In this capacity, there are nurses who practice on her license that she supports and audits. (RX 3, p. 18). Finally, Dr. Conibear explained that she is hired by HR representatives to question FMLA certifications provided by the employee's choice of physician where employees are paid for their time off. (RX 3, p. 19-20).

Dr. Conibear is the sole owner of Occupational Medicine Specialists, Ltd. (RX 3, p. 13). Dr. Conibear is also the President and sole stockholder of Carnow, Conibear & Associates, Ltd., an environmental and occupational health consultancy firm. (RX 3, p. 14). Most of her work is billed under OMS, but she is responsible for all executive decisions regarding both corporations. (RX 3, p. 15).

OMS holds itself out to be a scheduling service for IMEs with a database of examiners. (RX 3, p. 20). Dr. Conibear stated that 15-20% of the revenue for OMS is generated by Independent Medical Examinations. (RX 3, p. 16). All of this work is referred by the defense, except for one plaintiff's firm for which Dr. Conibear consults on black lung cases. *Id.* Dr. Conibear was previously certified as an Independent Medical Examiner by the ABIME, but this has expired. (RX 3, p. 13). Dr. Conibear charges $400 per hour for examination and report preparation and $600 per hour for deposition. (RX 3, p. 21). In the instant matter, Respondent was charged $3,500.00 for the report and $2,600.00 for the deposition. (RX 3, p. 28).

Carnow, Conibear & Associates, Ltd. has performed environmental consulting services for IDOT, CTA, Metra, and Pace. (RX 3, p. 21). The firm has performed air quality surveys to measure diesel fumes. *Id.* The firm was hired by Metra in 2010 to determine the levels of diesel exhaust commuters were being exposed to. (RX 3, p. 22, 23). Dr. Conibear testified that health concerns about diesel exhaust exposure include pulmonary conditions, asthma, COPD, and now lung cancer. (RX 3, p. 22). The firm is also employed by Pace for industrial hygiene where hygienists go out and do air sampling or any safety ergonomic things. (RX 3, p. 26). Dr. Conibear has worked for Pace in this capacity for a couple of decades. (RX 3, p. 27). However, she could not recall whether she has done any air quality testing in Pace facilities to measure diesel fumes like she did for Metra. (RX 3, p. 28).

Dr. Conibear did not examine or speak with Mr. Shabez. (RX 3, p. 12-13). Dr. Conibear reviewed records from Dr. Collins from 2006 to 2009, Dr. Dybal from March and April 2009, as well as a work history received from Respondent's Counsel. (RX 3, p. 7). Dr. Conibear understood that Mr. Shabez works as a mechanic for Pace. (RX 3, p. 8). He started working on urban buses starting in November 1979 at the age of 30 and continued until he stopped working at age 63. *Id.* The Arbitrator notes that Petitioner would have only been 59 years old when he

stopped working for Pace in May 2009. After reviewing these records, Dr. Conibear authored a letter under date of June 18, 2013. (RX 3, RX Dep. 3).

Reference Studies Cited by Dr. Conibear

Dr. Conibear cited four references in her letter of June 18, 2013. She referenced a chapter on bladder cancer from the book Cancer Epidemiology and Prevention by Shottenfeld and Fraumeni, published in 2006. Dr. Conibear referenced this chapter to point out other known risk factors such as drinking water disinfection byproducts and infection or bladder stones. (RX 3, p. 33). According to this chapter, two studies actually found no support for a causal association between urinary bladder infection and risk of bladder cancer. *Id.* Also according to this resource, Dr. Conibear confirmed that bladder infection is more strongly associated with squamous cell cancer, which is not the type of cancer suffered by Mr. Shabez. *Id.* With regards to water disinfection byproducts or chlorinated surface water, this chapter identified a handful of studies done which have concerned specific residents of certain towns or counties where chlorinated surface water was supplied to the residents. (RX 3, p. 34). There was nothing in Dr. Conibear's file to identify that Mr. Shabez has resided in one of these areas. *Id.* There was also nothing in Dr. Conibear's file to indicate whether Mr. Shabez even drinks tap water. *Id.*

According to this chapter in Cancer Epidemiology and Prevention, page 1107, "No increased risk has been associated with passive smoking in two case controlled studies and one cohort study conducted to date." (RX 3, p. 35). This chapter also explains on page 1105, "Cessation of cigarette smoking has been associated with a 30 to 60 percent reduction in bladder cancer risk in many studies." *Id.* This chapter further explains that painters have an increased risk with duration of the occupation, twenty or more years yields a risk of 4.1, printers, metal workers, chemical workers, even truck drivers have an increased risk with duration of the job, however the findings in most of the occupations were not persuasive. (RX Dep. 3, p.1109)

Dr. Conibear also used the National Toxicology Program, Analysis of Diesel Exhaust Particulate as a Carcinogen, published in 1998. She cited the more recent National Toxicology Program opinion of the carcinogenicity of diesel exhaust published in 2011. Finally, she referenced a paper published by Pronk in which he reviewed the exposure of various studies that have measured diesel exhaust in various work environments. (RX 3, p. 8-9). Dr. Conibear cited to all three of these resources for the proposition that Mr. Shabez's job would be classified in the intermediate exposure group. (RX 3, p. 41).

Opinion Testimony of Dr. Conibear

Dr. Conibear testified to a reasonable degree of medical certainty that there was no association with Mr. Shabez's exposure to diesel exhaust and his bladder cancer. (RX 3, p. 8, 12). Dr. Conibear concluded that based on the conclusions of the IARC and NTP that to a reasonable degree of medical certainty bladder cancer is not associated with diesel exhaust exposure. (RX 3, p. 9).

Dr. Conibear indicated that kidney stones and frequent urinary tract infections are risk factors for the development of bladder cancer. *Id.* Dr. Conibear felt that Mr. Shabez had a

history of both, although the medical evidence and testimony in this matter seem to suggest otherwise. Dr. Conibear did not review medical records prior to 2006 that would support any history of hematuria. (RX 3, p. 29-30). Dr. Conibear also identified parasitic infection, radiation, and chemical exposure as risk factors for bladder cancer. (RX 3, p. 37). There was no data in Dr. Conibear's file to suggest that Mr. Shabez was exposed to any of these risk factors. *Id.*

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An "occupational disease" is one "arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment." 820 ILCS 310/1(d).

Petitioner may recover under the Occupational Diseases Act ("Act') for a disease caused by his employment and disease aggravated by his employment. *Fitts v. Industrial Commission*, 172 Ill.2d 303, 666 N.E.2d 4, 216 Ill.Dec. 836 (1996).

To establish that his injury arose out of his employment, Petitioner must establish a causal connection between a work condition and his disease; that is, that his disease originated from or was aggravated by a risk connected to his employment and that his disease naturally resulted from that risk. 820 ILCS 310/1(d).

Under the Act, the length of hazardous exposure is irrelevant if the employee is "employed in an occupation or process in which the hazard exists." 820 ILCS 310/1(d).

An aggravation of a disease must "arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d).

"A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all circumstances, a causal connection between the conditions under which the work is performed and the occupational disease." 820 ILCS 305/1(d); *Anderson v. Indus. Comm'n*, 321 Ill.App.3d 463, 467 (2001).

The disease does not have to be foreseen or expected, but after its contraction it must appear to have its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. (820 ILCS 310/1(d).

Occupational disease claimants need not even introduce evidence regarding the amount, time, or duration of exposure to agents which are claimed to have given rise to the relevant occupational disease. *U.S. Industrial Chemical Co. v. Indus. Comm'n*, 143 Ill.App.3d 881 (1986); *Beissinger v. IIT*, 99WC 18101, 7 IWCC 958 (2007).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of his employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment or, more specifically, that he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act ("Act") on April 8, 2009, as claimed.

An "occupational disease" is one "arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment." 820 ILCS 310/1(d). Petitioner may recover under the Occupational Diseases Act ("Act') for a disease caused by his employment and disease aggravated by his employment. *Fitts v. Industrial Commission*, 172 Ill.2d 303, 666 N.E.2d 4, 216 Ill.Dec. 836 (1996). To establish that his injury arose out of his employment, Petitioner must establish a causal connection between a work condition and his disease; that is, that his disease originated from or was aggravated by a risk connected to his employment and that his disease naturally resulted from that risk. 820 ILCS 310/1(d). Under the Act, the length of hazardous exposure is irrelevant if the employee is "employed in an occupation or process in which the hazard exists." 820 ILCS 310/1(d). An aggravation of a disease must "arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d).

The Arbitrator notes that two doctors provided testimony regarding causal connection in this matter, Dr. Dybal, one of Petitioner's treating doctors and Dr. Conibear, Respondent's IME doctor, who worked for among other companies Pace Bus, the Respondent. Dr. Flanigan Petitioner's oncologist did not testify. Dr. Collins, Petitioner's primary physician, did not testify,

but did author a letter on January 29, 2011, wherein he opined "that there is *probably a causal relationship* between his bladder cancer and his exposure to diesel exhaust while working for Pace Bus." (PX 3, 1/19/11) emphasis added.

The studies that both doctors relied on indicated that there have been several attempts to study whether exposure to diesel fuel exhaust is linked to bladder cancer. The studies indicate that there are several aspects of the inquiry which make it difficult to make the determination. One difficulty is the fact that there are many components to diesel exhaust and it is felt that all the components need to be studied. Another complication is that it is difficult to determine the required level of exposure that would place an individual at an increased risk because that would involve using human test subjects.

Researchers have determined that diesel exhaust is very strongly linked to lung cancer. They report that higher incidences of bladder cancer from occupational exposure to diesel exhaust have been suggested but are still not proven. Researchers have not been able to quantify how much exposure is needed to qualify as hazardous, neither percentage of air polluted by the exhaust or the length of time. They have attempted to categorize the risk based upon exposure of certain jobs but even that has not yet been accepted as scientifically established standards with respect to determining risk levels.

Dr. Conibear admitted that it is possible for exposure to vary depending on individual environments. (RX 3, p. 55). She also admitted she has no knowledge whether Pace was compliant with EPA standards regarding elemental carbon and diesel particulates. (RX 3, p. 58-59). Dr. Conibear admitted that actual air quality samples from the facility where Mr. Shabez worked would have been better evidence with which to classify his exposure, than studies of people that worked in his profession. (RX 59-60). There is no evidence that the Respondent was not compliant with EPA standards and there is no evidence of what the actual air quality of the facility was. Dr. Conibear, Dr. Dybal and Dr. Collins all had the same information upon which to reach their opinions with respect to EPA compliance and air quality at the Respondent's place of business.

Dr. Dybal reviewed the World Health Organization, International Agency for Research on Cancer, Press Release No. 213, dated June 12, 2012. (PX 6, RX Dep. 1). He agreed that this states that there was sufficient evidence that diesel exhaust is a cause of lung cancer and also noted a positive association (limited evidence) with an increased risk of bladder cancer. *Id.* Dr. Dybal testified that for him limited evidence is enough. (PX 6, p. 22). "Limited evidence," is not sufficient to meet the standard of a preponderance of the evidence.

Dr. Shirley Conibear testified to a reasonable degree of scientific and medical certainty that exposure to diesel exhaust does not cause bladder cancer. (RX 3, p. 8-9). She does not dispute that some studies find a correlation however, after looking at all the studies as a whole and grading them for quality, organizations like the International Agency for Research on Cancer and the National Toxicology Program in the United States have not found a positive and meaningful correlation between bladder cancer and diesel exhaust exposure and have placed the risk at an intermediate or limited evidence level. (RX. 3, p. 40). This inconclusive finding on the

link between diesel exhaust and bladder cancer does not meet the "convincing" level required under the preponderance of the evidence standard.

For the above stated reasons the Arbitrator finds that the Petitioner has not proven by a preponderance of the evidence that he sustained accidental injuries or was last exposed to an occupational disease that arose out of and in the course of his employment with the Respondent.

With respect to the Arbitrator's decision with regard to (2) Did the Petitioner give the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is the Respondent liable for the unpaid medical bills to Dr. Collins, Dr. Dybal, Loyola University Med. Center and Hines VA Hospital; (5) Is Petitioner entitled to TTD from May 26, 2009 through July 2, 2013; and (6) What is the nature and extent of the injury.

As explained above, Petitioner failed to establish that a compensable accident or exposure to an occupational disease arose out of and in the course of his employment. All other issues are moot and all requested compensation and benefits are denied.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson — Signature of Arbitrator

Jan 14, 2015 — Date

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

Gary Goodson,

Petitioner,

vs. NO. 08WC002370

Monterey Coal Company,

Respondent.

15IWCC0752

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2015 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.

15IWCC0752

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

DATED: SEP 28 2015
SJM/sj
o-9/10/2015
44

Stephen L. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOODSON, GARY
Employee/Petitioner

Case# **08WC002370**
15IWCC0752

MONTEREY COAL COMPANY
Employer/Respondent

On 1/21/2015, 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
PO BOX 335
SPRINGFIELD, IL 62705

15IWCC0752

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gary Goodson
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # 08 WC 02370

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 18, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 31, 2006, 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 occupational disease 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 alleged occupational disease.

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $1,029.97.

On the date of accident, Petitioner was 57 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits commencing October 8, 2007, of $497.739 per week for the duration of the disability because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner compensation that has accrued from October 8, 2007, through November 18, 2014, and shall pay the remainder of the award 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.

William R. Gallagher, Arbitrator

January 16, 2015
Date

JAN 21 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart arising out of and in the course of his employment for Respondent. The Application alleged a date of last exposure of August 31, 2006, and that Petitioner sustained an occupational disease as a result of inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes and vapors for a period in excess of 33 years.

Petitioner's date of birth was February 21, 1949, and he was 65 years of age at the time of trial. Petitioner began working for Respondent in January, 1974, and his last day of work for Respondent was August 31, 2006. For all 33 years of his work as a coal miner, Petitioner worked underground.

Petitioner testified that he graduated from high school, had some college and that he had a degree from Rankin Tech where he studied diesel and gasoline engines. Prior to working for Respondent, Petitioner worked at Olin Brass, a gas station and a company that manufactured plastic cottage cheese containers.

Petitioner worked a variety of jobs during the time he was employed by Respondent, including laborer, shuttle car operator, roof bolter, utility worker and continuous miner operator. Petitioner spent his last 25 years as a continuous miner operator which he described as being one of the dustiest jobs in the mine. The continuous miner is the machine that grinds the coal out of the face and this process creates a significant amount of dust.

Petitioner testified that he began to experience breathing problems which got progressively worse during the last seven to eight years he worked in the mine. Petitioner stated that he smoked approximately one-half pack of cigarettes a day and that he started when he was either 15 or 16 and quit when he was either 57 or 58. He has not smoked since then.

Petitioner testified that since he left mining, his breathing problems have worsened. Petitioner stated that when he walks approximately one-quarter of a mile he becomes short of breath and that if he has to climb seven to eight steps, he has to stop and rest. Petitioner has also had a number of other health issues which included pacemaker surgery, prostate cancer, hernias, left and right shoulder surgeries and hypertension which requires medication. Petitioner stated that if he were offered a job in the mine today he would not take it because he is unable to do the work because of his numerous health issues.

After Petitioner left the employment of Respondent, he was able to secure another job at Duda Ace Hardware. Petitioner worked there from sometime in 2006 up until the spring of 2014. Petitioner worked as a store clerk, stockman and forklift driver, worked three to four days per week for eight hours a day and was paid $9.50 to $9.75 per hour.

James Bunge testified on behalf of the Petitioner at trial. Bunge is also a coal miner and he worked with Petitioner for significant period of time when Petitioner was a continuous miner operator and Bunge was a repairman. Bunge confirmed that Petitioner worked in an extremely dusty environment and that he observed Petitioner coughing a lot.

At the request of Petitioner's counsel, Dr. Henry Smith, a B-reader, reviewed a chest x-ray dated October 8, 2007. He opined that the film was positive for pneumoconiosis with interstitial fibrosis P/S with a profusion of 1/1 (Petitioner's Exhibit 4).

At the direction of Petitioner's counsel, Petitioner was examined by Dr. Glennon Paul, a physician who specializes in allergy and pulmonary diseases, on March 27, 2008. When Dr. Paul examined Petitioner he also reviewed a chest x-ray as well as pulmonary function studies. Dr. Paul opined the x-ray revealed multiple small fibronodular areas compatible with simple coal workers' pneumoconiosis. In regard to the pulmonary function test, he noted that Petitioner had a positive Methacholine Stimulation Test. He opined that Petitioner had simple coal workers' pneumoconiosis complicated by atrial fibrillation (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Paul was deposed on June 20, 2011, and his deposition testimony was received into evidence at trial. Dr. Paul's testimony was consistent with his medical report and he reaffirmed his opinions contained therein. He opined that the x-ray revealed small fibronodular areas throughout both lung fields compatible with simple coal workers' pneumoconiosis. He opined that the significance of there being fibronodular is that they could represent the first stage of progressive fibrosis. In regard to the positive Methacholine Stimulation Test, Dr. Paul diagnosed Petitioner with asthma. He opined that Petitioner had coal workers' pneumoconiosis and asthma, both of which were caused by Petitioner's exposure in the coal mine (Petitioner's Exhibit 1; pp 11-13).

In regard to Petitioner's smoking, Dr. Paul opined that cigarette smoking can cause reactive airways disease, but that it did not cause the reactivity of the airways that he observed in the Petitioner. He also stated that Petitioner cannot return to work to underground mining, but that he can do other work (Petitioner's Exhibit 1; pp 12; 20).

Dr. Maish Mathur is an internist at Staunton Clinic and has been Petitioner's family physician since June, 2010. Dr. Mathur has treated Petitioner for a number of health issues and his medical records for treatment provided by him from June 7, 2010, through December 20, 2012, were received into evidence at trial. When Petitioner saw Dr. Mathur on October 19, 2012, he complained of chest tightness and stated that the preceding summer was dusty. He also related the fact that he was exposed to dust and fumes when he worked in the mine (Petitioner's Exhibit 7).

Dr. Mathur was deposed on February 14, 2013, and his deposition testimony was received into evidence at trial. Dr. Mathur testified that Petitioner has asthma and that this condition was aggravated by Petitioner's coal mine employment. He further opined that Petitioner could not return to work in the mine because it would be a risk to his health and that while Petitioner could return to work, it would be limited to light to medium work (Petitioner's Exhibit 2; pp 7-10).

At the direction of the Respondent, Petitioner was examined by Dr. Peter Tuteur, a pulmonologist, on September 8, 2010. In connection with his examination of Petitioner, Dr. Tuteur reviewed x-rays and pulmonary function tests obtained on that same day. He opined that Petitioner did not have coal workers' pneumoconiosis but that he did have some degree of

bronchial reactivity which he attributed to Petitioner's history of cigarette smoking (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Tuteur was deposed on June 25, 2013, and his deposition testimony was received into evidence at trial. Dr. Tuteur reaffirmed the opinions in his medical report and stated that Petitioner did not have coal workers' pneumoconiosis or any pulmonary condition related to his coal mine exposure (Respondent's Exhibit 1; pp 15-16).

In regard to the bronchial reactivity, when he was deposed, Dr. Tuteur acknowledged that Petitioner was exposed to coal mine dust which can produce an obstructive abnormality which is virtually identical to those which may be produced as a result of cigarette smoking. He noted that these cannot be differentiated from one another clinically and that coal dust becomes another risk factor. Dr. Tuteur agreed that Petitioner had sufficient exposure for coal workers' pneumoconiosis and other dust related disease processes, including chronic bronchitis (Respondent's Exhibit 1; pp 12-13; 29).

At the direction of the Respondent, Dr. Jerome Wiot, a B-reader, reviewed the chest x-ray of September 8, 2010, and opined that it revealed no evidence of coal workers' pneumoconiosis (Respondent's Exhibit 2).

At the direction of Petitioner's counsel, Petitioner was evaluated by June Blaine, an employment/vocational expert, on January 14, 2014. Blaine reviewed Petitioner's work history and administered some tests. She opined that the wage Petitioner was earning at that time ($9.75 per hour) was representative of the highest wage he could expect to earn (Petitioner's Exhibit 3; Deposition Exhibit 2). Blaine was deposed on February 4, 2014, and her deposition testimony was received into evidence at trial. She reaffirmed the opinions she stated in her report (Petitioner's Exhibit 3).

At trial, Petitioner tendered into evidence a copy of a page from Bituminous Wage Agreement. At the time this case was tried, if Petitioner had remained employed by the Respondent, his hourly rate would have been $28.415. With a 40 hour work week, his weekly wage would have been $1,136.60.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an occupational disease arising out of and in the course of his employment for Respondent that manifested itself on August 31, 2006.

In support of this conclusion the Arbitrator notes the following:

Dr. Paul opined that an x-ray revealed small fibronodular areas compatible with simple coal workers' pneumoconiosis and, because of a positive Methacholine Stimulation Test, he diagnosed Petitioner as having asthma. He opined that both conditions were caused by Petitioner's coal mine exposure.

Dr. Mathur opined that Petitioner had asthma and that this condition was aggravated by Petitioner's coal mine exposure.

While Dr. Tuteur opined that Petitioner did not have coal workers' pneumoconiosis, he testified that Petitioner's bronchial reactivity was related to Petitioner's history of cigarette smoking. He further testified that both cigarette smoking and coal dust exposure could produce obstructive abnormalities and that there is no way to distinguish between them.

The Arbitrator finds the opinions of Dr. Paul and Dr. Mathur to be more persuasive than that of Dr. Tuteur.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to a wage differential payment of $497.73 per week as provided in Section 8(d)1 of the Act commencing on October 8, 2007, the date Petitioner was initially diagnosed as having pneumoconiosis.

In support of this conclusion the Arbitrator notes the following:

Dr. Paul and Dr. Mathur both opined that Petitioner is precluded from returning to work in a coal mine because it would be detrimental to his health.

The testimony of June Blaine that Petitioner is only capable of earning $9.75 an hour was unrebutted.

40 hours at $9.75 per hour equals $390.00. If Petitioner had been able to continue to work for Respondent, his weekly wage would have been $1,136.60. The difference between these two is $746.60, two-thirds of which equals $497.73.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ 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

David Weidenaar,
Petitioner,
vs.

15IWCC0740

NO: 14 WC 6327

UPS,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 4 2015
KWL/vf
O-9/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0740

WEIDENAAR, DAVID
Employee/Petitioner

Case# 14WC006327

UPS
Employer/Respondent

On 11/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2675 COVEN LAW GROUP
MARK J SCHECHTER
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
VIRGINIA GRAVES
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0740

David Weidenaar
Employee/Petitioner

v.

UPS
Employer/Respondent

Case # **14** WC **6327**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 29, 2014**. By stipulation, the parties agree:

On the date of accident, **August 15, 2013**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**61,643.08**, and the average weekly wage was $**1,189.29**.

At the time of injury, Petitioner was **46** years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**9,061.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,061.27**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **August 15, 2013**, through **July 29, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Walter Black

Signature of Arbitrator

November 7, 2014
Date

NOV 10 2014

Petitioner testified that he is currently employed as a "combo employee" package handler for Respondent and that he has worked for Respondent for 28 years. Petitioner testified that he lifts packages of various weights, while loading packages onto trailers, and then sorting and labeling packages later in his shift.

Petitioner testified that on August 15, 2013 he was working in his capacity sorting packages, when he picked up a box and felt a sharp pulling sensation and pain in his stomach region. He continued working and continued to have pain. He noticed that his belly button was protruding. Petitioner testified that he never sustained an injury to that area before or since. Petitioner was sent to Clearing Clinic and was diagnosed with an umbilical hernia (PX1).

Petitioner was placed on light duty, with a lifting restriction of 20 pounds. The job consisted of filling out forms while sitting at a desk

He was referred to MacNeal Hospital where he underwent a CT scan to confirm the diagnosis. He was instructed to see a physician (PX2).

Petitioner's personal physician, Dr Robert Wrona, referred him to Dr. Thomas J. Vasdekas, a surgeon (PX3). Dr. Vasdekas performed surgery on September 7, 2013 at Palos Community Hospital, consisting of a repair of incarcerated ventral/umbilical hernias with mesh and revision of a 4 centimeter umbilical scar (PX4)

Post operatively, Petitioner was not released to return to work until November 25, 2013.

Petitioner was examined on May 19, 2014 by Dr. John J. Koehler on behalf of Respondent. Dr. Koehler diagnosed umbilical and ventral hernia status post-surgical repair, healed will with no residual symptomology and authored an impairment rating of 0% (RX1). Petitioner testified that the examination took approximately fifteen minutes, and did not replicate the activities performed at work.

Petitioner testified that he is more cautious in his job duties and now uses other methods when lifting. Petitioner testified that he has minimized his golf activities because it causes a strain in the center of his abdomen which lasts for approximately 2 hours. Petitioner testified that coughing and sneezing cause pain. Petitioner testified that takes Advil for pain. Petitioner testified that he is not now seeing a physician for any treatment related to his hernia or abdominal area.

In determining the nature and extent of Petitioner's injury, the Arbitrator takes into consideration the five factors set forth in Section 8.1b of the Act

1. Level of impairment: Dr. Koehler wrote 0% impairment. Petitioner testified that the examination did not replicate the activities performed at work that can elicit pain.
2. Occupation of Petitioner: Petitioner testified that he is a package handler and is required to lift and move packages of various weights throughout the day.
3. Age of Petitioner: Petitioner was 46 years old when he was injured. The type of work that Petitioner performs will impact upon his abdominal region throughout his career.
4. Future earning capacity: Petitioner's earning capacity does not appear to be diminished. Petitioner returned to the same job and has been performing that job without incident.
5. Evidence of Disability: Petitioner's injury is corroborated by the medical records.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained a 4% loss of the person as a whole.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Yuhan,

Petitioner,

vs. NO. 14 WC011428

15IWCC0745

The Millard Group Inc,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary disability, medical expenses, prospective medical, penalties and fees, 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 October 24, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 8 2015
SJM/sj
o-9/3/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

YUHAN, ANTHONY
Employee/Petitioner

Case# **14WC011428**
14WC011427

THE MILLARD GROUP INC
Employer/Respondent

15IWCC0745

On 10/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0222 GOLDBERG WEISMAN & CAIRO LTD
JAMES J NAWROCKI
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0745

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Anthony Yuhan
Employee/Petitioner

v.

The Millard Group, Inc
Employer/Respondent

Case # **14** WC **11428**

Consolidated cases: **14 WC 11427**

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 Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **October 9, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

15IWCC0745

FINDINGS

On the date of accident, **March 24, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**62,802.34**; the average weekly wage was $**1,207.74**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

Because Petitioner failed to prove an accidental injury arising out of his employment, the claim for compensation is hereby denied.

Because Petitioner failed to prove that his condition of ill being was causally connected to his employment, the claim for compensation is hereby denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

October 24, 2014
Date

ICArbDec19(b)

OCT 24 2014

15IWCC0745

Statement of Facts

Petitioner, Anthony Yuhan, has been an employee of Respondent, the Millard Group, Inc. for 20 years as a metal refinisher. His duties are to clean architectural hardware on buildings. Petitioner testified that he had prior low back treatment in 2006. Petitioner testified that he had nerve blocks at that time. Petitioner testified that he had pain in his neck and right arm in May, 2013. He was seen at the hospital in Munster, Indiana and saw Dr. Marc Levin, an orthopedic surgeon. He had physical therapy from June, 2013 to July 11, 2013. He was released initially to light duty and returned to full duty at the end of July, 2013. Petitioner testified that he did not seek any further treatment until after March 24, 2014. Petitioner testified that in July, 2013 he had requested that he be released to full duty. He had no problems and was "ready to go."

On March 24, 2014, Petitioner's job duties took him to 5 properties (Rx 5). The fourth property listed was 111 West Illinois Street, Chicago, Illinois. The work order lists the duties as cleaning the steel canopy ceiling and fascia, the stainless steel entrance doors and revolving door unit. Petitioner testified that to clean the canopy, he was on a scaffold. Petitioner testified that in order to clean the stainless steel, he had to hold on to the canopy with his right arm and reach with his left arm with his neck hyper extended to look up and clean the steel over the railing of the scaffold. Petitioner testified that while performing this task, he felt a twinge in his neck and, shortly thereafter, pain and numbness down his right arm. Petitioner testified he did not have a specific accident at work which involved some sudden occurrence. Petitioner further testified that the nature of work he performed on March 24, 2014 was the same type of varied work he performed every day and that it was no different than other work days.

Petitioner testified that, after the incident, he completed the rest of the workday. Petitioner testified that his helper, Jose Padilla did most of the work. Petitioner testified that he returned to Respondent's office in Lincolnwood and reported the injury to Allan Schlegal, Respondent's general manager and Petitioner's supervisor. Mr. Schlegal testified that Petitioner told him that his arm had numbness just like last year. Mr. Schlegal testified that Petitioner did not report an accident. Mr. Schlegal testified that if a work injury was reported, Petitioner would have been sent for a drug test per the company policies (Rx 4). Petitioner was never sent for a drug test. Mr. Schlegal told Petitioner to see a doctor. Mr. Schlegal testified that he did receive a call on the Wednesday after March 24, 2014 from Petitioner requesting the Workers Compensation number, and from Dr. McClenic's office. He testified he told Dr. McClenic's office staff that he was not authorized to approve the visit under Workers Compensation.

Petitioner testified that he saw Dr. McClenic on March 26, 2014. He had an epidural steroid injection on April 3, 2014. Petitioner testified that the injection did not work and he was referred to Dr. Marc Levin. Petitioner testified that he also saw Dr. O'Campo for his blood pressure on April 10, 2014. Petitioner testified that he saw Dr. Marc Levin on April 10, 2014. Dr. Levin ordered a new MRI and a CT scan and recommended surgery. Petitioner underwent a two level cervical fusion on June 18, 2014. Petitioner testified that his medical bills are being paid through his Union health insurance. Petitioner testified that he had 20 physical therapy visits. Petitioner testified that was all that his plan allowed. He is now doing home exercises. Petitioner testified that Dr. Marc Levin has not released him to return to work. Petitioner testified that his next office visit with Dr. Levin is October 13, 2014.

The records of Community Hospital in Munster, Indiana (Px 1) include Petitioner's earlier treatment from 2005 through 2006. The July 24, 2006 Pain Management Center report includes a history of significant low back pain for 16 years and a family history of scoliosis. Prior records included from Advanced Pain Consultants show a blockade of the medical branch of the dorsal ramus on February 4, 2005 and refer to a June, 2003 MRI read as showing abnormal disc changes at L1-2, L2-3 and L3-4 with a disc herniation at L5-S1 and scoliotic changes in the lumbar spine. Additional facet injections were performed on December 2, 2005.

Dr. McClenic performed additional nerve blocks on 8/9/2006 from T12 to L3. While this treatment was focused on the thoracic and lumbar spine, the 7/17/2006 exam note includes findings of "Posture: Neck: Protruded and Scapular (R): Winging", and "Palpation: decreased tone right parascapular area." The records of Dr. O'Campo (P. Ex. 2) from 2009 through 2012 document continued use of Vicodin or other pain medications for chronic back pain and thoracolumbar scoliosis.

Petitioner was treated for his cervical condition beginning May 27, 2013 at Community Healthcare (Px 1). The records record a history of falling off a ladder 3 weeks ago. The MRI report notes disc osteophytes throughout the cervical spine with a disc herniation at C6-7. The neurosurgery consult note dated May 27, 2013, assesses acute radiculopathy. The note also records history "per wife patient has chronic history of severe neck pain and scoliosis." The May 29, 2013 consult note from Dr. Ibrahim records a history of severe right arm pain radiates from the scapula down into the hand and at time goes into the fifth and fourth fingers. The pain has been present for two weeks with no exact known inciting event. Petitioner underwent a cervical epidural injection on May 30, 2013. Petitioner saw Dr. Marc Levin beginning June 3, 2013 (Px 4). The health assessment form records symptoms starting three weeks ago, gradually, while sanding copper panels. Petitioner was seen further at Interventional Spine and Pain Centers on June 13, 2013 (Px 3). The note contains a history of pain for 3 weeks with no known precipitating event or activity. Petitioner was released to return to work by Dr. Marc Levin on June 27, 2013 (Px 4). At that time Petitioner still complained of occasional sharp pain in the right shoulder area.

Petitioner had filed an application for adjustment of claim number 14 WC 11427 for an alleged date of accident of May 27, 2013. This claim was voluntarily dismissed by Petitioner before trial in this matter.

Following March 24, 2014, Petitioner went to Dr. McClenic on March 26, 2014. The record of that March 26, 2014 office visit (Px 3) provides a history of the previous visit 9 months ago with an epidural steroid injection with 75% improvement of his pain. He presents with right arm pain which is now medial involving the thumb and fore finger. No history of accident is recorded. Petitioner underwent another epidural steroid injection on April 3, 2014.

Petitioner returned to Dr. Marc Levin on April 10, 2014 (Px 4). Dr. Marc Levin records the prior evaluation in the spring of 2013. He reviewed the 2013 MRI and notes he reads it as showing herniations at C5-6 and C6-7. He records a history of the cervical epidural block which helped for only a short time and then Petitioner began experiencing pain again in his neck and also his right upper extremity. Over the next number of months he continued to have pain and discomfort. On March 24, 2014 he had an injury at work when he was working with his arms and started developing a very significant pain in his neck radiating into his right arm. It was Dr. Marc Levin's opinion that Petitioner has failed conservative therapy and he discussed surgical intervention. Dr. Marc Levin scheduled an EMG and new MRI. Petitioner underwent an EMG which was read as negative and a new MRI (Px 4). He also underwent a CT scan. Dr. Levin recommended a cervical fusion. The surgery was performed on June 18, 2014 for a two level cervical discectomy and fusion at C5-6 and C6-7. Petitioner remains in post operative treatment and is not released to return to work.

Dr. Marc Levin was deposed on August 7, 2014 (Px 5). He testified that the May 27, 2013 MRI showed a small C6-7 disc herniation. He testified that when he saw Petitioner on April 10, 2014, he took a history of the accident on March 24, 2014 and the development of symptoms. He testified that the new MRI showed an increase in the size of the disc herniation at C6-7 and a new herniation at C5-6. He opined that Petitioner holding his arms overhead for a prolonged period of time could aggravate the symptoms. He opined that a disc can herniate from Petitioner hyper extending his neck for a prolonged period of time. Dr. Marc Levin opined that the March 24, 2014 incident was the cause of Petitioner's current condition.

On cross examination, Dr. Marc Levin stated he had not reviewed Dr. McClenic's March 26, 2014 note. He stated that the note states "activity does not make it worse." This is not the consistent with the history Dr. Marc Levin was given.

He testified that note did not contain any mention of a work injury. His opinions were based on the history of Petitioner working overhead, using an implement and hyper extending. He testified that it would need to be for a prolonged, holding something out and looking up at the same time to cause the symptoms. Daily activity of raising your arms overhead would not be for hours and hours in a row. The doctor testified he drafted a report to Petitioner's attorney dated May 2, 2014. He admitted that the report stated "that tests were done and did show herniations at C5-6 and C6-7, not much different that the scan previous." Dr. Marc Levin testified that he meant to say that the C6-7 disc was not much different, but somewhat larger, but the C5-6 disc herniation was now present.

A report by Dr. Jay Levin of a record review was admitted as Respondent's Exhibit 1. Dr. Jay Levin reviewed the medical records, including the May 2, 2014 narrative report from Dr. Marc Levin which detailed treatment and opinions through that date. He also reviewed the MRI films from May 27, 2013 and April 23, 2014. He notes Dr. Marc Levin's comment that these MRI scans are not much different. He opines that his reading agrees with that opinion. He opines that the April 23, 2014 MRI does not demonstrate any acute pathology. Dr. Jay Levin opines that the onset of symptoms on March 24, 2014 is consistent with the pre existing C5-6 and C6-7 disc herniations. Dr. Jay Levin opines that the March 24, 2014 incident is not the cause of Petitioner's condition or his need for surgical intervention.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

Petitioner bears the burden of proving, by a preponderance of the evidence that he sustained an accident arising out of his employment.

Petitioner testified that on March 24, 2014, while cleaning the canopy at 111 West Illinois Street, Chicago, Illinois, he felt a twinge in his neck, and shortly thereafter, pain and numbness down his right arm. He testified that he reported this incident that day to Mr. Schlegal. His testimony is not supported the testimony of Mr. Schlegal or by the medical records in this matter.

Mr. Schlegal testified that Petitioner said that his arm had numbness just like last year. Mr. Schlegal testified that Petitioner did not report an accident. Mr. Schlegal testified that if a work injury was reported, Petitioner would have been sent for a drug test, per the company policies. He testified that Petitioner had ongoing medical issues.

Dr. McClenic's records of March 26, 2014 and April 3, 2014 do not document any history of the March 24, 2014 accident. The records also document that Petitioner was having symptoms before March 24, 2014. Dr. McClenic's June 13, 2013 record states only 75% improvement in his pain after the May 30, 2013 injection. This is repeated in his March 26, 2014 note. Dr. Marc Levin's April 10, 2014 note records a history of the cervical epidural block from May, 2013 which helped for only a short time and then Petitioner began experiencing pain again in his neck and also his right upper extremity. Over the next number of months he continued to have pain and discomfort.

In assessing the Petitioner's credibility, the Arbitrator also notes that Petitioner was able to complete the workday on March 24, 2014 and worked the day after. The Arbitrator also has reviewed the records of the 2013 treatment. The Petitioner provided multiple conflicting histories to his treating doctors including advising Community Hospital that he fell from a ladder, telling Dr. Ibrahim that there was not any known inciting incident, and completing a form for Dr. Marc Levin claiming symptoms starting three weeks ago, gradually, while sanding copper panels.

Based upon the totality of the evidence submitted, the Arbitrator finds Petitioner's testimony unpersuasive. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries which arose out of his employment with Respondent on March 24, 2014.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner claims that his condition of ill being in the cervical spine and right arm and the treatment for this condition including the June 18, 2014 surgery are causally connected to his work incident on March 24, 2014. Petitioner testified to a prior history of treatment to his neck. The medical records more definitively reflect the prior treatment and complaints. Petitioner testified that his earlier 2006 treatment was for the low back. The records of Community Hospital, 7/17/2006 exam note includes findings of "Posture: Neck: Protruded and Scapular (R): Winging", and "Palpation: decreased tone right parascapular area." Petitioner was prescribed narcotic pain medication for many years.

Petitioner was treated for his cervical condition beginning May 27, 2013 at Community Healthcare (Px 1). The records record a history of falling off a ladder 3 weeks ago. The MRI report notes disc osteophytes throughout the cervical spine with a disc herniation at C6-7. The neurosurgery consult note dated May 27, 2013, assesses acute radiculopathy. The note also records history "per wife patient has chronic history of severe neck pain and scoliosis." Dr. O'Campo's records contain ongoing notations of chronic back pain and thoracolumbar scoliosis with prescriptions for Vicodin.

Dr. McClenic's June 13, 2013 record states only 75% improvement in his pain after the May 30, 2013 injection. This is repeated in his March 26, 2014 note. Dr. Marc Levin's April 10, 2014 note records a history of the cervical epidural block from May, 2013 which helped for only a short time and then Petitioner began experiencing pain again in his neck and also his right upper extremity. Over the next number of months he continued to have pain and discomfort. The MRI report dated April 23, 2014 also only notes a disc protrusion on C6-7. At his first return visit in 2014, Dr. Marc Levin diagnosed a failure of conservative care.

Dr. Marc Levin testified by deposition to his opinion that the March 24, 2014 work incident was the cause of Petitioner's condition and need for treatment including surgery. An expert's opinion is only as valid as the bases and reasons for the opinion. Upon review of the testimony and medical evidence, the Arbitrator finds Dr. Marc Levin's opinion unpersuasive and contradicted by his own records and the other evidence presented.

Dr. Marc Levin testified that the April 23, 2014 MRI showed an increase in the size of the C6-7 disc protrusion and a new C5-6 disc protrusion. But his own note of April 10, 2014 states that he has reviewed the 2013 MRI and finds disc herniations at both C5-6 and C6-7. His May 2, 2014 report is quoted in Dr. Jay Levin's report as stating the 2014 MRI was not much different from the previous scan. His explanation of this statement in his deposition on cross examination is unconvincing, particularly in light of his April 10, 2014 note.

Dr. Marc Levin also premised his causal connection opinion on the basis that Petitioner was working with his arms overhead, holding something out and looking up at the same time for a prolonged period of time. In response to the question on cross examination concerning being in this position during activities of daily living, Dr. Marc Levin refers to doing this activity for hours and hours in a row. On March 24, 2014, the undisputed testimony was that Petitioner completed five different assigned jobs, only the assignment at 111 West Illinois, Chicago, Illinois involved the overhead work of cleaning the canopy, and this was only part of the duties performed at that location. There is no evidence that Petitioner was doing this overhead activity for a prolonged period of time on that date.

Based upon the testimony presented and the medical evidence and exhibits submitted, the Arbitrator finds the opinion of Dr. Jay Levin more persuasive and consistent with the facts in this matter. The Arbitrator finds that Petitioner failed to prove that the current condition of ill being alleged in the cervical spine and right arm is causally connected to his employment with Respondent.

In support of the Arbitrator's decision with respect to (G) Wages, the Arbitrator finds as follows:

The parties submitted Petitioner's wage records (Rx 2). That exhibit contained earnings for a period of greater than the 52 weeks preceding the date of accident. Using the 52 weeks ending with last full pay period immediately preceding the date of injury alleged, removes the pay periods ending 2/24/13, 3/10/13, and 3/24/13 from the exhibit. Using the remaining periods Petitioner earned **$62,802.34**. The average weekly wage was **$1,207.74.**

In light of the Arbitrator's decision concerning Accident and Causal Connection, the remaining issues of (E) Notice, (J) Medical, (K) Prospective Medical, (L) Temporary Compensation, and (M) Penalties are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julius Perryman,

Petitioner,

vs. No. 09 WC 24134

Illinois Department of Transportation,

15IWCC0746

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On June 8, 2009, Petitioner filed an application for adjustment of claim alleging that on April 21, 2008, he sustained accidental injuries to "[l]eft wrist/arm, back, left ankle" that arose out of and in the course of his employment with Respondent. Following a section 19(b) hearing on November 5, 2009, Arbitrator Peterson filed a (corrected) decision on April 12, 2010, finding that Petitioner failed to prove the accident aggravated his left carpal tunnel syndrome or left cubital tunnel syndrome, and that he also failed to prove his complaints of back pain after July 14, 2008, are causally connected to the accident. On review, in a decision dated March 22, 2011, the Commission modified the Arbitrator's decision. The Commission found that "Petitioner's lower back problems as well as his problems involving his left wrist are causally connected to the accident on April 21, 2008." The Commission accordingly awarded temporary total disability benefits and medical expenses, and remanded the matter to the Arbitrator for further proceedings.

On July 24, 2014, Arbitrator Williams held a hearing on the remaining issues. Petitioner sought additional temporary total disability benefits, from November 6, 2009, through December 19, 2010, and permanent partial disability benefits. On September 19, 2014, Arbitrator Williams filed a corrected decision denying additional temporary total disability benefits, and awarding permanent partial disability benefits representing a 5 percent disability to the person as a whole and 3 percent loss of use of the left hand. The Commission agrees with the Arbitrator's award of permanent partial disability benefits. However, the Commission disagrees with the denial of temporary total disability benefits.

Petitioner, a laborer, testified at the second arbitration hearing that his job was heavy duty. Petitioner was injured while stacking 100-pound tires inside a trailer truck. Eventually, Petitioner came under the care of Dr. Lorenz and Dr. Bardfield at Hinsdale Orthopaedics for his back condition. Dr. Lorenz imposed restrictions, which Respondent did not accommodate.

The medical records admitted into evidence at the second arbitration hearing show that on October 23, 2009, Petitioner saw Dr. Bardfield on a referral from Dr. Lorenz "for additional conservative treatment." Petitioner complained of back pain radiating to the legs, which he attributed to the work injury. Dr. Bardfield noted that X-rays were unremarkable, but an MRI performed in June of 2009 showed disc bulges at L4-L5 and L5-S1 with facet arthritis and foraminal stenosis. Petitioner had already undergone physical therapy and work conditioning, plateauing in work conditioning at lifting no more than 75 pounds. Physical examination was notable only for hamstring tightness bilaterally with straight leg raise test. Dr. Bardfield diagnosed lumbar radiculopathy with significant foraminal stenosis at L4-L5, and recommended epidural steroid injections at L4, followed by additional work conditioning. He also took Petitioner off work. Petitioner testified that Respondent did not authorize the injections or work conditioning.

The medical records further show that on January 28, 2010, Petitioner followed up with Dr. Bardfield, reporting no improvement. Dr. Bardfield noted the treatment had not been approved. Petitioner requested a release to return to work on light duty because he was having financial problems. Dr. Bardfield changed his diagnosis to mechanical low back pain with bilateral foraminal stenosis at L4 and L5. He again recommended epidural steroid injections and work conditioning, and released Petitioner to return to work on light duty. Petitioner testified that Respondent did not offer him light duty work, so he did not work. The medical records further show that on August 12, 2010, Petitioner followed up with Dr. Bardfield, complaining of increased low back symptoms and radiation down the left leg. Dr. Bardfield noted that none of the treatment had been approved. On physical examination, the range of motion was limited at end forward flexion. Seated straight leg raise test was positive on the left at 80 degrees. Gait pattern was mildly antalgic on the left side. There was tightness and tenderness to palpation of the lumbar paraspinal musculature. Dr. Bardfield diagnosed a flare-up in lumbar radiculopathy with significant foraminal stenosis and lumbar paraspinal myofascial pain. He continued to recommend epidural steroid injections and physical therapy/work conditioning, and kept Petitioner on light duty. Petitioner testified that he last saw Dr. Bardfield on August 12, 2010.

Petitioner further testified that he also saw Dr. Panio for problems with his hands. At one point, Dr. Panio recommended surgery. The surgery was never performed. The medical records further show that on December 20, 2010, Petitioner's primary care physician, Dr. Jensen, released Petitioner to return to work full duty, stating his condition had improved. Petitioner testified that he asked Dr. Jensen to release him to return to work. Petitioner further testified he promptly returned to work full duty and was assigned to shovel asphalt and concrete. He continued to work for Respondent full duty until the end of his employment with Respondent on October 16, 2012.

In denying temporary total disability benefits the Arbitrator stated:

> "Based on the evidence and the Decision and Opinion on Review on March 22, 2011, the petitioner failed to prove that he was entitled to temporary total disability benefits after November 5, 2009. The Commission's decision indicated that the petitioner was only entitled to temporary total disability benefits for 79-6/7 weeks (April 22, 2008 through November 1, 2009), the date Dr. Lorenz felt that he would release the petitioner to return to work. Implicit in this binding finding of the Commission is that the petitioner was at maximum medical improvement on November 2, 2009. The petitioner failed to establish by sufficient evidence that he was not at maximum medical improvement after November 1, 2009. Moreover, the respondent's time records for the petitioner indicate a non-work related 'Health Leave of Absence' for the entire period after November 1, 2009."

The Commission finds that the Arbitrator misinterpreted our decision of March 22, 2011. In our decision, the Commission found as follows: "Dr. Lorenz prescribed physical therapy through September 25, 2009 and on October 14, 2009 felt that he would release Petitioner to return to work on November 2, 2009 and the only restriction is that he should get some help when lifting greater than 75 pounds." Our award of temporary total disability benefits states: "Respondent shall pay to the Petitioner the sum of $732.77 per week for a period of 79 6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any." The Commission's decision was based on the record made at the 19(b) hearing held on November 5, 2009, only days after Petitioner was to return to work per Dr. Lorenz. The record at the time did not permit a determination of whether Petitioner had reached maximum medical improvement.

The record from the second hearing in this matter shows that on October 23, 2009, less than ten days after seeing Dr. Lorenz, Petitioner saw Dr. Bardfield on a referral from Dr. Lorenz "for additional conservative treatment." Dr. Bardfield recommended epidural steroid injections at L4, followed by additional work conditioning, and took Petitioner off work. Petitioner

followed up with Dr. Bardfield on January 28, 2010, and August 12, 2010, reporting persistent or worsening symptoms. Dr. Bardfield continued to recommend epidural steroid injections and work conditioning, and released Petitioner to return to work on light duty at his request. Subsequently, Dr. Jensen released Petitioner to return to work full duty on December 20, 2010, stating his condition had improved. The record shows that Respondent did not authorize any of the treatment recommended by Dr. Bardfield or offer Petitioner light duty work during the time he was under restrictions.

Respondent stipulated that Petitioner was temporarily totally disabled from November 6, 2009, through December 19, 2010, although Respondent denied liability. The Commission finds that Petitioner proved he is entitled to temporary total disability benefits from November 6, 2009, through December 19, 2010.

IT IS THEREFORE ORDERED BY THE COMMISSION that the (corrected) Decision of the Arbitrator filed September 19, 2014, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $732.77 per week for a period of 58 3/7 weeks, from November 6, 2009, through December 19, 2010, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 31.15 weeks, as provided in §§8(d)2 and 8(e) of the Act, for the reason that the injuries sustained caused permanent disability to the extent of 5 percent of the person as a whole and loss of use of the left hand to the extent of 3 percent thereof.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 28 2015
o-09/03/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

PERRYMAN, JULIUS
Employee/Petitioner

Case# **09WC024134**

ILL DEPT OF TRANSPORTATION
Employer/Respondent

15IWCC0746

On 9/19/2014, 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 0.04% 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:

2988 CUDA LAW OFFICES LTD
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

5048 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CENTRAL MGMT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

SEP 19 2014

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0746

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

JULIUS PERRYMAN
Employee/Petitioner

Case #09 WC 24134

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on July 24, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

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. ☐ 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. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- An amended arbitration decision was filed on April 12, 2010, pursuant to a Section 19(b) hearing by Arbitrator Peterson on November 5, 2009, awarding the petitioner medical expenses and temporary total disability benefits through July 14, 2008, for the condition of ill-being with his back.

- A Decision and Opinion on Review #11IWCC0289 was entered on March 22, 2011, awarding the petitioner medical expenses for the condition of ill-being with his lower back and left wrist and temporary total disability benefits up to November 2, 2009, the date Dr. Lorenz felt he would release the petitioner to return to work.

- The parties agreed that the respondent paid $58,516.80 toward the prior Section 19(b) award.

- The parties agreed that the petitioner was off work from November 6, 2009, through December 19, 2010, and was not paid any temporary total disability benefits.

ORDER:

- The petitioner's request for temporary total disability benefits after November 5, 2009, is denied.

- The respondent shall pay the petitioner the sum of $636.15/week for a further period of 31.15 weeks, as provided in Section 8(e) and (d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% of the man as a whole and 3% of his left hand.

- The respondent shall pay the petitioner compensation that has accrued from April 21, 2008, through July 24, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his low back and left wrist was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills,

including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

September 19, 2014

Date

SEP 19 2014

FINDINGS OF FACTS:

After the November 5, 2009, Section 19(b) hearing, the petitioner saw Dr. Bardfield on January 28, 2010, who noted that the petitioner's symptoms were the same if not slightly worse and that he had back pain with occasional referral to both lower extremities. His impressions were mechanical low-back pain with bilateral foraminal stenosis at L4-5 and L5-S1. The doctor again recommended epidural steroid injections and work conditioning, which were not approved when first recommended in October 2009. Pursuant to the petitioner's request, he was given light-duty work restrictions. The petitioner reported itching due to his medication to Dr. Bardfield's office on February 17, 2010. Dr. Bardfield noted increased symptoms on August 12, 2010, and recommended physical therapy, epidural injections and the continuation of the same work restrictions.

Dr. Jensen saw the petitioner on December 16, 2010, and noted that he was ready to go back to work. Dr. Jensen's handwritten notes are not clearly legible and are subject to misinterpretation. The petitioner saw Dr. Jensen three more times for various medical problems through May 8, 2012.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his low back and left wrist was reasonable and necessary and is awarded.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Based on the evidence and the Decision and Opinion on Review on March 22, 2011, the petitioner failed to prove that he was entitled to temporary total disability benefits after November 5, 2009. The Commission's decision indicated that the petitioner

was only entitled to temporary total disability benefits for 79-6/7 weeks (April 22, 2008 through November 1, 2009), the date Dr. Lorenz felt that he would release the petitioner to return to work. Implicit in this binding finding of the Commission is that the petitioner was at maximum medical improvement on November 2, 2009. The petitioner failed to establish by sufficient evidence that he was not at maximum medical improvement after November 1, 2009. Moreover, the respondent's time records for the petitioner indicate a non-work related "Health Leave of Absence" for the entire period after November 1, 2009. The petitioner's request for temporary total disability benefits from November 6, 2009, through December 19, 2009, is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner currently has back pain and numbness and stiffness in his thumb. He takes Advil for pain. He returned to full-duty work on December 20, 2010. The respondent shall pay the petitioner the sum of $636.15/week for a further period of 31.15 weeks, as provided in Section 8(e) and (d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% of the man as a whole and 3% of his left hand.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL D. BATES,

Petitioner,

vs. NO: 07 WC 47974

MONTERREY COAL CO.,

15IWCC0717

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident/exposure, notice, causation, medical expenses and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an occupational disease arising out of and in the course of his employment with Respondent on September 30, 2009, for the reasons stated below.

Petitioner testified that he worked for Respondent for over 31 years, all but four weeks of this time working in underground mines. Over this time his jobs included belt shoveling, rock dusting, buggy runner, ventilation, miner helper, operator, roof bolter, long wall, long wall back bleeder examiner and belt mover. He testified to exposure to coal dust, silica dust, roof bolting glue, tile epoxy and diesel fumes. He also was involved in a smoke inhalation incident in the 1980's. (Tr. 11-15, 20-26).

He worked for Respondent until his retirement on March 31, 2005, and testified he was exposed to coal dust that day. He testified that he developed some degree of breathing problems in his later years in the mine, as well as at the time of his retirement, and it was a factor in his decision to retire. He testified his condition gradually worsened while working in the mine, and that he had been prescribed inhalers including Symbicort and Advair. Petitioner testified that he

had been treating with Dr. Johnson, and that when Johnson indicated the mine environment was not good for him, he indicated he needed to make a living and that leaving the mine was not an option at that time. (Tr. 15-17, 26-31). He was a smoker in the past, but had not smoked since approximately 1980.

He subsequently went into business with his son-in-law building spec homes, building several through 2012. He also worked as a pastor at various churches over the course of 34 years until retiring in 2013. (Tr. 17-21).

Petitioner's testimony regarding his mine exposures was verified by witness James Daugherty. (Tr. 37-41).

Dr. Paul testified on October 11, 2010 that he relied on the x-ray readings of Dr. Smith indicating Petitioner had coal workers' pneumoconiosis (CWP). He noted that normal pulmonary function testing does not rule out the existence of CWP. Pulmonary function testing shows the type of respiration abnormality and the severity, but it does not reflect the etiology. (Px1, p. 15-18). He also testified that chronic bronchitis is a chronic obstructive pulmonary disease (COPD), and you can also have it despite normal pulmonary testing. It was Dr. Paul's opinion that the only reason Petitioner was disabled from mine work was CWP. He agreed that Petitioner had normal pulmonary function testing as well as chest examination, and was not undergoing active respiratory treatment or taking respiratory medications. (Px1).

Dr. Paul again testified on March 13, 2012. (Px2). At that time he testified that pulmonary function testing reflected Petitioner had reactive airways disease (RAD)/asthma. Noting aggravating factors for this condition, such as roof bolting glues, coal chute repair glues, diesel fumes, petroleum products and biochemicals in water suppression systems, he opined that Petitioner's work in the mine was a causative factor in the RAD/asthma. (Px2, pp. 5-8). On cross examination he agreed that Petitioner's baseline pulmonary function testing was normal, but the methacholine test results and presence of asthma reflect a respiratory restriction. (Px2, pp. 8-9). He further testified that once you have RAD/asthma, there are many symptomatic triggers, both inside and outside of the mine. (Px2, pp. 13-15).

Petitioner's general practitioner, Dr. Johnson, also opined that Petitioner had RAD/asthma. He wasn't certain if the methacholine challenge testing was the best way to test for RAD/asthma, but it is the most commonly used method. (Px3, pp. 11-13, 26-27). He further testified that prior incidents of smoke inhalation (2005) and gas fume exposure could have been causative factors in Petitioner's development of the condition. He wasn't certain if other mine exposures were causative since he didn't know the exact onset of the RAD/asthma, but opined that they were aggravating factors in the disease process. (Px3, pp. 11-13). He has prescribed inhalers to Petitioner to manage asthma, bronchitis and bronchospasm. Dr. Johnson believed Petitioner was prohibited from mine work due to asthma, chronic bronchitis and rhinitis, indicating it would be a significant risk. (Px3, pp. 13-16, 24-25).

Dr. Tuteur examined Petitioner at the request of Respondent pursuant to Section 12 of the Act. He opined that there was no evidence that Petitioner had CWP, asthma or any other occupational lung disease. He did agree that Petitioner's history of shortness of breath in winter air, helped by inhaler use, is consistent with RAD, but not diagnostic of RAD. He disareed with Dr. Paul's interpretation of the methacholine challenge test, but agreed that if Dr. Paul's indication that the FEV1 fell 21% would be consistent with chemically induced RAD. He also agreed that exposure to certain roof bolt glues or plant glues could be causative factors. He also testified that things like diesel fumes, combusted petroleum products, some bioaerosols and smoking tires could aggravate reactivity in someone with RAD. Dr. Tuteur agreed that someone with RAD/asthma resulting from mine exposure should avoid further exposure. (Rx1, pp. 12-20).

Dr. Tuteur opined that Petitioner did not have CWP, based on his examination and review of chest x-rays. He agreed with Dr. Paul that not only could pulmonary function testing be normal in a CWP patient, but it is actually more of the rule than the exception. (Rx1). Dr. Shipley and Dr. Tarver, both B-readers, reviewed Petitioner's chest x-rays and concluded that there was no evidence of CWP. (Rx2; Rx3).

Under Section 1(d) of the Illinois Occupational Disease Act, an occupational disease: "means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public."

Additionally: "A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists." (OD Act, Section 1(d)).

Based on the totality of the evidence and our factual findings above, we find that the Petitioner has proven exposure to various types of dusts, fumes, glues and smoke while working for Respondent in a coal mine over the course of 30 plus years. Based on the evidence presented, we find that the Petitioner failed to prove that he has coal workers' pneumoconiosis. In making such finding, the Commission relies on the fact that three physicians (Dr. Tuteur, Dr. Shipley and Dr. Tarver) all reviewed chest x-rays of the Petitioner and determined that there was no evidence of CWP. Dr. Tuteur also performed a chest examination. Dr. Paul is the only physician who has opined in this case that the Petitioner does have CWP, and his opinion was that the perfusion rate was 1/0. He also testified that the Petitioner's chest examination was normal. Based on the

totality of the evidence, the Commission finds that the greater weight of the evidence indicates that the Petitioner does not have CWP.

The Commission does find, however, that the Petitioner has developed RAD/asthma, and that the condition was at least contributed to by his exposures in Respondent's coal mine. As such, we find that Petitioner's work exposures are a contributing cause to Petitioner's development of RAD/asthma, and thus that the condition is causally related to Petitioner's employment.

The Petitioner has made no claim for medical expenses or temporary total disability in relation to the claim at bar. The Commission makes no awards in relation to these noted workers compensation benefits. We do find, however, that the Petitioner has sustained permanent partial disability as a result of the development of RAD/asthma.

The Petitioner did not make any claim, per the Request for Hearing form, for temporary total disability (TTD) or medical expenses related to this matter. The Commission thus does not award either of these benefits. We note that the Petitioner testified that he retired voluntarily, albeit per his testimony with some contribution from his difficulties with breathing, and continued to work after his retirement as a pastor and home builder. We also note that the medical records in evidence reflect no ongoing treatment for pulmonary or lung-related illnesses. The Petitioner testified that he continued to have difficulty with respiratory problems, and they've worsened somewhat since he left the mine. He uses inhalers regularly. Dr. Paul testified that Petitioner could put his health at risk were he to continue to perform mine work. We find that the Petitioner sustained the loss of 10% of the man as a whole as a result of his work-related respiratory illness.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed, as indicated above, and the Commission finds that Petitioner sustained an occupational disease arising out of and in the course of his employment on March 31, 2005.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $425.00 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the permanent loss of 10% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including any and all awarded medical expenses that were previously paid; any medical credit is limited as noted above.

15IWCC0717

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 17 2015
TJT: pvc
O 07/20/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BATES, MICHAEL D
Employee/Petitioner

Case# **07WC047974**

MONTEREY COAL COMPANY
Employer/Respondent

15IWCC0717

On 1/21/2015, 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
PO BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS. 15IWCC0717
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael D. Bates
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # 07 WC 47974

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 18, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On March 31, 2005, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did not sustain an occupational disease that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the alleged occupational disease.

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $708.33.

On the date of accident, Petitioner was 55 years of age, married with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator

January 16, 2015
Date

JAN 21 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart arising out of and in the course of his employment for Respondent. The Application alleged a date of last exposure of March 31, 2005, and that Petitioner sustained an occupational disease as a result of inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes and vapors for a period in excess of 31 years.

Petitioner's date of birth was September 28, 1949, and he was 65 years old at the time of trial. Petitioner worked for Respondent from January 21, 1974, to March 31, 2005. With the exception of approximately four weeks, Petitioner worked underground. Petitioner testified that he worked a number of jobs in the mine including laborer, buggy runner, continuous miner helper/operator, roof bolter and the job that he retired from, belt mover. During that time, Petitioner was exposed to coal dust, silica dust, roof bolting glue fumes and diesel fumes.

Prior to working for Respondent, Petitioner served in the U.S. Army for two years, worked at Eagle-Pitcher, worked on the railroad and as a police officer. Petitioner did not complete his senior year of high school so that he could enlist in the military; however, he completed his GED after he was discharged.

Petitioner began smoking cigarettes when he was 16 years old and smoked until he was approximately 28 to 30 years old. When he smoked, he smoked less than one pack per day. Petitioner testified that he has not smoked for 35 to 40 years.

Petitioner testified he began to experience breathing problems during the latter years at the mine, in particular, when he was exposed to diesel fumes. At the time of trial, Petitioner stated that he could walk approximately 100 yards at a normal pace before he would become short of breath. If he climbed 12 to 15 steps, Petitioner stated that he would need to take a rest. Petitioner also said that his breathing difficulties have worsened since he left the mine. Petitioner said that if a job in the coal mine were offered to him at this time he would not take it because of his health concerns.

James Daugherty testified on behalf of the Petitioner at trial. Daugherty is a coal miner and he worked with Petitioner as a roof bolter. Daugherty confirmed that Petitioner was exposed to roof bolting glue fumes and that Petitioner worked in a very dusty environment. He also observed Petitioner having breathing difficulties on a number of occasions.

Dr. Phillip Johnson has been Petitioner's family physician since 1998. Three sets of medical records for treatment provided by Dr. Johnson to Petitioner were received into evidence at trial. One was for treatment from January 22, 2001, through March 13, 2008 (Petitioner's Exhibit 7). The second record was for treatment provided from August 13, 2008, through August 8, 2012 (Petitioner's Exhibit 9). The third record was for treatment provided from August 8, 2012, through August 13, 2014 (Respondent's Exhibit 4).

Theresa Durbin, Dr. Johnson's PA, saw Petitioner on February 3, 2005, following an incident at work where he was exposed to smoke at work that occurred as result of overheating of some

tires. Petitioner was treated for smoke inhalation and, when seen on March 4, 2005, his condition had improved. On March 23, 2005, Petitioner was diagnosed pneumonitis. When Petitioner was subsequently seen on June 24, and October 7, 2005, Petitioner had no respiratory symptoms or shortness of breath (Petitioner's Exhibit 7).

When Dr. Johnson saw Petitioner on April 7, 2009, he diagnosed Petitioner with allergic rhinitis, caused unspecified. Dr. Johnson periodically treated Petitioner for rhinitis, bronchitis and sinusitis. In his record of June 1, 2011, he noted that Petitioner had black lung disease (Petitioner's Exhibit 9). In his record of February 4, 2013, Dr. Johnson again noted that Petitioner had black lung disease; however, the respiratory examination was normal (Respondent's Exhibit 4).

Dr. Johnson was deposed on August 15, 2013, and his deposition testimony was received into evidence at trial. When deposed, Dr. Johnson opined that Petitioner's exposure in the coal mine could have aggravated Petitioner's bronchitis and rhinitis. He also opined that Petitioner was no longer physically capable of working in the mines because of his respiratory conditions (Petitioner's Exhibit 3; pp 14-16).

At the direction of Petitioner's counsel, Petitioner was examined by Dr. Glennon Paul, an allergy and pulmonary specialist, on March 11, 2008. On clinical examination, Dr. Paul's assessment of Petitioner's chest was normal. A chest x-ray showed moderate to small nodules throughout both lung fields with some areas of mild fibrosis. Pulmonary function tests conducted that day were normal. Dr. Paul opined that Petitioner had simple coal workers' pneumoconiosis (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Paul was deposed on October 11, 2010, and again on March 13, 2012. Dr. Paul testified that Petitioner had coal workers' pneumoconiosis and that it would have been present at the time Petitioner was last exposed in 2005. Dr. Paul only saw Petitioner on that one occasion and he agreed that the physical examination of the chest and pulmonary function tests were both normal and that Petitioner was not under any treatment for a respiratory condition (Petitioner's Exhibit 1; pp 10, 32).

When Dr. Paul was deposed for the second time, he opined that Petitioner had asthma which he attributed to Petitioner's exposure in the coal mine, in particular, to roof bolting glue, diesel fumes and other biochemicals. Dr. Paul could not testify as to when Petitioner first developed asthma and he again stated that Petitioner was not being treated for any respiratory condition at the time of his examination (Petitioner's Exhibit 2; pp 6-11).

At the direction of the Respondent, Petitioner was examined by Dr. Peter Tuteur, a pulmonologist, on June 9, 2010. When examined by Dr. Tuteur, Petitioner informed him that he was able to walk two miles on flat ground without stopping and climb six flights of stairs without stopping. Dr. Tuteur also reviewed a chest x-ray and pulmonary function tests performed that same day. He opined that the x-ray revealed no evidence of coal workers' pneumoconiosis and that the pulmonary function tests were normal (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Tuteur was deposed on April 26, 2012, and his deposition testimony was received into evidence at trial. Dr. Tuteur's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner did not have coal workers' pneumoconiosis or any lung disease related to his occupation as a coal miner. Dr. Tuteur also described Petitioner's ability to walk and climb stairs as being "excellent" (Respondent's Exhibit 1; pp 7, 12).

Dr. Henry Smith, a B-reader, reviewed a chest x-ray of September 7, 2007, and opined that it was positive for early mild pneumoconiosis with interstitial fibrosis, profusion 1/0. He also reviewed a chest x-ray of June 9, 2010, and opined that it was positive for simple coal workers' pneumoconiosis, profusion 1/0 (Petitioner's Exhibit 5).

Dr. Ralph Shipley and Dr. Robert Tarver, both B-readers, reviewed the chest x-ray of June 9, 2010, and both opined that it did not reveal evidence of coal workers' pneumoconiosis (Respondent's Exhibits 2 and 3).

Petitioner testified that after he ceased his employment with Respondent, he went into business with his son-in-law building spec houses and doing some remodeling jobs. He was in that business from 2005 to 2012. Petitioner has also worked as the Pastor of four Baptist churches and he has earned approximately $200.00 to $300.00 per week while working in that capacity.

At the direction of Petitioner's counsel, Petitioner was evaluated by June Blaine, an employment/occasional expert, on November 29, 2013. When Blaine evaluated Petitioner, she obtained information from him regarding his education and work history and administered some tests. Blaine opined that Petitioner demonstrated an ability to earn $12.50 per hour (Petitioner's Exhibit 4; Deposition Exhibit 2). Blaine was deposed on March 25, 2014, and her deposition testimony was received into evidence at trial. Her testimony was consistent with her report and she reaffirmed her opinion regarding Petitioner's earning capacity (Petitioner's Exhibit 4).

At trial, Petitioner tendered into evidence a copy of the page from the Bituminous Wage Agreement. If Petitioner had been able to continue to work for Respondent, his hourly rate at the time of trial would have been $28.415 (Petitioner's Exhibit 8). With a 40 hour work week, his weekly wage would have been $1,136.60.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment for Respondent that manifested itself on March 31, 2005.

In support of this conclusion the Arbitrator notes the following:

Although Petitioner testified that he experienced breathing problems during the latter years of his employment by Respondent, this is not supported by the medical records of Dr. Johnson. The exception to this is the treatment Petitioner received in 2005 subsequent to the smoke inhalation; however, Petitioner subsequently recovered from that incident.

While Dr. Paul opined Petitioner had coal workers' pneumoconiosis and asthma related to his exposure as a coal miner, his findings on clinical examination and the pulmonary function tests were both normal. Further, he acknowledged Petitioner was not under any active treatment for respiratory problem at the time of his examination.

When Petitioner was evaluated by Dr. Tuteur, Petitioner advised Dr. Tuteur that he was able to walk two miles or climb six flights of stairs without stopping which Dr. Tuteur described as being "excellent." Dr. Tuteur also opined that Petitioner did not have coal workers' pneumoconiosis or any lung disease related to his employment.

The Arbitrator finds the opinion of Dr. Tuteur to be more persuasive than those of Dr. Johnson and Dr. Paul.

In regard to disputed issues (E) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathleen Bialek,

Petitioner,

vs. NO: 08 WC 38471

Cook County Sheriff's Department,

Respondent.

15IWCC0714

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability-nature and extent only, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Accident and causal connection had been found with prior §19(b)

- Petitioner was a 54 year old employee of Respondent, who described her job as a sheriff's department sergeant. This matter was previously heard under §19(b) by then Arbitrator DeVriendt November 25, 2009. Petitioner then had testified of her treatment with Dr. Mass and she had remained under the care of Dr. Mass after that hearing. Petitioner had returned to Dr. Mass December 22, 2009 and then she was in therapy at Southwest Hand Rehabilitation. Dr. Mass had performed another surgery February 17, 2010 and she had additional therapy after that surgery. Petitioner had another surgery August 4, 2010 and again continued therapy after that. Petitioner testified that at the time of that prior hearing from her IP joint to the end of her finger had healed but it had healed

at an extreme angle from her hand and that had necessitated the next surgery to re-fuse it as it had not fused; so she had to have a third fusion surgery. Petitioner stated after that she had to have a basilar joint reconstruction and the MCP joint repair. Petitioner testified all together she had five surgeries by Dr. Mass. After the August 4, 2010 surgery, her next surgery was December 28, 2010 and then another June 14, 2011. All except the first surgery-(2009) were done at the University of Chicago Medical Center. Each time after a surgery, Dr. Mass had put Petitioner into physical therapy, which was done at Southwest Hand, until they closed; prior to her last surgical procedure. When Petitioner had the June 2011 surgery, the doctor had prescribed a bone stimulator and she had used that until the doctor told her to stop using that for about four months. Petitioner indicated it took a long time for the stimulator to get approved and then she had used it for at least four months. After she had stopped using the stimulator, Dr. Mass had recommended one more surgery and the doctor also referred Petitioner to a neurologist and she saw Dr. Jeffrey Curtin in January 2012 and that doctor recommended injections for the injury, thumb, and the doctor then referred Petitioner to Dr. Angelopoulos. Following her last surgery in 2012, Petitioner had therapy at Hand Therapy in Chicago Ridge. Petitioner did have some unrelated surgery not due to this case; carpal tunnel release and ulnar nerve relocation on her right arm/hand. Petitioner had therapy after that surgery. After her last surgery in 2012 Petitioner testified that she would experience swelling and severe coldness and then she would experience very hot sensation and it would discolor. For those symptoms, Dr. Mass had referred Petitioner to Dr. Anitescu; she had seen Dr. Angelopoulos prior to that and Dr. A had recommended ganglion bundle blocks, injection to her throat; Petitioner had four of those injections and she testified those series of injections-(starting February 2014) provided no relief. Petitioner last saw Dr. Angelopoulos about March 2014 and she had still been treating with Dr. Mass in February 2014. Petitioner had been ordered back to work August 29, 2013 and she did return to clerical work at that time. Petitioner testified that the job she returned to involved filing and a lot of repetitive motion and it involved overuse of her right hand, and it involved pulling papers apart and stapling them and looking at ledger books, copying numbers down and other such clerical matters. She had performed those duties at the Daley Center. Petitioner testified that at that point she noticed her right hand/arm, she was experiencing a greater intensity of pain and the changes in color of her hand and arm were very dramatic and very frequent and she had developed a lump at the scar, at the base of her right thumb. Petitioner had then returned to Dr. Mass and Dr. Mass again took Petitioner off of work (about February 18, 2014). Petitioner then remained off work until September 7, 2014.

- Petitioner agreed Respondent sent her for an IME on two occasions with Dr. Michael Cohen; August 14, 2013 initially. Dr. Cohen did not recommend any treatment at the first examination. The second exam by Dr. Cohen was May 2014. After Petitioner stopped seeing Dr. Angelopoulos she had continued to see Dr. Mass who sent Petitioner to Dr. Anitescu at the University of Chicago (first around May 12, 2014) and the doctor recommended a regimen of Gralise, 1800 milligrams, which was to be built up gradually, and also Tramadol and a compound of topical prescription, and further therapy. Petitioner had that therapy at Athletico through about July 29, 2014. That therapy was trying to desensitize her hand as she would get hypersensitive, and they also tried to build her strength. Petitioner testified with that therapy she did not notice any significant change

with her thumb. Petitioner had returned to Dr. Anitescu August 25, 2014, just prior to returning to work. The doctor had kept her on the prior noted regimen with the medication, but not the therapy. Petitioner was not released by Dr. Mass until August 29, 2014.

- When Petitioner returned to work September 8, 2014, Respondent had her supervising the jail compound at 31st and California at the Visitor Information Center. She testified they never really made clear to her what her work activities were, other than problems that were brought to her and she did her best to resolve the problems considering she never really had training in that particular section and she indicated her time working there was a nuisance. She stated she tried to assist with answering phones and disseminating information to the public. She had to solve problems at a division visit if someone was attempting to visit a Petitioner who had an order of protection she had to find a solution. She had worked in a large desk area. Petitioner testified that she had not been allowed to carry a weapon since her injury. She had tried to fire the weapon since her injury but she could not do the amount of rounds in the time constraints required by State guidelines for firearm requalification; so she could not requalify and she was then told she was not able to carry a weapon. Petitioner was not currently working for Respondent; she stopped working October 24 or 25, 2014 when she retired.

- Petitioner did have an appointment with Dr. Anitescu January 22, 2015 and she was still on medications-(Gralise and Tramadol and Topamax daily). Petitioner stated the Gralise makes her nauseous and she gets woozy for 3-4 hours after taking it and it affects her equilibrium. Petitioner testified the medication does help with her problems but she still has pain every day and the pain does limit her activities. Petitioner stated she had lost a lot of strength in her right hand and she drops things that she thinks she has a grip on. Petitioner testified that the pain wakes her several times per night. The pain prevents her from doing a lot of the activities she did before including limiting her to requalify with her forearm. Petitioner testified that it had just generally affected a lot of her activities. Petitioner testified that she has some coldness and swelling with her hand; not as frequent or to the severity as prior to seeing Dr. Anitescu. Petitioner is right hand dominant.

- Petitioner viewed PX12 and identified it as the bills that were paid via BCBS through Respondent and she had made co-payments on bills also. Petitioner viewed PX13 and noted those as the receipts of her out of pocket payments; $682.75 to the various providers. Petitioner viewed PX14 and identified it as copies of outstanding bills from University of Chicago Hospital; $1,153.00. Petitioner viewed PX15 and identified it as a bill from Dr. Anitescu; $255.00. The bills were still outstanding as she knew. Petitioner was not working for anyone at this time.

- On cross examination, Petitioner indicated that not all surgeries had been to her thumb; the last was to her inner forearm, basilar joint reconstruction by Dr. Mass. Petitioner stated that was related to the injury she sustained May 2, 2008. The Arbitrator viewed the 3-4 inch scar up from Petitioner's right wrist and also a scar on her right hand. Petitioner agreed she had a carpal tunnel release in January or February, or March 2009 which was a separate operation with an ulnar release. She agreed it was also her right arm. Petitioner

testified that the Carpal tunnel syndrome-(CTS) and ulnar release were "emphatically 100% unrelated" to this matter. Petitioner testified that the ganglion blocks were done for the pain in her right arm/hand for the diagnosis of RSD-(reflex sympathetic dystrophy)/CRPS-(complex regional pain syndrome). Petitioner agreed she was off of work for about 6 years. One reason she was off was because she could not qualify with a weapon and also because of waiting for approval to get the procedures that Dr. Mass requested be done. Petitioner had not tried again to qualify with a weapon because she was told not to as that could cause the RSD to exacerbate so she could not qualify with a weapon. Petitioner agreed Respondent had offered her a job with the restrictions as a supervisor; she stated it seemed to comply, but it was theory versus application. She agreed she had returned to work with the restrictions at 26th and California in the supervisory position. Petitioner agreed there had been no wage difference between that and her previous position. Petitioner had worked that position from about September 9, 2014 until she retired in October (she worked the light work for about 7-8 weeks). Petitioner testified that the environment was not conducive; she agreed no one forced her to retire. Petitioner is over 60 years old and qualified to retire on her years of service (she had over 30 years of service). Petitioner agreed she had been examined by Dr. Cohen August 14, 2013 and again on May 15, 2014.

The Commission finds that the records and unrebutted testimony clearly evidences Petitioner sustained an injury to her dominant right hand, thumb. Petitioner's surgery for CTS and ulnar appear evidenced as unrelated. There is no indication of an arm injury to make a permanent partial disability-(PPD) award as a loss of use of her arm. Petitioner is, however, unable to qualify with her weapon due to her right hand injury so Petitioner was unable to return to her former position. Respondent had, however, provided Petitioner with an accommodated supervisory position and there was no wage loss as a result of that position. There is no indication that Petitioner would not have still been working in that position, but for the fact that Petitioner opted to retire, after working that duty for 7-8 weeks, as she had been working about 30 years with Respondent. As such, there appears no basis of Petitioner's argument to consider an award as a person as a whole and again, this was a hand/thumb injury. Petitioner did sustain a significant dominant hand/thumb injury that resulted in multiple surgeries and various injections and diagnosis of RSD/CRPS. Petitioner testified of an ongoing condition of ill-being that is fully supported in the record. Despite the Respondent §12 examination opinion questioning the RSD/CRPS diagnosis to the contrary, there is clearly an evidenced significant injury and significant medical treatment with a relatively poor outcome. The evidence and unrebutted testimony finds support for a higher PPD award for a significant loss of use of her right dominant hand given that she could not even qualify on her weapon to return to her former sergeant position (albeit she was accommodated in a supervisory position at no loss of wage). The evidence and testimony clearly supports a higher PPD award of 50% loss of use of her right dominant hand-(102.5 weeks), Petitioner clearly met that burden of proof here. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, modifies to increase the PPD award to 50% loss of use of Petitioner's right hand. The remainder of the decision is affirmed and adopted.

15IWCC0714

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $929.99 per week for a period of 306-4/7 weeks-(5/3/08-8/28/13 & 2/18/14-9/7/14), that being the period of temporary total incapacity for work under §8(b) of the Act. (Respondent paid $261,987.32 in TTD).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 102.5 weeks-($65,205.38 total PPD), as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 50% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,090.75 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: SEP 15 2015
d-7/16/15
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BIALEK, KATHLEEN
Employee/Petitioner

Case# **08WC038471**

COOK COUNTY SHERIFF'S DEPT
Employer/Respondent

15IWCC0714

On 2/13/2015, 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:

0320 LANNON LANNON & BARR LTD
PATRICIA LANNON KUS
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

0132 STATES ATTORNEY OF COOK COUNTY
CURTIS JAMES ASA
547 RICHARD J DALEY CTR
CHICAGO, IL 60602

15IWCC0714

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kathleen Bialek
Employee/Petitioner
v.

Case # 08 WC 38471

Consolidated cases:

Cook County Sheriff's Dept.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **12/9/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?

O. ☒ Other **Attorney's fees**

FINDINGS

On **5/2/08**, 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 $**72,538.96**; the average weekly wage was $**1,394.98**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**261,987.32** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**261,987.32**.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**929.99**/week for **306-4/7** weeks, commencing **5/3/08** through **8/28/13 and 2/18/14 through 9/7/14**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**261,987.32** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**2,090.75**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $**17,902.37** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $**636.15**/week for 51.25 weeks, because the injuries sustained caused the 25 % loss of a hand

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

15 IWCC 0114

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.

Kelli Steffen
Signature of Arbitrator

2/11/15
Date

FEB 13 2015

15IWCC0714

STATE OF ILLINOIS)
)
COUNTY OF Cook)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kathleen Bialek
Employee/Petitioner

Case # 08 WC 38471

v.

Cook County Sheriff's Dept.
Employer/Respondent

FINDINGS OF FACT

The Petitioner, Kathleen Bialek was employed as a sergeant for the Cook County Sheriff's Department on May 2, 2008. She was restraining a prisoner and injured her right thumb and left wrist. The case was previously tried under Section 19(b) of the Act on November 25, 2009. Arbitrator DeVriendt rendered a decision on December 8, 2009, finding that the Petitioner did sustain an accident that arose out of and in the course of her employment, and the Petitioner's condition of ill-being regarding the surgery she underwent for her right hand and thumb was related to the accident. He awarded temporary total disability benefits through the date of the arbitration hearing.

The Respondent filed an appeal of the Arbitrator's decision but eventually dismissed the appeal and the Arbitrator's decision became final. The findings of fact in the original decision are hereby incorporated in this decision (Px.#16).

Following the arbitration hearing in November 2009, the Petitioner continued under the care of Dr. Mass at the University of Chicago. She returned to the doctor on December 22, 2009 (Px.#1, p.14 of 33). His diagnosis was status post interphalangeal joint fusion and resection of neuroma of the right thumb. The Petitioner had previously undergone surgery on July 30, 2008, for excision of mucoid cysts/spurs. She had an additional surgery on February 17, 2009, consisting of a capsulectomy of the interphalangeal joint of the thumb and a z-plasty closure. On August 4, 2009, the Petitioner underwent a third surgery which consisted of an arthrodesis with internal fixation and bone graft and the excision of a neuroma.

Following the third surgery, Dr. Mass recommended that the Petitioner continue with physical therapy and begin a desensitization program (Px.#1). When the Petitioner returned to Dr. Mass on February 15, 2010, he gave her an injection into the MP joint due to her ongoing complaints of pain (Px.#1, p.13 of 33).

On April 5, 2010, the Petitioner returned to Dr. Mass. He noted that she had to shoot her gun to qualify and developed a bump over the MCP joint of her thumb. The doctor gave her a prescription to try and continue shooting for the next 4 to 6 weeks but to remain off work (Px.#1, p.12 of 33).

On June 17, 2010, when the Petitioner returned to Dr. Mass, he noted that she was unable to shoot fast because the pressure from the gun was located against the proximal phalanx and web space. He recommended an osteotomy of the IP fusion in order to bring her thumb straighter so she can get a good pinch against her weapon (Px.#1, p.10 of 33).

The Petitioner subsequently underwent an additional surgery at the University of Chicago on December 28, 2010. The doctor removed the deep implant and performed a phalangeal osteotomy for a mal-union of the IP fusion. The post-op diagnosis was non-union of the IP joint fusion (Px.#1, p.8-9 of 33).

Following the surgery, the Petitioner was sent back to physical therapy. She attended therapy at Southwest Hand Rehabilitation. However, she returned to Dr. Mass on March 24, 2011, and the doctor felt that the casting that was being done was not working and the fusion had not taken. He recommended a repeat fusion (Px.#1 p. 4 of 33).

The Petitioner underwent another surgery on June 14, 2011, at the University of Chicago. The doctor performed an arthrodesis for the non-union of the IP joint fusion (Px.#1, p.1-2 of 33). Following the surgery, the Petitioner returned to Dr. Mass and was given a bone stimulator which she used for several weeks (Px.#2, p.1 of 1).

The Petitioner started physical therapy at Southwest Hand Rehabilitation on September 21, 2011. She continued therapy until January 27, 2012. The treatment was discontinued since Dr. Mass recommended another surgery (Px.#6).

When the Petitioner returned to Dr. Mass on January 19, 2012, he charted that the MP joint was getting more stress and showed signs of ulnar lateral ligament laxity. He had previously given the Petitioner an injection in September 2011 but he noted that the injection had worn off. He recommended that the Petitioner undergo a lateral collateral ligament repair versus a tightening versus a reconstruction to look at the basilar joint. He felt that if there were arthritic changes then he could perform a

basilar joint arthroplasty. If there were no arthritic changes then he would perform a ligament tightening procedure (Px.#2, p.2 of 6).

The Petitioner subsequently underwent a sixth surgery on November 30, 2012, at the University of Chicago. Dr. Mass performed an arthroscopy of the basilar joint on the right and an arthroplasty with an FCR tendon transfer with an ulnar collateral ligament reconstruction. The post operative diagnosis was arthritis of the basilar joint on the right with an instability of the metacarpophalangeal joint of the thumb on the right (Px.#2, p.5-7 of 19).

Following the surgery, Dr. Mass removed the sutures, prescribed a splint, and made a custom fabricated forearm based thumb spica orthosis for the arm. He then referred her to occupational therapy (Px.#2, p.2-3 of 19).

The Petitioner returned to physical therapy, and continued to see Dr. Mass. On July 11, 2013, Dr. Mass charted that her IP joint was in slight extension which was not ideal for grip strength in regard to holding her gun. At that point, he was considering a repeat procedure to ensure flexion of the IP joint and placing the thumb in some ulnar deviation in order to improve her grip (Px.#3, p.1-2 of 22).

The Respondent scheduled an independent medical evaluation for the Petitioner with Dr. Michael Cohen on August 14, 2013. Dr. Cohen stated that the Petitioner had significant stiffness of the thumb and CMC joint. He felt that the Petitioner would be unable to fire a weapon and that she could either live with the thumb in its present condition or she could undergo another surgery to obtain more flexion (Rx. #2).

The Petitioner did not undergo the additional surgery. She was offered light duty work by the County and returned to a different job on September 8, 2013. The job was clerical in nature and consisted of filing, repetitious motion, pulling papers and stapling. The Petitioner testified that she continued to experience more pain and color changes of her hand.

She was subsequently seen for an orthotic evaluation at the University of Chicago on November 19, 2013. Dr. Mass recommended a thumb spica custom orthosis forearm IP splint for protection and to decrease pain (Px.#4, p.10-11).

The Petitioner returned to Dr. Mass on January 14, 2014. She advised the doctor that she was still having pain even though she was wearing the splint. Dr. Mass referred the Petitioner to a neurologist, Dr. Jeffrey Curtin for evaluation of muscle reflex sympathetic dystrophy (hereinafter "RSD"). Dr. Mass felt the Petitioner could continue to perform desk duty but with limited use of her right hand (Px.#5, p.2).

The Petitioner saw Dr. Curtin on January 15, 2014, and he recommended an x-ray of her right wrist and thumb. His diagnosis with osteomyelitis and RSD (Px.#7).

Dr. Curtin referred the Petitioner to Dr. Nicholas Angelopoulos, a pain specialist. The Petitioner saw Dr. Angelopoulos on February 5, 2014. The doctor diagnosed RSD of the right arm and pain in the right hand. The doctor suspected that the Petitioner had complex regional pain syndrome (hereinafter "CRPS") and recommended stellate ganglion blocks accompanied by physical therapy (Px.#8).

The Petitioner underwent a series of four blocks by Dr. Angelopoulos (Px.#8). However, the Petitioner testified that her pain did not improve. The Petitioner

returned to Dr. Mass on February 18, 2014. The doctor noted that she had been seen by a pain management physician and had undergone an injection. The doctor stated that she had developed CRPS and should continue undergoing the injections. He also took her back off work (Px.#5, p.8).

When the Petitioner returned to Dr. Mass on April 3, 2014, he charted that the Petitioner had a lack of improvement and referred her to a new pain specialist, Dr. Anitescu, at the University of Chicago. He noted that Dr. Anitescu had extensive experience with CRPS and he felt that she could get better control of her symptoms with that doctor (Px.#5, p.14).

The Petitioner saw Dr. Anitescu on May 12, 2014. The doctor diagnosed CRPS and recommended that she continue physical therapy. She prescribed Gralise and a topical cream. She also noted that the Petitioner could consider a ketamine infusion in the future.

The Petitioner was also attending therapy at Athletico. She had begun the therapy on February 7, 2014. On May 14, 2014, just after the evaluation with Dr. Anitescu, the therapist charted that the patient would benefit from continued interventions with new medications to promote functional mobility and strength. The Petitioner was still experiencing pain with range of motion, and a decrease in strength as compared to the left. The therapist stated that deficits and impairments were persisting when compared to the left hand and wrist (Px.#9).

The Respondent had the Petitioner re-evaluated by Dr. Michael Cohen on May15, 2014. Dr. Cohen felt that the Petitioner's disability was unchanged from the prior IME and that she was not able to grip a weapon due to the position of her thumb.

He felt that she had subjective symptoms. He did not feel she would be able to return to full duty work as a sheriff. Dr. Cohen recommended a triple phase bone scan. He felt that consideration of an FCE would also be appropriate (Rx. #1).

The Petitioner underwent the bone scan at Palos Community Hospital on June 9, 2014. There was no abnormal uptake in the forearms, wrists or hands (Px.#10).

Dr. Mass saw the Petitioner on June 2, 2014. He noted that she had a healed right thumb but it was in slightly poor position for shooting a gun. He also stated that the Petitioner had developed classic CRPS of the RSD type where the hand turns mottled. He felt that the CRPS was related to her original injury since it was due to the multiple surgical procedures she underwent as a result of that injury. He felt that she would be unable to work due to chronic pain and the malposition of her thumb. He also noted that she could not work at a desk because of the chronic hand pain and swelling (Px.#5, p.30).

The Petitioner returned to Dr. Anitescu on June 12, 2014. Dr. Anitescu felt that she had right hand chronic pain in the context of injury and multiple surgeries with atrophy of the thenar eminence possibly related to CRPS syndrome versus neuromuscular injury. She continued the Petitioner on Gralise but noted that the Petitioner had nausea and dizziness from the medication. She also recommended a topical ointment, prescribed Ultram, and renewed the physical therapy prescription (Px.#5, p.39-40).

The Petitioner was eventually discharged from Athletico. The therapist charted that she had attended 26 sessions and that her rehab potential was only fair.

ANALYSIS/FINDINGS

F. Is Petitioner's current condition of ill-being causally related to the injury?

The Petitioner underwent three additional surgeries following the initial 19(b) hearing. The first three surgeries were found to be causally related to the Petitioner's injury on May 2, 2008.

Dr. Mass performed additional surgery on December 28, 2010, for removal of the implant and a phalangeal osteotomy. His post operative diagnosis was malunion of the prior fusion that had been performed. Dr. Mass stated that the Petitioner needed the osteotomy to place her in a better position and refix the bone from the prior surgeries.

Dr. Mass also performed an additional surgery on June 14, 2011, consisting of an arthrodesis as a result of a prior non-union from the surgeries. He noted that the fusion had not healed properly.

The final surgery was performed on November 30, 2012, consisting of a basilar joint arthroplasty and ulnar collateral ligament reconstruction which was needed as a result of instability of the joint. Dr. Mass stated that the metacarpal phalageal joint had been injured and the fusion had increased the torque on the joints necessitating further surgery.

Petitioner's treating physicians have causally connected the need for the surgeries to the work accident. The prior 19(b) hearing opinion finds the first three surgeries to be causally connected (PX16) and the Petitioner has proven through her testimony and medical records evidence that the subsequent treatment was also causally connected. In addition to the procedures, Petitioner has testified that she also

The therapist stated that Petitioner had impairment of radio-ulnar mobility and impairment with CMC joint mobility (Px.#9).

The Petitioner returned to Dr. Anitescu on August 25, 2014. At that point, the doctor noted some improvement in pain overall although there was still ongoing pain in the right hand with numbness at times. The doctor stated that she would require Tramadol or Ultram occasionally and she should continue using the compound cream and Gralise. She noted that as long as the pain was well controlled on the current medications she would not have to follow up in the pain clinic unless the pain flared again. Her diagnosis was CRPS and neuropathic pain of the right hand (Px.#5, p.49-50).

The Petitioner subsequently underwent a functional capacity evaluation at ATI on August 28, 2014. The test was valid. The test results indicated that the Petitioner's physical capabilities were consistent with a light physical demand level. The therapist charted that a sheriff's deputy job was considered medium physical demand level (Px.#11).

The Petitioner testified that the County promoted her to a job as a supervisor in the sheriff's department. The job consisted of sitting in an office answering phones and disseminating information at 26th Street. She further testified that she is not allowed to carry a weapon and has been unable to qualify to use the weapon. The Petitioner retired from the County on October 24, 2014. She continues to take medication and continues to have problems with her right hand and arm.

developed CRPS and RSD. Dr. Mass stated that the condition was brought on by the number of surgeries the Petitioner had undergone over the years. Dr. Anitescu, a specialist in this area, has given a well-reasoned causal connection opinion linking this to Petitioner's original injury and the medical treatment resulting therefrom. Both, Dr. Curtin and Dr. Angelopoulos also confirm the diagnosis of RSD. Dr. Mass referred the Petitioner to Dr. Anitescu who is a pain specialist who noted that the medications improved her condition but did not cure her.

IME physician, Michael Cohen, evaluated the Petitioner on his evaluation on May 15, 2014. He does not concur with the evidence of CRPS or RSD on physical exam. He opined that there is no objective finding supporting Petitioner's complains and that the other opinion are based on Petitioner's subjective complaints.

The Arbitrator concludes that the Petitioner's need for the three additional surgeries as well as the diagnosis of CRPS/RSD is causally related to the injury of May 2, 2008. Arbitrator gives more weight to the opinion of Petitioner's treating physician because the opinion is also backed by findings of Dr. Curtin and Dr. Angelopoulos who confirm the diagnosis of RSD. The Arbitrator relies on the opinions of Dr. Mass and Dr. Anitescu over the opinion of Dr. Cohen regarding the CRPS/RSD diagnosis and finds that this condition is causally related to the work accident and treatment that stemmed from the accident.

J. Were the medical services that were provided to Petitioner reasonable and necessary?

The Petitioner submitted into evidence outstanding medical bills from University of Chicago Hospital in the amount of $1,153.00 and the University of Chicago Physician's

Group in the amount of $255.00 (Px.#14, 15). The medical records regarding the treatment rendered on those dates of service were placed into evidence. The Petitioner received treatment which was related to the work injury. Therefore, the Respondent is liable for those charges.

The Petitioner also submitted into evidence payments which were made by her totaling $682.75. These were payments that the Petitioner paid to University of Chicago Physician's Group and Athletico. The treatment she received was again related to the work injury. Therefore, the Respondent is liable to reimburse the Petitioner for these charges.

Finally, the Petitioner placed into evidence bills that were paid by Blue Cross Blue Shield of Illinois. The carrier paid $17,902.37 to various providers for treatment received by the Petitioner as a result of her work injury.

The Petitioner testified that her group insurance was provided by the Respondent. Therefore, the Respondent is entitled to a credit for the bills that were paid by Blue Cross Blue Shield of Illinois pursuant to Section 8(j) of the Act. However, the Respondent shall hold the Petitioner harmless from any claims by any of the providers of the services for which Respondent is receiving the credit pursuant to Section 8(j) of the Act.

L. What is the nature and extent of the injury?

The Petitioner underwent six surgical procedures involving her right hand and thumb as a result of the work injury. The Petitioner further developed CRPS/RSD due to the surgical procedures. Petitioner was unable to qualify for her weapons exam but was accommodated and promoted by the Respondent to a supervisory position.

Although Petitioner is unable to pass the exam, she was able to return to her job as a Cook County Sheriff in a supervisor capacity. There is no loss of earnings and Petitioner was eligible for earned, age-related retirement and pension and sought to voluntarily retire. Petitioner has asked for a finding under Section 8(d)2 of a person as a whole rather than a loss of use of a hand. Petitioner has argued that although she was offered and worked as a supervisor, she is still unable to perform all of the job duties as a sheriff as she is not able to carry a gun. Additionally, she would be unable to find work as a sheriff in another county or district after retirement; therefore, a 8(d)2 award is appropriate.

The Arbitrator finds that the Petitioner has suffered a 25 % loss of use of hand. The FCE report (PX11) dated August 28, 2014 indicates that the Petitioner is capable of light physical demand level work. Petitioner self-reported that her job duties required the ability to accurately file a weapon. The sheriff's job duties consists of medium level work. The Respondent offered the Petitioner a supervisory position that allowed her to perform her job duties without the weapons qualification test and within her medical limitations. Arguably and reasonably, Petitioner could have worked these duties indefinitely. The Petitioner opted to voluntarily retire from her job duties. Based on these factors, the Arbitrator finds that the Petitioner has not suffered a loss of profession and that a loss of use of a hand is the more appropriate finding. Undoubtedly, Petitioner is unable to perform the weapons qualification part of her old job duties as a sheriff's officer. Her initial injury was to her thumb and the extensive nature of the surgeries and the resulting compromise to her thumb and hand makes a case for injury to the hand. The Arbitrator finds that although the Petitioner is unable to perform one aspect of her

profession as a sheriff, she is able to and was offered work as a supervising sheriff. Therefore, there is no loss of profession. The compromise and the continued pain and limitations caused by her work injury amounts to a 25% of a hand award.

In reaching this conclusion, the Arbitrator notes that the injury is limited to the hand/arm, that Petitioner has restrictions using her right extremity to perform lifting activities, she was 54 years old at the time of her accident and 60 years old at the time of her voluntary retirement. The Arbitrator also finds that there is no loss of earnings and although there may be some loss of future earning capacity that the nature of that evidence is purely speculative and given far lesser weight. The Arbitrator does find that the Petitioner is credible and that there are the Petitioner's thumb is greatly compromised as a result of the work accident and the resulting six surgeries. Because of the extensive nature of the medical treatment and the resulting issues with CRPS and RSD the Arbitrator finds that the award for the hand, not merely the thumb, is appropriate and proper.

O. Attorney's Fees

The law firm of Cornfield & Feldman initially filed the Application for Adjustment of Claim on this case on August 29, 2008. The law firm subsequently withdrew and the firm of Lannon Lannon & Barr, Ltd., filed its Appearance on September 9, 2009.

The firm of Cornfield & Feldman filed a Fee Petition for the work it performed for the Petitioner. The firm agreed to accept $500.00 in payment of its Fee Petition. The Arbitrator finds that Lannon Lannon & Barr, Ltd., is entitled to a 20% fee and that the sum of $500.00 will be given to Cornfield & Feldman in payment of its fees per the agreement of the parties.

Arb. Kethi Steffen 2/11/18

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD MARTINEZ,

Petitioner,

vs. NO: 08 WC 6943

CITY OF CHICAGO,

15IWCC0692

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's Section 19(h) Petition. A hearing was held before Commissioner Michael J. Brennan on February 13, 2015. After reviewing the record in its entirety and being advised of the applicable law, the Commission hereby grants Petitioner's Petition and finds that Mr. Martinez established a material increase in his condition as required under Section 19(h) of the Act. The Commission finds that Petitioner is entitled to an additional 12.5% loss of use of the man-as-a-whole (MAW) pursuant to Section 8(d)(2) of the Act. The parties have advised the Commission that all issues relative to Section 8(a) of the Act have been resolved and all medical bills have been satisfied.

By way of procedural history, Mr. Martinez slipped and fell on black ice causing injury to his neck, right shoulder and wrist on February 7, 2008. Dr. Theodore Fisher of Illinois Bone and Joint performed an anterior C4-C5 and C5-C6 cervical diskectomy and fusion on April 22, 2008. Petitioner subsequently returned to work on March 2, 2010 as a full-duty construction laborer. T.7. Petitioner's duties included constructing and building scaffolding and "everything else." T.9. His job required the ability to lift up to 100 pounds, which he could not do. T.10. He could use pulleys and hoists. *Id.*

This matter was tried before Arbitrator Hagan on November 2, 2010. The Arbitrator found Petitioner sustained an injury to his neck, right shoulder, and wrist following the February

15IWCC0692

7, 2008 accident. Petitioner was awarded temporary total disability (TTD) benefits from February 8, 2008 through February 10, 2008, February 22, 2008 through January 11, 2009, January 22, 2009 through March 4, 2009, and March 31, 2009 through May 2, 2010, representing 112 -4/7 weeks, plus all unpaid medical bills. Petitioner was found to have sustained 25% loss of use of the right arm, 15% loss of use of the left hand, and 30% MAW.

The Petitioner subsequently filed an 8(a) Petition requesting the Commission to order Respondent to authorize and pay for a C3-C7 laminectomy and partial laminectomy of C2-T1. The Commission granted the Petition on June 14, 2012. The Circuit Court subsequently confirmed the Commission's Decision.

Mr. Martinez underwent an MRI of the cervical spine on July 26, 2013 at Illinois Bone Joint Institute. The MRI revealed the previous cervical fusion at C4-C6. The worse level was above the fusion at C3-C4 where there was moderate spinal stenosis and mild-to-moderate cord compression. There was cord atrophy as well as cord myelomalacia at C4-C5. PX.3.

Dr. Fisher performed a C2 through T1 laminectomy with partial laminectomy of C2 and T1 on August 20, 2013. The post operative diagnosis was cervical stenosis, cervical spondylitic myelopathy, and previous anterior cervical diskectomy and fusion. PX.3.

Dr. Fisher last examined Mr. Martinez on April 10, 2014. Petitioner reported significant improvement with work conditioning, although he was not lifting enough to return to work full-duty. Light duty was not available. His pain was 0 out of 10 at rest, but increased with heavy lifting. He walked with a normal reciprocating gait. He had no tenderness to the paraspinous muscle throughout the cervical and thoracic spine. He had 5/5 strength in the deltoids, biceps, triceps, wrist extensors, wrist flexors, finger flexors and finger abductors. The diagnosis was cervical stenosis and status post laminectomy. He was returned to work full-duty with no restrictions on May 1, 2014. PX.3. Mr. Martinez testified that he asked Dr. Fisher to release him to full duty work as he did not want to work in an accommodated position. T.21.

Mr. Martinez testified that he has continued to work full-duty since May 1, 2014 and has had no additional injuries to his neck. T.13. Petitioner testified that he has limited range of motion since the second surgery, which hinders his ability to fully perform his work duties. His motion is restricted from the left and right, and he has a hard time looking up or down. His left side is also stiff. T.11.

Because of his limitations, Petitioner testified that he has to have a co-worker help install hoists as he cannot look up or down. T.15. He can no longer operate the work golf cart as he can no longer turn around to drive the cart in reverse. He can only lift 65 pounds now whereas he could lift up to 125 pounds prior to the second surgery. T.17. Because of this, Mr. Martinez has to have other laborers lift a full capacity load. *Id.* Further, Petitioner can only work the phones during snow detail as he cannot operate the machinery. T.23.

Petitioner takes Advil or Ibuprofen daily, but does not take any prescription medication. T.18., T.22. He has no follow-up medical appointments. T.21. He also has difficulty parking his car as he cannot turn around to back his car into a parking slot. T.19.

Pursuant to Section 19(h):

> [A]s to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement or award may at any time within 30 months... after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

In *Gay v. Industrial Commission*, 178 Ill. App. 3d 129, 132 (1989), the Illinois Supreme Court explained that:

> [t]he purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657). To warrant a change in benefits, the change in a petitioner's disability must be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.) Whether there has been a material change in a petitioner's disability is an issue of fact, and the Industrial Commission's determination will not be overturned unless it is contrary to the manifest weight of the evidence. *Howard*, 89 Ill. 2d 428, 433 N.E.2d 657; *United States Steel Corp.*, 133 Ill. App. 3d 811, 478 N.E.2d 1108.

Based on the totality of the evidence, the Commission finds that Mr. Martinez established a material increase in his condition. Since the Commission's first Decision, the Petitioner underwent a C2 through T1 laminectomy with partial laminectomy of C2 and T1. While the surgery has improved his pain, it has increased Mr. Martinez's disability. Petitioner testified that he has limited range of motion since the second surgery, he cannot operate certain machinery, and he can now lift 65 pounds only whereas prior to the second surgery he could lift up to 125

15IWCC0692

pounds. Because of those limitations, Petitioner requires assistance from his co-workers to perform certain aspects of his job duties.

The Commission finds that Petitioner has suffered a material increase in his condition pursuant to Section 19(h) of the Act to the extent of an additional 12.5% loss of use of the man-as-a-whole.

IT IS THEREFORE ORDERED BY THE COMMISSION Petitioner's 19(h) Petition is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $636.15 per week for a further period of 62.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused an additional 12.5% loss of use of the man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The 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: SEP 9 - 2015

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 8-10-15
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, RICHARD
Employee/Petitioner

Case# **08WC006943**

CITY OF CHICAGO
Employer/Respondent

15IWCC0692

On 4/18/2011, 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:

2221 VRDOLYAK LAW GROUP LLC
JAMES P TOOMEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
SUSAN E WALSH
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g)
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICHARD MARTINEZ
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **08** WC **6943**

15IWCC0692

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 **Kathleen A. Hagan**, arbitrator of the Commission, in the city of **Chicago**, on **November 2, 2010**. 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. ☐ 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. ☒ 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 **February 7, 2008**, 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 $ **68,952.00**; the average weekly wage was $ **1,326.00**
- At the time of injury, the petitioner was **52** years of age, ***single*** with **no** children under 18.
- Necessary medical services ***have in part*** been provided by the respondent.
- To date, $ **97,373.40** has been paid by the respondent for TTD and/or maintenance benefits. Respondent is entitled to an 8(j) credit in the amount of $74,049.16 for medical payments paid pursuant to the Fee Schedule.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **884.00**/week for **112 4/7** weeks of temporary total disability for which compensation is payable. Respondent is entitled to credit for TTD benefits previously paid.
- The respondent shall pay the petitioner the sum of $ **636.15**/week for a further period of **244** weeks, as provided in Sections **8(d-2) and (e)** of the Act, because the injuries sustained caused **the permanent disability of the Petitioner's right arm to the extent of 25% thereof, his left hand to the extent of 15% thereof and to his body as a whole to the extent of 30% thereof**.
- The respondent shall pay the petitioner compensation that has accrued from **2/8/08** through **11/3/10**, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay for necessary medical services, as provided in Section 8(a) of the Act pursuant to the Fee Schedule.
- 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.

Signature of arbitrator
Kathleen A. Hagan

April 14, 2011
Date

APR 18 2011

Richard Martinez v. City of Chicago, 08 WC 6943

FINDINGS OF FACT

Petitioner testified that as of February 7, 2008, he was employed as a construction laborer with Respondent, City of Chicago. He testified that he is right hand dominant. On February 7, 2008, at approximately 7:20 AM, Petitioner arrived at 71st and Langley in Chicago to repair a frozen fire hydrant. He testified that there was black ice on the entire street. Petitioner slipped on the black ice, his body left the ground, and he hit his head, bilateral shoulders, and back on the ground. He testified that he could not get up from the ground, and that his arms were spasming and "flapping" uncontrollably. Petitioner testified that immediately after hitting the ground, he felt a hot "flash" from his neck down. He testified that his co-workers covered his body with jackets to keep him warm and that paramedics from the City of Chicago Ambulance arrived on site. Petitioner testified that immediately before he slipped and fell on the black ice, he never previously injured his neck, his right shoulder, or his left wrist. He also testified that he had no pain in any of the above body parts immediately before he fell on the date of accident.

Petitioner was transported by City of Chicago ambulance to St. Bernard Hospital on the date of accident. He underwent CT scans of both the head and cervical spine. Dr. Kerri Robertson noted that the CT of the head was normal, while the CT of the cervical spine revealed extensive degenerative joint disease from C4 to C7, with a minimal central bulging disc at C3-4. Pet. Ex. 1. Petitioner was discharged with a note from Dr. Athihalli Nagaraj keeping him off work until Monday, February 11, 2008.

Petitioner presented to Dr. Teresa Haskins on February 8, 2008, complaining of pain in the anterior throat and right shoulder, with some tenderness in the left shoulder. Pet. Ex. 2, p. 1. Dr. Haskins diagnosed a cervical strain and bilateral shoulder strains, right greater than left. Pet. Ex. 2, p. 1.

Petitioner returned to Dr. Haskins on February 14, 2008, complaining of a constant headache with burning pain in the right shoulder with a "prickly" sensation down the right arm, as well as spasms in the left side of the back. Pet. Ex. 1, p. 2. Dr. Haskin ordered continued use of ibuprofen, a switch from Flexeril to Norflex, and a referral to Dr. Jeffrey Kramer. Pet. Ex. 2, p. 2.

Petitioner presented to Dr. Jeffrey Kramer on February 21, 2008. Pet. Ex. 3. Dr. Kramer performed an examination and diagnosed cervical radiculopathy or stenosis, left sided L4 radiculopathy, and post traumatic syndrome. Pet. Ex. 3. He ordered MRIs to be conducted on the cervical and lumbar spine, as well as a prescription for Prednisone. Pet. Ex. 3. Petitioner followed up with Dr. Haskins on the same date, who took him off duty as of February 21, 2008. Pet. Ex. 2, p. 2.

Petitioner underwent MRIs of the cervical and lumbar spine at Preferred Open MRI on February 22, 2008. Dr. Alexander Gorodetsky reviewed both MRIs, noting multilevel spondylotic and desiccation changes of the lumbar spine, with bulges at the L4-5 level with bilateral osteophyte formation and a broad posterior central disc material and osteophyte complex with partial effacement of the ventral thecal sac. Pet. Ex. 2, p. 22. Dr. Gorodetsky noted multilevel spondylotic and desiccation changes of the cervical spine, with a protrusion/ early herniation with partial effacement of the thecal sac at C3-4, broad posterior central disc material and osteophyte complex with possible myelopathy at C4-5, broad posterior central and right paracentral disc material with osteophyte complex at C5-6, and an osteophyte complex at C6-7.

Petitioner presented to Dr. Kramer on March 11, 2008, noting improvement with the headaches. Pet. Ex. 3. Dr. Kramer reviewed the MRIs and diagnosed severe spinal stenosis at C4-5 and lumbar spondylosis at L4-S1. Pet. Ex. 3. Dr. Kramer requested a neurosurgical consultation. Pet. Ex. 3.

Petitioner presented to Dr. Theodore Fisher on March 26, 2008, complaining of neck pain, bilateral upper extremity right greater than left, as well as low back pain on the left side, and headaches. Pet. Ex. 4, p. 2. Dr. Fisher performed an examination and reviewed the MRIs of the cervical spine and diagnosed herniated nucleus pulposa at C3-4, C4-5, C5-6, and C6-7, with degenerative disc disease at these levels, and cervical spondylotic myelopathy at C4-5. Pet. Ex. 4, p. 4. Dr. Fisher recommended a C4-5 and C5-6 anterior cervical discectomy and fusion, which Petitioner wished to proceed with upon insurance approval. Pet. Ex. 4, p. 4. Dr. Fisher prescribed Celebrex. Pet. Ex. 4, p. 4. Petitioner followed up with Dr. Kramer on April 8, 2008, who agreed with the above plan. Pet. Ex. 3.

On April 22, 2008, Dr. Fisher (with assistance from Dr. Charles Slack) performed an anterior cervical discectomy and fusion at C4-5 and C5-6 at Mercy Hospital. Pet. Ex. 4, p. 6. Dr. Kramer noted large anterior osteophyte formations and used a high-speed bur to remove the osteophytes from C4 to C6. Pet. Ex. 4, p. 7. Post-surgery, Petitioner noted that the decreased sensation to his left upper extremity had resolved, and that the hypersensitivity to both forearms had resolved. Pet. Ex. 4, p. 9.

Petitioner presented to Dr. Fisher for follow-up on May 7, 2008, noting improvement with decreased sensation and numbness, but noted mild residual decreased sensation to the tips of his first three fingers of his left hand. Pet. Ex. 4, p. 14. Dr. Fisher ordered and reviewed x-rays of the cervical spine and noted no evidence of hardware failure or loosening. Pet. Ex. 4, p. 14. Dr. Fisher ordered continued use of the Philadelphia collar full-time and no lifting greater than 5 pounds. Pet. Ex. 4, p. 14.

Petitioner presented to Dr. Fisher for follow-up on June 4, 2008, reporting 100% improvement in the decreased sensation to the upper extremities. Pet. Ex. 4, p. 16. Dr. Fisher

ordered x-rays of the cervical spine and noted no hardware failure or loosening, and ordered Petitioner to wean himself from the Philadelphia brace and continue his walking exercises. Pet. Ex. 4, p. 16.

Petitioner presented to Dr. Fisher for follow-up on July 16, 2008, noting that he weaned himself from the C-collar but was hesitant to do range of motion of his neck. Pet. Ex. 4, p. 18. Dr. Fisher ordered gentle range of motion exercises of the cervical spine as well as continued walking. Pet. Ex. 4, p. 18. Dr. Fisher ordered and viewed x-rays of the cervical spine and noted bone formation in the disc space. Pet. Ex. 4, p. 18.

Petitioner presented to Dr. Fisher for follow-up on August 13, 2008. Pet. Ex. 4, p. 21. Dr. Fisher ordered Petitioner to increase his daily exercise routine and eliminated his lifting restrictions. Pet. Ex. 4, p. 21. Dr. Homer Diadula of MercyWorks kept Petitioner on a lifting restriction of 15 pounds, sedentary duty only. Pet. Ex. 2, p. 7.

Petitioner presented to Dr. Fisher for follow-up on September 24, 2008, complaining of mild posterior neck pain and recurrent occipital headaches over the past week or two, with some slurring of his speech. Pet. Ex. 4, p. 22. Dr. Fisher ordered Petitioner to follow-up with Dr. Kramer for the slurred speech complaints as well as the posterior occipital headaches. Pet. Ex. 4, p. 23. Dr. Fisher also ordered physical therapy for cervical spine range of motion, and placed him with a 20 pound lifting restriction. Pet. Ex. 4, p. 23. Petitioner presented to Dr. Kramer on September 29, 2008 who ordered physical therapy. Pet. Ex. 3.

Petitioner presented to Dr. Fisher for follow-up on October 22, 2008, noting further improvement, but still complaining of some numbness in the first three fingers of his left hand. Pet. Ex. 4, p. 28. Dr. Fisher ordered continued physical therapy with a transition into work hardening. Pet. Ex. 4, p. 28.

Petitioner underwent 14 sessions of physical therapy from September 29, 2008 through October 20, 2008. Pet. Ex. 2, p. 7-9. He underwent seven sessions of occupational therapy at Michigan Occupational Therapy from November 20, 2008 through December 2, 2008. Pet. Ex. 2, p. 10.

Petitioner presented to Dr. Fisher on December 3, 2008, reporting a lifting capacity of 50 pounds at work hardening. Pet. Ex. 4, p. 30. Dr. Fisher ordered another four weeks of work hardening and a transition back to full-duty work as of January 5, 2009. Pet. Ex. 4, p. 30-31. Dr. Fisher discharged Petitioner to return on an as needed basis. Pet. Ex. 4, p. 30.

Petitioner underwent an additional 16 sessions of work hardening from December 8, 2008 through December 31, 2008 at Michigan Occupational Therapy. Pet. Ex. 2, p. 11-12.

Petitioner presented to Dr. Diadula at MercyWorks on January 2, 2009, complaining that he hurt his right shoulder during occupational therapy two weeks earlier when his weights were

increased. Pet. Ex. 2, p. 13. Dr. Diadula placed Petitioner on restrictions of no lifting overhead greater than 27 pounds, no carrying more than 47 pounds, no pushing or pulling more than 33 pounds. Pet. Ex. 2, p. 13.

Petitioner presented to Dr. Diadula for follow-up on January 12, 2009. Pet. Ex. 2, p. 13. Dr. Diadula released Petitioner to full-duty work. Pet. Ex. 2, p. 13.

Petitioner presented to Dr. Spiros Stamelos on January 22, 2009, complaining of right shoulder pain. Pet. Ex. 5, p. 8. Dr. Stamelos noted difficulty in determining whether the right upper extremity pain was due to the shoulder or the cervical spine. Pet. Ex. 5, p. 8. Dr. Stamelos prescribed Vicodin ES, Mobic, Zantac, and Soma, and ordered MRIs of the cervical spine and right shoulder. Pet. Ex. 5, p. 9. Dr. Stamelos ordered Petitioner off work as of January 22, 2009. Pet. Ex. 5, p. 9.

Petitioner presented to Lakeshore Open MRI and CT on January 24, 2009 for MRIs of the cervical spine and right shoulder. Dr. George Kuritza noted post-surgical changes at C4 through C6 on the cervical imagining, with a subligamentous central posterior disc herniation indenting the ventral surface of the thecal sac with mild central stenosis, and a slight diffuse inhomogeneity of the spinal cord at the C4-5 level, possibly mild gliosis. Pet. Ex. 5, p. 10. With regard to the right shoulder, Dr. Kuritza noted a subtle attenuation of the distal supraspinatus portion of the rotator cuff tendon, suspect for at least a partial thickness tear. Pet. Ex. 5, p. 11. Dr. Kuritza also noted tendinitis and/or bursitis around the rotator cuff, with AC arthritic changes with mild to moderate impingement, and a small glenohumeral effusion. Pet. Ex. 5, p. 11.

Petitioner presented to Dr. Stamelos for follow-up on February 5, 2009, complaining of right shoulder pain and left wrist pain with left hand numbness. Pet. Ex. 5, p. 12. Dr. Stamelos reviewed the MRIs and diagnosed cervical syndrome with radiculopathy. Pet. Ex. 5, p. 12.

On February 17, 2009, Dr. Stamelos ordered an EMG of the upper extremities. Pet. Ex. 5, p. 13. Dr. Stamelos diagnosed a rotator cuff tear of the right shoulder, radiculitis of the cervical spine, and carpal tunnel syndrome of the left wrist. Pet. Ex. 5, p. 13. He ordered Petitioner to remain off work. Pet. Ex. 5, p. 13.

Petitioner underwent an EMG/NCV of the bilateral upper extremities on April 14, 2009 by Dr. Milena Appleby of Professional Neurological Services, Ltd. Pet. Ex. 5, p. 16-19. Dr. Appleby made a diagnosis of moderate to severe left median nerve neuropathy due to carpal tunnel syndrome. Pet. Ex. 5, p. 17.

Petitioner presented to Dr. Stamelos for follow-up on April 23, 2009, complaining of continued right shoulder and left wrist pain. Pet. Ex. 5, p. 21. Dr. Stamelos recommended a right shoulder acromioplasty and a left carpal tunnel release. Pet. Ex. 5, p. 21.

On September 24, 2009, Dr. Stamelos performed a right shoulder acromial arthroplasty, a Mumford procedure, and advancement of the deltoid bursectomy at Lakeshore Surgery Center. The post-operative diagnosis was severe impingement syndrome, buffed rotator cuff, separation and degeneration of the AC joint of the right shoulder. Pet. Ex. 5, p. 31-32.

Petitioner presented to Dr. Stamelos for his post-surgical evaluation on October 6, 2009. Pet. Ex. 5, p. 27. Dr. Stamelos dispensed Norco and ordered one week of rest prior to starting therapy. Pet. Ex. 5, p. 27. Dr. Stamelos ordered therapy for the week following his follow-up on November 5, 2009. Pet. Ex. 5, p. 39.

On November 12, 2009, Dr. Stamelos performed a left wrist carpal tunnel release at Lakeshore Surgery Center. Pet. Ex. 5, p. 40. Petitioner presented to Dr. Stamelos for his post-surgical evaluation on November 19, 2009. Pet. Ex. 5, p. 41. Dr. Stamelos provided a wrist support. Pet. Ex. 5, p. 41. On November 24, 2009, Dr. Stamelos dispensed Vicodin ES and ordered physical therapy. Pet. Ex. 5, p. 42.

Petitioner continued to follow-up with Dr. Stamelos through April 20, 2010, at which time Dr. Stamelos declared him to have reached maximum medical improvement. Pet. Ex. 5, p. 49. Dr. Stamelos ordered Petitioner to return to work full duty with a follow-up in four weeks. Pet. Ex. 5, p. 49. On April 30, 2010, Dr. Diadula of MercyWorks ordered Petitioner to take Vicodin ES only when very necessary and to return to work full duty effective May 3, 2010. Petitioner was discharged.

Petitioner underwent 63 sessions of physical therapy at United Rehab Providers from October 19, 2009 through April 28, 2010. Pet. Ex. 6.

Petitioner testified that he had not presented for medical treatment since his discharge on April 30, 2010 from MercyWorks, but that Dr. Stamelos provides refill prescriptions for his Vicodin 750 pills.

Petitioner testified that he received temporary total disability from the City while off duty. On the Request for Hearing both parties submitted prior to hearing (Arb. Ex. 1), Petitioner alleges temporary total disability from February 8, 2008 through February 10, 2008, from February 22, 2008 through January 11, 2009, from January 22, 2009 through March 4, 2009, and from March 13, 2009 through May 2, 2010. Respondent alleges that Petitioner was temporarily totally disabled from February 8, 2008 through February 10, 2008, February 22, 2008 through January 11, 2009, and from March 18, 2009 through May 2, 2010, with Respondent claiming a TTD overpayment. Resp. Ex. 2. Petitioner testified that he received both temporary total disability payments and pay for his vacation and personal days. Petitioner testified that when he was placed at fully duty by Dr. Diadula effective January 12, 2009, he returned to work from January 12, 2009 through January 14, 2009. He took vacation time from January 15, 2009 through March 4, 2009. Resp. Ex. 2. He briefly returned to work from March 5, 2009 through March 12, 2009 (1/2 days worked) and went off again effective March 13, 2009. He took

vacation and sick days from March 13, 2009 through March 17, 2009. Resp. Ex. 2. Respondent paid a total of $97,373.40 in TTD benefits. Arb. Ex. 1. Petitioner testified that he used up all his vacation and sick time. Petitioner testified that he was placed back on duty disability by Respondent effective March 18, 2009. He also testified that his vacation and sick banks were not restored.

Petitioner testified that several bills remaining outstanding for medical treatment related to his work injury on February 7, 2008. He testified that he has an outstanding bill from the City of Chicago Ambulance for a date of service of February 7, 2008 in the amount of $34.90 (Pet. Ex. 7), an outstanding bill from St. Bernard Hospital for a date of service of February 7, 2008 in the amount of $2,243.00 (Pet. Ex. 8), an outstanding bill from Foundation for Emergency Services for a date of service of February 7, 2008 in the amount of $286.00 (Pet. Ex. 9), an outstanding bill from Universal Radiology for a date of service of February 7, 2008 in the amount of $419.00 (Pet. Ex. 10), a bill from Mercy Hospital for April 22, 2008 through April 23, 2008 in the amount of $25,559.57 (Pet. Ex. 11), an outstanding bill from Dr. Kramer in the amount of $145.00 (Pet. Ex. 3), an outstanding bill from Lakeshore Open MRI for a date of service of January 24, 2009 in the amount of $3,761.22 (Pet. Ex. 12), an outstanding bill from Dr. Spiros Stamelos for various dates of service in the amount of $6,002.00 (Pet. Ex. 5), an outstanding bill from United Rehab Providers for various dates of service in the amount of $11,270.00 (Pet. Ex. 19), an outstanding bill from Western Touhy Anesthesia for dates of service of September 24, 2009 and November 12, 2009 in the amount of $1,980.00 (Pet. Ex. 15), an outstanding bill from Lakeshore Surgery Center for physicians' charges for dates of service of September 24, 2009 and November 12, 2009 in the amount of $2,009.80 (Pet. Ex. 14), an outstanding bill from Lakeshore Surgery Center for facility charges on September 24, 2009 and November 12, 2009 in the amount of $7,695.28 (Pet. Ex. 13), an outstanding bill from Professional Neurological Services Ltd. for a date of service of April 14, 2009 in the amount of $3,923.55 (Pet. Ex. 17), and out-of-pocket costs for Ibuprofen on the date of accident in the amount of $20.00 (Pet. Ex. 16). As of the trial date, Respondent had paid a total of $74,049.16 in medical bills and is entitled to a credit for all bills paid. Any unpaid amounts will be awarded pursuant to the Fee Schedule. Arb. Ex. 1.

Petitioner testified that before the accident on February 7, 2008, his neck condition was "fine." He testified that since the accident on February 7, 2008, he lacks the range of motion and takes Vicodin for the pain. Petitioner rates his neck pain at a five to a six with the use of medication. Petitioner additionally testified that he occasionally experiences migraine headaches. He denied hurting his neck since the February 7, 2008 date of accident.

Petitioner testified that before the accident on February 7, 2008, his right shoulder condition was "fine." He testified that as of the date of hearing, his right shoulder condition was fine and had no complaints. He denied injuring his right shoulder since the incident occurred while lifting at occupational therapy.

Petitioner testified that before the accident on February 7, 2008, his left wrist condition was fine. He testified that as of the date of hearing, his left wrist condition was fine and had no complaints. He denied injuring his left wrist since the February 7, 2008 date of accident.

Petitioner additionally testified that the only limitation he currently experiences in his work capacity is the limitation in turning his neck. He testified that as of the week of hearing, he was transferred to a different position within the water department, which requires less lifting than his previous position. He possesses the same job title of construction laborer and receives the same rate of pay.

Petitioner admitted that he had no follow-up appointments scheduled for his neck, right arm or left hand.

CONCLUSIONS OF LAW

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?

After hearing Petitioner's testimony, reviewing the medical records, and reviewing the pertinent medical bills, the Arbitrator rules that Petitioner received reasonable and necessary medical services for the accident sustained on February 7, 2008. However, the Arbitrator finds that Respondent has not paid all appropriate charges for the reasonable and necessary medical services. The Arbitrator therefore orders Respondent to pay Petitioner for the charges listed on the attachment to Petitioner's group Exhibit sheet per the limitations set out by Section 8.2 of the Act.

K. Is Petitioner entitled to temporary total disability? Is Respondent entitled to a credit for a temporary total disability overpayment?

After reviewing the testimony of Petitioner and reviewing the exhibits submitted, the Arbitrator finds that Petitioner was temporarily totally disabled from February 8, 2008 through February 10, 2008, from February 22, 2008 through January 11, 2009, from January 22, 2009 through March 4, 2009, and from March 13, 2009 through May 2, 2010, a period comprising 112-4/7 weeks. The dispute between the parties arises over "double-dipping" that the Petitioner received while taking vacation and personal time while Respondent believed he was able to return to work full duty from Dr. Diadula's release effective January 12, 2009. The Arbitrator initially finds that Petitioner was off work with a valid order by Dr. Stamelos effective January 22, 2009. The Arbitrator further finds that while Petitioner was not entitled to temporary total disability for the short period Petitioner worked while he was placed off duty (from March 5, 2009 through March 12, 2009) by Dr. Stamelos, the Petitioner was in fact temporarily totally disabled during the period that Dr. Stamelos took him off duty and he could use his entitlement vacation and personal days during that period. Respondent proffered no testimony disputing Petitioner's contention that none of the vacation days or sick days that he used during the period in question was replenished by Respondent. As such, at the agreed TTD rate of $884.00, Petitioner is entitled to a total amount of TTD of $99,513.14. Since the parties agreed that Respondent paid an aggregate amount of TTD of $97,373.40, the Arbitrator orders that Respondent pay Petitioner the remaining $2,139.74 that he is owed.

L. What is the nature and extent of the injury?

The Arbitrator concludes that as a result of the injuries sustained at work on 2/7/08, Petitioner has sustained permanent partial disability to the extent of 30% pursuant to Section 8(d-2). 25% loss of use of the right arm pursuant to Section 8(e) and 15% loss of use of the left hand pursuant to Section 8(e).

N. Is Respondent due any credit?

The Arbitrator concludes Respondent is entitled to TTD benefits paid. Respondent is not entitled to credit for the personal and vacation time Petitioner utilized when he was not paid TTD benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ 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

Diane Davis,
Petitioner,

vs.

15IWCC0689

NO: 10 WC 15775

Pace,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, permanent partial disability, average weekly wages, credit and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 26, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 8 - 2015
DLG/vf
O-9/3/15
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0689

DAVIS, DIANE
Employee/Petitioner

Case# **10WC015775**

PACE
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0996 WILLIAM B MEYERS LTD
NICHOLAS RUBINO ESQ
100 N KINZIE ST SUITE 325
CHICAGO, IL 60654

1505 SLAVIN & SLAVIN
NICOLE NELSON ESQ
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0689

DIANE DAVIS
Employee/Petitioner

v.

PACE
Employer/Respondent

Case # 10 WC 15775

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **February 26, 2014 and March 19, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **12/26/08**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$45,247.80**; the average weekly wage was **$870.15.**

On the date of accident, Petitioner was **57** years of age, ***Married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$16,952.34** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Petitioner is entitled to permanent partial disability payments of $522.09/week for a total of 15 weeks for a 3% loss of the man as a whole under section 8(d)2 of the Act..

Petitioner is entitled to temporary total disability benefits in the amount of $580.10/week for 18-3/7 weeks, as she was temporarily and totally disabled from December 27, 2008 through March 27, 2009 and July 8, 2009 through August 14, 2009.

Respondent is required to pay medical expenses per the medical fee schedule as set forth below and shall receive credit for all amounts paid.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

4/3/14
Date

APR 3 - 2014

BEFORE THE ILLINOIS WORKER'S COMPENSATION COMMISSION

Diane Davis, Petitioner,	)	15IWCC0689
vs.	)	No.: **10 WC 15775**
Pace, Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

In support of the Arbitrator's decision related to: **(F) Is the Petitioner's present condition of ill-being related to the injury?; (J) Were the medical services that were provided to Petitioner reasonable and necessary?; (K) Amount of compensation due for temporary total disability (L) What is the nature and extent of the injury?,** the Arbitrator finds the following facts:

Petitioner testified she has been employed by the Respondent since 1999. She testified that on December 26, 2008 her bus slide into a snow bank. Petitioner stepped of her bus to inspect the damage and slipped on the curb falling backwards and hitting the ground. She felt immediate pain in her lower back that radiated into her right leg.

An ambulance was called to the scene where Petitioner was complaining of neck and lower back pain. (Pet. Ex. 1). Later that day, Petitioner went to Alexian Brothers Corporate Health Services where she was complaining of low back and right hip pain. Dr. Sindhu Perumal diagnosed Petitioner with low back strain and placed her on modified duty. Petitioner followed up with Dr. Perumal on several occasions and was eventually prescribed physical therapy treatment. (Pet. Ex. 2)

On January 26, 2009, Petitioner initiated physical therapy treatment at Accelerated Rehabilitation Centers. Petitioner reported low back and right hip pain with radiation into her right leg. Kevin Richardson, PT recommended physical therapy three times a week for two weeks. Petitioner continued physical therapy until February 23, 2009. (Pet. Ex. 3)

Petitioner sought further treatment at the Illinois Spine Institute with Dr. Carl Graf. Petitioner described her pain as in the mid portion of her low back radiating to the right buttocks. (Pet. Ex. 5) Dr. Graf ordered an MRI and placed Petitioner on light duty.

On March 16, 2009, Petitioner presented to Westchester Diagnostic Imaging and received an MRI of her lumbar spine. The MRI revealed a left foraminal disc protrusion at L4-5 causing mild impingement of the existing left L4 nerve root and a central disc herniation with interior extrusion at L5-S1. Dr. Graf reviewed the MRI results on March 18, 2009 where he noted the MRI showed no frank disc herniation, rather disc degenerative change. (Pet. Ex. 5).

On March 27, 2009, Petitioner informed Dr. Graf that she would like to return to work. She had full strength in her lower back at this time. She was returned to work on March 28, 2009. (Pet. Ex. 5) Petitioner returned to Dr. Graf on April 15, 2014 requesting a prescription for steroids. Petitioner informed Dr. Graf that she has taken them for back pain in the past.

Petitioner continued to work full duty and did not seek additional medical treatment for almost three months. However, she returned to treatment on July 10, 2009 when she presented to Concentra complaining of back pain allegedly linked to her December 26, 2008 accident. (Pet. Ex. 7) Petitioner did not give an inciting event rather she stated she just developed low back pain radiating into her right foot. Dr. Stanley Simon

diagnosed Petitioner with lumbar pain/sprain/degeneration. He placed Petitioner back on restrictive duty.

On July 16, 2009, Petitioner received an Electroneuromyography at the request of Dr. Leonard Spishakoff. (Pet. Ex. 3) The findings were within normal limits. Petitioner initiated physical therapy again on July 20, 2009 at Accelerated Rehabilitation Centers. Petitioner informed her physical therapist that she had no lower back pain prior to December 26, 2008. (Pet. Ex. 3) Ilyse Boddy, PT recommended physical therapy three times a week for one to two weeks. Petitioner continued physical therapy until July 30, 2009. She was discharged on August 20, 2009 for lack of attendance at scheduled physical therapy visits.

On August 18, 2009, light duty work within Petitioner's restriction became available therefore, Petitioner returned to work in a light duty capacity.

Due to Petitioner's continued pain, Dr. Simon referred Petitioner to Dr. Barbara Heller at Advanced Occupational Medical Specialists. (Pet. Ex. 6) Petitioner presented to Dr. Heller on August 28, 2009 complaining of low back pain but said the radiating symptoms had resolved. Dr. Heller diagnosed Petitioner with discogenic low back pain and recommended she go back to physical therapy. Petitioner returned to physical therapy on September 2, 2009 at Accelerated Rehabilitation Centers. She was instructed to complete therapy two times a week for four weeks. Petitioner was discharged on September 23, 2009 while only putting forth moderate effort. She was given a home exercise program however her compliance was questionable. (Pet. Ex. 3)

On September 25, 2009, Petitioner returned to Dr. Heller with complaints of numbness in her legs. Dr. Heller performed an examination

and diagnosed Petitioner with resolved mechanical low back pain, placed Petitioner at MMI, and released her back to full duty. (Pet. Ex. 6) Petitioner was unclear if or when she returned to work as a bus driver for a second time at trial. However, Pace's records show Petitioner returned to full duty work on September 26, 2009 through April 7, 2010. (As agreed by the parties). Petitioner was capable of working full duty as a bus driver for almost seven months with no treatment or time off work related to her low back injury.

It was not until April 7, 2010 that Petitioner reported low back pain again. She reported to Dr. Simon at Concentra Medical Centers stating of the past 8-9 months while working full duty she developed low back pain from driving over potholes. (Pet. Ex. 7) Petitioner did not indicate any specific date of the inciting event. She made no mention of the original injury on December 26, 2008. Dr. Stanley placed Petitioner on restrictive duty and recommended physical therapy. However, at trial Petitioner testified she did not irritate her back from driving over potholes. Further, Petitioner stated she was not working the majority of those 8-9 months. At trial, Petitioner attributed her ongoing low back pain to her original accident and firmly denied aggravating her back from driving over potholes.

On May 10, 2010, Petitioner presented to MacNeal hospital for an MRI of her lumbar spine. The results of the MRI showed a small broad based disc protrusion at L5-S1 without definite nerve root impingement or spinal canal stenosis. (Pet. Ex. 4) After reviewing the MRI, Dr. Simon recommended physical therapy. Petitioner began physical therapy at MacNeal hospital on May 26, 2010.

On August 5, 2010, Petitioner was sent to an independent medical examination with Dr. Gunnar Andersson. Petitioner reported complaints of

pain in the low back and some radiation of pain into the right lower extremity. She informed Dr. Andersson that she injured her low back when she slipped and fell on December 26, 2008. (Resp. Ex. 1) Petitioner also stated on April 7, 2010 when she returned to Concentra complaining of low back pain this was not a work related aggravation. After an examination, Dr. Andersson diagnosed Petitioner with degenerative disc disease and back pain. He stated her latest aggravation "was not caused by work, but rather is from everyday activity which is very common with this kind of problem." He placed Petitioner at MMI and stated she could return to full duty work. (Resp. Ex. 1).

On September 13, 2010, Petitioner presented to Orthopedic Associates of Riverside per Dr. Spishakoff. After an examination, Dr. Scott Seymour diagnosed Petitioner with chronic back pain. He recommended Petitioner continue with nonoperative care and follow up with a lumbar specialist. (Pet. Ex. 4).

Petitioner presented to Dr. Sean Salehi at Neurological Surgery and Spine Surgery per Dr. Spishakoff's recommendation on September 30, 2010. Petitioner stated she awoke on April 6, 2010 with extreme pain in the low back shooting down her right leg. After an examination, Dr. Salehi diagnosed Petitioner with a herniated lumbar disc and lumbar degenerative disc disease. He could not find a good anatomic explanation for her leg pain. He recommended 1-2 lumbar steroid injections. If that fails, he recommended a lumbar discogram at L5-S1. (Pet. Ex. 8).

On October 15, 2010, Petitioner presented to United Pain Services. Petitioner informed Dr. Volodimir Markiv that her low back pain had been present since 2008. After an examination, Dr. Markiv recommended proceeding with the lumbar steroid injection. (Pet. Ex. 9). The first injection

was performed on October 29, 2010. Petitioner reported on follow up that the injection made her pain manageable and denied pain in the lumbar spine.

Petitioner followed-up on November 24, 2010 stating her pain was aggravated after a recent bus ride (not driving). She requested a second epidural injection which was performed on December 1, 2010. Petitioner's next date of service was November 18, 2011, almost a year later with Dr. Markiv. She received another epidural steroid injection however her pain had switched from predominately right sided to predominately left sided. (Pet. Ex. 9)

Petitioner has applied and received Social Security Disability as of December 2, 2010. She testified she can no longer move the way she used to or engage in a lot of activity.

Low Back Treatment Prior to 12/26/08

Petitioner testified that she had never received treatment to her lower back prior to her December 26, 2008 accident. Petitioner further testified that she had never taken time off work for low back pain. However, during cross examination, when shown specific dates of prior treatment, she recalls prior back pain and stretches of time off work for low back pain two week to two months at a time.

Petitioner in fact has had low back pain since 2004. On January 1, 2005, Petitioner received X-rays of her lumbar spine showing probable facet joint osteoarthritis. On April 28, 2006, Petitioner complained of low back pain and was unable to work. In December 2006, Petitioner complained of low back pain stating there is almost always some mild degree of back pain. She received an EMG from Neurological Care Associates due to her pain radiating into both of her legs on December 16,

2009. Petitioner also experienced a low back pain flare up on February 5, 2008. She was diagnosed with osteoarthritis and released back to work. (Resp. Ex. 3)

Petitioner specifically testified that from her return to work date after her April 8, 2008 accident on May 15, 2008 until her accident on December 26, 2008 that she experienced no low back pain. However, on December 9, 2008, Petitioner presented to her primary care physician, Dr. Leonard Spishakoff complaining of severe low back and hip pain. She was forced to stay in bed for two days due to her pain. Dr. Spishakoff diagnosed Petitioner with lumbar strain. (Pet. Ex. 4) She later presented on December 16, 2008, ten days prior to her December 26, 2008 accident, to Advanced Occupational Medicine Specialists complaining of low back and hip pain. She stated she awoke on December 9, 2008 with pain in her right hip and low back. She was prescribed Flexiril and returned to work. (Resp. Ex. 4)

Deposition of Dr. Andersson

The deposition of Dr. Gunnar Andersson was taken on September 27, 2013. Dr. Andersson testified consistent with his August 5, 2010 report. He stated, "I thought Petitioner had degenerative disc disease, including the two work related injuries, but also on previous occasions and on subsequent occasions in a non-work related situation." (Resp. Ex. 2, p.13). When pressed on cross-examination, Dr. Andersson stated that it is possible for Petitioner to re-aggravate her low back similarly to her first accident but she could also re-aggravate it by just walking around, bending, tying her shoes, or whatever. (Resp. Ex. 2, p. 26).

Dr. Andersson also discussed the results of her MRI and how they were degenerative in nature. He stated that a discal tear occurs when discs

age, they lose some of their mechanical strength and cracks and fissures occur in the disc substance. Dr. Andersson testified that Petitioner was capable of returning to full duty work.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (F) IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Petitioner has failed to meet her burden of proof by a preponderance of credible evidence that her current condition of ill-being is related to the December 26, 2008 incident. Petitioner has an extensive history of low back pain and treatment. Despite denying any prior low back pain, the medical records of Dr. Leonard Spishakoff and Advanced Medicine Specialists paint a different story.

Petitioner did admit on cross-examination that she has taken off anywhere from two weeks to two months at a time for her low back pain prior to December 26, 2008. As seen in Petitioner's treating records prior to December 26, 2008 she complained at various times of low back pain with radiation into her lower extremities. Dr. Andersson explained that with the Petitioner's disc degeneration flare-ups of pain are common and can be caused by everyday activities. Petitioner experienced these flare-ups frequently prior to her December 26, 2008 accident and after reaching MMI on September 26, 2009.

Further, Petitioner was experiencing low back and right hip pain just 10 days prior to the accident on December 26, 2008. She reported to Dr. Spishakoff on December 9, 2008 and Advanced Occupational on December 16, 2008 reporting waking up with extreme low back pain and

hip pain since. She informed her physicians that her pain was not work related.

Petitioner testified that her current low back pain was a continuation from her injury on December 26, 2008 however, the Arbitrator finds Petitioner to be an uncreditable witness. Petitioner testified that she had never received prior treatment for her low back or that she had taken time off work for low back pain. Only after showing specific dates and treatment records did Petitioner admit to having prior treatment. Additionally, Petitioner failed to admit on several occasions to her treating physicians that she had experienced low back pain prior to December 26, 2008.

Petitioner was capable of working full duty from September 27, 2009 until April 6, 2009 without taking any days off or receiving any medical treatment related to her low back. At trial, Petitioner denied returning to work for this period of time. Her initial medical record on April 7, 2010 showed she claimed to have low back pain after hitting a few potholes over the course of 8-9 months of driving full duty. At trial, Petitioner adamantly denied aggravating her low back injury by driving over potholes. Petitioner's story changed once again when she was examined by Petitioner's IME doctor. She informed Dr. Andersson her aggravation around April 7, 2010 was not work related. When initiating treatment with Dr. Volodimir Markiv and Dr. Scott Seymour she only informed them of the accident on December 26, 2008, not of any re-aggravation after returning to full duty. Petitioner told yet another story when initiating treatment with Dr. Sean Salehi. She informed Dr. Salehi that she just work up with extreme pain in the low back shooting down her right leg on April 6, 2010.

At most, Petitioner temporarily aggravated her pre-existing low back degenerative condition on December 26, 2008. She fully recovered from

this injury on September 26, 2009 when her treating doctor, Dr. Heller, placed her at MMI and returned her to full duty work. Any subsequent low back pain is an aggravation of her pre-existing back condition. It is very unclear how Petitioner aggravated her low back after returning to full duty as her story changed with each provider and at trial. Therefore, Petitioner has failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her December 26, 2008 incident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (J) HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR CONCLUDES AS FOLLOWS:

For the above reasons, the Arbitrator respectfully finds Petitioner has reached MMI with regards to her December 26, 2008 as of September 26, 2009. Therefore, Respondent is responsible for the payment for any reasonable and necessary medical bills related to Petitioner's low back prior to September 26, 2009 subject to the lesser of the Illinois Medical Fee Schedule or the pre-negotiated rate. However, as Petitioner has reached MMI, any medical bills after September 26, 2009 are not related to her December 26, 2008 accident. Therefore, the Arbitrator denies any and all medical bills after September 26, 2009.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

For the above reasons, the Arbitrator finds that Petitioner only suffered a temporary aggravation of her pre-existing condition. Petitioner had reached MMI as of September 26, 2009. The Arbitrator finds that Temporary Total Disability is due for the following time periods: December

27, 2008 through March 27, 2009 and July 8, 2009 through August 14, 2009. Further, Respondent will be given a credit of $16,952.34 for previously paid TTD benefits.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Petitioner at most suffered a temporary aggravation of her pre-existing low back condition. Her treating physician, Dr. Heller, placed Petitioner at MMI on September 26, 2009, less than a year after the initial accident. As stated above, any pain after September 26, 2009 is related to a new aggravation of her pre-existing degenerative condition that is not work related. Therefore, the Arbitrator finds permanency at 3% loss of the person as a whole under section 8(d)23 of the Act.